SECONDARY AND VICARIOUS TRAUMATIZATION AMONG DOMESTIC VIOLENCE SHELTER STAFF

A Dissertation by

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In memoriam


Özay Sarıönder (1941-2012)

Mücteba Sarıönder (1938-2013)
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I would like to thank my spouse Jens Kreinath who encouraged me to pursue a doctoral degree and supported me throughout my endeavors at Wichita State University.

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Workers of domestic violence shelters belong to professionals who regularly encounter crisis situations and hear trauma stories that can lead to indirect traumatization. Secondary trauma can influence professionals as if they are experiencing the trauma of their clients, and hence lead to symptoms that resemble post-traumatic stress disorder (PTSD) (Figley, 1995a). Vicarious trauma describes the long-term effects of working with traumatized clients that can change helpers’ cognitive schemas and imagery system of memory (McCann & Pearlman, 1990). Through conducting a case study with the staff members of a domestic violence shelter, the current study sought to explore to what extent the helpers are influenced by secondary and vicarious trauma. A further point of interest in this study was to examine the self-care and coping strategies utilized by the staff members to deal with the work stress. Fifteen staff members participated in the qualitatively designed research that, besides individual interviews, also included a questionnaire to measure secondary traumatic stress and compassion satisfaction. Thematic analysis was used to analyze the interviews from which three broad themes emerged, including work in the area of domestic violence, strengths and challenges of the workplace culture, and self-care and coping strategies. According to the scores of the survey, none of the participants showed high level of secondary traumatic stress while their level of compassion satisfaction was either average or high. The thematic analysis implied that participants have possible changes in their cognitive schemas as suggested by the construct of vicarious traumatization. This study suggests that the self-care and coping strategies employed by participants in and outside of the workplace help to decrease and prevent the stress of working with traumatized clients.
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CHAPTER 1

INTRODUCTION

The purpose of this study is to contribute to the research on secondary or vicarious trauma among domestic violence shelter workers. Through a case study of an emergency shelter in a mid-sized city in the state of Kansas, this study aims to examine the extent of traumatic stress among the staff along with the self-care and coping strategies they use to deal with working with traumatized clients.

Domestic violence and violence against women are social problems that affect people of all ages, ethnicities, and socioeconomic backgrounds. The estimations of international independent studies assess that the possibility of violence by an intimate partner would be between 10% and 60% in a lifetime. Also, the Multi-Country Study on Women’s Health and Domestic Violence Against Women conducted by World Health Organization (WHO) had similar results from 10 countries. It estimated that between 15% and 71% of women have experienced intimate partner violence (Johnson, Ollus, & Nevala, 2008).

Reports on the national level show that one in every four women and one in every seven men have fallen victim to severe physical violence1 by an intimate partner. Estimates suggest about 20 people are physically abused by intimate partners every minute, and there are more than 10 million abuse victims annually (Black et al., 2011). In the United States, domestic violence

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1 Black et al. defines physical violence and severe physical violence as follows: “Physical violence includes a range of behaviors from slapping, pushing or shoving to severe acts such as being beaten, burned, or choked. In this report, severe physical violence includes being hurt by pulling hair, being hit with something hard, being kicked, being slammed against something, attempts to hurt by choking or suffocating, being beaten, being burned on purpose and having a partner use a knife or gun against the victim” (2011, p. 10).
hotlines receive more than 20,000 phone calls daily (National Coalition Against Domestic Violence, 2017).

Since the 1990s, violence against women has been considered as a human rights violation (Merry, 2009). After the years of struggle endured by the international women’s movement to raise attention to domestic violence as a global issue, an internationally agreed definition of violence came about in 1993 in the United Nations Declaration on the Elimination of Violence Against Women as “any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (Johnson et al., 2008, p. 1). In 1995, this definition, with further elaborations, was approved by the majority of the world’s countries at the World Conference on Women in China (Robinson, 2004).

In the United States, the Violence Against Women Act (VAWA) was launched in 1994 within the scope of the Violent Crime Control and Law Enforcement Act. Besides giving grants and providing funding to communities and institutions that deal with domestic violence issues, this act contributed to changes in the legislative area nationally (Jackson, 2007). Through a mandate of this act, the National Research Council was asked to form a research agenda on violence against women to increase its understanding and control (Kruttschnitt, McLauughlin, & Petrie, 2004). This initiative hence supported the body of literature on domestic violence with numerous studies and publications (see Kruttschnitt et al. (2004, pp. 17-34) for a sample list of the studies done between 1995 and 2000).

In the beginning of the 1970s, the international women’s movement identified emergency housing as a priority for battered women. The first shelter was opened in England in 1971 and
was followed by a call for shelter in the United States in 1972. The first shelters in the United States were established in 1974. Since then, about 1200 shelters were opened nationwide. These institutions provide services in a variety of areas including housing and food, crisis hotlines, counseling, legal and medical advocacy, children’s services, education, and prevention (DeBare, 2009; DiPietro, 2005; Stark & Buzawa, 2009; Vaughan, 2009). Because their job includes such services, those who deal with domestic violence survivors prefer to call themselves advocates (Vaughan, 2009). I refer to these workers as advocates herein.

Providing such services and working with clients and survivors of domestic violence can be challenging. Advocates, like therapists and counselors, deal with individuals who have experienced various types of abuse and violence and support their clients both emotionally and psychologically. Commonly, these experiences include traumatic events. Working with traumatized people can cause indirect trauma that influences advocates’ work. Since the end of the 1980s, there has been a growing interest in understanding the issues that therapists, counselors, and consultants have encountered due to working with trauma survivors. Although the research has been growing, this issue is certainly understudied among domestic violence shelter workers, and this is the primary focus of this research.
CHAPTER 2
WORK-RELATED STRESS AND WORKING WITH TRAUMATIZED PEOPLE

It has been known for quite some time that professionals, such as therapists and counselors, are vulnerable to job-related stress. Even though countertransference and burnout have been identified as possible constructs that influence the work of these professionals, work-related trauma was not acknowledged until more recently. In order to elaborate on the relationships and differences between these different kinds of work-related stress, I will give a brief overview of the concepts of countertransference and burnout, and then will elaborate on secondary and vicarious trauma.

Countertransference refers to the therapist’s personal feelings and reactions that arise from working with the patient (Pearlman & Saakvitne, 1995), whereas burnout implies the stressful job situation that leads to mental and emotional tiredness (Maslach & Schaufeli, 1993; Schaufeli, Leiter, & Maslach, 2009). Countertransference is described as the rise of unconscious feelings as reactions to the client’s transference. It was believed that these feelings resulted from the unresolved personal conflicts of the therapist. For example, for Freud, these feelings would interfere with the work of the therapist and hence need to be overcome (Figley, 1995a; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

The newer literature on countertransference is broader and includes all responses that are not only unconscious but also conscious. They could be positive or negative, and spoken or unspoken. Hence, there is the possibility that work-related traumatic stress and countertransference could influence each other, in spite of the fact that they are different constructs and experiences (Pearlman & Saakvitne, 1995). In this sense, countertransference
addresses the responses of the professional to the client independent of the existence of a traumatic experience (Pearlman & Caringi, 2009).

Burnout, a concept developed by Freudenberger and Maslach in the 1970s, refers to enduring job stress developed over an extended period resulting in mental exhaustion. Workers experiencing burnout deplete emotionally and lose their motivation and commitment to work. At the beginning, the term burnout was reserved for professionals in human services who deal with people, like in the areas of healthcare, social work, psychotherapy, legal services, and police work. More recently, it has been understood as a syndrome that can also occur in other professions, such as in managerial, administrative, creative and manual work. Hence, burnout evolved from an occupational hazard that was specific to some professions to a general workplace hazard that can happen in any occupation (Maslach & Schaufeli, 1993; Schaufeli et al., 2009). Burnout is seen as a result of the external conditions of the workplace, such as “the imbalance between demands and resources at work, and the conflict between values (i.e. between personal values and those of the organization, and between the officially stated organizational values and the values in action)” (Schaufeli et al., 2009, p. 210).

Burnout symptoms in professionals who work with populations like victims and survivors of traumatic events may be similar to the symptoms displayed in the traumatized individual (e.g., experiencing numbness and avoidance). However, recent studies show that burnout is not necessarily related to trauma work (McCann & Pearlman, 1990). Further, vicarious and secondary trauma has the potential to arise abruptly with only one instance of a traumatic event, whereas burnout develops gradually over time (Figley, 1995a).

Researchers have first hypothesized that helpers who work with traumatized people
would show symptoms like “intrusive imagery, avoidant responses, physiological arousal, distressing emotions, and functional impairment” (Bride, 2004, p. 31). Further, exposure to trauma through clients can also transform the cognitive world of the helper (McCann and Pearlman 1990), and can influence the sense of self, worldview, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory of the helpers (Pearlman, 1995). This type of trauma is considered “a normal reaction to the stressful and sometimes traumatizing work with victims” (McCann & Pearlman, 1990, p. 145). It can also affect the helpers in such a way as if they are exposed to direct trauma, and lead to symptoms that are similar or same as post-traumatic stress disorder (PTSD), such as reexperiencing the trauma event, avoidance or numbing of reminders of the event, and persistent arousal (Figley 1995a, 1995b).

Since the beginning of the studies and publications on this topic, there has been no specific name assigned to the trauma that is experienced by the professionals who deal with traumatized people; ‘secondary victimization,’ ‘co-victimization,’ ‘secondary survivor,’ and ‘vicarious traumatization’ are some of the terms used in the literature (Figley, 1995a). Meanwhile, secondary trauma or secondary traumatic stress (Figley, 1993; Stamm, 1995) and vicarious trauma or vicarious traumatization (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, 1995b) are the most prevalent terms used in the studies. A further term, ‘compassion fatigue,’ has been considered as the synonym for secondary trauma, which corresponds to PTSD (Figley, 1995d). Figley, who developed the concept of compassion fatigue, proposed the verbiage “compassion fatigue” instead of secondary trauma because the former is a more friendly term that addresses compassion for one’s work (Figley, 1995a).

Most of the scholars do not differentiate between these terms and often use them as if they were synonyms, because it seems that there is not enough distinction between them (Stamm,
2010). On the other hand, there have been some endeavors to differentiate between the constructs of vicarious trauma and secondary trauma or compassion fatigue (e.g. Baird and Kracen 2006, Jenkins and Baird 2002). Some scholars, like Stamm (2010), do not consider these efforts as successful in finding real differences among them and continue to use both terms interchangeably.

Although it has become clear that there are some overlaps in both terms, they differ in their conceptual emphases. The main difference between the constructs of vicarious trauma and secondary trauma is the applied theoretical approaches. Both constructs and their underlying theories are presented below.

2.1 Secondary Trauma and Post-Traumatic Stress Disorder (PTSD)

Figley (1995, 2002), and others who followed his work, developed and preferred the terms secondary trauma and compassion fatigue, which underlined an approach that focused on symptoms and emphasized how not only direct exposure, but also indirect exposure can inflict trauma that resembles the symptoms of post-traumatic stress disorder.

One of the most distinct features of secondary trauma is that this type of traumatization can have the same symptoms as PTSD as the consequence of helping, assisting, or consulting others. After PTSD was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, researchers began to realize that this could include also the individuals who are exposed to traumatization through others. Figley was one of the first researchers who suggested that being exposed to traumatic events could therefore also lead to traumatization. In this sense, he maintained that not only the next people to the directly traumatized, such as the circles of family and friends, but also the professionals who listen to their stories can be at risk
for traumatization (Figley, 1995a, 1995b, 1995d).

Professionals, who care for traumatized clients, may feel the same as their clients; thereby, professionals who are empathic with their clients can be influenced by their stories. Hence, they can begin to show the same symptoms of trauma as if they experienced the trauma first-hand. These symptoms can present similarly to PTSD (Figley, 1995a). Thus, it is claimed that the development of primary and secondary trauma can be comparable to each other and hence the same theories can explain these developments (Munroe et al., 1995). Figley called this the “cost of caring,” and defined Secondary Traumatic Stress “as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995a, p. 7).

Similar to PTSD, people who experience secondary traumatization can, therefore, re-experience the traumatic event through a recollection of the event, through dreams about the event, and can be distressed by reminders of the event. They can show signs of avoidance and numb reminders of the event as they try to evade thoughts and feelings as well as activities and situations. Avoidance can also occur through psychogenic amnesia. Their affect, as well as interest in activities, can decrease. They can experience detachment and estrangement from other persons and develop a sense of foreshortened future. In addition, they can experience persistent arousal, have difficulties concentrating, and falling or staying asleep. They can develop outbursts of anger, hypervigilance for the traumatized person, an exaggerated startle response, and physiologic reactivity to cues (Figley, 1995a).
2.2 Vicarious Trauma and Constructivist Self-Development Theory

While considering symptoms that can occur after being exposed to the trauma of others, vicarious traumatization points toward the possible transformation of the helpers. McCann and Pearlman coined the term ‘vicarious traumatization’ in 1990 as they found that former conceptualizations of burnout, countertransference, and others were not sufficient enough to describe and analyze the experiences of therapists who work with traumatized victims (McCann & Pearlman, 1990). The concept of vicarious traumatization thus emphasizes the long-term effects that can be experienced by the helpers working with traumatized individuals. These effects, in other words, can disrupt the helpers and cause pain for them. They can continue for an extended time, like over months or years, following the work of the helpers with traumatized clients (McCann & Pearlman, 1990). Feeling empathy with a trauma survivor is therefore now considered to be the cause of the helper’s transformation (Saakvitne & Pearlman, 1996).

In addition to secondary traumatization, McCann and Pearlman (1990) underlined the importance of meaning, adaptation, and transformation of the helpers’ beliefs, expectations, and assumptions. McCann and Pearlman do not dispute that experiences of the helpers may lead to the development of PTSD symptoms (McCann & Pearlman, 1990), adding that helpers can develop feelings of numbness and emotional distance that would hinder them to work empathetically and to respond adequately to their clients.

In order to grasp the complexity of this phenomenon, and to understand the reactions of the helpers, McCann and Pearlman proposed a new approach that they call ‘Constructivist Self-Development Theory’ (CSDT) (McCann & Pearlman, 1990). Accordingly, exposure to traumatic events can influence and alter the helpers’ cognitive schemas and imagery system of memory. They claim that experiencing trauma not only disrupts the cognitive schemas and memory
system of the survivor but also of the helper who works with the survivor. Traumatic memories of their clients might cause painful images and emotions by the helpers who then may embed these in their own memory system. The alteration of the memory systems can be short-term or long-term. The helpers can embed the memories or memory fragments of the trauma victims into their memory systems so that they experience flashbacks, dreams, or intrusive thoughts, and think of these as their own.

Besides the alteration of the memory system, McCann and Pearlman (1990) suggest that the helper’s schemas about self and world can change due to the work with traumatized people. The change in the helper’s cognitive schemas occurs in the areas that relate to psychological needs, like trust, safety, power, independence, esteem, and intimacy. Hearing and dealing with the stories of the trauma survivors, in which the survivors had to go through violations of trust and betrayal, commonly with the ones whom they feel emotionally dependent, the helper can lose trust in people and question their motives. Survivor’s experience with threats and harm can lead the helper to question their own safety. Identification with the survivor can lead the helper to feel more vulnerable to violent incidents. The helplessness and vulnerability experienced by the survivor and helpers’ exposure to this can cause the helper to question their sense of power and control over their life-world.

McCann and Pearlman also suggested that the loss of independence and personal freedom by the survivor in the aftermath of the traumatic event can lead to feelings of vulnerability by the helpers, who identify themselves with the survivor. Instances of human cruelty told in the stories of trauma can weaken the helpers’ esteem for others or in general humanity, which can lead to making them feel bitter, cynical, or pessimistic. They can feel angry towards all humans. As the trauma survivors feel alienated from people around them or even from the world, the helpers can
develop similar feelings that would damage their sense of intimacy to their circles of family, friends, or coworkers (McCann & Pearlman, 1990).

Pearlman and Caringi (2009), while admitting that combining the terms would ease to work on the responses of the helpers, state that distinguishing between the constructs of vicarious trauma, and compassion fatigue, i.e. secondary traumatic stress, would enrich the nuances of both constructs. They also underline the importance to differentiate between PTSD and the other constructs because it supports the claim that there is no need for a construct like compassion fatigue or vicarious trauma if PTSD is sufficient to describe the symptoms (Pearlman & Caringi, 2009).

In light of this discussion, in this study, the terms “secondary” and “vicarious trauma” will not be used interchangeably in order to focus on the symptoms that can mimic PTSD symptoms as well as to the changes that can happen in the cognitive schemes and memory systems of the participants.

2.2.1 Risk and Protective Factors

The vulnerability to secondary and vicarious trauma is theorized to be dependent upon a variety of factors, such as exposure and empathy. These factors contribute to the formation of secondary and vicarious trauma as well as increase or decrease the degree to which advocates feel traumatized. Besides their current work situation, a unique constellation of individual, social, community, political, and cultural settings of the helper, would influence the degree of the helper’s traumatization. Therefore, despite the research that shows that helpers “are at risk of experiencing symptoms of traumatic stress, disrupted cognitive schema, and general psychological distress as a result of their work with traumatized populations…the severity of
these experiences varied across studies” (Bride, 2004, p. 42). Most of the empirical studies to-date have focused on individual and workplace contributors that relate to the formation and development of helpers’ traumatization, which I will review below.

2.2.1.1 Exposure

Exposure to the traumatized people is regarded as the primary contributor to secondary and vicarious trauma (Bride, 2004; Figley, 1995a; Lerias & Bryne, 2003). However, as presented below, the studies present mixed results that show that exposure alone does not lead to traumatization of the helpers.

In the studies exploring the relationship between secondary exposure and secondary and vicarious traumatization, the measures mostly refer to the years of experience in the area the helper is working, the proportion of traumatized people in the helpers’ caseload, and the length of hours helpers work with the survivors. The research findings were mixed on this issue. Despite the numerous studies that found a relationship with exposure measures, studies by Ghahramanlou and Brodbeck (2000), and Baird and Jenkins (2003) could not find any significant relationship (Slattery & Goodman, 2009).

Several studies have found a direct relationship between stress symptoms and length of experience. Chrestman reported in her research with therapists that high caseloads with trauma clients are associated with increased traumatic symptoms, especially in intrusion and avoidance (Chrestman, 1995). Also, Birck (2001) found in her study that longer experience in trauma settings is related to more symptoms of secondary traumatization. Further studies found that the length of experience of the professionals who work in the area of disaster mental health services
(Wee & Myers, 2002), and who work with traumatized children (Meyers & Cornille, 2002) is related to increased symptoms of secondary and vicarious traumatization.

In contrast, the study by Pearlman and Mac Ian (1995) found that trauma therapists who have more experience showed less general distress and had fewer disruptions in self-trust, self-intimacy, and self-esteem. The researchers point to the possibility that the helpers who had higher disruptions could have quit their jobs earlier or their disruptions could have been decreased eventually. A further explanation could be that helping their clients could heal them. Also, helpers working longer in the area could tend to receive further professional training.

Studies focusing on professionals’ caseload trauma survivors found that the helpers with higher caseload of clients with traumatization found relationships to higher degrees of secondary and vicarious traumatization. For example, a study by Kassam-Adams (1995) showed that higher proportions of trauma survivors in helpers’ caseloads led to higher levels of indirect traumatization. Parallel results were found in a study done with mental health providers (Sprang, Clark, & Whitt-Woosley, 2007). Also, the majority of the social workers in Bride’s study experienced symptoms of secondary trauma, and even 15% met criteria for a PTSD diagnosis (Bride, 2007). In addition to this, Schauben and Frazier (1995) reported that helpers’ beliefs about the goodness of others were disrupted. Chrestman (1995) found increased levels of dissociation, anxiety, intrusion, and sexual abuse trauma symptoms in association with secondary exposure. Chrestman’s study also indicated that frequent and intensified work with trauma survivors showed a positive correlation to increased avoidance.
2.2.1.2 Empathy

It was argued that empathy, or the lack of it is one of the main factors for the development of vicarious and secondary trauma. Empathy is defined broadly as perceiving another person’s feelings or taking another person’s perspective (Eisenberg & Strayer, 1987). Hence, empathy encompasses experiencing the emotions of others as well as understanding their feelings (Eisenberg, 2000). Accordingly, the empathic engagement of the helper with the survivor’s trauma can contribute to the formation of vicarious and secondary trauma (Figley, 1995a; Pearlman & Saakvitne, 1995).

The effort to understand the trauma and to have empathy with the survivor seems to lead the helpers to identify themselves with the suffering and traumatized person (Figley, 1995d; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). With opening up oneself for the pain of the traumatized person and imagining the trauma, the helper experiences empathy as well as distress and negative feelings (Pearlman & Caringi, 2009). The helper develops and experiences parallel emotions and feelings to the survivor, including “visual images (e.g. flashbacks), sleeping problems, depression, and other symptoms that are a direct result of visualizing the victim’s traumatic experiences, or of being exposed to the symptoms of the victim or both” (Figley, 1995c, p. 252).

In contrast, in a study conducted with social workers, it is suggested “that there is a significant opportunity to use empathy in the preparation of social work practitioners to cope with the factors related to burnout and STS [Secondary traumatic stress]” and “empathy may be a factor contributing to the maintenance of the well-being and longevity of social workers in the field” (Wagaman, Geiger, Shockley, & Segal, 2015, p. 206). According to the researchers, this use of empathy can be attained through a special training. This training would include a variety
of strategies, techniques, and exercises such as mindfulness techniques, strategies of boundary setting, and exercises related to controlling physical or verbal reactions of the helpers.

Hence, in spite of the fact that empathy is considered a positive ability of a helper, this can also be a contributing factor to the development of vicarious and secondary trauma. In this context, the lack of ability to depersonalize and distance oneself from the situation would add to the intensity of the vulnerability. Further, the ability to find satisfaction and gratification in the work of helping would also influence the degree of intensity of secondary trauma positively (Figley, 1995c, 1995d). Thus, helpers have to maintain their ability to be empathetic in order to understand their clients but must be aware of the possibility of developing secondary and vicarious trauma due to this ability, and therefore acquire strategies to protect themselves so that their clients do not overwhelm them.

2.2.1.3 Personal Trauma History

A further factor to vulnerability is considered the helpers’ personal trauma history. Helpers’ own experience of trauma could resemble the experiences of the people they work with. Some researchers have claimed that unresolved trauma experiences of the helper can be activated through listening to the client’s trauma story (Figley, 1995a; Lerias & Bryne, 2003; McCann & Pearlman, 1990; Slattery & Goodman, 2009). On the other hand, like in the area of empathy, “helpers with trauma histories (sometimes referred to as “wounded healers”) may bring both special gifts and unique responses to the work” (Pearlman & Caringi, 2009, p. 211). They might have the potential to grasp and identify the survivor’s trauma more easily due to the similarity of shared experience.
However, some studies failed to find any relationship between personal trauma history and vulnerability to secondary and vicarious trauma. For example, a study conducted by Schauben and Frazier (1995) revealed that female psychologists and rape crisis counselors who have been victims of rape, sexual assault, sexual abuse, or sexual harassment were not more stressed than the ones without a history of victimization. In a further study with mental health and law enforcement professionals, it is found that professionals with childhood trauma history did not show higher degrees of stress than their colleagues with a trauma history (Follette, Polusny, & Milbeck, 1994). Also, Bober and Regehr (2006) could not find an association between stress symptoms and personal trauma history in their study with therapists. A further study done on this topic with disaster mental health workers responding to the September 11 attacks could not reveal a significant relationship between personal trauma history and secondary and vicarious trauma (Creamer & Liddle, 2005).

Despite these studies that could not find a relationship between personal trauma history and secondary trauma indicators (Bride, 2004), findings of other studies showed significant and strong relationships between personal trauma history and vicarious and secondary trauma. In a study done with trauma therapists on personal trauma history, Pearlman and Mac Ian (1995) found that the work of these therapists with a trauma history influenced them negatively compared to those without such a history. Specifically, their scores were higher in intrusion, avoidance, general psychological distress, and alterations in their cognitive schemas, like of safety, trust, esteem, and intimacy in comparison to the therapists without a personal trauma history (Pearlman & Mac Ian, 1995). A further study by Ghahramanlou and Brodbeck (2000) reported similar results. They found that sexual trauma counselors with a personal history of
trauma showed the higher intensity of secondary traumatization and general distress in comparison to those without a personal trauma history.

Some studies went further and elaborated on different types of traumas. The results indicated that childhood traumas have a greater impact on helpers’ indirect traumatization than other types of past traumas. Kassam-Adams’ study on psychotherapists working with sexually traumatized clients showed that childhood incidence of trauma showed the strongest relationship to trauma symptoms (Kassam-Adams, 1995). Similar results came from a study of child welfare workers. In the study of Nelson-Gardell and Harris (2003), it is shown that any type of childhood trauma was related to secondary traumatization, with the strongest relationships found for emotional and sexual abuse. Further, the workers who experienced more than one type of childhood maltreatment showed the highest risk of vulnerability to secondary traumatization.

2.2.1.4 Organizational and Workplace Environment

Research shows that organizational support that is defined as the general work environment and organizational structural aspects can affect the helper’s performance. The organizational setting can affect the degree and intensity of secondary and vicarious trauma of a helper. The organizational culture including coworker and peer-support, as well as prevention opportunities offered by the organization like supervision, can contribute to the increase or decrease of secondary and vicarious trauma (Bell, Kulkarni, & Dalton, 2003).

Studies found that sociopolitical support, described as the support of peers and coworkers, along with the general support in the organization decreases secondary and vicarious trauma (Bride, Jones, & MacMaster, 2007; Catherall, 1995; Choi, 2011; Townsend & Campbell, 2009). Despite the study by Kassam-Adams (1995) with therapists who work with survivors of
sexual violence, which did not find an association between social support at workplace and level of secondary and vicarious trauma, the study by Iliffe and Steed (2000) with domestic violence advocates showed that peer support has a positive influence on their work. Similarly, there are mixed results to the effect of supervision. For instance, Kassam-Adams’ (1999) study showed that the availability of supervision was not associated with the symptom levels of the helper. Also, the study by Simonds (1996) with therapists working with survivors of childhood sexual abuse could not present findings of the relationship between supervision and vicarious and secondary trauma. On the other hand, inadequate supervision was found to be related to secondary and vicarious trauma (Ullman & Townsend, 2007).

### 2.2.1.5 Coping and Self-Care Strategies

It is a widely accepted premise that professionals should be aware of possible traumatization and related feelings and emotions. In order to provide helpful services and maintain healthy relationships in their personal and professional lives, they should develop and maintain strategies to cope with possible traumatization symptoms and effects (Meadors & Lamson, 2008; Pearlman, 1995). Due to the complex individual and environmental dynamics of the helper “in the face of trauma, each person will adapt and cope given her current context(s) and early experiences: interpersonal intrapsychic, familial, cultural, and social” (Saakvitne & Pearlman, 1996, p. 27).

In the literature, there are various strategies suggested to reduce vicarious and secondary trauma. Suggested strategies include balancing work and personal life, personal therapy, peer consultation, supervision, professional training, and reducing the number of trauma cases on caseload. Further recommendations are activities like stress management training, leisure time including time with family, vacation, hobbies, exercise, and healthy living (Bober & Regehr,
2006; Canfield, 2005; Dutton & Rubinstein, 1995; McCann & Pearlman, 1990; Schauben & Frazier, 1995). McCann and Pearlman (1990) add to these other professional activities like research and teaching as well as political engagement for social change. As a venue for prevention, they suggest holding a weekly case conference, where the helpers have the opportunity to address difficult victim cases and talk about their own feelings due to painful experiences. These suggestions were consistent with research findings of Schauben and Frazier (1995) who studied coping strategies of counselors working with sexual violence survivors. These strategies included seeking emotional and social support, exercise, leisure activities, meditation, and cognitive restructuring.

On the other hand, there are studies that could not find an association between coping strategies and the reduction of stress related to secondary and vicarious trauma. In their study with professionals including social workers, psychologists, nurses, and physicians, Bober and Regehr reported that although “participants generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities, and supervision”, “there was no association between time devoted to leisure, self-care, research and development, or supervision and traumatic stress scores” (Bober & Regehr, 2006, p. 7). Parallel to this, a study by Killian (2008) with clinicians could not reveal any significant correlations between engaging in individual coping strategies and traumatic stress.

2.3 Domestic Violence Advocates and Vicarious and Secondary Trauma

Secondary and vicarious trauma issues are studied extensively for other professions that deal with traumatized people. Nevertheless, experiences of advocates working with survivors of domestic violence experience are under-researched; I was able to identify only six studies conducted with domestic violence advocates about secondary and vicarious traumatization.
Like other professionals who offer support to their clients, domestic violence advocates support survivors by listening to their stories, which involve various instances of physical, sexual, emotional, and psychological abuse. In addition, many of them assist the survivors in the areas of safety planning, medical, legal, and financial assistance, and immigration and employment services. They also engage in sociopolitical activities against domestic violence, as well as in activities for education and prevention. Besides working with co-workers in shelters, some advocates work in more isolated environments like hospitals and courts, where they would need more support and feedback (Slattery & Goodman, 2009).

In a qualitative study examining 18 counselors with 50% or more of their caseloads made up of domestic violence survivors, Iliffe and Steed (2000) addressed various effects of secondary and vicarious trauma. As the personal impact of hearing traumatic material from domestic violence counseling, the participants of the study stated that they felt disturbed sometimes about the stories their clients shared with them. However, nearly 50% of the participants stated that since they had listened to a variety of horrifying examples of women’s violation that these are not shocking them anymore (Iliffe & Steed, 2000). Most of the participants reported the experience of visual imagery of the stories as well as physical responses including churning stomach and nausea. The study also found changes in the cognitive schemas of the participants. Most shared their feelings of lessened security in this world. The participants stated that their worldview changed in the areas of power and control issues. They would not lose trust in all people, but then again, they would behave towards some people with more caution. They also indicated that they now pay more attention to issues related to gender, power, and control, like in areas of language use and in their behavior towards other people.
A further qualitative study conducted with a convenience-based sampling of 11 domestic violence shelter counselors found signs of vicarious trauma among these counselors (Beckerman & Wozniak, 2018). The research participants talked about emotions, such as fear, numbness and helplessness, similar to their clients. They reported that their work with domestic violence clients influenced their dreams as well as their relationships. Beckerman and Wozniak underlined that the counselor’s closeness to violence leads to an overwhelming emotional struggle. The participants stated that they worry about being harmed by their clients’ perpetrators. Their work influenced their personal lives and relationships in that they became more fearful. Also, their worldview shifted in a negative way in that they perceived the world around them less optimistically due to the pervasive violence they encounter through their work.

Although not exclusively focusing on domestic violence advocates, Baird and Jenkin’s study on vicarious traumatization and secondary trauma included 101 participants of which 35 were sexual assault counselors, 17 were domestic violence counselors, and 49 were serving as both. Their results failed to show significant levels of symptoms due to their work with traumatized people (Baird & Jenkins, 2003). Similar results came out from the study by Bell (2003). In her qualitative study with 30 domestic violence counselors, only 10% reported that their work negatively affects them, or they have negative feelings toward others.

Another quantitative study on 148 domestic violence advocates by Slattery and Goodman (2009) found that coworker support, clinical supervision, and shared power at the workplace had a significant and inverse correlation with secondary and vicarious trauma. In their study, the single factor that contributed to an increase of indirect trauma was the advocate’s own trauma history with domestic abuse. Similar findings were reported in a quantitative study by Choi (2011) with 154 social workers who assisted family violence or sexual assault survivors. The
results showed that workplace support lowered the levels of secondary and vicarious trauma. In addition, due to access to more strategic information in the organization, the social workers experienced lower levels of indirect trauma.

As addressed above in various studies with mostly mixed findings, the existence and level of secondary and traumatic stress depend upon numerous factors. This multifaceted issue is related to the unique constellation of the personal and environmental dynamics in which the helpers are situated. Taking this complexity into account, this study aims to contribute to the research on secondary and vicarious trauma with a case study on staff members of a domestic violence shelter.
CHAPTER 3

METHODS

3.1 Goals of the Study

This study examines if and to what extent domestic violence shelter staff members experience secondary and vicarious trauma. The goal is to explore the potential contributors to secondary and vicarious trauma; therefore, personal and organizational contributors are of major interest. A further focus of examination is to reveal what coping strategies the staff develops to deal with experiencing trauma. Thus, this study aims to answer the following questions:

1. To what extent is the staff of a domestic violence shelter influenced by secondary and vicarious trauma?

2. How does this stress manifest itself by shelter staff?

3. How is this related to the social structure in their organization?

4. What are the coping strategies used to manage this stress?

3.2 Identifying the Case: Wichita Family Crisis Center

Wichita Family Crisis Center, which used to be known as the YWCA-Wichita-Women’s Crisis Center until the end of 2016, works to eliminate domestic violence and has done so ever since 1976 when the Crisis Center opened the first safe house in the state. They started with a small home that provided safety for only four women at a time. Now, the Wichita Family Crisis Center is a mid-sized organization with 19 full-time employees, four part-time employees, and
some volunteers. Besides the Executive Director, the management team includes three directors with different functions.

The Crisis Center serves the Wichita area with its 24-hour crisis line, an emergency shelter with 22 beds, and outreach services. It helps about 1,000 women and their children annually through shelter and outreach services. For example, in 2016, 294 victims stayed in the shelter, and more than 2,000 crisis calls were answered. The 22-bed facility operates at 99-100% capacity year-round. Due to lack of space, the center is unable to provide emergency shelter to hundreds of women and children who are seeking a safe place away from their abuser at the time of the call to its crisis line (Wichita Family Crisis Center, 2017)

The services are designed to support individuals and their children who experience domestic violence or are at risk of being abused. Women who are homeless due to domestic violence can also use these services. Besides providing weekly evening classes on domestic violence and parenting, the staff of the outreach services also hold weekly support groups in the Sedgwick County Jail. In addition, the outreach staff engages in education and prevention. Staff members provide various community groups with information about domestic violence. For example, outreach advocates go to high schools and set up information tables and provide information about available resources in the community.

Advocates also support victims when they need assistance in legal court systems and protective orders. When requested, advocates go to medical and mental health facilities to support and assist the victims in finding services and resources in domestic violence. The Wichita Family Crisis Center works also with the police officers, who are required to call the crisis shelter if a case is related to domestic violence and has the potential of lethality.
3.3 Recruitment of Participants and Data Collection

Participants for this study were recruited from the staff members of the Wichita Family Crisis Center. The Institutional Review Board (IRB) approval was granted prior to any data collection. In order to recruit participants, I made an announcement of the study in an all-staff meeting. After this meeting I also utilized an additional approach that was more personal and asked some staff members individually. Fifteen of 23 staff members consented to participate in the study. Before the data collection began, I ensured that they had read the information on the consent form including the procedures and the purpose of the study. Then, I asked them to sign and date an informed consent form both for the survey and interview which also included their permission to be audio recorded. Each recording was given a code consisting of a number from one to fifteen so that the interview recording was not identified with a participant’s name.

The data for this case study was collected using two methods, namely surveying and interviewing. First, a questionnaire was delivered and completed by each participant. Secondly, a semi-structured interview was conducted as a follow-up based on the questionnaire by the respective participant. The aim to first collect data through questionnaire was to assess staff members’ level of secondary trauma and their perception about their organization’s support. After the participant finished the first part of the survey related to the secondary trauma, and while they took the second part of the survey related to the organization’s support, I scored the first part. Immediately after the participant completed the second part of the survey, an interview was conducted.

The interview questions were tailored to fit the results of the participant’s individual survey. Besides exploring other areas related to secondary and vicarious trauma and prevention strategies, the interview questions were asked in order to gain more elaboration and depth into
the issues that came up in the survey questions. Demographic information including age, years in
the organization, years of working in the area of domestic violence, and education level of the
staff members were also asked during the interview.

3.3.1 Survey

The survey questions aimed to find out the answer to the first research question, namely
to what extent the workers of the domestic violence shelter experience secondary and vicarious
trauma issues. The first part of the questionnaire included 30 items of the Professional Quality of
Life Scale (ProQOL) by Stamm (2010) (see Appendix A) and has three subscales, each having
10 items. According to Stamm (2010), subscale scores equal or less than 22 are considered as
low, scores between 23 and 41 are considered as average, and scores equal or more of 42 are
considered as high. The possible lowest score is 10 and the possible highest score is 50 for each
subscale.

The ProQOL was specifically created to be used for helping professionals and to measure
their secondary trauma level along with their work satisfaction and burnout. Hence, the norm is
based on the scores of helpers who work with traumatized clients. The ProQOL is not a
diagnostic test, yet it can address issues related to the positive and negative experiences one
encounters in the workplace. This scale was chosen because it is the most widely used measure
for helpers who work with extremely stressful clients (Stamm, 2010). The subscale compassion
satisfaction, with $\alpha=.82$, addresses the pleasure and satisfaction one gets from doing the job. The
subscale burnout, with $\alpha=.71$, refers to the negative feelings of hopelessness and having
problems doing the job effectively. The subscale secondary traumatic stress, with $\alpha=.78$, includes
the traumatic experiences due to the secondary exposure to trauma at the workplace. After
calculating the scores in the subscales, the individual results were interpreted according to the
guidelines given in Stamm (2010). These results built a foundation for the interview partner’s questions related to work-related stress issues.

The second part of the questionnaire included a short version with 8 items from Perceived Organizational Support (POS), “[b]ecause the original scale is unidimensional and has high internal reliability, the use of shorter versions does not appear problematic” (Rhoades & Eisenberger, 2002, p. 699). Perceived Organizational Support refers to how the employees perceive that their contribution is valued by the organization, and how the organization cares about their well-being (Rhoades & Eisenberger, 2002). The items in this scale are used in the interviews to have an idea about the staff’s perception of organizational support and were taken into consideration as the participant answers the interview questions related to the strategies dealing with secondary traumatic stress in the organizational level and their perception of organizational support.

3.3.2 Interviews

Interviews are considered as supremely suitable for research questions that explore experiences as well as personal understandings and perceptions (Braun & Clarke, 2013). Thus, semi-structured interviews were conducted with every staff member on an individual basis to address if and how secondary and vicarious traumatic stress manifested itself by shelter staff, and whether or not this is related to the social structure in the shelter. An additional goal of the interview was to explore the coping and self-care strategies that were used by the staff members to deal with work-related stress.

In a semi-structured interview, which is also called a qualitative interview, in-depth interview or general interview guide approach, the questions are not pre-set with exact wording
and order, but the questions serve as a guide for a list of issues to be covered. The wording and
order of the questions can be changed and adapted as the interview flows. Although the focus on
specific issues continues, the interviewer asks questions that will clarify and illuminate the issues
in a conversational style. Oftentimes new questions are raised as a follow-up during the
interview that were not planned beforehand (Patton, 2002; Robson & McCartan, 2016).

Thus, the open-ended questions in this study addressed the work of the staff members
with traumatized people and its influence on their personal and professional lives. Examples of
questions include “Can you tell me about your experiences working with traumatized clients?”
and “What are the most difficult aspects of working with traumatized clients?” (see Appendix C
for the interview guide questions). Further, I asked questions about coping strategies and self-
care strategies related to this stress. In addition, I asked each participant if they would be willing
to go through and elaborate on the items of the second part of the survey related to their
perception of the organizational support (see Appendix B), like “The organization would ignore
any complaint from me” or “The organization really cares about my well-being”.

The interviews were audio recorded with the participant’s consent. After I transcribed the
interviews, a thematic analysis of the data followed.

3.3.2.1 Thematic Analysis

The aim of thematic analysis is “to find repeated patterns of meaning” (Braun & Clarke, 2006, p.
86). Hence, thematic coding is done through identifying patterns of experiences within the data
set, corresponding to all the interviews in this study. In the next step, related patterns are
combined and merged into themes. Braun and Clarke (2006) suggest that thematic analysis can
be dominated either by a theory-led approach that embraces the premises of a theory for the data
analysis or by a data-led approach that looks for the characteristics of the data and use them for its analysis. In this study, I followed the latter approach and used the data as a source for the themes and for their analysis.

As we are dealing with qualitative data, there is no rule about the prevalence or number of the themes to be identified as such. Hence, the significance of a theme does not depend on the size or how many times it occurs in the data, but its relevance for the research question. This means that the question about the size of a theme does not depend necessarily on its prevalence in the data. Braun and Clarke address succinctly this issue as follows: “Ideally, there will be a number of instances of the theme across the data set, but more instances do not necessarily mean the theme itself is more crucial” (2006, p. 82).

One can look for prevalence of themes either through counting their frequency in each interview or through identifying their number of occurrence through all interviews, but the important issue here is to find out how the different themes fit together and what story one can take from them in relation to the extracts they belong to (Braun and Clarke 2006). Hence, the first measure would indicate an “overall thematic intensity” while the second would give “the breadth of theme expression across one’s sample” (Guest, MacQueen, & Namey, 2012, p. 172). At the same time, looking at prevalence can help in the process of identifying the patterns. Although “frequency alone cannot tell … the importance of a given theme for answering a particular research question, … it gives a rough outline of the way participants in this sample responded [to given questions]” (Guest et al., 2012, p. 137). Thus, in this study, the frequencies of the themes will be given within each individual interview as well as the frequency of the themes across all the interviews in an order as part of the analysis to support the creation of the thematic networks. This will help to identify whether the specific themes are systemic or not.
After the collection of the themes, an interpretation of patterns and thematic networks or maps is developed in the light of the existing literature (Aronson, 1995) in this study on secondary and vicarious trauma. Themes will be then assembled into similar and coherent groupings, which then become the thematic networks. Although there are no strict rules about how many themes would make a thematic network, in order to adequately and justly deal with the data a range of 4 to 15 themes is suggested. The themes and the groupings they belong to are hence non-hierarchical and can be illustrated as web-like representations. In the next step, the networks are explored and described in full. The last step is bringing together all the networks in a coherent story while elaborating on the research questions (Attride-Stirling, 2001).

The following table, borrowed from Braun and Clarke (2006, p. 87), summarizes the phases of thematic analysis, which was followed in this study:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarizing your data:</td>
<td>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes:</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes:</td>
<td>Collating codes into potential themes, gathering all data relevant to each potential theme.</td>
</tr>
</tbody>
</table>
4. Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.

5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.

6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

In line with the plan above, I first transcribed the interviews and generated initial codes on their printouts going through the entire data set several times. After entering the transcripts into the NVivo 10 qualitative data analysis software program, I collated the data relevant to each code in this program. Then, I collated codes into potential themes and subthemes. The frequency tables as well as the thematic maps in this work were produced with the help of this program.
CHAPTER 4

RESULTS

From the 15 participants of this study, all but one were women. Four of the participants were administrative staff, including one staff member who just switched from being an advocate to a director, the executive director, the secretary, and the director for the client services. They were between 26 and 59 years old. Their length of employment at WFCC ranged from three weeks to 16 years. The education level of the staff members varied from high school diploma to Doctorate degree. Three of the staff members had a high school diploma, three had a college degree, eight had a master’s degree, and one had a doctorate degree.

| TABLE 1 |
| SAMPLE CHARACTERISTICS |

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N (15)</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>14</td>
</tr>
<tr>
<td>Man</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>26-35</td>
<td>3</td>
</tr>
<tr>
<td>36-45</td>
<td>8</td>
</tr>
<tr>
<td>46-59</td>
<td>4</td>
</tr>
<tr>
<td>Years in the agency</td>
<td></td>
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<tr>
<td>Under 1 year</td>
<td>4</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>8</td>
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<tr>
<td>Above 5 years</td>
<td>3</td>
</tr>
<tr>
<td>Education</td>
<td></td>
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<tr>
<td>Highschool diploma</td>
<td>3</td>
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<tr>
<td>College degree</td>
<td>3</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>8</td>
</tr>
<tr>
<td>Doctorate degree</td>
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</table>

Eight participants volunteered or worked in the area of domestic violence before their current employment at WFCC. Three participants worked in organizations that did not directly specialized in domestic violence, but they came across with survivors of domestic violence in
their work recurrently, while four participants did not have any prior experience working in the
area of domestic violence before working at WFCC.

According to the scores of the subscale of Secondary Traumatic Stress of Professional Quality of
Life Scale (PROQOL), no participant had trauma scores higher than the typical helper. Similarly,
they did not score higher than the typical helper in the burnout subscale. Their compassion
satisfaction scores were not lower than the typical helper. The scores of the participants in the
Professional Quality of Life Scale (PROQOL) can be seen in the table 2. The mean score of the
Compassion Satisfaction subscale was 39.3, the mean score of Burnout subscale was 21.9, and
the mean score of Secondary Traumatic Stress subscale was 23.1. According to Stamm (2010),
scores above 42 in the Secondary Traumatic Stress and Burnout subscales, and scores below 22
in the compassion satisfaction subscale could be considered as problematic. None of the
participants had scores in these ranges.

<table>
<thead>
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<th>TABLE 2</th>
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<tr>
<td>PROFESSIONAL QUALITY OF LIFE SPACE (PROQOL) SCORES</td>
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<table>
<thead>
<tr>
<th>Participants</th>
<th>Compassion Satisfaction</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
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<tbody>
<tr>
<td>1</td>
<td>26</td>
<td>33</td>
<td>27</td>
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<td>2</td>
<td>40</td>
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<td>12</td>
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</table>
The relationships between secondary traumatic stress, compassion satisfaction, and burnout were investigated using the Pearson product-moment correlation coefficient. There was a medium, negative correlation between the two variables of secondary traumatic stress and compassion satisfaction, \( r = -0.48, n=15, p<.01 \), with high levels of compassion satisfaction associated with lower levels of secondary traumatic stress. There was a strong, positive correlation between secondary traumatic stress and burnout, \( r = 0.67, n=15, p<.01 \), with high levels of secondary traumatic stress associated with higher levels of burnout. In addition, there was a strong, negative correlation between compassion satisfaction and burnout, \( r = -0.88, n=15, p<.01 \), with high levels of compassion satisfaction associated with lower levels of burnout. There were not any patterns in the data based upon demographics, like education level, age, or time in the agency that correlated with the high or low levels of secondary traumatic stress.

The interviews allowed me to both elaborate on the results of these scores and examine their thematic analysis to explore some of the reasons of their scores in the secondary traumatic stress scale. Three broad themes emerged from the thematic analysis of the interviews as can be seen in the thematic map below.
4.1 Work in the Area of Domestic Violence

Some of the guiding questions of the interview aimed to explore the experiences of the staff members and the most difficult aspects of working with traumatized clients. The participants responded to these questions addressing different aspects of their work and its influences on them. Two subthemes emerged, namely hard and difficult work, and compassion satisfaction. Within the first subtheme of hard and difficult work, participants referred to various issues, including emotional influences of their work, empathy, and length of experience. They also talked about issues that included change in their worldview and interpersonal relationships which are addressed by McCann and Pearlman (1990) in their Constructivist Self-Development Theory as change in cognitive schemas and worldview.
4.1.1 Hard and Difficult Work

Most of the staff members identified their work with domestic violence survivors as hard and difficult. Looking from an ecological point of view, some participants elaborated on the current situation of domestic violence issue. They remarked how the stories of the survivors have not changed over the decades and how they resemble each other in many points. In this vein, one participant shared her thoughts as follows:

“It is very frustrating to me that I started this work in the early 90s, so almost twenty years [ago]. I can’t believe that I am hearing the same kind of things. I mean I feel like there could be on a societal level that are changes. And I feel like there's not much. It makes me feel like there's not much concern in the society about women and children, because we are still talking about issues, I am still seeing the kinds of trauma that I was seeing twenty years ago.” (Interview 2).
Not only was there not enough change on a societal level, but it seems that after decades of prevention and intervention policies, there are still not enough resources that can be offered by the advocates to meet the needs of the survivor.

“Being able not to have the resources we need, it is the hardest that affects me. You know what they want, and you know what they need, and it is not out there.” (Interview 13)

Due to scarcity of resources and alternatives, sometimes basic needs like a place to stay or transportation cannot be offered to the survivors:

“I think probably the most difficult thing is not being able to offer something to someone that they desperately need. So, whether be shelter or rents; or [they] need 25 dollars [for] gas in their cars. But we can’t do that out of our pocket, because that starts the slippery slope. That is hard, you know, when you can’t help, and you want to.” (Interview 12)

“One of the most difficult things is the challenge if they are not a fit for the shelter, or they need some place safe to stay helping them find options. And then if there are not any options for safety planning. That seems to be the most challenging. Especially when they are very much in crisis, and they may not like the options that are available, so you know a feeling that the I'm really not able to help them in the moment probably is the most challenging thing.” (Interview 9)

In this context, helpers also addressed the difficulty dealing with the possibility of recurrent violence some of their clients have gone through or would probably experience in the future. Since there have been clients who stayed more than once in the shelter, the workers never know if the survivors become victims again:
“I think it is hard about the job that you see a lot of women that go back, go back to drugs, to the same guy. It is like the story of Sisyphus pushing the rock.” (Interview 2).

This makes the advocates feel as though they are not making a difference in survivors’ lives. Further, this influences some workers emotionally in a negative way because they want that the survivors succeed in their search for a non-violent life:

“Just sometimes it can make you depressed sometimes yourself as a person, because you don’t want to see these people go on with all this trauma, and you wish the best for them. You know they don’t deserve it, you know nine out of ten chances they got to go back” (Interview 8).

Therefore, advocates get especially frustrated when no matter the help and services they provide, some women go back to the violent partner.

“They got this guy at home, want her back, and she doesn’t get moving. She can be back there anyway and get beat up. You know what I mean. I guess this is the roughest part on me. Hard. […] They are not ready yet.” (Interview 13).

Another aspect of advocates’ frustration is due to the attitudes of the clients who dismiss the work and the help of the advocates and do not show interest in using the resources that are available or made available to them by the advocates:

“And a lot of times, you make appointments with people [clients], they don’t show up. We get things, we get whole bunch of stuff together and they don’t do anything with it or they never come.” (Interview 2)
4.1.1.1 Emotional Influenced of Domestic Violence Work on the Staff Members

None of the staff members scored higher than the typical helping professional on secondary traumatic stress scale; however, this does not mean that they are not at all influenced or stressed by their work. They stated that the stories of the clients make them sad. For example, in some cases they can feel like crying:

“It makes me sad. Sometimes, you know, I've been around it so much, I don't feel like crying, but like certain things make you almost want to cry because you feel sad for the ladies.” (Interview 8)

In some cases, they in fact cry:

“I just, I don't know that, it really does [affect me]. Sometimes I cry. I go to the bathroom or go to the one of the coworkers. They talk me through it.” (Interview 7)

Although not very often, the stories of the clients occupy the staff workers even after work hours:

“You definitely think about it when you're at home, you know. I'm sometimes, if I'm leaving a hard call or something, I'll drive around for a little bit like I'll just take the long way home instead going just straight home to kind of process it a little bit. And so, you don't go immediately from that going back home because it is hard to switch off those hats.” (Interview 3)

There are some cases and instances that particularly affect the staff members. One of them is when survivors come to the crisis center with visible injuries:
“I think the impact that the things that still stick with me the most from that is when there are visible injuries that you see they are coming in.” (Interview 4)

When the advocates are called from medical institutions to visit survivors, they might encounter people who endured some physical violence:

“For instance, maybe on a medical call, where we go to the hospital to meet with a survivor who may just have been assaulted. And I would say that, you know, often here [shelter] we don't have clients come in with visible injuries always. And so just being there right, you know, that same day when you know those injuries happened, and seeing those.” (Interview 9).

Another instance that affects the staff members more than others is when accompanying children are involved who survived domestic violence:

“Anytime there's children involved coming in that is and has been the biggest impact for me. And probably the most emotional impact or challenging for me to see and work through.” (Interview 4).

Cases including sexual violence and child sexual abuse are further instances which are found by some advocates especially difficult to process:

“I would say more what bothers me is when we have survivors who maybe you talk about being molested or sexually assaulted. […] I think I would have more difficulty doing that piece then the domestic violence piece.” (Interview 9)
4.1.1.2 Empathy and Length of Experience

A majority of the participants addressed the aspect of time spent dealing with traumatized people that developed their ability not to personalize or to be withdrawn by the trauma stories. Due to the years of experience of encountering people in trauma and crisis, they stated that they are not influenced as much as they were at the beginning of their career, as one participant expressed, the trauma stories made her “a lot tougher” (Interview 8). They learn to detach themselves from the trauma:

“After a while you kind of just have to get immune to it to be able to deal with it. You can't. I mean, first I worked in shelter with clients, it would make you upset, but then it didn't. … I kind of have to just like not become completely detached, but to some extent.” (Interview 1)

With time, the empathy felt for the clients can decrease and hence they can get desensitized to the trauma stories:

“It can be hard, I think, that you do become desensitized a little. And so, then you also kind of start to feel guilty about that like if you don't feel, you know, because a lot of the stories have similar components to them. And so, if you don't feel maybe as empathetic as you did when you first started doing the work” (Interview 3)

Another participant expressed the decrease of empathy as a sense of numbness to the stories:

“I think that it was an eye opener, but I can tell you over the years you become numb to it. Once in a while something will get you, but not that you don’t feel mostly for them, but it is like you learnt how to set it aside, I guess. You know it is hard.” (Interview 12)
4.1.1.3 Change in Worldview and Interpersonal Relationships

As participants talked about their work with domestic violence survivors, they addressed some changes in their worldview about people and societal issues. They also pointed out how their work changed their thoughts and behaviors in their daily and private lives. Some staff members mentioned how their work with clients was a revelation for them about the situation of domestic violence in the society. Regardless of what they knew about domestic violence before, with their job, they got a more accurate picture of what is happening in families and relationships:

“It is very sad, you know, kind of eye opening what is really happening.” (Interview 10)

“It does make you sad that someone could do that to another person.” (Interview 11)

An advocate shared with me how she is frustrated about people, especially the ones in her private circles, who are not interested in social issues and do not try to contribute to the well-being of the community:

“I think what it most affects me is that it is hard for me to go back to my real life, my other life, you know, my life with my family and children and see everyone else is going about their daily lives, and not get extremely frustrated that they could be doing something, and they are not. I don't understand how people don't do community service work. I get out here and I am like oh my god how can people be so blind. […] And it is stunning to me that people could live so blind to the horrible poverty and trauma you know of other people just a few miles away.” (Interview 2)
The work with domestic violence survivors made the advocates more aware and watchful in their daily and individual lives. They began to pay more attention to people in their immediate family, neighborhood, and even to people they do not know but see around:

“I become more watchful of situations around me. I become more observant and be aware of people I see in the grocery store or my neighbors. Or if I have a family member or a friend who is going through a situation, I try to dig in in my brain and see: Is there a situation that I have had with a client that's similar and how did I help them, what resources did I give them that might be helpful for this situation in my personal life?” (Interview 14)

In addition, the advocates became more cautious and careful in their own private relationships or in intimate relationships:

“Because I'm single and that I'm probably a little bit hyper aware of people who could be potential abusers. And I would say personally that affects me that I may see red flags early on and maybe they aren't really red flags, but they look like red flags.” (Interview 9)

Another aspect of caution is expressed with the potential danger of the survivors’ abusers. One of the staff members expressed her concern with feeling unsecure as following:

“With this job … we never know if somebody follows us home so that is how it affects me sometime. Not only that but because we never know that somebody tells their abuser where they are at. It is more that to me just being scared that somebody … could follow us home or do us something. So, I am concerned about some of these things sometime.” (Interview 8)
4.1.2 Compassion Satisfaction in Doing Domestic Violence Work

To reiterate, the Professional Quality of Life Scale (PROQOL) scale also includes a subscale of compassion satisfaction. In this subscale, all of the staff members scored average or high, as can be seen in the Table 2.

The staff members also addressed the theme, compassion satisfaction, directly or indirectly in the interviews, as they talked about their work or their clients. Besides considering their work with domestic violence survivors as hard and difficult and being in some cases negatively influenced by it, staff members were involved in their work compassionately. The tough work with domestic violence survivors could even encourage their engagement in their work as can be seen in the words of an advocate:

“You know, a lot of times it is really sad. And that only motivates me more to help them to find solutions that are safe, and better options and making sure that they have all the resources that they need. So, I'm kind of driven through their sadness to find solutions.” (Interview 14)

Notwithstanding the fact that the cases can be challenging to work with, there are numerous stories that make the advocates happy and hopeful. They are positively influenced by their work:

“I am a good listener, so I guess I try to pick up something positive from what they are saying. It affects me, it is good, you know, healthy, because they come from such an unhealthy environment. We got here something, […] I feel hope for them because they feel hope.” (Interview 13)
While they try not to be influenced by the traumatic stories from their clients, the advocates try to do their best to support them and enjoy their job:

“I love working with the clients. I feel like I do a really good job. […] And I probably do more than I should have to, you know, what is asked of me. I do it because I really do enjoy it.” (Interview 11)

4.2 Workplace Culture: Strengths and Challenges

My initial intention of giving a short-version of the scale of Perceived Organizational Support was to look at its relationship to the level of Secondary Traumatic Stress. After conducting the first two interviews and analyzing them, I realized that the interviewees addressed directly or indirectly issues that were covered in this scale. Thereupon beginning with the third interview, I asked the participants at the end of the interview if they want to elaborate on the items and their responses in this scale. Participants who already addressed some of these issues in the interviews repeated them or went into detail with these issues. Some participants picked up particular scale items and elaborated on them, and some participants, particularly the ones whose employment history in this agency was not long, preferred not to discuss them with the argument that they do not know the organization well yet.

In addition to the themes associated with the items in this scale, other themes related to the workplace emerged, especially themes connected to the policies and structures of the agency, administration, and co-workers which are shown in the Figure 3 and will be discussed below.
4.2.1 Inter-Personnel and Interpersonal Relationships

As we will see in the section of coping and self-care strategies, one of the strengths of this workplace is the feeling of support among staff members. However, related to the challenges at the workplace, staff members also addressed issues with which they are not content. Most of the time, they support each other wherever possible, nevertheless it seems that there is some disconnection between administration staff and others as well as between supervisors and advocates:

“Advocates are very supportive of other advocates. There's always been a management issue. But advocates support each other and so it is almost like there is a separation here.”

(Interview 12)

Hence, some advocates do not feel supported by the supervisors and administration:
“I think professionally I feel very supported by the other advocates. I feel they are smart, they are informed, and I can go to them. … But when it comes to the supervisors and the administration they are oblivious and that I think is extremely frustrating.” (Interview 2)

One of the staff members shared this viewpoint that advocates could make use of more support from the supervisors:

“I would say from what I've observed maybe to have it be a little more structured when it comes to the advocates and being more supportive. I think sometimes what I've noticed is some advocates don't feel as supported with certain decisions they are making.” (Interview 5)

It seems that there is no designated time or space for the advocates to talk about their problems or frustration in dealing with clients and discussing about their or other advocates’ decisions about clients:

“We have gotten a lot of training about being trauma informed because that is so much part of the advocacy training; but I think that not only with maybe clients who can be difficult but also just as team members as working together. And maybe, you know, one team member might have a certain opinion on how to deal with a client situation and the other advocate may not agree. So, I think some work on better communicating as a team and working through that conflict [would be good]. And whether that means some kind of like not necessarily a retreat but a time when we focus on better communicating with each other like hard conversations or crucial conversations. That don't necessarily happen.” (Interview 9)
Also, it seems that a space or designating time for addressing issues among personnel is lacking. The agency has an open-door policy that should allow advocates to visit with administration or supervisors one-on-one, however some have the impression that their concerns and complaints are ignored and not taken seriously:

“I went to [name of the supervisor] with numerous complaints about staff issues and inappropriate comments, and it still goes on, so I don't think that it has been addressed.”

(Interview 3)

4.2.2 Structural Challenges

As talking about the workplace, some participants also addressed challenges that are related to work conditions and scarcity of resources that could be an additional stress in their daily work. They shared with me that although they sometimes have to work overtime, they have not been compensated. Another issue with which the participants were not satisfied was the lack of sick pay. Full-time workers have 3 weeks of paid-time off, however any sick leave must come from this time.

“It is not like this is a corporation. It is a non-profit. People are earning very little money. They barely make up their needs, barely afford childcare, health insurance, things like that. That is an additional stress on top of the trauma that we see.” (Interview 2)

Some participants claimed that although this agency is a non-profit, nonetheless it is run like a business in which the priority is to get the job done, but it is not interested in how it is done. One staff member articulated this viewpoint with quite intense word choice:
“This place is about business. This has nothing to do with your feelings as a human. For this place you are body to them and that's it. So, if you are sick shame on you. If you feel like something's wrong within the agency and you voice about it shame on you.”

(Interview 15)

Another workplace challenge was related to scarcity of resources:

“I mean it is frustrating. It is hard when there is just never enough funding, not enough staff support, not enough space for people.” (Interview 4)

The scarcity of work space, in particular, was addressed by many participants. Due to scarcity of room, the advocates do not have their own offices, but work in an open plan office. Even though they put that they are aware of the fact that this is not to be changed currently due to funding, they stated that this condition affects their teamwork:

“I think the challenge is because we're all in one big room and maybe you want to have a crucial conversation with somebody, but she really doesn't want the whole room to be listening in.” (Interview 9)

Hence, the space issue adds another layer of stress to inter-personnel and interpersonal relationships:

“With our small space we have, we get on each other’s nerve a lot. And that causes a lot of friction. And I think that does not help things, I think that makes things more stressful.” (Interview 11)
4.3 Coping and Self-Care Strategies

Staff members stated a variety of strategies that they apply to deal with the stress they encounter at workplace dealing with traumatized clients. These strategies can be collected broadly under two categories, namely strategies employed outside of the workplace, in their private time, and at the workplace. In addition to these themes, a theme called suggestion for the workplace will also be elaborated on as it was one of the questions asked in the interviews.

![Coping and self-care strategies thematic map](image)

Figure 4. Thematic map: Coping and self-care strategies

4.3.1 Strategies Outside of Work

The strategies employed by the staff members outside of their worktime can be categorized under individualistic and social strategies. All participants had reported that they use individualistic strategies, and eight participants applied social strategies. In the table below, we can see a list of activities that are done by the participants to relieve and prevent stress outside of the workplace:
### TABLE 3
**STRATEGIES OUTSIDE OF WORK**

<table>
<thead>
<tr>
<th>Individualistic strategies</th>
<th># of participants using the strategy</th>
<th># of times the strategy is mentioned</th>
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<tbody>
<tr>
<td>Being in the nature</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Cooking</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Eating unhealthily</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Gardening</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Going to casino</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Meditation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Playing music</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reading</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Scrapbooking</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Shopping</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Showering</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Singing in the car</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sleeping and vegging out</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Time alone</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Traveling and planning for traveling</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Walking after work</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Watching TV</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working out and doing sports</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Social strategies</td>
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<td></td>
</tr>
<tr>
<td>Spending time with family and friends</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Talking out with partners, family members and friends</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Time with pets</td>
<td>2</td>
<td>2</td>
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</tbody>
</table>

Individualistic strategies included mostly activities to rest the mind. As I asked the staff members what kind of coping strategies they have, most of them mentioned that they would prefer activities to switch off their minds like watching television or reading texts that are not intellectually demanding.

“Reading a book, you know. Watching mindless TV”. (Interview 12)
“Watching sports that it takes my mind off.” (Interview 10)

“And taking time to read, you know, bad fiction. It doesn't have to be always, you know, reading most intellectual thing. It is a time when I turn my brain off.” (Interview 2)

Most of the cited physical activities were applied by the participants with the aim of relaxation. Working out and doing sports helped them to relieve stress. For example, one of the few staff members who exercised regularly stated that “I love to run and exercise. That is hugely helpful for me, mentally” (Interview 20). Walking was also considered as a strategy to relax and to clear the mind:

The biggest thing when I am able to do is trying to get out and walk. And I do that by myself generally, because it just gives me some process and quiet time; to get everything out of my head. (Interview 4)

It is noteworthy that some participants disclosed that certain activities they do as self-care are not positive or healthy choices but help them to cope with the stress, like shopping, going to the casino or eating unhealthy foods such as sweets. However, one of the staff members was concerned about the unhealthy life style of her co-workers:

“There are very unhealthy habits here that I have not seen in a long time in other work places. People eat very poorly, they are overweight, they smoke. It is unfortunate.” (Interview 2).

Social strategies, on the other hand, mostly involved coming together with partners, family, and friends, as well as spending time with pets. Some especially underlined that they try
to create time to spend with their children, like during the evenings and weekends. Staff members would meet with family members and friends to socialize for self-care:

“If I’m frustrated or need to take care of myself you know I spend a lot of time with my family and friends” (Interview 14).

Some staff members stated that they also talk with their partners, family, and friends about issues they encounter at the workplace:

“I guess with the stress how I deal with it is talking things out with like friends and family.” (Interview 3)

Partners play an especially important role in discussing issues:

“I think I have an amazing husband. He gets it. He gets all of it. He gets that there is always a larger like … societal, political, you know, economic consequences to this work. Yes, it is very hard. Politically and society-wise, he gets it. I go to him.” (Interview 2)

Here, it is important to note that some advocates stated that being on call outside of their shifts—that some have to do in a rotational schedule during nights and weekends—hinder them to engage in self-care activities:

“So, I couldn't ever be really do anything without the chance of having to stop what I'm doing: so, sleeping, grocery shopping, cleaning, cooking, you know, working out, all that. I would get calls and stop. … Could not ever just like go out for drinks, or anything like that.” (Interview 3)
4.3.2 Strategies at Work

Strategies at work addressed also some strategies that are either individualistic or social in character. Seven participants used individualistic strategies, while ten of them were engaged in social strategies to deal with the work stress. In addition to these, staff members cited strategies that they had to learn by themselves throughout the years of their career dealing with traumatized clients. I categorized these coping strategies under self-developed strategies that were addressed by nine participants.

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>STRATEGIES AT WORK</th>
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</thead>
<tbody>
<tr>
<td><strong># of participants using the strategy</strong></td>
<td><strong># of times the strategy is mentioned</strong></td>
</tr>
<tr>
<td><strong>Individualistic strategies</strong></td>
<td></td>
</tr>
<tr>
<td>Bringing joy to others</td>
<td>7</td>
</tr>
<tr>
<td>Meditation</td>
<td>1</td>
</tr>
<tr>
<td>Scrapbooking</td>
<td>2</td>
</tr>
<tr>
<td>Taking a walk</td>
<td>1</td>
</tr>
<tr>
<td>Taking breaks</td>
<td>3</td>
</tr>
<tr>
<td>Taking PTO (Paid Time Off)</td>
<td>2</td>
</tr>
<tr>
<td>Time management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Social strategies</strong></td>
<td></td>
</tr>
<tr>
<td>Talking to co-workers</td>
<td>10</td>
</tr>
<tr>
<td>Talking to supervisor</td>
<td>1</td>
</tr>
<tr>
<td><strong>Self-developed strategies</strong></td>
<td></td>
</tr>
<tr>
<td>Accepting limits</td>
<td>9</td>
</tr>
<tr>
<td>Mindful distancing</td>
<td>4</td>
</tr>
<tr>
<td>Not taking home, leaving at the door</td>
<td>3</td>
</tr>
<tr>
<td>Setting boundaries</td>
<td>2</td>
</tr>
</tbody>
</table>

Like the strategies in private lives, some staff members engage in activities that bring relaxation during work hours, like taking a walk outside, or taking breaks. One staff member
stated that time management would be her coping strategy and elaborated on how she manages her cases so that she can have time for relaxation activities:

“I think my focus for here to keep me under control is what's the priority and that's case by case. So, if one of my cases take precedence over another, I want to make sure I'm working that one first so that way if there's some down time the other client can come in. But I always work priority wise without letting the others feel like they're not a priority, if that makes sense. And that way I can allow breaks within my time to process what they've just told me or to go report to [supervisor’s name] what they told me things like that. But here I'll take breaks, going walks around the building or just go outside and chit chat with the workers here and then come inside and dust it off and start all over.”

(Interview 15)

Another coping strategy at work is talking to co-workers and supervisors. Several staff members shared with me that if they feel stressed about their clients they would go to their co-workers to vent about the situation. Some of them underlined that advocates are very supportive of each other and understand each other very well when they are challenged with client issues. Here, a staff member stated how she communicates with co-workers about clients as a self-care strategy:

“As far as here, I think having team members that you can kind of talk about the situation if it's distressing [is a self-care strategy]; kind of share it with someone else or say this is how I dealt with it, you know, ‘do you have any other ideas?’, but just being able to talk about it with a team member is helpful.” (Interview 9)
In addition to relaxation and social support strategies, several interview partners mentioned that they developed strategies and skills throughout the years in order not to be affected by the client issues. One of them is de-personalization. They trained themselves not to take these issues personally:

“I definitely try to be compassionate, but I have been doing this for a long time. … I try to empathize but at the same time I don’t connect personally with the trauma.” (Interview 6).

Another strategy of increasing the ability of de-personalization is uttered by an advocate as follows, as she tries to self-intervene in order to distance herself from the clients’ traumas:

“I just tell myself: ‘it’s not about me, you are upset about their situation’, so I take myself out, but I have to tell it to myself in the moment. I have to make myself say to myself in my head: ‘it is not about you’. So, I have to do that daily.” (Interview 5)

Some learnt not to carry stress with themselves so that when they leave work they try to leave the stress at the workplace:

“What I do is, I learned it long time ago, I find a way on my way home and just dump it, because I can’t take it home with me.” (Interview 13)

“I try not to take it home with me, try to leave at the door. But sometimes, I mean, of course I sit there, hear something on TV and maybe think of, oh my goodness, what if that happened to my client. But I try to just leave it at work and be with my family and spend the time with them.” (Interview 10)
4.3.3 Suggestions for the Workplace

In the interviews, I also asked the advocates about the services that are offered by the agency for self-care and their suggestions that can be added to the self-care activities at their workplace. From the answers to these questions, it came out that the agency offers almost no services to their workers that are specifically related to self-care. In this vein, some participants shared their viewpoints of this lack of services and how they feel unsupported by the agency in self-care issues.

The services related to self-care offered by the agency were addressed in very few interviews. Only one participant shared that the workers were given a book about self-care:

“Only way that they've ever address self-care is they gave us a book one time on selfcare. ‘Here read this book.’ Well, thanks. I mean that's not selfcare. I think their viewpoint for a long time, that of administration, has been that selfcare is something you do yourself. That is not true. We need your help and assistance. We need your help and support to feel it is implemented and part of our agency.” (Interview 1)

Like this participant, others stated that the agency considers self-care activities as individualistic activities that should be preferably done outside of worktime. Besides taking breaks during worktime, like taking lunch breaks or going away from their work desk, there were no other offers or suggestions made by the administration.

Another service that seemed to be very recently offered was a counseling service. This was addressed by a small number of participants. Some even did not know about it at all, as I asked them if they made use of it.
One of the very few workers who knew about the counseling service was not impressed by it since the workers were not able to use it during work hours unless they would take paid time off:

“Well, so recently I know we have a contract with [the name of the counseling service], which is outside counselling service that is free of charge. ... However, you cannot go there during your shift. … That means you have to take time off; there is no sick pay.” (Interview 12)

Regarding the scarcity of the services provided by the agency for self-care, 14 participants suggested a variety of activities that can be implemented at their workplace:

<table>
<thead>
<tr>
<th>SUGGESTIONS FOR THE WORKPLACE</th>
<th>Number of participants referenced the activity</th>
<th>Number of times the activity is mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appreciation of the workers</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Group activity</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Inquiring about well-being and job stress</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Massage therapy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Need for an HR</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Separation of sick pay and paid time off</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Staff break room</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Treadmill</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

As it can be seen from the list above, the suggestion of group activities stands out. The majority of the participants suggested regular meetings of the whole staff for self-care group activities. Some stated that leaving the building and going outside would be helpful:
“I always think things would be fun especially when it's nice outside like do an outside activity with everybody. Maybe we go and just kind of meditate for a minute outside, do yoga, play kickball, or go over the park and eat sandwiches and just like get some sunshine, and get really outside.” (Interview 14)

Others wished to participate in group activities on a regular basis:

“I would probably suggest, you know, like we have a full staff meeting to let the supervisors or who is in charge kind of take a brainstorming session and see what ways we come up with; to put it a part of our regimen or our schedule. Almost kind of make it accountable and voluntarily at the same time. Does not penalize when we don’t do but offers certain incentives for as to do. I’d like to see something like that. Even if it is one day a week, we have a walk day.” (Interview 6).

Some underlined the importance of activities that would enhance team-building:

“I know the team building has always been the best, because you trust those on your team. You can depend on one another because at the end of the day when you're working with clients in crisis and sometimes you just bogged down with everything. It's good to have that team support.” (Interview 5)

Some combined the idea of team-building with a retreat:

“Like a staff retreat or something like that, I think would be very helpful. Not just to show how important it is to have selfcare and how the organization sponsors some of that but also give us time as a team to do that together, I think would be very good.” (Interview 9)
Another suggestion in this vein was to include training on self-care into the retreat:

“Maybe taking everyone, I know that other agencies do this, going on a retreat for a day. We never have done anything like that. Retreat could be even with extensive training. You know, something. And a piece of that could be, the last half of it how to take care of yourself and deal with the trauma, you know, because we've all had cases where they haunt us.” (Interview 12)
CHAPTER 5

DISCUSSION

The aim of this study was to contribute to the research about domestic violence shelter workers and to what extent and how they are influenced by their work with traumatized clients. Since workers of a domestic violence shelter belong to professionals who are exposed to clients with trauma, they are vulnerable to develop secondary traumatic stress themselves. This study also aimed to learn about the social structure in the agency, and how this would influence the stress of the participants. Also of interest were the coping and self-care strategies of the participants to deal with this stress in their private and professional lives as well as their suggestions for institutional strategies that the agency could implement.

Thematic analysis found three broad themes. These themes covered 1) the qualities of the work with traumatized people in the domestic violence area, 2) the workplace culture including its strengths and challenges, and 3) the strategies to deal with work stress. The first theme underlined the importance of compassion satisfaction among workers even if the work with domestic violence survivors is hard and difficult. The second theme addressed how the participants felt supported by their co-workers and peers, while they felt challenged by work conditions and scarcity of resources. Coping and self-care strategies that emerged as a third theme, showed that every participant had used strategies or engaged in activities in order not to be influenced by their work or to reduce the effect of their work with traumatized clients.

5.1 Domestic Violence Work and Secondary and Vicarious Trauma

Measured by the Professional Quality of Life Scale (PROQOL), the participants of this study, namely staff members of a domestic violence shelter, did not score high on secondary traumatic stress. The participants also did not reveal in the interviews any information related to
the symptoms of secondary traumatic stress that are similar to the symptoms of Post-Traumatic Stress Disorder (PTSD) in the domains of re-experiencing the trauma events, avoidance of reminders of an event, and persistent arousal (Figley, 1995a). These results show that working with traumatized people did not negatively influence the majority of the staff. This supports the existing literature, including the study by Baird and Jenkins (2003) with sexual assault and domestic violence counselors as well as the study by Bell (2003) studying domestic violence counselors.

The participants did not mention any symptoms of secondary traumatic stress, but they stated that their work with domestic violence survivors influence them emotionally, especially making them sad, supporting the previous research on domestic violence counselors in the study done by Iliffe and Steed (2000). The most emotionally laden instances for the participants included when the clients have visible injuries and are accompanied by children, as the participants in the previous study also stated. In addition, some participants of the current study found it especially difficult when sexual violence is involved in the case.

Although some stories of the clients preoccupy them beyond the work hours or for a longer time, most of the stories—also because they are similar to each other—lead them to develop feelings of indifference and numbness, as indicated by McCann and Pearlman (1990) and Iliffe and Steed (2000). Despite the physical signs of violence and the stories told by the survivors, none of the participants reported re-experiencing visual imageries or suffering under physical responses.

The development of this emotional distance of the participants to their clients in turn influenced the participants’ feeling of empathy that seems to decrease with time. Empathy that has been counted as a quality of a professional helper is simultaneously considered as a factor
that could enhance the development of vicarious and secondary trauma (Figley, 1995a; Pearlman & Saakvitne, 1995). Participants try to be empathetic while distancing and depersonalizing themselves from the situation of the client. This reduces their vulnerability to secondary trauma in line with Figley (1995c, 1995d), and hence, could be one of the factors as to why they did not score high in the secondary traumatic stress scale.

Further, this study confirms some premises of the ‘Constructivist Self-Development Theory’ (CSDT) proposed by McCann and Pearlman (1990) for their conceptualization of vicarious trauma. Even though none of the participants talked about issues that would hint at a possible change in their imagery system of memory, there were several instances cited that can be identified as a transformation in their cognitive schemas and in their esteem for others and humans in general.

The stories they heard from their clients made the participants more knowledgeable about the severity of issues of domestic violence in the society and of partner violence in intimate relationships. Although they knew about domestic violence in general, working with survivors led them to understand the extent and severity of it. Consequently, they underwent a transformation in their thoughts and engaged in behaviors they had not done before. They became more cautious, watchful, and worried in their daily lives, looking for signs of danger and risks of violence not only in their immediate environment and personal and intimate relationships but also in the communities where they live.

Thus, this study supports the mixed results of studies that examined the relationship between exposure and secondary and vicarious traumatization. In contrast to the findings of some studies that found a relationship with exposure measures, including the proportion of traumatized people in work caseload and years of experience in the area, this study showed that...
exposure to trauma with a full work caseload of domestic violence clients would not necessarily contribute to traumatization. In agreement with some other studies, the results of the current study demonstrated how more experience along with decreasing empathy and increased depersonalization would become a protective factor against secondary traumatic stress.

This study strengthens the premise of a further possible protective factor, namely the ability to find satisfaction in helping professions that has a positive influence on the degree of intensity of secondary trauma (Figley, 1995c, 1995d). As assumed by Stamm (2002) and supported with the study by Conrad and Kellar-Guenther (2006), compassion satisfaction enhances resiliency to traumatization. In this study, not only survey results with at least average or high scores in compassion satisfaction, but also the analysis of the interviews showed that the participants work compassionately for their clients, enjoy working with them, and are positively influenced by their work.

Besides the work stress that can be caused by clients, this study revealed that societal conditions and the consequent scarcity of resources for domestic violence survivors are further contributors to stress. Participants feel frustrated about their incapability to offer the needed resources to the survivors. The scarcity of resources along with a lack of funding are also partly responsible for the vicious circle of violence where the survivors return to their abusers, making the participants feel as though their effort and help is ineffective.

5.2 Social Structure and Organizational Culture

The existence or lack of organizational support and co-worker and peer support are considered as important factors that can influence the intensity of secondary and vicarious trauma. In contrast to Kassam-Adams (1995) who could not find any association between social support and secondary and vicarious trauma in her study with psychotherapists, the current study
found that the participants feel and appreciate the peer-support in their organization that they also use as a coping strategy with the work stress. Hence, the current study was in line with the studies done with domestic violence advocates by Iliffe and Steed (2000) and Slattery and Goodman (2009) that showed a positive influence of peer-support on the work of domestic violence advocates.

Interestingly, they do not always feel supported by the supervisors and especially by the administration. There is even the perception that the needs and complaints of the advocates are neglected and ignored by their supervisors and administrators. For example, there is not any designated time and space for either advocate-client issues or inter-personnel issues. Regular staff and team meetings are mostly occupied with time planning and case management, such as organizing shifts and paid time offs, and talking about the needs of the clients with the needs of the staff ignored. Nevertheless, the inadequate supervision and administrational support and the resulting frustration do not constrain them from working compassionately for their clients.

Further stress factors that come about due to the social and organizational culture were related to working conditions that only partly depended on lack of funding. Even though the agency is a non-profit organization, participants have a perception that their working conditions resemble a for-profit corporation. They feel that the agency takes advantage of them in the areas of overtime and paid-time-off. Although being an agency that advocates the rights of women, it lacks pro-women policies for its workers, for example, not offering maternal leave. On the other hand, other working conditions, like scarcity of work space, that also cause some interpersonal stress among staff members are tolerated since the participants understand that depends on lack of funding which is a consequence of policies in the domestic violence area.
5.3 Coping and Self-Care Strategies

The significance of coping and self-care strategies is generally recognized—despite some conflicting studies—as an important factor that help to decrease and prevent secondary trauma. The results of this study support the positive impact of these strategies as suggested by Meadors and Lamson (2008) and Pearlman (1995). All participants employ a wide range of strategies in their private and professional lives to reduce work stress. The strategies outside of work consist of individualistic strategies such as leisure time activities, hobbies, exercise, as well as social strategies such as spending time with family, friends, and pets as well as talking out about issues that concern them at work with partners, family and friends. The strategy of spending time with family and friends not only helps to relax and have fun, but it is also used as a time to talk and discuss work related issues to help process them, and to hear other viewpoints regarding the issues at hand.

In addition to strategies in their private time, participants use a variety of strategies at work. Besides individualistic strategies, like meditation, taking a walk, or taking breaks, the majority of the participants use talking to supervisors, but especially to co-workers to decrease or prevent the effects of their work with domestic violence survivors. This peer-consultation stood out as the most used social strategy by the participants.

Another equally used coping method that emerged from the current study includes strategies that participants developed throughout the years as they were gaining more experience in dealing with trauma cases. These self-developed strategies involved accepting their limits and setting boundaries, and hence, balancing work and self-care activities. They have also learned how to depersonalize and distance themselves from the trauma stories and cases and have found
it beneficial to leave work-related issues and problems at the workplace and not bringing them home.

This study also showed that domestic violence shelter workers need services and activities for self-care offered by the agency. This lack of institutional services made the participants feel and perceive that their work is not appreciated or recognized. Moreover, it led them believe that their well-being is not taken seriously, and they are not cared for as individuals, since the agency gives its workers the impression that self-care is something done individually. One of the suggestions for institutional self-care made by the majority of the participants was organizing regular, outside group activities which include team-building activities as well as professional training on how to deal with trauma.

5.4 Limitations and Future Directions

Studying a single case qualitatively has the potential to contribute to the larger discussion of the issue under examination through in-depth study (Yin, 1993). However, like every study, a qualitative case study has its limitations. The first limitation of the present study is its small sample size with 15 participants. Another limitation is that I conducted the research with a convenience sample of staff members who were willing to participate in the study, namely 15 of 23 (65.2%). Note that six of those who chose not to participate worked at nights or on weekends and would have had to come in for the interview when they were not working.

Regarding the mixed results on secondary and vicarious traumatization of helping professionals and the few studies done in this area with counselors, workers, and advocates of domestic violence survivors, it is evident that additional quantitative and qualitative studies are needed. Future research can be done with case studies focusing exclusively on agencies, centers, and institutions that serve domestic violence survivors in order to see how the environmental
factors due to workplace conditions influence the level of secondary and vicarious trauma by domestic violence workers.

As already indicated in the literature, standard definitions and well-validated measures are lacking in the area of secondary and vicarious trauma (Slattery and Goodman 2009). Therefore, further future direction of research could include an intentional differentiation between the constructs of secondary and vicarious trauma—not using both constructs interchangeably—and examine both constructs separately through symptoms and outcomes. As shown in this study and in some others using a similar population, the participants reported instances of vicarious trauma even though symptoms of secondary trauma were not recognizable. Hence, it would have been very helpful if I had included interview questions that directly and specifically address the premises of vicarious trauma including the different aspects of the changes in cognitive schemas and imagery memory systems.

Future research could include a time- and resources-bound longitudinal study in which surveys and interviews would be conducted with domestic violence shelter workers over time, ideally at the beginning of their employment, after one year, and after two years. Such a study would bring new insights into the research area of secondary and vicarious trauma to look at how work time and experience with traumatized people would influence the level of trauma along with other contributors.

5.5 Conclusion

The participants considered working with traumatized clients hard and difficult. They expressed a variety of challenges and frustrations with the conditions and structural difficulties at the workplace. Yet, the reported self-care and coping strategies of the staff, along with
satisfaction with the work, are likely factors to prevent the development of high levels of secondary traumatic stress.

Specific to this case study were the challenges with the administrators and supervisors and the lack of institutional self-care services and activities. In light of the suggestions of the participants and the existing literature to prevention strategies, we can see that in addition to regular and structured whole-staff group activities with a variety of trainings, a regular case conference, as proposed by McCann and Pearlman (1990), would meet the needs of the participants. A weekly case conference would not only provide a designated time and space to talk about difficult survivor cases and advocates’ own feelings but also to discuss the interpersonal issues among the staff members, which most of the time are not openly addressed and remain unsolved. Such an activity would also intensify the team spirit among the staff members as well as strengthen them individually. This could also help the agency to decrease the high turnover rate that is expressed by research participants with about two years.

This study also showed that using only a scale of secondary traumatic stress and its underlying theoretical premises is not enough to understand the stress of helpers due to their work with traumatized people. There were indications of having changes in cognitive schemas and social relationships that are not addressed by the construct of secondary traumatization but by the construct of vicarious traumatization. Therefore, this study implicated that combining the terms of secondary traumatization and vicarious traumatization or using them interchangeably would not reveal some issues that are related to this work stress. Thus, maintaining the differentiation of both terms while underlining their nuances would not only enrich the research but also our understanding of the phenomenon. Further research would be needed to specify
these nuances and determine their relevance based on new data collected in the direction of this phenomenon.
REFERENCES
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APPENDICES
APPENDIX A


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.


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 B

QUESTIONNAIRE: PERCEIVED ORGANIZATIONAL SUPPORT (SPOS),
EISENBERGER ET. AL. (1986) (SHORT 8 ITEM VERSION)

1. The organization values my contribution to its well-being.
2. The organization fails to appreciate any extra effort from me.
3. The organization would ignore any complaint from me.
4. The organization really cares about my well-being.
5. Even if I did the best job possible, the organization would fail to notice.
6. The organization cares about my general satisfaction at work.
7. The organization shows very little concern for me.
8. The organization takes pride in my accomplishments at work.
APPENDIX C

INTERVIEW GUIDE QUESTIONS

• Can you tell me about your experiences working with traumatized clients?

• What are the most difficult aspects of working with traumatized clients?

• How does it feel to hear about traumas your clients have?

• How do clients’ trauma affect you? If at all, what impact does it have?
  o At workplace?
  o In personal life?

• How do you deal with that? What strategies, if any, do you use to manage that?
  o What are the services offered by your organization?
  o What are the self-care strategies you have?

• What are your suggestions to better deal with this stress?
  o On organizational level
  o On personal level

Demographic questions:

• Age

• Years in the organization

• Years of working in the area of domestic violence

• Education