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Contexts of Best Practices for Addressing Vicarious Trauma in VAW Work

A Review of the Literature

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June 2012

Introduction

While numerous studies and literature are devoted to documenting the occurrence and significance of vicarious trauma experienced by individuals working with survivors of abuse, trauma and violence, little research has been devoted to the prevention of vicarious trauma, nor strategies to counter it. This review of the literature highlights the many factors and variables which contribute to contexts for best practices in addressing vicarious trauma in front-line shelter and counselling work. A number of major themes for best practices and contexts for dealing with vicarious trauma emerged from this review and include: characteristics of those most at risk, models for self-care, organizational structure and work environment, and the role of peer supports, groups, supervision, training and education.

Previous research on vicarious trauma in sexual violence workers reveals several methodological problems, including a lack of agreed operational definitions, poor response rates, inadequate control for confounding factors, and lack of comparison groups. To a certain extent, these echo the limitations of generic research on vicarious trauma. These methodological issues will need to be addressed if vicarious traumatisation/secondary traumatic stress is to be empirically verified as a useful and relevant theoretical concept for psychological practitioners who work with survivors of sexual violence and childhood sexual abuse (Chouliara, Hutchison, & Karatzias, 2009).

Definitions

The reviewed literature reflects varying definitions of vicarious trauma, as well as overlap between understandings of burnout, secondary traumatic stress and vicarious trauma. In

a previous literature review of the effects of vicarious trauma on mental health workers, it was determined that there is a need for further research to more aptly define the boundaries of the concept of vicarious trauma relative to other terms (Sabin-Farrell & Turpin, 2003). To this end, the use of qualitative methods to uncover more of the internal processes in individual practitioners may further our understanding of vicarious trauma constructs (Betts Adams, Matto & Harrington, 2001).

However, for the purpose of this literature review and in order to understand best practices for mitigating vicarious trauma, it is important to understand the definitions related to vicarious trauma. Pearlman and Saakvitne (1995) describe vicarious trauma as the "transformation in the therapist's inner experiences resulting from the empathic engagement with clients' traumatic material". (Pearlman & Saakvitne, 1995, p. 151) Theoretically and as measured by the Trauma Symptom Inventory (TSI) Belief Scale, vicarious trauma has 10 components: self-safety, other safety, self-trust, other trust, self-esteem, other esteem, self-intimacy, other intimacy, self-control, and other control (Pearlman, 1996). Vicarious trauma can have a profound effect on therapists' world and self-view sense of meaning and identity, professional functioning, and personal relationships (Pearlman & Saakvitne, 1995).

In an effort to broaden the scope of appropriate practices that may be useful for VAW agencies, the important elements associated with vicarious trauma, as determined and redefined by Sabin-Farrell & Turpin (2003) are also considered. These include:

> the cognitive, emotional, behavioural, and physical responses, which might be considered as a normal response to hearing traumatic material, the symptomatic responses, which might be considered as extreme versions of the responses previously mentioned, cognitive changes in beliefs and attitudes, and additional effects on interpersonal and

occupational functioning. These effects may occur in the short or long term. (Sabin-

Farrell & Turpin, 2003, p.453)

While secondary traumatic stress is very similar to vicarious trauma, disrupted cognitions about

self, or the beliefs that clinicians have about themselves are an important distinction of vicarious

trauma (Way, VanDeusen, & Cottrell, 2007). The extent to which clinicians trust their instincts,

feel comfortable being alone, and/or hold themselves in high esteem may be negatively impacted

by providing trauma treatment. Clinicians who hear their clients' traumatic material may

experience a diminished sense of self-competency and self-worth (Way et al. 2007).

Of utmost importance to note is that not all reactions to trauma exposure are negative. In

an effort to shed light upon the positive outcomes for counsellors who work with victims of

trauma, it is important to consider the notion of vicarious resilience. Engstrom, Hernandez, &

Gangsei (2008) outline the three components of vicarious resilience that contribute to the

empowerment of a counsellor as cognition of the human capacity to thrive, altering of

perspectives of one's life through behaviours, emotions and cognitions, and reaffirming the value

of therapy. According to their research, in order for these processes to occur and for vicarious

resilience to be realized, the counsellor must engage empathically with the client and must

engage in conscious exploration of the phenomenon of vicarious resilience. This exploration

would require a context or opportunity to do this work, such as supervision, in order prioritize

the finding of new meaning in one's work.

In the research of Jenkins, Mitchell, Baird, Whitfield &Meyer (2011) a majority of

participants discussed positive changes in themselves as a result of trauma work (a topic virtually

absent from the literature), while still indicating experiencing symptoms of vicarious trauma. In

an effort to explain this phenomenon, the researchers noted that "compared to secondary

traumatic stress, which is unrelated to positive changes, vicarious trauma is more cognitive, and low to moderate scores might reflect in part a realistic awareness of danger in the world. Thus, counselors who described improved relationships with others and rated themselves lower on vicarious trauma might be expressing feelings of increased safety and trust, as well as esteem, intimacy, and/or control". (Jenkins et al. 2011, p.2409)

Who is Vulnerable to Vicarious Trauma?

In an effort to prevent the occurrence of vicarious trauma and be better attuned to the needs of those who experience it, it is important to identify those individuals who may be more susceptible. There is general recognition and agreement in the literature regarding the characteristics which make some individuals working with survivors of trauma and abuse more at risk for vicarious trauma. These factors include being female, younger, inexperienced, having greater exposure to trauma clients, and having a personal trauma history (Adams & Riggs, 2008; Baird & Jenkins, 2003; Bell, Kulkarni, Dalton, 2003; Lerias and Byrne, 2003). An exploratory study of therapist trainees (Adams & Riggs, 2008) found that novice therapists were more likely to engage in self-sacrificing behaviours and be less self-aware of their defense style, than those with more experience in trauma work. In studies of therapists, counsellors and social workers interacting with clients who had experienced trauma, more than half of the participant samples for each study identified as having a personal trauma history (Baird & Jenkins, 2003; Slattery & Goodman, 2009). In a recent survey of service providers working with survivors of family and sexual violence (Choi, 2011b) over 80% of the workers identified as having experienced at least one traumatic event, and over 70% of workers identified as having experienced traumatic events related to family violence or sexual assault.

The propensity for workers in this field to have experienced personal trauma themselves and therefore be at a higher risk for experiencing vicarious trauma, is a pivotal argument for the responsibility of organizations and agencies to address the occupational hazards of working with trauma clients (Bell, Kulkarni, Dalton, 2003; Harrison & Westwind, 2009). Much of the literature points to the ethical imperative of employers to address employee vicarious trauma. This will be discussed further in a subsequent section of this review.

There also exist many protective factors for vicarious trauma. Spending time in work activities other than working with trauma clients decreases the risk of vicarious trauma (Brady, Guy, Poelstra & Brokaw, 1999). Also, having a more diverse caseload with a greater variety of client problems, as well as participating in research, education, and outreach appear to mitigate the effects of traumatic exposure (Bell et al. 2003; Brady et al. 1999).

An important first step in addressing vicarious trauma is addressing the stigma associated with it. Much of the literature points to the need for vicarious trauma to be normalized in the work environment (Brady et al. 1999; Bride, 2007; Trippany & White Kress, 2004). In particular, normalizing the response has appeared to be a significant and primary therapeutic intervention. "Staff frequently have commented that hearing and understanding that there is nothing "wrong" with them and that their experience is understandable provides almost immediate subjective relief". (Maltzman, 2011, p.312)

As mentioned previously, one of the primary predictors for vicarious trauma is the number of hours per week spent working with traumatized people. Therefore, part of the solution seems more structural than individual. That is, organizations must determine ways of

distributing workload in order to limit the traumatic exposure of any one worker (Bober &

Regher, 2005).

Supervision

The literature clearly indicates the importance and necessity of regularly scheduled

supervision in combatting vicarious trauma for workers in the field of violence and trauma

(Berger & Gelkopf, 2011; Brady, Guy, Poelstra, & Brokaw, 2006; Slattery & Goodman, 2009;

Trippany & White Kress, 2004).

Supervision that is authentic, engaging, and empowering has been shown to lessen the

incidences of vicarious trauma and is essential to managing and alleviating the painful effects of

trauma work (Slattery & Goodman, 2009).   It is important, however, that the supervisor be in

tune to the signs and symptoms of vicarious trauma and be ready to introduce the phenomenon to

the supervisee if necessary. Ben-Porat & Itzhaky (2011) found that workers were satisfied with

supervision despite experiencing vicarious trauma. This perhaps points to the question of what a

worker's perceived role of supervision is and what their expectation is regarding supervision

subject matters.   Therefore, there may be a need for the supervisor to bring up the topic of

vicarious trauma, and introduce it as a possible issue (Ben-Porat & Itzhaky, 2011). If the role of

supervision is made clear and explicit to the worker, this may help in authentic engagement in

the supervision process and may help demonstrate the merits of supervision; as "those who

believed in the value of supervision were more likely to devote time to it". (Bober & Regher,

2005, p.7)   Interestingly, Bober and Regher (2005) also found that supervisors were more likely

to believe in the value of supervision than frontline workers.

When working with a supervisee, the supervisor needs to be alert to identity confusion and disrupted self-concept (Adams & Riggs, 2008). It should also be noted that validation of personal accomplishment is a protective factor for vicarious trauma (Baird & Jenkins, 2003) which may contribute to the level of competence a worker feels, a process that may lend itself well to supervision. When a worker is able to increase their perceived role competence the prevalence of vicarious trauma is decreased (Ben- Porat & Itzhaky, 2011). The increase in perceived role competence may be related to the worker's capacity for vicarious resilience; whereby through engagement in the conscious exploration of the phenomenon of vicarious resilience, new meaning in one's work is realized and their belief in the inherent value of therapy is increased (Engstrom et al. 2008).

While clinical supervision should not be framed as therapy or a replacement to therapy, it may be useful to more directly address the multiple components which contribute to vicarious trauma, such as a personal history of trauma. For example, "being cognizant of childhood messages regarding sexuality and relationships may offer clinicians insights into their reactions to working in this field". (Way et al. 2003, p.96) For this reason, a safe and trusting supervisor-supervisee relationship can be a central means to combatting vicarious trauma.

However, some studies did question as to whether or not workers should disclose personal trauma to their supervisor (Adams & Riggs, 2008), especially if the supervisor also holds an evaluative position over the worker. Bell et al. (2003) note that if at all possible, supervision and evaluation should be separate functions in an organization due to a worker's potential reluctance to divulge issues in their work that might imply a struggle with vicarious trauma. In their study they found that "the number of times a worker received non-evaluative

supervision and the number of hours of non-evaluative supervision were positively related to low levels of secondary traumatic stress". (Bell et al. 2003, p.468) They further suggest that in situations where supervisors cannot separate the supervisory and evaluative functions, agency administrators should consider contracting with an outside consultant for trauma-specific supervision.

Slattery and Goodman (2009) also found that a supervisor's use of self-disclosure through sharing of personal and professional stories, might promote an atmosphere where advocates are able to take risks and discuss their mistakes.

There is general agreement in the literature of the need for further research addressing the factors that affect the quality of the supervisor-supervisee relationship. For example, "how do differences of race, culture, and ethnicity affect the quality of the relationship between supervisor and advocate, as well as the overall emotional well-being of the advocate? Studies on the experience of new and minority social workers, in particular, would add to the knowledge base in the area of both burnout and vicarious trauma". (Slattery & Goodman, 2009, p.1373) Specifically pertinent to this review, Ben-Porat and Itzhaky (2011) also noted the lack of research regarding the role of supervision for workers in the field of domestic violence.

Maltzman (2011) outlines a number of recommendations for supervisors in the social services sector yielded from her research. These include:

1) Be an active listener when a staff person needs support. The support should focus on the staff's concerns, not the supervisor's
2) Be mindful of how debriefing specific cases occurs. This is best done in 1:1 contacts, not in group meetings where additional staff are unnecessarily exposed to case specifics.
3) It is appropriate to share personal experiences as learning tools. However, it is not appropriate to share descriptions of particularly distressing case specifics from past experience (e.g., "war stories"). These descriptions expose staff unnecessarily to additional traumatic material.

4) Do not unintentionally use debriefings or supervision as venues for one's own processing of past cases. (Maltzman, 2011, p.313)

It is also interesting and important to point out that there is a paucity of research with regards to supervision, vicarious trauma and VAW work in unionized work environments. As such, we need to be mindful of the challenges and/or strengths of the nature of this type of supervision in unionized work environments.

One interesting study related to supervision was conducted by Sommers and Cox (2006). They found evidence of the usefulness of stories in supervision with sexual violence counsellors. Most participants in this study expressed an interest in exploring their personal experience of vicarious trauma through the lens of stories. The use of stories, both popular and those created by the supervisee, acted as an entry point for supervisors to broach and explore the supervisee's challenges and frustrations related to their work, that might otherwise have not been expressed. "Encouraging supervisees to identify tales that relate to their experiences or to share a title for a self-authored book about their work, provides multiple opportunities to make meaning of experience". (Sommers & Cox, 2006, p.12) This narrative approach was described as a creative way to help the supervisee create meaning out of their struggles and allow for authentic self-reflection.

Self-Care

Much of the research dedicated to vicarious trauma specifies the importance of personal therapy for professionals working in the trauma field (Bell et al. 2003; Harrison & Westwood, 2009). More specifically, it was recommended that organizations provide insurance to their

employees to ensure this is a financially viable option for them (Bell et al. 2003; Berceli & Napoli, 2006; Trippany & White Kress, 2004). There was also broad support in the literature for all professionals having access to a wide array of self-care conferences and training and to be made aware of their necessity (Berceli & Napoli, 2006; Bell et al. 2003).

While some of the research endorsed self-care activities that promote physical and spiritual well-being (Berceli & Napoli, 2006; Brady et al. 1999; Harrison & Westwind, 2009; Sommers, 2008; Trippany & White Kress, 2004) as well as more unique activities such as a worker writing a letter to themselves regarding their commitments to self-care and the agency mailing it to them 2 months later (Clemens, 2004), not all of the literature confirmed the usefulness of self-care techniques. A study by Bober and Regher (2005) found that despite workers believing in the usefulness of recommended coping strategies for vicarious trauma, there was no association found between the belief that leisure and self-care were useful and the time allotted to engage in these activities. Most importantly, there was no association between time devoted to leisure, self-care, research and development, or supervision and traumatic stress scores. Thus, there is no evidence that using recommended coping strategies is protective against symptoms of acute distress.

The study by Brady et al. (1999) examined spirituality amongst established trauma therapists. While these therapists were all older and more experienced, they also shared the common trait of a strong sense of spirituality. They all held common viewpoints regarding the central tenants of their life, including meaning, hope, connection, and idealism. Consequently, this research found a strong link between a high case load of trauma clients and increased spiritual well-being. Of course the chicken or the egg question remains: had the high number of trauma cases resulted in the need to increase spiritual well-being or are those with established

spiritual well-being better suited to and more apt to engage in trauma work? Regardless,

spirituality, mindful self-awareness and meditation have been noted as effective strategies for

vicarious trauma (Harrison & Westwind, 2009; Sommers, 2008; Trippany & White Kress

2004) as well as guided meditation, breath work, and reflective reading (Sommers, 2008).

Mindfulness has also proved effective as a preventative measure for vicarious trauma (Berceli &

Napoli, 2006). While some of the research points to the need for individualized and personal

coping mechanisms (Trippany & White Kress, 2004) and self-directed techniques to cope with

the emotional numbing and hyper arousal (Berceli & Napoli, 2006) other research reveals the

effectiveness of the implementation of self-care models at an organizational level (Maltzman,

2011).

Peer and Group Supports

There was general recognition in the literature regarding the importance of peer supports

in alleviating the effects of vicarious trauma. Campbell (2008) found peer support to be the most

significant factor in combatting vicarious trauma, (as well as supervision and organizational

practice). In a study of nurses involved in treating traumatized patients, group cohesion, team

building, sharing of stress management techniques, and a sharing of hope, were understood as

positive peer group activities for mitigating vicarious trauma (Berger & Gelkopf, 2011).

Similarly, peer supervision was also assessed as a useful strategy for counsellors working with

trauma survivors, as it provided a means for normalization, support, and shared strengths in

dealing with vicarious trauma (Trippany & White Kress, 2004). Peer groups also provided a

context for validation, venting, decreased isolation, and improved objectivity (Slattery &

Goodman, 2009). The necessity for the normalization of vicarious trauma amongst peers is an

important one. Clemens (2004) lauded the role of peer groups for their powerful ability to provide mutual aid, de-stigmatize vicarious trauma, and lend themselves to the creation of positive peer connections. For example,

> Participants shared data about their experiences. This, in and of itself, was powerful. Participants also started to discuss taboo areas, such as using sleep or alcohol to cope with work stress. Through introductions and focused facilitation… participants began to see that they are "all in the same boat," as trauma workers and that their experiences with vicarious trauma are normal. (Clemans, 2004, p.64)

Slattery and Goodman (2009) underscored the role that administrators play in creating and encouraging an environment where workers are able to share their reactions to the work, discuss their own values and visions, and respond to each other in a positive manner, as well as identifying and removing barriers to peer support (Slattery &Goodman, 2009).

It should be recognized, however, that sharing case material may also potentially increase the risk of further secondary traumatization among advocates and, therefore, group consultation and supervision should provide the necessary support and structure to minimize this possibility (Slattery & Goodman, 2009).

In addition to self-care and supervision, Bell et al. (2003) found that peer support groups, team debrief groups, and reading groups (reading books and articles related to vicarious trauma) were invaluable venues for workers to express their fears and vulnerability, normalize their reactions to clients, as well as gain an understanding of the normal and acceptable reactions and behaviours for clients dealing with trauma. McNamara (2010) also found weekly group supervision (of one and a half hours duration) extremely useful in mitigating the effects of

vicarious trauma, which included staff development on key issues and research relevant to the prevention and treatment of vicarious trauma as well as debriefing of critical incidents.

Further to group members discussing their experiences of vicarious trauma, it was found to also be important to be aware and address the possibility of group think/conformity, victim blaming, and increased vicarious trauma due to hearing others stories, in the context of this group work. Also, similar to the conflict of interest findings on supervision, "when groups are held within agencies, there is the potential problem generated by conflicting roles in the group, such as a supervisor who is both supporter and evaluator or a co-worker/supervisor who is also a friend" (Bell et al. 2003, p.468). This stresses the importance of ensuring that the strategies set up within an organization to address vicarious trauma, are free from the barriers that may limit safety.

Training and Education

The literature revealed that one of the most concrete ways of preventing the vicarious traumatization of workers is trauma training specific to the clinician's needs (Adams & Riggs, 2008; Bell et al. 2003; Ben-Porat & Itzhaky, 2011; Brady et al. 1999; Campbell, 2008; Harrison & Westwind, 2009; Trippany & White Kress, 2004). Trauma-specific education can diminish the potential for vicarious trauma. Training in trauma and vicarious trauma can help individuals to name their experience and provide a framework for understanding and responding to it (Bell, et al. 2003). It is important to note that formal trauma training was described most often in the literature, not as a one-time happening, but rather, multiple intensive workshops and on-going training (Adams & Riggs, 2009).

As well as trauma training, Maltzman (2011) found the need for both self-directed and formal education for workers, in defining and maintaining boundaries with their clients, in order to prevent over identification with their clients. "Discussing the difference between 'caring' and 'caring too much' has been particularly useful and meaningful for staff. Staff have expressed concern that if they do not feel emotionally 'pulled' by a case, it means they are becoming calloused or disengaged". (Maltzman, 2011, p.311) It is also significant to consider the relief expressed by the participants of this study in regards to hearing that emotional boundaries between self and client are professionally necessary. Once again, this underscores the importance of addressing the perceived expectations that staff believe are in place regarding their work and their agency.

Trauma training does not always result in decreased levels of vicarious trauma in workers, but can however result in increased feelings of competence. In their study of domestic violence workers, Ben-Paret and Itzhaky (2011) reported that those who had received professional training in the field of domestic violence reported higher levels of role competence in the components of general competence and task knowledge problem solving than did those who had not received training, but found no effect on the workers levels of vicarious trauma. According to Urquiza, Wyatt and Goodlin-Jones (1997) efforts to educate staff about vicarious trauma can begin in the job interview. Similarly, Pearlman and Saakvitne (1995) report that agencies have a duty to warn applicants of the potential risks of trauma work and to assess new workers' resilience and Bell et al. (2003) maintain that new employees can be educated about the risks and effects associated with trauma, as new and inexperienced workers are likely to experience the most impact.

Learning new ways to address clients' trauma may also help workers limit their own vicarious trauma. Theories, such as constructivist self-development theory (McCann & Pearlman, 1990) on which the theory of vicarious trauma is based, maintain a dual focus between past traumas and the client's current strengths and resources. Working from a theoretical framework that acknowledges and enhances client strengths and focuses on solutions in the present can feel empowering for both the client and the worker and reduce the risk of vicarious trauma.

Understanding theory related to the development of the self can be useful in normalizing a worker's response to traumatic material. The constructivist self-development theory is helpful to understanding vicarious trauma as a normal, adaptive process which works to protect an individual from the potential harms of working with victims of violence and trauma.

While training in trauma has been reported as a useful strategy in preventing vicarious trauma, there are suggestions in the literature that knowledge alone regarding trauma does not equate to reduced levels of vicarious trauma symptoms. Campbell (2008) found the opposite is true. "As participants' level of knowledge (of vicarious trauma) increased, so did 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". (Campbell, 2008, p.105) This suggests that more structured supports must be implemented in conjunction with training and education.

Organizational Factors

In considering the relationship between the workplace environment and the potential for or prevention of vicarious trauma, a number of issues were identified in the literature. Workplace conditions and supports were directly related to workers' vicarious trauma (Baird & Jenkins, 2003; Brady et al. 1999) and treating vicarious trauma as a serious matter by acknowledging it within the organization, holding regular agency staff meetings about its effects on workers and addressing it in agency policies were seen as critical (Brady et al. 1999; Burke et al. 2006; Harrison & Westwind, 2009). Agency responsibility in the form of consultations, education, ensuring varied case loads, insurance for personal therapy, and paid vacation were also sighted as key to combatting vicarious trauma (Trippany & White Kress, 2004).

Slattery and Goodman (2009), in their study of vicarious trauma as it relates to workplace risks and protective factors, highlighted the impact of organizational structure and power and problematized agencies where, as a result of large disparities in power, workers had limited access to support and feedback. "Some settings adhere to more traditional hierarchical models, whereas others offer advocates greater access to power within the organization through a decentralized management structure". (Slattery and Goodman, 2009, p.1359) These kinds of differences may significantly shape a worker's ability to cope with the challenging realities of their job. Furthermore, this study also found that workers within agencies that adopted a shared power scale perceived their work environment as more empowering and were less likely to report symptoms of secondary traumatic stress. It is hypothesized that the opportunity to experience respect and equality in the workplace may counteract the traumatic effects of VAW work (Slattery & Goodman, 2009). Likewise, Maltzman (2011) reports that organizational

structure that permits or promotes cohesive staff relationships and teamwork also promotes a

buffering effect against secondary trauma and vicarious trauma by enhancing peer social support.

Clemans (2004) also stresses the significance of a responsive agency in addressing the

issue of workers' vicarious trauma. The inherent conflict between the wider organizational desire

for cost effective strategies that allow for clients to be fixed and discharged quickly versus the

individual worker's altruistic desire to help clients in a meaningful way, necessarily results in a

situation that requires agencies to take a step back and consider the well-being of their staff. Not

only is this an important step towards maintaining happy and healthy workers, it can also help

ensure an organization's bottom line is met.

Similarly, Pack (2008), discusses how individual worker's vicarious traumatization and

an organization's broader agenda "to move clients swiftly through" result in discourses of failure

in relation to client progress. Patterns of disconnection and impatience with clients are likely to

be a reflection of problems within the agency, not problem clients. The author saliently details

what may have been a useful strategy for vicarious trauma in her own experience.

> Instead of remaining unspoken, these issues could have been collectively and openly
>
> discussed...the creation of a range of narratives within this "field" of experience might
>
> have enabled our teams and individuals to author a range of narratives within the wider
>
> organization. Having the space to choose one's own narrative among multiple discourses
>
> would have been a powerful mediator to the vicarious traumatization that I and no doubt
>
> others experienced individually and collectively within the team and wider organization
>
> at that time. (Pack, 2008, p.42)

Further to the importance of reducing the stigma associated with vicarious trauma and the worker's associated feelings of inadequacy and ineffectiveness, an organizational culture that "normalizes" the effect of working with trauma survivors can help to create a supportive environment for social workers to address those effects in their own work and lives (Bell et al, 2003; Way et al. 2007). As well, having policies that support workers' emotional well-being or including in their mission statement, a dedication to staff self-care and support can be an important first step for organizations, in demonstrating their commitment to staff well-being, in conjunction with structured vicarious trauma prevention and treatment strategies (Bell et al 2003; Way et al 2007).

Bell et al (2003) also suggest, for those agencies with limited funding or resources for staff self-care, partnering with other agencies and sharing training demands, as well as sending one staff member to a conference or workshop and then asking that person to present what he or she learned to co-workers. Free options might include a lunch time walking or meditation group.

In a study of the development and implementation of a large-scale organizational self-care model within a child welfare system that employed over 800 protection workers and supervisors, (Maltzman, 2011), a common theme that emerged was workers' beliefs that there were organizational expectations about which reactions to traumatic material were considered "normal" and that the organization also expected staff to be nonreactive to traumatic events and that any reaction of anxiety or sadness was perceived as weakness. As well, staff believed that self-deprecating behaviour or the sacrificing of one's well-being for the greater good of the clients and the organization were considered normal and expected practice. It was believed that this was a major barrier to staff initiating or maintaining self-care strategies and underscored the need for an organizational approach and a shift in organizational culture.

The general purpose of the self-care model was to provide proactive and preventive

psycho-education for direct service and support personnel, as well as direct support at the

individual and unit level secondary to critical incidents. The goals were to mitigate the

potential for secondary trauma and vicarious trauma by providing proactive support as

well as acute symptom relief, thereby promoting staff well-being and maintaining

successful organizational functioning. Organizational structure, at the system and unit

level, sets parameters for the development of staff cohesion and peer support. (Maltzman,

2011, p.316)

The work of Choi (2011a) speaks to the importance of an established support system within an

organization and the trickledown effect that can result. Her research highlights how, when there

is an embedded culture of support and normalization in an organization, regarding vicarious

trauma, workers are better able to access more resources from their social networks, as well as

obtain necessary help from their colleagues and administrators, in order to better assist their

clients; and "when workers are able to help their clients to resolve issues or difficulties related to

family violence or sexual assault, they also witness clients' traumatic experiences being

transferred into positive and rewarding experiences. This positive helping experience, as a result

of sociopolitical support, could be a buffering factor that reduces or prevents vicarious trauma".

(Choi, 2011a, p.235)

McNamara (2010) also outlines important measures employers can take to ensure

vicarious trauma is being addressed in their organization. These include the provision of

information and normalization of vicarious trauma, identification of strategies for managing the

negative impacts of their employees' work, the development of self-care plans, the debriefing of

critical incidents. As well, McNamara (2010) points out the importance for individual and

systemic factors that increase the impact of vicarious trauma to be identified and that all staff be invited and encouraged to develop and share ideas for addressing both individual and systemic issues.

While self-care and training are deemed important strategies in the research, there is also a strong theme in the literature that points to the responsibility of agencies and organizations to address vicarious trauma. As Bober & Regher (2005) point out, efforts to address vicarious and secondary trauma with staff needs to shift from worker education to employer advocacy for improved and safer working conditions.

Additionally, a most relevant issue for agency directors and boards to consider is the notion of vicarious trauma and liability. If an agency develops policies and mandates which identify and outline the risks for vicarious trauma, employers may find they have a duty of care to staff in enabling them to address any specific issues (e.g., prior trauma histories) that may be relevant. It would therefore be prudent to also consider "contextual factors such as litigation and compensation, pensions, and early retirement… in relation to claims that a worker is suffering from vicarious trauma (Sabin-Farrell & Turpin, 2003).

Conclusion

It is clear in the literature that there is no one solution to the issue of vicarious trauma. While there exist many concrete strategies for mitigating the negative effects of working with victims of violence and trauma, no one approach claims to be the panacea. In fact, a very ubiquitous theme in the literature is the need for a multifactorial approach to the problem of vicarious trauma. No one intervention or strategy was seen as capable of or pivotal to prevention or treatment. "Knowledge base, supervision and collegial support indicate a strong inverse

relationship to vicarious trauma symptoms. However, individually, each of these variables does not significantly impact the experience of vicarious trauma" (Campbell, 2008, p.103).

What is clear from the literature is that vicarious trauma is a very real and complicated issue for VAW workers and requires focussed and dedicated attention in the areas of self-care, peer and group supports, training and education, supervision and organizational practice. This effort is not only important for the health and well-being of individual workers, but also for the overall health and effectiveness of the organization and the welfare of the clients they seek to serve. What is vitally important for the leadership of the VAW sector to consider is the specificity of VAW work relative to vicarious trauma and to this end, we can only encourage more research in this arena in order to fully grasp and understand the textured and complex issues which can emanate from vicarious trauma impacting the professional lives of those individuals working in the VAW sector.

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