

ABSTRACT

**Secondary Traumatic Stress, Vicarious Trauma, and
Compassion Fatigue Among Victim Advocates**

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Secondary Traumatic Stress (STS), Vicarious Trauma (VT), and Compassion Fatigue (CF) are conditions resulting from exposure to secondary trauma. Victim advocates provide support and information to victims after they have been victimized and work intensely with victim populations. Their work with trauma victims makes them susceptible to STS, VT, and CF. This quantitative study examines the prevalence and risk factors of STS, VT, and CF among victim advocates across the United States. A survey was emailed to victim advocates across the country to measure the conditions. Results indicated that the presence of support provided through an advocate's work, such as trainings or peer support, raised levels of compassion satisfaction, and lower levels of burnout. The more support types provided also raised compassion satisfaction and lowered burnout. Hours worked and direct hours working with victims also had significant positive correlations with STS levels. The results from this study provide a better understanding of those that are affected by STS, VT, and CF, and helps guide prevention and intervention efforts for all advocates in the field.

TABLE OF CONTENTS

ABSTRACT.....	i
BACKGROUND.....	1
INTRODUCTION.....	2
Secondary Traumatic Stress.....	2
Vicarious Trauma.....	3
Compassion Fatigue.....	5
LITERATURE REVIEW.....	7
RESEARCH METHODOLOGY.....	14
Data Collection.....	14
Instruments.....	15
Research Questions.....	17
RESULTS.....	18
Participants.....	18
Sample Characteristics: Dependent Measures.....	21
STS Results.....	21
VTS Results.....	22
ProQOL Results.....	22
Hypothesis Testing.....	23
DISCUSSION.....	30
Limitations.....	32
SUMMARY.....	33
REFERENCES.....	35
APPENDICES	
Appendix A: Demographic Questionnaire.....	39
Appendix B: Secondary Traumatic Stress Scale.....	42
Appendix C: Professional Quality of Life Scale.....	43
Appendix D: Vicarious Trauma Scale.....	44

LIST OF TABLES

Table 1: Demographic Characteristics of Victim Advocates.....	20
Table 2: Time Worked.....	21
Table 3: Secondary Traumatic Stress Scale Results.....	21
Table 4: Vicarious Trauma Scale Results.....	22
Table 5: Professional Quality of Life Scale Results.....	23
Table 6: ANOVAs Between Measure Scores and Demographics.....	24

LIST OF FIGURES

Figure 1: Hours Worked vs STSS Score.....	27
Figure 2: Direct Hours vs STSS Score.....	27
Figure 3: Hours Worked vs Burnout Score.....	28
Figure 4: Hours Worked vs STS/CF Score.....	28

STS, VT, AND CF AMONG VICTIM ADVOCATES

Background

Post-Traumatic Stress Disorder (PTSD) is a mental disorder following the firsthand exposure to a traumatic event characterized by re-experiencing the event, negative thoughts about the event, avoidance of trauma reminders such as people and places associated with the event, and increased arousal including startled responses, hypervigilance, and trouble concentrating (American Psychiatric Association [APA], 2013). As described above, the first criterion for a diagnosis of PTSD is the primary exposure to the traumatic event, meaning that a person has been directly exposed or witnessed a traumatic event, learned of a family member or friend experience a traumatic event or experienced extreme indirect exposure to a traumatic event, such as repeated exposure to pictures or media (APA, 2013). A traumatic event is defined as an event in which the person experiences a life threatening event, violent/sexually violent or threatened violent/sexually violent experience (APA, 2013).

Exposure to trauma can also be experienced secondarily. Secondary exposure to trauma occurs when a traumatic event of a primary victim is told to another individual. This can occur in a number of ways, such as a client discussing their victimization with a therapist, a nurse treating a sexually abused patient, or a child services worker talking with an abused child.

The quality of life of professionals providing care to those who have undergone a trauma is a recent interest among researchers (Stamm, 2010), and their secondary exposure to trauma is a necessary path to be studied. When providing care to trauma victims, the professional is exposed to the trauma secondarily, and this exposure can have an impact on the professional's well-being. Professionals can experience similar

STS, VT, AND CF AMONG VICTIM ADVOCATES

symptoms to those experiencing the trauma firsthand, although usually at a less critical level (DiPietro, 2005). A variety of different conditions have been developed with the varying impacts on different types of providers, as a result of the impact of secondary trauma on care providers.

Introduction

The purpose of this thesis was to examine the prevalence of three defined conditions, Secondary Traumatic Stress (STS), Vicarious Trauma (VT), or Compassion Fatigue (CF), among the provider population of victim advocates to gain insight on risk factors for developing STS, VT, and CF, as well as effective prevention efforts. There is debate on these conditions and their definitions, as they are not medically defined in the Diagnostical and Statistical Manual of Mental Disorders, 5th Edition DSM-5, which houses all recognized psychiatric conditions. The terms Secondary Traumatic Stress, Vicarious Trauma, and Compassion Fatigue are defined as distinct conditions, but they are often used interchangeably. The inconsistencies in definition cause research and review of previous literature to be difficult. For the purpose of this thesis, the terms are defined in the following sections.

Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is defined as the stress resulting from one's indirect exposure to a trauma or traumas and the related behaviors and feelings (Figley, 1995). The symptoms of STS nearly mirror those of PTSD (Figley, 1995). Both conditions develop these symptoms suddenly. The symptoms of PTSD can include nightmares, intrusive thoughts and flashbacks of the traumatic event, and behaving as if the event was reoccurring (Kozarov, 2007). STS differs from PTSD in the exposure.

STS, VT, AND CF AMONG VICTIM ADVOCATES

With PTSD, the exposure must occur firsthand, while in STS the exposure is secondary. Symptoms of STS among care providing professionals can include changes in arousal such as sleeping trouble, fear, disruptive and invasive thoughts of clients and their traumas, and avoiding anything in association with the secondary trauma (Stamm, 2010). The commonly used measures for assessing STS symptoms (Secondary Traumatic Stress Scale) and assessing PTSD symptoms are very similar, with differences primarily in the wording to account for the secondary exposure or firsthand exposure to trauma (Bride, Robinson, Yegidis, & Figley, 2004; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013). See Appendices 1 for Secondary Traumatic Stress Scale.

The symptoms of STS appear similar to those of Vicarious Trauma (VT), but VT develops slowly and often results after contact with multiple clients (McCann & Pearlman, 1990; Stamm, 2010). Another differing factor between STS and VT is that STS is symptomatically based and does not necessarily involve a change in cognition. After coining the term Secondary Traumatic Stress, Figley soon changed it to Compassion Fatigue (Figley, 1995). Although it replaced the term for a time, today they are two separate terms. Inconsistencies in definitions of these terms are still frequent in the literature. For the purpose of this study, Secondary Traumatic Stress and Compassion Fatigue are defined as separate terms. Figley has since acknowledged a difference in definitions, and explains that Compassion Fatigue is a result of STS over time (Figley, 2007).

Vicarious Trauma

Vicarious trauma (VT) is the secondhand collection of memories about traumatic experiences that impacts multiple aspects of one's personal life, because of a change in

STS, VT, AND CF AMONG VICTIM ADVOCATES

their cognitions (McCann & Pearlman, 1990). The difference between STS and VT is the exposure time (Pearlman & Saakvitne, 1995) and the resulting effects. STS can develop after one interaction or exposure to a victim and their story, whereas VT occurs after chronic exposure (Pearlman & Saakvitne, 1995). Much of the previous research on the condition has studied therapists, but other helping or care-giving professionals are also at risk (McCann & Pearlman, 1990). VT alters the care-provider's outlook on the world and includes intrusive images that affect their lives (McCann & Pearlman, 1990).

According to McCann & Pearlman (1990), those experiencing VT have less trust and confidence in people as a whole, a greater sense of vulnerability, a feeling of powerlessness or lack of control over the happenings in their lives, and a sense of isolation from the rest of society. The symptoms of the provider are similar to their client's, but are "usually at a sub-clinical level," (DiPietro, 2005, pg 4). The symptoms of VT differ from STS in their effect on the person. STS has abrupt symptoms, such as nightmares or the avoidance of a client, but VT changes the person's cognitions and how they feel about various aspects of their life.

The loss of trust and confidence in people as a whole likely stems from seeing different forms of betrayal between the client and the client's offender. The greater sense of vulnerability may be caused by the exposure to the various crimes committed against their clientele. The lack of power in their life leads back to the knowledge of various crimes, and the knowledge that traumatic events happen all the time to people for no reason. Helping professionals may experience obsessive thoughts of hypothetical situations, and how they would respond to a crime to feel a sense of control over their life (McCann & Pearlman, 1990). The sense of isolation from the rest of society occurs

STS, VT, AND CF AMONG VICTIM ADVOCATES

because helping professionals are exposed to traumas that other occupations are not aware of, separating their beliefs and outlooks on life (McCann & Pearlman, 1990).

Compassion Fatigue

An additional term that is cited in the VT and STS literature is Compassion Fatigue (CF). While these three terms are often used interchangeably, CF relates more specifically to one's ability to be empathetic (Meadors, Lamson, Swanson, White, & Sira, 2009). Stamm's Concise ProQOL manual explains STS in terms of the severity of compassion fatigue. The effects of STS may cause a person to be less compassionate in their work (2010). Burnout is also an element of CF (Stamm, 2010). Burnout is a feeling of being overwhelmed and discontent with one's job, along with a feeling of not being where one wants to be in life (Stamm, 2010). Burnout is not specific to care-providing professionals (Stamm, 2010).

The impacts of STS, CF, and VT can be seen in a wide variety of professions, and although they do not impact every worker, the conditions are inevitable (Salston & Figley, 2003). These conditions can be predicted, and with sufficient knowledge, STS, VT, and CF can be treated (Salston & Figley, 2003). Researchers have investigated STS, CF, and VT among nurses, therapists, and social workers (Hensel, Ruiz, Finney & Dewa, 2015; Aparicio, Michalopoulos & Unick, 2013). While anyone is susceptible to these conditions, healthcare providers, such as doctors, nurses, and therapists are at a higher risk because their occupations require constant empathy and exposure to high levels of secondary trauma (Meadors, Lamson, Swanson, White, & Sira, 2009). Research has not focused on the entire provider population, though STS, CF, and VT can potentially affect

STS, VT, AND CF AMONG VICTIM ADVOCATES

anyone exposed to a secondary trauma. Victim Advocates remain a population that has been neglected in the literature on STS, VT, and CF.

Victim advocates are professionals that provide emotional and informational support to victims throughout their post-trauma experience (National Center for Victims of Crime, 2008). Trauma is defined by the American Psychological Association as, “an emotional response to a terrible event,” (2016). Victims are those who have undergone a form of harm, mental or physical, as a result of the actions of another human or sudden, dangerous, disruptive event (McCann, Sakheim, & Abrahamson, 1988). Victim advocates work with victims of traumas including child abuse, domestic abuse, sexual assault, and family death. Advocates provide support at crime scenes, accompany victims to legal hearings, and refer victims to needed services, such as counseling. Aside from providing emotional support, necessary resources, community assistance, and other services, victim advocates increase the quality of life of their clients and reduce depression symptoms (Sullivan & Bybee, 1999). Victim advocates are exposed to others’ traumas during their work and are likely at a higher risk of developing STS, VT, or CF than the average person because of the similar case exposure as a social worker or therapist, and their task of providing care to victims.

The purpose of this quantitative study is to examine the prevalence of Secondary Traumatic Stress (STS), Vicarious Trauma (VT), or Compassion Fatigue (CF) among victim advocates. Without information on how this professional population is impacted, effective resources for this group cannot be developed. If a victim advocate develops STS, CF, or VT his/her ability to render effective and appropriate services to victims can be hindered. While research has been conducted on STS and VT among nurses, social

STS, VT, AND CF AMONG VICTIM ADVOCATES

workers, and therapists (Hensel, Ruiz, Finney & Dewa, 2015; Aparicio, Michalopoulos & Unick, 2013), victim advocates remain a neglected population in the extant literature. The work of the victim advocate is similar to the work of nurses, social workers, and therapists in that all of these professionals work to better the lives of victims, but victim advocates have a unique role as they are not providing treatment to the victim, but helping the victim with paperwork, resources, and providing support. Victim advocates, as well as any others prone to STS, VT or CF, should have the knowledge to properly cope, as well as the resources necessary to prevent these conditions. Without proper coping or intervention, these conditions can lead to poor service to clients, and ultimately, advocate burnout. Unfortunately until a better understanding of how this professional population is impacted by STS, VT or CF, effective resources cannot be developed. This study aims to examine the prevalence of STS, VT, and CF among victim advocates, as well as identify risk factors that predict the development of the three conditions. Ultimately results from this study can be used to guide prevention efforts geared at reducing STS, VT or CF.

Literature Review

A review of the literature on Secondary Traumatic Stress (STS), Vicarious Trauma (VT) and Compassion Fatigue (CF) returned varying and inconsistent definitions of STS, VT, and CF. The inconsistencies have created gaps in the literature, as well as set minimal solid groundwork in this area. Although there exist published definitions of STS, VT, and CF (McCann & Pearlman, 1990; Figley, 1995), no one definition for any of them appears to be strictly defined. With researchers using different terms to define one condition, such as CF being used interchangeably with STS (Figley, 1995), measurement

STS, VT, AND CF AMONG VICTIM ADVOCATES

validity of STS and CF is also in question and requires a great deal of caution when generalizing findings. After reviewing the literature on STS, VT, and CF, and analyzing the differences in the defined terms, the following definitions will be used for this study. Secondary Traumatic Stress (STS) is defined as the stress resulting from one's indirect exposure to a trauma or traumas and the related behaviors and feelings (Figley, 1995). The symptoms of STS are nearly identical to symptoms of PTSD and can have a rapid onset (Figley, 1995). STS is also an element of Compassion Fatigue (Stamm, 2010; Figley, 2007). Vicarious Trauma (VT) is the secondhand collection of memories about traumatic experiences that impacts multiple aspects of one's personal life, because of a change in their cognitions (McCann & Pearlman, 1990). Compassion Fatigue (CF) is a tiring in one's ability to be empathetic in their work (Meadors, Lamson, Swanson, White, & Sira, 2009), and a feeling of being overwhelmed (Stamm, 2010). It is possible for these conditions to coexist, as well as have similar symptoms to one another, which may be the cause of some of the confusion within the field (Stamm, 2010). There is no defined line between conditions causing a difficulty in measuring STS, VT, and CF with complete accuracy.

Previous research has looked at the prevalence and predicting factors of STS, VT, and CF, but only in select populations, and rarely all three conditions in the same study (Aparicio, Michalopoulos, & Unick, 2013; Meadors, Lamson, Swanson, White, & Sira, 2009). The literature published on victim advocates and these conditions is limited and not generalizable because of the specific content, varying instruments to measure conditions, and single type of victim advocates, such as domestic violence victim advocates (Slattery, 2003). Today there exist victim advocates in many different work

STS, VT, AND CF AMONG VICTIM ADVOCATES

environments such as hospitals, police stations, and community organizations that may play different roles and experience secondary trauma differently (Slattery, 2003). For this reason, the current study will measure STS, VT, and CF. By using multiple measures, results will cover more aspects of secondary trauma symptoms, as recommended by Bride, Radley, & Figley (2007).

The first studies conducted on STS, VT, and CF are primarily involved with social work, although recent studies have looked at healthcare providers as well (Aparicio, Michalopoulos, & Unick, 2013; Meadors, Lamson, Swanson, White, & Sira, 2009). These professions are similar to victim advocates because they both work with traumatized clients and are exposed to these traumas secondarily, but because the purpose of their work differs, the effects of secondary traumas on individuals in these occupations cannot be generalized. The impact of secondary and vicarious trauma on victim advocates must be researched in addition to other care providing professions.

The first published study on the effects of trauma on victim advocates was in 1998 (Slover, 1998). Charlene Slover performed a pre/posttest study on 32 newly trained, on-call victim advocates working for the police jurisdiction in Denver, using the TSI Belief Scale, the Maslach Burnout Inventory and the Impact of Event Scale. Their posttest was completed 6 months after the start of their work as a victim advocate. The TSI Belief Scale is an 80 item self-report instrument used to measure disturbances in one's cognitions, specifically in the areas of safety, trust, esteem, intimacy and control (Slover, 1998). The Maslach Burnout Inventory is a 22 item instrument that is used to measure burnout by looking at emotional exhaustion, depersonalization and personal accomplishment (Slover, 1998). The Impact of Event Scale was a 15 item self-report

STS, VT, AND CF AMONG VICTIM ADVOCATES

instrument, now 22 item, used to measure one's reaction to a particular event, specifically intrusion and avoidance of a particular event (Slover, 1998).

This study found significance in a few different categories, revealing that victim advocates are affected by secondary trauma, and they should not be skipped over as research subjects in the field. The results of this study revealed significance between advocates with a history of being a trauma victim and those that had experienced no firsthand trauma prior to the training (Slover, 1998). Although there was significance between those identifying as victims and those that did not, it was minimal. The two categories that revealed significance were "self-intimacy," in the TSI Belief Scale, and "emotional exhaustion," of the Maslach Burnout Inventory (Slover, 1998). Self-intimacy refers to one's ability to feel, "connected to oneself in a meaningful way," (pg 104). Advocates that were not victims of trauma showed a larger decrease in self-intimacy than those that identified as victims (Slover, 1998). Slover predicts this to be because those that previously experienced a trauma have developed ways to cope with similar feelings that their work may cause. More recent research has shown the opposite effect, where previously abused advocates had higher rates of STS symptoms than those that had not experienced abuse (Slattery, 2003). Slover's finding was in one subcategory of the TSI Belief Scale, and was only measuring self-intimacy, meaning the two studies are not necessarily in opposition. The PTSD Checklist was employed in Slattery's study, a different measurement for STS, making a comparison of specific findings difficult. Emotional exhaustion refers to a feeling of being, "emotionally overextended," or exhausted by one's work (pg 108). Slover's study found that those identifying as victims had higher levels of emotional exhaustion than non-victims.

STS, VT, AND CF AMONG VICTIM ADVOCATES

Another finding in this study was that between the pre and posttests, advocates experienced a decrease in self-esteem measured by the TSI Belief Scale (Slover, 1998). Slover indicates this could be a result of seeing similar victimizations over and over, causing an advocate to feel a devaluing of self-worth in that they cannot stop clients from being victimized. (Slover, 1998). The reality of the work and their previous assumption of what it would be like are not consistent with one another. Slover's study found an increase in avoidance in victim advocates, but no significant change in intrusion measures. Avoidance is described in Slover's study as the, "denial of the meanings and consequences of an event, blunted sensations, behavioral inhibition or counter phobic activity, and awareness of emotional numbing," (pg 104). The hypothesized reason behind an increase in avoidance and no increase in intrusion measures is that the avoidance tactics prevent intrusive symptoms from fully developing (Slover, 1998).

Since this study was conducted, more specific measurements have been developed to better define the symptoms specific to STS, VT, CF or burnout. Slover's study tested for burnout in advocates, but it is well established that there are conditions such as STS, preceding burnout that are problematic (Campbell, 2013). Newer developments on the topic of secondary trauma have moved research forward, but Slover first brought attention to victim advocates as an affected population.

More recent literature on victim advocates has studied STS, VT, and CF along with burnout (DiPietro, 2005; Slattery, 2003). Slattery (2003) conducted a study that examined STS among domestic violence victim advocates. The results showed that nearly 50% of participants met criteria for STS (Slattery, 2003). Although her findings are based on the PTSD Checklist, our hypothesized results remain similar. More research

STS, VT, AND CF AMONG VICTIM ADVOCATES

is needed to make conclusive claims on the prevalence and predictors of STS on domestic violence victim advocates, as well as all victim advocates. Because this study only examined one of the three conditions in our study, it is difficult to predict its implications on the effects of VT and CF. DiPietro (2005) performed a study on the reducing the effects of VT and CF among domestic violence victim advocates. CF and STS are used interchangeably in the study. In DiPietro's study, a program was implemented to minimize the effects of VT and CF among advocates, but results were not included.

In order to better predict the prevalence and predicting factors of STS, VT, and CF, and because the literature involving victim advocates is minimal, we broadened the review to include studies of STS, VT, and CF among other care-providing professionals. Although still a little researched topic, a number of studies have been done on the prevalence of STS, VT, and CF among nurses, therapist, social workers, and other healthcare providers (Aparicio, Michalopoulos, & Unick, 2013; Meadors, Lamson, Swanson, White, & Sira, 2009). When discussing the prevalence of STS, different occupations have reported differing numbers. A study examining child protective service workers found 34% of participants to fit STS criteria (as cited in Hensel, 2015), while another found 15.2% of social workers to fit the criteria (Bride, 2007). Slattery's (2003) study, mentioned above, suggested nearly half of the victim advocate participants met criteria for STS. These number gaps could occur for reasons such as differing scales of measurement, differing clientele, geography, etc. The inconsistencies and wide ranges are another indication that the research in this area is lacking. It is consistent that participants experience some symptoms of these conditions across all studies, but as in Bride's 2007 study, participants may only experience one or two symptoms that don't

STS, VT, AND CF AMONG VICTIM ADVOCATES

yield significance. In Bride's study measuring STS based on PTSD symptoms in social workers (2007), more than 70% experienced at least one symptom of PTSD, but only 15.2 met the full criteria. This reiterates that providers may not always reach clinical levels for a diagnosis, and their secondary trauma may not be as severe as a primary trauma, but it is detrimental to one's health. Compared to the 70% that experienced one or more symptoms, 15.2% appears to be a small number, but this is nearly double that of the general population (Bride, 2007; (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Social workers are at a higher risk than the general population, and they provide many of the same or similar services as victim advocates.

The various factors predicting the variance in prevalence are abundant, with the most common factors being past personal trauma, trauma of clientele, social support, and supervision. A meta-analysis of 38 STS studies found previous personal trauma to be a significant risk factor in all 38 (Hensel, 2015). The significance statistic varied, but remains an important predicting factor for identifying those at higher risk of STS. Although social support and supervision have been mentioned as predicting factors of STS, results are inconsistent among multiple studies and therefore insignificant (Hensel, 2015).

Personal trauma history showed positive significance in all 38 studies of a meta-analysis looking at studies on STS (Hensel, 2015), meaning that providers with their own trauma experience were more likely to develop or show signs of STS. Slattery found that trauma history was the only individual factor that predicted STS (2003). The amount of time spent with traumatized clients has shown to be a predictive factor of STS, meaning the more time one spends working directly with traumatized clients, the more likely they

STS, VT, AND CF AMONG VICTIM ADVOCATES

are to develop STS (Slattery & Goodman, 2009). The findings on this are mixed, as Baird and Jenkins (2003) found no significance.

In addition to previous trauma, experience and age are often examined in research on STS, VT, and CF. Experience, age, and hours of service were not predictive of STS (Baird & Jenkins, 2003; Slattery, 2003). The workplace environment has played a role in STS, VT, and CF research, and as with much of it, the results are mixed. Supervision relationships among therapists can reduce symptoms of STS when they are positive (DiPietro, 2005).

As the literature review reveals, there are multiple inconsistencies in the research in this field. More research must be done before definitive claims can be made. Any current findings must be questioned based on which instruments were used to measure, what findings contradict them, and what differences there are in definitions. This study will attempt to start bridging the gap in order to better the mental health of care-providers. With a better knowledge of secondary trauma and its effects on different populations, preventative measures can reduce the risk.

Research Methodology

Data Collection

Approval for this study was obtained from the University of Nevada, Reno Institutional Review Board (IRB). A web search was conducted using the term “victim advocate” to find contacts to agencies employing victim advocates across the country. These agencies were then contacted by phone, and asked for email contact of their victim advocates so as to send them an invitation to participate in this study. Participants were sent an e-mail that contained an invitation to participate in the study and a link to an

STS, VT, AND CF AMONG VICTIM ADVOCATES

introduction/consent form, a demographic survey, and the study instruments (which were administered via Survey Monkey). Estimated time to complete the survey was 20 minutes. The email invitation requested that the recipient of the e-mail forward the survey on to [other] advocates. A total of 115 victim advocates responded to the survey. Eight surveys were not complete and were excluded from analyses.

Instruments

Demographic Questionnaire. The Demographic Questionnaire was created for this study. Information about the advocates' age, ethnicity, gender, education, income, and dependents in household was gathered, along with information about their work. Their years of experience, hours worked per week, and direct hours working with victims per week were requested in the Demographic Questionnaire. The type of victims and the services that victim advocates provide were also included. Advocates were asked about their systems of support. They were asked what types of support they had in their lives, what type of support their work provided to them, and what type of self-care and coping mechanisms they engage in. Finally, advocates were asked if they themselves had ever been a victim of trauma. See Appendix A for the demographic questionnaire.

Secondary Traumatic Stress Scale (STSS). The Secondary Traumatic Stress Scale measures Secondary Traumatic Stress (Bride, Robinson, Yegidis, & Figley, 2004). Bride et al. tested this scale with results measuring high in reliability and validity (2004). His participants were master's level social work students. The scale is designed to measure STS in anyone exposed to Secondary Trauma, but the validity and reliability measures were only tested on social workers. This is considered a limitation as this study will look strictly at victim advocates. Although primarily tested on social workers, the

STS, VT, AND CF AMONG VICTIM ADVOCATES

scale has been used to measure STS in people of different service occupations (Meadors, Lamson, Swanson, White, & Sira, 2009). The Secondary Traumatic Stress Scale contains 17 self-report questions answering on a 5-point Likert scale “designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with STS resulting from working with traumatized populations,” (Bride, 2007). The scale focuses on the past 7 days.

The Vicarious Trauma Scale. The Vicarious Trauma Scale measured Vicarious Trauma. Vrkleviski and Franklin developed the VTS “to assess subjective levels of distress associated with working with traumatized clients (2008). The scale contains 8 questions with answers on a 7 point Likert scale. This scale originally measured Vicarious Trauma in criminal lawyers (Vrkleviski and Franklin, 2008). Past studies have often used the Impact of Event Scale as a measure for VT (Slover, 1998), but Vrkleviski and Franklin have shown a significant correlation revealing the VTS to have similar findings with less questions. The Impact of Event Scale is tied to one specific event, and was originally designed to measure PTSD. The Vicarious Trauma Scale was a better fit for our study.

Professional Quality of Life Scale (ProQOL). The Professional Quality of Life Scale (Pro-QL) was used to measure Compassion Fatigue among victim advocates. This scale was developed by Beth Stamm and contains 30 self-report questions with answers on a 5 point Likert scale (Stamm, 2002). The scale is broken down into three subscales and measures Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. When scored, each subscale is scored separately. High scores on the Burnout and Secondary Traumatic Stress subscales are indicative of Compassion Fatigue. This scale’s validation

STS, VT, AND CF AMONG VICTIM ADVOCATES

measures are based on research of social workers and mental health professionals (Stamm, 2002).

Research Questions

The purpose of this quantitative study was to examine the prevalence and possible predicting and protective factors of Secondary Traumatic Stress (STS), Vicarious Trauma (VT), and Compassion Fatigue (CF) among victim advocates. To address the purpose of this study, a number of research questions were developed. These included:

- **Research Question 1:** What is the relationship, if any, between an advocate's demographics and their STSS scores, VTS scores, and CF scores?
- **Research Question 2:** What is the relationship, if any, between an advocate's own victim status and their score on the Secondary Traumatic Stress Scale?
- **Research Question 3:** What is the relationship, if any, between the presence or lack of support from an advocate's work and their score on the STSS, VTS, or ProQOL?
- **Research Question 4:** What is the relationship, if any, between an advocate's experience or the time an advocate spend working and their scores on the STSS, VTS, and ProQOL?
- **Research Question 5:** What is the relationship, if any, between the number of victim types an advocate works with or the number of tasks they perform, and their scores on the STSS, VTS, and ProQOL?

STS, VT, AND CF AMONG VICTIM ADVOCATES

- **Research Question 6:** What is the relationship, if any, between the number of self-care activities an advocate engages in or the support they have from work or other parts of their lives, and their scores on the STSS, VTS, and ProQOL Scale?

Results

The purpose of this quantitative study was to examine the prevalence and possible predicting and protective factors of Secondary Traumatic Stress (STS), Vicarious Trauma (VT), and Compassion Fatigue (CF) among victim advocates. A total of 115 advocates responded to the study invitation and of those 115, 8 did not complete the survey and were excluded from analyses. Thus, data from a total of 107 respondents were analyzed.

Participants

The sample consisted of 99 women (92.5%) and 8 men (7.5%), with an average age of 39.3. The majority of the sample self-identified as White (78.5%), married (38.3%), and held a Bachelor's Degree (58.9%). See Table 1 for a breakdown of demographic information. A total of 71 (66.4 percent) advocates reported being a victim of trauma themselves.

The advocates in this study had an average of 9.0 years of experience in the field, and averaged 38.4 hours of work per week, with 24.5 hours of direct victim contact (Table 2). Advocates worked with a wide range of victims including victims of assault, sexual assault, domestic abuse, child abuse, adult survivors of child abuse, self-harm, and families of suicide and homicide. A majority of the advocates indicated working with at least 3 different types of victims (83.2 percent). Victims of sexual abuse (84.1 percent) and victims of domestic abuse (93.5 percent) were the most common type of victims

STS, VT, AND CF AMONG VICTIM ADVOCATES

helped. The advocates worked in different settings: non-profit organizations, district attorney's offices, police departments, correctional centers, as well as other offices employing victim advocates. Advocates provide a variety of services to victims such as accompanying victims to court hearings and legal proceedings, assisting victims in finding housing, transportation, jobs, etc., providing emotional support, helping victims with paperwork, and informing victims of their rights, along with other services.

Providing emotional support was the most common service provided by advocates, with 100 advocates (93.5 percent) indicating they provide emotional support. See Appendix A for the Demographic Questionnaire.

STS, VT, AND CF AMONG VICTIM ADVOCATES

Table 1. Demographic Characteristics of Victim Advocates Responding to Secondary Trauma Survey (N=105)

	n	Mean	SD	%
Sex	107	-	-	-
Female	99	-	-	92.5
Male	8	-	-	7.5
Age	105	39.7	13.1	-
Ethnicity	107	-	-	-
White	84	-	-	78.5
Hispanic/Latino	15	-	-	14.
American Indian/Alaska Native	1	-	-	1.0
More than 1 ethnicity	6	-	-	5.6
N/A	1	-	-	1.0
Marital Status	107	-	-	-
Single	25	-	-	23.4
Married	41	-	-	38.3
Divorced	11	-	-	10.3
Widowed	3	-	-	2.8
Unmarried but in a relationship	26	-	-	24.3
N/A	1	-	-	1.0
Education level	107	-	-	-
No High School Diploma	1	-	-	1.0
High School Diploma/ GED	1	-	-	1.0
Associate's Degree	9	-	-	8.4
Some college	13	-	-	12.1
Bachelor's Degree	63	-	-	58.9
Master's Degree	18	-	-	16.8
Professional Degree	2	-	-	2.0
Household Income	107	-	-	-
Below \$40,000	29	-	-	27.2
\$40,000-\$80,000	45	-	-	42.0
\$80,000 or more	29	-	-	27.0
N/A	4	-	-	3.7
Dependents in household	107	-	-	-
0	63	-	-	58.9
1	16	-	-	15.0
2	15	-	-	14.0
3 or more	12	-	-	11.2
N/A	1	-	-	1.0

*Percent totals over 100% are due to rounding error.

STS, VT, AND CF AMONG VICTIM ADVOCATES

Table 2. Time Worked (N=107)

	Minimum	Maximum	Mean	Std. Deviation
Years of Experience	0	35	9.0	7.99
Hours Worked per Week	5	60	38.4	9.49
Direct Services to Victims per Week	1	60	24.5	11.91

Sample Characteristics: Dependent Measures

STSS results. The 17 item self-report survey was measured on a 5 point Likert scale, with 1=Never, 2=Rarely, 3=Occasionally, 4=Often, and 5=Very Often. Scores of each of the 17 items were summed with a minimum possible score of 17 and a maximum score of 85. A total score over 38 is suggestive of the presence of STS measured by PTSD criteria (Bride, 2007). A higher score indicates a more severe level of STS. Of the 107 respondents that completed the measure, 45 respondents scored 38 or above (42.1 percent), signifying the presence of STS at a clinical level (Table 3). The average score within the population was 36.1. This average is below the cutoff score, indicating a majority of advocates have low levels of Secondary Traumatic Stress. A total of 62 respondents (57.9 percent) scored below the cutoff score of 38.

Symptoms were considered to be endorsed if a respondent selected 3 or higher. The most commonly reported symptoms were intrusive thoughts about work and clients (68.2 percent), and trouble concentrating (55.1 percent).

Table 3. Secondary Traumatic Stress Scale Results (N=107)

Score	Less than 38	38 and over	Mean	Std. Deviation
# of Participants	62	45	36.1	11.7

STS, VT, AND CF AMONG VICTIM ADVOCATES

Vicarious Trauma Scale Results. Vicarious Trauma was measured by the Vicarious Trauma Scale (Vrklevski, & Franklin, 2008), an 8 item self-report survey. The measure is scored on a 7 point Likert scale with 1=Strongly disagree, 2=Disagree, 3=Slightly disagree, 4=Neither agree nor disagree, 5=Slightly agree, 6=Agree, 7=Strongly agree. Scores of each of the 8 items were summed for an overall score ranging from 8 to 56. Scores of 8-28 indicate low Vicarious Trauma, 29-42 indicate moderate or average Vicarious Trauma levels, and 43-56 indicate high levels of Vicarious Trauma. 107 respondents completed the measure. A majority (51.4 percent) of advocates scored in the moderate range of the Vicarious Trauma scale, while the analysis revealed 30 (28 percent) respondents scored in the high Vicarious Trauma range.

Table 4. Vicarious Trauma Scale Results (N=107)

Score	Low	Moderate	High	Mean	Std. Deviation
	22	55	30	36.3	8.2

Professional Quality of Life Scale Results. This 30 item self-report test was measured on a 5 point Likert scale with 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often. Scores for this measure were broken down into three subsections: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress/Compassion Fatigue. Scores for each subsection were summed. A score of 22 or less in each is considered low, 23-41 is moderate, and 42 or more is considered high. Compassion Satisfaction consisted of questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30. Results for this measure were positively skewed, meaning respondents had high levels of Compassion

STS, VT, AND CF AMONG VICTIM ADVOCATES

Satisfaction. No respondents scored below 22, and more than half of the respondents were categorized as having high Compassion Satisfaction (52.3 percent). Burnout consisted of questions 1, 4, 8, 10, 15, 17, 19, 21, 26, 29, with questions 1, 4, 15, 17, and 29 being reverse scored (1=5, 2=4, 3=3, 4=2, 5=1). 68 advocates scored a 22 or below, indicating low levels of burnout. The highest measured score was 38, resulting in no advocates with high level burnout. Secondary Traumatic Stress consisted of questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28. Similar to burnout measures, a majority of advocates scored under 22, indicating low levels of Secondary Traumatic Stress. 64 respondents have little to no indication of Secondary Traumatic Stress, while zero respondents scored in the high range (Table 5).

Table 5. Professional Quality of Life Scale Results (N=107)

	# in Low range	Moderate	High	Mean Score	Std. Deviation
Compassion Satisfaction	0	51	56	40.7	6.5
Burnout	68	49	0	21.5	6.2
Secondary Traumatic Stress	64	43	0	21.2	7.1

Upon determining the prevalence of STS, VT, and CF among victim advocates, our research focus shifted to risk factors of these conditions.

Hypothesis Testing

Research question 1: To answer Research Question 1 (*Is there any relationship between an advocate's demographics and their STSS scores, VTS scores, and CF scores?*) a series of one-way ANOVAs were calculated for ethnicity, marital status, education level, and income as the dependent variables. No significant values were

STS, VT, AND CF AMONG VICTIM ADVOCATES

calculated among STSS scores, VTS scores, Compassion Satisfaction scores, Burnout scores, and Secondary Traumatic Stress/Compassion Fatigue scores. See Table 6.

Table 6. Analysis of Variance Between Measure Scores and Demographics

	df	F	P
STSS			
Marital Status	5	1.034	.402
Education	6	.753	.608
Income	11	1.277	.250
Ethnicity	3	.904	.442
VTS			
Marital Status	5	.148	.980
Education	6	.880	.513
Income	11	.844	.597
Ethnicity	3	.487	.692
ProQOL Compassion Satisfaction			
Marital Status	5	.568	.724
Education	6	.759	.603
Income	11	.850	.591
Ethnicity	3	.174	.914
ProQOL Burnout			
Marital Status	5	.334	.892

STS, VT, AND CF AMONG VICTIM ADVOCATES

Education	6	.445	.847
Income	11	1.100	.370
Ethnicity	3	.674	.570
<hr/>			
ProQOL STS			
Marital Status	5	.763	.578
Education	6	.540	.776
Income	11	.897	.546
Ethnicity	3	.410	.746

Research question 2: To answer Research Question 2 (*Is there a relationship between an advocate's own victim status and their score on the STSS, VTS, and ProQOL?*) a one-way analysis of variance (ANOVA) was calculated for each measure and no significance was found. There was no significant correlation between an advocate's status as a victim and their STSS score, $F(1, 105) = .074, p = .785$, their VTS score, $F(1, 105) = 0.040, p = .842$, or their ProQOL scores: Compassion Satisfaction, $F(1, 105) = 0.017, p = .898$, Burnout, $F(1, 105) = 0.445, p = .506$, STS/CF, $F(1, 105) = 1.896, p = .171$.

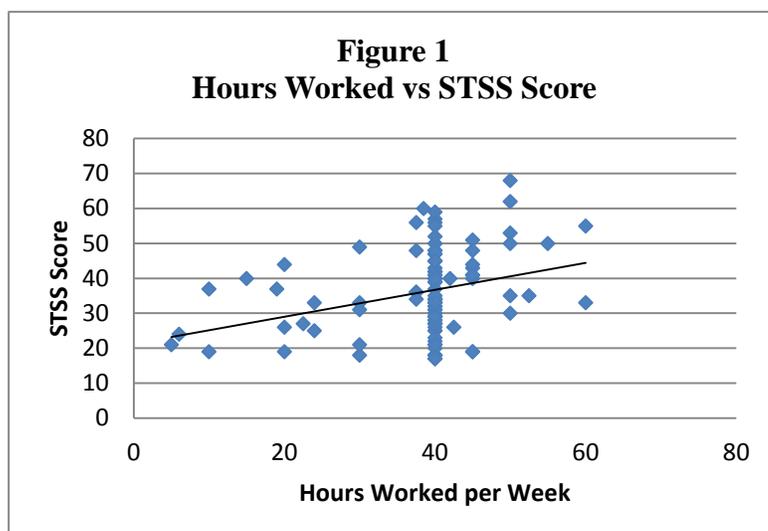
Research question 3: To answer Research Question 3 (*Is there a relationship between the presence or lack of support from an advocate's work and their score on the STSS, VTS, or ProQOL?*) a one-way ANOVA for each measure calculated a significant effect between work support and Compassion Satisfaction, $F(1, 105) = 14.02, p < .001$, and a significant effect between work support and Burnout scores, $F(1, 105) = 7.890, p = .006$. Those receiving work support of some kind reported a mean score of 41.84

STS, VT, AND CF AMONG VICTIM ADVOCATES

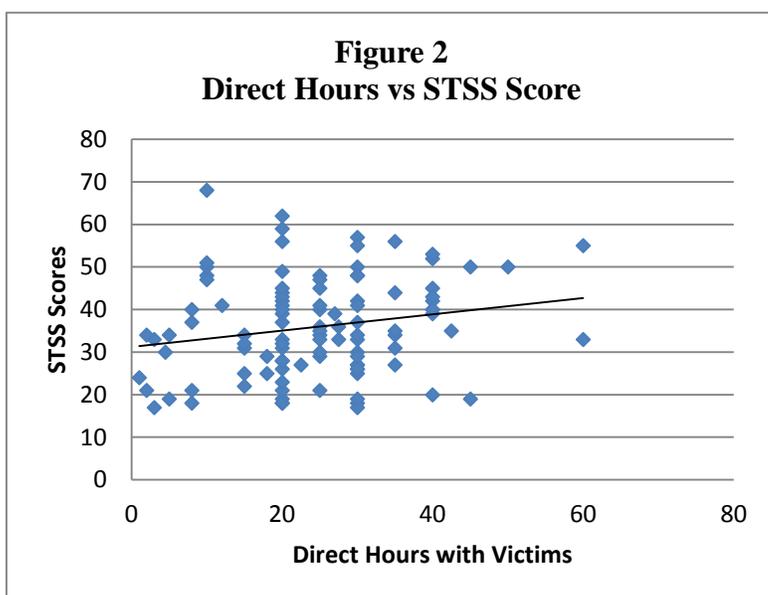
(SD=5.67) for Compassion Satisfaction, while those that reported having no work support provided had a mean score of 36.29 (SD=7.62). The mean Burnout score for those with work support was 20.48 (SD=5.83), while those with no support had a higher mean score of 24.76 (SD=6.56). No other measures reported significance with respect to work support. STSS scores were near the significant level, $F(1, 105) = 2.770, p = .099$, with work support resulting in an insignificant decrease in score.

Research question 4: To answer Research Question 4 (*Is there any relationship between an advocate's experience or the time an advocate spend working and their scores on the STSS, VTS, and ProQOL?*) correlational analyses were run for three independent variables: years of experience, hours worked per week, and direct hours spent with victims per week. The STSS had a positive correlation with hours worked, $r(105)=.31, p=.001$, and direct hours worked, $r(103)=.20, p=.044$. See Figures 1 and 2. STSS scores were not correlated with years of experience as a victim advocate. Vicarious Trauma Scale results and Compassion Satisfaction scores were not correlated with hours, direct hours, or years of experience. Burnout measures and STS/Compassion Fatigue measures were strongly correlated with total hours worked each week, $r(105)=.26, p=.008$ and $r(105)=.26, p=.006$, respectively, although direct hours spent with victims did not have any significant correlation, nor did years of experience.

STS, VT, AND CF AMONG VICTIM ADVOCATES

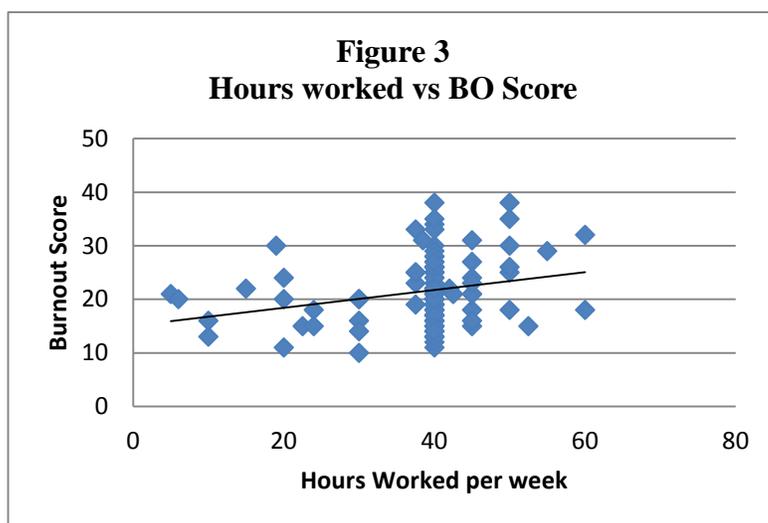


$r(105)=.31, p=.001$

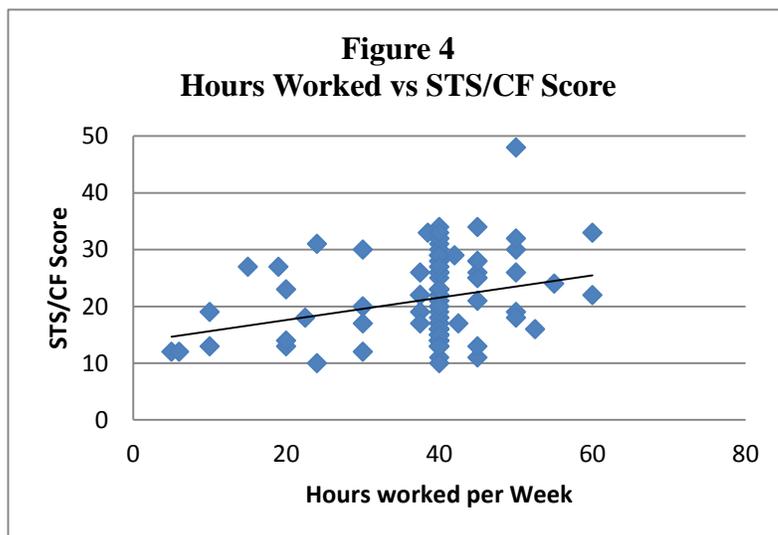


$r(103)=.20, p=.044$

STS, VT, AND CF AMONG VICTIM ADVOCATES



$$r(105) = .26, p = .008$$



$$r(105) = .26, p = .006$$

STS, VT, AND CF AMONG VICTIM ADVOCATES

Research question 5: To answer Research Question 5 (*Is there any relationship between the number of victim types an advocate works with or the number of tasks they perform, and their scores on the STSS, VTS, and ProQOL?*) correlational analyses were run and showed no significant correlations between number of victim types or number of tasks performed, and STSS, VTS, and ProQOL scores. The number of victim types neared the significant level with respect to a correlation with the STSS, $r(105)=.18$, $p=.06$. The number of activity types also neared a significant level with respect to the number of services an advocate provides, $r(105)=.17$, $p=.08$.

Research question 6: To answer Research Question 6 (*Is there any relationship between the number of self-care activities an advocate engages in or the support they have from work or other parts of their lives, and their scores on the STSS, VTS, and ProQOL Scale?*) correlational analyses for self-care activities were run twice for each measure: once with all listed self-care activities, and once without “Smoking” and “Alcohol Consumption” removed from analyses. Because these activities may be viewed as negative coping mechanisms, the analyses were examined for both cases so as not to skew results and interpretation. The Vicarious Trauma Scale score was positively correlated with self-care activities when smoking and alcohol consumption were included, $r(105)=.20$, $p=.04$, but was not significant when they were excluded from analyses, $r(105)=.11$, $p=.25$. This would indicate that those that engage in smoking and alcohol consumption have higher levels of Vicarious Trauma. No other measures reported significant correlations with self-care.

The number of support types that advocates had outside of their work provided supports was not correlated with their scores on any of the measures, but the number of

STS, VT, AND CF AMONG VICTIM ADVOCATES

supports provided by their work did report significance. Those with more types of supports provided through their work had higher scores on the Compassion Satisfaction measure, $r(105)=.37, p<.001$, and lower Burnout scores, $r(105)=-.27, p=.005$.

Discussion

The purpose of this quantitative study was to examine the prevalence of and risk factors that predict Secondary Traumatic Stress (STS), Compassion Fatigue (CF) and Vicarious Trauma (VT). Victim advocates are exposed to secondary trauma through their victim clientele and are therefore at risk of developing STS, VT, and/or CF. A review of the literature revealed that STS, VT, and CF have been studied among populations such as therapists (Hensel, Ruiz, Finney & Dewa, 2015), nurses (Alsop, 2012), and social workers (Bride, 2007). Few studies have looked at the effects of secondary trauma on victim advocates, and more research is needed on this population in order to better prevent and treat these conditions.

The results of the current study were consistent with Slattery's (2003) study of domestic violence victim advocates, where nearly 50 percent of the study's respondents met STS criteria. Both the current study and Slattery's results reported a much higher prevalence than the 15.2 percent among social workers (Bride, 2007) and significantly higher than the general population. The lifetime prevalence of PTSD in America among the general population is 6.8 percent. Women are slightly more at risk with 9.7 percent being affected, and men have a prevalence of 3.6 percent (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). According to the results of the STSS,

STS, VT, AND CF AMONG VICTIM ADVOCATES

victim advocates are nearly 7 times more likely to develop Secondary Traumatic Stress or PTSD symptoms.

Following the results of Slover's (1998) study of domestic violence victim advocates, and Hensel's meta-analysis of 38 STS studies (2015), this study hypothesized a correlation between an advocate's status as a victim of trauma and their levels of STS, VT, and CF. No significant correlation was found. The lack of significance was unexpected because it had been found consistently in previous studies.

Past studies have had little success in showing a consistent correlation between social support or type of victim and levels of STS. Mixed results have also been found with respect to correlations between experience or time worked and levels of STS. The current study did find that there is a relationship between hours worked per week and STS scores. The amount of direct hours was also indicative of STS levels as Slattery & Goodman also found (2009). The correlation between hours worked and burnout scores was positive, but direct hours was not significant, possibly revealing that this effect would be present in any occupation. Burnout is not only related to service providing careers (Stamm, 2010). Because the results were not significant with respect to direct hours spent with victims, this finding could simply mean the more time anyone spends working per week, the more likely they are to experience burnout.

Figley explains that those suffering from Compassion Fatigue are likely to experience Compassion Satisfaction (Figley, 2007). In opposition to this claim, Collins and Long found negative correlations between burnout and STS with satisfaction levels, indicating that compassion satisfaction acts as a sort of buffer to higher levels of burnout, STS, and ultimately Compassion Fatigue (2003). The relationship between Compassion

STS, VT, AND CF AMONG VICTIM ADVOCATES

Satisfaction and Compassion Fatigue is still unknown, which is why the ProQOL is scored on three subscales, instead of a composite score (Stamm, 2010).

The implications of this study are many, with the first being that, in agreement with previous research, STS, VT, and CF are not easily predicted. The prevalence may be defined, but there appears to be few risk factors that are consistent throughout the literature. The significance with work provided support is an area that should be more closely examined. Support such as family, friends, and therapists showed no significant correlation to STS, VT, and CF if they were present, but the support provided by one's work made a difference. Examining the effectiveness of trainings, staff meetings, and other supports provided would be a step in the direction of prevention. An effective method of maintaining low levels of STS, VT, and CF could assist those employing advocates throughout the country.

Limitations

As with any research, the results of this study contain a number of limitations, and further research must be conducted to come to any certain conclusions. This study was dependent on self-report measures which may limit the reliability of the responses. The respondents were invited to participate via email, and those that chose not to participate could have been different from those that chose to take the survey. Those with symptoms of STS, VT, or CF may have chosen not to participate out of fear that the questions would cause discomfort. Or alternatively, those with STS, VT, and CF symptoms may have participated because they wanted to help with a study that applied to their current state.

STS, VT, AND CF AMONG VICTIM ADVOCATES

The wide scope of the study may be cause for concern as well because people in different geographic regions differ. Because the survey was anonymous, there is no way of sorting out what region the results were from. The type of office that an advocate works within was not examined in the survey, and there could be differences within the field of victim advocacy itself. Those that work for the district attorney may assist a higher number of a certain type of victim than an advocate working for a non-profit organization. Those that selected the services they provide may provide these services at different rates depending on their caseload. These are considerations that could be examined in a following study.

Another future direction would be to examine the supports and self-care activities in more depth. This study found that more support types was helpful in maintaining compassion satisfaction, but which types are the most effective is unknown. Self-care activities fall into the same category. The activities that are helpful and detrimental to one's level of STS, VT, and CF are unknown.

Summary

This study revealed the prevalence of STS, VT, and CF among victim advocates in the United States. Demographic information had no significant relationship with the scores on the measures for STS, VT and CF. Support provided through an advocate's work, such as trainings, conferences, and peer support impacted the levels of these conditions, with more support having a negative correlation with burnout and a positive correlation with compassion satisfaction. The number of hours worked was also related to the various scores, with higher hours worked per week being positively correlated with

STS, VT, AND CF AMONG VICTIM ADVOCATES

burnout and STS. Future studies must be done to better understand the risk factors of these conditions in order to provide more suitable prevention efforts for victim advocates.

STS, VT, AND CF AMONG VICTIM ADVOCATES

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STS, VT, AND CF AMONG VICTIM ADVOCATES

Appendix A. Demographics questionnaire**Age:** _____**Sex:**

- Male
- Female

Race/Ethnicity:

- American Indian or Alaska Native
- Hawaiian or other Pacific Islander
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- White

Marital Status:

- Single
- Married
- Divorced
- Widowed
- Unmarried but in a relationship
- Prefer not to answer

Education level: (highest achieved)

- High School (no diploma)
- Grade 12 or GED (high school graduate)
- Some college (no degree)
- Associate's degree
- Bachelor's degree
- Master's degree
- Professional Degree
- Doctoral Degree
-

Yearly Household Income:

- Less than \$10,000
- \$10,000 to \$19,999
- \$20,000 to \$29,999
- \$30,000 to \$39,999
- \$40,000 to \$49,999
- \$50,000 to \$59,999
- \$60,000 to \$69,999
- \$70,000 to \$79,999

STS, VT, AND CF AMONG VICTIM ADVOCATES

- \$80,000 to \$89,999
- \$90,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 or more
- Prefer not to answer

How many dependents live in your household?

- 0
- 1
- 2
- 3
- 4 or more
- Prefer not to answer

Are you paid for your services as a victim advocate?

- Yes
- No

Years of experience as a victim advocate: _____

How many hours on average do you work as a victim advocate per week?

How many hours on average do you directly work with victims per week? _____

What types of activities do you engage in? (Check all that apply)

- Accompanying victims to court hearings and legal proceedings
- Helping victims find housing, work, or transportation
- Providing victims with referrals to necessary services
- Providing one on one emotional support to victims
- Providing support to victims through support groups
- Intervening with other parties on behalf of the victim
- Assisting victims with applications and paperwork
- Informing victims of their rights
- Other (please explain):

What types of victims do you currently work with? (Check all that apply)

- Victims of assault/battery
- Victims of sexual assault
- Adult survivors of sexual abuse
- Children who have been sexually abused
- Children who have been physically abused (non-sexual)
- Victims of self-harm
- Victims of domestic abuse

STS, VT, AND CF AMONG VICTIM ADVOCATES

- Other (please explain):

What types of support do you have in your life? (Check all that apply)

- Family
- Partner or Spouse
- Friends
- Therapist/counselor
- Support group
- Other (please explain):

What self-care activities do you engage in? (Check all that apply)

- Journaling
- Peer Support
- Meditation/yoga
- Reading
- Creative arts (music, drawing, painting. Etc.)
- Smoking
- Alcohol Consumption
- Exercise/ sports
- Taking mental health days
- Volunteering
- Prescription or non-prescription medication
- Other (please explain):

Does your work provide you with support?

- Yes
- No

What supports does your work provide? (Check all that apply)

- Workshops/ Trainings
- Conferences
- Yoga/ Meditation
- Support Groups
- Counseling
- N/A
- Other (please explain):

Have you ever been a victim of trauma?

- Yes
- No

STS, VT, AND CF AMONG VICTIM ADVOCATES

Appendix B. Secondary Traumatic Stress Scale

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

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

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

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Intrusion Subscale (add items 2, 3, 6, 10, 13)

Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)

Arousal Subscale (add items 4, 8, 11, 15, 16)

TOTAL (add Intrusion, Arousal, and Avoidance Scores)

Intrusion Score _____

Avoidance Score _____

Arousal Score _____

Total Score _____

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

STS, VT, AND CF AMONG VICTIM ADVOCATES

Appendix C. Professional Quality of Life Scale (ProQOL)

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

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

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a victim advocate.
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 victim advocate.
11. Because of my victim advocacy, I have felt “on edge” about various things.
12. I like my work as a victim advocate.
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 victim advocacy 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 victim advocate.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed because the caseload/workload seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
24. I am proud of what I can do to help.
25. As a result of my helping, I have intrusive, frightening thoughts.
26. I feel “bogged down” by the system.
27. I have thoughts that I am a “success” as a victim advocate.
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.

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Appendix D Vicarious Trauma Scale

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Please read the following statements and indicate on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) how much you agree with them.

1. My job involves exposure to distressing material and experiences.
 2. My job involves exposure to traumatized or distressed clients.
 3. I find myself distressed by listening to my clients' stories and situations.
 4. I find it difficult to deal with the content of my work.
 5. I find myself thinking about distressing material at home.
 6. Sometimes I feel helpless to assist my clients in the way I would like.
 7. Sometimes I feel overwhelmed by the workload involved in my job.
 8. It is hard to stay positive and optimistic given some of the things I encounter in my work.
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Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology*, 14(1), 106–118.