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AN ANALYTICAL UNDERSTANDING OF ADMINISTRATIVE PRACTICES
MINIMIZING VICARIOUS TRAUMATIZATION IN DOMESTIC
VIOLENCE ORGANIZATIONS IN FLORIDA

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
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ABSTRACT

Working within the field of domestic violence can result in the occurrence of vicarious traumatization. The literature supports that collegial support and supervision are effective tools organizations can implement to assist in minimizing vicarious trauma. This study, guided by constructive self development theory and feminist theory, examines whether the level of vicarious trauma is impacted by knowledge base, collegial support, and supervision.

Staff within certified shelters in the state of Florida were surveyed using a research designed instrument and the Trauma and Attachment Belief Scale. A total of 112 participants were recruited using the Tailor Design Method of surveying.

Findings indicate that uniquely none of the independent variables significantly impacted vicarious trauma symptoms. However, collectively knowledge base, collegial support and supervision did impact minimizing vicarious trauma. Further, five of the ten subscales of vicarious trauma showed a statistically significant relationship with the independent variables. Implications for domestic violence agencies, practitioners, and future research are drawn.

This dissertation is dedicated to my daughter
Rebecca Suzanne Campbell-Posner who is the light of my life and
brings me more joy than words can say.

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Completing a dissertation requires more than the mind, it also requires the support, encouragement, and strength of those around you. Therefore, I would like to acknowledge those who were most instrumental in this process.

Most of all I am especially grateful to my wife Deborah who has stood by my side and always supports my endeavors. This would not have been possible without her support. I also want to acknowledge Dr. Abel for her encouraging me to apply to this program, supporting me in my learning process and always being patient as I learn in my own way. In addition, I want to acknowledge my parents for always encouraging me to reach for the stars. And, to the participants at the domestic violence shelter who took their time and efforts to complete the surveys, thank you for participating and for doing the work you do.

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LIST OF ABBREVIATIONS/ACRONYMS

CSDT	Constructive Self Development Theory
FCADV	Florida Coalition Against Domestic Violence
NCADV	National Coalition Against Domestic Violence
TABS	Traumatic Attachment and Belief Scale
VT	Vicarious Traumatization

CHAPTER 1 INTRODUCTION

Over the past decade, social service organizations have become more cognizant of the impact that the traumatic experiences of clients have on direct care staff members. The literature indicates that direct care staff members providing therapeutic interventions regarding trauma often experience vicarious traumatization {Palm, 2004 #1; Bell, 2003 #2}. McCann & Pearlman (1990) explain the process of vicarious traumatization as, "profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized person" (p. 133). It is the intensity of vicarious traumatization and the occurrence of cognitive changes, evident by the effect on a worker's personal and professional responsibilities, which lead Saakvintine & Pearlman (1996) to warn that vicarious traumatization leads to distress within the worker.

Domestic violence workers are especially prone to the experience of vicarious trauma. As Blair & Ramones (1996) describe, "the continual exposure to the darkest aspects of the human condition can produce symptoms strikingly similar to the post-traumatic symptoms of their patients" (p.24). And, they go on to note, "this may lead to over- or underinvestment in

patients and may result in therapeutic incompetence" (p. 24). It is this potential of therapeutic incompetence, due to the experience of vicarious traumatization, that at minimal can limit the effectiveness of the staff member; and in severe cases could lead to serious concerns for safety and liability within organizations.

It is crucial for domestic violence organizations to recognize the severity and impact of vicarious traumatization on the worker and the workplace. Pearlman & Saakvintine (1995) suggest that vicarious traumatization is to be an expected outcome of trauma therapy, viewing it as an occupational hazard and explaining that it is inevitable when working in traumatic environments. Domestic violence organization workers clearly fall into the realm of this occupational hazard. It is the challenge of domestic violence organizations to create an organizational culture that enhances personal and professional development in the midst of trauma, rather than contributing to the traumatic impact via policies and procedures. Bell, Kulkarni, & Dalton (2003) note, "[a]n organizational culture that 'normalizes' the effect of working with trauma survivors can provide a supportive environment for social workers to address those effects in their own work and lives" (p. 466).

That process of normalization can be developed through organizational policies and procedures.

There is limited research specifically on how organizations' policies and procedures address vicarious trauma within their culture; however, the literature does note the workplace interventions of related phenomena of burnout, compassion fatigue, and countertransference {Anncheutz, 1999 #8; Hesse, 2002 #9; Riemer, 2001 #30}. Two primary interventions of focus are collegial support and supervision. The literature indicates that collegial support and supervision serve multiple benefits such as decreased isolation, normalization of feelings, access to vent, and education {Bell, 2003 #2; Palm, 2004 #1; Haykas, 2005 #11; Figley, 1995 #12; Pearlman, 1995 #7}. Developing interventions for minimizing vicarious trauma on an organizational level communicates to direct care staff members that the organizations' understanding of how trauma therapy impacts the individual therapist.

Organizations that develop such interventions for minimizing vicarious trauma must do so within their own context. Domestic violence organizations use of interventions including collegial support and supervision can serve as tools in minimizing the implications of vicarious trauma. Comprehension of the use of these tools can be better understood by knowing a brief history

of the domestic violence movement in which direct care staff members continues to be impacted.

Domestic Violence Movement Overview

The domestic violence movement began in the 1970's, sometimes referred to as the 'Battered Women's Movement', and redefined domestic violence as a social problem rather than a 'home matter'. Prizzey (1974) in her book, "Scream Quietly or the Neighbors will Hear", documented, for the first time, accounts of violence towards women within the homes and how society had failed battered women. Direct care service providers began to become formalized and these providers began to hear multiple stories of horrific abuse. This was the beginning of providing services to battered women and the creation of direct care providers in such services.

As the issue of domestic violence began to be more openly discussed, it became apparent that domestic violence was a rampant issue. This was evident by the 1976 Bureau of Justice report noting a staggering statistic of nearly 3,000 women murdered by intimate partners {, 1994 #31}. Although the rate of intimate partner violence has decreased substantially, there were still 28.8% or 1,455 known murders due to violence from a spouse or intimate partner reported in 2005 {, 2005 #32}.

Domestic violence began to be identified as a social issue and one that demanded attention.

In drawing attention to the issue, women began to develop services to assist victims of domestic violence. Between 1964 and 1972 grassroots organizations started to form, setting out on a mission to educate and empower women that violence was not acceptable {, 2005 #15; , 2005 #16}. Often beginning services out of someone's home, such as Women's Advocare in Minneapolis, MN, who operated out of a one-bedroom apartment, these organizations operated with minimal support {, 2005 #15}. As they increasingly educated the public, society began to respond. Over the last 35 years, these shelters have organized and expanded. In 1978 the National Coalition Against Domestic Violence (NCADV) was formed when advocates came together, and since then NCADV s grown to now represent over 2000 programs and serve as the leading expert in the domestic violence movement {, 2006 #33}. Within the state of Florida, advocates joined together in 1977 to create the Refuge Information Network, which later formed into the Florida Coalition Against Domestic Violence (FCADV){, 2005 #17}.

The Impact of Working Within the Movement

As these formal organizations emerged, it became apparent that the stories of clients who sought out services often reflected some common themes. Victims and survivors of domestic violence tell their stories of emotional, physical, and sexual abuse. Walker (1979) noted how victims and survivors often describe a duality of their abusers as a Jekyll & Hyde personality. After hearing story after story of abuse Dr. Lenore Walker (1979) published, "The Battered Woman"; perhaps the most notable book within the domestic violence movement. Here, she attempted to define and construct an understanding of a battered woman noting:

A battered woman is a woman who is repeatedly subjected to any forceful physical or psychological behavior by a man in order to coerce her to do something he wants her to do without any concern for her rights {Walker, 1979 #18}.

Defining battered women in that time was a critical step toward formalizing services and helping pull together resources.

As these battered women seek desperately to share their stories, often the direct care staff members continually strive to listen, hearing graphic detail after detail. The staff members endure many hours of hearing horrific details of brutality. Hesse (2002) illustrates this stating, "therapists who work with trauma survivors may also learn of other people's

acts of cruelty, deception, betrayal, or violation of trust towards their clients" (p. 299). Direct care providers take in this traumatic information including: graphic details of violence, a persons ability to be cruel to another, and reenactments of trauma {Saakvitne, 1996 #5}. Offering an empathic ear, direct care staff members of domestic violence shelters serve to educate and empower women who have been emotionally and physically battered, often until they no longer can identify themselves.

Geller, Madsen, & Ohrenstein (2004) note that "like primary trauma reactions, secondary trauma may disturb the worker's ability to think clearly, to modulate emotions, to feel effective, or to maintain hope" (p. 416). Effective workers must be able to withstand the emotional drain of a victim describing various details of being beaten, bruised, battered, and berated. Victims and survivors of abuse can recant stories in which they were hit, punched, kicked, dragged, stabbed, shot, isolated, degraded as a woman, physically held down, and raped, among others types of abuse {Walker, 1979 #18}. These stories are all too common. Direct care staff members within shelters empathically listen to these stories many times within each shift they work. As they hear detail after detail they must remain objective enough, stoic enough, and strong enough to

offer a gentle hug, a moment of silence, validation of a variety of feelings, and the resources and education to empower these women to survive and even thrive.

As staff gives so much of themselves to their clients, they will be challenged to also be able to fulfill their own needs to remain physically and emotionally healthy. It is well documented that trauma work can and often does take a toll on one's emotions, which in turn will impact one in a variety of ways {Pearlman, 1995 #7; Geller, 2004 #19; Palm, 2004 #1; Haykas, 2005 #11; McCann, 1999 #21}. Just as the implications for this work show in the individual, those individuals will impact the organization. As direct care providers are impacted physically and psychologically, organizations they operate within will inevitably be affected by this occupational stress. The Bureau of Labor Statistics identifies this reality of occupational stress, and explains that in many ways this stress can be more of an organizational concern than other occupational risks. The Bureau of Labor Statistics reported that:

The median absence from work for these cases [occupational stress] was 23 days, more than four times the level of all nonfatal occupational injuries and illnesses. And, more than two-fifths of the cases resulted in 31 or more lost workdays, compared to one-fifth of all injury and illness cases {, 1999 #22}.

In addition, the United States Department of Labor (2004) notes that health care and social assistance work account for 14.9% of all nonfatal workplace injuries, second only to manufacturing {, 2004 #23}. The need to understand the impact of stress within organizations is becoming more and more evident. There is an increasing amount of literature noting how emotionally demanding jobs such as social services, health care, and public service workers show high turnover, increased use of sick time, and decreased efficiency and effectiveness {Blair, 1996 #29; Palm, 2004 #1; Trippany, 2004 #25; Richardson, 2001 #20; Bell, 2003 #2; Figley, 1995 #26}.

In organizations, such as domestic violence shelters, recognition and interventions regarding the impact from the nature of the work is vital for the effectiveness of direct care staff members. Issues of burnout, counter-transference, compassion fatigue, and secondary traumatic stress have been identified within trauma work environments {Hesse, 2002 #9; Arvay, 2001 #34; Salston, 2003 #35}. The accumulation and occurrence of these issues, along with individual cognitive changes create the foundation of vicarious traumatization. It is crucial to determine organizational strategies for addressing the occurrence of vicarious traumatization and its' implications for direct care staff members within the domestic violence

movement, as well as for the organizations they are employed by and the clients they serve.

Addressing the Impact

Utilizing the previous research on implications from trauma work on direct care staff members, organizational strategies repeatedly suggested are collegial support and supervision {Figley, 1995 #12; Figley, 1995 #26; Tilley, 2003 #24; Tilley, 2003 #36; AbuAlRub, 2004 #37}. It is not determined whether these interventions are effective; nor if staff members of domestic violence organizations are even knowledgeable about the concept of vicarious trauma. The proposed study aims to specifically determine the knowledge base of domestic violence providers regarding vicarious trauma, and the effectiveness of collegial support and supervision as organizational interventions for minimizing vicarious traumatization. This study lays a foundation for understanding the relationship of collegial support and supervision to that of vicarious trauma symptoms.

Statement of the Problem

Despite its severity, vicarious traumatization may be unknown to many organizations, especially in rural areas where information disseminates at a slower pace. Inadequate information leaves individuals and organizations unaware of the extent, or worse yet the existence, of vicarious trauma. Failure to recognize vicarious trauma leads to continued personal problems within the worker {McCann, 1999 #21; Pearlman, 1995 #7; Richardson, 2001 #20}. Furthermore, concerns regarding efficiency and effectiveness will continue to arise when vicarious trauma is not addressed in meaningful ways within the organization.

The literature indicates how organizations are impacted through various examples of reduced efficiency including, but not limited to, decreased performance levels, absenteeism, tardiness, and turnover rates {AbuAlRub, 2004 #37; Salston, 2003 #35; Figley, 1995 #26; Blair, 1996 #29; Richardson, 2001 #20}. In addition, the literature provides ample evidence of the impact on effectiveness of those who work in traumatic work environments {AbuAlRub, 2004 #37; Salston, 2003 #35; Arvay, 2001 #34; Figley, 1995 #12; Hesse, 2002 #9; Neumann, 1995 #38}. Efficiency and effectiveness of organizations have substantial impact on the quality of services provided to clients, and

within the realm of domestic violence can have true human consequences.

Consequences of vicarious trauma can be determined in a variety of organizational implications. For example, Richardson (2001) suggests that one specific impact on the workers functioning is decreased level of quality, which results in increased mistakes, decreased communication, and irresponsibility. Similarly, Graesser, Gurriss, and Pross (2001) note that working with victims of trauma can place professionals at risk for symptoms such as of hopelessness, rapid fatigue, and disillusionment. Organizations, including domestic violence shelters, must be cognizant of their ethical and legal responsibility to employees and clients. Education and an implementation of individual and organizational interventions for addressing vicarious traumatization can illustrate personal and organizational awareness of this responsibility.

Effective guidelines for individuals addressing vicarious trauma range from relaxation techniques to therapy for the therapist {Pearlman, 1995 #7; Blair, 1996 #29; Figley, 1995 #12; Saakvitne, 1996 #5}. However, there are minimal sources providing workplace recommendations and guidelines for addressing vicarious trauma {Bell, 2003 #2; Richardson, 2001 #20; Sexton, 1999 #39} This lack of directives addressing

vicarious traumatization contributes to a continual negative impact on workers within domestic violence organizations.

Implications' regarding vicarious traumatization go beyond the individual worker and impacts the workplace via efficiency and effectiveness. Efficiency is impacted through elements such as stunted work progression, continual tardiness, and increased absenteeism. In addition, effectiveness is impacted by increased errors in documentation, increased staff disconnect, increased apathy, and lower productivity {Trippany, 2004 #25; Bell, 2003 #2; Figley, 1995 #12; Rudolph, 1997 #40}. An illustration of vicarious trauma can be seen in the below example.

Example of vicarious trauma within a domestic violence shelter:

Linda is a therapist who provides support groups in a domestic violence shelter. Linda's group time often involves victims of abuse sharing their experiences in graphic detail. Linda considers herself to be a strong woman and very independent. However, Linda has noticed that since she has begun working at the shelter she does not go to the mall at night by herself anymore and often will ask a friend to join her if she is going somewhere unfamiliar. Linda's supervisor has noticed that since Linda began doing direct client care, Linda has been asking for security to escort her to her car when she leaves. And recently, Linda has been stating that she is uncomfortable in the group room with clients alone and has been leaving the group room door open when she is facilitating support groups. Linda's supervisor recalls that when Linda was hired, she had stated that she was a "trusting person". Her supervisor is concerned that Linda may now be experiencing vicarious trauma which is leading to therapeutic errors. For example, leaving the group room door open can result in a breach of client confidentiality.

Addressing vicarious trauma, through knowledge of related concepts, is vital to a positive workplace.

Related concepts of burnout, compassion fatigue, counter-transference, and secondary traumatic stress have been empirically evaluated and have outlined effective workplace interventions, including collegial support and supervision {Figley, 1995 #12; Figley, 1995 #26; Geller, 2004 #19; Tilley, 2003 #24; Elman, 1997 #41; Stamm, 1995 #42}. Unfortunately, there appears to be limited empirical literature delineating organizational interventions that are effective at minimizing vicarious traumatization in the workplace. This study specifically seeks to empirically evaluate knowledge base, collegial support and supervision as organizational interventions that minimize vicarious trauma symptoms among direct care providers.

CHAPTER 2

THERORETICAL FRAMWORK

The concept of vicarious trauma was coined from the theoretical understanding of constructive self development theory (CSDT) {Pearlman, 1995 #7}. CSDT details the consequences of working in a traumatic work environment. A traumatic work environment includes the work of domestic violence organizations, which are deeply intertwined within the feminist theory, especially the use of feminist organizational theory. These theories, as the theoretical framework of this research, provides a foundation for understanding vicarious traumatization within domestic violence organizations in the state of Florida and the impact on those who work within these organizations. Further, there will be an explanation of how these theories support administrative practices of supervision and collegial support as viable strategies for positively addressing vicarious traumatization symptoms specifically within domestic violence organizations

Feminist Theory

Understanding the unique makeup of domestic violence shelters requires an understanding of their deep roots within feminist philosophies. Van Den Bergh (1997) explains how feminism is an understanding of gender reality and women's lives, noting, "to that extent, women's victimization experiences via incest, domestic violence and rape...create standpoints for the analysis of oppression based on gender" (p. xxvii). Domestic violence shelters formed with the reality that oppression is beyond societal structures, and is within the women's own homes. Although each organization may vary in structure and design, they all have a core feminist base: a base in which democratic procedures, processes, and empowerment are central themes.

This core base can be seen within the guiding principles of FCADV, which certifies domestic violence shelters within the State of Florida. Each certified domestic violence shelter agrees to principals including:

acknowledging and respecting that feminists were at the forefront and are the foundation of the battered women's movement, proactively embracing the feminist principles of social, political and economic equality, and making fundamental change through social reform by systematically eliminating all forms of oppression {, 2005 #17}.

The feminist philosophy these shelters operate within lay a foundation for the organizational culture.

Organization culture has been defined and explained on a variety of realms. For the purpose of this paper, organizational culture is defined as: "a set of shared mental assumptions that guide interpretation and action in organizations by defining appropriate behavior for various settings" {Ravasi, 2006 #44}. This broad definition essentially notes organizational culture as agreed upon set of the values and norms or "the personality of the organization" {McNamara, #45}. The culture encompasses the structure and the philosophical base in which organizations operate within. Domestic violence organizations use a variety of feminist structures, which are indicative of their shared feminist values and norms. The core of feminist organizational structures focuses on "context and design, and asserts that individual perceptions of sex roles are influenced by both place and level in the organization" {Norton, 2003 #38}.

One can identify the emphases of core feminist values in the organizational culture of feminist organizations such as domestic violence shelters by their use of collegial support and processing of supervision. For example, Chernesky (1997) discusses the difference of an administration within a feminist

culture, defining it as:

the exercise of a leadership style based on feminist values and principles that recognize, validate, and incorporate traditional feminine attributes and that use organizational structures that shift responsibility, authority, and control away from hierarchal arrangements and relationships to create workplace environments and service delivery systems that improve women's lives and empower individuals whether they are staff, volunteers, or clients (p. 74).

This style of administration is the core of the domestic violence movement, and although some organizations hold fast to these values more than others, all of them are based on these central themes.

It is not only the working of feminist administration that impacts the occurrence of vicarious trauma within domestic violence organizations, feminist practitioners often work from a different mannerism, too. Putnam & Kolb (2000) provide an illustration of feminist mannerism when referring to the act of negotiation, something that occurs in a variety of ways within the workplace. They contend that negotiation is, "rooted in feminist assumptions of connectedness, and co-construction of the process" (p. 77). And, Putnam & Kolb (2000) continue to explain that, from a feminist practitioner perspective, this process is one that focuses on getting to settlements rather than on bargaining tactics. This example of negotiation is a communication style difference seen among individual

practitioners in their relationships with co-workers and in their communication to supervisors. All of these aspects impact the organizational style of communication and the organizational culture.

In addition, a feminist lens of a closed-system management style can clarify how organizations have the ability to control their organizational culture. David Austin (1995) explains that such styles:

assume that significant elements affecting organizational effectiveness and efficiency are within the organization and are thus to various degrees, under the control of the organizational executives or others who are in position of authority (p. 1652).

Therefore, the focus is on those internal aspects, such as collegial support and supervision, which can be adjusted, modified, or changed to improve the organization. Total Quality Management theory also incorporates closed-system management style by placing an emphasis on 'collective orientation' and 'teamwork performance' {Hawkins, 1999 #50}. From such a perspective, domestic violence organizations implementing interventions of collegial support and supervision can take steps to minimize the impact of trauma work on direct care providers.

Communication style is not the only element that can be impacted internally in an organization working from a feminist

perspective. Another key element in understanding vicarious traumatization among direct care staff members is that of how support is perceived {McCann, 1990 #4; Pearlman, 1995 #27; Saakvitne, 1996 #5}. Direct care staff members who perceive a high level of collegial support and supervision have effective outlets for the emotional warfare of their mind. Bullis and Stout (2000) identify how perceived support can be important, noting that workers who believe they can go to their supervisor when unsure of a situation are more likely to be effective and correct in their assessments than those who do not. They continue to explain that providers "thrived when they negotiated relationships with their supervisors that were not overly egalitarian or overly directive" (p. 54), and determined that "adjustments were more positive when there were higher proportions of closer peer relationships and lower proportions of informal relationships" (Bullis & Stout, 2000, p. 54).

In addition, Ashcraft (2000) details how feminist organizations strive to avoid 'impersonality' by recognizing that the personal and professional are deeply intertwined and goes on to note, "feminist workplaces often serve as a social center for members...[including] institutionalized frequent self-disclosure and collective discussions of feelings" (p. 355). The ideology of equal relationships and open communication are core

concepts of feminist philosophy and within domestic violence organizations. Such organizational communication can enhance and be facilitated by collegial support and supervision.

Utilizing the feminist philosophical background of domestic violence shelters can empower organizations in minimizing symptoms of vicarious traumatization. Domestic violence is a source of disempowerment, control, and violence. Those who are courageous enough to work within domestic violence shelters, and empathic enough to hear the stories of victims, will be impacted by the continuous intake of trauma {Ilyffe, 2000 #28}. Direct care staff members, and the organizations that employ them, must be cognizant of the impact of absorbing such trauma. The reality of self-identification for direct care staff members, as well as the direct care staff member's own personal past trauma's, can impact vicarious traumatization {Ilyffe, 2000 #28; McCann, 1999 #21; Pearlman, 1995 #7; Saakvitne, 1998 #52}. It is vital that direct care staff members of domestic violence shelters employ strategies of feminist communication, develop collegial support systems, and have accessible empowerment based supervision.

Constructive Self Development Theory

Overview

As the research regarding trauma, including the work with domestic violence and the therapeutic relationship, has evolved,

there has been an abundance of documented implications of trauma work on the therapist such as burnout, counter-transference, and compassion fatigue {Figley, 1995 #26; Geller, 2004 #19; Neumann, 1995 #46; Stamm, 1995 #42; Tilley, 2003 #24}. Each of these concepts addresses a vital aspect of trauma's impact on the worker and the therapeutic relationship. A full review of these concepts can be found in a variety of sources{Blair, 1996 #29; Figley, 1995 #12; Stamm, 1995 #42}. Although there is some overlap in the concepts, none of these truly incorporate the full complexity and all-encompassing ramifications of trauma on the provider, the therapeutic relationship, and the organization (Cunningham, 2003).

Recognizing the multifaceted impact of trauma on the therapists, McCann & Pearlman (1990) coined the term 'vicarious traumatization'. Vicarious traumatization looks at the depth of the trauma, the multitude of trauma implications on the worker and the vigorous demands of the therapeutic relationship. The intricate framework of vicarious traumatization demanded a theoretical background that could grasp the complexity yet attempt to simplify the process. CSDT, devised by McCann and Pearlman (1995), responds to this need.

CSDT is a multitude of theories brought together within the realm of trauma. McCann & Pearlman (1999) explain CSDT as, "a

framework from which the individual orders and assigns meaning to a new experience". Thus, traumatic events "can be understood only within the context of the victim's unique meaning system" (p. 190). The construction of meaning is a core component of cognitive theories. Derubeis, Tang, & Beck (2001) discuss how the basic theory of cognitive therapy with a depressed person is that the client "exhibits distorted information processing, which results in a consistently negative view of him- or herself, the future, and the world" (p. 350). CSDT builds on the foundation of the individual's development. In addition, CSDT emphasizes how trauma can and does change one's schemas.

Therefore, applying CSDT, a domestic violence organization can expect that a direct care staff member who holds trust as a core concept of their being, and encounters violations of trust in their daily service delivery to clients, would be likely to show distortions in their schematic perceptions of trust in their lives. Organizational strategies of collegial support and supervision can be utilized to help identify these distortions, and normalize direct care staff members' reactions to trauma work (Saakvitine & Pearlman, 1996). This can be done through utilizing the various components of constructive self development theory in addressing vicarious traumatization.

CSDT Components

At the very core of CSDT is the key component of schemas. Welburn, Coristine, Dagg, Pontefract, & Jordan (2002) explain that "schemas are underlying cognitive structures that help to mediate and organize one's experience of the world (reality filters)" (p. 519). The concepts of schemas have been around since 1929 when first defined by Jean Piaget {, 2006 #56}. McCann & Pearlman (1999) defined schemas within the context of trauma work as:

beliefs, expectations, and assumptions about oneself, other people, and the world. Schemas are templates that individuals develop through their experiences, then use to organize information and future experiences (p. 190).

They go on to explain, "over time, these schemas come to be associated with specific emotions or feeling states" (McCann & Pearlman, 1999,p. 190). The concept of schemas is vital to understanding the cognitive impact of trauma.

Perception of ones' world, i.e. the schematic make-up of an individual, is drastically altered by trauma. Understanding this core concept of schemas facilitates an understanding of CSDT. Beck, Emery & Greenberg (2005) also offers an understanding of schemas as "the basic structural components of cognitive organization...[they] are used to label, classify, interpret, evaluate, and assign meaning to objects and events" (p. 54-55). And, they note that schemas can be broken down into subsystems

or modes, and it is the collection of subsystems that, "provides a composite picture of a specific situation" (p. 55). Utilizing this understanding of schemas, one can infer the implications of trauma work on the providers within domestic violence organizations.

Initially, direct care staff members within domestic violence organizations enter the field with defined schemas of themselves and their world. Thereafter, these staff members' schematic make-up is often negatively impacted by the consistent descriptions of violence and brutality of the clients they serve {Iliffe, 2000 #28; McCann, 1990 #4}. Nelson (2005) illustrates how direct care staff members can be impacted negatively, and how this impact is within the norm, by noting feelings of being "out-raged, horrified, shocked, and vulnerable" (p. 1). Within CSDT the changes in cognitive schemas occur with regard to specific areas referred to as one's 'experience of self'. The creation of one's 'self' is impacted by direct and indirect trauma, which in turn applies to the therapeutic relationship and the organizational outcomes as well {Bell, 2003 #2}.

The impact of continuous traumatic material on the providers' schematic make-up and 'experience of self' can be further broken down. McCann and Pearlman (1999) details' the complexity of the 'experience of self' by identifying five

central areas: frame of reference, ego resources, perceptual and memory systems, self-capacities, and central psychological needs. In addition, CSDT further elaborates the central psychological needs into six specific needs: safety, trust, independence, power, intimacy, and esteem. Iliffe & Steed (2000) illustrate various ways the direct care staff members of domestic violence organizations 'experience of self' are impacted including: loss of confidence, taking on too much responsibility, and changes in perception of respect for the clients. Environments rich in collegial support and supervision can assist to identify these changes in ones 'experience of self'.

These manifestations of trauma within the 'experience of self' are best understood by identifying the specific central psychological needs impacted by the provider displaying the behavior. An understanding of the complexity of the 'experience of self' and the central psychological needs illustrates how the occurrence of vicarious traumatization within the domestic violence organizations is something that cannot be prevented, but can be minimized and even manipulated into positive outcomes for the worker and the organizations. Taking into account how ones' 'experience of self' and their psychological needs serve

as an understanding to the background of the individual and is a beginning step in CSDT.

Identification of one's 'frame of reference' is another step. Where is this person coming from and what is his/her life understanding to this point? What schemas have already been developed? These concepts create the basis for the therapists' frame of reference. McCann and Pearlman (1990) identify the frame of reference as, "the supraordinate need within constructivist self development theory" (p. 62) and goes on to note the important aspects include: "one's frameworks for interpreting experience (or schemas), including customary ways of making sense of events (causality), orientation towards the future (hope), and usual source of reinforcement (locus of control)" (p. 62). These aspects of an individual develop the framework upon which the individual works from. As direct care staff members provide services to victims of domestic violence, these aspects will be challenged, modified, and can become distorted.

Along with the direct care staff members' frame of reference is their ego resources. Ego resources serve as "abilities that tolerate strong affect, moderate self-loathing, accept aloneness, and soothe or calm the self" {Hattendorf, 1997 #59}. Just as clients within the domestic violence services must

determine appropriate ways to assimilate and accommodate the trauma that has occurred, so too must the therapists. Hattendorf (1997) notes the need for therapists to provide role modeling and teaching of appropriate ego resources to those clients who are striving to achieve balance. Direct care staff members that are cognitively defining the trauma in negative frameworks in their own lives can be detrimental not only to themselves, but also to the clients and organizations in which they serve.

That process of defining the trauma in a negative framework is often based on the workers' perceptual and memory systems. This area of constructive self-development theory emphasizes the vital cognitive structuring that individuals do on a conscious and sub-conscious level. Saakvitne (1998) explains that:

In response to a traumatic life event, the individual must integrate the event and its context and consequences into his or her existing beliefs about self and others. The intensity of the somatic, affective, and interpersonal components of the experience determines the availability of the event for cognitive processing (p. 279).

The impact of one's memory and perceptual system can be evaluated on many levels. For the purpose of this paper, the perceptual and memory systems serve as a primary function within the context of CSDT.

Another primary function within the CSDT is that of self-capacities. Trippany, White Kress, and Wilcoxon (2004) define

self-capacities as that which "allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others" (p. 33). Four self-capacities identified by McCann and Pearlman (1990) as most influential within the realm of trauma are: 1. managing strong affects without inappropriate actions, 2. acceptance of and welcoming alone time, 3. capacity to calm oneself, and 4. accepting criticism without damaging one's sense of worth. These self-capacities are what one utilizes to develop self-esteem and identity, if influenced by trauma either directly or indirectly self-capacities hold the potential for negative implications. Therefore, these concepts of one's self-capacities must be evaluated and considered within the realm of experiencing trauma. A direct care staff member who has difficulty expressing strong affect without inappropriate actions may find his/her reaction to the horrific details of a client's abuse inappropriate, and possibly even detrimental to the clients' work towards survival. Understanding staff members' self-capacities will build the groundwork for fostering their development of one's self {Bell, 2003 #2}and therefore foster positive interactions with clients.

Often domestic violence shelters work from a 'start where the client is' philosophy {Carlson, 2006 #60}; it is critical

that these same organizations apply this when evaluating and fostering growth in their own staff members as well.

Organizations that consider workers self-capacities into their professional development can provide appropriate and effective supervision and facilitate professional growth. Etherington (2000) explains that supervision can serve as a place where providers can identify and explore disruptions in one's self-capacities.

Along with the developing of one's self, another component of the CSDT is the understanding of individuals' central psychological needs. The central psychological needs consist of five areas: safety, trust, esteem, intimacy, and control.

Central Need - Definition

Self Safety – Disruptions in cognitions of ones' safety that can lead to harming one's self or inappropriately feeling unsafe.

Other Safety – Disruptions in cognitions of others safety that can lead to harming others or inappropriately feeling others are unsafe.

Self Trust – Disruptions in cognitions of one's trust that can lead to ones inability to trust oneself such as in the area of decision making.

Other Trust – Disruptions in cognitions of trusting others that can lead to inappropriate suspiciousness.

Self Esteem – Disruptions in cognitions of self esteem that can lead to distorted view of self worth.

Other Esteem – Disruptions in cognitions of others worth that can lead to disrespect.

Self Intimacy – Disruptions in cognitions of one's intimacy that can lead to a lack of self awareness, alienation, and attachment issues.

Other Intimacy – Disruptions in cognitions of intimacy towards others that can lead to isolation and emotional avoidance.

Self Control – Disruptions in cognitions of one's ability to control emotions that can lead to anxiety or disassociation.

Other Control – Disruptions in cognitions of control in relations to others that can lead to aggression or withdrawal.

McCann and Pearlman (1990) identified these needs as most important based upon the review of how individuals are impacted

by trauma, and by utilizing the social learning theory. They went on to note that, "none of these needs is in itself more or less adaptive, nor does having a particular need reflect a problem" (p.230). And, they continue to explain that "these aspects of the self develop and are affected by trauma interdependently" (p. 23).

The complexity of an individual and their needs varies based on a variety of environmental factors. Saakvitne (1998) provides a poignant illustration of the impact on one's central psychological needs as described in this traumatic situation:

when it is unbearable to be helpless as a witness and victim of abuse, a child may come to believe, 'If I were smarter, I could have protected my mother and me from my father's beatings' and deny the belief that 'there was nothing I could have done because I was too small and helpless as a child' (p. 279).

This illustration serves to put trauma in the context of the individuals needs. However, it additionally displays the cognitive implications that CSDT addresses.

The various components of the constructivist self-development theory (See appendix A) provides a foundation through which the impact of vicarious trauma can be theoretically understood. Within the field of domestic violence, the continuous exposure to traumatic material may impact each worker in a different manner; however, as explained within CSDT,

there are underlying themes that persist. Therefore, the affect on the direct care staff members will be most dramatic in those areas most salient to the worker {Saakvitne, 1998 #62}. For instance, if a worker values trust above many other emotions, then counseling within domestic violence would most likely impact that worker through various trust issues. Saakvitne, Tennen, & Affleck (1998) note CSDT "permits us to examine relations among variables within a given individual" (p. 285). Providers within domestic violence organizations will come into the field with their own history, what CSDT proposes is that their history will play a role in determining how they will be impacted by the continuous traumatic material they absorb. Domestic violence organizations who consider the implications for how the workers cognitive processes are changed from the work they do will be better equipped to create policies and procedures that allow for staff improvement, client protection, and high service delivery.

The occurrence of vicarious traumatization within direct care staff members of domestic violence shelters can be understood and addressed using constructive self-development theory. This theory provides a theoretical base, a map, to how trauma impacts the worker. Direct care staff members who are empowered by organizational strategies of collegial support and

supervision will be provided avenues for exploring how they are personally experiencing vicarious traumatization {AbuAlRub, 2004 #37; Etherington, 2000 #61; Haykas, 2005 #11}. Utilizing the CSDT the direct care staff member also can be better prepared for 'normalizing' their experiences {Bell, 2003 #2}.

Organizations such as domestic violence shelters that understand the impact of trauma work on their workers are better equipped to develop practices that minimize vicarious traumatization and empower staff members.

Theory Conclusion

The critical issue of vicarious traumatization within domestic violence shelters can better addressed when understood within the context of constructive self development theory and the feminist philosophies. Feminist philosophies help to explain the structural operations of the domestic violence shelters as well as the difference of practitioners who work from a feminist standpoint, including but not limited to their style of communication and perception of support. CSDT serves to break down the cognitive impact of trauma to the worker into the distinct areas of schematic processes, frame of reference, ego resources, perceptual and memory systems, self-capacities, and central psychological needs. This breakdown provides a

theoretical base for the cognitive impact of trauma specifically within traumatic environments.

Understanding the implications of vicarious traumatization within the providers would begin to also explain how vicarious traumatization impacts the organizations. The feminist framework explains the need for administrative practices of collegial support and supervision as venues for minimizing symptoms of vicarious traumatization. In addition, CSDT would predict that the knowledge of vicarious traumatization and the use of appropriate strategies would minimize symptoms of vicarious traumatization. The use of these theoretical bases serves to explain and expound upon the occurrence of vicarious traumatization and its impact on the worker, their therapeutic relationship, as well as the organization within which they work. Accordingly, both of these theoretical frameworks are used to guide this study.

CHAPTER 3 LITERATURE REVIEW

There is a copious amount of literature detailing the impact of work on individuals; how people become stressed, and how that impact then has implications for the workplace and the services provided {Bell, 2003 #2; Blair, 1996 #29; Figley, 1995 #12; Pearlman, 1995 #7; Richardson, 2001 #20}. Nowhere is this concern more critical than in those areas where ones individual well-being is constantly being depleted. Within the field of domestic violence, providers can be impacted by their work on a variety of levels including: generalized stress, burnout, PTSD, counter-transference, compassion fatigue, and vicarious traumatization. Each of these concepts brings implications for organizations and their practitioners.

A brief description of these concepts as to how they relate to the phenomena of vicarious traumatization will be detailed. Utilizing these relevant concepts, pertinent literature regarding the understanding of vicarious traumatization, and the implications for organizational practices will be examined. Focus of the implications of the organizational practices will be specific to collegial support and supervision. In addition, how the concepts of efficiency and effectiveness within

organizations as impacted by the direct care staff member's symptoms of vicarious traumatization will be reviewed.

Recognizing the differences as well as the complex interrelationships of these concepts can assist domestic violence organizations in developing preventative and proactive organizational strategies for addressing practitioners' emotional well-being.

Layers Within Vicarious Trauma

Those practitioners who work as direct care staff members within domestic violence organizations consistently endure horrific stories of abuse, they open their own emotions to offer clients the support they need, and they often do so in environments of minimal fiscal support. The grass-root nature of domestic violence shelters often means the organizations are smaller, thus creating an environment of lower pay, less benefits, and fewer resources {Martin, 1990 #63}. These conditions can lead an exasperation of generalized stress from the work environment.

Aside from these issues, work is considered one of the most stressful issues individuals address on a routine basis {, 2006 #64}.

Nilsson-Weiskott (2001) notes:

the costs of unmanaged stress are extraordinarily high to individuals and organizations. An estimated one million workers are absent every day because of stress related complaints. Nearly half of all Americans suffer from symptoms of burnout, and more than 40% of job turnover is stress-related" (p. 88).

The generalized stress of work serves as one layer to the complex impact of vicarious trauma.

As an added layer to those experiencing generalized stress from the job, direct care staff members may experience burnout within their role. Imai, Nakao, Tsuchiya, Kuroda, & Katoh (2004) describes burnout as, "a syndrome characterized by extreme physical and mental fatigue and emotional exhaustion" (p. 764). And, they go on to note that burnout, "represents a problem in the working environment rather than in an internal human problem"(p. 764). Burnout produces numerous negative implications for a worker and the workplace. Elman and Dowd (1997) discuss the increased risk of burnout in those who work within social services noting:

it is not uncharacteristic for human services workers to enter the field to make life better for others and to give their own life more meaning. To the extent that an individual is committed to this idealistic value, the greater may be the risk of burnout as a result of disappointment in the results of one's efforts, due to unrealistically high standards and expectations (p. 57).

An example of burnout for providers in domestic violence shelters is evident in the report that "on average, victims of domestic violence leave their abuser seven times before staying away for good" {Berlinger, 2004 #67}. Thus these providers may be working with a victim of domestic abuse, see her return to the abusive home, and yet return to the shelter again, often worse than before. Graessner, Gurriss, & Pross (2001) assert that working with victims of trauma puts one at risk for burnout, but emphasize "the concept of burnout...does not suffice to describe the possible aftereffects of working with torture victims" (p. 202). Burnout can and does, however, serve as a contributing layer to vicarious traumatization.

Generalized stress and burnout are not the only factors in influencing vicarious trauma; another factor that influences vicarious trauma is the increased likelihood of direct care staff members uncovering personal traumas {Pearlman, 1995 #27}. Within the domestic violence field, the occurrence of Post Traumatic Stress Disorder (PTSD) is commonly discussed. PTSD is a clinical diagnosis recognized by the Diagnostic and Statistical Manual of the American Psychological Association. PTSD is the presence of traumatic symptoms because of a perceived traumatic event.

PTSD is defined as:

the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (DSM IV, 1995, p. 463).

This diagnosis is critical for those who develop various symptoms as an aftermath of a traumatic incident. The occurrence of vicarious trauma differentiates from that of PTSD in that PTSD is determined by the direct experience of a traumatic event, whereas vicarious trauma is often focused more on the secondary experience of a traumatic incident. However, a providers' personal struggle with PTSD can exasperate the experience of vicarious trauma.

Counter-transference is an additional concept that can exasperate the occurrence of vicarious trauma. By the nature of the definition, counter transference is easily differentiated from vicarious traumatization. Neumann & Gamble (1995) characterizes the counter-transference process, noting, "the relationship which develops between the client and the therapist comes to reflect the client's self-representations" (p. 342). This explanation of counter-transference describes the therapist's reaction to the client as a reflection of the

therapist's own issues. Counter-transference represents the therapist's feelings about the client coming from their experiences and issues in life. Although counter transference can be an active part of the experience of vicarious trauma, the occurrence of this reaction is only one aspect of vicarious traumatization.

Compassion fatigue, also known as secondary traumatic stress, is more difficult to differentiate from vicarious traumatization. Figley (1995a) explored the concept of secondary trauma as he noted, "scholars and clinicians require a conceptualization that accurately describes the indices of traumatic stress for both those in harms way and for those who care for them and become impaired in the process" (p. 10). Compassion fatigue describes how those who bear witness to another's trauma are impacted on a very deep emotional level. Figley (2005) noted in a telephone interview how "compassion fatigue is an integral part of the experience of vicarious trauma". Vicarious traumatization is multifaceted; unlike compassion fatigue and the other related previously noted concepts. Although these related concepts are often used interchangeably, vicarious trauma is more in dept and inclusive of experience.

The emotional level of impact is not the only way that trauma plays out on the therapist. Pearlman and MacIan (1995) explain that, "vicarious traumatization goes beyond burnout through adaptation of this information into the helpers' own life" (p. 280). The repetitive occurrence of hearing trauma stories can produce symptoms far exceeding those from one isolated incidence of trauma {Saakvitne, 1996 #5}. Vicarious traumatization refers to the impact on the workers empathy in addition to the repetitive nature of trauma therapist's work. Vicarious trauma recognizes the integral aspect of emotions and how trauma permeates through one's cognitive, emotional, spiritual, and physical well-being.

Examining Vicarious Trauma

The most notable writing on vicarious trauma is Pearlman and Mac Ian's 1995 study. This study was the first scientific review of the newly coined term vicarious trauma. The study "was designed to explore the relations among aspects of trauma therapy, aspects of the therapist, and the therapist's current psychological functioning" (p. 559). Pearlman and MacIan researched 136 self-identified trauma therapists to understand the effects of their work. They received a 32% response rate out of 780 surveys mailed out. Their study examined the

participants' work with trauma survivors in relation to the exposure of trauma material. Utilizing the Traumatic Stress Institute Belief Scale, they attempted to identify issues of safety, self-esteem, other-esteem, self-trust, other-trust, self-intimacy, and other intimacy.

Their results indicated a positive correlation between length of time providing trauma therapy and presence of vicarious trauma symptoms, as well as an inverse correlation between percentage of survivors on a caseload and symptoms of vicarious trauma. In addition, they found a relationship between vicarious trauma symptoms and the therapist's personal trauma history. Although there were limitations in the sampling procedure and a lack of clear definitions, this article served as a beginning for establishing empirical evidence of vicarious trauma and its correlates.

Another important article that contributed to the knowledge of vicarious traumatization is McCann and Pearlman's (1999) article that coined the term 'vicarious trauma'. This article differentiates various concepts of trauma. In regard to vicarious traumatization, they emphasize how the impact occurs at a different magnitude. Those who work in the field of trauma therapy continually encounter stories of horror that are often graphic, devastating, and unimaginable. However, in their jobs

they empathetically listen to these traumatic incidents on a daily basis to provide a therapeutic setting for victims to become survivors. This is not done without affecting who the therapist is, what his or her beliefs are, and how he or she interacts with the world.

McCann and Pearlman (1999) describe this impact on the therapist as vicarious traumatization. They note the phenomenon of vicarious traumatization as a process where "persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (p. 133). This article distinguishes between other similar terms that play a role in vicarious trauma. McCann and Pearlman (1999) go on to discuss CSDD, which serves as a foundation for the concept of vicarious traumatization. This theoretical article serves as a foundation for additional research on the understanding of vicarious trauma.

Understanding the implications of vicarious traumatization on the providers and the organizations is further elaborated on by Trippany, White-Kress, & Wilcoxon (2004). They detail what direct care staff members need to know about vicarious traumatization as well as other related concepts. They explored the implications of vicarious traumatization of vital aspects of

the direct care staff members functioning including needs of safety, trust, esteem, intimacy, and control. Trippany White-Kress, & Wilcoxon (2004) note personal impact of the provider and organizational concerns such as compromised ethical and therapeutic boundaries. They recommend peer supervision, opportunities for supervision, consultation, and staffing as measures for preventing vicarious traumatization. Although they have noted these recommendations for preventing vicarious traumatization they do indicate any specific scientific validation for use of these strategies.

Utilizing a personal vignette, Hesse (2002) outlines the case for organizational responsibility in addressing vicarious traumatization. Exploring her own experience of vicarious traumatization, she then utilized that vignette to expound on how vicarious traumatization manifests within the therapist and the clients they serve. Hesse (2002) notes:

trauma therapists who work in organizations and are affected by secondary trauma should not be alone in the areas of coping and prevention. In addition to having understanding and supportive supervisors, agencies that deal of issues of trauma need administrators who not only recognize and accept that secondary trauma exists among their workers, but that there are steps that can be taken by the organization to help prevent it (p. 305).

As a personal vignette it has limited scientific value and cannot be utilized on a broader base. However, it is a beginning

in understanding the implications and ability of organizations to assist in minimizing vicarious traumatization through practices such as collegial support and supervision.

Collegial Support

Organizational use of collegial support is one meaningful way that vicarious traumatization can be addressed. Crothers (1995) discusses therapists' views of how vicarious trauma affects them within the work setting giving special attention to asking how participants felt their type of work affected them within the work setting. Various answers were discussed, including difficulty in performing the job, sense of helplessness, and a hyper-awareness of their surroundings. Crothers (1995) goes on to explain how length of time working in the trauma therapy field can impact the level of vicarious trauma experienced. In addition, staff was asked what they saw to be helpful in preventing trauma. Crothers (1995) summarizes that it is important to have adequate support systems in the work environment through colleagues and supervisors. And, concludes that fostering team support can be an asset in the prevention of trauma symptoms. This study is important for laying a foundation for understanding the impact on an

organizational level, but lacks the empirical evaluation that is necessary.

Another article emphasizing the importance of collegial support as an important factor suspected to minimize vicarious trauma is written by Bell, Kulkarni, & Dalton (2003). They discuss the importance of collegial support noting, "time for social interaction between coworkers such as celebrating birthdays or other events as well as organized team building activities and staff retreats, can increase workers' feelings of group cohesion and mutual support" (p. 467). They further explain how using group support "can often clarify colleagues' insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of the social worker" (Bell, et al, 2003, p. 467). This article supports the need for organizations to utilize collegial support as an administrative practice for minimizing vicarious traumatization symptoms among staff; however, additional lacks empirical support.

One study that does provide empirical support from a related concept is written by Elman and Dowd (1997). These authors discuss how higher rates of burnout can be alleviated by use of "informal work group relationships" (p. 57). Their study sample comprised of seventy-nine random therapists from twelve

different facilities to evaluate burnout. Specifically they were hypothesizing, among other items, that the "degree of social support will correlate negatively with degree of burnout" (p. 58). A multiple correlation analysis indicated support for their hypothesis. The data indicated that as social supports increased the level of burnout decreased. Thus, suggesting that collegial support has a vital role to play within organizations. Since burnout is a component of vicarious trauma it might be inferred that such supports would also assist in minimizing vicarious trauma symptoms, especially among high trauma situations such as domestic violence shelters.

Collegial support has also been empirically substantial in addressing job related stress. AbuAlRub (2004) evaluated a correlation between job stress and social supports among hospital nurses. Surveying 303 nurses via a web-based questionnaire, perceived social support was evaluated against job stress. Utilizing a hierarchal regression, AbuAlRub (2004) noted, "analysis showed that the background variables, job stress, social support from co-workers, and the interaction between job stress and social support explained 20% of the variation in job performance" (p. 77). Although this study is limited by the use of a convenience sample, it does serve to begin empirical validate of the importance of collegial support.

Boscarino, Figley & Adams (2004) report an additional study that indicates an empirical base for collegial support in minimizing vicarious trauma among direct care staff members, such as those within a domestic violence shelter. They sought to investigate the occurrence of compassion fatigue in social workers after the September 11th attacks. Surveying 236 respondents regarding compassion fatigue, supportive work environment and job burnout Boscarino, Figley & Adams (2004) noted that supportive work environment showed to be important to both compassion fatigue and job burnout, whereas secondary trauma only showed to be significant within compassion fatigue. This study serves as an empirical evaluation of a supportive work environment being a key measure for addressing compassion fatigue and job burnout.

Collegial support can be understood in a variety of manners. For the purposes of this paper, conceptualization of collegial support is based on Yassens' (1995) explanation where "one has the opportunity to receive from and give support to colleagues who are involved in similar work tasks" (p. 194). Collegial support can be formal or informal; however, this paper is specifically focused on formal structures of collegial support that are currently in place by administration of domestic violence shelters.

Supervision

The literature indicates that, in addition to collegial support, supervision is vital to addressing vicarious trauma. Steed and Downing (1998) addressed, among other aspects, the role of supervision in regards to vicarious trauma within the field of sexual abuse/assault. After discussing the definition and understanding of vicarious trauma, they briefly mentioned their methodology. This lack of specifics within their methodology was a major limitation of this study. However, they noted their participants of 12 therapists completed a semi-structured interview. Of this study, Steed and Downing (1998) concluded that there were specific dominant emotional reactions of trauma work, and that staff noted being impacted by their workload levels. They stressed the importance of debriefing, professional development, and supervision.

In relation to job stress and burnout, Haykas (2005) finds clinical supervision to be empirically significant. Utilizing a random sample and standardized testing, Haykas (2005) reports that clinical supervision showed to be beneficial in lowering job stress and burnout for nurses working in psychiatric and mental health settings. Although this study was conducted in Finland, and the results could be culturally impacted, the tools utilized have been utilized within the states. This study's

emphasis on the role of clinical supervision as a tool in assisting direct care staff is in line with other literature.

For example, Bell, Kalkarni & Dalton (2003) detail supervision as vital within the role of minimizing vicarious trauma as they note "responsible supervision creates a relationship in which the social worker feels safe in expressing fears, concerns, and inadequacies" (p.466). They outline how aspects within the organizations control, including the organizational culture, provision of supervision, and work environment can all minimize the occurrence of vicarious traumatization. Etherington (2000) also emphasizes the role of supervision and goes on to note that supervision can serve as a source of healing, thus minimizing vicarious trauma. Expounding on previous literature, Ertherington (2000) notes:

when counsellors are burdened by their client's re-enactments and feel enmeshed in the complexity of the therapeutic relationship we [supervisors] can help them untangle and ground themselves again by increasing understanding and reframing these experiences as positive communications from the client that can lead to therapeutic change" (p.387).

In addition, Bell, et al (2003) note the role of supervisors to provide emotional support, education, and supportive nurturing. Describing the importance of supervision in minimizing vicarious traumatization symptoms, Bell, et al (2003) explain "if at all possible, supervision and evaluation should be separate

functions in an organization because a concern about evaluation might make a worker reluctant to bring up issues in his or her work with clients" (p. 8). The need to separate supervision from evaluation within the context of a trauma work environment is important. Bell, et al emphasized the need for supervision to be defined incorporating the work environment, the impact of such an environment, and the worker themselves.

The role of supervision can be defined and understood in a variety of manners. Pearlman & Saakvitne (1995) offer one option for understanding supervision within the trauma work environment as they briefly define trauma-related supervision. This form of supervision is explained as the supervisory process where there is an intentional focus on the trauma work that is a daily part of the job. However, this paper uses the conceptualization of the term 'supervision' according to Figley's (1995) notation of supervision as the process where one is provided "the opportunity to have someone listen solely to us, as we have had to do with our clients" (p. 194). Thus, for the purpose of this study, supervision is defined as any formal process where providers have that opportunity.

Impact on Efficiency and Effectiveness

The concepts of collegial support and supervision stand out as possible effective means of addressing the impact of work on the worker. Summarizing the previous literature, it is suggested that organizations can maximize efficiency and effectiveness of organizations by implementing organizational strategies for minimizing symptoms of vicarious traumatization among direct care providers. The impact on the personal and professional lives of staff members will impact the organization. This can be evaluated on a variety of levels including efficiency and effectiveness.

Rudolph, Stamm, & Stamm (1997) specifically looked at the efficiency and effectiveness of administrative interventions impacting symptoms of compassion fatigue within 179 participants of a public health nurse convention. They note, "the health of an organization depends upon the health of it's staff" and go on to detail that organizations rely on provider's "accurate perception, sound judgment, and decision making" (p. 2).

Rudolph, Stamm, & Stamm's (1997) concluded that "administrators and policy makers need to make policies that account for the organizational and financial goals of the institution without compromising the well being of providers" (p. 3).

They are not alone in clarifying how vicarious traumatization symptoms can impact the effectiveness and efficiency of the worker. Trippany, R.L., White Kress, V.E., & Wilcoxon S.A. (2004) reported "the potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases" (p. 34). They go on to explain "the disruptions in cognitive schemas may lead to counselors compromising therapeutic boundaries" (p. 34). These manners in which providers are impacted are examples of how organizations without strategies for addressing vicarious traumatization can be impacted.

Annscheutz (1999) notes implications for professional function for those impacted by secondary traumatic stress to include the decrease in quality and quantity of work produced. In addition, the negative impact was detailed to not only influence job performance aspects but also to impact morale, interpersonal, and behavioral issues including, but not limited to, poor communication, staff conflicts, absenteeism, and dissatisfaction {Annscheutz, 1999 #8}. All of these aspects are critical in the ability of direct care staff members to function.

The implications on efficiency and effectiveness for direct care staff members within domestic violence shelters are also

challenged by some particulars of the work they do. Iliffe & Steed (2000) note specific challenging aspects of domestic violence work includes: the critical need and complexity of confidentiality, necessary changes due to safety needs of the clients, concern and fear for clients, and personal feelings of isolation and powerlessness. Each of these challenges can have implications on the direct care staff members' ability to be effective and efficient within their work.

Although these studies are vital to the understanding of vicarious traumatization, there appears to be minimal empirical evidence as to what direct administrative practices are best at minimizing the occurrence of vicarious trauma. The literature shows a clear definition of vicarious trauma and the specific manner of impact. While there is some exploratory research on how vicarious trauma impacts the workplace and what practices are believed to be effective, there remains is a paucity of empirical data specifically indicating what administrative practices organizations should utilize to minimize vicarious trauma.

Study Purpose & Hypotheses

The purpose of this study is to (1) examine whether the knowledge base of vicarious traumatization among those who work

in domestic violence organizations impacts the level of vicarious trauma reported and (2) to identify whether the level of vicarious trauma for those who work within domestic violence organizations is impacted by the administrative strategies of collegial support and supervision.

The following research questions are posed:

1. Are any of the possible predictor variables of knowledge about vicarious trauma, perception of collegial support and perception of administrative supervision, either uniquely or as a linear composite, significantly correlated to the report of the experience of vicarious trauma?
2. If so, what are the relative contributions?
3. Are any of the possible predictor variables of knowledge about vicarious trauma, perception of collegial support and perception of administrative supervision, either uniquely or as a linear composite, significantly correlated to any of the ten subscales of vicarious trauma?
4. If so, what are the relative contributions?
5. Is there a difference in the scores for the experience of vicarious trauma between those participants who provide direct care to clients and

those participants who do not provide direct care but rather provide administrative supervision to the direct care providers?

From these questions, three corresponding hypotheses are generated. These hypotheses are stated in the null form since no speculation is made regarding the predictive value of the variables. Hypotheses are stated as:

Ha₁: There will be a significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and the report of vicarious trauma symptoms of the shelters' direct care and administrative staff. This hypothesis identifies three independent variables that will be considered as possible predictors of the outcome variable of the report of vicarious trauma symptoms.

Ha₂: There will be a significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and any of the ten subscales of vicarious trauma symptoms, as measured by the Trauma and Attachment Belief Scale (TABS), reported by direct care and/or administrative staff. The ten

subscales of the TABS instrument include: self safety, other safety, self trust, other trust, self esteem, other esteem, self intimacy, other intimacy, self control and other control. This hypothesis identifies three independent variables that will be considered as possible predictors of the outcome variable of the report of each vicarious trauma subscale. To examine these relationships, multiple regression analyses will be conducted.

Ha₃: There will be a significant difference in the scores for vicarious trauma symptoms between those participants that provide direct care to clients and those participants that supervise the direct care providers. This hypothesis identifies one dependent variable that will be measured and compared in two groups. The data will be analyzed by means of an independent samples t-test to evaluate the difference in the means for the two groups.

CHAPTER 4

METHODOLOGY

This cross-sectional, explanatory study tests the predictive relationship between the independent variables of knowledge of vicarious traumatization, perception of collegial support, and perception of supervision provided and the dependent variable of experiencing vicarious trauma symptoms among employees of domestic violence shelters. Additionally, the variable of experiencing vicarious trauma symptoms was compared between two groups, those participants whose job function is to provide direct care to clients and those participants whose job function is to provide administrative support.

Preliminary Work

Prior to the onset of the full study a pilot study was conducted so that any needed changes could be made accordingly. Results of the pilot study can be reviewed in the Findings section.

Full Study

Setting

Data were collected from those individuals employed by a domestic violence center. There are 41 domestic violence centers in the State of Florida that are certified through the Florida

Coalition Against Domestic Violence (FCADV). In addition to basic guidelines and structural requirements, FCADV requires each of the certified shelters to work under a core philosophical belief system. This core belief system includes the premises that each shelter will "proactively embrace the feminist principles of social, political and economic equality, empower battered women, confront power and control issues in ourselves, our society, our organizations, and in the way we do business" {, 2005 #17}.

Sample

This study was limited to staff employed by a certified domestic violence shelter and whose primary roles consist of working within the shelter rather than other areas of the organizational structure (i.e. outreach, courthouse). Each organization size varies with some being extremely small while others operating numerous shelters. In order to make it possible for each shelter to participate, this study sought to recruit a minimum of three direct care staff members and one administrator from each of the domestic violence organizations. This study recruited a total of 112 participants in all ($n = 112$). The demographic instrument asked questions that were used to screen for the inclusion/exclusion criteria.

The sample consists of those shelter employees that report functioning in the capacity of direct-care provider and administrators who supervise direct-care staff. There is no limitation to whether they are employed on a full-time basis or minimum time working within the facility. Excluded were those shelter employees that have no direct care relationship with the clients and those that do not supervise those staff members who provide the direct care.

Sampling Procedure

A convenience sample was recruited from each of the shelters whose administrator gave permission for data collection to take place in the facility. In order to determine an adequate sample size for the number of variables and the appropriate statistical techniques to analyze the data, a priori estimation of sample size was made based on a review of previous studies, anticipated participation rate, and a power analysis.

Findings from Previous Studies

Determining the level of appropriate sample size as determined by the anticipated response rate was difficult due to the inability to determine the exact population size of the study and the lack of consensus on what constitutes an

appropriate response rate. Although it is known that there are a total of 41 shelters, the total number of staff members in each shelter varied, with some organizations having shelters that are very small in size and others operating more than one shelter. It was anticipated that all shelters could provide a minimum of three direct care staff and one administrator.

Therefore, to best determine an appropriate sample size, use of previous similar research was evaluated. Rudolph, Stamm, and Stamm (1997) evaluated compassion fatigue via a mail survey and received a 59% response rate. In looking at the influence of supervision on burnout Burnard et al (2003) reported a 32% response rate on their mail surveys. And, an evaluation of vicarious trauma among therapists by Way et al (2004) reported a 33% response rate in their mail surveys. Looking specifically at studies which utilized the Trauma and Attachment Belief Scale in a mail survey VanDeusen and Way (2006) noted a 33% response rate.

Anticipating the higher of the obtained response rate noted from the previous research on vicarious trauma or related concepts utilizing mail surveys, this study operated on the assumption that a 59% response rate would be the expected participation rate; therefore this study sought to recruit a minimum of 96 participants.

Power Analysis

This study poses three research hypotheses. Hypothesis 1 considers four variables, three independent variables and one outcome variable. This hypothesis was analyzed for relationships by the statistical test of multiple regression. Hypothesis 2 considers the three independent variables and the ten subscales of the dependent variable. This hypothesis was also analyzed for relationships by the statistical tests of multiple regression. Hypothesis 3 compares two independent groups on the one variable of experiencing vicarious trauma symptoms.

Power analysis considered the means to control for both Type I (*a*) and Type II (*b*) errors, power, effect size, and type and tailedness of the statistical tests. In order to control for the probability of making a Type I error, the level of significance is set at $\alpha = .05$. Type II (*b*) error rate was set at four times the Type I error rate, .20. Effect size was arbitrarily set as medium ($ES = .15$). To achieve an alpha of .05 (two-tailed tests) with a power of .80, a sample size of 84 participants was required to detect a medium effect {Cohen, 1992 #77; Buchner, 2001 #78}.

Protection of Human Subjects

Efforts were made to conform to the ethical and legal principles related to the protection of human subjects. All policies for protection of human subjects mandated by the University of Central Florida Institutional Review Board (IRB) (See appendix B), the administrative requirements of the agencies where the study was conducted, and U.S. Federal Guidelines for conducting research with human subjects (U.S. Department of Health and Human Services [DHHS], 2001) were followed.

Informed consent was explained in the form of a letter that included with each survey packet. This letter explained the purpose of the study, the anticipated benefits and risks of participation. A contact number was provided if any such adverse effect should occur. Moreover, the letter explained that participation was voluntary and the person was able to decline participation with no adverse effect to their employment. Surveys were mailed back to the primary investigator with no identifying data.

Procedures were used to assure the protection of the participants from any attempted coercion or unethical influence on the part of the researcher. Only the researcher has access to

the raw data and results are reported in aggregate form. Participants were informed that they may withdraw from the study at any time with no adverse consequences. However, as no identifiers will connect responses to the individual, once data is collected there will be no way to identify their surveys or remove their responses from the data.

All instruments are maintained in locked file cabinet in the researcher's office for five years. At the end of this five-year period all surveys and data files will be destroyed. Instruments will be shredded and data files will be erased from the computer.

There are no known risks related to participation in this study. There are no direct benefits to the participants. However, it was explained that the knowledge gained from this study would be used to identify and better meet the needs of those who work within the field of domestic violence and especially those who create policies and procedures within the shelters serving victims of domestic violence. Other benefits to the participants included: having the opportunity to actively participate in a research study, and making a contribution to science and knowledge related to vicarious trauma and the impact of working within the field of domestic violence.

Procedure and Recruitment

Following approval from the University of Central Florida's Institutional Review Board (IRB) and the participating agencies' administrative authorization, data collection commenced. Procedures followed those outlined by Dillman (2000), the Tailored Design method.

Contact information for certificated shelters was obtained FCADV. Between June 2007 and July 2007, shelter administrators were contacted via telephone by the researcher. The study was described and participation was requested. Shelters that agreed to participate provided the name and contact information of an administrator that would serve as liaison. Liaison's received an introduction letter (See Appendix C) that detailed the duties including receiving the research packets, distributing and collecting the completed instruments, and returning them to the researcher via mail.

Each facility received at least four research packets. The contact liaison was instructed to distribute one set to an administrator and one packet each to three direct-care staff.

The next step occurred one week after distribution of the survey packets. At this time, the contact person received a

followed up call to address any questions and to encourage participation. Four weeks from delivery date, step three was an additional follow-up call to each non-responding shelter's contact encouraging completion of the surveys. Within the sixth week after initial delivery of the surveys, the final step was that each shelter was contacted via telephone and thanked for their participation or encouraged final participation. Upon receipt of all survey packets, or upon the eighth week from original mail-out date, data collection was terminated and data was commenced.

Instrumentation

Participants were asked to complete a survey instrument. The first survey questionnaire asked questions regarding demographic information used to describe the sample and screen for inclusion/exclusion criteria. Additional items on this questionnaire measures aspects of the role that have been associated with the experience of vicarious trauma symptoms including length of time working within the field, employee age, and educational level.

Participants were asked to complete a section of items designed to measure their knowledge of vicarious trauma as well as their perception of the administrative practices of collegial

support and supervision employed by the facility (See appendix D). Lastly, survey participants were asked to complete the Trauma and Attachment Belief Scale.

Measurement of the Independent Variables

Knowledge of vicarious trauma, perception of collegial support, and perception of supervision are measured by means of researcher-developed instruments (Appendix D). Items operationalizing the perception of collegial support and the perception of supervision were identified utilizing the literature on vicarious trauma and secondary traumatic stress {Richardson, 2001 #20; Saakvitne, 1996 #5}. Questions were formed based upon the on-going needs that have been identified by Richardson (2001) as "provide supervision that supports recognition of vicarious trauma," (p. 76) "provide self-care days," (p. 74) "develop definitions of peer consultation," (p. 85) and "making time to address vicarious trauma...both symbolically and pragmatically" (Saakvitine & Pearlman, 1996, p. 82).

The principles of a Tailored Design method survey were employed in this process. Items were created with consideration of length, precise wording, order effects, clarity of instructions, and visual navigation {Dillman, 2000 #80}. Details

were placed in each aspect of the questionnaires to enhance clarity and conciseness while maintaining validity. Psychometric estimates of reliability and validity were obtained through data collected in a pilot study.

Reliability

The independent variables were measured by an investigator-designed survey. As the instrument had not been employed in prior research, test-retest reliability could not be established. However, in an effort to determine the appropriateness of the instrument Cronbach alphas were calculated for each item. Factor analysis indicated that each of the three sections of the instrument measured a unidimensional construct (See appendix E for summary of factor analysis).

Validity

Face validity was established via the pilot study where participants had no suggestions for revisions, noted the instrument was easy to read and completed in minimal time.

Knowledge of Vicarious Trauma

Participants' level of vicarious trauma knowledge was assessed through Likert-type questions that define vicarious trauma and identify vicarious trauma in practice. In addition, participants were asked to identify the symptoms of vicarious

trauma through a checklist question designed to assess knowledge base. The total of number of symptoms identified answered one question regarding vicarious trauma knowledge. That question was combined with the Likert-type questions to create a final evaluation of the participant's knowledge base of vicarious trauma.

Scoring. The instrument measuring knowledge of vicarious trauma consists of a composite of nine items. Participants responded to eight questions of knowledge designed on a Likert scale with "5" indicating strong agreement, "4" indicating agreement, "3" indicating disagreement, "2" indicating strong disagreement, "1" indicating no opinion and "0" indicating unknown. "No opinion" was coded as a 1 score due to the assumption that if a participant has no opinion of the statement they are unable to demonstrate knowledge on the subject. In addition, it is a stronger indication of a gap in knowledge if the participant answers the question with "unknown" therefore "unknown" was scored as 0.

The score from these eight items was combined with the score from the symptom checklist question. This checklist was scaled between 1 and 4 based on the number of symptoms identified. If three or less symptoms were identified, the score was 1. If 10 to 12 symptoms were identified the score was 4.

The composite possible score for knowledge ranged between 0 and 44. High scores indicated a higher level of knowledge regarding vicarious trauma and low scores indicated lower level of knowledge.

Perception of Collegial Support

Perception of collegial support was measured by response to six statements. Each of these statements was created based on the literature indications of defining and providing collegial support.

Scoring. Response format was designed to allow for "no" (0) or "yes" (1). In addition, all "unsure" responses were collapsed into a 0 (or "no") score based on the assumption that if one was unsure such support was provided then their perception would be that type of collegial support did not exist in a meaningful manner. Possible scores for perceived collegial support ranged from 0 to 6. Higher scores indicated a greater perception of the existence of the administrative practice of collegial support.

Perception of Supervision

Perception of supervision offered within the organization was measured by participant response to six items. Each of these

statements was created based on the literature indications of defining and supervision.

Scoring. Response format was designed to allow for "no" (0) or "yes" (1). In addition, all "unsure" responses were collapsed into a 0 (or "no") score based on the assumption that if one was unsure such support was provided then their perception would be that type of supervision did not exist in a meaningful manner. Possible scores for perceived supervision ranged from 0 to 6. Higher scores indicated a greater perception of the existence of the administrative practice of supervision.

Measurement of the Dependent Variable

The Trauma and Attachment Belief Scale (TABS) has been utilized in various studies regarding trauma including those studying the phenomenon of vicarious traumatization (More information regarding the TABS can be obtained at <http://portal.wpspublish.com>). The TABS instrument measures the level of vicarious trauma symptoms as a whole and within five areas of need in regards to self and others. These areas of needs are: safety, trust, esteem, intimacy and control (See description noted in Methodology, p.30). It has been reported that the TABS has been successfully employed to predict post-

traumatic stress disorder (PTSD) with 90% accuracy {Pearlman, 2003 #81}.

The instrument:

Measures beliefs related to five need areas that are sensitive to the effects of traumatic experiences - safety, trust, esteem, intimacy, and control. Within each need area, separate sets of items tap into beliefs about oneself and beliefs about others, yielding ten subscale scores and a total score {Pearlman, 2003 #81}.

Reliability

It is reported that the TABS has been successfully employed to predict PTSD with 90% accuracy {Pearlman, 2003 #81}.

Reliability of the dependent variable of vicarious trauma symptoms has been further defined within each central area of need. According to Pearlman (2003), the TABS test-retest reliability was reported at .75 and within the sub-scales (the 10 central need areas) the test-retest reliability ranged from a .60 to a .79 (p.35).

The TABS scale has been utilized in a variety of studies and it has been noted that, "the TABS has good internal consistency and test-retest reliability" (Briere, 2004, p. 554). In determining homogeneity by the use of internal consistency, Pearlman (2003) found that the TABS total score was .96 and the subscales ranged from .67 to .87 (p. 35).

Validity

In a review of the TABS by the Buros Institute (2005) it was noted that the instrument's development followed the constructive self-development theory. "Items were generated from statements by trauma survivors. These items were then reviewed and refined for content validity by a panel of clinical psychologists" (p. 2).

Scoring

The TABS consists of 84 items. Each item is formatted in a Likert scale ranging from 1 (disagree strongly) to 6 (agree strongly), with a possible range of raw scores from 84 to 504. The questionnaire is designed so that the researcher can transfer the raw scores onto a TABS Profile Sheet. This sheet converts the raw score into a normalized T-score. This study utilizes the normalized T-scores to allow for comparison between surveys. Using the profile sheet, a total of 11 normalized T-Scores, one for each of the subscales and a total scale, was calculated for each participant.

Possible normalized T-scores from the TABS range from 0 to 100. These scores are further grouped into categories for comparing one participant to others. This scoring break into 7 rankings: >29 indicated very little disruption, 30-39 indicated very low disruption, 40-44 indicated low average disruption, 45-

55 indicated average disruption, 56-59 indicated high average disruption, 60-69 indicated very high disruptions and <70 indicated substantial disruption. Lower normalized T-scores equate to lower disruption or trauma, whereas higher scores report more substantial disruption or trauma. T-scores were used in the statistical analyses herein.

Statistical Analysis

Descriptive statistics were used to describe the sample. Psychometric estimates of internal consistency for knowledge of vicarious trauma scale were established by means of Cronbach's alpha. The scales for perception of collegial support and perception of administrative supervision generated dichotomous data so were evaluated by means of Kuder-Richardson-20 (KR-20). The KR-20 is equivalent to Cronbach's alpha. In addition to employing Cronbach's alpha, the investigator ran a factor analysis for each of the three sections of the investigator designed survey tool (i.e. knowledge, collegial support, administrative support). Outcomes of the factor analysis indicate that each section of the instrument is, indeed, measuring a unidimensional construct. Hypotheses were analyzed by means of hierarchical standard multiple regression and non-paired t-tests. The hypotheses indicate the use of a two-tailed test and level of significance is set at .05.

Regression analysis is a method of explaining the "nature and closeness of the relationship between two or more variables, specifically, the extent to which you can predict some by knowing others, and the extent to which some are associated with others" (Vogt, 1993, p. 192). It assesses the degree to which the dependent (outcome) variables are related to the independent (predictor) variable or to predict the score of the dependent (outcome) variable from scores on several independent (predictor) variables.

In multiple regression, it is possible for a variable to appear unimportant when it is actually correlated with the dependent (predictor) variable. If a significant R^2 value is obtained, the beta (β) weights associated with each variable were examined for their comparative contribution to the prediction equation. Tests to check tolerances and to avoid violations of assumptions of multiple regressions, normality, multicollinearity, homoscedasticity, and linearity were conducted prior to analysis (Cohen & Cohen, 1983; Pedhazur, 1982; Vogt, 1993).

Data Management and Quality Control

Data was entered into Statistical Package for the Social Science (SPSS) for Windows v12 (SPSS, 2002) for quantitative

analysis. Data from all of the instruments were entered into a single spreadsheet to facilitate analysis.

Surveys containing missing data points were excluded from data analysis. A quality check procedure was conducted to minimize data transcription errors. The researcher manually summed the scores, then entered the items into SPSS and summed the scores by computer. A comparison of the two sums allowed for detection of errors of entry.

All data were downloaded onto a compact disk (CD) and is kept in a locked file cabinet in the researcher's office and will remain so for a period of five years following the completion of the study. Access to anonymous raw data is limited to the researcher. All survey data was aggregated for purposes of reporting, presentation, and publication. Grouped and aggregated data protects and assures the anonymity of the study participants.

Data entered into SPSS spreadsheets is saved on storage devices (e.g., compact disks, flash drive) in case of loss or damage to the original data. Only aggregated data was used for the purpose of data analysis.

CHAPTER 5 FINDINGS

The purpose of this study was to (1) examine whether the knowledge base of vicarious traumatization among those who work in domestic violence organizations impacts the level of vicarious trauma reported and (2) to identify whether the level of vicarious trauma for those who work within domestic violence organizations is impacted by the administrative strategies of collegial support and supervision.

Preliminary Work - Pilot Study

Since the research instruments had not been used for data collection from this population previously, a pilot study was conducted. The participants were considered to be an expert panel and were asked to evaluate the instruments for face validity, readability and logical flow.

Pilot Study Setting

A domestic violence shelter located in Missouri agreed to participate in the pilot study. The shelter was a certified shelter within the State of Missouri and ascribed to the same philosophical base as those certified shelters within the State of Florida.

Pilot Study Participants

A total of 10 participants were recruited to complete the survey instruments for the pilot study. This all female group consisted of two (20%) administrators and eight (80%) direct care staff. A summary of additional characteristics of the pilot study participants is provided in Table 1.

Table 1: Characteristics of the Pilot Participants (N = 10)

Variable	<i>n</i>	%
Age		
18 – 25 years	1	10.0
26 – 35 years	3	30.0
36 – 45 years	3	30.0
45 – 55 years	2	20.0
> 55 years	1	10.0
Years of experience		
1 – 5 years	5	50.0
6 – 10 years	2	20.0
> 10 years	3	30.0
Education level		
Some college	1	10.0
Bachelor’s degree	5	50.0
Master’s degree	4	40.0
Marital status		
Married	4	40.0
Divorced/single	6	60.0

Pilot Study Results

The participants of the pilot reported the survey was easy to read, and could be completed within 25-30 minutes. Face validity was established as the participants recommended no suggestions for change and the instrument was left unchanged.

The Main Study

Description of the Sample

A total of 112 individuals volunteered to serve as participants for the main study. The overwhelming majority were female ($n = 111, 99.1\%$) with only one male ($.9\%$). A large number of participants ($n = 61, 54.5\%$) did not report their employment position; of those participants that did, 39 (34.8%) were classified as direct care staff; 12 (10.7%) were employed in administrative positions. A summary of additional characteristics of the sample are presented in Table 2.

Table 2: Characteristics of the Sample (N = 112)

Variable	<i>n</i>	%
Age		
18 – 25 years	7	6.3
26 – 35 years	34	30.4
36 – 45 years	27	24.1
45 – 55 years	26	23.2
> 55 years	17	15.3
No response	1	.9
Years of experience		
<1 year	18	16.1
1 – 5 years	42	38.2
6 – 10 years	27	24.1
> 10 years	23	20.5
No response	2	1.8
Education level		
High school	13	11.6
Some college	37	33.0
Bachelor's degree	41	36.6
Master's degree	21	18.8
Marital status		
Married	54	48.2
Divorced/single	51	45.5
Other	5	4.5
No response	2	1.8

Response to Measurement Scales

Estimation of Reliability: Main study participants' responses to the measurement scales were analyzed for internal consistency by means of Cronbach's or KR-20 alpha depending on the type of data generated. The results of the item analysis and internal consistency are presented in Table 3. Tukey's estimate of power to which observations must be raised to achieve additivity was considered (knowledge = .25, collegiality = .76, support = 1.44). Criteria used to identify poorly functioning items included (1) an increase of more than .10 in the total reliability when the item was deleted and (2) a correlation of <.30 between an item and the subscale score. Alpha for the entire 21 item scale was .66.

Table 3: Item Analysis and Internal Consistency of the Scales: Knowledge of Vicarious Trauma, Perception of Collegiality Support, and Perception of Administrative Supervision

	<i>M</i>	<i>SD</i>	Item-Total Correlation	If item deleted
Knowledge of Vicarious Trauma (<i>n</i> = 109)				
(1)	2.73	1.46	.38	.70
(2)	1.83	.98	.55	.66
(3)	1.68	.78	.51	.68
(4)	1.45	.82	.23	.71
(5)	3.50	1.52	.33	.71
(6)	1.68	1.03	.33	.70
(7)	1.50	.72	.43	.69
(8)	1.74	.95	.48	.68
(9)	3.20	1.12	.44	.68
$\alpha = .72$				
Perception of Collegiality Support (<i>n</i> = 111)				
(1)	.47	.50	.09	.54
(2)	.36	.48	.25	.46
(3)	.34	.48	.23	.47
(4)	.43	.50	.21	.48
(5)	.51	.50	.41	.36
(6)	.22	.41	.36	.41
$\alpha = .50$				
Perception of Administrative Supervision (<i>n</i> = 112)				
(1)	.48	.50	.27	.71
(2)	.88	.32	.37	.68
(3)	.51	.50	.31	.70
(4)	.83	.38	.50	.64
(5)	.71	.45	.56	.61
(6)	.69	.47	.65	.58
$\alpha = .70$				

Descriptive for the Measurement Scales

Knowledge of Vicarious Trauma: A total of 109 of the 112 participants completed the scale measuring knowledge of vicarious trauma. The scores ranged from 1 to 27 ($M = 19.44$, $SD = 5.33$). There was a possible range from 0 to 45. Scores indicate a low degree of knowledge of vicarious trauma among the participants.

Perception of Collegial Support: A total of 111 of the 112 participants completed the scale measuring perception of collegial support. The scores ranged from 0 to 6 ($M = 2.33$, $SD = 1.54$). There was a possible range from 0 to 6. Scores indicate that the participants perceived a low degree of collegial support.

Perception of Administrative Supervision: A total of 112 participants completed the scale measuring perception of administrative supervision. Possible scores ranged from 0 to 6; participants scores ranged from 0 to 6 ($M = 4.11$, $SD = 1.67$). These scores indicate the participants perceived a moderate amount of administrative supervision.

TABS: A total of 110 of the 112 participants completed the entire instrument measuring experience of vicarious trauma symptoms. Possible scores ranged from zero to 100; participants scores ranged from 15 to 57 ($M = 33.15$, $SD = 8.71$). These scores

indicate the participants experienced a very low degree of disruption.

Hypotheses Testing

Hypothesis 1

Hypothesis 1 states: There will be no significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and the report of vicarious trauma symptoms of the shelters' direct care and administrative staff. The null hypothesis was rejected. Multiple regression found that 10.7% ($R^2 = .107$, $Adj. R^2 = .081$) of the variance in the scores for vicarious trauma symptoms was accounted for by the three predictor variables of knowledge of vicarious trauma, perceived collegial support and perceived administrative supervision, $F(3, 103) = 4.12$, $p < .01$. Table 4 summarizes the test of significance of multiple correlations. Table 5 reports the beta weights (β) and their accompanying significance levels of each variable in the model.

However, stepwise regression analysis found that only the score for perception of collegial support entered the model;

8.6% ($R^2 = .086$, *Adj. R*² = .08) of the variance in the scores for vicarious trauma symptoms was accounted for by this one variable, $F(1,105) = 9.90$, $p < .01$.

Table 4: Test of Significance of Multiple Regression Predicting the Experience of Vicarious Trauma from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	854.48	284.83	4.12	.00*

*p < .01

Table 5: Multiple Regression Analysis Full Model: Experience of Vicarious Trauma (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	-8.055	.15	.05	.53	.60
Perception of Collegial Support	-1.11	.62	-.20	-1.79	.08
Perception of Administrative Supervision	-.86	.57	-.17	-1.51	.13

Hypothesis 2

Hypothesis 2 states: There will be no significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and the score for any of the one of the ten subscales of vicarious trauma symptoms of the shelters' direct care and administrative staff. This hypothesis identified three independent variables that were considered as possible predictors of the outcome variable of the score of each one of the vicarious trauma subscales. To examine these relationships, multiple regression analyses were conducted.

The null hypothesis was partially rejected. The predictor variables of knowledge of vicarious trauma, perception of collegial support and perception of administrative supervision were not significantly related, either uniquely or as a linear composite, to the scores for the subscales of self-safety, other safety, other trust, self esteem, or self control. However, these same predictors were found to be predictive of the scores on the subscales of self-trust, other esteem, self intimacy, other intimacy, and other control.

The three predictor variables, as a linear composite accounted for 32.1% ($R^2 = .32$, $Adj. R^2 = .08$) of the variance in

the scores for self-trust, $F(3, 103) = 3.94, p < .01$ (See Table 6). None of the predictor variables was found to be uniquely related to the outcome variable (See Table 7).

Table 6: Test of Significance of Multiple Regression Predicting Self-trust from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	18.13	6.04	3.94	.01*

* $p < .01$

Table 7: Multiple Regression Analysis Full Model: Self Trust (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	1.60	.02	.07	.71	.48
Perception of Collegial Support	-.15	.09	-.19	-1.68	.10
Perception of Administrative Supervision	-.13	.08	-.17	-1.51	.13

The three predictor variables, as a linear composite, accounted for 27% ($R^2 = .27$, *Adj. R*² = .05) of the variance in the scores for other esteem $F(3, 103) = 2.70$, $p < .05$ (See Table 8). None of the predictor variables was found to be uniquely related to the outcome variable (See Table 9).

Table 8: Test of Significance of Multiple Regression Predicting Other Esteem from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	12.07	4.02	2.70	.05*

* $p < .05$

Table 9: Multiple Regression Analysis Full Model: Other Esteem (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	-1.95	.02	-.08	-.87	.38
Perception of Collegial Support	-9.80	.09	-.12	-1.08	.28
Perception of Administrative Supervision	-.13	.08	-.17	-1.54	.13

The three predictor variables, as a linear composite, accounted for 31.4% ($R^2 = .31$, $Adj. R^2 = .07$) of the variance in the scores for self intimacy $F(3, 103) = 3.75$, $p < .01$ (See Table 10). Perception of administrative supervision was the only predictor that was uniquely significantly related to the outcome variable (See Table 11).

Table 10: Test of Significance of Multiple Regression Predicting Self Intimacy from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	19.54	6.51	3.75	.01*

* $p < .01$

Table 11: Multiple Regression Analysis Full Model: Self Intimacy (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	3.74	.02	.15	1.56	.13
Perception of Collegial Support	-9.33	.10	-.01	-.10	.93
Perception of Administrative Supervision	-.22	.09	-.28	-2.47	.01*

* $p < .01$

The three predictor variables, as a linear composite, accounted for 30.8% ($R^2 = .31$, $Adj. R^2 = .07$) of the variance in the scores for other intimacy $F(3, 103) = 3.60$, $p < .01$ (See Table 12). None of the predictor variables was found to be uniquely related to the outcome variable (See Table 13).

Table 12: Test of Significance of Multiple Regression Predicting Other Intimacy from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	15.36	5.12	3.50	.01*

* $p < .01$

Table 13: Multiple Regression Analysis Full Model: Other Intimacy (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	1.27	.02	.06	.58	.56
Perception of Collegial Support	-.15	.09	-.19	-1.71	.09
Perception of Administrative Supervision	-.11	.08	-.15	-1.35	.18

The three predictor variables, as a linear composite, accounted for 31.1% ($R^2 = .31$, $Adj. R^2 = .07$) of the variance in the scores for other control $F(3, 103) = 3.68$, $p < .01$ (See Table 14). The predictor variable of perception of collegial support was the only variable found to be statistically significantly related to the outcome variable (See Table 15).

Table 14: Test of Significance of Multiple Regression Predicting Other Control from the Full Model (N = 107)

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Regression	3	12.25	4.08	3.68	.01*

* $p < .01$

Table 15: Multiple Regression Analysis Full Model: Other Control (N = 107)

Predictor Variable	<i>B</i>	<i>SE B</i>	<i>b</i>	<i>t</i>	<i>p</i>
Knowledge of Vicarious Trauma	1.25	.02	.06	.65	.52
Perception of Collegial Support	-.19	.08	-2.7	-2.39	.02*
Perception of Administrative Supervision	-3.43	.07	-.05	-.48	.63

* $p < .05$

Hypothesis 3

Hypothesis 3 states: There will be no significant difference in the means of the scores for vicarious trauma symptoms between those participants that provide direct care to clients and those participants that supervise the direct care providers. This hypothesis identified one variable that was compared in two groups. The data was analyzed by means of an independent samples t-test to evaluate the difference in the means for the two groups. The null hypothesis was not rejected. The mean score for experience of vicarious trauma reported by direct care providers ($n = 39$, $M = 30.74$, $SD = 8.32$) was not significantly different from the mean score reported by the supervisors of direct care ($n = 12$, $M = 28.42$, $SD = 7.68$).

Summary of Results

The study was conducted in two phases. The initial phase involved testing the researcher developed instruments to measure the independent variables by a pilot study consisting of 10 domestic violence staff, representative of the target population, to assure face validity. Based on the feedback from this panel, the instruments seemed to be valid measure of the constructs. Therefore the instruments were used for collection

of data in the main study. Estimates of internal consistency were based on the data obtained in the main study.

The main study involved 112 participants. The sample was overwhelmingly female which likely created gender bias. While not all instruments were completed by all participants, adequate data was provided to allow for statistical analyses.

The first step in the analysis was to consider the reliability of the researcher developed instruments. The instruments measuring knowledge of vicarious trauma and perception of administrative supervision demonstrated a high degree of item-total correlation; only one item in each of these scales was correlated at $<.30$. The instrument measuring perception of collegial support demonstrated less internal consistency with only two items, items five and six, correlating at $>.30$ with the respective item and the total sum score. However, the deletion of these items would have left the scales with fewer items, thereby further reducing reliability, and did not improve the reliability coefficient alpha by $>.10$ so they were left in the scale.

Three hypotheses were tested. The first hypothesis considered the predictive relationships between the scores for the independent variables and the total, summed score on the TABS instrument for the experience of vicarious trauma among the

participants. While all three independent variables entered the model, the only one found to be significantly predictive was the perception of collegial support. The relationship was inverse indicating that the higher the score for perception of collegial support, the lower the score for experiencing vicarious trauma.

The second hypothesis examined for relationships between the three independent variables and each of the subscales on the TABS instrument. The independent variables, as a linear composite, were found to be predictive of the scores on the subscales of self-trust; none of the independent variables were uniquely significantly related to the outcome variable. The relationship between knowledge of vicarious trauma and the score for self-trust was positive while the relationships between perception of collegial support and perception of administrative supervision with the scores for self trust were negative.

The same was found for the relationships between the independent variables and the scores for the subscales for other esteem. The composite of the independent variables were predictive while none of the independent variables made a unique contribution to the predication. However, in this analysis, all were inverse relationships.

Of the three independent variables, the only one found to be uniquely predictive of the score on the subscale for self-

intimacy was perception of administrative supervision. There is an inverse relationship between perception of administrative supervision and vicarious trauma; as the scores for administrative supervision increased, the scores for the experience of vicarious trauma decreased.

The three independent variables, as a composite, were found to be significantly predictive of the scores for the subscale, other intimacy. The relationships between the independent variables of perception of collegial support and perception of administrative supervision to the experience of vicarious trauma were inverse, while the relationship with knowledge of vicarious trauma was positive.

The three independent variables, as a composite, were found to be significantly predictive of the scores for the subscale, other control. However, the only statistically significant variable is perception of collegial support. This is an inverse relationship. As the score for collegial support went up; the scores for perception of vicarious trauma went down.

Hypothesis 3 compared the means of the scores for the experience of vicarious trauma between the two groups: those participants who provided direct care to clients and those participants who only provided administrative supervision to the direct care providers. Analysis found no difference in the means

of the two groups indicating no difference in the experience. However, a large number of participants failed to provide information regarding their job role so the results of this analysis must be viewed conservatively.

CHAPTER 6 DISCUSSION

This study tested for relationships between the independent variables of knowledge of vicarious trauma, perception of collegial support and perception of administrative supervision and the dependent variable, the experience of vicarious trauma, among the direct care providers and administrative employees of selected domestic violence shelters in Florida.

Summary and Integration of the Results

Findings of this study suggest that the process of minimizing vicarious trauma is as multifaceted as vicarious trauma itself. Results of hypothesis 1 illustrate that the combined composition of knowledge base, supervision and collegial support indicates a strong inverse relationship to vicarious trauma symptoms. However, uniquely each of these variables does not significantly impact the experience of vicarious trauma. This is consistent with Trippany, Kress, and Wilcoxon's (2004) report that preventing vicarious trauma requires a multitude of approaches. Vicarious trauma focuses on the cognitive changes of the therapist, the therapist schemas and on the therapists' central needs. Utilizing and maximizing a variety of dynamic administrative avenues for addressing

vicarious trauma may be the key to addressing the multifaceted implications of trauma work. This study supports the use of diverse administrative interventions; education, collegial support and supervision, to minimize vicarious trauma within the workplace.

Vicarious trauma of the therapist does not occur in a vacuum; the organizations, the staff, the nature of work, the perceived support all have an impact. That interconnectedness is evident not only in the hypothesis 1 significance of a composite inverse correlation between the independent variables of level of knowledge, perception of collegial support and perception of supervision; but also in hypothesis 2, where the subscales of vicarious trauma demonstrates the complexity of how some factors significantly impact vicarious trauma while others have no statistical impact.

Although some of the subscales of vicarious trauma were not seen to be significantly correlated with the independent variables as noted in the hypothesis 2, there were five subscales in which the independent variables were seen to be significantly related. The five subscales that were impacted were: self trust, other esteem, self intimacy, other intimacy, and other control. While there appears to be a relationship between these subscales and the independent variables, only

limited information can be denoted from this research as to the unique role that collegial support and supervision in particular play in minimizing the experience of vicarious trauma in regards to these specific areas.

Interestingly, even within these five subscales that showed a significant relationship there was not consistency regarding the impact of the independent variables to that of vicarious trauma symptoms. Only in the subscale of other esteem were all three variables of level of knowledge, perception of collegial support and perception of supervision inversely related. More importantly were the findings that in the remaining four subscales there was a statistically significant negative correlation, thus indicating that the independent variables did assist in minimizing vicarious trauma. In addition, there was also a positive correlation between knowledge level and vicarious trauma symptoms. Therefore, as participants' level of knowledge increased so to do their symptoms of vicarious trauma. That would suggest that although one is aware of vicarious trauma and can report an increased knowledge base regarding vicarious trauma, that same knowledge base does not translate into skills for minimizing vicarious trauma.

In regard to theory, CSDT explains that the occurrence of vicarious trauma is about cognitive shifts in the therapists as

avenues for interpreting the trauma they are digesting.

Therefore, occurrence of vicarious trauma per CDST predicts that the workers' "experiences are normal counselor adaptations to recurrent client presented traumatic material" and that "CSDT proposes that irrational perceptions [of the worker] develop as self-protection against these emotionally traumatic experiences" {Trippany, 2004 #25@31}. Thus, educating the staff members about vicarious trauma and increasing their knowledge base alone would not be sufficient in addressing the cognitive shifts in how the trauma is incorporated into daily functioning. These results validate and reiterate the need for organizations to utilize a variety of tools to help staff members, educating them is simply not enough.

There are two other findings in regards to hypothesis 2 that are worthy of further discussion. One finding was the statistically significant relationship between self intimacy and perception of administrative supervision. These results indicate that there is a unique and important relationship between ones view of intimacy and their one on one supervision provided in the realm of trauma work. Hess (2002) notes that, "regular and adequate supervision can help the trauma therapist discuss his or her reactions to client material and pay closer attention to how his or her feelings may be affecting the therapeutic

relationship" (p. 305). And, the literature goes as far in indicating supervision as such an intimate role that it is recommended that the person providing the trauma supervision should be separate from the supervisor providing the evaluation {Bell, 2003 #2; Trippany, 2004 #25}.

The second finding that should be noted relative to hypothesis 2 that was statistically significant was the role between other control and ones perception of collegial support. This study indicates that in regards to the experience of vicarious trauma as a whole, collegial support is important when combined with supervision and knowledge. However, the study also indicates that collegial support by itself can assist in minimizing vicarious trauma within the specific area of other-control. Administrators have to consider and reconcile that direct care staff members' perception of external forces (such as their supervision style and policy making) can and do impact their experiences of vicarious trauma. Meyer and Ponton (2006) illustrate the occurrence of vicarious trauma in staff by a metaphor of a tree. They note, "As leaf mites devour, drought starves, and air pollution suffocates, the previously hearty tree begins to weaken and bend under the enormous environmental strain" (p.192).

Data analysis related to hypothesis 3 did not indicate any disparities or similarities between the perceptions of administration and perceptions of direct care staff members. The descriptive statistics of this dataset is not sufficient to draw conclusions on the impact of one's position within the organization in relationship to their experience of vicarious trauma.

Study Limitations

While this investigation has indicated some important findings, they must be considered within the context of the study's specific limitations. One of the primary limitations of this study relates to the strength of the investigator designed instrument. General guidelines for social research indicate an alpha of .70 or greater to be acceptable {Santos, 1999 #85}. While the TABS met this requirement, the total alpha of the investigator designed instrument fell slightly short (.66) It is anticipated that continued use of this new tool will allow for the necessary fine tuning needed to strengthen the instrument.

In addition, there is the limitation that the administrators were the person handing out and collecting the surveys. This creates two limitations. One limitation is that the administrators have the ability to "hand-pick" the

participants. Although, from phone conversations most administrators noted they would ask everyone who could to complete the surveys, there is no way to validate that such practice actually occurred. The second limitation that arises from administrators disseminating the survey is that there is the possibility that participants were not as forthcoming in fear that their administrators would view the results. Administrators were asked to hand out, collect and seal the surveys in front of staff members; however, this process could not be validated.

A limitation, specifically in regard to hypothesis 3 is the low response rate of participants identifying their positions within the organization. The low response rate failed to produce enough power to calculate an accurate statistical analysis for hypothesis 3. There could be a variety of reasons that participants did not indicate their organizational position including, lack of clear guidance from the study instruments or fear of identification.

Theoretical Implications

The results of this study demonstrate that understanding vicarious trauma and the implications of trauma work requires a composite of numerous theoretical understandings. This investigation specifically looked at feminist theory and

constructive self development theory. Most domestic violence shelters operate within a feminist framework {, 2005 #17}. The cognitive changes experienced by those who work in such settings can be identified as vicarious trauma. Understanding the connectedness of these theories in practice allows for productive and effective strategies for positive outcomes of organizational culture and functioning. Reger (2004) notes that "organizational processes use cognitive techniques and emotions work to create emotional states that can promote collective action" (p.220).

Outcomes of this research support the use of collegial support and supervision to enhance the ability of both the organization and the worker to reduce the impact of vicarious trauma.

Implications for Social Work

The occurrence of vicarious trauma within direct care staff members of domestic violence shelters may be seen as inevitable. However, that does not mean that vicarious trauma can be ignored. Rather, it indicates more of a need to create measures for assisting staff members. This study serves to provide a foundation for establishing organizational accountability to their workers and their clients. The effects of vicarious trauma on the provider can be detrimental to the worker and to the

quality of their work. Recognition of vicarious trauma within social service organizations requires the use of a multitude of approaches to assist their staff members, including the implementation of policies and practices that provides knowledge, collegial support and supervision. This study validates that not only can the individual take actions to minimize the occurrence of vicarious trauma, so too can organizations. Moreover, the findings suggest that organizations who do provide diverse and varied interventions are more effectively able promote healthy staff members.

Educators within social work can utilize this study as a means for encouraging students to explore and examine the effect of working in traumatic environments. Arming students with a knowledge base of the professional implications of trauma work may enhance their ability to be more prepared for such work. Lastly, this study suggests that clear administrative guidelines and practices, directed at addressing vicarious trauma, may serve to reduce the negative impact of vicarious trauma on direct line staff members.

Implications for Public Affairs

The work that is done inside of domestic violence shelters is but a part of the whole effort employed in the battered

women's movement. Shelter staff members are not alone in providing assistance to battered women and thus are not alone in being prone to vicarious trauma. Direct care staff members that provide services to battered women also include the front line workers within the criminal justice system such as the police and victim advocates; the healthcare workers who provide services to the battered woman such as the emergency room workers; the policy makers within the court and government entities that establish laws uphold court orders; and the researchers who assist in creating new interventions and strategies protecting battered women. Trauma work is a part of every aspect of public affairs. Therefore, it would be advantageous for organizations in all of these arenas to be cognizant of the occurrence of vicarious trauma and implement administrative strategies of knowledge base, collegial support and supervision that fit their specific workplace dynamics.

Implications for Future Research

This exploratory research provides a first step in assessing organizations strategies for reducing the impact of vicarious trauma in the domestic violence field. Additional research into administrative practices can provide valuable insight for organizations who want to provide adequate and

effective strategies for minimizing vicarious trauma. Use of this study as a starting point developing statistically stronger instruments and wider research bases can provide a wealth of opportunities. This study does indicate a connection. Future research that investigates the connection between organizational practices and staff member's experiences of vicarious trauma, and the dept of that connection, is vital to sound practice. This study suggests that vicarious trauma can be minimized through a combination of administrative practices. Future research will elaborate on the practices of knowledge, collegial support and supervision; in addition to other strategies.

Summary

Although none of the independent variables of knowledge base, collegial support or supervision alone was able to statistically significant in minimizing vicarious trauma; together they have a statistically significant association. In addition, the sub-scales of vicarious trauma: self trust, other esteem, self intimacy, other intimacy, and other control, appear to have a strong relationship to the collective administrative practices of knowledge, collegial support and supervision.

Unique findings were determined between three specific areas of the subscales. The first unique finding was the

relationship between knowledge base and these subscales. With the exception of other control, all other subscales showed a positive correlation with knowledge base. Therefore, as collegial support and supervision worked to minimize vicarious trauma symptoms, the participants who reported higher levels of knowledge also reported higher vicarious trauma symptoms within these subscale areas.

The second unique finding was the statistically significant inverse correlation between self-intimacy and ones perception of supervision. This finding emphasizes the important relationship supervision can offer in assisting domestic violence staff members in addressing specific areas of vicarious trauma.

In addition, the third area where a unique finding was identified was the relationship between other-control and collegial support. The results indicate that the perception of collegial support in addressing vicarious trauma on the subscale of other control is significantly significant. All of these findings invite further research and discussion.

CHAPTER 7 CONCLUSION

Working within a traumatic workplace of domestic violence shelters impacts the worker. Researchers and clinicians have been trying to explain and detail this occurrence for years under the explanation of concepts such as burnout, compassion fatigue and secondary traumatic stress. The most recent and all encompassing term to explain such impact of the work is that of vicarious traumatization.

Domestic violence shelter staff members repeatedly hear traumatic stories, stories of horrific and devastating abuse. This information is cognitively absorbed on a routine basis, thus resulting in vicarious trauma. How this information is absorbed and later translated into their work should be a concern for both the staff members and the organizations they work within.

Understanding the impact of trauma work within domestic violence organizations is best grasped within the context of the domestic violence movement and a comprehension of the impact is of working within that movement. Staff members who work with battered women must be continuously empathic and empowering while enduring horrific story after story of abuse.

Since vicarious trauma is seen as an inevitable part of trauma work {Pearlman, 1995 #7} it would behoove organizations to understand administrative practices that can assist in minimizing vicarious trauma. The research to date has detailed a number of methods for an individual to minimize vicarious trauma {McCann, 1990 #4; Richardson, 2001 #20; Saakvitne, 1996 #5}. However, there is a clear lack of scientific data on what organizations can do to assist their workers. Previous related research indicates that organizational interventions of collegial support and supervision can minimize vicarious trauma {Figley, 1995 #26; Tilley, 2003 #24}.

Feminist theory and constructive self development theory provides a theoretical base for minimizing vicarious trauma within staff of domestic violence shelters. Domestic violence shelters are deeply rooted in the feminist framework {, 2005 #17} and this framework creates a unique style for the organization and direct care staff. The feminist shared values and norms of supervision and collegial support can assist in minimizing vicarious trauma.

In addition, CDST serves as the core conceptualization of vicarious trauma. CSDT recognizes the individuals' ability to process traumatic material and assign understanding to that material is a multifaceted experience. Domestic violence

organizations can use CSDT as a foundation in developing administrative practices of knowledge base, collegial support and supervision to minimize the occurrence of vicarious trauma among the direct care staff members.

The literature on vicarious trauma details various important aspects of how the worker can minimize vicarious trauma and how vicarious trauma occurs at a different magnitude than the experiences of related concepts {McCann, 1999 #21; Pearlman, 1995 #7; Pearlman, 1995 #27}. In addition, Hess (2002) through a personal vignette attempted to address the organizational responsibility. However, there remains a paucity of scientific research on what organizations can do to minimize vicarious trauma.

The research that has been compiled utilizing related concepts have support the uses of collegial support and supervision as mechanisms for minimizing the impact of the trauma work on the therapist {Bell, 2003 #2; Haykas, 2005 #11}. In addition, the research has indicated that collegial support and supervision can serve organizations as strategies to address effectiveness and efficiency of staff members that experience effects of the trauma work .

This study sought to (1) examine whether the knowledge base vicarious traumatization among those who work in domestic

violence organizations impacts the level of vicarious trauma reported and (2) to identify whether the level of vicarious trauma for those who work within domestic violence organizations is impacted by administrative strategies of collegial support and supervision. Three hypotheses were posed:

Ha₁: There will be a significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and the report of vicarious trauma symptoms of the shelters' direct care and administrative staff.

Ha₂: There will be a significant contribution, uniquely or as a linear composite, between the predictor variables of knowledge of vicarious trauma, perceived collegial support, or perception of supervision provided by domestic violence shelters and the report any of the ten subscales of vicarious trauma symptoms of the shelters' direct care and administrative staff.

Ha₃: There will be a significant difference in the scores for vicarious trauma symptoms between those participants that provide direct care to clients and those participants that supervise the direct care providers.

This cross-sectional, explanatory study evaluated these hypotheses through surveys among shelter staff employees of

certified domestic violence shelters within the state of Florida. Based on a power analysis a minimum of 84 participants were needed for a medium effect size, and taking previous research response rates into account a minimum of 96 participants were recruited.

The primary investigator contacted each shelter requesting participation of at least 3 direct staff members and 1 administrator, those shelters who agreed to participation were sent a packet which consisted of the primary investigator designed survey and the TABS instrument for each participant.

The primary investigator designed survey obtained demographic data and measured the independent variables of knowledge base, perception of collegial support and perception of supervision. The TABS instrument measured the level of vicarious trauma symptoms. A pilot study was conducted with a shelter outside of Florida to establish face validity to the primary investigator designed instrument and the TABS has been shown to be both reliable and valid (Buros Institute, 2005). Descriptive statistics was used to describe the data and regression analysis to assess the degree to which knowledge base, collegial support and supervision can predict vicarious trauma symptoms.

Results indicated that the study sample consisted of 112 total participants who were overwhelmingly female. Participants varied in age range, years of experience, and educational background. The hypothesis 1 null hypothesis was rejected, finding that there is a statistically significant relationship between the linear composite of knowledge base, collegial support and supervision and the level of vicarious trauma symptoms reported. Hypothesis 2 was partially rejected, in that 5 of the 10 subscales of vicarious trauma were correlated with knowledge base, supervision and collegial support. The null hypothesis for hypothesis 3 was not rejected due to insufficient data.

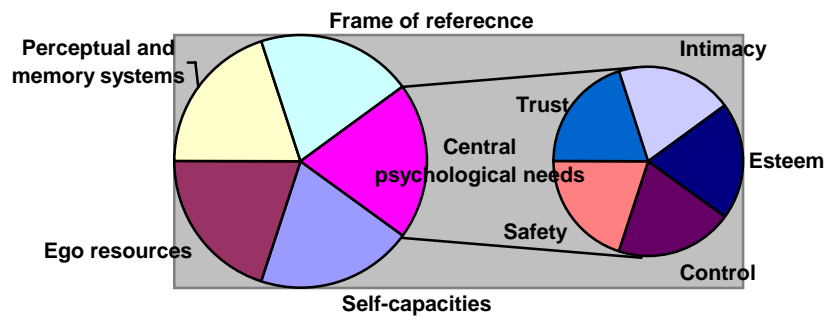
These findings indicate that addressing vicarious trauma is as complex as the experience of vicarious trauma. Utilizing a multitude of approaches, knowledge base, collegial support and supervision, can minimize the experience of vicarious trauma. Organizations who take these all into account will be providing the most benefit to their staff members.

In addition, organizations can begin to address specific areas of vicarious trauma by focusing on collegial support and supervision. As the findings suggested the subscale of other esteem can be impacted by the variety of approaches, the subscale of self intimacy can be impacted by supervision, and

the subscale of other control can be impacted by collegial support. It is important to recognize that on a variety of the subscales as the level of knowledge increased so too did the level of vicarious symptoms. Therefore, knowledge of vicarious trauma alone is not enough; supportive administrative practices are vital.

This study serves as a foundation in establishing best practices within the realm of addressing vicarious trauma in domestic violence organizations. Having a baseline of scientific understanding on how the work impacts the worker and what works to minimize that impact is the beginning to providing sound and productive organizational interventions. Further research is needed to support and build upon this understanding.

APPENDIX A: EXPERIENCE OF SELF



APPENDIX B: IRB APPROVAL LETTERS



Office of Research & Commercialization

December 6, 2006

Katharine Cambell
c/o Eileen Abel, Ph.D.
University of Central Florida
School of Social Work
HPA 343
Orlando, FL 32816-3358

Dear Ms. Campbell:

With reference to your protocol #06-4012 entitled, "An Analytical Understanding of Administrative Practices Minimalizing Vicarious Trauma in Domestic Violence Organizations in Florida," I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office. **This study was approved on 12/6/06. The expiration date for this study will be 12/5/2007.** Should there be a need to extend this study, a Continuing Review form must be submitted to the IRB Office for review by the Chairman or full IRB at least one month prior to the expiration date. This is the responsibility of the investigator.

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board through use of the Addendum/Modification Request form. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur.

Should you have any questions, please do not hesitate to call me at 407-823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

A handwritten signature in cursive script that reads "Joanne Muratori".

Joanne Muratori
(FWA00000351 Exp. 5/13/07, IRB00001138)

Copies: IRB File
Eileen Abel, Ph.D.

JM:jm

12201 Research Parkway • Suite 501 • Orlando, FL 32826-3246 • 407-823-3778 • Fax 407-823-3299

An Equal Opportunity and Affirmative Action Institution

Thank you for your participation in this study. This study entitled **An Analytical Understanding of Administrative Practices Minimizing Vicarious Trauma in Domestic Violence Organizations in Florida** is being conducted by Katharine Campbell, LCSW, Doctoral Candidate under the Ph.D. in Public Affairs program within the University of Central Florida under the guidance of dissertation chair Dr. Eileen Abel (within the School of Social Work). Katharine Campbell can be reached at 954-790-7926 or via email at info@KatharineCampbell.com and Dr. Eileen Abel can be contacted at 407-823-2000 or via email at cabel@ucf.edu

Your work is important to so many and it is the goal of this study, which involves research, to gain a better understanding of how your work impacts you and your organization. This survey is designed to gather some basic information about you, your organization, and your knowledge of vicarious trauma. The scientific purpose of this research is to determine if there is any correlation between knowledge base and administrative practices of vicarious trauma and the level of vicarious trauma symptoms. It is hopeful that upon completion of this survey you will feel to have helped in determining effective administrative practices for direct care staff within domestic violence shelters.

Your participation will consist of completing each of the attached surveys to the best of your knowledge. You do not have to answer any question that you do not wish to answer or feel uncomfortable in answering when completing the surveys. The surveys will take approximately 45 minutes to complete. Please be advised that this survey is sensitive in nature. The survey is to be completed on a voluntary basis, if at any time you wish to stop you are free to do so. You have the right to withdraw at any time without consequence. In addition, if for any reason this survey causes distress please contact your local United Way counseling services (which is provided by your organization prior to beginning the survey).

Your information will be kept with utmost confidentiality. **You name in not to be placed on any of the survey items.** In addition, only the primary investigator and those within the institution in which this study is being conducted will view the surveys. The surveys will be maintained within a locked file by the primary investigator for a minimum of seven years. Please note you must be 18 years of age or older to participate.

This research study has been reviewed and approved by the UCF Institutional Review Board. Questions or concerns about research participants' rights may be directed to the UCF IRB office, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The telephone number is (407) 823-2901.

And, again thank you for your participation.





University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephones: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

EXPEDITED CONTINUING REVIEW APPROVAL

From : UCF Institutional Review Board
FWA00000351, Exp. 5/07/10, IRB00001138
To : Katharine M Campbell
Date : December 10, 2007
IRB Number: SBE-06-04012

Study Title: **An Analytical Understanding of Administrative Practices Minimizing Vicarious Trauma in Domestic Violence Organizations in Florida**

Dear Researcher,

This letter serves to notify you that the continuing review application for the above study was reviewed and approved by the IRB Vice-chair on 12/8/2007 through the expedited review process according to 45 CFR 46.

Continuation of this study has been approved for a one-year period. The expiration date is 12/7/2008. Because the previous IRB approval for this study expired, there was a period of time when there was no IRB approval in place. You may not use any data collected during that lapse between 12/5/2007 and 12/8/2007, and any data that may have been collected during that period must be destroyed.

This study was determined to be no more than minimal risk and the category for which this study qualified for expedited review is:

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

All data must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

To continue this research beyond the expiration date, a Continuing Review Form must be submitted 2 – 4 weeks prior to the expiration date. Use the Unanticipated Problem Report Form or the Serious Adverse Event Form (within 5 working days of event or knowledge of event) to report problems or events to the IRB. Do not make changes to the study (i.e., protocol methodology, consent form, personnel, site, etc.) before obtaining IRB approval. Changes can be submitted for IRB review using the Addendum/Modification Request Form. An Addendum/Modification Request Form cannot be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>.

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 12/10/2007 09:27:55 AM EST

APPENDIX C: LETTER TO ORGANIZATIONS

Katharine Campbell,, Doctoral Candidate
University of Central Florida
Doctoral Candidate
PhD in Public Affairs

Date

**Each letter will be personalized to the
point person who was contacted via
telephone and agreed to participate.**

Dear _____:

I want to begin by thanking you and your organization for taking the time to participate in this survey. As mentioned per our conversation on _____, this survey is designed to understand an organizations' knowledge of vicarious trauma and to gather information on whether there are current practices organizations utilize to minimize vicarious trauma.

Included in this packet you will find four surveys. Please have one administrative staff, preferably those who directly supervise direct-care staff, complete this survey. The additional three surveys are to be completed by direct-care staff on a voluntary basis. Once those surveys are completed please return them in the enclosed self-addressed stamped envelope.

Because this survey is sensitive in nature, it is requested that whoever distributes the surveys' collect the completed surveys and seal the return envelope in the staff's presence to illustrate the information was not reviewed by anyone at the shelter. In addition, it is requested that the local United Way Help-line number in your community be provide to everyone completing the survey.

Your time and effort is greatly appreciated.

Sincerely,

Katharine Campbell, LCSW, Doctoral Candidate

APPENDIX D: PRIMARY INVESTIGATOR DESIGNED QUESTIONNAIRE

Thank you for your participation in this study. This study entitled **An Analytical Understanding of Administrative Practices Minimizing Vicarious Trauma in Domestic Violence Organizations in Florida** is being conducted by Katharine Campbell, LCSW, Doctoral Candidate under the Ph.D. in Public Affairs program within the University of Central Florida under the guidance of dissertation chair Dr. Eileen Abel (within the School of Social Work). Katharine Campbell can be reached at 954-790-7926 or via email at info@KatharineCampbell.com and Dr. Eileen Abel can be contacted at 407-823-2000 or via email at eabel@ucf.edu

Your work is important to so many and it is the goal of this study, which involves research, to gain a better understanding of how your work impacts you and your organization. This survey is designed to gather some basic information about you, your organization, and your knowledge of vicarious trauma. The scientific purpose of this research is to determine if there is any correlation between knowledge base and administrative practices of vicarious trauma and the level of vicarious trauma symptoms. It is hopeful that upon completion of this survey you will feel to have helped in determining effective administrative practices for direct care staff within domestic violence shelters.

Your participation will consist of completing each of the attached surveys to the best of your knowledge. You do not have to answer any question that you do not wish to answer or feel uncomfortable in answering when completing the surveys. The surveys will take approximately 45 minutes to complete. Please be advised that this survey is sensitive in nature. The survey is to be completed on a voluntary basis, if at any time you wish to stop you are free to do so. You have the right to withdraw at any time without consequence. In addition, if for any reason this survey causes distress please contact your local United Way counseling services (which is provided by your organization prior to beginning the survey).

Your information will be kept with utmost confidentiality. **You name in not to be placed on any of the survey items.** In addition, only the primary investigator and those within the institution in which this study is being conducted will view the surveys. The surveys will be maintained within a locked file by the primary investigator for a minimum of seven years. Please note you must be 18 years of age or older to participate.

This research study has been reviewed and approved by the UCF Institutional Review Board. Questions or concerns about research participants' rights may be directed to the UCF IRB office, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The telephone number is (407) 823-2901.

And, again thank you for your participation.

I am at least 18 years of age and completing this survey constitutes my informed consent.

Participant Information:

Please check one

Gender: ___ Male ___ Female

Age: ___ 18-25 ___ 26-35 ___ 36-45 ___ 45-55 ___ 55+

Relationship Status: ___ Married ___ Divorced ___ Single ___ Other

Number of years working with victims of domestic violence:

___ 0-1 ___ 1-5 ___ 6-10 ___ 10+

Educational Level:

___ High School ___ Some College ___ Bachelors Degree ___ Masters Degree

Organization Information:

Please check one

Number of staff who work in the shelter:

___ 1-25 ___ 26-50 ___ 51-75 ___ 76-100 ___ 100+

Number of staff who work within entire organization (if different from above):

___ 1-25 ___ 26-50 ___ 51-75 ___ 76-100 ___ 100+

Number of facilities/locations operated by the shelter or by the parent organization:

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 or more

Number of year's shelter has been in operation:

___ 0-5 ___ 6-10 ___ 11-15 ___ 16-20 ___ 21+

General population served: ___ Inner City ___ Suburban ___ Rural

Please place an X in the appropriate box for each of the below questions:

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Unknown
	1	2	3	4	5	6
1. Vicarious trauma is the impact of trauma therapy?						
2. Vicarious trauma is cumulative?						
3. Vicarious trauma can occur after one trauma incident?						
4. Trauma can be physical, sexual or emotional.						
5. Trauma must occur to the individual to experience vicarious trauma.						
6. Vicarious trauma can influence a staff members' ability to provide services.						
7. An employer can offer counseling to minimize vicarious trauma.						
8. Team building exercises minimize vicarious trauma.						

Signs of vicarious trauma include (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Nightmares/ Night terrors | <input type="checkbox"/> Change in fundamental beliefs | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Changes in eating pattern | <input type="checkbox"/> Diminished self-esteem | <input type="checkbox"/> Hypervigilance |
| <input type="checkbox"/> Intrusive images | <input type="checkbox"/> Social withdrawal | <input type="checkbox"/> Emotional flooding |

Please place an "X" in the appropriate box:

	Yes	No	Unsure
Does your organization offer an EAP?			
Is the well-being of staff addressed in your organizations mission statement?			
Does your organization offer "mental-health" days?			
Are team building exercises a routine aspect of your staff meetings?			
Does your organization offer retreats for direct-service staff?			
Are there specific times designated where staff can discuss how they are feeling to one another?			
Does your organization offer peer support groups?			
Does your organization supervisor's offer an open-door policy?			
Does your organization have policies that routinely praise direct care services work?			
Can you go to your supervisor regarding feelings of being overwhelmed with your work?			
Does your supervisor ask you how you are coping with the work you do?			
Does your supervisor encourage you to take time off when you are feeling overwhelmed?			

General questions, please answer to the best of your ability:

- Do you believe someone in your workplace is experiencing vicarious trauma (circle one)? Yes/No
- If "yes" to the above question, what are the indicators for you to answer yes? _____

- Why do you believe vicarious trauma occurs? _____

~The end.....Thank you for your participation. ~

**APPENDIX E: FACTOR ANALYSIS OF ITEMS ASSOCIATED WITH
THE THREE SUBSCALES**

Factor Loading for Knowledge Base

	Factor Loading
Knowledge1	.645
Knowledge2	.620
Knowledge3	.683
Knowledge4	.478
Knowledge5	.417
Knowledge6	.555
Knowledge7	.581
Knowledge8	.671
KnowSxs	.689
Eigenvalue	4.192

Factor Loading for Collegial Support

	Factor Loading
EAP	.808
MissionState	.615
Team	.658
Retreats	.835
SupportTime	.787
SupportGroup	.768
Eigenvalue	2.190

Factor Loading for Supervision

	Factor Loading
DaysOff	.317
OpenDoor	.669
Praise	.326
Overwhelmed	.723
Coping	.711
TimeOff	.829
Eigenvalue	2.192

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