5-2012

Agency Level Interventions for Preventing and Treating Vicarious Trauma: A Qualitative Study

Jessica Johnson
St. Catherine University

Agency Level Interventions for Preventing and Treating Vicarious Trauma: A
Qualitative Study

Submitted by Jessica A. Johnson
May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation Requirement for MSW
students at St. Catherine University/University of St. Thomas School of
Social Work in St. Paul, Minnesota, and is conducted within a nine-month
time frame to demonstrate facility with basic social research methods.
Students must independently conceptualize a research problem,
formulate a research design that is approved by a research committee
and the university Institutional Review Board, implement the project, and
publicly present their findings. This project is neither a Master's thesis
nor a dissertation.

School of Social Work
St. Catherine University & University of St. Thomas
St. Paul, Minnesota

Committee Members:
Kendra Garrett, PhD., (Chair)
Todd Erickson
Traci Boser, LICSW

Abstract

The purpose of this study was to explore what types of strategies agencies are using to prevent and/or reduce vicarious trauma. To do this, five qualitative interviews were conducted with participants who work directly with individuals who have survived trauma. The findings showed mixed results, as some agencies employed multiple strategies, while others employed few. Agencies seemed to provide adequate benefits and training to employees, and to also encourage them to engage in self-care. While most agencies required supervision/consultation, only one agency encouraged staff members to discuss how they are being impacted by their clients' trauma. Agencies also did little to manage caseload sizes, as only two participants said that their agencies work to be mindful of the number of trauma cases each staff member has on their caseload. While employees should be held accountable to taking an individual stance in preventing vicarious trauma, agencies also need to make conscious efforts to ensure that staff members are receiving adequate supervision/consultation, training, and benefits, and that they are also being encouraged to engage in self-care. If agencies do not provide adequate support to their employees, the wellbeing and work of their employees, as well as the care of their clients, could be jeopardized.

TABLE OF CONTENTS

Agency Level Interventions for Preventing and Treating Vicarious Trauma: A

Qualitative Study

Working with survivors of trauma can have both positive and negative impacts

on social workers. There tends to be something about just knowing that one is helping

another person in need that can make a social worker feel good; in other words, it can

be emotionally rewarding to help survivors of trauma overcome obstacles in their lives.

On the other hand, working with survivors of trauma can also lead to adverse effects,

such as vicarious or secondary traumatization.

Vicarious traumatization (VT) is "the transformation that occurs within the

therapist [or trauma worker] as a result of empathetic engagement with clients' trauma

experiences and their squeal" (Pearlman & Mac Ian, 1995, p.1). The effects of vicarious

trauma can lead to a change in the way that the social worker experiences him/herself,

others, and the world in general (Pearlman & Mac Ian, 1995). It can lead the social

worker to experience a disrupted frame of reference, changes in identity, alterations in

sensory experiences (i.e. intrusive images, dissociation, and depersonalization), and

disrupted psychological needs and cognitive schemas (Saakvatine & Pearlman, 1996).

Other areas that changes are often seen in are self-trust, (one's belief in terms of trust in

their own judgments and perceptions of reality), self-intimacy (belief of feeling that one

can connect to oneself), and self-esteem (one's belief of whether or not they are

valuable) (Pearlman & Mac Ian, 1995).

It has been thought that several different factors play into the experience of

vicarious trauma. Some believe that it is the empathetic engagement with clients that

impacts a social worker's experience with VT (Pearlman & Mac Ian, 1995; Pearlman &

Saakvitne, 1995). Others believe that it is due to the transference, countertransference,

identification, and projective identification (through internalizing clients' experiences)

that take place in clinical work with clients (Cerney, 1995).

Researchers have also looked into whether or not factors outside of the social

worker/client relationship impact VT. Several researchers have found a positive

relationship between the worker having a history of trauma him or herself and later

experiencing VT as a result of his/her work (Bober & Regehr, 2005; Cunningham, 2003;

Pearlman & Mac Ian, 1995; and VanDeusen & Way, 2006). This suggests that social

workers that have personal histories of trauma could be more susceptible to

experiencing VT as a result of working with trauma survivors. Researchers have also

noted that having large caseloads of trauma survivors has shown to increase PTSD-like

symptoms in social workers (Schauben & Frazier, 1995).

Some of the negative impacts that VT can create in the workplace include: re-

traumatization or reinforcement of clients' negative beliefs about themselves; missed

phone calls and or appointments; failure to complete required work duties due to

withdrawing; and violating boundaries in supervisor and client/worker relationships

(Pearlman & Saakvitne, 1995).

Another impact that working with trauma survivors can have on social workers

is secondary traumatic stress (STS). Secondary traumatic stress is similar to vicarious

trauma in that they both occur due to working with trauma survivors. Secondary

traumatic stress is often defined as the outcomes similar to Posttraumatic Stress

Disorder that can occur as a result of working with trauma survivors (Pearlman &

Saakvitne, 1995). Posttraumatic Stress Disorder can include symptoms of recurrent

and intrusive recollections of a traumatic event; dreams about the traumatic event;

physiological reactivity when exposed to triggering stimuli; and acting or feeling as if

the event is happening again (American Psychiatric Association, 2000).

Some previous literature has differentiated between the terms vicarious trauma

and secondary traumatic stress (STS), while others have used them interchangeably.

Given the close nature of VT and STS, both will be used when exploring literature on VT.

In respect of previous literature, when citing others' work, the specific terms used in

previous literature will also be used in this paper.

Given the negative consequences that vicarious trauma can have on social

workers' personal and professional lives, as well as the lives of their clients, families,

friends, and colleagues, it is important to recognize ways to try to prevent VT from

occurring, and also to develop strategies for reducing VT once it has already occurred.

Catherall (1995) suggested that virtually everyone is responsible for preventing

vicarious trauma (VT). By this, he meant that it is not only up to the individual social

worker, but that it is also up to the agency that employs the social worker. When

exploring that idea, the current study found that much of the previous literature has

focused on individual methods for prevention and treatment, while only a small body of

literature has focused on agency level interventions for preventing vicarious trauma. A

large portion of that literature is also theoretical, rather than empirical research. The

current paper will then focus on determining what strategies agencies are using to

prevent social workers from experiencing vicarious trauma, as well as what strategies

are used to treat vicarious trauma once experienced.

Literature Review

As previously noted, much of the current literature has focused on individual-level strategies for preventing and treating VT, while only a small body of literature has focused on agency-level interventions. The following two sections will review the literature that exists for both individual and agency-level interventions.

Individual Strategies

Prevention Strategies. A large body of literature currently exists on strategies that can be used to prevent VT. The majority of the literature that does exist, however, is theoretical. As will be discussed throughout the current paper, the majority of the literature also focuses on self-care methods as a means of preventing VT. The few studies that have assessed whether or not self-care strategies are beneficial in preventing VT have found mixed results.

Empirical literature on prevention strategies. A study done by Bober and Regehr (2005) found no relationship between scores on a traumatic stress inventory and the amount of time that participants spent engaging in leisurely activities, self-care, supervision, and research and development. This study then suggested that those methods are only recommendations and are not actually shown to prevent VT or STS.

A study done by Schauben and Frazier (1995), however, looked the relationship between types of coping strategies used and the outcomes of trauma symptoms after using those strategies. The researchers found the use of positive coping strategies (i.e. seeking emotional support or doing something about the problem) to be positively associated with lower symptoms of vicarious trauma in participants who worked with sexual violence survivors. They also found the use of negative coping mechanisms (i.e.

drugs) to be related with higher symptoms of VT. This could potentially be because those who were most traumatized were also more likely to use drugs as a means of coping with their trauma; it could also be that their drug use impacted their perceptions of the trauma, thus making the trauma feel worse.

Way, VanDeusen, Martin, Applegate, and Jandle (2004) also looked at the relationship between positive and negative coping strategies and the amount of distress that clinicians experienced. That study found that clinicians who experienced greater distress from trauma were also more likely to use both positive and negative coping strategies, suggesting that clinicians who experience distress from working with trauma survivors are more likely to be actively using some type of strategy, whether positive or negative, to cope with the distress. The study did not, however, determine whether or not the strategies were successful in preventing VT.

One last study looked at whether or not the amount of social support the participant had influenced their level of STS. The results of the study showed a negative relationship between the amount of social support the participant had and his/her level of STS (Ortlepp & Friedman, 2002), meaning that those who had greater social support also had lower levels of STS. The mixed finding among the previous studies suggest that further research needs to be done to determine whether or not self-care practices are helpful in preventing VT.

Theoretical preventative strategies. The remaining literature that was explored for the current study on preventing VT focused on logical or theoretical methods, much of which stems from the idea of self-care. One widely agreed upon self-care method that is thought to help prevent VT is to maintain a balance between

professional and personal lives (Cerney, 1995; Harrison & Westwood, 2009; Iliffe &

Steed, 2000; Saakvatine & Pearlman, 1996; Schauben & Frazier, 1995; Yassen, 1995).

This could include balancing professional activities, such as appointments with clients,

with non-professional leisurely activities, such as reading a book for pleasure.

Balancing fun activities with professional tasks can help by providing relief from the

traumatic experiences that clients share. Some authors also suggest that along with

balancing personal and professional lives, social workers should also balance their

work schedules to include breaks between sessions or meetings with trauma survivors

(Pearlman & Saakvitne, 1995; Saakvatine & Pearlman, 1996) and should take advantage

of annual vacation allowances (Iliffe & Steed, 2000). Taking frequent breaks between

working with individual clients can provide the social worker a period of personal time

in which he/she is able to engage in non-emotionally impacting tasks.

Maintaining physical and mental health has also been recommended by

researchers as a way to prevent VT (Cerney, 1995; Schauben & Frazier, 1995; Iliffe &

Steed, 2000; Yassen, 1995). This can be done through adequate eating, sleeping, and

physical exercise. It has been recognized that regular exercise can have positive

impacts on depression and anxiety (Landers, n.d.). It is no surprise then that social

workers have recognized the importance in these activities as a means to preventing

VT.

Along the same lines of maintaining mental health comes the idea of attending to

spiritual practices. Being active in spiritual practices and meditation (Pearlman &

Saakvitne, 1995; Schauben & Frazier, 1995; Yassen, 1995), and creating meaning in life

(Harrison & Westwood, 2009; Pearlman & Saakvitne, 1995; Saakvatine & Pearlman,

1996) were also acknowledged as good modalities to utilize in preventing VT. Creating

meaning can help remind social workers what values they hold in life, and why this type

of work is important to them. This could perhaps be a factor that increases resilience in

social workers, and thus works to prevent VT.

Another strategy that has been suggested by multiple authors as a means of

preventing VT is to seek out peer consultation or supervision (Pearlman & Saakvitne,

1995; Schauben & Frazier, 1995; Cerney, 1995; Yassen, 1995). Consultation can be

beneficial as it allows a person to release some of the traumatic stories that they are

holding for their clients through sharing them with others (Saakvatine & Pearlman,

1996). Consultation could include formal group consultation, a five-minute chat with a

co-worker, or supervision with a more experienced social worker.

Not only is it important to have professional support, it is also important to have

personal emotional support. Spending time with family and friends as a means of

receiving emotional support has been suggested as beneficial for social workers

working with trauma survivors (Schauben & Frazier, 1995; Yassen, 1995). Perhaps this

is because it allows for a separation between work and personal life. Along similar

lines, Ryan and Cunningham (2007) suggested that social workers that work with

children who have been abused should try to spend time with children who have not

been abused. This is thought to help the worker to maintain an idea of what typical

child behavior and development look like. This could also be beneficial in helping social

workers separate their personal life from their professional life.

Other, less unanimously, noted strategies for preventing vicarious trauma

include participating in activism or community activities (Saakvatine and Pearlman,

1996; Yassen, 1995); being emotionally available and empathetic while allowing for some detachedness from the traumatic material (could be thought of as setting emotional boundaries) (Rothschild, 2006); and maintaining a realistic idea of the number of, and types of, cases that can be taken on (Cerney, 1995).

Coping strategies. Along with understanding ways to prevent VT, individual social workers should also recognize different strategies that they can use to cope with VT once experienced. The body of literature that exists on ways to cope with VT is virtually all theoretical. Saakvatine and Pearlman (1995) discussed the importance of being able to recognize how the social worker is being impacted by the trauma, in terms of his/her intimacy, trust, esteem, safety, and control. For example, it would be appropriate to explore the social workers' sense of intimacy in terms of how connected they feel to themselves and others; their sense of trust in terms of how much they trust their own judgments and perceptions, and how much they feel they can rely on others; their beliefs on how valuable they feel they are and how valuable they think others feel they are (esteem); their safety based on their beliefs of how secure or vulnerable they are to harm (Pearlman & Mac Ian, 1995); and their control in terms of how much control they feel they have over their life circumstances. Once identified, the social worker can then challenge his/her negative beliefs as a means of transforming them into positive self or world perceptions (Pearlman & Saakvatine, 1996). This could potentially be done through practicing affirmations, or through processing the negative beliefs in supervision and determining their relation to their work with their clients.

Another strategy discussed throughout the literature is the idea of seeking out mental health services (Pearlman & Saakvatine, 1995; Ryan & Cunningham, 2007;

Yassen, 1995). Although it could be difficult for some social works to utilize services in

their own area of expertise, therapy has shown to be beneficial for clients who have

experienced severe trauma, and thus would also likely be beneficial for reducing VT in

social workers.

Agency Level Strategies

Given the fact that agencies will be impacted by employees who are experiencing

vicarious trauma, it is important for them to recognize and accept that VT does exist

(Hesse, 2002). It is also important to recognize that VT will impact not only the

employee and the agency, but that it could also impact the individual clients and

families that the social worker treats (Hesse, 2002). Since preventing VT is therefore in

the best interest of the client and the therapist (Hesse, 2002), it is important for

agencies and employers to be involved in taking precaution and preventative measures

against VT (Harrison & Westwook, 2009; Trippany, White Kress, Wilcoxon, 2004).

Similar to the literature on individual-level strategies that can be used to prevent VT,

the current body of literature that exists on agency level approaches of preventing VT is

mostly theoretical.

Empirical literature on preventative strategies. Schauben and Frazier

(1995) compared the percentage of sexual violence survivors on the counselors'

caseloads with their level of psychological distress, and found that counselors who had

higher percentages of trauma survivors on their caseload also showed more PTSD-like

symptoms than those with lower percentages of trauma survivors on their caseload.

This suggests that the number of clients that are trauma survivors on a social worker's

caseload can impact his/her experience with VT. This is also consistent with some of

the theory that exists, which says that social work management should try to diversify the caseloads that their employees are taking on (Bell, Kulkarni & Dalton, 2003; Catherall, 1995; Trippany, White Kress, & Wilcoxon, 2004), meaning that employers should minimize the number of trauma clients that employees see back to back. For example seeing five clients in a row who have experienced immense trauma is probably more likely to increase the social worker's risk of VT than seeing two trauma clients and three clients with other concerns.

Theoretical preventative strategies. The remainder of the literature that exists on agency-level interventions for preventing VT is theoretical. The most commonly recommended methods aimed towards agencies with the goal of preventing VT include providing support (Catherall, 1995; Naturale, 2007; Pearlman & Saakvitne, 1995; Saakvatine & Pearlman, 1996; VanDeusen & Way, 2006) and providing education to employees (Hesse, 2002; Pearlman & Saakvatine, 1995; Schauben & Frazier, 1995; Saakvatine & Pearlman, 1996; Trippany, White Kress, Wilcoxon, 2004; Way, VanDeusen, Martin, Applegate & Jandle, 2004). Catherall (1995) suggests that agencies should provide experiences for trauma workers to engage in group discussions about feelings and impacts of working with clients. Discussing how their clients' experiences are impacting them can help by normalizing their feelings as they may recognize that others are also being impacted in a similar manner. It should also be considered a concern of the group as a whole, rather than an individual pathology (Catherall, 1995).

Along similar lines is the idea of case consultation. Saakvatine and Pearlman (1996) suggest that time should be set-aside for workers to engage in regular case consultation and supervision. This again allows social workers to release some of the

traumatic stories they hold in through talking to others. They can also then bounce ideas back and forth on what may be helpful when working with clients as a means of reducing the impact that their clients' traumatic stories.

Another commonly recommended strategy that can be used at the agency-level to prevent VT from occurring is education. One suggestion in terms of increasing education is to provide and mandate specialized training sessions to inform employees of the risks associated with working with survivors of trauma (Pearlman & Saakvitne, 1995; Trippany, Way, VanDeusen, Martin, Applegate, & Jandle, 2004; White Kress, Wilconon, 2004). Included in this training could be information on what VT is and who is impacted, what the symptoms are, and what can be done to prevent VT. It has also been suggested that leaders in agencies should encourage their employees to participate in continuing education surrounding the concept of vicarious trauma (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Schauben & Frazier, 1995). Employers could even go as far as to organize continuing education for their employees and perhaps incorporate VT into a conference. Vicarious trauma could also be an educational discussion brought up my management during staff meetings (Saakvatine & Pearlman, 1996).

Environmental level methods that organizations can use to try to prevent VT are to develop a cohesive sense of community in the agency (i.e. through celebrating birthdays, developing newsletters, or hosting a book club) (Hesse, 2002; Pearlman & Saakvitne, 1995); to decorate the environment in a manner that conveys safety, comfort, beauty (Saakvatine & Pearlman, 1996); and to encourage respect (Pearlman & Saakvitne, 1995);

Other suggested methods include ensuring that social workers are provided benefits that include adequate mental health coverage (Bell, Kulkarni & Dalton, 2003; Pearlman & Saakvitne, 1995), and paid time off (Saakvatine & Pearlman, 1996). Catherall (1995) also suggests that employers should implement a prevention program for VT that includes (1) trying to determine how much VT exists in their workplace, (2) a plan of how often VT should be addressed and how support should be given, (3) psychoeducation on VT, (4) preparedness in how the plan will be administered, and (5) an evaluation of the set program. Having a program designed specifically to prevent VT is likely to help prepare workers in terms of what the potential effects could be and what actions will be taken.

Given the need for expanded knowledge on methods for preventing VT, that much of the previous literature is theoretical and has focused specifically on what individuals, rather than agencies are doing to prevent VT, and that the research that does exist is contradictory, the current paper will focus on determining what strategies agencies are using to prevent social workers from experiencing vicarious trauma, as well as what strategies are used to treat vicarious trauma once experienced.

<div align="center">**Conceptual Framework**</div>

The theoretical frameworks that will be used in the current study are the Generalist Perspective and the Strengths Perspective. Both theories are deeply rooted in social values, and are foundations for social work practice.

Generalist Perspective

The Generalist Perspective is a holistic approach to social work that binds together multiple theories as a lens for social workers to view world around them.

When working with clients, social workers bring their Generalist Perspective with them as a means of making sense out of their clients' situations. They then use their Generalist Practice methods to develop interventions appropriate for their individual clients' needs (Timberlake, Farber & Sabatino, 2002). The goal of the Generalists Perspective is to be able to use different approaches in multiple different practice settings with a diverse body of clients.

The Generalist Perspective focuses on working with clients and developing appropriate interventions at the micro (individual, family, or small groups), mezzo (teams, organizations, or networks) and macro (community, institutional, and societal) levels (Miley, 2011). This study aims to seek out intervention and prevention strategies that agencies (mezzo) are using to prevent and treat VT. It is also hoped that the findings from the current study can be used by various types of agencies that employ social workers working with trauma survivors (i.e. mental health clinics, hospitals, social service agencies, child protection agencies, crisis centers, and domestic violence shelters, among others).

Strengths Perspective

The Strengths Perspective, a sub-theory of the Generalist Perspective, is the second theoretical framework that will be used in the current study. It "assumes that every client [agency] has the capacity for growth and change" (Miley, 2011, p. 74). The Strengths Perspective looks at individuals and agencies in terms of their capacities, talents, competencies, possibilities, visions, values, and hopes, rather than at their problems and pathologies (Saleeby, 1996).

There are three different primary assumptions of the strengths perspective that give it a base for working with clients. The three assumptions are:

1. It acknowledges that clients have resources and knowledge that can be drawn upon and used as needed,

2. It supports the idea of magnifying mastery and competency, rather than deficits, and

3. It recognizes that problems occur between systems, rather than due to specific individuals or systems (Miley, 2011).

Saleeby (1996), through reviewing literature, composed a list of words that are often associated with the strengths perspective. He found that social workers that use the Strengths Perspective work with clients on finding resources that are available to them; they then *empower* their clients to use those resources. They also look to clients' pasts to determine what has helped them to be *resilient* when working through previous difficult situations. Lastly, social workers help clients recognize their *membership*, as a means of fighting feelings of oppression (Saleeby, 1996). The strengths perspective thus focuses on looking at the positive characteristics and resources of the client, and uses those to help the client move forward.

The current study will use the strengths perspective in developing interview questions that seek out what agencies are currently doing, and have found to be beneficial, to prevent and treat vicarious trauma. The strengths perspective will also be used through the paper as a framework for language. For example, when describing the trauma clients that social workers work with, they will be referred to as trauma survivors, rather than victims of trauma.

Methods

Research Question

What strategies are agencies using to prevent social workers from being impacted by vicarious trauma, and what are they doing to treat social workers already experiencing vicarious trauma?

Research Design

Data for this study was collected through qualitative interviewing. Qualitative research was chosen as a method of data collection rather than quantitative, as according to Monette, Sullivan, and DeJong (2011), qualitative interviews allow for a deep, rich understanding of the topic. It also allows participants to respond and expand on their responses, which is important in understanding specifically what participants mean when answering questions.

Sample

Five participants were recruited to participate in the current study though non-probability purposive sampling. Participants were selected based on their work with trauma survivors in agencies located throughout St. Paul, Minneapolis, and the surrounding suburbs. Participants were selected from multiple different types of agencies, including inpatient mental health residential treatment facilities, outpatient mental health clinics, and crisis centers. Specific agencies and participants were located through a basic Internet search looking for agencies that work with survivors of trauma. Four of the participants had professional backgrounds in social work, while one participant had a professional background in marriage and family therapy. Four of the participants were female, while the fifth participant was a male. Three of the

participants stated throughout the interviews that they were supervisors in their

agencies. It is unclear whether or not the other two participants were supervisors at

their agencies, as this the status in the agency was not asked during the interviews.

Potential participants were initially contacted by letter (see appendix), which provided

a brief background of the study. Following the initial letter contact, participants were

then contacted via phone to be formally invited to participate in the study.

Procedure

Once recruited, participants participated in either an in-person, or a phone

interview. The interviews took between 15 and 35 minutes each. Three of the

interviews were audio recorded, while two of the interviews were not recorded due to a

malfunction of the audio recorder. The focus of the interviews surrounded the topics of

what the agencies are doing to prevent/treat vicarious trauma, and what the

participants felt should be done to further prevent VT. All of the interview questions

were extracted from previous research described in the literature review. Care was

given to ensure that each of the questions were reliable and valid. The following is a list

of the specific questions that participants were asked during the interview. The

questions are listed below in the order in which they were asked during the interviews.

- In what ways does your agency support clients who have experienced trauma?

- Does your agency provide any special training on the impacts that working with
  trauma survivors can have?

- Does your agency have any programs implemented to prevent vicarious trauma?
  What about treating vicarious trauma?

- Does your agency have a policy regarding how many clients you can see in a day? What about trauma clients?

- How has your agency encouraged self-care?

- What type of benefits does your agency provide you?

- Does your agency provide supervision that focuses on employees' needs that result from their experiences of working with trauma survivors? If so, how often?

- Does your agency provide any discussion or support groups for social workers?

- Does your agency require social workers to participate in peer case consultation regarding their clients who have shared traumatic stories?

- Does your agency encourage continuing education surrounding the impacts of working with trauma survivors?

- What do you feel would be beneficial at the agency level to further prevent vicarious trauma?

Human Subjects

To minimize distress in participants, the researcher has carefully worded interview questions to maintain the focus at the agency level, rather than the individual level. The interview questions did not ask participants to discuss any personal experiences with VT, nor did they ask them to identify strategies that participants individually use to prevent or cope with VT. In addition, participants were notified of their ability to withdraw from the study at any time during the interview.

Along with attempting to minimize distress in participants, all identifying information about the participants was kept confidential. The only way that

participants could potentially be identified was through voice recognition in the audio-recorded interviews. To prevent participant identities from being revealed, interviews were recorded directly onto the researcher's computer. Once saved, the audio recordings required a password to be opened. Transcriptions of the audio-recordings were also kept on the researcher's computer, and also required a password to be accessed.

Limitations of Study

One of the major limitations of the current study was the sample size. It was hoped for that the current study could recruit a minimum of 10 participants, however, due to time restrictions in data collection, the researcher was only able to obtain five participants. Given the sample size of five participants, and that participants were recruited though non-probability purposive sampling, the data from this study should not be generalized.

Another limitation of the current study is researcher bias. The only apparent bias in the current study is the belief that agencies should have programs set in place to prevent social workers from being impacted by their clients' trauma. To prevent this bias from impacting participant responses, questions were asked verbatim in each interview. The researcher also attempted to minimize all reactions to participant responses given. When analyzing the data, the researcher attempted to minimize all biases through developing a coding scheme to ensure that all interviews were coded equally.

A third limitation to this study is that during two of the five interviews, the audio recorder malfunctioned and did not record the interviews. Due to the malfunction,

interview transcriptions were developed based on field notes taken throughout the

interviews. To minimize bias while transcribing, only information that was specifically

written down as field notes was included in the transcriptions, and all other

information was excluded as a means of preventing manipulation of the data.

Data Analysis

To analyze the data, the audio recordings were transcribed verbatim.

Transcriptions were developed for the two interviews that were unable to be recorded

based on the specific phrases noted in the case notes. Due to the lack accuracy, quotes

from those two interviews were not used in the results section of this paper. Once

transcribed, the researcher used content analysis to code the data and develop common

themes (Monette, Sullivan, & SeJong, 2007). Several common themes and sub-themes

emerged throughout the five different interviews.

<div align="center">

Results

</div>

After analyzing the data, multiple themes emerged among the five interviews.

The themes were then grouped together to form four major themes, with multiple sub-

themes. The major themes include: *supervision, training*, *self-care*, and *agency policies*

and procedures. Each of the themes and sub-themes will be discussed in this section.

Supervision

The respondents stated that supervision was frequently used at their agencies to

overcome any challenges related to vicarious trauma. When analyzing the data on

supervision, two sub-themes emerged. The sub-themes include: *clinical supervision* and

consultation.

Clinical supervision. Clinical supervision was a topic that nearly all of the participants spoke of immediately when asked about what their agencies are doing to prevent vicarious trauma. The responses from the participants posed two different ideas on the use of supervision; one was the idea of using supervision for both the staff members' needs and the clients' needs (i.e. to focus on vicarious trauma or countertransference), while the other focused on using supervision solely for the purpose of discussing the clients' needs.

Three of the participants said that their agencies encourage them to discuss during supervision how they are being impacted by their clients' trauma stories, while one participant said that she felt there is a fine line between supervision for clients' needs and the therapists' personal needs. The fifth participant said that he does not receive any type of supervision in his agency (due to his level of licensure).

Two of the participants said that during supervision staff members are encouraged to consider and openly discuss any feelings of countertransference or transference, as well as to discuss how they are being impacted by their clients' trauma. One of these participants, who is a clinical supervisor at her agency, stated:

> *I think that any of their clients' stories can be very very compelling for any one of us, and so to really look at transference and countertransference* [is important in supervision]. *We try to deal not only with taking good care of the client, but saying also 'this is wonderful that you're having those feelings, and this is something you wanna look at not only now but in the future, because I wonder what else you might be feeling, and what you might be feeling about yourself.'*

Another participant, who is also a clinical supervisor, spoke of the importance of discussing how trauma stories are impacting staff members:

We discuss their interactions with the clients, and if a trauma story comes

up or if it happens in some of their countertransference... if there's

interactions that are triggering the staff, I try to be on top of that as much

as possible. Ya know, we talk about it.

One participant said that she felt it was important for all staff to receive clinical supervision as a means of reducing and/or preventing vicarious trauma. She said "*all clinicians have weekly supervision, regardless of their level of license or requirement to have supervision. This is important as it allows us to talk about our cases and how we're being impacted.*" So at her agency, social workers licensed at the LICSW level (meaning social workers who have at least two years of full-time clinical experience and are not required to receive supervision) still receive clinical supervision as a means of addressing vicarious trauma as well as any other impacts that working with trauma survivors can have on the clinician.

The same participant also said that her agency tracks whether clinicians are "at-risk" for experiencing vicarious trauma, and that if it is determined a clinician is experiencing vicarious trauma symptoms, they move forward to determine whether or not it is appropriate to make a referral to an outside agency for further support.

As noted above, one participant discussed her stance on supervision as being focused on the clients' needs, rather than specifically on the social workers' needs. This participant stated:

Implicitly we do [focus on the social workers' needs in supervision as a

result of working with survivors of trauma], *but not explicitly. I think*

there's a fine line in what is clinical supervision, so I would say to a degree

[we do]*, but not beyond what would become a dual relationship, I guess I*

would say.

Her response to the question suggests that the majority of the supervision

sessions at her agency focus specifically on the client, rather than also on the

staff members' needs as a result of working with trauma.

Consultation. Consultation is another area of supervision that was

discussed by all of the participants. All of the participants said that their

agencies require them to participate in consultation either weekly or bi-weekly.

While they all said that they are mandated to participate in consultation, only

one participant said that her agency encourages staff members to discuss how

they are being impacted by their clients' trauma. The other four participants

said that their consultation groups are specifically focused on the needs of their

clients, or on how their clients are being impacted by their trauma, rather than

how they are being impacted by their clients' trauma stories. One participant

also said that her agency has consultation groups designed specifically towards

trauma-focused treatment modalities, but that those consult groups are focused

on the clients' needs.

The one participant said that her agency uses consultation to focus on

both the needs of her clients and her personal needs. She stated:

> *What it does provide me is a wonderful set of colleagues that I could use as*
>
> *a professional to seek consultation. I think they certainly encourage*
>
> *anything I need, like taking time off, continuing my education, and being*
>
> *available for each other to talk through* [staff] *issues.*

The same participant said that there are also typically staff members available to

consult with, if needed, outside of the regular scheduled consult group. This was noted

through her statement:

> *We have an open door policy… I think we always try to listen for what's*
>
> *happening with the* [staff] *around the issues they have. Often after sessions,*
>
> *because they're very complex with the immigrants and refugees and*
>
> *sometimes we have interpreters too, sometimes there's just a little bit of*
>
> *time taken to just kind of shake your head out and talk about what was*
>
> *heard and going on.*

Two participants spoke positively about trauma-focused consultation groups,

and how they feel that having consultation groups dedicated specifically to working

with trauma is beneficial. One participant said that since the majority of the population

served at her agency has experienced either chronic or acute trauma, the agency has

three different consult groups. She said that there is a general consult group, a consult

group for clinicians who do Eye Movement Desensitization Reprocessing therapy, and a

third consult group for clinicians who do Trauma-Focused Cognitive Behavioral

Therapy.

Another participant, who does not have a trauma-focused consultation group at

his current agency discussed his positive experience with having one at a different

agency. He said that as a result of not having one, him and a group of colleagues outside

of his place of employment decided to develop a separate consult group to meet their

personal needs. He said that when the group meets, they are open to discussing how

they are being impacted by their clients, and to give and receive feedback to and from

other clinicians.

The results of the study showed that two agencies provided both supervision

and consultation that focused on the needs of the staff as a result of working with

survivors of trauma, while one agency provided only supervision that focused on the

staff members' needs. The other two participants said that their agencies provide

neither supervision nor consultation that focuses on the needs of the staff as a result of

working with survivors of trauma. One of the two participants stated that she felt that

providing supervision surrounding the social workers' needs would be a violation of

boundaries in the supervisory relationship.

Training

Training is another theme that emerged throughout the interviews with regards

to what agencies are doing to prevent / reduce vicarious trauma. The two sub-themes

that emerged are *trauma-focused training* and *continuing education.* Specifically,

trauma-focused training relates to what agencies are doing initially to teach their staff

members about the impacts of vicarious trauma and trauma in general, while

continuing education focused more on whether the agencies are encouraging their staff

to seek out continuing education around the concept of vicarious trauma.

Trauma focused training. Four of the five participants said that their agencies

provides staff members with training specifically on trauma and the impacts that

working with survivors of trauma can have on clinicians. For example, one participant,

who is also a supervisor at her agency, said that one of the first things she talks about

with new staff is the impact of working with trauma. She said that she often uses a

metaphor to help them understand:

> *'You know when you're working in a hospital and things are contagious,*
>
> *you kind of have to beef up your immune system. Well it's the same way* [in]
>
> *that our clients can't help but impact us, so we have to have support outside*
>
> *of work, and even inside of work with one another about how we're doing*
>
> *and coping with everything our clients throw at us.'*

A different participant, whose agency employs staff from multiple different professions,

said that her agency hosts in-service trainings for their new clinical staff, as well as for

the new staff in other professions who may have less training and knowledge on trauma

in general.

 While four participants said that their agencies do provide training on vicarious

trauma, one participant said that his agency did not provide him any training on

vicarious trauma, or on the impacts of working with survivors of trauma. This

participant said that all of his knowledge on vicarious trauma has been learned

independently out of his own curiosity and desire to learn.

 When asked about what they thought could be done at the agency level to

further prevent and/or treat vicarious trauma, three participants responded by saying

that agencies should continue to work towards increasing awareness on vicarious

trauma including what it is and how it impacts professionals. One participant stated:

Promoting [knowledge on vicarious trauma] *a little bit more and letting*

people know it's okay and that it's a given; it's an occupational hazard of

the job. So really talking about it more, so of 'it's not a matter of if it's

gonna happen, but when it's gonna happen.'

Continuing education. Along with talking broadly about what their agencies

do upon hire to teach them about the impacts of vicarious trauma, participants also

talked about how their agencies encourage continuing education. All of the participants

said that their agencies encourage them to participate in continuing education,

however, only three participants said that their agencies encourages continuing

education focused on trauma and the impacts that trauma can have on clinicians. Two

participants said that their agencies offer in-service trainings to clinical staff that focus

on vicarious trauma. One of the participants, however, said that the trainings are often

off-site, making them inaccessible to many clinical staff. The second participant said

that not only does her agency offer in-services on vicarious trauma at the office, but

they also offer retreats for clinical staff to participate in, many of which focus on the

impacts of trauma on the professional.

While these were the only participants that said their agencies provide them

with continuing education focusing specifically on vicarious trauma, two other

participants said that their agencies encourage continuing education on trauma in

general. One participant said that her agency encourages all of their staff to seek out

continuing education on trauma regarding their clientele population. She said "*so*

trauma with children, trauma with the elderly. 'Do you have SPMI clientele', and whether

there are traumas that they experienced. 'Are they homeless or victims of sexual assault

or abuse?'

When asked what would be beneficial at the agency level to further prevent

vicarious trauma, one of the participants recommended increasing education on

vicarious trauma: "*I think that continuing to educate staff on vicarious trauma would be*

helpful, and also making them more aware of what they may be experiencing. I would

also like to see the agency continue to institutionalize services, like in-service trainings."

One participant also said that her agency provides her a yearly stipend to use towards

continuing education. She said that her agency pays for her first $500 in continuing

education units, as a means of encouraging her to stay up to date.

Self-Care

A third major theme that emerged throughout the interviews was self-care.

Specifically participants frequently spoke about how their agencies are promoting and

encouraging self-care. The theme of self-care was broken down into two sub-themes of

general self-care and *agency-focused self-care*.

General self-care. Four of the participants said that self-care is strongly

encouraged by their agencies, with two of them saying that self-care is addressed

almost immediately upon hire. One of the participants stated "*Well I think it's one of the*

first things we talk about." Another participant said:

> *We talk about it a lot. We encourage it. We have people identify* [self-care
>
> strategies]*. Even on the point of an interview, we talk about it. So we talk*
>
> *with our staff about what they do to keep themselves healthy through*
>
> *some of these difficult work environments. So it's really about self-*

> *identifying. It's about giving people opportunities if they're having a tough*
>
> *situation or something impacts them directly, we encourage them to take*
>
> *time off or look at their needs.*

Three participants also said that self-care is addressed through supervision, in which the supervisee and supervisor look at how the staff is being impacted and their situation, and then develop a plan as to how the staff member can increase their self-care. The same three participants said that they encourage their staff members to seek out outside sources or to take time off as needed. One participant said that while she is doing supervision, she is also assessing for signs of vicarious trauma:

> *Like twice I've referred people that I've been in supervision with to the*
>
> *Walk-in Counseling Center, or to more long-term counseling. Once I've*
>
> *even hospitalized a staff who was exhibiting plans of suicidality and*
>
> *couldn't contract for safety. So when I'm doing supervision, I'm kinda*
>
> *assessing for all the signs, and if it's getting out of hand and maybe more*
>
> *than we can contain at our agency level.*

Another participant, who is a supervisor at her agency, said that while she is supervising, she tries to help her supervisees understand the reality of their duties and capabilities as social workers, and also encourages self-care:

> *I used to say to the people I supervised 'you have this many social work*
>
> *hours. If you burn the candle at both ends, and make your boundaries too*
>
> *permeable and try to be a savior, you're not gonna last in social work. So*
>
> *go home, have a life, have friends, do things that are fun, and use*

supervision.' I didn't have a self-care regimen, but I think I did have a self-

care mentality.

Agency focused self-care. In terms of what is being done specifically at the

agency level to increase self-care and mindfulness, two participants said that their

agencies have programs implemented towards self-care.   Both of the participants said

that their agencies have daily walking groups to encourage staff to take a break away

from their jobs. One participant said that her agency also has a fitness group and a

health group, while the other said that her agency has also developed a yoga group. The

same participant said that her agency has also contracted with an outside acupuncturist

that goes to her agency twice a week to provide acupuncture:

[My agency] *is really big into health wellness; that's like our thing. We are*

building a wellness center. Right now we have over in our admin building…

space where an acupuncturist comes in and has time twice a week for

clients and also twice a week for staff. So they can go in and get

acupuncture for free.

Agency Policies and Procedures

The last common theme that emerged throughout the interviews was agency

policies and procedures. Three subthemes were developed under the general theme of

agency policies and procedures. The sub-themes include: *caseload*, *environment*, and

benefits.

Caseload. Participants were asked if their agencies have any restrictions on

how many clients they can see per day, as well as if there are any restrictions as to how

many trauma-focused clients they could see per day. Three of the participants said that

they have little, if any, control over the makeup of their caseload, while the other two

participants said that there is not specific limit, but that their agencies tend to be

mindful of caseloads.

One of the participants said that rather than having restrictions on how many

clients he can see per week, he is instead required to meet a quota. He said that he

needs to "*meet a 70% quota. Right now I would say that about half of my caseload is*

trauma focused." This means that he needs to spend 70% of his time face to face with

clients, and that about approximately 35% of his time is spent talking with clients who

have survived trauma. Two other participants, that both work in residential facilities,

also said that they are required to meet quotas. One said that her caseload is "*whatever*

the mix is," while the other said *"you couldn't just be like 'I've met my quota for the day so*

your crisis is going to have to wait.' That's just not feasible in this type of setting."

As noted above, the other two participants said that while they do not have

specific policies regulating how much of their caseload is trauma focused, their agencies

tend to be mindful when assigning cases to staff. For example, one participant said, "*I*

think we're very careful… I think as supervisors we try to make sure that things stay in

balance." The other participant said that while the agency does not have a specific

policy as to how many trauma-focused clients they can see, they try to maintain a low

ratio of clients to staff members, and that they recruit volunteers to help support them

and to make the ratio smaller.

Environment. Three of the participants said that they feel that it is important

to develop a work environment that encourages positive communication and strength

among staff. Specifically, two participants said that they try to create cohesiveness in

their environment. One said, "*I think there is a lot of laughter and there's a lot of food,*

and occasions for celebration. I think that's important." A second participant spoke

directly about her role in working towards a positive work environment:

> *I really try to make sure that there is a cohesive system that can support*
>
> *everyone, and if there are issues between co-workers or* [between] *clients*
>
> *and staff, then I adjust the dynamics. I invest a lot of time in building team*
>
> *cohesiveness.*

Along similar lines, a third participant said that she felt it was important to have

a positive and encouraging work environment. She said that her agency takes on an

empowerment approach, in which staff are encouraged to seek out support or outside

services if needed, and that they are commended for seeking additional support:

> *We also try to create a team atmosphere that says our whole approach to*
>
> *working with a family is acknowledging how hard it is to ask for help, and*
>
> *commending clients for actually putting themselves out there in that*
>
> *position. So we really try to also encourage that with our staff as well -*
>
> *that asking for help is a sign of strength is kinda our motto. So not just the*
>
> *families, but with our staff as well.*

Benefits. The last sub-theme that emerged out of the interviews is benefits.

Participants were asked to talk about the benefits that their agencies provide them, and

whether or not their agencies provide mental health coverage for outside treatment, if a

staff member wanted to seek out additional mental health support. Four of the

participants said that their agency provides them with a full package of benefits,

including mental health coverage. The fifth participant said that her agency does not

provide her with those benefits, as she has a full package of benefits provided outside of her agency.

Of the four participants who said that their agency provides them with benefits, three of them said that they are provided with personal time off, rather than vacation time. One participant spoke of this positively by saying:

Our vacation benefits are all personal time off so people can use it for whatever they need it for. So rather than having sick time and vacation time, it's just much more generous in that it can be for whatever. So again, promoting the idea that they're in charge in how they choose to use it.

Finally, in terms of an employee assistance program (EAP), two participants said that they have EAPs offered though their agency. A third participant said that while her agency does not offer an EAP, they do have a committee called Psychological First Aid (PFA). She said that the PFA is a program that staff can use as a resource to talk with somebody who is not their supervisor without fear of consequences or judgment. So although the agency does not offer an EAP, they do have the PFA, which is similar to an EAP.

Discussion

The findings of this study add to the current body of knowledge by comparing what current agencies are doing to prevent and/or treat vicarious trauma with what previous literature has suggested. The findings of this study show mixed results, as several agencies are doing some, but not all, of the strategies suggested in the literature. Several common themes and sub-themes emerged throughout the five interviews. The major themes included supervision, training, self-care, and agency policies and

procedures. Each theme will be discussed in relation to what the literature states on

what can be done to prevent or reduce vicarious trauma.

Supervision

Supervision and consultation. Several participants discussed their agency's

use of both supervision and clinical consultation throughout the interviews, often

noting the value that their agency places on supervision and consultation. Although all

of the participants in this study said that their agencies require consultation and

supervision (aside from one participant who said that he is not required to participate

in supervision due to his level of licensure), only two participants said that staff

members at their agencies are encouraged to discuss feelings of countertransference or

to talk about how they are being impacted by their clients during clinical supervision.

These findings show little support for the findings of Saakvatine and Pearlman (1996),

who suggested that agencies should allow time for staff members to engage in regular

case consultation and supervision as a means of releasing some of the traumatic stories

that they have held in for their clients.

Catherall (1995) suggested that agencies should provide group discussions

about feelings and impacts of working with individuals who have experienced trauma.

This suggestion is also conflicting with the findings of this study, as none of the

participants said that their agencies offer a discussion or support group for staff

members. One participant noted that since his agency does not offer or encourage

discussion about the impacts of working with survivors of trauma, a group of colleagues

and he decided to start up their own consultation/support group.

Training

      Trauma-focused training. A second theme that emerged throughout this study

was vicarious trauma-focused training, specifically on whether or not agencies are

teaching their staff members about the impacts of working with trauma survivors.

Several authors have suggested that agencies should mandate staff members to

participate in vicarious trauma-focused training as a way of increasing awareness and

the ability to identify symptoms (Pearlman & Saakvitne, 1995; Trippany, White Kress, &

Wilconon, 2004; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). The findings of

this study support the recommendations of those studies. Four of the five participants

said that their agencies provided them with training specifically on the types of impacts

that working with survivors of trauma can have on staff members. One participant,

however, said that his agency provided him with no training on the concept of vicarious

trauma, and that all of his knowledge came from his own research and curiosity.

      Continuing education. Encouraging staff members to participate in continuing

education focused on vicarious trauma was recommended multiple times throughout

previous literature as a means continuing to keep staff members up to date on the

current vicarious trauma literature. (Pearlman & Saakvitne, 1995; Schauben & Frazier,

1995; Saakvitne & Pearlman, 1996). The findings of the current study show

inconsistencies with this suggestion, as only three participants said that their agencies

encourage them to focus some of their continuing education units on vicarious trauma.

One participant said that her agency often provides in-services and retreats for staff

members that focus on vicarious trauma. She said that she felt that this was convenient

for staff members. A different participant, however, said that although his agency

encourages and provides training on vicarious trauma, the trainings are often at

different locations that are inaccessible to many staff members. The findings from

these two participant responses suggest that if trainings are accessible, staff will be

more inclined to attend.

Agency policies and procedures

        Caseload. Schauben and Frazier (1995) looked at the relationship between the

number of clients who have survived trauma on a workers' caseload with the amount of

PTSD like symptoms experienced by the worker. The findings of that study showed a

positive relationship, suggesting that workers who have fewer clients who have

experienced trauma are at a lower risk of experiencing PTSD-like symptoms. The

current study found contradicting support for the idea of restricting the number of

survivors of trauma that a staff member can see per day, or have on his/her caseload.

All of the participants said that their agencies pose no restrictions as to how many

clients they can see per day, nor are there any restrictions as to the number of trauma-

focused clients that they can see per day or have on their caseload. Although none of

the participants said that their agency enforces restrictions, two participants said that

their agency tries to be mindful of caseload sizes.

        Benefits. Previous literature has also suggested that agencies should provide

benefits for staff members, including adequate mental health coverage (Bell, Kulkarni &

Dalton, 2003; Pearlman & Saakvitne, 1995), and paid time off (Saakvatine & Pearlman,

1996). The findings of the current study were consistent with these suggestions. Four

of the participants said that they have mental health coverage and paid time off/paid

vacation through their agency.

Although it was not discussed in the literature, two participants also noted that they are offered an Employee Assistance Program (EAP) through their agency. A third participant said that her agency has a program called Psychological First Aid, in which she described as being similar to an EAP. So not only do those three participants have mental health insurance, they also have the opportunity to take advantage of a limited number of therapy sessions without their insurance benefits being impacting.

Agency environment. Several authors have discussed the importance of having a positive work environment. Hesse (2002), and Pearlman and Saakvitne (1995), have suggested that agencies work to develop a cohesive sense of community among staff members to better facilitate a positive and supportive environment. The current study found mixed findings between the data in this study and what has been suggested in previous literature, as only three participants said that they feel that their agency strives towards a cohesive environment. One of these participants, however, said that she works hard as a supervisor to develop team building activities to bring the staff members closer together, while the other said that her agency often shares food and laughter as a way to take a break from any stress.

Self-Care

Self-care was the final theme that emerged throughout the five interviews. Although little, if any, previous literature has talked about the importance of agencies encouraging staff members to engage in self-care strategies, four of the five participants in this study said that their agencies strongly encourage them to utilize self-care mechanisms. Two of these four participants said that self-care is one of the first things that supervisors talk about with newly hired supervisees. Three of them also said that

self-care is frequently addressed in supervision regarding what staff members are

doing to care for themselves, and what staff members could be doing to better improve

their self-care (i.e. time off, more intense treatment, healthy eating, exercising).

Although self-care was not discussed as being recommended at the agency-level

in previous literature, several authors have recommended that individuals engage in

self-care themselves. Few empirical studies have been done, however, those that have

been done have found mixed results as to whether or not self-care is helpful in

preventing or reducing vicarious trauma. One study found no relationship between

scores on the traumatic stress inventory and the amount of time the participants

engaged in self-care or leisurely activities (Bober & Regehr, 2005). This is in contrast

with other research that has shown positive coping strategies at the individual-level

(i.e. seeking out support, exercising, balancing activities) to be associated with lower

vicarious trauma symptoms (Schauben & Frazier, 1995; Orlepp & Friedman, 2002).

Given the lack of research on this topic, and the conflict between studies, it has not yet

been determined whether or not self-care is helpful in preventing vicarious trauma.

Implications

Based on the findings of this study in combination with previous research,

several implications have been developed. In terms of practice, it is recommended that

agencies encourage staff members to discuss feelings of how they are being impacted

by their clients in supervision and consultation. If this is not possible, perhaps agencies

could facilitate a separate consultation or discussion group that allows staff to receive

support in working with their clients. Staff members could also develop their own

consultation groups, as one participant in this study did, to meet the needs of receiving

support and discussing how their clients' trauma has impacted them.

Another suggestion for practice is that agencies ensure that all of their staff have

knowledge on the impacts of vicarious trauma through providing them with initial

training upon hire. It is also recommended that agencies encourage their staff to

participate in continuing education on vicarious trauma as a means of keeping staff up

to date on symptoms, impacts, etc. Trainings and continuing education for staff

members produced by the agency should also be accessible for staff members as a way

to encourage them to attend. One last suggestion for practice is that agencies be

mindful of the number of clients that each staff member takes on, as well as the number

of trauma survivors on staff members' caseloads.

Along with implications for practice, implications for research have also been

developed based on the current study. Given the limitations of number of participants

in the current study, the findings in this study cannot be generalized. Perhaps future

researchers could replicate, or conduct a similar study, with more participants to gain a

better idea of what other agencies are doing to prevent or reduce vicarious trauma.

Future researchers could also look at whether or not there is a difference in emphasis

and types of strategies used based on the type of agency and population served (i.e.

residential, outpatient, schools, child protection, etc.).   One further recommendation

for future researchers to look at the effectiveness of the strategies discussed in this

study. For example, researchers should look at whether supervision and consultation,

training, self-care, and having agency policies and procedures are actually beneficial in

reducing / preventing vicarious trauma, as is suggested throughout the literature.

Lastly, it is suggested that academic programs incorporate teaching students about the concept of vicarious trauma as a means of teaching professionals early in their careers what types of impacts working with survivors of trauma can have on them. It is also suggested that educators who host continuing education conferences be mindful of providing continuing education on vicarious trauma.

Conclusion

Given the impacts that vicarious trauma can have on not only the social worker, but also on the agency in which the social worker is employed, and on the clients that the social worker works with, it is important for agencies to take action in helping to prevent staff from being impacted by vicarious trauma. The findings of this study suggest that while some agencies are actively working to prevent their employees from being impacted by vicarious trauma, other agencies are not providing adequate support. Agencies therefore need to keep in mind the key role that they can play in preventing/treating vicarious trauma through adequate supervision/consultation, training, benefits, and encouraging self-care.

References

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*,

 Fourth Edition, Text revision. Washington, DC, American Psychiatric Association,

 2000.

Bell, H., Kulkarni, S. & Dalton, L. (2003). Organizational prevention of vicarious trauma.

 *Family and Society: The Journal of Contemporary Human Services,84(*4), 463-470.

Bober, T. & Regehr, C. (2005). Strategies for reducing secondary or vicarious trauma: Do

 they work? *Brief Treatment and Crisis Intervention, 6*(1), 1-9.

Cerney, M. S. (1995). Treating the heroic treaters. In Figley, C. R. *Compassion fatigue:

 Coping with secondary traumatic stress disorder* (131-149). New York:

 Brunner/Mazel.

Catherall, D. R. (1995). Preventing institutional secondary traumatic stress disorder. In

 Figley, C. R. *Compassion fatigue: Coping with secondary traumatic stress disorder*

 (232-247). New York: Brunner/Mazel.

Cunningham, M. (2003). Impact of trauma on social work clinicians: Empirical findings.

 Social Work, 48(4), 451-459.

Harrison, R. L. & Westwood, M. J. (2009). Preventing vicarious traumatization of mental

 health therapists: Identifying protective practices. *Psychotherapy Theory, Research,

 and Training, 46*(2), 203-219.

Hesse, A. R. (2002). Secondary trauma: How working with trauma survivors affects

 therapists. *Clinical Social Work Journal, 30*(3), 293-309.

Iliffe, G. & Steed, L. G. (2000). Exploring the counselor's experience of working with

  perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence,*

  15(4), 393-412. Doi: 10.1177/088626000015004004.

Landers, D. M. (n.d.). The influence of exercise on mental health. Retrieved on October 16,

  2011, from http://www.fitness.gov/mentalhealth.htm

Miley, K., O'Melia, M. & Dubois, B. (2011). *Generalist Social Work Practice: An*

  Empowering Approach(Updated edition, 6/e). Boston: Allyn & Bacon.

Monette, D.R., Sullivan, T.J., & DeJong, C. R. (2007) *Applied Social Research: Tool for the*

  Human Services (7th ed). Belmont, CA: Brooks/Cole.

Newell, J. M. & MacNeil, G. A. (2010). Professional burnout, vicarous trauma, secondary

  traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors,

  and preventative methods for clinicians and researchers. *Best Practices in Mental*

  Health: An International Journal, 6(2), 57-68.

Ortlepp, K. & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress

  in workplace lay trauma counselors. *Journal of Traumatic Stress, 15*(3), 213-222.

Pearlman, L. A. & Mac Ian, P. (1995). Vicarious traumatization: An empirical study of the

  effects of trauma work on trauma therapists. *Professional Psychology: Research and*

  *Practice, (26)*5, 558-565.

Perlman, L. A. & Saakvitne, K. W. (1995). Treating therapist with vicarious traumatization

  and secondary traumatic stress disorder. In Figley, C. R. *Compassion fatigue: Coping*

  with secondary traumatic stress disorder (150-177). New York: Brunner/Mazel.

Rothschild, B. (2006). *Help for the helper*. New York: W. W. Norton & Company.

Ryan, K. & Cunningham, M. (2007). Helping the helper: Guidelines to prevent vicarious

      traumatization of play therapists working with traumatized children. In Web, N. B.

      (3rd ed.) *Play therapy with children in crisis* (443-460). New York: The Guilford

      Press.

Saleebey, D. (1996). The Strengths Perspective in social work practice: Extensions and

      cautions. *Social Work, 41*(3), 296-305.

Schauben. L. J. & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors

      of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49-

      64.

Saakvatine, K. W. & Pearlman, L. A. (1996). *Transforming the pain: A workbook on

      vicarious traumatization*. New York: W.W. Norton and Company

Timberlake, E. M., Farber, M. Z. & Sabatino, C. A. (2002). The general method of social

      work practice: McMahon's generalist perspective (3rd ed.). Boston, MA: Allyn and

      Bacon

Trippany, R. L., White Kress, V. E. & Wilcoxon, S. A. (2004). Preventing vicarious trauma:

      What counselors should know when working with trauma survivors. *Journal of

      Counseling and Development, 82*, 31-37.

VanDeusen, K. M. & Way, I. (2006). Vicarious trauma: An exploratory study of the impact

      of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of

      Sexual Abuse, 15*(1), 69-86. Doi: 10.1300/J070v15n01_04

Way, I., VanDeusen, K. M., Martin, G., Applegate, B. & Jandle, D. (2004). Vicarious

      trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual

offenders. *Journal of Interpersonal Violence, 19*(1), 49-69. Doi:

10.1177/088626050359050

Yassen, J. (1995) Preventing secondary traumatic stress disorder. In Figley, C. R.

Compassion fatigue: Coping with secondary traumatic stress disorder (178-208).

New York: Brunner/Mazel.

Appendix

Date

Address

Dear_____:

You are receiving this letter because you have been selected as a candidate to participate in a study that seeks to explore agency level interventions for preventing and treating vicarious trauma. You have specifically been selected to participate due to your employment in an agency that provides services to individuals who have survived trauma.

This study is being conducted as a Master of Social Work level Clinical Research Paper through the University of St. Thomas. Your participation is completely voluntary. If you decide to participate in this study, you are free to withdraw at any time. You are also free to skip any questions asked throughout the study. Your decision to or not to participate will have no impact on your current or future relations with the University of St. Thomas.

If you chose to participate in this study, you will be asked to participate in an audio-recorded interview that will take approximately 45-60 minutes of your time. The interview will be centered on determining what types of services / benefits your agency provides to prevent and/or reduce the impacts of vicarious trauma.

Given that the study focuses on the concept of vicarious trauma and specifically on what your agency is doing to prevent vicarious trauma, it is possible that the interview questions could caused you to experience negative emotional responses due to personal memories, and/or due to reflecting on what your agency is or is not doing to prevent vicarious trauma.

In approximately one week I will be contacting you by phone to provide you more information on the study, and to formally invite you to participate. If you have any questions or concerns, please feel free to contact me is by email at john5614@stthomas.edu.

Sincerely,

Jessica Johnson