HELPING PROFESSION HAZARDS FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT, AND STALKING (DVSAS) SERVICE PROVIDERS: A FOCUS ON WORKFORCE WELL-BEING

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I will miss you immensely, Jennifer!
It has been a privilege to know you, collaborate with, and learn from you!

Celebrating the Life of Jennifer McLaughlin

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Abstract: The prevalence of domestic violence, sexual assault, and stalking (DVSAS) places tremendous stress on survivors as well as the growing body of helping professionals providing services. According to the Centers for Disease Control, there are 20 victims of intimate partner violence per minute in the United States (CDC, 2010). To date, no research has examined DVSAS leadership's awareness of the work related hazards facing staff and volunteers or their recommendations regarding mitigating these hazards. The current study utilized a qualitative and phenomenological research design through on-site interviews with Directors or their designees from 10 of 27 certified DVSAS programs in Oklahoma. Results indicated Directors are aware of secondary trauma, burnout, and compassion fatigue and desire staff training to mitigate the inherent helping profession hazards. Directors reported a need for more staff training and that volunteers received any training. Directors expressed a critical component to workforce well-being was to "practice what we preach", but all Directors reported several obstacles to overcome including funding deficits and lack of resources occurring simultaneously with increased request for services. These inherent helping profession hazards in conjunction with difficult service dynamics can dramatically increase the risk of secondary trauma, burnout, and compassion fatigue. Discussion concludes with implications for prevention and intervention.

Keywords: Oklahoma, Directors, domestic violence, sexual assault, stalking, training, qualitative, phenomenological, secondary trauma, burnout, compassion fatigue, workforce, well-being, compassion satisfaction

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CHAPTER I

INTRODUCTION

Across the United States, there are 20 victims of intimate partner violence (IPV) per minute (Centers for Disease Control [CDC], 2010). Sexual violence affects 1 in 2 women and 1 in 5 men in their lifetime (CDC, 2010). Stalking affects 1 in 6 women and 1 in 19 men, with the majority of the perpetrators being someone known by the victim (CDC, 2010). The trajectory of abusive relationships is too often lethal, in the United States and abroad. According to research examining data from 66 countries, intimate partners commit approximately 13.5% of all homicides (Stöckl et al., 2013), with the United States second only to Southeast Asia for the highest percentage of female homicides due to IPV; projected to be over 40% (Pilger & Watts, 2013; Stöckl et al., 2013). The prevalence of IPV, domestic violence (DV), sexual assault, and stalking (DVSAS) places tremendous stress on survivors as well as the growing body of helping professionals providing services.

Since the 1970s, a growing field of services developed across the United States focused on supporting individuals affected by DVSAS and ending the cycles of violence and abuse. The movement that started with grass roots efforts in Minnesota, resulted in

the first DVSAS program in Oklahoma being provided through the Young Women's Christian Association (YWCA) in Oklahoma City in 1974 (OCADVSA, 2016). DVSAS programs across Oklahoma began to develop, representatives from these programs formed the Oklahoma Coalition Against Domestic Violence and Sexual Assault (OCADVSA), which was incorporated in 1981 and still leads the movement today (OCADVSA, 2016). In an effort to address the severity of DVSAS on a national scale, the 1994 Violence Against Women's Act (VAWA) was legislated to strategize in reducing violence against women by promoting offender accountability and expanding emergency services for survivors (VAWA, 2016, 2017). While DVSAS services offer options to address many of the needs individuals encounter related to the traumas of DVSAS, providing these social services presents unique risks and occupational hazards to helping professionals.

Many social service providers and helping professionals consider it a privilege to serve others, but caring comes at a cost (Maslach, 1982; Pearlman & MacIan, 1995; Perry, 2014). Among the costs and hazards facing helping professionals working in the DVSAS field are secondary trauma, burnout, and compassion fatigue (Baird & Jenkins, 2003; Bemiller & Williams, 2011; Gentry, Baranowsky, & Dunning, 2002; Jenkins & Baird, 2002; Jirek, 2015; Maslach, Schaufeli, & Leiter, 2001; Pearlman & MacIan, 1995; Slattery & Goodman, 2009). According to the American Psychological Association (APA), secondary trauma results from episodic exposure to another person's trauma and can produce symptoms similar to Post Traumatic Stress Disorder (PTSD), including intrusive thoughts, flashbacks, and avoidance (APA, 2013; Bober & Regehr, 2006; Coles, Astbury, Dartnall & Limjerwala, 2014; Figley, 2002b). Secondary trauma is a broad

construct that can affect anyone acquainted with or in a relationship with a trauma survivor, not just an intimate relationship, and occurs upon the exposure of another person's traumatic events (Gentry, Baranowsky, & Dunning, 2002). Burnout results from prolonged and persistent unmitigated job stressors, reported symptoms are more detrimental, presenting in the forms of exhaustion, cynicism, and inefficacy (Maslach, 1982; Maslach, 2003; Maslach, Schaufeli & Leiter, 2001). Compassion fatigue can result from the chronic exposure to secondary traumatic stress (STS) and burnout, and can produce symptoms similar to PTSD accompanied with a deeper detrimental effect on cognitive schemas. The cognitive changes reported are interpersonal beliefs and morale, detachment and withdrawal or hypervigilance and agitation (Cerney, 1995; Chamberlain & Miller, 2008; Collins & Long, 2003; Figley, 1995; Figley, 2002b; McCann & Pearlman, 1990a; Salston & Figley, 2003). Compassion fatigue is a more defined construct for caregivers and helping professionals working with trauma survivors. All of these conditions can result from residual effects of trauma negatively affecting the helping party; and are often the outcomes of the helping professional not practicing self-care and/or the absence of a supportive environment (Bell, Kulkarni, & Dalton, 2003; Maslach, 1982). Examined through general systems theory (Boss, Doherty, LaRossa, Schumm & Steinmetz, 2009) and ecological theory (Bronfenbrenner, 1979; Boss, et al., 2009; Forest, 2015; & White, Klein, & Martin, 2015) helps obtain an understanding of the importance of including individual, relationship, organizational, and societal factors when promoting social service programs and workforce well-being in helping professions.

In addition to these occupational hazards, the ever-changing funding climate produces additional stress in the DVSAS field. In a nation-wide survey conducted in 2012, the National Network to End Domestic Violence (NNEDV, 2013) reports the majority of DVSAS programs report challenges from repeated budget cuts. The report states DVSAS programs are "stretched to the max and we really need additional staff" (NNEDV, 2013, pg. 2). With 88% of state coalitions reporting increased requests for services, while 69% of their DVSAS programs experienced budget cuts, which resulted in 80% of the programs reducing staff numbers and 70% of programs reducing direct client services, this places additional strain on service providers and helping professionals (NNEDV, 2013). Multiple sources reported funding reductions in 80-90% of the state DVSAS Coalitions, including local city/county sources, private donations, and United Way support (NNEDV, 2013). Oklahoma DVSAS Program Directors also reported in an assessment by the Oklahoma State Department of Health (OSDH) that 89% of their surveyed programs conducted community educational programs to prevent domestic violence and sexual assault; however, 95% of those Directors reported funding was inadequate to meet community needs (OSDH, 2010). Operating in these conditions produces quantitative job demands and negative employee responses to overload, which have produced direct correlations to burnout in field research (Maslach, Schaufeli, & Leiter, 2001; Salston & Figley, 2003).

These funding challenges also have a dramatic effect on trauma survivors, as one study revealed that only a small fraction of survivors with PTSD were referred or received appropriate treatment (Schreiber, Maercker, & Renneberg, 2010). The barrier mentioned most often by these 43 survivors of interpersonal traumatization that inhibited

them from receiving assistance was, "…the shortage of resources in the help-system…especially for immediate crisis intervention" (Schreiber et al., 2010, p. 7). The same group of survivors also reported another obstacle was a shortage of qualified counselors and therapists for their post-trauma care (Schreiber et al., 2010). Initiation of this project itself resulted out of concern for shifting DVSAS services in the state of Iowa into regional service areas (W. Michael Fleming, personal communication, June 13, 2014).

The difficult dynamics within the DVSAS service field dictate a protocol of self-care and workforce well-being for self-preservation. It is imperative to promote and protect the well-being of all helping professionals within the DVSAS field. As it takes a special person to work in a stressful environment for minimal wages, these seasoned professionals often accumulate hundreds of hours of training and experience equipping them to be more adept at meeting the needs of survivors who are often in life-threatening situations (Baird & Jenkins, 2003). Protecting the DVSAS workforce is especially salient in Oklahoma. According to CDC research, women in Oklahoma reported the highest and men in Oklahoma reported the second highest national rates of DVSAS over the lifespan (2010). Oklahoma ranked third highest in the nation in domestic violence homicides according to a report from the Domestic Violence Fatality Review Board (ODVFRB, 2013). State statistics suggest service providers in Oklahoma are exposed to secondary trauma at concerning rates with minimal study on the effects to their well-being (Slattery & Goodman, 2009).

Due to the concerning prevalence of trauma exposure to helping professionals, it is important to explore DVSAS program leadership's awareness of the significance of

trainings and programming in mitigating workforce hazards (Joinson, 1992; Figley, 2002a; Leiter & Maslach, 1998). In addition to leading their local program, approximately nine DVSAS Executive Directors also donate their time to comprise the OCADVSA Board. The OCADVSA Board provides many functions for the DVSAS field, including but not limited to: providing training and oversight for the Certified Domestic and Sexual Violence Response Professional (CDSVRP), leading the membership for the 28 Attorney General certified agencies and 3 tribal programs, and leading legislative awareness activities that historically resulted in State budget allocations for DVSAS programs (OCADVSA, 2016). The expertise and input of Executive Directors is critical to the future of the DVSAS movement and decisions determining staffing, education, and training agendas. While research reports a negative correlation between workforce trauma symptoms and participation in education (Baird & Jenkins, 2003), there is currently no research exploring DVSAS leaderships' awareness of the risks and protective factors affecting their workforce. In an effort to fill that research gap, the proposed qualitative, phenomenological study is a first step toward addressing and preventing secondary trauma, burnout, and compassion fatigue among DVSAS service providers and volunteers. As I uncover the primary themes reported by Oklahoma DVSAS program leadership, I hope to identify how aware supervisors are of the high-risk nature of staffs and volunteers work with trauma survivors and obtain recommendations to address any training gaps. The DVSAS Executive Directors are vital and instrumental in guiding the DVSAS movement. These dedicated Directors often volunteer their time to keep the focus of program improvement in the forefront.

Through this research, I hope to articulate levels of awareness of secondary trauma, burnout, and compassion fatigue in the DVSAS field; assess the themes in current DVSAS trainings in Oklahoma; evaluate the suitability of current field training; and accumulate recommendations for future focus on workforce well-being. There are many potential benefits to promoting workforce well-being: lower rates of staff turnover; less agency expense for retraining; fewer staff experiencing secondary trauma, burnout, and compassion fatigue; and better front-line services provided to trauma clients (Baird & Jenkins, 2003; Jenkins & Baird, 2002; Maslach, 1982). Ultimately, I hope to assist helping professionals who assist survivors of DVSAS in Oklahoma, while promoting workforce well-being in difficult service dynamics. The goal to learn more about and contribute to the growing and evolving body of knowledge from the DVSAS experts in the field regarding ways to enhance programs and promote workforce well-being is the aspiration of this thesis.

CHAPTER II

REVIEW OF LITERATURE

The following literature review will be comprised of seven sections. The first section provides the complex and intertwined definitions of secondary trauma, burnout, and compassion fatigue. This section also defines concepts that combat these phenomena, including workforce well-being and compassion satisfaction, and concludes with helpful concept comparisons. The second section examines survivor statistics and clinical prevalence, defining some trauma symptoms of domestic violence, sexual assault, and stalking (DVSAS), due to trauma exposure and posttraumatic consequences. The third section discusses trauma specific to domestic violence (DV) and intimate partner violence (IPV), including a DV spectrum (with appendices). The fourth section examines statistics and clinical prevalence of secondary trauma to DVSAS helping professionals. Exploration of protective factors through literature focused on workforce well-being at individual and organizational levels, in addition to research on compassion satisfaction, is the content of the fifth focus area. Theoretical foundations comprise the sixth section. The seventh section contains the social history and is critical to keep in context when examining social service/intervention program practices and making recommendations for future focuses of the DVSAS movement. The chapter will conclude with the research goals.

The Cost of Caring: Definitions of Constructs

The definitions of secondary trauma, burnout, and compassion fatigue have been researched and discussed for several years; however, there is still a lack of consensus for clear operational definitions (Adams, Boscarino, & Figley, 2006; Slattery & Goodman, 2009). This presents an opportunity for additional exploration and understanding, as the concepts are similar but not synonyms and clarity is necessary to define, determine, and implement self-care strategies (Newell, Nelson-Gardell, & MacNeil, 2016). For the purpose of this research, the following descriptions operationally define the key constructs explored:

Secondary trauma. Trauma transmitted through episodic exposure to witnessing or hearing of another person's trauma or a traumatic event is secondary trauma (Figley, 2002b). Secondary trauma affects others closely connected to the traumatized individual, although they do not experience the trauma first hand. Secondary trauma can produce a broad spectrum of posttraumatic stress symptoms for anyone encountering a trauma survivor. Some examples of secondary trauma could be the effects on the partner or parent of a sexual assault survivor or the child(ren) of a survivor of IPV/DV (Figley, 2002b). This form of trauma can result in posttraumatic symptoms for any individual in a relationship with a primary trauma survivor (Figley, 2002b). According to Figley, the trauma survivor's "radiating distress" unintentionally transfers to another individual (2002b, p. 124). Several cited research findings report a correlation with a personal trauma history and the severity of secondary trauma symptoms in various fields (Dougall, Herberman, Delahanty, Inslicht, & Baum, 2000; Follette, Poulsny, & Milbeck, 1994; Moran & Britton, 1994; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Ursano,

Fullerton, Vance & Kao, 1999). However, the research does reveal inconsistencies that could be attributable to participant roles, such as counselor or advocate (Frey, Beesley, Abbott & Kendrick, 2016; Pearlman & MacIan, 1995; Schauben & Frazer, 1995; Ullman, 2010). The following section will discuss post-traumatic stress disorder (PTSD) criteria and symptoms in detail.

Vicarious traumatization is a similar term used to refer to the specific secondary trauma effects on professionals (Pearlman & Saakvitne, 1995). The unique trademark of secondary trauma effects, known as vicarious trauma, is disrupted spirituality or meaning and hope (Pearlman, 2012) that changes the individual's inner experience and worldview (Baranowsky, 2002). Professionals impacted by vicarious trauma can experience unique posttraumatic symptoms resulting in a negative self-transformation and may question where is God in all this suffering; are we really making a difference; or are we ever going to break this vicious cycle? (Pearlman, 2012). The DVSAS field often uses the term vicarious trauma, which has also been described as the immediate psychological transfer of a victim's traumatic experience, requiring current exposure (Sansbury, Graves, & Scott, 2015). The unmitigated accumulation of secondary traumas, regardless of exact definition or presentation, may lead to burnout and compassion fatigue (Figley, 2002b; Sansbury et al., 2015).

Burnout. First cited by Sober in 1947 and expanded by Freudenberger in 1974 (Freudenberger, 1989), the concept of burnout was greatly expanded by Maslach in 1982 (Adams, et al., 2006; Chamberlain & Miller, 2008; Russell & Brickell, 2015; Salston & Figley, 2003). Figley (2002b) also reported the debilitating outcome resulting from a depleted emotional bank account resulted in burnout. It is frequently the result of

unmitigated trauma exposure, often through secondary trauma, that results in emotional exhaustion, depersonalization, and disillusionment from working with distressed clients and job-related crises (Figley, 1998). Additional researchers cited burnout to be the prolonged response to persistent emotional and interpersonal stressors on the job, presenting in three dimensions: exhaustion, cynicism, and inefficacy (Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Maslach, 2003). Some examples of burnout might present as, "…frustration, powerlessness, and inability to achieve work goals" (Valent, 2002, p. 19).

Burnout is a phenomenon that can develop from individual and/or organizational attributes (Maslach, 2003; Valent, 2002). This phenomenon can manifest from conflict between individual values and organizational goals, demands, and overload (Salston & Figley, 2003). Burnout likely perpetuates in a detrimental work environment with "hierarchical pressures, constraints, and lack of understanding" (Valent, 2002, p. 19). Work place conflict, overload, the perception of inequity, lack of supervisor support, and inadequate rewards are all reported agency or organizational contributors to burnout (Maslach & Leiter, 1997; Maslach et al., 2001). High job demands and/or low resources are additional contributors cited to correlate with burnout (Shoji et al., 2015). The definition of burnout has also included the emotional and physical depletion of the service provider, resulting from providing ongoing services and support to chronic cases involving trauma survivors (Figley & Kleber, 1995; Sansbury et al., 2015). Burnout could result in someone who was previously dedicated to the cause, leaving the field completely (Maslach, 2003). The importance of understanding, recognizing, and

addressing these phenomena is critical to workforce well-being, especially when assisting populations with high rates of trauma exposure in challenging settings (Figley, 2002a).

Compassion fatigue. Compassion fatigue is often used synonymously with secondary traumatic stress (STS), but is a separate construct (Adams et al., 2006; Figley, 2002b). Joinson first recognized and defined compassion fatigue in the nursing field in 1992. Joinson was concerned with the taxing trademarks of physical and emotional exhaustion exhibited in emergency room staff from secondary trauma that resulted from exposure to work related distress (Adams et al., 2006; Chamberlain & Miller, 2008; Collins & Long, 2003; Figley, 2002a; Salston & Figley, 2003). Joinson articulated the importance of examining this form of trauma transmission, maintaining, "Compassion fatigue is almost impossible to recognize without a heightened awareness of it" (Joinson, 1992, p. 116), and Joinson maintained teaching this awareness was possible and imperative. Figley (1995) further articulated this form of trauma transmission; he referred to the specific STS among helping professionals as compassion fatigue that he described as a normative condition resulting from natural, hazardous occupational components of working with trauma survivors.

Individuals who possess a colossal capacity for feeling and expressing empathy are more inclined to be vulnerable to this type of compassion stress, as these individuals have a deep desire to assist those who are hurting (Figley, 1993; Salston & Figley, 2003). According to Figley, "compassion fatigue is one form of burnout" (2002b, p. 5), resulting in another example of connected concepts and possible co-occurring conditions. The distinction between compassion fatigue and STS is that compassion fatigue is the accumulation of exposure to another's traumatic event(s) (Figley, 2002b). Trauma

transmission to the helping professional occurs through a condition of secondary trauma exposure resulting in symptomology similar to PTSD, often displaying changes in cognitive schema through indirect pathways of the helping professional and the helping professional's personal trauma history (Adams et al., 2006; Figley, 1995; Figley, 2002b; Jenkins & Baird, 2002; McCann & Pearlman, 1990a; Salston & Figley, 2003). Compassion fatigue has also been defined as the convergence of primary traumatic stress, secondary traumatic stress (Stamm, 1997), and cumulative stress/burnout (Maslach, 1982) "in the lives of helping professionals and other care providers" (Gentry, Baranowsky & Dunning, 2002, p. 124).

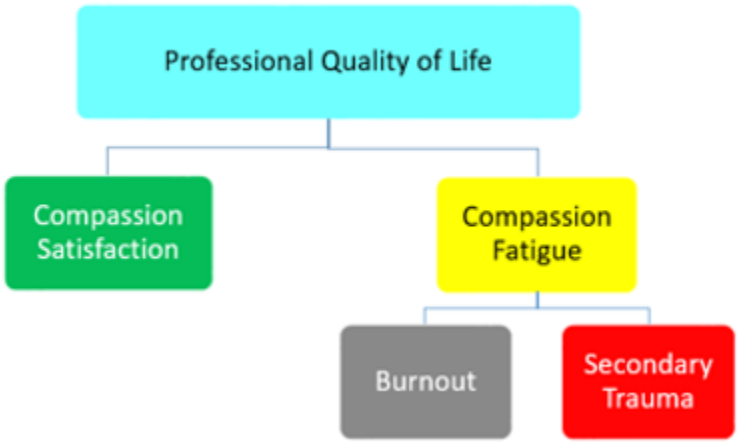
As the helping professional begins to exhibit their own traumatic stress symptoms, this exacerbates the development of compassion fatigue with repeated exposure to secondary trauma of the client(s). Some examples of this condition might be a service provider who begins to miss workdays and has a desire to avoid client contact (Figley, 2002b). Understanding this is a natural response to an unnatural circumstance that can be treated and prevented, enables caring professionals to continue and enjoy their work if they are educated to, mindful of, and practicing self-care to mitigate the risks (Figley, 2002b). While these concepts are very important to learn, understand, and educate the workforce in regards to, it is also important to include positive traumatology components (Tedeschi & Calhoun, 2004), and encourage more DVSAS field research in this area. The discussion section examines components in more detail. This literature review will examine two of the concepts that mitigate these workforce hazards, workforce well-being and compassion satisfaction.

Workforce well-being. The presence and promotion of an environment of flourishing workers who benefit from a safe, supportive workplace engaging in satisfying work, and enjoying a fulfilling work life defines workforce well-being (Schulte et al., 2015). Another area of research cites the presence of social support, clinical supervision, and shared power as important components promoting protective factors resulting in workforce well-being (Slattery & Goodman, 2009). Other reported ways of promoting workforce well-being not only include fostering a supportive environment, but include debriefing helping professionals after they experience either primary or secondary traumas by: encouraging emotional release, talking through fears and regrets, and promoting peer support groups which, "…minimize the likelihood of severe secondary traumatic stress symptoms" (Meyers & Cornille, 2002, p. 52; Stamm, 2009). This environment of support can also promote compassion satisfaction.

Compassion satisfaction. Another important construct that is attributable to individual factors contributing to workforce well-being is compassion satisfaction, which reiterates the positive power of participating in another person's healing process (Bell, 2003; Kulkarni, Bell, Hartman, & Herman-Smith, 2013; Schauben & Frazier, 1995; Stamm, 2005, 2009). Compassion satisfaction is often the underlying catalyst for many individuals dedicated to human service work and is instrumental in contributing to the professional quality of life (Stamm, 2002, 2009). It is imperative for an individual to have hardiness and social support for compassion satisfaction to develop full protective factor potential (Stamm, 2002). Stamm's definition of hardiness is "…control, commitment, and viewing change as a good challenge" (2002, p. 109). Stamm also categorizes social support as "collegial…structural…and/or functional" (2002, p. 109).

Stamm (2002) also explains compassion satisfaction as the portal for "efficacy" and the blueprint to make the world a better place by being the prototype (p. 113). Understanding and encouraging the pathways to compassion satisfaction can also be instrumental in enhancing worker well-being and improving client services (Kulkarni, Bell, Hartman, & Herman-Smith, 2013). It is important to have a good conceptual foundation of trauma risks and protective factors when working with highly traumatized populations. Noted in Figure 1 are Stamm's core concepts of Compassion Satisfaction and Compassion Fatigue (CS-CF) (2009).

Figure 1. CS-CF Model



Stamm, B. H. (2009)

Concept comparison. A concept comparison can be helpful to articulate and clarify complicated concepts. A summary looking at burnout and compassion fatigue would reveal that emotional exhaustion is present in both. Figley articulated an inability to offer compassion and connect with the client as being fundamental elements of compassion fatigue (1995). Maslach articulated depersonalization and reduced personal efficacy present in burnout (2003). Further clarification was provided by Figley, "While

different from compassion fatigue, burnout might also be an important risk factor or precursor to compassion fatigue…burnout is a gradual wearing down of helpers who feel overwhelmed by their work and incapable of facilitating positive change (1995)" as cited in Collins & Long (2003, page 421; Adams et al., 2006). Another way to differentiate the concepts is to think about STS and burnout being two subscales of compassion fatigue: STS results from fear(s) and burnout results from being worn out (Stamm, 2009).

Another comparison developed by the National Child Traumatic Stress Network (2017) articulates the differences between the concepts, as noted in Figure 2:

Figure 2. Secondary Traumatic Stress and Related Conditions

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

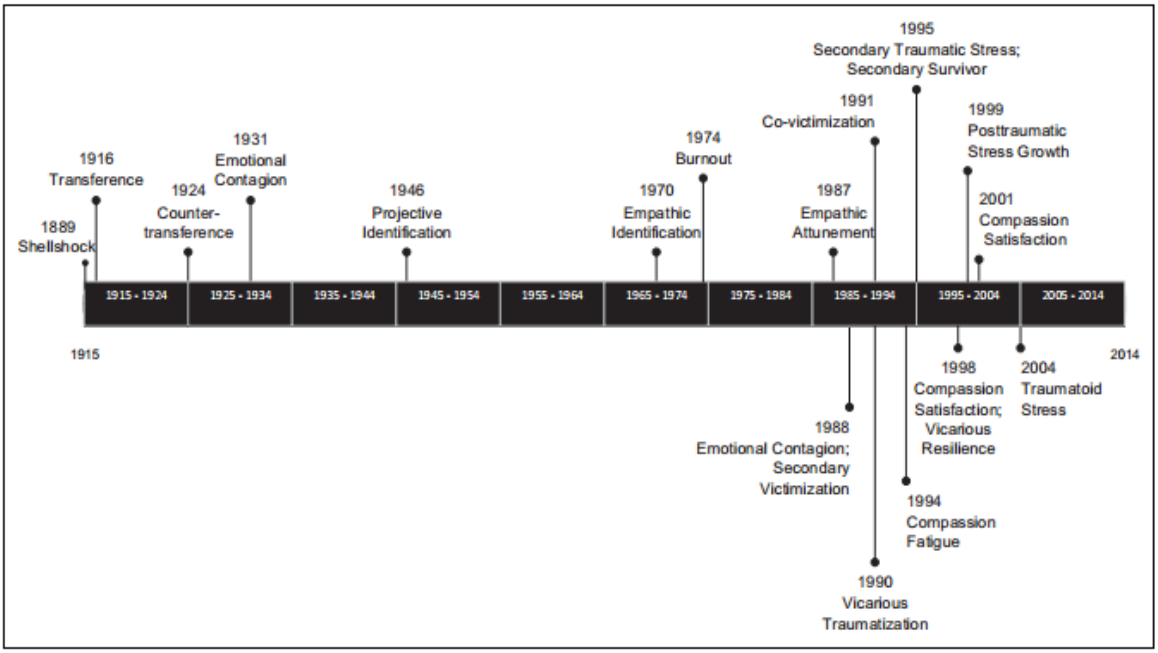
Compassion fatigue is a less stigmatizing way to describe secondary traumatic stress and has been used interchangeable with the term.	Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.
Compassion Satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes meaningful contributions to clients and society.	Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

National Child Traumatic Stress Network (2017)

An interesting longitudinal study conducted in Poland and the United States examined which came first, burnout or STS (Shoji et al., 2015). The results revealed that burnout led to STS, but STS did not result in burnout (Shoji et al., 2015). This study helps to confirm the work hazards trajectory, which can be instrumental to mitigate the

effects, “establishing what comes first in the job burnout-STS relationship could be an essential step guiding prevention, treatment, and education programs for human services professionals, enabling them to reduce negative consequences of work stress” (Shoji, et al., p. 2). Another helpful tool in understanding the research and concept trajectory is the chronological timeline developed by Newell, Nelson-Gardell, and MacNeil in 2016, as illustrated in Figure 3.

Figure 3. Terminology and Construct Timeline



Newell, Nelson-Gardell, & MacNeil (2016)

The Traumas of DVSAS to Survivors

Kubany et al. (2004) reported survivors of DVSAS have been one of the greatest traumatized groups in North America, and perhaps even the world. Upon a review of 28 articles conducted through research over almost a decade, researchers hypothesized DVSAS contributed to the detriment of physical and mental health conditions across all demographics, socioeconomic statuses, and sociocultural stratospheres (Macy, Ferron, &

Crosby, 2009). Survivor trauma symptoms and prevalence affect not only the individual survivor, but also those in personal and/or professional relationships with the survivor.

Survivors' symptoms and prevalence. Within the DVSAS field, trauma exposure presents in several forms. Trauma survivors often face physical injury; emotional and psychological abuse; sexual assault and reproductive coercion; child abuse; leaving the abuser; returning to the abuser; the court processes; fighting/losing custody of children; relocating or not being able to relocate; and lack of financial, housing, and transportation resources (Campbell, Webster, & Glass, 2009; Dixon & Graham, 2011; Finkelhor, Turner, Hamby & Ormrod, 2011). Defined under trauma and stress related disorders by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychological Association [APA], 2013), trauma is categorized by directly experiencing, witnessing, or indirectly experiencing an event that is "catastrophic or aversive" (pg. 265). The APA defines some trauma experiences highly correlated with PTSD to include but are not limited to threatened or actual physical assault, including sexual violence; being kidnapped, taken hostage, or tortured; and observing threatened or actual injury, many of which are often present in DVSAS (2013). These traumas are cited to be especially "severe or long-lasting when the stressor is interpersonal and intentional" (APA, 2013, p. 275), as is often the case in DVSAS. Survivors of sexual abuse have significant risk of multiple psychiatric disorders and mental health problems (Chen et al., 2010; Macy, Ferron, & Crosby, 2009). Although the distress is variable (APA, 2013), if significant and untreated or unmitigated, symptoms and disorders may arise.

The most prevalent consequences of unmitigated trauma exposure are depression and PTSD (Campbell, 2002). While the estimated lifetime risk for PTSD among all adults in the United States is cited to be 8.7% (APA, 2013), some of the highest reported rates of PTSD, ranging from 30% to over 50%, are observed in survivors of interpersonal trauma, including DVSAS (APA, 2013). Yet, some studies report significantly higher rates of PTSD among DVSAS survivors at 87% and maintain it is often a chronic condition (Kubany et al., 2004). Statistical differences could result from obtaining data in DVSAS shelter populations, where higher rates of depression and PTSD are often present (O'Campo et al., 2006). O'Campo et al. (2006) reported studies correlating IPV and mental health consequences to be relatively small and have historically been obtained from "clinical, domestic violence shelter, or mental health treatment settings", which would likely yield higher rates of PTSD due to sample populations. Trauma-specific services that engage in promising practices acknowledge and offer treatment for DVSAS survivors and the "mental health sequelae of IPV", reiterating the importance of educating, acknowledging, and mitigating workforce hazards inherently present to their staff as well (O'Campo et al., 2006, p. 109).

The *DSM-5* outlines PTSD diagnostic criteria to include, but is not limited to: intrusive, recurring memories/flashbacks or dreams; dissociation; trauma associated triggers; similar stimuli avoidance; amnesia; angry outbursts; exaggerated startle responses; and hypervigilance that last more than one month causing the survivor significant distress (APA, 2013). Trauma symptoms includes, but is not limited to grief, depression, anxiety, fear, rage, shame, nightmares, flashbacks, intrusive images, and numbing and/or avoidance (Clark & Gioro, 1998; Collins & Long, 2003; Figley, 1995;

Harbert & Hunsinger, 1991; Herman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; Stamm, 1995). Additional somatic symptoms such as sleep disturbance, gastrointestinal difficulties, and headaches are also cited to be trauma symptoms (Collins & Long, 2003; Figley, 1995; Herman, 1992). There have also been correlations with addictive and compulsive conduct – substance abuse, excessive work, and compulsive eating; physiological hyperactivity – palpitations and hypervigilance; and impediment of daily living – diminished social and personal functioning, including missed appointments, chronically late, isolating/alienating self, withdrawing from supervision, and unappreciative (Clark & Gioro, 1998; Collins & Long, 2003; Davis, 1996; Dutton & Rubinstein, 1995). There are an array of trauma symptoms for survivors and helping professionals. Johnson (2011) discovered a correlation of DVSAS trauma symptoms and a spectrum of IPV types.

The Spectrum of DV and IPV

To further illustrate the risks to DVSAS survivors and helping professionals, it is important to understand the spectrum of IPV (Johnson, 2011) (see Appendix A). With the most detrimental health outcomes for DVSAS survivors of severe and chronic abuse (Macy, Ferron, & Crosby, 2009) it is important to delineate differences in dynamics. Johnson identified three separate categories of IPV as: (a) intimate terrorism, (b) violent resistance, and (c) situational couple violence (2011). Intimate terrorism presents significant traumatic stress for the survivor and potentially the service provider due to the magnitude of the pattern of coercive power and control, which often has the greatest possibility for lethality (Johnson, 2011) and was present in as many as 65% to 80% of femicide cases (Messing et al., 2014). Femicide is the homicide of the female intimate

partner (Messing et al., 2014). Intimate terrorism may be the catalyst for most survivors who seek shelter, although it may not be the most prevalent (Gondolf, 1988; Johnson, 2011; Pence & Paymar, 1993).

As the physical violence escalates in severity and/or frequency, often does the survivor's request for professional assistance (Berk, Berk, Newton, & Loseke, 1984; Bonomi, Holt, Martin, & Thompson, 2006; Coker, Derrick, Lumpkin, Aldrich & Oldendick, 2000; Gondolf, 1988; Henning & Klesges, 2002; Johnson, 1990; Macy, Nurius, Kernie & Holt, 2005) and correlates with an increase in survivor's severe health consequences (Macy, Ferron & Crosby, 2009). Intimate terrorism presents in a pattern of power and control dynamics, normally accompanied with other patterns of abuse, including economic, coercion, intimidation, emotional abuse, isolation, minimization, using children, and gender privilege (Johnson, 2011; Pence & Paymar, 1993). Victims of intimate terrorism have much higher rates of PTSD at approximately 79% versus 37% of situational couple violence victims (Johnson, 2011), which in turn, presents more risk for the helping professional to experience the inadvertent transmission of trauma. It has also been cited that as the level of violence increases in IPV, there are significant mental health issues regardless, "…of the strengths and resources a woman has" (Macy, Ferron & Crosby, 2009). It would be uncommon for a survivor of DVSAS not to have psychological effects; the psychological effects are a normal response to abnormal circumstance.

Violent resistance normally occurs in response to intimate terrorism and results in physical reaction/assault to the batterer's initiated violence (Johnson, 2011). Johnson (2011) views violent resistance as a reaction or self-preservation and not retaliation.

Johnson (2011) reports the most common IPV is situational couple violence, which is usually not connected with a pattern of coercion and/or power and control, but normally arises because of a stressful situation when a single argument turns aggressive and should be addressed differently (see Appendix B). Black et al. (2011) estimated that approximately 35% of women and 14% of men living in the United States experience some form of IPV over their lifespan. In 2011, Johnson reviewed 30 years of research and reported an estimated 3% of IPV victims in 1970 were men, and by 2000, that statistic had increased to 13% of intimate terrorism victims being male (see Appendix A).

All forms of DV are not only harmful attacks on the individual and family, but also expensive attacks on humanity and society. Projected costs of IPV are projected to exceed an estimated $8 billion annually in lost wages, medical, and mental health care costs (Max, Rice, Finkelstein, Bardwell & Leadbetter, 2004). The economic statistics are sparse especially in program evaluation and social investment, "In general, very few evaluations of partner violence interventions examine economic impact" (Logan, Walker, & Hoyt, 2012, p. 1138). Research conducted a few years later, reported excess health care costs for survivors of IPV to be $19.3 million for every 100,000 women, compared to their non-abused cohorts in the study (Rivara et al., 2007). In addition, IPV survivors' health care costs remained 20% higher 5 years after escaping abusive relationships, therefore, "the potential for cost savings from intervention programs is great" (Rivara et al., 2007, p. 94). There is some research exploring economic savings to DVSAS survivors. Logan, et al. researched economic savings of DVSAS survivors obtaining a protective order in one state and estimated an annual savings of $85 million in only one year (2012). A protective order is a civil court order prohibiting DVSAS offending

behavior(s) with the petitioner (Logan et al., 2012). The justification and benefit to individuals and society through "social investment" of programs, practices, and policies is a necessary focus with concerning DVSAS statistics and DVSAS program budget concerns (Logan et al., 2012). If child abuse and trauma are included in this accounting of preventable atrocities, this adds another $103.8 billion to the United States budget (Sansbury et al., 2015). Another sobering statistic discovered in the National Network to End Domestic Violence 24-hour census in 2011, revealed 37,519 abuse victims were residing in United States shelters, with 5,686 victims needing unavailable shelter due to staff and funding shortages (Merchant & Whiting, 2015). In that same census, there were 33,129 adults and children receiving non-residential assistance (Merchant & Whiting, 2015). This is a large population of trauma survivors that may be seeking services from DVSAS programs, presenting risk for occupational hazards.

Secondary Trauma among DVSAS Professionals

Figley (2002b) maintained that trauma transmission transferred to the helping professional through spreading PTSD symptoms due to continual exposure to clients with PTSD symptoms. Figley (2002b) avowed symptoms of PTSD perpetuated through the same pathways for families and/or service providers, especially when coping skills and self-care is not learned, encouraged, or practiced. Researchers have documented the vulnerability of trauma service providers, with 50% at risk for experiencing secondary trauma (Figley, 1995; McCann & Pearlman, 1990b; Stamm, 1997). A study of rape crisis center staff revealed 44% suffered STS symptoms and burnout (Ullman & Townsend, 2007). A 2009 study of domestic violence service providers found that 47.3% met clinical assessment levels of PTSD (Slattery & Goodman, 2009). Bober & Regehr

(2006) described secondary trauma in helping professionals as the result of working with survivors of traumatic events.

Professionals' symptoms and prevalence. Secondary trauma is reported to be a hazard of the occupation rather than any pathology or purpose on the part of the service provider or the survivor – another example of a normal response to an abnormal circumstance (Figley, 2002b; Tehrani, 2007). Research among the DVSAS field for STS rates is sparse. One study conducted among mental health case managers in Australia by Meldrum, King and Spooner (2002) revealed the two criteria strongly associated with STS were working with clients who had been in life-threatening situations or faced threats to their physical well-being. Secondary trauma has also been a concern for researchers studying survivors of violence, particularly sexual violence. Researchers' reported individual, clinical presentation of intrusive trauma symptoms after studying survivors of sexual violence. The secondary trauma symptoms reported included re-experiencing the survivor's trauma via thoughts, feelings, and images, which can result in avoidance (Coles, Astbury, Dartnall & Limjerwala, 2014) and can produce a silencing response (Baranowsky, 2002).

Burnout among DVSAS professionals. Baird & Jenkins (2003) reported the biggest risk factors associated with burnout among helping professionals to be continuous, rigorous requirements of interpersonal demands accompanied with insufficient structural or organizational support for addressing those demands. Job performance may suffer – absenteeism, decreased productivity, and turnover can begin to infiltrate the workforce (Maslach et al., 2001). The organizational context is another important area to examine when looking at burnout, as organizational structure, policy,

and available resources are part of the dynamics (Maslach et al., 2001). Burnout research also highlights a correlation between organizational structure and larger societal, cultural, and financial forces; citing organizations have endured many challenges due to cutbacks, which have had tremendous negative effects on staff (Maslach et al., 2001). How society defines and prioritizes the social problems it faces often dictate policy, protocol, and funding priorities. A lack of priority to DVSAS issues within a country, community, or organization can dramatically affect helping professionals' attitudes. Neglecting to prioritize DVSAS program funding can produce a cognitive shift in the staff, through what Maslach et al. refer to as psychological contract, which is the staffs' perception of employee rights, benefits, compensation, and minimum work environment (2001). A breach in the perceived psychological contract is plausible to produce burnout as it erodes the notion of reciprocity, which is imperative in maintaining workforce well-being (Maslach et al., 2001). Viewed as an often-impossible task, this could present in helping professionals as a belief that they are expected to do more and more with less and less. Failing to address the hazards of the work environment in helping trauma survivors may contribute to burnout among helping professionals (Adams et al., 2006).

Baird and Jenkins (2003) suggested there is a deficiency in research studying burnout among paid and volunteer staff devoted to the trauma field, including workers in the DVSAS field. Research that is available, cited 39% of a randomized sample of 751 social workers identified current burnout and 75% identified with burnout at some previous time in their careers (Siebert, 2005). A study of caseworkers in child protective services reported 62% exhibited emotional exhaustion (Anderson, 2000). As there are often co-occurring family safety issues, child welfare and DVSAS service providers

frequently have clients in common, with a reported cause of DV in 25.1% of all 2013 child welfare substantiated reports (ODVFRB, 2013). These statistics confirm there is still a lot of collaboration and work to do to raise awareness of the increased risk of burnout among helping professions assisting families impacted by DVSAS.

Compassion fatigue among DVSAS professionals. As previously stated, the definition of compassion fatigue used for this research is the convergence of STS and burnout, which can be very detrimental if not addressed in DVSAS and other helping professions (Figley, 2002b; Stamm, 2009). However, there is a lack of published research reporting the prevalence of compassion fatigue in the DVSAS field. Compassion fatigue research has focused on therapists, child welfare workers, nurses, and emergency responders. This presents an important opportunity for future research that may contribute to improvements in the DVSAS field and other social service programs and practices, to accumulate recommendations to promote workforce well-being (Conrad & Kellar-Guenther, 2006; Figley, 1995; Hyman, 2004; Salston & Figley, 2003; Stamm, 1997).

Workforce Well-being Protective Factors

Individual factors. Worker well-being is important to examine on the individual and institutional levels. The most related individual factors to lower levels of burnout specifically are: staff age (over the 30 to 40 years old range) with more experience; staff who are married; staff with higher levels of hardiness-choosing to be involved in activities/events and being receptive to change; and staff who have an internal locus of control (Maslach et al., 2001). Research conducted by Schauben and Frazier (1995) among female mental health professionals working with sexual assault survivors,

reported effective individual routines of self-care mitigated some of the costs of caring. These self-care practices included adhering to a helpful habit of diet and exercise, being engaged in spiritual activities, and seeking supportive emotional connection with others (Salston & Figley, 2003).

In additional attempts to address the occupational hazards, Pearlman's research discovered self-reported, self-preservation techniques that included staffing cases with colleagues, training workshops, personal time with family/friends, having holidays, socializing, exercising, workload limits, spiritual life development, and adequate supervision as the most beneficial buffers (1999). With proper support and a positive personal belief system, 72% to 79% of service providers in various fields reported experiencing feelings of competence, self-fulfillment, and belief that they had done a good job; that also mitigated the risk of secondary trauma (Tehrani, 2007).

Organizational factors. Salston & Figley (2003) declared employer support is imperative to interrupting trauma transmission. In 1990, Dershimer described staff support as a necessity and not a luxury (as cited in Salston & Figley, 2003). Also cited as characteristic in promoting workforce well-being at the institutional level is autonomy while having influence on decision-making and freedom to obtain support, information, resources, and opportunities to meet goals (Slattery & Goodman, 2009). The study conducted by Slattery and Goodman reported workplace social support and shared power were inversely related to STS symptoms, while the quality of clinical supervision was negatively related (2009). The presence of workplace social support appears to mitigate occupational hazards and promote workforce well-being, perhaps reconciling the cost of caring (Beaton & Murphy, 1993; Catherall, 1999; Herman, 1992; House & Kahn, 1985;

Moos, 1988; Perlman & MacIan, 1995; Repetti, et al., 1989; Revicki, et al., 1993; Slattery & Goodman, 2009; Terry, 1999; Yassen, 1995).

Another organizational factor contributing to workforce well-being is quality clinical supervision. Several studies have revealed correlations between mitigating the occupational hazards of trauma work and engaged, supportive supervision, with mutual respect (Catherall, 1999; Coles, Astbury, Dartnall, & Limjerwala, 2014; Herman, 1992; Jordan, Kaplan, Miller, Stiver & Surrey, 1991; Miller & Stiver, 1997; Munroe, 1999; Perlman & Saakvitne, 1995; Rosenbloom, Pratt & Pearlman, 1999; Slattery & Goodman, 2009). An additional consideration to promote workforce well-being was staff perception of access to power and viewing the work environment as empowering (Hopkins & McGregor, 1991; Schechter, 1982; Slattery & Goodman, 2009). Slattery & Goodman (2009) maintained shared power was the biggest factor contributing to mitigating STS symptoms, outside of individual factors.

Several researchers in this literature review confirmed agencies are also encouraged to ensure education is provided regarding the risks to helping professionals and workforce well-being encouraged, while striving to create a supportive work environment (Adams, Matto & Harrington, 2001; Ben-Porat & Itzhaky, 2009). A supportive work environment can be subjective. Several commonly cited supportive work environment characteristics include positive management, career opportunities, clarity of roles, and performance feedback; social support through supervision, communication, and praise; and informal mentoring and social worker forums that promote a supportive network and friendships (Ben-Porat & Itzhaky, 2009; Figley, 2002b; Forbes et al., 2011; Ross, Altmaier, & Russell, 1989). These may be especially

helpful and critical for new helping professionals in the field (Adams, Matto & Harrington, 2001; Pearlman & MacIan, 1995). What better way to teach resilience than model resilience for clients in the workplace by practicing healthy coping strategies, arousal management, practicing positive decision-making, and problem-solving skills on the job (Forbes, et al., 2011).

Another possible component to a supportive work setting could consist of practicing psychological first aid and safety planning appropriate for the field, cited to be effective in high-risk organizations (Forbes, et al. 2011). According to Jacobs (2007), it is realistic to expect psychological adjustment/improvement and less time off work utilizing such indices. Without workplace adoption, endorsement, practice, and promotion of workforce well-being and good self-care, service providers have a higher risk of many detrimental side effects, including apathetic detachment, cynicism, and inflexibility (Cherniss, 1980; Jenkins & Baird, 2002), not to mention the potential individual health effects on the social service providers. Although there has been expanded focus in this area, the impact of traumatic events on service providers in the DVSAS field remains an understudied area (Slattery & Goodman, 2009). In addition, in some states (like Iowa) there is an increased reliance on volunteer workers (W. Michael Fleming, personal communication, June 13, 2014). Although there may be some semblance of institutional projection for employees (e.g., debriefing meetings, direct clinical supervision), it is unlikely these same protections are offered to volunteers (W. Michael Fleming, personal communication, June 13, 2014). Though this is an enormous area of study, more focus on positive traumatology has the potential to mitigate the abovementioned hazards of helping professionals.

Compassion satisfaction. Another protective factor for secondary trauma, burnout, and compassion fatigue is compassion satisfaction, the intrinsic reward of helping others (Collins & Long, 2003). Articulated by Stamm, who argued that not all trauma workers suffered STS, therefore a mechanism must be in place to mitigate (1998). If satisfaction in serving others is part of an individual's belief system, this can be an integral part of the equation for mitigating STS (Collins & Long, 2003). King, King, Fairbank & Adam (1998) affirmed additional research with compassion satisfaction revealed that personal resilience was defined as feelings of control, commitment, and viewing change as challenge. Other studies reported compassion satisfaction was present with feelings of coping with confidence (Bell, 2003), acceptance of complexity, possessing professional satisfaction, and the ability to make sense of suffering (Harrison & Westwood, 2009). Additional concepts of compassion satisfaction consist of positivity involved in caring and gratification received from helping others (Phelps, Lloyd, Creamer & Forbes, 2009; Simon, Pryce, Roff, & Klemmack, 2006; Ray, Wong, White, & Heaslip, 2013).

With an analysis of 25 intervention programs, over 80% revealed reduction in employee burnout symptoms with programs that promoted positive and supportive individual and organizational employee well-being; in addition to stronger effects, the improvements were maintained longer than programs promoting individual change alone (Awa, Plaumann, & Walter, 2010; Kulkarni, Bell, Hartman, & Herman-Smith, 2013). The long overdue positive psychology focus could be the conduit for understanding why some research reports positive outcomes, work engagement, and posttraumatic growth (Kulkarni et al., 2013). It is also important to continue longitudinal studies that assess the

intervention effectiveness to alleviate burnout (Maslach et al., 2001). There is still much work to do, but promising practices continue to emerge.

Several researchers studied trauma effects in the past decade to examine the interaction and exchange that can occur in working within systems of vulnerable populations who have suffered the biopsychosocial effects including military veterans, child abuse survivors, and DVSAS survivors (DeYoung, Kenardy & Cobham, 2011; Figley, 1998; Figley, 2002b; Herman, 1996; & Kulkarni et al., 2013; Pearlman, 2012). It is imperative to strive to create a more sustainable workforce to continue meeting the needs of traumatized populations as the requests for services exceeds the capability to meet those needs. Empathetic personalities and the desire to see lives empowered draw helping professionals to the DVSAS field. However, some of those same personal attributes can contribute to the likelihood of secondary trauma, burnout, and compassion fatigue (Figley, 2002b); "…we are really empathetic…and because of that, it can wear on us," (Director 1, p. 29). It is important to be continually cognizant of the fact that the very nature of the work, accompanied with the skill and gift to be empathetic, are the very components that put one at psychological risk (Campbell, 2002; Figley, 2002b). Challenges present opportunities to educate and recommend improvements. As this social change movement is facing many challenges, it also provides an opportunity to review the life cycle of these social change issues and collaborate to meet those challenges (Worth, 2014). The research goals of this thesis are one small component of this social change movement. It is also important to examine secondary trauma, burnout, and compassion fatigue at the macro level, through theoretical foundational lens.

Theoretical Foundations

Trauma transmission can be analyzed through at least two theoretical frameworks. The general systems theory will be the first to be examined. Another possible theoretical foundation to explain these phenomena is the ecological theory.

General systems theory. The general systems theory maintains there is an interrelationship with people or objects that are in contact with one another (Boss et al., 2009). As the trauma survivor and service provider are linked through the system of support networks and service programs, and the desire of each party to rectify the wrongs suffered by the survivor (White, Klein, & Martin, 2015), there can be residual effects. If we honestly examine the systematic interaction between service provider and survivor, "All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship" (Hilfiker, 1985, p. 207 as cited in Figley, 2002b, p. 1).

Systems theory also promotes a relationship balance. The outline of Parsons' system equilibrium first defined in 1937 and then in 1951, articulates the importance of four core components in systems exchanges: A=daptation, G=oal, I=ntegration, and L=atency (AGIL) (White et al., 2015). The systems are considered interrelated elements in an environment that can be mutually influential, and individuals are influenced by the roles they occupy (White et al., 2015). If the dynamic is in harmony, a positive feedback loop is often the result. When the pathway is out of balance or equilibrium, either or both of the participants in the exchange can be affected, producing a negative feedback loop. The withdrawal of the component out of equilibrium is a type of self-preservation, a seeking of homeostasis (White et al., 2015). This could present in secondary trauma symptoms of disengagement and emotional disconnect by the helping professional. The

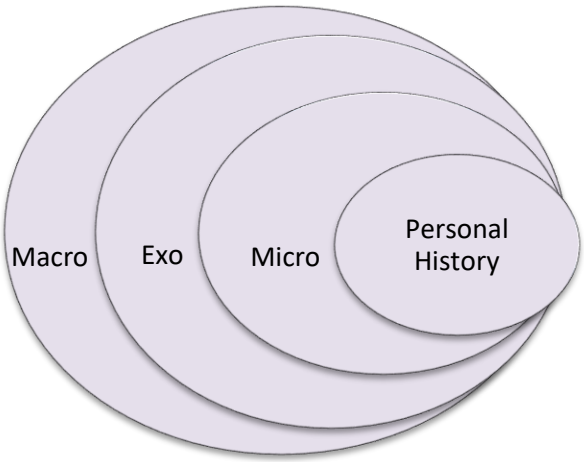
dynamics of the interrelated workforce well-being components provides an opportunity to explain the phenomena through the ecological theory as well.

Ecological theory. Within the systems theory emerges another important aspect of the theoretical foundation, as each system is an ecological layer in the conduction of either trauma transmission or compassion satisfaction within worker well-being models. Human ecology theorists propose that the surroundings of the individual effect their own and other lives within which they have contact and interaction (Bronfenbrenner, 1979; Boss, et al., 2009; Forest, 2015; White, Klein, & Martin, 2015). Research conducted by Schreiber et al. (2010) reported the complexity of interactions between help-seeking trauma survivors and their environment. Schreiber et al. maintained an emphasis on system levels of interaction, "…with an ecological framework describing the interdependence of individuals and their social environment…Individual responses to traumatic events can thus be conceptualized as the result of complex interactions among individuals, events, and sociocultural context" (2010, p. 7). Schreiber et al. also stressed, "The sociocultural context provides a source of meaning, appraisal, and understanding of the event for the victim and for family, friends, and help-providers" (2010, p. 7). It is important to examine DVSAS within the ecological framework to properly explain the complexity of the phenomena and properly provide support services at all levels of the human ecology (Alaggia, Regehr & Jenney, 2012).

One important component at the macro level is for policy makers and service providers to be mindful of each ecological layer and the structural barriers that can exist for survivors of DVSAS (Alaggia et al., 2012). Unintended consequences from policy and practice can create additional hardships for DVSAS survivors (Alaggia et al., 2012).

The premise of ecological theory reiterates the importance and influence of the individual in and within their multiple environments (Alaggia et al., 2012; Heise, 1998). As outlined in Figure 4, the individual history includes components of personal characteristics and family history (Alaggia et al., 2012; Heise, 1998). The microsystem represents the individual in their primary environment with family, peers, and culture (Alaggia et al., 2012; Heise, 1998). The exosystem symbolizes the individual in the secondary environment with neighborhood and community (Alaggia et al., 2012; Heise, 1998). The macrosystem has also been articulated to include the mesosystem, which embodies the individual in the extended environments of economic, social, and political arenas (Alaggia et al., 2012). Heise (1998) advised the nested ecological theory maintains an assumption that all levels are interrelated, however no convincing empirical research to date definitively delineates causal factors properly contributing a distinct mesosystem.

Figure 4. Factors Related to IPV at Ecological Levels



Personal History
Witnessing marital violence as a child;
Being abused oneself as a child;
Absent or rejecting father;

Micro System
Male dominance in the family;
Male control of wealth in the family;
Use of alcohol;
Marital/verbal conflict;

Exo System
Low socioeconomic status/unemployment;
Isolation of woman and family;
Delinquent peer associations;

Macro System
Male entitlement/ownership of women;
Masculinity linked to aggression and dominance;
Rigid gender roles;
Acceptance of interpersonal violence; and
Acceptance of physical chastisement.

Heise, 1998

The ecological theory can provide helping professionals insight into the complexity of the phenomena of DVSAS and the multifaceted risks survivors and helping professionals may be exposed to through the process of serving this population (Alaggia et al., 2012). The ecological theory reiterates the importance of examining DVSAS on multiple levels (Alaggia et al., 2012). The historical and social timeline of DVSAS acknowledgement helps articulate the transformation of those cultural and ecological systems, which continues to affect the field today.

The Social History of DVSAS

The shift from DVSAS being a private, family matter to a public health concern emerges as far back as the 17th century. Puritans in the New England colonies in the 1640s had the belief that family was a religious value expression and essential to a life of holiness (Cosimo, 2011). The Puritans defined the sin of DVSAS and child abuse as "wicked carriage" and a hazard to social order (Cosimo, 2011, p. 8). They promoted a community mindset that watched out for one another in order to attempt to keep the sin at bay and not endanger the holiness of the community in God's eyes (Cosimo, 2011). In 1641, the Massachusetts Bay Colony was the first known organized group of citizens to criminalize DVSAS (Cosimo, 2011). In 1859, John Stuart Mill maintained that the state had a responsibility to exert authority over its citizens in an attempt to stop harm to others (Cosimo, 2011).

The paradigm shift from DVSAS being a private family matter to a public health concern began to wane. The pendulum of public opinion continued to swing back and forth until additional states passed additional laws in 1976 criminalizing DVSAS and providing funding for successful criminal court procedures (Cosimo, 2011). The first

documented beginning of a grass roots movement to address the problem of battered women in the United States began in October 1974 (Vobejda, 1994). A group of friends from St. Paul, Minnesota, led by Lisbeth Wolf, opened their homes to assist victims of DVSAS. The first known shelter opened near downtown St. Paul the same month as the need for refuge soon overwhelmed the group's capacity, with 15 women waiting to have a safe place to lay their heads (Vobejda, 1994). Nearby Duluth, Minnesota, began a movement of a coordinated community response to address the epidemic of DVSAS, which kept it in the focus of the public health paradigm (Cosimo, 2011). How a society delineates a social problem forms the focus of intervention (Cosimo, 2011). This is an instrumental step in the stages of social change (Andreasen, 2006).

In 1994, the very high profile case involving the death of Nicole Brown Simpson preceded a federal push to address this social epidemic. During this era, DVSAS was proclaimed to be a serious health issue by the American Medical Association (AMA, 1992), and the March of Dimes recommended all doctors screen all pregnant females for DVSAS (Vobejda, 1994). Congress soon passed the Violence Against Women's Act (VAWA) presented by then Senator Joseph R. Biden, Jr., which he cited signaled an American government attitude change about gender based violence, particularly domestic violence (Vobejda, 1994). The previous two decades resulted in a remarkable reformation in the response to DVSAS by public opinion as well as the criminal justice, social service, and health care systems (Campbell et al., 2003). Congress reauthorized VAWA in 2000, 2005, and 2013. Even with all previous progress, there are still hurdles to clear. DVSAS are still social problems that affect too many American families, which also affects the well-being of many in the workforce dedicated to providing services to

assist those families. It is important to evaluate and educate on the macro, ecological level regarding the sociocultural context and address the pathways violence is embedded within contexts and cultures (Liang, Goodman, Tummula-Narra & Weintraub, 2005). Once the problem is better defined and understood, then societies and social programs can begin to address the detrimental effects. One very critical component in paving these pathways is DVSAS field leadership.

DVSAS field leadership is central in guiding service programs, in guiding the focus of the state movement, and encouraging legislative change. DVSAS Executive Directors comprise the majority of the Board of Directors at the Oklahoma Coalition Against Domestic Violence and Sexual Assault (OCADVSA) and donate their time on top of very hectic schedules to guide the movement. OCADVSA formed in 1979 and continues to be the membership organization for all Oklahoma DVSAS programs (OCADVSA, 2016). OCADVSA provides many important services for state programs, especially through the Legislative Committee, and is instrumental for getting the "line item in the state budget for domestic violence programs" (OCADVSA, 2016). OCADVSA was instrumental in shifting the oversight from the Department of Mental Health to the Office of the Attorney General, helping to ensure accountability for the crime was at the forefront. The OCADVSA Board of Directors is comprised of Chair, Co-Chair, Funding & Finance, By-Laws, Personnel, Membership, Legislative, Professional Development, and Fundraising Members (OCADVSA, 2016). Their leadership and input is very important to guide the future of the field; four decades of research from 70 countries revealed "autonomous mobilization of feminists in domestic and transnational contexts…is the critical factor accounting for policy change" (Htun &

Weldon, 2012, p. 548). Htun and Weldon further explain their analysis revealed that societal norms on a global scale affect domestic policy, "…pointing to the importance of ongoing activism and a vibrant civil society" (2012, p. 548). The increase in community level service needs should alert social service leadership to be prepared to address the workplace hazards of assisting traumatized clients (Meldrum et al., 2002). The staffing challenges that accompany these phenomena may require "specialized training in assessment of and response to post traumatic reactions and PTSD among professional staff" (Meldrum et al., 2002, p. 101). Meldrum et al. maintain, "…the impact of STS on professional capability has not been addressed in many workplaces" and is often first noticeable through decreased staff morale, which can have a contagion effect (2002, p. 88). A negative workplace environment has significant correlation with burnout (Adams et al., 2006; Baird & Jenkins, 2003; Figley, 2002b; Maslach et al., 2001). Field leadership plays a very important role, and leadership input is decisive to determine what steps are necessary and what areas of training are needed to continually combat the risks and occupational hazards inherent in the DVSAS field.

Research Goals

The proposed qualitative, phenomenological study is a first step toward addressing and preventing secondary trauma among DVSAS service providers and volunteers. As the primary themes identified by Program Directors in the DVSAS field are uncovered, this study aims to fill the research gaps by addressing:

- What is the level of awareness of secondary trauma, burnout, and compassion fatigue in the DVSAS field;

- Are there current and/or recommended trainings in the DVSAS field to address secondary trauma, burnout, and compassion fatigue; and
- What options might be beneficial to address any identified training gaps?

CHAPTER III

METHODOLOGY

The current study is a secondary analysis of qualitative data collected from domestic violence, sexual assault, and stalking (DVSAS) program leadership as part of a multi-state and multi-phased study focused on factors associated with secondary trauma, burnout, and compassion fatigue in paid and volunteer DVSAS staff in Iowa and Oklahoma. The current study only included data from Oklahoma due to the purpose of this research project. The goal of the Oklahoma project was to ascertain DVSAS leaderships' awareness of helping profession hazards and gather their recommendations to mitigate those hazards. The Verizon Foundation, the Oklahoma State University Center for Family Resilience, and the University of Northern Iowa funded this project.

Research Approach and Strategy

The initial purposive sampling frame for the current study included Executive Directors or their designees (hereafter referred to as Directors) of DVSAS programs across the state of Oklahoma. It is important to obtain input from DVSAS field leadership, as they are the best equipped to provide an organizational perspective on the extent to which secondary trauma, burnout, and compassion fatigue affect paid and volunteer staff. The DVSAS program Directors are also in the position to institute protocol, activities, and promising practices within their respective DVSAS agencies to

mitigate these workforce hazards. Erlandson, Harris, Skipper, & Allen (1993) reported purposive sampling the most efficient mode of obtaining answers to questions under study.

The qualitative research method was determined to be the best approach to obtain the data in the natural setting of the social service agencies. Barkhuizen, Jorgensen, & Brink (2014) stated the qualitative approach is designed to obtain the participants' perspective from their environment in open and less structured ways. Patton (2015) reported qualitative research practices to be helpful in depicting, observing, and analyzing human patterns.

The phenomenological analytical framework was determined to be more appropriate than grounded theory, as it is important to translate the experience of the particular group under study regarding their perception, description, feelings, and processing of the events (Patton, 2015). The purpose of the study was not to develop a new theory, but rather to articulate the phenomena of secondary trauma, burnout, and compassion fatigue; "…there is an essence or essences to shared experience" (Patton, 2015, p. 116). The transcendental, phenomenological paradigm concentrates on the essence and description of personal experience (Patton, 2015).

Study Procedures

Oklahoma State and University of Northern Iowa Institution Review Boards approved all study procedures (IRB, HE-14-20) (see Appendix C). Prior to initiation of the study, a team of two graduate assistants (including the author of the current thesis research) and one undergraduate research assistant attended a 3-hour training conducted by project professors. The training agenda included an introduction, overview,

recruitment, recording equipment operation of the Marantz Professional recorder (model PMD620MKII), in-depth interviewing techniques, and role-play using the semi-structured interview guide (see Appendix D). All research assistants completed a mock interview prior to initiation of study procedures.

Following completion of training and mock interviews, research assistants placed a phone call to the Executive Director of the Oklahoma Coalition Against Domestic Violence and Sexual Assault (OCADVSA), the membership organization for certified DVSAS programs, explaining the project and inviting participation. A follow-up email was promptly provided to the OCADVSA Executive Director to explain the project in more detail, which could be easily forwarded to Executive Directors of OCADVSA member programs to encourage participation. Research assistants utilized the OCADVSA member programs list provided through the OCADVSA website to begin participant recruitment. Each research assistant took an assigned service area and called the respective DVSAS program Directors approximately once a week (for a maximum of four weeks), to schedule interviews. The team determined which research assistant would cover their respective geographic areas, so not to duplicate.

Research assistants invited 12 of the 27 OCADVSA member programs to participate in the phase of the data collection utilized in the current study. The goal of 10 interviews was determined by the research team to provide adequate data to analyze, with plans to add another phase if saturation was not reached. Research assistants confirmed approximately one-third of the OCADVSA member programs were participating, which represented a region of the state of Oklahoma. DVSAS programs certified through the Office of Oklahoma Attorney General's (OAG) have operating standards under Title 75

O.S. Chapter 15 which outlines the mission to "eliminate domestic violence, sexual assault, and stalking in the state of Oklahoma" and outline minimum services, training requirements, and other standards for DVSAS programs (OAG, 2016, p. 1).

Approximately 48 hours before the interview, research assistants contacted the DVSAS Director or their designee to confirm date, time, and location of interview or reschedule as necessary. Research assistants emailed a copy of the informed consent (see Appendix E) to each Director. The informed consent advised the individual participation was voluntary and the participant could decline any question or withdraw from the research at any time. Research assistants provided a paper copy of the informed consent to Directors at the time of the interview.

Data Collection and Analysis

All interviews followed an in-depth, semi-structured interview guide developed by the Principal Investigator and collaborators. Two of the three trained research assistants conducted all interviews. Interviews began by reviewing the informed consent, explaining the study, and asking the DVSAS Director if they had any questions. Research assistants then proceeded through the interview guide. The interview guide was designed to tap all aspects of the organization's awareness of and response to potential cases of secondary trauma, burnout, and compassion fatigue among paid staff and volunteers (see Appendix F). The interview guide included basic information about the Director or their designee (10 questions); agency/organization information (30 questions); worker well-being training and protocol (30 questions); and ideas and issues for worker well-being training (6 questions).

Research assistants asked each Director if they had anything additional they would like to include at the completion of the interview guide. Research assistants expressed appreciation for their time to participate and for the services they provide for DVSAS survivors in the State of Oklahoma. Directors received no remuneration for participation.

Data recording. The interviews were audio recorded with the exceptions noted next. One interview had a recorder malfunction and one Director preferred not to be recorded. The research assistant transcribed these two interviews from lengthy field notes the same day of each interview. Interviews ranged from 55 to 80 minutes in length and were transcribed verbatim by team members. The data was transcribed using NVivo software and compared to voice recordings to ensure accuracy. The Project Coordinator conducted spot checks of audio recordings and transcripts.

Data analysis. After data collection and transcription, data analysis was completed in Microsoft Word using the qualitative coding analysis process outlined by Taylor-Powell and Renner (2003). The analysis was conducted with the goals stated in the research questions as the foundation for examination. The recommended Analysis Process Steps begin with getting to know your data (Taylor-Powell & Renner, 2003). The transcripts were read and re-read, in addition to listening to the audio recordings on multiple occasions. Field notes were also utilized when needed to better examine and confirm limited sections of data. The next step involved focusing the analysis (Taylor-Powell & Renner, 2003). The data was coded according to categories in the interview guide.

Cluster analysis grouped by research question was utilized to organize information and form themes and subthemes (Barkhuizen, Jorgensen, & Brink, 2014; Taylor-Powell & Renner, 2003). The coding structure was created, revised, and edited with Excel software. The initial six themes that emerged were volunteers, staff, awareness, training, recommendations, and external threats. If the same data emerged among two or more DVSAS Directors, it was initially coded in the six original themes. Regarding volunteers, Directors discussed employment policy, recruiting and retention, and the importance of interns to DVSAS programs. The primary themes Directors discussed concerning staff included employment policy, recruiting and retention, internal strengths, and internal weaknesses. The awareness themes Directors responded to included secondary trauma, burnout, and compassion fatigue. Concerning training, Directors reported the status of current training in the DVSAS field, training required for direct service providers, volunteer training, staff training, and recommended training. Directors contributed several types of recommendations for the DVSAS field: the importance of training regarding boundaries and self-care, collaboration with external agencies, follow-up through well-being monitoring, the importance of agency culture, and lack of technology. The last theme Directors discussed was external threats through our culture, judicial system, and funding insecurity.

Three themes and nine sub-themes were extracted through phases of coding; separating the data into substantial analytical sections and classifying the sections (Barkhuizen, Jorgensen, & Brink, 2014; Taylor-Powell & Renner, 2003). The additional sub-theme that emerged through the analysis process was communication gaps. Theme definitions were refined through an iterative process with the internal auditor (Taylor-

Powell & Renner, 2003). Categories were outlined and themes clustered until no new topics emerged (Taylor-Powell & Renner, 2003). The original themes were abridged to fit the scope and aims of this study, with the guidance and supervision of the internal auditor. This purging of qualitative data proved and has been reported to be a difficult task, "The particular challenge of qualitative reporting is reducing the sheer volume of data into digestible morsels" (Patton, 2015, p. 621).

In order to provide fluid content, minor modifications excluding non-essential words (e.g., uhm, and so on, well, ah, uh) was performed after the interviews were transcribed verbatim, during the coding and analysis steps (Barkhuizen, Jorgensen, & Brink, 2014). The six primary themes that emerged were abridged into three primary themes to accurately focus on the research questions and workforce well-being recommendations for this project, as mentioned above. The final three primary themes include: awareness - implications for agency and staff; current/recommended training - what we need; and training gap options - obstacles to overcome, which will be discussed in the next section. Auditors deliberated discrepancies and resolved through discussion, consensus, and several revisions.

An external auditor, a PhD Research Scientist in the field of Human Development and Family Science provided perspective on the rigor and trustworthiness of coding and interpretations. The external auditor provided a thorough review of all aspects of qualitative analysis and interpretation. The external auditor confirmed the final themes and interpretations reached, but advised theme names should include some component of the research questions. Therefore, additional title descriptions were developed to better align with the research goals.

Researcher Identity

My current thesis resulted from a desire to continue and expand the original funded research project. Having spent over 11 years in the DVSAS field, I have witnessed secondary trauma (often referred to in our field as vicarious trauma), burnout, and compassion fatigue in paid and volunteer staff. Due to interest in continuing the research and supporting the DVSAS field, I decided to pursue this area of study for my thesis. I acknowledge my personal, deep desire to better understand and promote workforce well-being within myself and in the DVSAS field. The deep desire to do no further harm, may also bias the difficult questions that need to be examined to promote DVSAS workforce well-being. The mere presence of the researcher can bias the exchange (Erlandson et al., 1993; Patton, 2015). The potential bias also exists in interpreting findings from the Directors of the field in which I am employed. The naturalistic inquiry approach acknowledges the mutual influence between the researcher and the respondents that may exist (Erlandson et al., 1993). More importantly is the commitment the researcher must possess to examine the very human interactions that are the heart of qualitative research (Erlandson et al., 1993). It is important to reiterate true paradigm shifts must occur from within a phenomenon (Lincoln & Guba, 1985; Patton, 2015), so in order to truly understand and examine secondary trauma, I had to first start with an unbiased examination of myself. The presence of bias is not in and of itself a detrimental attribute.

Bias in a legal context can present in the form of prejudice; bias in a research or service context can present in the form of passion and commitment to the cause. With progress in neural science, now we know that passion and emotion can function

synonymously with reason and empathy; and can enhance, enrich, and deepen human understanding (Patton, 2015); “One of the characteristics of naturalistic inquiry is that it empowers the various people who are involved in it” (Erlandson et al., 1993, p. 40). As I began this project, I anticipated this would also be a very helpful journey of self-reflection and empowerment, a refueling to continue this work. I believe it is truly a privilege to try to assist families and call that a career, but it can be challenging. I am even more privileged to be involved with research that can hopefully assist those who assist others!

CHAPTER IV

FINDINGS

The aim of the current qualitative research project was to explore workforce well-being awareness, as well as training and prevention practices and recommendations from the perspective of domestic violence, sexual assault, and stalking (DVSAS) program Directors.

Participants

Ten Executive Directors or their designees of the Oklahoma Coalition Against Domestic Violence and Sexual Assault (OCADVSA) member programs participated in data collection. The final sample consisted of five Executive Directors and five Director Designees (e.g., Assistant Directors, Advocates). For the purpose of maintaining anonymity, all participants will be referred to as Directors and limited demographic data of individual participants or agencies is included. All Directors interviewed were female; the average tenure of DVSAS program Directors was 13.2 years. Educational attainment was provided by 7 of the 10 Directors, with 4 holding master's degrees, 2 bachelor's degrees, and 1 special certification. Two Directors also reported having obtained their Certified Domestic and Sexual Violence Response Professional (CDSVRP) distinction through OCADVSA.

On average, the 10 DVSAS programs represented by Directors in the sample employed 12 full-time, 2 part-time, and 68 volunteers. All programs provided a crisis line, shelter (ranging in size from 12 – 35 beds), and support services of one or more varieties such as peer counselors, transitional living, transportation, parenting classes, and education/support groups. Eight of the 10 programs represented also provided sexual assault services, with 7 of those 8 having access to a sexual assault nurse examiner (SANE), and support systems for victims of sexual assault.

Directors represented agencies that served urban, suburban, and rural areas of Oklahoma. Questions regarding agency geographic catchment area was included in the interviews. Five agencies covered one or two counties, while the remaining five agencies covered three or more counties. According to the 2010 Census, the counties participating in this research would be responsible to provide services for 2,281,847 of the estimated 3,751,351 Oklahoma residents, or 60% of the state's population (US Census, 2010).

Qualitative Themes

Findings are reported across three primary themes and subsequent subthemes outlined in Table 1. Quotes relevant to each theme and subtheme are included to support the findings and are designated with Interview/Director numbers 1 through 10 to safeguard anonymity.

Table 1

Themes and Subthemes

Awareness - Implications for Agency & Staff	Secondary Trauma Burnout Compassion Fatigue
Current/Recommended Training - What We Need	Training Intensive Retreats Practice What We Preach
Training Gap Options - Obstacles to Overcome	Funding & Lack of Resources Retention Communication Gaps

Theme 1: Awareness - Implications For Agency and Staff

Directors acknowledged the danger of working in difficult service dynamics without proper support. Every Director was aware of the concepts of burnout and compassion fatigue. Although just one Director, Director 10 reported she was not aware of secondary trauma, all Directors were able to describe negative impacts of helping profession hazards when boundaries and self-care were not modeled and practiced in their agency.

All Directors volunteered an observation of one or more of these concepts in one or more of their paid or unpaid staff (volunteers). Director 1 explained the distress of secondary trauma to, "…sometimes prevent us from providing [clients] the best services possible." Director 2 reported seeing increased number of sick days among staff who may be combating compassion fatigue. Some of the Directors (n = 4) commented that funding challenges and anticipated future budget cuts could amplify the emotional challenges and workforce hazards of DVSAS work. Director 3 described the struggles some agencies face in trying to mitigate the implications of workforce hazards:

The problem goes on...when funds are low and [DVSAS agencies]

> don't have money, then they can't afford [i.e. training, therapy] ...cause a lot of them don't have a therapist who's willing to come in and do things for free…they don't have the funds to pay for that kind of stuff, and so you know it's just…it's such a hard deal cause so many [DVSAS agencies] want to incorporate the practices.

Secondary trauma. Directors described secondary trauma as trauma that rubs off on you. Director 1 defined secondary trauma as, "…when you feel the trauma for that person, or…when we re-traumatize them." Director 2 defined secondary trauma as, "…every now and then all of us have clients who tell us stories that really stick to us, that have, we just have a harder time shaking off." Director 3 also stated, "…it has real implications for your staff…real implications for your agency and your ability to serve your clients in your community."

Burnout. Directors defined burnout as "being done" with being a helping professional, a mindset that detrimentally affected the quality of service provision or resulted in helping professionals leaving the field. The majority of Directors believed burnout to be the last state of secondary trauma and compassion fatigue. Director 3 stated, "…it was a lot within the office, the politics…it was more internal than the externals…you're not getting the support." Director 9 affirmed burnout by stating, "I believe the cause may be lack of support. Some signs and symptoms might be absenteeism." Director 10 stated, "It can be a lot of factors, it can be the fact that the victims go back to their abuser…and you feel like you're not doing your job, or…you're not effective enough."

Compassion fatigue. Directors articulated compassion fatigue as the point when the work gets to you. The acknowledgement of Director 3 emphasized the cognitive shift present with compassion fatigue, "We start to have that shift in our world view you know…because people have an innate need to return always to homeostasis." Director 1 identified compassion fatigue as having, "…no reaction to things you should have a reaction to." Director 5 stated:

> Compassion fatigue…is when someone is so overwhelmed that they become harsh…I don't think it's that they don't care, it's just they're not operating in the realm where they care. And that actually is a piece of why I knew it was time to take a break.

Theme 2: Current/Recommended Training - What We Need

DVSAS agency Directors reported there is very limited, local training educating the field regarding the helping profession hazards of secondary trauma, burnout, and compassion fatigue. Directors reported they needed inexpensive, logistically accessible training that could accommodate different cohorts of attendees to ensure staff coverage at the programs. The logistical training recommendations varied, however the majority recommended off-site, interactive coaching models. Directors expressed a desire to return to a time when workforce well-being was emphasized through a burnout retreat. Directors also expressed a sense of responsibility to be the model of workforce well-being they desired in their staff, a duty to practice what they preach.

Training. All Directors clearly stated more training promoting workforce well-being was desired. No programs reported their volunteers received training on secondary trauma, burnout, or compassion fatigue even if they provided direct client services.

Directors advised easily accessible training focused on preventing the emotional toll of DVSAS work was nearly nonexistent. Director 4 stated, "There are no training opportunities focused on workforce well-being in this geographic area." A similar sentiment was also expressed by Director 5, "…there's just not a lot there for…team work and team building, and self-care…we struggle to find those that aren't expensive." Directors did report limited training was available in extended regions, but it was difficult to allow staff to attend due to budget and staff shortages. Director 5 stated the trainings available are, "…almost all for high profit, high dollar." When Directors were asked what type of training content they thought would be most valuable, two critical components recommended to be included were boundaries and self-care.

Directors reported boundaries were important to train, to model, and to mentor and were a vital component to include in promoting workforce well-being. Directors conveyed setting consistent boundaries with clients was critical to professional service delivery. Concerning sense of duty and setting healthy boundaries, Director 3 advised, "…finding that balance, and it doesn't make you a bad person, but actually that's what makes a program and agency successful." As empathy and compassion were reported to be critical characteristics for this type work, those same characteristics can also put a helping professional at risk for workforce hazards. Director 5 stated, "They are really hard to teach, because…a healthy boundary for individuals that are in this work and are wired to be compassionate, a healthy boundary typically feels harsh. Because a healthy boundary is watching out for yourself."

Another critical component DVSAS Directors recommended to train, to model, and to mentor was self-care. Recommendations for training content from Director 2

included, “recognizing how to help yourself, recognize your own personal signs of burnout…how to communicate that to your supervisor…accountability of actually doing it…how to combat it…different types of burnout or fatigue, and what it feels like.” Director 5 recommended, “…self-care classes…how to mentally process all that junk that you just absorbed…I have yet to set through something that has really helped me process what to do with that information.” Directors also desired assistance with developing tools their agencies could use to monitor and respond to detrimental outcomes of not practicing good boundaries and self-care.

Practice what we preach. Directors also recognized the need to model desired behavior in agency culture and practice. Director 3 stated, “…it’s the cultural…how you set up your culture…that’s when it trickles down…it has to be important, because if it’s not a priority for a Director…the staff is not going to get it.” The belief that one cannot help others if they are not helping themselves first was also expressed by Director 3, “…how can we go on and help other people when we’re not helping ourselves…it contradicts what we do.” Director 5 stated the need for practicing a workforce well-being mindset:

> And I try really hard to model that, you know. I don’t know that I’m always successful…I try to keep that balance and, to encourage that. I feel like...in my position, if I’m putting in 60 hours a week and not taking care of myself and that’s the model I’m setting, staff are going to understand that to be the expectation, and then I might get 60 hours a week out of them, but for how long? And at what cost? And so I try really hard to set that moderate pace so that we’re

investing in the client and we're doing our jobs, but we're not burning ourselves out.

Several Directors also specifically mentioned the importance of the agency culture and supervisors creating an atmosphere that was supportive of staff (n = 5). Director 3 stated, "As supervisors, our job is to create an environment where we are supportive of our staff," and stressed the importance of being continually aware of, and training in regards to, workplace hazards. Several Directors discussed former training through the burnout retreat being very helpful for staff, an avenue to practice what we preach, and again needed for the DVSAS field.

Intensive retreats. Directors reported former burnout training, *Don't Make An Ash of Yourself,* was very beneficial. The training was conducted in an overnight, retreat model with licensed health care providers, group processing, experiential exercises, great food, and physical activities (n = 5). There were also different weekends designated for supervisory and front-line staff, so everyone could openly share. Funding insecurities appear to have eliminated this training from the OCADVSA budget; however, Directors clearly voiced its former positive impact. Director 1 stated, "There was this amazing burnout retreat"; Director 6 proclaimed, "put that in 'BIG BOLD LETTERS' anywhere you want, that we need a burnout retreat! That burnout retreat was a pivotal moment in my life." Director 8 warned of the need to reassess no longer offering the burnout retreat, "Now that we don't have that…I think it's something that we're going to have to really take a look at."

The former burnout retreat model contained training that could potentially address many of the themes/subthemes mentioned as important concerns for several Directors in

this research project, included but not limited to: volunteer/staff retention, colleague support, caseload overload, secondary trauma, burnout, compassion fatigue, direct service delivery, boundaries, self-care, well-being monitoring, and mitigating the internal effects of external challenges. Director 10 echoed this recommendation specifically, "…have it in a retreat model where you teach them while they're there…have them practice the exercise."

Theme 3: Training Gap Options - Obstacles to Overcome

Three primary sub-themes emerged regarding agency options and obstacles to overcome in promoting workforce well-being. Directors expressed a desire to be able to do more employee wellness initiatives; however, there were major hurdles to clear before workforce well-being could become the priority they needed it to be. Funding and lack of resources to meet public demands and balance workforce well-being was a reoccurring challenge. Another obstacle experienced by Directors was volunteer and staff retention. The final subtheme included was a perceived internal communication gap.

Funding and lack of resources. All 10 Directors articulated that the DVSAS programs they represent are trying to do the best they can with what they have. One consuming concern was the constant challenge of budgeting for staffing and training cost. Director 5 implied the constant funding insecurity made workforce well-being training even more critical, but created a hurdle to achieving. When Director 2 was asked her opinion about what she believed to be the biggest external threats to the agency, she stated, "…the potential of ever loosing grant money. We are…largely grant based; I think that's absolutely the biggest threat." Directors reported another predominant area of challenge was lack of resources. Director 6 warned, "…the funding climate puts a

strain, because lack of staff means more burnout…lack of resources, even for the clients can mean burnout for staff because we're trying to take up the slack." This can create a vicious cycle for staff who are deeply committed to the cause.

Another area where lack of resources affects staff is lack of data management. Oklahoma does not have the technology to streamline paperwork, reports, and data management. Director 1 stated, "It's hard to carve an hour out of your day…when you spend so much time face-to-face with clients, and so you have to spend so much of the rest of your time doing paperwork." Director 8 advised data/donor management technology/software would be a tremendous assistance, as providing services is becoming ever-more challenging, "…it's just coming at us too fast!"

Retention. The majority of Directors reported problems with retention of volunteers and staff (n = 7). Director 10 advised a challenge with consistency and keeping volunteers engaged with the program were hurdles, and advised it was often very difficult to retain volunteers if they had a large number of clients who were children. Director 2 stated, "It is difficult to have so much turnover in the volunteers." Director 5 said she believes the problem with volunteer turnover in their agency could result from the volunteer position not having defined parameters to perform within, "I think it's even harder for volunteers to get the concept of boundaries and prevent secondary trauma than it is for staff, because you don't necessarily have that job description to stay within." A volunteer position may not have a written job description and the same routine supervision; the work structure is often different in a volunteer capacity. Director 10 shared, "They [volunteers] come here with these big hearts and then they find that it's a lot harder than they thought." These obstacles make it more imperative to develop and

include workforce well-being training for volunteers. Programs with Volunteer Coordinators reported fewer problems with volunteer recruiting, training, and retention.

Retention of DVSAS staff also plagued many programs (n = 6). Director 3 asserted, "I have a lot of Directors tell me they lose staff to McDonald's, because McDonald's pays $9 an hour." Directors 1 and 2 also reported they routinely had a lack of qualified applicants and positions remained unfilled for considerable time spans. In addition to lack of applicants, the nature of the work required a mindful and deliberate search of the best candidate to serve in each position, as Director 2 explained:

> …depending on the position, we may keep it open long enough, and we do, to make sure we get the best person…but that also means it's a challenge in staffing, because if someone leaves a position, like this position I had, stayed open for at least seven months, I think, before I came.

Several programs reported there was high turnover believed to be due to the stressful nature of the work. Director 1 reported, "I've known people that have left…a lot of people leave…it's stressful work." Director 2 stated similar concerns in regards to staff turnover, "The causes of that, I think, have a lot to do with being short staffed at work…constantly working in crisis mode." The majority of the programs struggling with retention had staff who had been there five years or less and Director 4 reported having a "continually revolving door" regarding staff retention.

Communication gap. DVSAS Directors acknowledged the importance of communication in the field, especially in regards to mitigating secondary trauma, burnout, and compassion fatigue. Communication and debriefing is reported to be a critical component to promote workforce well-being. Some Directors sensed a perceived

communication gap between front-line workers and management. When Directors were asked to articulate internal weaknesses, Director 1 maintained, "…paid staff would probably say there's…a gap or weakness in communication…" Directors also reported communication gaps create difficulty in trying to promote a cohesive agency culture. Director 7 articulated, "…togetherness is something that we need to work on, and stay on the same page…" Communication is often a challenge in healthy, supportive environments and is even more critical in stressful environments with traumatized populations.

CHAPTER V

DISCUSSION

In an effort to address and prevent secondary trauma, burnout, and compassion fatigue among domestic violence, sexual assault, and stalking (DVSAS) service providers and volunteers, the current study aimed to assess leaderships' awareness of the inherent hazards and gather recommendations for any identified training gaps in the DVSAS field. This study presents a unique opportunity to gather field recommendations to harness the hazards within the helping profession.

Awareness of Risks

All 10 Directors participating in the current study were aware of burnout and compassion fatigue and were able to recognize and provide examples from within their agencies and among staff or themselves. The majority of Directors were aware of secondary trauma and were able to recognize and provide examples of the phenomena within their agencies and staff as well. Overwhelmingly, DVSAS Directors recognized and articulated the necessity to practice what they preach regarding workforce well-being. Directors reported many obstacles to overcome in the DVSAS field which are correlated with burnout: prolonged, persistent stressors; organizational demands and overload; inadequate rewards; and high job demands/low resources (Maslach, 1982; Maslach & Leiter, 1997; Maslach et al., 2001; Salston & Figley, 2003; Shoji et al., 2015).

The current findings suggest it is imperative to be proactive in raising staff awareness and practicing workforce well-being protocols and psychological safety planning in DVSAS social service programs.

Training and Prevention

Joinson (1992) maintains awareness can be taught, corroborating the consensus of DVSAS Directors that more staff training is imperative to properly educate the workforce. Awareness of workforce hazards is critical to the population of people who chose helping professions. The literature reiterates that capacity for caring and being empathetic, common traits directors reported their DVSAS staff and volunteers possess, also places helping professionals at increased risk for the helping profession hazards under study (Figley, 1993; Salston & Figley, 2003). Some studies also report higher risk for some aspects of burnout among volunteers (Baird & Jenkins, 2003; Thieleman & Cacciatore, 2015). In some capacities volunteers may contribute substantial amounts of time (Thieleman & Cacciatore, 2015) and have less training and less structural or supervisory support (Baird & Jenkins, 2003), which can increase risk for burnout.

Other important findings that emerged from the data were internal and external challenges reported, in some fashion, at every agency. All Directors reported lack of resources and funding challenges among the obstacles that make providing services difficult. The simultaneous struggle reported by Directors is that these funding challenges are occurring while requests for services continues to be on the rise. This places DVSAS staff at risk of unrealistic and demanding workloads. As demanding workloads and high job demands are significantly correlated with burnout (Farber & Heifetz, 1982; Maslach & Florian, 1988; Maslach & Leiter, 2005; Shoji et al., 2015;

Thompson, Amatea, & Thompson, 2014), it is theorized more demanding workloads can negatively affect the helping professionals' sense of self-efficacy. This demanding workload, coupled with many helping professionals' tendencies to take on the role of "over-functioning", can lead to an internalizing blame, rather than the staffs' recognition of unrealistic workloads, producing additional workforce well-being risk (Galek, Flannelly, Greene, & Kudler, 2011, p. 637). This work environment and staff internalization can become the perfect storm, so to speak, heightening the inherent hazards of helping professionals. DVSAS Directors reported awareness of these risks, with a particular focus on workforce well-being and the challenge of available, adequate training in this area.

The majority of Directors provided specific recommendations for mitigating workforce hazards, expressing workforce well-being as an important and relevant issue to sustaining DVSAS staff and programs. The helping professions often attract talented and empathic service providers. One way to try to retain this talent is through training recommended by all DVSAS Directors. The majority of Directors advised the DVSAS field needed more training regarding secondary trauma, burnout, and compassion fatigue; intensive training retreats; and articulated the necessity to put into practice what they preach and address communication gaps. I hope to further this focus and assist in collaborating to host an Annual McLaughlin Memorial ~ "Don't Make an Ash of Yourself" ~ Workforce Well-being Workshop, in honor of a pioneer in the DVSAS field in Oklahoma (see acknowledgements). The McLaughlin Measurement could be developed and administered to attendees before and after the training, workshop, or retreat to indicate the effectiveness of the training. There could be a self-report

component administered through a questionnaire and/or field recommended assessments discussed in a future section and included as appendices.

Delivery formats of the training through a Workforce Well-being Workshop and/or Burnout Retreat should be at the discretion of the individual DVSAS agency. Attendance to an overnight, retreat model may not be feasible to balance work/family life for some staff and volunteers. It is also important to offer a condensed workshop version, as it is of utmost importance that every intervention be the decision of the staff/volunteer receiving services (Everstine & Everstine, 1983; Salston & Figley, 2003). It is also important that these support and intervention services not only be offered on an individual, tailored basis; but they should also be offered routinely (Salston & Figley, 2003).

Tedeschi & Calhoun reported in 1995, if an individual has been able to make sense and understand the traumatic experience(s), they are more likely to experience post trauma growth. The former Burnout Retreat in Oklahoma discussed by DVSAS Directors included all the components recommended by Figley (1995) to enhance workforce well-being: 1) physical health and fitness maintenance; 2) work/life balance; 3) meditation and spiritual practices; 4) social support; 5) professional boundaries/limits clearly defined; and 6) professional/consultative supervision and support. At the time of this writing, there was no literature located exploring the effectiveness of trainings or intensive retreats in the DVSAS field. Nurses were some of the pioneers to recognize the unique workforce hazards in helping professions.

A review of research on the effectiveness of various burnout interventions reported improvements in physical and mental health, satisfaction of their patients, and

the organizational bottom line (Henry, 2013). One study examined found a 25% increase in satisfaction with job roles and management aspects after an overnight compassion fatigue retreat program, with long-term benefits reported at 3 and 6-month post-event measurement (Lambert & Steward, 2007). In another study of nurses, secondary trauma and impact of event scores declined after a series of 90-minute trainings over 5 weeks and maintained mitigation of secondary trauma 6 months after program completion (Potter et al., 2013). Findings with nurses indicate hope in mitigating helping profession hazards inherent in the DVSAS field with appropriate attention, training, and research.

Although research among other helping professions report significant clinical ramifications if the risks of burnout and compassion fatigue are ignored, such as increased blood pressure, weight gain, cardiovascular disease, diabetes, and immune dysfunction (Aycock & Boyle, 2009; Radziewicz, 2001), minimal research exists exploring workforce hazards in the DVSAS field. The current findings lay the groundwork for future research with DVSAS professionals who provide safety from violence, promote empowerment, and assist with trauma restoration. DVSAS Directors in the current study reported a vital component to program success and longevity is retaining the best-prepared workforce. One way to accomplish these goals is for agencies and organizations to routinely provide proactive and preventative workforce well-being supports to paid and volunteer staff and psychological safety planning for staff, rather than only post stressor or crisis responses (Aycock & Boyle, 2009; Barnard, Street & Love, 2006). This could present in the form of incorporating routine continuing education regarding helping profession hazards, self-care strategies, debriefing, critical incident responses, and post-exposure practices. DVSAS Directors, staff, and ultimately

clients would benefit from resources designated to provide preventive care, as decreases in staff turnover may be one extremely significant benefit that would remove some obstacles for agencies. Perhaps best articulated by a pioneer in the literature almost three decades ago, "How effective is a workshop if we do not also have impact on the stressors that exist within the organization and on its leadership" (Freudenberger, 1989, p. 7). Leadership's awareness and adoption of policy, protocol, and practice to mitigate the helping profession hazards can offset many of the risks helping professionals face, which in turn benefit leadership, staff, and clients; however, there must be practical ways to implement or Directors will continue to face the budgeting dilemmas of providing client services or protecting their workforce.

The agency culture expressed by DVSAS Directors corroborated previous findings. Most Directors described extremely close and committed cohorts of agency staff, while some described groups with communication gaps and high turnover, which was an unexpected finding further discussed in an upcoming section. As agency culture was revealed to be both a protective and risk factor by DVSAS Directors, the importance of guarding against detrimental work environments is strongly supported (Valent, 2002; Salston & Figley, 2003; Maslach & Leiter, 1997; Maslach et al., 2001) especially with high job demands and/or low resources (Shoji et al., 2015). The literature reports work environments that are supportive report lower levels of burnout and compassion fatigue (Adams et al., 2006; Collins & Long, 2003; Thieleman & Cacciatore, 2014). Valent (2002) reported the social systems surrounding the helping professional, including their peers, organizations, family, and community, are extremely influential in mitigating risks in the helping profession. Out of balance agency and social supports can be career-

ending combinations without recognition of and implementation of proactive, promising practices to mitigate secondary trauma, burnout, and compassion fatigue. If DVSAS programs focus only on, or primarily on, client needs exclusively, this can undermine the wellness and sustainability of the workforce. One promising practice that promotes both goals of protecting the workforce and engaging support systems is raising awareness of helping profession hazards and psychological safety planning.

Progress in providing more agency support was reported by several Directors, which included allowing a mental health day, team building workshops, and flextime. Freudenberger (1989) recommended programs "…explore questions within organizations, such as how can we build in strong support networks and flexibility in job functioning, how can we reduce routine dulling and deadness, and how can we offer opportunities for individual development and reinforce skills for effective stress resolution while we diminish work load" (p. 8). These practices may be difficult to incorporate, but are even more imperative to examine as all DVSAS Directors in the current sample reported increased request for services simultaneously with shrinking budgets. Research suggests that stress management alone cannot combat all the risks. It takes the collaboration of the individual, the organization, and the community (Aycock & Boyles, 2009; Bober & Regehr, 2005). Perhaps one avenue to pursue and include in training is raising more awareness to the importance of collaboration and the positive psychological aspects of helping professions, such as compassion satisfaction and vicarious resilience.

One positive psychological component important to include in future DVSAS training material reported to help mitigate helping profession hazards is compassion

satisfaction (Stamm, 2002, 2009; Thieleman & Cacciatore, 2015). Stamm (2009) reported the social support required to perpetuate compassion satisfaction was reported by a majority of the DVSAS Directors to be a positive part of the internal agency culture. Many Directors reported colleagues to be instrumental in their support system. Due to the fact, many people survive adversity, abuse, and trauma with success and resilience; and many helping professionals do the same, it is important to examine positive psychological attributes that may be present. According to Stamm, "…to protect the workers, it was necessary to address both the positive and negative aspects of caregiving" (2002, p. 111). Stamm reported compassion satisfaction to be the manifestation of efficacy and could possibly be derived from the intrinsic desire to be what you want the world to reflect (2002). One study reported higher levels of compassion satisfaction correlated with lower levels of anxiety in therapists who worked with sexual assault survivors (Samios, Abel, & Rodzik, 2013). Stamm maintained education regarding trauma effects should prepare staff and agencies to develop protocol to increase compassion satisfaction and decrease burnout and compassion fatigue (2002). Another positive psychology concept important to mention regarding helping professional positive pathways is posttraumatic growth through vicarious resilience.

A relatively new concept and area of research, vicarious resilience has also been reported to offset negative outcomes of secondary traumatic stress among helping professionals (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017). One study examining vicarious resilience conducted among sexual assault and domestic violence advocates presented an opportunity to inform organizational leadership how to build on staff strengths and growth rather than just mitigating helping profession hazards (Frey,

Beesley, Abbott, & Kendrick, 2016). The study included 222 domestic violence and/or sexual assault advocates. The results indicated that experience of personal trauma and peer relational quality predicted increased vicarious resilience, while organizational support was correlated with compassion satisfaction only (Frey et al., 2016). The implications cited from this study reflect the importance of including positive psychology in advocate training and organizational policies and procedures and taking a multidimensional approach (Frey et al., 2016).

Perhaps we need to put more focus on what is strong, rather than what is wrong. As an advocate in the DVSAS field for 11 years, I was not aware of the concepts of compassion satisfaction or vicarious resilience until I began this research project. Researchers have proposed a "better understanding of the positive impact of advocacy work would allow organizational leaders, supervisors, and trainers to build on strengths and identify strategies to foster advocate growth versus simply addressing prevention of vicarious traumatization" (Frey et al., 2016, p. 1). Another article maintains "a parallel need to highlight the unique strengths of advocates" due in large part to their historical contributions to the movement (Slattery & Goodman, 2009, p. 1373). The State of Oklahoma has many dedicated professionals who desire to improve DVSAS workforce well-being. Leadership is aware of the inherent helping profession hazards and one of the main goals in the DVSAS field is to do no further harm. Secondary trauma, burnout, and compassion fatigue could drastically affect the quality of services we provide, not to mention the individual toll to the helping professionals. A focus on workforce well-being could be considered psychological safety planning for paid and volunteer staff. This research revealed DVSAS leadership is well aware of the risks and are willing to

implement promising practices to address it, but need tools and resources to accomplish the tasks.

Research collecting DVSAS leaderships' awareness and recommendations to address secondary trauma, burnout, and compassion fatigue was non-existent. It is imperative to include DVSAS program pioneers in charting the course towards improved workforce well-being protocol with empirical research; it is beneficial to conduct naturalistic inquiry to better understand a phenomena from the front-line (Hébert, 1986). Research assistants conducted on-site interviews with over 30% of DVSAS field leadership in Oklahoma. The contributions to the field include raising awareness of the importance stressed by Directors to have comprehensive consistency and be proactive in preventing, recognizing, and mitigating workforce hazards in the DVSAS field. One salient comment by Director 6 recommended training be required for staff and volunteers. Some research supports the requirement of including workforce well-being training (Aycock & Boyle, 2009). If this was a required component of the annual training for DVSAS program staff and volunteers through the certifying agency (Oklahoma Attorney General), the field may be better prepared to sustain the workforce and meet the needs of clients.

DVSAS certified programs operate under the Oklahoma Attorney General (OAG) Title 75, Chapter 15 *Standards and Criteria for Domestic Violence and Sexual Assault Programs* (OAG, 2016). Including workforce well-being and psychological safety planning in the required training under Sections 13-20.1 and 13-20.2 (OAG, 2016) could be a tremendous benefit to the DVSAS field. Section 13-20.1 outlines the required 30 hours of orientation training for every new staff or volunteer who will be providing direct

client services. There is a variety of topics from program goals, policies and procedures, confidentiality, and other important components. Section 13-20.2 outlines the required 16 hours of annual continuing education units for staff and volunteers who provide direct client services. Sexual assault and court advocates (and others) have additional required hours in Sections 13-24 through 13-29. None of the sections requires the inclusion of helping profession hazards or workforce well-being training. As Directors reported several obstacles to overcome, training to help promote skills to enhance workforce well-being can be even more critical in the current difficult funding climates and projected funding hurdles ahead.

The majority of DVSAS Directors reported funding insecurity as an obstacle to overcome. As Directors predict funding insecurity to remain an issue, this workforce well-being focus could help alleviate detrimental consequences for program sustainability, as the dependence on volunteers is predicted to increase. Considering anticipated and continuing national and state budget deficits, and regionalization of domestic violence service programs in other states, the reality of the need to provide more services with less funding is becoming more apparent. Regionalization in Iowa DVSAS programs occurred due to funding cuts; it is not uncommon to travel 250 miles between shelters for survivors (W. Michael Fleming, personal communication, June 13, 2014). This amount of distance can stretch the agency staff too thin, increase operating expenses to an unmaintainable level, and most importantly can be a factor that may influence whether a victim leaves a dangerous situation. As nonprofits continue to face challenging and changing funding climates, these imbalances and deficits in resources can contribute to higher rates of staff turnover and burnout (Worth, 2014).

In addition to fewer program resources, there are also continuing increases in requests for DVSAS services, "Demand for help is up, but budget problems are forcing some services to go away…counseling and prevention services have gone to the wayside just so we can keep the shelter open," (Canon, 2010, p. A13). The declining budgets to properly staff and address those demands for help creates stress on the internal and intrinsic program and staff dynamics. It is crucial to obtain field leaderships understanding, perception, and recommendations to transition through these pivotal points in the movement, while acknowledging the importance of investing in workforce well-being and retention of qualified and committed paid staff and volunteer personnel. Although the need for continual volunteer training presents challenges, with the funding climate and expected continual budgeting pressures, it could be imperative to the continued success and sustainability of many programs. It may also be helpful to have written job descriptions for all volunteers. Implications for staff (paid and volunteer) includes participation in training and promising practices to promote workforce well-being, psychological safety planning, and self-preservation to continue important work in difficult service dynamics. Implications for Directors includes better-prepared and functioning staff and volunteers which translates into higher quality programs and services to DVSAS survivors.

Workforce well-being training to assist with identification of distress symptoms and/or conditions presents an important opportunity to discuss and develop a self-care plan. There is not an exclusive way to treat the transfer of trauma; it should be a team effort with a trauma specialist and the traumatized (Salston & Figley, 2003). The personal preferences, availability of treatment options following a critical incident, and

whether the affected individual embraces the recommended intervention are all important factors to consider when promoting workforce well-being programs (Salston & Figley, 2003). Formal assessments can often be helpful and insightful to assist with recognition for the need of mitigating secondary trauma phenomena, practicing self-care, and staying on a healing journey (Adams et al., 2006). The Professional Quality of Life Scale (ProQOL), Version 5 (Stamm, 2009) examines both hazards and rewards. The 30-item assessment requests information from the past 30 days that examines burnout, compassion fatigue, and compassion satisfaction (see Appendix G). The Secondary Traumatic Stress Scale (STSS) is a 17-item assessment that examines hazardous interaction with clients over the past 7 days (see Appendix H) (Bride, Robinson, Yegidis & Figley, 2004). The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) measures hazards through a 22-question self-test designated by three sections identifying dimensions of burnout in human service professionals (see Appendix I) (Maslach, 1996).

Limitations and Future Research

The current study has several limitations including small sample size and lack of diversity, prohibiting generalizations. It would be important to expand the sample size in future research to ensure every region in Oklahoma is included, as there may be different responses and concerns from different geographic areas. Pertinent issues in the northeastern counties may be different from the southwestern counties. Future studies should also aim to include as many DVSAS program providers as possible, including those outside of the certified programs list. Some faith-based and Native American programs in Oklahoma were not included in the current study, yet play a key role in DVSAS service provisions in the state.

Another limitation of the study could be the use of terminology, which the research arena itself has not reached consensus. The use of vicarious trauma has been a customary term most often utilized among the DVSAS field, as cited by Frey et al. (2016), "This impact has been labeled vicarious trauma, described as the transmission of cumulative stress resulting from exposure to survivors' trauma (McCann & Pearlman, 1980)" (p. 1). I suspect this stems from the original field of study or school of thought, as Pearlman's work involved sexual abuse and incest survivors, while Figley's work began with veterans' PTSD. The traumatology terminology is still evolving, which creates limitations and confusion for researchers and participants as well, and "definitional overlap" may cause "ambiguity in differentiating" (Frey et al., 2016, p. 2).

Further limitations of the study were not including interview questions regarding the positive impacts of trauma work such as compassion satisfaction, vicarious resilience, or vicarious posttraumatic growth; in addition, "the bulk of the literature focused on the multiple stressors and systemic barriers that negatively impact advocates" (Frey et al., 2016, p. 1). In addition, due to the fact two research assistants were involved in the interview process and two interviews were not audio recorded, the potential for inconsistent inquiry and translation are possible. Another significant limitation was not obtaining front-line staff and volunteer perspectives, but this is being considered for future projects. Another limitation from the analysis resulted from this researcher being the only coder, presenting more potential for biased interpretation, which has been carefully examined by an external auditor.

Unique Findings and Implications

While not a theme that emerged throughout all interviews, one salient suggestion from Director 4 called for training and education for future workforce through undergraduate study programs before they even join the DVSAS field. Director 4 stated, "We also need a whole semester of self-care, especially in undergraduate degrees, etc. This is one area that needs big improvement." Researchers specializing in helping profession hazards recommend the following:

> The first step in preventing or ameliorating compassion fatigue is to recognize the signs and symptoms of its emergence. By continually monitoring themselves for the presence of symptoms, clinical social workers may be able to prevent the more negative aspects of compassion fatigue…The purpose of this article is to provide an overview of these instruments so that clinical social workers may make informed decisions regarding how to monitor their own experiences of compassion fatigue (Bride, Radey & Figley, 2007, p. 156).

Agency culture as a protective and risk factor was an unexpected, emergent theme. Directors reported an internal culture that in some ways enabled workforce hazards to perpetuate, but also mitigated secondary trauma, burnout, and compassion fatigue. For example, being a "work-a-holic" can be a benefit to the agency and team, but can increase risk for burnout and compassion fatigue. Director 6 described her staff as "work-a-holics" that contributed to a community atmosphere. Directors also reported the fortitude and dedication of the majority of the staff that serve with longevity in their organizations and described them as dedicated colleagues and extremely compassionate. Another attribute reported was the internal support that staff members provided to each

other. Directors believed the dedicated, supportive agency culture to be a protective factor against the workforce hazards under study, if kept in balance with setting boundaries and practicing good self-care. Directors with forethought of the significance of these agency cultural components recommended allowing flex or comp time when staff worked overtime, as long as positions were covered. Director 10 recommended a mental health day to help combat the helping profession hazards inherent with DVSAS work. Director 3 provided one salient quote, "…we have to put some things in place where our staff matters more than the clientele that comes, because we need to retain the talent we have." One study articulated and referenced promising practices well: "It is imperative that systems committed to the treatment of survivors be equally committed to advocates, who are often among the first to bear witness to survivors pain" (Frey et al., 2016, p. 7).

Conclusion

Collaboration among researchers and universities throughout Oklahoma, including the Oklahoma State University Center for Family Resilience and the University of Oklahoma Center for Applied Research for Nonprofit Organizations could do much to expand and translate this work into several fields of helping professionals facing significant workforce hazards. Perhaps a coherent strategy for addressing, delivering, and funding promising practices, accompanied with supportive agency environments that protect and monitor the well-being of DVSAS staff (both paid and volunteer) could be the proper partnership pursuit to ensure we have done all we can to be good stewards, continue this work, and pay it forward. It is concerning several recommendations from three decades ago are still obstacles echoed by Directors in the DVSAS field and stresses

the importance of continuing to study, disseminate information, collaborate, and follow-through to implement promising practices regarding workforce well-being and psychological safety planning. Almost three decades ago, Freudenberger recognized future endeavors to address burnout needed to, "…approach the individual, the administration and the organization" (1989, p. 8). Freudenberger further advised burnout prevention efforts, "…also needs to take into account the macro-sociological and political variables that…ultimately have impact on us, the service providers…Too few institutions speak of impairment, while too many professionals are impaired" (1989, p. 8).

The ultimate goal is to eradicate DVSAS from all communities. This lofty goal will take a well-educated and well-trained workforce who practices self-care and psychological safety planning. The ultimate goal will take all levels and layers of society working together, "Initiatives to reduce partner violence require commitment and vision—by the international community, local governments, and civil society," (Abramsky et al., 2011, p. 123). Recognizing that violence is not a single symptom or single source phenomena, it approaches with a social-ecological, multi-faceted model (Haegerich & Dahlberg, 2011); we must be willing to collaborate, take the risks of thinking outside the box, but first take care of ourselves. Research examining secondary traumatic stress, burnout, and compassion fatigue over the last three decades dictates that efforts to ensure workforce well-being and psychological safety planning for helping professionals becomes a fundamental field standard (Figley, 2002, 2002b; Freudenberger, 1989; Maslach, 1982; Pearlman, 2012; Pearlman & Saakvitne, 1995; Sansbury, Graves, & Scott, 2015; Shoji et al., 2015). Research over the last decade (Patton, 2015; Russell & Brickell, 2015) also confirmed workforce well-being may be subject to a subconscious,

natural response for empathic individuals that requires a conscious, mindful reaction, "Brain scans reveal when we read a detailed description, an evocative metaphor, or an emotional story, the brain is stimulated" (Patton, 2015, p. 607). Perhaps the most convincing finding relating to the understanding of secondary trauma during the past 10 years reveals dual activity in neural pathways upon the observation or imagination of another individual's experience (Russell & Brickell, 2015). Russell and Brickell discovered, "Literally, we empathize by actually recreating in ourselves the physiological emotional experience of another…and occurs automatically, outside the observer's awareness or control" (2015, p. 1087). Russell and Brickell (2015) presented the possibility of a spectrum of helping profession hazards with risk/vulnerability and resilience/protective factors, which can now be neurophysiologically measured.

Due to the stressful nature of the work and enormous workloads in DVSAS social service programs, workforce well-being must be more than a priority, it should be the norm. Psychological safety planning should become a routine field exercise. We now have over three decades of research and recent neuroscientific findings to corroborate what many trauma and research professionals have hypothesized. What we do with this information is critical to the future of all helping professions.

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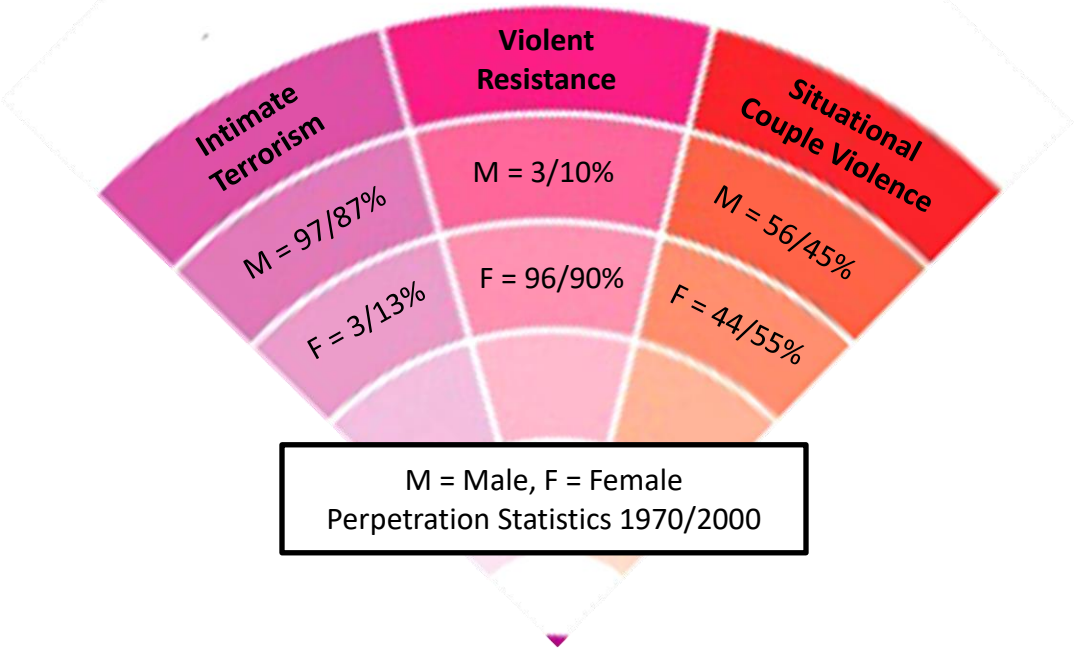
APPENDIX A

Domestic Violence Spectrum



Johnson, 2011

APPENDIX B

Domestic Violence Spectrum Interventions

Primary Prevention/Education –

- Intimate Terrorism
  - Equality & respect;
- Violent Resistance
  - Intimate terrorism danger signs;
  - Safety planning;
  - Entrapment/escape issues; and
- Situational Couple Violence
  - Education regarding conflict source (noted below).

Screening/Triage –

- Individualized model for every client;
- Assess coercion & violence for both partners;
- SAFETY FIRST!
  - Initially assume worst (intimate terrorism);
  - If situational couples' violence seems likely, individual approach; and
  - If confident and safety has been demonstrated over time, move to couples' approach with safety plans.

Intimate Terrorism Survivors –

- Long-term support;
- Alternatives to violent resistance;
- Empowerment to leave; and
- Transitional support.

Situational Couple Violence Survivors –

- Address conflict source;
- Anger management;
- Healthy communication; and
- Substance abuse treatment.

Johnson, 2011

APPENDIX C

Oklahoma State University Institutional Review Board

Date:	Thursday, February 04, 2016	Protocol Expires:	6/3/2017
IRB Application No:	HE1420		
Proposal Title:	Workforce Prevention of Compassion Fatigue among Paid and Volunteer Domestic Violence and Sexual Assault Support Personnel		
Reviewed and Processed as:	Exempt **Modification**		

Status Recommended by Reviewer(s) **Approved**

Principal Investigator(s):

Pam Pearsall
Stillwater, OK 74078

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233 HES
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The requested modification to this IRB protocol has been approved. Please note that the original expiration date of the protocol has not changed. The IRB office MUST be notified in writing when a project is complete. All approved projects are subject to monitoring by the IRB.

☑ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

The reviewer(s) had these comments:

Modification to make Pam Pearsall the PI and Dr. Gallus the advisor.

Signature :

Hugh Crethar, Chair, Institutional Review Board

Thursday, February 04, 2016
Date

APPENDIX D

In-depth Research Interviews
Kami L. Gallus, Ph.D., LMFT

The purpose of the In-depth Research Interview is to obtain a qualitative description of the experience of the participant. The interview is an interpersonal experience, a conversation about a theme of mutual interest. The interview is the "raw data" for the later process of meaning analysis. The quality of the interview is decisive of the later analysis and reports

Quality Criteria for Research Interviews

- extent of spontaneous, rich, specific, and relevant answers
- shorter questions, and longer answers
- degree to which the interviewer follows up and clarifies the meanings of the relevant answers
- "self-communicating" – it is a story contained in itself that requires little extra description or explanation

It is up to the Interviewer to...

- ➔ create contact, in a matter of a short time, that allows the interview to get merely beyond a polite conversation
- ➔ use him/herself as a research instrument to monitor implicit bodily and emotional modes of "knowing" that allows access into the participants experience and meaning
- ➔ have a sense for good stories and assist participants in unfolding their narratives
- ➔ be confident in the subject and structure of the interview
    - The interviewer must have clear answers to the what, why and how of the interview
        - **what:** know what the subject matter of the interview is
        - **why:** formulate a clear purpose for the interview
        - **how:** be familiar with the interview questions and protocol

Facilitating quality in-depth interviews requires the Interview to be...

1. ***Open-minded.*** Judgment or criticism can act as barriers to communication, so it is important to maintain openness. If participants perceive they are being judged or evaluated, they are less likely to openly share their opinions.
2. ***Flexible and responsive.*** Human interactions are complex and people's responses to questions are rarely predictable. Good interviewers can think on their feet, respond to challenges, and make sure that the core purpose is being served. Let participant's answers determine the direction the interview takes (keeping within topics of interest). Use probes as needed:
    - Could you please tell me more about...
    - I'm not quite sure I understood ...
    - Could you tell me about that some more?
    - I'm not certain what you mean by...
    - Could you give me some examples?
    - Could you tell me more about your thinking on that?
    - You mentioned....Could you tell me more about that? What stands out in your mind about that? Can you elaborate on that idea?
    - This is what I thought I heard...Did I understand you correctly?
    - So what I hear you saying is..."
    - Can you give me an example of...
    - What makes you feel that way?
    - What are some of your reasons for liking it?
    - You just told me about.... I'd also like to know about....
    - Is there anything else?
3. ***Patient.*** Allow the respondent to speak freely and open up at a pace that is comfortable. Do not move on to a new topic until you have explored the informant's knowledge/opinion on the question at hand. (TIP: Embrace silence. Count to 10 before moving on to the next question.)
4. ***Observant.*** Good interviewers are observant, picking up subtle cues such as facial expressions, body language, and tone of voice.
5. ***A good listener.*** A good listener is one who listens actively, using strategies such as:
    - **Attending fully** to what the speaker is saying. Active listening requires the listener to give full attention to the speaker until either the message has been received or the speaker has finished speaking. But remember to remain neutral: don't approve or disapprove
    - **Paraphrasing** what the speaker is saying to confirm to the speaker that the listener is actually listening and that the message conveyed is the message received. Paraphrasing involves repeating back to the client what he or she has said – using other words. "So, in your agency...(+ probe/follow up question)."
    - **Reflecting** back to the participant the emotions inherent in the message. By paying attention to tone, body language, and emotional content, the interviewer can gain a greater understanding of the messages being delivered. An example of a reflection, "I can see how you might feel...(+ probe/follow up question)."

APPENDIX E

The CFR is a unit of The College of Human Sciences.
The vision of The College of Human Sciences
is to be a world leader in the discovery and application of knowledge, preparing the next and upcoming generations of professionals who advance the quality of life.

Informed Consent

You are invited to participate in a research study. The research is being conducted by University of North Iowa and Oklahoma State University.

Before you decide, it is important for you to understand why the research is being conducted and what will be involved. Below is important information about the study.

The purpose of the research is to:

- Learn about the potential threats of secondary trauma, compassion fatigue, and burnout administrators identify among the domestic violence and sexual assault workforce.
- Learn about any initiatives your agency has in place addressing these issues; and your beliefs about alternative ways of getting initiatives in place.
- Identify strategies for protecting the well-being of the domestic violence and sexual assault workforce (paid and volunteer).

The interview will take about 1 hour. Risks associated with participation in this study are expected to be minimal. The interview questions do not ask for personal experiences, but rather focus on perceptions of other personnel and agency experiences, procedures, and protocols.

Your responses in this interview will be kept strictly confidential. Research records will be stored securely and only researchers and individuals responsible for research oversight will have access to the records. Study results will not use participants' real names and any other personal identifying information will be changed. Data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These include, but may not be limited to, incidents of abuse and suicide risk.

Participation in this study is strictly voluntary. You can refuse any question or end the interview at any point.

If you have questions about this study or your rights as a participant, you may contact Dr. Joe Grzywacz, the Lead Researcher, by phone (918-594-8440) or email (joseph.grzywacz@okstate.edu) or Dr. Kami Gallus (405-744-8351) or email (kami.gallus@okstate.edu). If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, Institutional Review Board (IRB) Chair, 219 Cordell North, Stillwater, OK 74078, by phone (405-744-3377) or email (irb@okstate.edu).

A research assistant will be contacting you in the near future to schedule a time to meet, if you agree to participate in the research study.

Okla. State Univ.
IRB
Approved 6/4/14
Expires 6/3/17
IRB # HE-14-20

Revised 4/29/15

APPENDIX F

The CFR is a unit of The College of Human Sciences.
The vision of The College of Human Sciences
is to be a world leader in the discovery and application of knowledge, preparing the next and upcoming generations of professionals who advance the quality of life.

Workforce Prevention of Compassion Fatigue among Paid and Volunteer Domestic Violence and Sexual Assault Support Personnel

INTERVIEW GUIDE

Topics to be covered in the in-depth interview:

1) Director Information;
2) Agency/Organization Information;
3) Worker well-being training and protocols; and
4) Ideas and issues for implementing workforce well-being training.

INTERVIEWER: _____ DATE: _____ LOCATION: _____

Thank you for agreeing to participate in this study *and Thank you for what you do!* Please think of this as a conversation between the two of us *and please ignore the recorder*. As we have already talked about, the goal of this interview is to identify strategies for protecting the well-being of the domestic violence and sexual assault workforce. I am particularly interested in your beliefs about the potential threat of secondary trauma, compassion fatigue, and burnout; *any* initiatives your agency has in place addressing these issues; and your beliefs about alternative ways of getting initiatives in place. When you are thinking about your "workforce", I want you to *please* consider both paid and volunteer personnel who engage directly with your agency's clients, even if it is for only a short period of time. What you think and believe is important to me. Your experiences and concerns are also important to me. Please speak openly and say what you believe. *Remember this will be compiled totally anonymous, with no identifying factors included in the data reported.*

BASIC INFORMATION

I would like to start by getting to know you a little better.

Please tell me about yourself:

How old are you?

Are you married, living as married?

Do you have children, if so, how many and what are their ages?

Tell me about your education/licenses/certifications, etc.

How do you balance work/family?

Please tell me how you came to be the {Executive Director/Function Lead} in this agency/*organization*.

How did you come to be in this role?

How long have you been in this job? Have you done this type of work elsewhere?

Tell me about your credentials for being in this role.

What type of educational background is needed for this role?

What type of training did you need to have?

What life experiences are needed to do this job well?

APPENDIX F

AGENCY/ORGANIZATION INFORMATION

Now I would like to learn more about your {agency/organization}.

Please tell me about the mission of your organization.

Do you have a mission statement?

Please tell me about the scope of your services:

Tell me about hours of operation;

Tell me about all the ways you help your clientele –

Do you have shelter or emergency housing? If so, tell me about that?

Do you *provide* outreach? If so, tell me about that?

Do you have a crisis line?

What is your {agency/organization's} geographic catchment area?

Tell me about the volume of clients typically served in the year.

Can you say anything about trends? Is that number going up or down?

What can you tell me about the clients you serve?

Please tell me about the personnel you oversee? Let's start with paid staff:

How many do you have, and what are their responsibilities?

What challenges does the agency have in recruitment/retention?

Tell me about terms your organization requires of paid personnel?

Tell me about the tenure of your staff?

Do you have exit interviews…if so, are there any themes in why people are leaving?

Tell me about regular activities your paid staff engage in week to week or day to day?

Please tell me about the personnel you oversee that are unpaid or volunteer staff:

How many do you have?

How does your agency recruit unpaid staff or volunteers?

What challenges does the agency/*organization* have in recruitment/retention?

Tell me about the terms your *agency*/organization requires of volunteer staff:

Does your *agency*/organization limit whether victims of domestic violence or sexual assault are allowed to volunteer?

Are they organized to perform different functions?

What conditions shape which function a volunteer is placed into?

Tell me about the tenure of your volunteers?

Do you have exit interviews…if so, are there any themes in why people are leaving?

Tell me about regular activities your volunteer staff engage in week to week or day to day?

Please think about the perspective of your paid staff:

What are the major internal strengths of your {agency/organization}?

What are the major internal weaknesses of your {agency/organization}?

What are the major external opportunities to your {agency/organization}?

What are the major external threats to your {agency/organization}?

APPENDIX F

Please think about the perspective of your *unpaid/volunteer* staff:

What are the major internal strengths of your {agency/organization}?
What are the major internal weaknesses of your {agency/organization}?
What are the major external opportunities to your {agency/organization}?
What are the major external threats to your {agency/organization}?

WORKER WELL-BEING TRAINING AND PROTOCOLS

Now I want to change our conversation toward workforce well-being. Remember, by workforce, I mean both paid and unpaid/volunteer staff. Well-being refers to concepts like compassion fatigue, burnout, and secondary trauma.

Please tell me when you think about compassion fatigue, what does that mean to you?
What is compassion fatigue?
What causes compassion fatigue?
What are the signs and symptoms of compassion fatigue?
What are the consequences of compassion fatigue?
What is the best way to "treat" or manage compassion fatigue?

Please tell me when you think of burnout, what does that mean to you?
What is burnout?
What causes burnout?
What are the signs and symptoms of burnout?
What are the consequences of burnout?
What is the best way to "treat" or manage burnout?

Please tell me when you think of secondary trauma, what does that mean to you?
What is secondary trauma?
What causes secondary trauma?
What are the signs and symptoms of secondary trauma t?
What are the consequences of secondary trauma?
What is the best way to "treat" or manage secondary trauma?

Please tell me if you believe it differs by type of staff?

Please tell me what training opportunities focused on workforce well-being exist in this geographic area?
Where are the trainings available?
What do the trainings cover?
How often are they made available?
How useful are the trainings?

Please tell me if you believe organizations like yours should provide training on compassion fatigue, burnout, or secondary trauma to workers?
Why or why not?
How often?
What should the training cover?
Who should receive *the* training?
How should the training be distributed to different types of workers?

APPENDIX F

Some organizations have plans in place to monitor workers' well-being and make referrals as needed, does your agency/organization have this type of plan?

If so, how does it work?

How is well-being monitored?

What is the referral process?

How well is it used?

How valuable is this process to your *agency*/organization?

If not, is this something that would be valuable to your organization?

Why?

Do you use the same procedures for paid and unpaid/volunteer staff?

ALMOST DONE!

IDEAS AND ISSUES FOR WORKER WELL-BEING TRAINING

The last section of the interview is focused on alternative ways of designing and implementing workforce well-being training alternatives. I would like to hear your thoughts on the best way to approach this training. Please consider each issue with an eye toward both paid and unpaid/volunteer staff.

What do you think is the most appropriate format for training:

Webinar?

Lectures?

Train-the-Trainer?

What type of content do you think is most valuable?

How long would workers be willing to spend on well-being content?

What are barriers your workers would have to participating in well-being focused training?

What issues do you see on the horizon that would make well-being focused training more or less relevant?

Would instructional materials on developing a worker well-being monitoring & referral procedure be useful to your *agency*/organization?

If yes, what would be most useful to you?

THANK YOU FOR YOUR TIME! AND *Thank you again for your dedication and the difficult job that you do!*

Revisions in italics.
pkp - 8/27/15

APPENDIX G

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1 = Never **2 = Rarely** **3 = Sometimes** **4 = Often** **5 = Very Often**

	1.	**I am happy.**
	2.	***I am preoccupied with more than one person I [help].***
	3.	**I get satisfaction from being able to *[help]* people.**
	4.	***I feel connected to others.***
	5.	**I jump or am startled by unexpected sounds.**
	6.	***I feel invigorated after working with those I [help].***
	7.	**I find it difficult to separate my personal life from my life as a *[helper]*.**
	8.	***I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].***
	9.	**I think that I might have been affected by the traumatic stress of those I *[help]*.**
	10.	***I feel trapped by my job as a [helper].***
	11.	**Because of my *[helping]*, I have felt "on edge" about various things.**
	12.	***I like my work as a [helper].***
	13.	**I feel depressed because of the traumatic experiences of the people I *[help]*.**
	14.	***I feel as though I am experiencing the trauma of someone I have [helped].***
	15.	**I have beliefs that sustain me.**
	16.	***I am pleased with how I am able to keep up with [helping] techniques and protocols*.**
	17.	**I am the person I always wanted to be.**
	18.	***My work makes me feel satisfied*.**
	19.	**I feel worn out because of my work as a *[helper]*.**
	20.	***I have happy thoughts and feelings about those I [help] and how I could help them.***
	21.	**I feel overwhelmed because my case [work] load seems endless.**
	22.	***I believe I can make a difference through my work.***
	23.	**I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.**
	24.	***I am proud of what I can do to [help].***
	25.	**As a result of my *[helping]*, I have intrusive, frightening thoughts.**
	26.	***I feel "bogged down" by the system.***
	27.	**I have thoughts that I am a "success" as a *[helper]*.**
	28.	***I can't recall important parts of my work with trauma victims.***
	29.	**I am a very caring person.**
	30.	***I am happy that I chose to do this work.***

APPENDIX G

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason — for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, fieldwork in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

APPENDIX G

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test and then you can compare your score to the interpretation below. To find your score on each section, total the questions listed on the left in each section and then find your score in the table on the right of the section.

Compassion Satisfaction Scale:

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

TOTAL _____

Sum of Compassion Satisfaction Questions	Score Equals	Level of Compassion
22 or less	43 or less	Low
22 to 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale:

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

*REVERSE scores for those that are starred (0=0, 1=5, 2=4, 3=3, 4=2, 5=1)

TOTAL _____

Sum of Burnout Questions	Score Equals	Level of Burnout
22 or less	43 or less	Low
23 to 41	Around 50	Average
42 or more	57 or more	High

Secondary Trauma Scale:

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

TOTAL _____

Sum of Secondary Traumatic Stress Questions	Score Equals	Level of Compassion
22 or less	43 or less	Low
23 to 41	Around 50	Average
42 or more	57 or more	High

APPENDIX H

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

		Never	Rarely	Occasionally	Often	Very Often
1.	I felt emotionally numb ……	1	2	3	4	5
2.	My heart started pounding when I thought about my work with clients ……	1	2	3	4	5
3.	It seemed as if I was reliving the trauma(s) experienced by my client(s) ……	1	2	3	4	5
4.	I had trouble sleeping ……	1	2	3	4	5
5.	I felt discouraged about the future ……	1	2	3	4	5
6.	Reminders of my work with clients upset me ……..	1	2	3	4	5
7.	I had little interest in being around others ……	1	2	3	4	5
8.	I felt jumpy ……	1	2	3	4	5
9.	I was less active than usual ……	1	2	3	4	5
10.	I thought about my work with clients when I didn't intend to …..	1	2	3	4	5
11.	I had trouble concentrating ……	1	2	3	4	5
12.	I avoided people, places, or things that reminded me of my work with clients ……	1	2	3	4	5
13.	I had disturbing dreams about my work with clients …….	1	2	3	4	5
14.	I wanted to avoid working with some clients ……	1	2	3	4	5
15.	I was easily annoyed …….	1	2	3	4	5
16.	I expected something bad to happen …….	1	2	3	4	5
17.	I noticed gaps in my memory about client sessions …….	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score	_____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score	_____
TOTAL (add Intrusion, Arousal, and Avoidance Scores)	Total Score	_____

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14,* 27-35.

APPENDIX H

SECONDARY TRAUMATIC STRESS SCALE

For each subscale below, add your scores for the items listed. Add the three scores in the right hand column for a total score.

Subscale	Items	Score
Intrusion	2 3 6 10 13	
Avoidance	1 5 7 9 12 14 17	
Arousal	4 8 11 15 16	
	Total	

Score Interpretation[18]

Little or No STS	Mild STS	Moderate STS	High STS	Severe STS
27 or less	28-37	38-43	44-48	49+

Get further testing for PTSD that is caused by STS.

Further testing for PTSD that is caused by STS is recommended if the following combination is present:

Intrusion	at least 1 item +
Avoidance	3 items +
Arousal	2 items

[18] Bride, B E (2007). Prevalence of Secondary Traumatic stress among Social Workers. Social Work, 52:1, pp 63-70.

APPENDIX I

CHRISTINA MASLACH • SUSAN E. JACKSON

MBI–Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professionals view their job and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How Often 0–6	Statements:
1. _____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "How Often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number "5."

1055 Joaquin Road, 2nd Floor
Mountain View, CA 94043
800-624-1765 www.cpp.com

3463

APPENDIX I

MBI–*Human Services Survey*

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times times a week	Every day

How Often 0–6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)		cat.		cat.		cat.
	EE: _____	_____	DP: _____	_____	PA: _____	_____

APPENDIX I

Scoring & Interpretation Key – MBI-HSS

Instructions. For each column, transfer your response (0-6) from the original measure to the three columns below. Only transfer numbers to the unshaded/ungreyed spaces. Then, sum each column and place that number in the space provide below. This number represents your score for that dimension. Guidelines for interpretation can be found on the right side of the sheet.

Emotional Exhaustion	*Depersonalization*	*Professional Accomplishment*
How Often 0-6	**How Often 0-6**	**How Often 0-6**
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
6. _____	6. _____	6. _____
7. _____	7. _____	7. _____
8. _____	8. _____	8. _____
9. _____	9. _____	9. _____
10. _____	10. _____	10. _____
11. _____	11. _____	11. _____
12. _____	12. _____	12. _____
13. _____	13. _____	13. _____
14. _____	14. _____	14. _____
15. _____	15. _____	15. _____
16. _____	16. _____	16. _____
17. _____	17. _____	17. _____
18. _____	18. _____	18. _____
19. _____	19. _____	19. _____
20. _____	20. _____	20. _____
21. _____	21. _____	21. _____
22. _____	22. _____	22. _____

EE Sum_____ Dep Sum_____ PA Sum_____

Categorization: Emotional Exhaustion, Human Services & Educators Forms	
	Frequency
High	27 or over
Moderate	17-26
Low	0-16

Categorization: Depersonalization, Human Services Form	
	Frequency
High	13 or over
Moderate	7-12
Low	0-6

Categorization: Personal Accomplishment,* Human Services Form	
	Frequency
High	39 or over
Moderate	32-38
Low	0 - 31

VITA

Pamela Kay Pearsall

Candidate for the Degree of

Master of Science

Thesis: HELPING PROFESSION HAZARDS FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT, AND STALKING (DVSAS) SOCIAL SERVICE PROVIDERS: A FOCUS ON WORKFORCE WELL-BEING

Major Field: Human Development and Family Science

Biographical:

Education:

Completed the requirements for the Master of Science in Human Development and Family Science - Developmental and Family Science at Oklahoma State University, Tulsa, Oklahoma December, 2017. Nonprofit Management Certification, projected completion 2018. Completed the requirements for the Bachelor of Science in Psychology at Rogers State University, Claremore, Oklahoma in 2005. Completed the requirements for the Associate of Arts in Business Administration at Rogers State University, Claremore, Oklahoma in 2003.

Experience:

Oklahoma State University, Tulsa, OK, 2014–16, Research Assistantship.

Safenet Services, Inc., 2006 - Current, Advocate & Group Facilitator; 2006-13, Victim/Court Advocate.

Oklahoma Department of Human Services – 2005-06, Child Welfare Specialist.

Professional Memberships:

Oklahoma Coalition Against Domestic Violence & Sexual Assault, Oklahoma City, OK – 2009, Certified Domestic & Sexual Violence Response Professional CDSVRP #09-312