

Secondary Traumatic Stress Among Domestic Violence Advocates: Workplace Risk and Protective Factors

Violence Against Women

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Abstract

This study identified workplace factors associated with secondary traumatic stress (STS) in a sample of 148 domestic violence advocates working in diverse settings. Findings indicate that coworker support and quality clinical supervision are critical to emotional well-being and that an environment in which there is shared power—that is, respect for diversity, mutuality, and consensual decision making—provides better protection for advocates than more traditional, hierarchical organizational models. Furthermore, shared power emerged as the only workplace variable to significantly predict STS above and beyond individual factors. The discussion includes implications for practice and policy as well as directions for future research.

Keywords

domestic violence, secondary traumatic stress, workplace

Over the last several decades, domestic violence services have expanded from small, grass-roots shelters to a nationally organized response by individuals and groups in medical, legal, and community organizations (Chalk & King, 1998). Domestic violence advocates now provide a broad range of essential services to battered women and their children (Peled & Edleson, 1994). Yet, surprisingly little is known about how the demanding work they do affects them or about aspects of their work environments that may endanger or protect their emotional well-being.

Literature on the psychological impact of trauma work among psychotherapists (Bober & Regehr, 2006; Pearlman & MacIan, 1995), domestic violence and sexual assault counselors (Baird & Jenkins, 2003; Wasco & Campbell, 2002), social workers (Bride, 2007), emergency medical personnel (Galloucis, Silverman, & Francek, 2000), and firefighters

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(Al-Nasar & Everly, 1999) has demonstrated the potential for burnout and secondary traumatic stress (STS) that accompanies work with trauma survivors.

Although this body of research provides clues toward understanding the experience of domestic violence advocates, the unique complexities of working with women who face real and present danger at the hands of an intimate partner remain relatively unexplored. Like therapists and counselors, domestic violence advocates offer emotional support by listening to women's stories, many of which involve terrifying acts of physical, sexual, emotional, and psychological abuse (Davies, Lyon, & Monti-Catania, 1998; Dutton, 1992; Koss et al., 1994). However, they may also provide specific expertise in safety planning; connect and accompany women through medical, legal, financial, immigration, or employment services; and provide direct care to traumatized women and children in shelters and other residential settings (Davies et al., 1998; Peled & Edleson, 1994). Many advocates also work to challenge organizational policies, institutional values, and/or public attitudes to improve system responsiveness to women in abusive relationships (Peled & Edleson, 1994). They may also write legislation, train law enforcement personnel, design public relations campaigns, and talk to students in local school systems.

Not only do domestic violence advocates engage in a wide variety of activities, they also work in a range of diverse settings that differ dramatically in terms of access to support and resources, and organizational climate and structure (Goodman & Epstein, 2008). For example, some advocates work in a team-oriented shelter setting, whereas advocates in hospitals and courts work in more isolated settings with limited access to support and feedback. Some settings adhere to more traditional hierarchical models, whereas others offer advocates greater access to power within the organization through a decentralized management structure. These kinds of differences may radically shape an advocate's ability to cope with a challenging job. Further empirical evidence is needed to understand what types of work environments produce the most beneficial outcomes for workers in the trauma field in general as well as those for domestic violence advocates in particular. This is a critical gap in the literature that hampers our ability to develop supportive contexts for domestic violence advocates. This study represents a first step toward filling this gap.

STS Defined

STS has been defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). Like a diagnosis of posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994), an STS reaction is considered to be a normal response to exposure to victims of traumatic events rather than an abnormal or pathological reaction (Figley, 1995; Herman, 1992). Indeed, Munroe (1999) called STS an occupational hazard for those working with trauma survivors.

Symptoms of STS parallel those of PTSD and include reexperiencing the client's traumatic event through thoughts, feelings, and imagery; avoiding or feeling numb to emotions that remind one of the event; and persistent arousal such as heart palpitations, sweating, or

sleep disturbances (Figley, 1995, 1999). Researchers attempting formally to assess STS have used a number of measures, most of which resemble symptom checklists for PTSD (Bober & Regehr, 2006; Brady, Guy, Poelstra, & Brokaw, 1999; Bride, 2007; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999). Highlighting the need for the development of specific instruments and procedures to assess STS, Dutton and Rubinstein (1995) recommended the use of PTSD scales to measure STS among trauma workers until more specialized instruments are made available.¹

Contributors to STS

Because so little research addresses risk factors for STS, this section considers the broader literature on contributors to psychological difficulties among trauma workers to develop a picture of those individuals at greater risk for a secondary traumatic response. This literature can be divided into individual and workplace contributors.

Individual Contributors

Two of the most commonly explored individual level contributors to psychological distress among trauma workers are degree of exposure to traumatized clients and personal trauma history. With regard to the first of these, worker exposure is commonly measured by the proportion of trauma survivors in a provider's caseload, and/or the number of traumatized client contact hours. Research findings are mixed. Schauben and Frazier (1995), for example, found that among a sample of female psychologists and rape crisis counselors, the number of trauma survivor clients in the therapists' caseloads was correlated with symptoms of PTSD. Similarly, Bober and Regehr (2006) found that the number of hours spent working with traumatized individuals was the primary predictor of trauma in their study of therapists, with a greater number of hours associated with a higher degree of PTSD symptoms. However, in their study of sexual assault counselors, Ghahramanlou and Brodbeck (2000) found that client contact hours with trauma survivors in counseling and in the emergency room did not significantly predict secondary trauma. Likewise, Baird and Jenkins (2003) found that higher rates of secondary trauma were not associated with exposure to survivors of domestic violence and sexual assault among their sample of trauma counselors.

Personal trauma history has been widely examined as a predictor of secondary distress among trauma workers, based on the idea that individuals with their own history of victimization will hear client stories and feelings and then be reminded of their own abuse (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Although this conceptualization is compelling, particularly as a way of thinking about domestic violence advocates who are often themselves survivors of intimate partner violence, empirical findings are mixed, possibly due to different definitions of "trauma history" used across studies. For example, Pearlman and MacIain (1995) found that 60% of trauma therapists in their study who responded *yes* to the item "Do you have a trauma history?" were more negatively affected by the work than those without a trauma history. Likewise, Kassam-Adams (1999) found among psychotherapists that both gender and personal trauma history were related

to PTSD symptoms of participants, with female therapists and therapists with trauma histories reporting more symptoms. Trauma history in this study was determined by asking participants to reveal if they had ever personally experienced, in childhood or adulthood, any of the following: physical abuse/maltreatment, emotional abuse, sexual abuse or assault, death of an immediate family member, home destroyed by fire or other natural disaster, or other traumatic experience.

However, in their study of female psychologists and rape crisis counselors, Schauben and Frazier (1995) reported that therapists with a personal history of victimization, measured by asking if they had experienced rape, attempted rape, incest/child sexual abuse, sexual harassment, or other sexual assault, did not show greater distress than those without such a history. Follette, Polusny, and Milbeck (1994) also found that childhood abuse history did not significantly predict trauma symptoms in their study of mental health professionals and law enforcement officers working with child sexual abuse. In their study of therapists, Bober and Regehr (2006) found that PTSD symptoms were not associated with having a personal trauma history in childhood or adulthood. Although these researchers compared scores for those working with survivors of wife assault, child abuse, child sexual abuse, sexual assault, and torture, it is not clear from the study how trauma history was defined.

Taken together, these mixed findings do not offer clear support for the hypothesized relationship between personal trauma history and negative psychological outcomes from trauma work. Furthermore, this line of research is limited in that it does not offer clear avenues for intervention—other than to suggest the possibility that trauma survivors should think twice before becoming trauma workers themselves. By contrast, studies examining current contextual factors that might contribute to, or protect against, the development of STS have more potential for offering avenues for intervention.

Similarly, the mixed research findings related to the hypothesis that level of exposure to traumatized clients leads to greater secondary trauma may have confounding environmental factors at work such as accessibility to supervision or degree of coworker support available.

Workplace Contributors

Three of the most important workplace contributors to psychological well-being in trauma workers may be social support, clinical supervision, and access to power.

Social support. When the stress occurs in the workplace, work-related sources of support appear to be more valuable than support provided by family and friends (House & Kahn, 1985). Not surprisingly, significant relationships have been found between social support in the workplace and the physical and mental health of individuals (Moos, 1988; Repetti, Matthews, & Waldron, 1989). In their qualitative studies of rape victim advocates, Wasco, Campbell, and Clark (2002) found a relationship between organizational support (including but not limited to coworker support) and the advocates' use of self-care routines, while Ullman and Townsend (2007) found vicarious trauma related to poor supervision as a significant problem for advocates.

Although the one quantitative study to examine workplace social support as a protective factor against STS did not find a relationship between the two (Kassam-Adams, 1999), qualitative research by Iliffe and Steed (2000) found that domestic violence counselors identified debriefing and peer support as the most important factors that helped them to deal with the work. Other research studies that have found a relationship between workplace social support and other forms of work stress provide additional indirect support for this connection (Beaton & Murphy, 1993; Revicki, Whitley, & Gallery, 1993).

Clinical supervision. Clinical supervision serves both an educational and professional development function for the clinician or service provider. Theoretical models regarding the structure and function of clinical supervision have emerged in recent years with an increasing emphasis on the supervisory relationship as the most central component of effective supervision (Holloway, 1995).

The nature of the relationship between supervisor and supervisee may also have important implications for the psychological well-being of the supervisee. For the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma (Pearlman & Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999). Surprisingly, however, empirical evidence on the psychological impact on the supervisee of the supervisory relationship is quite limited. Studies that have investigated the relationship between clinical supervision and negative psychological outcomes among trauma workers have focused mainly on the quantity (see, for example, Pearlman & Maclan, 1995), rather than the quality, of supervision.

Access to power. Throughout the 1960s and 1970s, the organizational structures of domestic violence shelters and agencies were made up of decentralized, nonhierarchical power structures that included consensual decision making, job rotating and sharing, and equal salary distribution (Thomas, 1999). Over time, however, changes have occurred to these organizations as a result of both external political and economic forces and internal, developmental shifts (Shepard, 1999; Thomas, 1999). For example, advocacy services for battered women have expanded to mainstream settings such as courts and hospitals in an attempt to meet the needs of the wider population seeking services. Although advocacy continues to be the primary form of service provision to women in these settings, it appears that many have become more hierarchical in their organization, with feminist and empowerment ideologies less central to their governing structures (Thomas, 1999). Little research has been done on how these organizational shifts have affected the well-being of advocates. In particular, how might an advocate's perception of their access to power be related to the experiences of STS?

Kanter's (1993) theory of structural power in organizations is a useful conceptual framework for considering this question. Kanter (1993) proposed that the behavior and attitude of individuals at work are determined in large part by their positions within the organization and their relative access to power. She states that the term *power* is synonymous with autonomy and freedom to act. Thus, in an empowering organization, individuals experience a sense of autonomy; they are able to participate in decision-making processes, and

they have the ability to obtain the support, information, resources, and opportunities that they need to meet their goals.

Consistent with Kanter's theory, Thomas (1999) conducted a qualitative study in 14 feminist health centers in operation since the 1970s to examine feminist ideology and the impact of organizational change on the individual and the group. She found that as some of the groups began to introduce more hierarchical structures, workers became less autonomous and less involved in the process of decision making. Participants in these centers reported lower job satisfaction, higher turnover, and feelings of disempowerment among staff. Access to power as a contributor to STS has not yet been considered by empirical researchers.

Summary

As the above literature review indicates, there are serious gaps in our knowledge about potential risk and protective factors for STS. The purpose of this study was to explore contributors to STS among domestic violence advocates in diverse work settings. Using an ecological perspective that highlights the interaction between individuals and their environment (Bronfenbrenner, 1979), we hoped to identify risk and protective factors that exist within an organization, rather than within an individual (e.g., coping style), that may be related to the symptoms of secondary traumatization. Specifically, we investigated the environmental factors of workplace social support (coworker cohesion), clinical supervision (quality), and access to power (shared power) within the organization. In addition, we were interested in exploring the relative significance of these work environment factors over and above individual variables such as survivor status and hours of direct service.

Method

Procedure and Participants

This study is based on a convenience sample of domestic violence advocates working in community health centers, courts and other legal settings, crisis and counseling centers, domestic violence service agencies, hospitals, shelters, and social service organizations in Massachusetts. We recruited participants in two ways over a period of 6 months. First, we obtained mailing lists from statewide advocacy programs and used them to disseminate an online access link to the survey, along with letters from the advocacy programs supporting the study and a cover letter from us. Second, we distributed surveys to advocates and administrators participating in state-level domestic violence meetings. Participants were given a cover letter outlining the purpose of the study. Individuals who decided to participate read the informed consent form and indicated their consent by signing the form or clicking on the appropriate bar for those completing it on the Web site. As an incentive, we explained to all participants that they would be eligible to enter into a raffle to win one of three health-related prizes. A debriefing form was provided to participants that included referral and resource information related to secondary trauma.

Measures

Background Questionnaire. This questionnaire obtained information regarding participant's sex, age, race/ethnicity, country of origin, number of years living in the United States, educational level, relationship status, number of children, sexual orientation, position title, employment status (full time or part-time), type of service, type of work setting (e.g., hospital, court, shelter), number of hours of direct service per week, and years of experience working in the field of domestic violence. Four questions were also included regarding specific responsibilities as advocates, quantity of clinical supervision available, staff meeting time allocated for case discussion, and whether participants had ever attended a formal advocacy or peer support group. One question also asked participants to state if their clinical supervisor is also their manager or administrator. This was for clarification purposes regarding their ratings of their clinical supervisor on the Relational Health Index–Mentor (RHI-M), described below. In addition, participants were asked to indicate whether they were survivors of a range of types of abuse, including intimate partner violence, rape or sexual assault, childhood physical abuse, emotional abuse or neglect, and/or being a child witness to violence.

STS. The PTSD Checklist–Stressor Specific Version (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report instrument that measures degree of PTSD symptomatology, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994). The PCL-S requires respondents to rate on a scale from 1 (*not at all*) to 5 (*extremely*) the degree to which they have experienced symptoms in the previous month, with higher scores associated with more symptoms. As suggested by the scale's authors, items that are rated as moderately severe or greater are classified as present symptoms. The measure demonstrated high internal consistency for this sample, with a Cronbach's alpha of .91.

Workplace social support. The Work Environment Scale (WES; Moos, 1994) is a widely used instrument designed to measure dimensions of the work environment. Although it contains 10 subscales, we used only the Coworker Cohesion subscale. Moos (1994) defined coworker cohesion as the extent to which employees are friendly and supportive of one another (e.g., "People take a personal interest in each other"). This subscale is made up of 9 items with higher scores indicating greater perceived support. The original version of the WES uses a true–false response format. However, following the example of Abraham and Foley (1984), we used a 4-point response format, with response choices ranging from 1 (*rarely*) to 4 (*usually*) in an effort to capture more accurately how advocates perceive the social climate of their workplace. In the current study, Cronbach's alpha for this subscale was .731.

Clinical supervision: Quality. The RHI (Liang et al., 2002) is a 37-item measure comprised of three scales that assess the quality of relationships with peers, mentors, and communities. The Relational Health Index (RHI; Liang et al., 2002) is based on the relational model of women's psychological development (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller & Stiver, 1997). The items consist of statements that are rated on a Likert-type scale that ranges from 1 (*never*) to 5 (*always*). A high score indicates a high degree of relational health. For our purposes, we used only one of the scales, the RHI-M, which measures

relationships with mentors to assess the quality of the clinical supervisory relationship. Slight modifications to the scale included the term *clinical supervisor* in place of *mentor* on each of the 11 RHI-M items (potential score range = 1-55) making up the index. Sample items include the following: "I can be genuinely myself with my clinical supervisor" and "My clinical supervisor tries hard to understand my feelings and goals." The internal consistency of this measure in our study was found to be strong with a Cronbach's alpha of .96.

Access to power. To fully capture the feminist aspect of work empowerment, we developed a 15-item measure, the Shared Power Scale, which assesses participants' perceptions of shared power within their organization (see appendix). Items came from three sources, including (a) literature on organizational structures and practices that promote nonhierarchical forms of administration, mutuality, and respect for difference in the workplace (see, for example, Huygens, 2001; Schechter, 1982; Thomas, 1999); (b) our discussions with a diverse group of advocates working in the field; and (c) our personal experiences as domestic violence advocates and clinicians. Once we developed an initial pool of 11 items, we invited a set of six advocates to review the items and add to or change them. These advocates represented a convenience sample selected with consideration of the demographic differences representative of domestic violence advocates working in the local area, availability to participate in focus group discussions, and willingness to provide feedback. This review process resulted in the addition of 4 items and word changes to 3 items. The final measure included 15 items, reflecting the following dimensions of shared power: equality, voice, representation, shared leadership, and respect. Examples of items include the following: "Do you feel that all staff are treated fairly and as equals?" "Do you feel that you have opportunities to initiate or lead projects?" and "Do you feel that differences among staff (e.g., cultural, age, ability, sexual orientation) are valued and respected?" The response choices range from 1 (*rarely*) to 5 (*often*) with higher scores representing more shared power. The internal consistency of this measure was found to be strong (Cronbach's alpha coefficient = .93); the construct validity was checked by correlating it with the other relevant measures, including the WES-Autonomy subscale (Moos, 1994), a measure of decision-making ability and self-sufficiency in the workplace ($r = .68$) and the Conditions for Work Effectiveness Questionnaire (CWEQ; Chandler, 1986), a measure of work empowerment defined as degree of opportunity and access to information, support, and resources within the organization ($r = .82$).

Data Analysis

Mean scores were calculated for each participant on all measures. Frequencies were computed for all categorical variables as well as means and standard deviations for all continuous variables. These preliminary analyses revealed a positive skew on the mean score of the PCL-S. A log transformation was therefore done on this scale. For the sake of simplicity, we will refer to this variable in its original term.

Simple correlations were conducted to address the following question: "Is each predictor related to the outcome at the univariate level?" Simultaneous regression analyses were used to address the question, "To what extent does each predictor uniquely

contribute to STS?” Because we were interested in the unique contribution of workplace variables over and above the contribution of individual level variables, the individual level variables were entered first, as a block, and then workplace variables were entered, as a block. For the purposes of the regression analyses, the survivor status variable was recoded as a dichotomous variable representing whether the participant reported any history of abuse.

Results

Description of Participants

Overall, 148 domestic violence workers participated in the study. One hundred and thirteen people began the survey online, though 34 stopped partway through, leaving 79 complete online surveys. Seventy-one additional participants completed paper surveys. Two of these were omitted because they did not meet eligibility criteria related to working with survivors of intimate partner violence. We compared the 79 online completers with the 69 paper survey completers and found no statistically significant differences between groups on all measures. Background characteristics of the 148 participants who composed the final sample are shown in Table 1. All participants were females with an age range of 19 to 65 years ($M = 36$, $SD = 12$). The majority described themselves as White (114; 77.6%); 11 (7.5%) described themselves as Hispanic/Latina, 9 (6.1%) as Black/African American, 4 (2.7%) as Asian American, 1 (0.7%) as Native American, and 8 (5.4%) as Biracial/Other. With respect to sexual orientation, 116 (80.0%) participants identified as heterosexual, 18 (12.4%) as bisexual, and 11 (7.6%) as lesbian/gay. Participants' highest level of education ranged from a high school diploma to a doctorate. Seventy-eight percent of participants graduated from college, and of these, 30.4% held a master's degree.

Participants were employed at shelters (29.1%), domestic violence service agencies (18.2%), courts or other legal settings (16.9%), crisis intervention centers (12.2%), community health centers (10.1%), social services agencies (8.1%), and hospitals (5.4%). They identified as advocates or counselor/advocates (74.8%), clinical or program coordinators (15%), directors (5.4%), or other (4.8%). One hundred and nine participants (74%) were working full time. Participants reported work responsibilities that included crisis intervention (88.5%), safety assessment and planning (86.5%), assistance with housing and shelter (68.2%), assistance with legal matters (64.9%), training and education (60.1%), consultation to community members/professionals (57.4%), and support groups (50%). Income levels ranged from less than US\$10,000 per year to just more than US\$50,000. Sixty percent of participants reported incomes in the range of US\$25,000 to US\$39,999. Direct service hours per week reported by participants ranged from 1 to 60 ($M = 24$, $SD = 12$). Years of experience in the domestic violence field ranged from less than 1 year to 25 years with a mean of 6 years of experience.

With respect to clinical supervision, 118 (80%) responded yes to the question “Do you have a clinical supervisor or someone with whom you meet regularly to discuss your

Table 1. Demographics of the Sample (in Percentages)

Race/ethnicity		Job title	
White	77.6	Advocate or counselor/advocate	74.8
Hispanic/Latina	7.5	Clinical or program coordinator	15.0
Black/African American	6.1	Director	5.4
Asian	2.7	Other	4.8
Native American	0.7	Workplace setting	
Biracial/Other	5.4	Shelter	29.1
Sexual orientation		Domestic violence service	18.2
Heterosexual	80.0	Court/legal service	16.9
Bisexual	12.4	Crisis center	12.2
Lesbian/gay	7.6	Community health center	10.1
Relationship status		Social service agency	8.1
Committed partner	56.4	Hospital	5.4
Single	31.3	Employment status	
Divorced	7.5	Full-time	73.6
Separated	2.7	Part-time	26.4
Widowed	2.0	Annual income	
Survivor status ^a		Less than US\$10,000	10.6
Survivor of abuse	55.4	US\$10,000-US19,999	9.8
Intimate partner violence	25.5	US\$20,000-US29,999	39.5
Child sexual abuse	19.9	US\$30,000-US39,999	33.8
Child witness to violence	18.8	US\$40,000-US49,999	5.6
Rape/sexual assault	17.7	US\$50,000-US59,999	0.7
Child physical/emotional abuse	5.0	Years of experience in the field	
No abuse history	44.6	1 to 2 years	29.9
Highest level of education		3 to 5 years	28.4
High school diploma or equivalent	2.7	6 to 10 years	31.2
Some college	11.5	10 to 25 years	10.5
Associates degree	7.4		
Bachelor's degree	33.8		
Some graduate school	13.5		
Master's degree	30.4		
Doctoral degree	0.7		

a. Survivors may have experienced more than one type of abuse so survivor status percentages do not sum to 100.

clients?" and 27 responded no, indicating that 18% of participants do not have someone with whom to meet regularly to discuss their clients.

Different types of past abuse reported included child sexual abuse, child witness to violence, intimate partner violence, rape/sexual assault, and child physical and emotional abuse or neglect. In our sample, 82 (55.4%) participants reported having experienced one or more of these types of abuse, whereas 66 (44.6%) participants reported no abuse history.

With respect to STS, 70 (47.3%) participants met the criteria for clinical levels of PTSD symptoms calculated according to *DSM-IV* criteria.

The means and standard deviations for the nonindividual predictor variables were as follows: secondary trauma ($M = 1.06$, $SD = 0.24$), coworker cohesion ($M = 3.03$, $SD = 0.58$), quality of clinical supervision ($M = 3.69$, $SD = 1.02$), and shared power ($M = 3.31$, $SD = 0.91$). Their correlations with each other ranged from $-.23$ to $.63$.

Correlations

As hypothesized, workplace social support was inversely related to STS ($r = -.229$, $p < .01$), the quality of clinical supervision was negatively related to STS ($r = -.226$, $p < .01$), and shared power was inversely related to STS ($r = -.303$, $p < .01$).

Simultaneous Multiple Regression Analyses

Results from the hierarchical multiple regression showed both individual and workplace variables significantly predicted STS (see Table 2). With respect to individual factors, the overall model explained 8% of the variance with survivor status ($\beta = .254$, $p < .01$) as the only factor found to significantly predict STS with an overall $R^2 = .08$. When workplace factors enter the model, the amount of variance explained increased to 19% with shared power ($\beta = -.294$, $p < .01$) as the only significant predictor of STS in a negative direction with an overall $R^2 = .19$. These findings indicate that regarding advocates' experience of STS, workplace variables explain an additional 11% of the variance, with shared power being the only significant contributor.²

Discussion

Despite the challenging nature of advocacy work, few studies have examined its impact on advocates' emotional and psychological well-being or considered the risk or protective factors that may be related to potential psychological difficulties faced by advocates. Moreover, the research that has been done has focused primarily on individual-level factors rather than on aspects of the workplace that may contribute to emotional distress or well-being.

To address this gap in the literature, we set out to identify those aspects of the workplace environment that best promote emotional well-being among domestic violence workers above and beyond individual difference factors such as degree of exposure to traumatic material and survivor status that is so prominent in the literature. In the following discussion of study findings, we review the univariate findings only briefly as they represent relationships out of context. We then provide a fuller discussion of the multivariate findings to highlight the significance of the results within a contextual framework.

Univariate Findings

Workplace variables predicting STS. As expected, support from coworkers, quality clinical supervision, and shared power were significantly and inversely correlated with STS.

Table 2. Summary of Hierarchical Regression Analysis Predicting Secondary Traumatic Stress

	Variable	B	SE	β	p
Step 1	Survivor status	.12	.04	.25	.003
	Hours of direct service	2.267E-03	.00	.12	.178
Step 2	Survivor status	.12	.04	.27	.002
	Hours of direct service	1.678E-03	.00	.09	.298
	Coworker support	-1.732E-02	.04	-.04	.686
	Quality of supervision	2.635E-04	.02	.00	.991
	Shared power	-7.605E-02	.03	-.29	.010

Workplace social support. Those participants who received higher levels of support from coworkers were less likely to experience STS. These results offer empirical support for recommendations in the clinical literature that individuals working in the trauma field need supportive professional relationships with their colleagues to protect them from the negative effects of bearing witness to traumatic stories and imagery (Catherall, 1999; Herman, 1992; Pearlman & Maclan, 1995; Terry, 1999; Yassen, 1995). This finding is also congruent with numerous empirical studies linking workplace social support with positive outcomes related to individual well-being (Beaton & Murphy, 1993; House & Kahn, 1985; Moos, 1988; Repetti et al., 1989; Revicki et al., 1993).

Clinical supervision. Participants who reported engaging, authentic, and empowering relationships with their supervisors were less likely to experience STS. This finding represents an important contribution to the literature in that the quality of clinical supervision is an aspect of support in the workplace that has yet to be studied. However, it is not surprising in light of recent theories related to women's growth and development. In particular, relational theorists contend that women's connections with others are critical to their psychological development and emphasize the important role of relationships based on mutuality and respect, which are believed to be essential to women's health and well-being (Jordan et al., 1991; Miller & Stiver, 1997). Applied to trauma workers, and domestic violence advocates in particular, this result lends much-needed empirical support to the assumption so pervasive in the clinical literature that clinical supervision is essential to managing and alleviating the more direct and painful effects of trauma work (Catherall, 1999; Herman, 1992; Munroe, 1999; Pearlman & Saakvitne, 1995; Rosenbloom et al., 1999).

Access to power. One of the most exciting findings from the study is that when advocates perceived their environment as empowering, they were less likely to report symptoms of STS. This is especially meaningful given the original feminist agenda of the battered women's movement (Hopkins & McGregor, 1991; Schechter, 1982) and represents a unique contribution to the literature in that this relationship has not been studied previously. It will be discussed in greater detail below.

Multivariate Findings

Although interesting, the univariate findings described above do not place individual aspects of the workplace in the context of each other or in the context of individual variables thought

to contribute to the emotional well-being of domestic violence advocates. To address this issue, we sought to determine whether environmental variables (workplace social support, quality of clinical supervision, and access to power) contribute to adverse psychological outcomes in domestic violence workers over and above the contribution of individual factor variables prominent in the literature (e.g., survivor status, hours of direct service).

Individual and Workplace Variables Predicting STS

Individual variables and STS. Results from the hierarchical multiple regression analysis showed that survivor status was the only individual factor to significantly predict STS. That is, advocates who are survivors of past abuse reported more symptoms of STS than those without abuse histories. This finding is important for domestic violence advocates given that more than half of the sample (55%) reported that they had experienced one or more types of abuse in their lifetime.

The finding that survivor status is related to STS is consistent with results reported in the empirical literature (see, for example, Kassam-Adams, 1999; Pearlman & MacLan, 1995). It indicates that survivors may experience greater vulnerability to the deleterious effects of trauma work. However, questions remain as to how survivors experience their work and the degree to which identification with the client plays a role in self-reported secondary symptoms (Herman, 1992; Kassam-Adams, 1999).

In contrast to other studies of this issue (e.g., Brady et al., 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), number of direct service hours was not predictive of STS in our sample. However, an examination of the type of trauma exposure investigated may explain these differential findings. For example, although Schauben and Frazier (1995) asked about work with trauma survivors more generally, 44% of their participants were working as counselors in sexual violence centers. It may be that the number of direct service hours was not significantly associated with STS in our study because of advocates' lack of exposure to sexual traumatic detail.

Workplace variables and STS. Shared power emerged as the only workplace variable to significantly predict STS above and beyond individual factors. That is, advocates who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma. This finding speaks to the importance of an empowering workplace to protect the emotional well-being of advocates, particularly those who are survivors. Perhaps, the opportunity to experience respect and equality in the work setting counteracts the effects of both one's own experiences of victimization and the difficult nature of domestic violence work.

The importance of this finding can best be understood in the context of the long and controversy-laced history of the battered women's movement (Hopkins & McGregor, 1991; Schechter, 1982). In her spirited historical account of this movement, Schechter (1982) highlighted the tension between feminist/egalitarian values and professionalization faced by feminist activists seeking to end violence against women and children. For example, she wrote,

The women's liberation movement not only helped create an atmosphere where women could understand and speak about battering; it also influenced the organization of work in the battered women's movement. As a result of the abuse of power

experienced in male dominated organizations, the women's liberation movement developed a strong suspicion of hierarchy and leadership. (p. 33)

Over time, however, their very success created a new set of obstacles. The new agencies created by these advocates required new sources of funding to continue. But the obvious sources of funding, including both governmental and nongovernmental institutions, required that domestic violence agencies develop conventional organizational structures to obtain funding. This eventually led many organizations back to more traditional, hierarchical structures, thus creating a division between administration and frontline service workers. This shift has been accompanied by ongoing and heated infighting between those who want to stay close to the feminist roots of the movement and those who wish to move toward greater professionalization of services (Goodman & Epstein, 2008; Schechter, 1982).

The Shared Power Scale that we developed operationalizes core features of the feminist empowerment model that remains a central aspect of many, though not all, battered women's services (Davies et al., 1998; Dutton, 1992; Schechter, 1982). The finding that shared power was the critical protective factor contributing to the well-being of domestic violence advocates supports ideas from early feminists in the battered women's movement concerning the central role that empowerment plays in the work, not only for battered women but also for the individuals who do the work and the organizations that provide the service.

Limitations of the Study

Although this research fills an important gap in the literature, this study like any others has certain limitations. As is true for all survey researchers, we are uncertain as to why some participants chose to complete the survey and some opted out, and how this may have influenced our findings. Furthermore, although our study did appear to draw a diverse group of advocates working in the field of intimate partner violence, the language that we used was notable in its emphasis on services for women in abusive relationships with men, and we acknowledge that our materials may have felt exclusionary to advocates working with gay and lesbian victims.

Our measures also have certain limitations. While following recommendations made by Dutton and Rubinstein (1995) that the experience of STS is currently best measured through the use of PTSD scales, we acknowledge that these scales may be limited in their capacity to adequately capture the full experience of secondary trauma or to separate out what might be posttraumatic stress symptoms resulting from direct exposure versus symptoms resulting from working with traumatized clients. Similarly, the measurement of the quality of clinical supervision is limited by the absence of a specific instrument to describe and characterize this relationship. We believe that our use of the RHI-M enabled us to capture some important qualities relevant to the supervisory relationship. However, there may be other aspects of the relationship that were not illuminated due to the nature of the measure used, including the capacity of the advocate to be open and to share her work, the ability of the supervisor to respond to the specific issues being addressed, and

other dynamics and differences between the supervisor and advocate that may prevent an open, safe, and helpful relationship. As a new measure, the Shared Power Scale has strengths in that it is based in feminist theory and showed good reliability in our study. However, we recognize that its reliability and validity need to be demonstrated through further utilization and development.

Finally, the selection of variables always poses a challenge for researchers, and our findings may have been limited by the omission of other key individual and organizational factors that may be relevant to advocate well-being, such as issues related to race and educational-level differences in an organization and employment variables such as pay rates, amount of paid time off, space and resource allocations, and access to training and professional development opportunities.

Implications for Practice and Policy

The findings of this study suggest that specific practices and policies could be implemented within organizations to improve the emotional well-being of domestic violence advocates. First, these results indicate that advocates benefit from an environment where coworkers support one another. Although there is a current trend that emphasizes a team approach, domestic violence services should continue to create structures that emphasize cooperation among advocates, effective communication, and conflict resolution skills. As Catherall (1995) suggested, it is critical that administrators actively create and encourage an environment where advocates are able to share their reactions to the work, discuss their own values and visions, and respond to each other in a positive manner. Evaluating possible obstacles to social support may be a first step. Yassen (1995) recommended an assessment of the physical environment, value system, expectations, and cultural characteristics of the organization prior to the development of any type of intervention plan to prevent STS. A cultural system that prohibits the expression of emotion, for example, may prohibit discussion of individual reactions to trauma work and discourage the type of personal disclosure necessary for the development of trust and sympathy between coworkers. Only by acknowledging these kinds of obstacles can real progress be made. In addition, it should be recognized that sharing case material may also potentially increase the risk of further secondary traumatization among advocates and, therefore, group consultation and supervision should provide the necessary support and structure to minimize this possibility.

With regard to supervision, these findings suggest that clinical supervision that engenders an atmosphere of respect, safety, and trust may help to minimize STS among domestic violence advocates. A close look at our measure of supervision quality suggests that supervisors may contribute to emotional well-being by valuing the advocate as a whole person, sharing personal and professional stories, and expressing openness to the feelings and concerns of advocates. Supervisors might also use self-disclosure to promote an atmosphere where advocates are able to take risks, discuss their mistakes, and learn from them (Stoltenberg, McNeill, & Delworth, 1998).

Finally, the implementation of policies and practices that emphasize shared power in organizations may require a move away from traditional hierarchical structural models of

operation. Describing some of the ways in which power is shared, Thomas (1999) noted that some feminist organizations “flatten the hierarchy” by combining administrative and service responsibilities within each job description and distributing responsibility for the more mundane organizational tasks through the creation of rotating committees. Participants in Thomas’s study reported that increasing workers’ control in these ways had the effect of increasing their commitment and decreasing turnover. The Sanctuary[®] model developed by Bloom (1997, 2000) features a flattened hierarchy and integration of multiple perspectives of both clients and workers. Madsen and her colleagues (Madsen, Blitz, McCorkle, & Panzer, 2003) described the use of this model in a domestic violence shelter and noted that it offers a dynamic approach to trauma treatment and shelter services that emphasize empowerment for both clients and workers by focusing on the quality of relationships through teamwork, communication, and respect for differences. Empirical research is needed to explore the benefits and challenges of this innovative model and its impact on client services and worker well-being.

None of these structural changes would work, however, without honest discussion of power differences between individual advocates that may or may not be related to their job responsibilities. Along these lines, Huygens (2001) noted specific ways that feminist collectives and organizations have developed procedures in which to address individual and cultural differences such as

assigning speaking time to women who were usually silent, making room for people to speak for themselves and avoiding interpretation, taking seriously challenges by less powerful women and groups, taking time to understand the issues raised, and attempting to act on the aspirations and needs expressed by all groups. (p. 395)

Directions for Future Research

As other researchers in the field have pointed out, our research is hampered by the absence of clear operational definitions and measurement tools with which to study STS (Figley, 1999; Pearlman & MacIan, 1995). Therefore, it is critical that we develop standard definitions and well-validated measures of our constructs.

Furthermore, just as Gilfus (1999) has challenged the field to move away from pathologizing trauma survivors, we argue that there is a parallel need to highlight the unique strengths of advocates. This research perspective is particularly important in light of the historical contributions that advocates have made in establishing and monitoring the goals and directives of the movement. Research focusing on the ability of advocates to work against oppressive systems would enable us to broaden our knowledge of their resilience as well as contribute to institutional reform.

Further research is also needed in the area of clinical supervision. For example, how do differences of race, culture, and ethnicity affect the quality of the relationship between supervisor and advocate as well as the overall emotional well-being of the advocate? We imagine that how these issues are handled in both the context of the individual supervisory relationship and in larger case consultation meetings may be highly relevant to the well-being of advocates and their perceptions of the organization.

We hope that our finding that shared power uniquely predicts STS over and above individual factors encourages others to investigate a broader and deeper range of feminist organizational structures and their relevance to the well-being of advocates. Future research might examine more closely how feminist principles are being, or could be, employed in the context of traditionally hierarchical, patriarchal systems such as hospitals and community health centers.

Domestic violence advocacy is the key component to meeting the needs of safety and healing for thousands of women and children escaping violence in the home. It is imperative that we continue to focus our attention on the well-being of the very individuals doing this important work in our communities. It is our hope that advocates will be strengthened by these research efforts and that our findings will help them to enhance current practices and develop new policies within their organizations based on the core feminist value of empowerment that is so central to the services they provide.

Appendix

Shared Power Scale

In your agency or organization, do you	Rarely	Sometimes	Often
1. feel that you have opportunities to implement changes to practice or policy?	1	2	3 4 5
2. believe that all staff are treated fairly and as equals?	1	2	3 4 5
3. feel that time is taken to understand issues raised by all staff members?	1	2	3 4 5
4. feel silenced by others within your agency?	1	2	3 4 5
5. believe that challenges by less powerful staff members are taken seriously?	1	2	3 4 5
6. feel able to voice a different opinion from that held by the agency, without risk of retribution?	1	2	3 4 5
7. believe that attempts are made to act on the needs and goals expressed by all staff members?	1	2	3 4 5
8. feel that you have opportunities to represent your agency in the larger community?	1	2	3 4 5
9. feel powerless relative to others in your agency?	1	2	3 4 5
10. feel that staff members who are usually silent are encouraged to speak?	1	2	3 4 5
11. feel that you have opportunities to initiate or lead projects?	1	2	3 4 5
12. feel that power is concentrated at the top of the agency?	1	2	3 4 5
13. feel shut out of important discussions?	1	2	3 4 5
14. feel that differences among staff (e.g., cultural, age, ability, sexual orientation) are valued and respected?	1	2	3 4 5
15. believe that you have a say in the direction of the agency?	1	2	3 4 5

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Notes

1. Bride, Robinson, Yegidis, and Figley (2004) have developed a Secondary Traumatic Stress Scale (STSS) that includes three of the posttraumatic stress disorder (PTSD) symptoms as its core—avoidance, arousal, and intrusion. STSS had not yet been published at the time of data collection for the present study.
2. Although we examined interactions between survivor status and each of the workplace variables, none was significant. This may be due to the relatively small sample size, and we encourage future researchers to explore potential interactions between individual and workplace factors more closely.

References

- Abraham, I. L., & Foley, T. S. (1984). The Work Environment Scale and the Ward Atmosphere Scale (short forms). *Perceptual & Motor Skills, 58*, 319-322.
- Al-Nasar, F., & Everly, G. S. J. (1999). Prevalence of posttraumatic stress disorder among Kuwaiti firefighters. *International Journal of Emergency Mental Health, 1*, 99-101.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18*, 71-86.
- Beaton, R. J., & Murphy, S. A. (1993). Sources of occupation stress among firefighters/EMTs and firefighter/paramedics and correlations with job-related outcomes. *Prehospital and Disaster Medicine, 8*, 140-150.
- Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.
- Bloom, S. (2000). Creating sanctuary: Healing from systematic abuses of power. *Therapeutic Communities, 21*, 67-91.
- Bober, T., & Regehr, C. (2006) Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6*, 1-9.

- Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30*, 386-393.
- Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*, 63-70.
- Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*, 27-35.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Catherall, D. R. (1995). Preventing institutional secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 232-248). New York: Brunner Mazel.
- Catherall, D. R. (1999). Coping with secondary traumatic stress. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 80-94). Lutherville, MD: Sidran.
- Chalk, R., & King, P. A. (Eds.). (1998). *Violence in families: Assessing prevention and treatment programs*. Washington, DC: National Academy Press.
- Chandler, G. E. (1986). *The relationship of nursing work environment to empowerment and powerlessness*. Unpublished doctoral dissertation, University of Utah, Salt Lake City.
- Davies, J., Lyon, E., & Monti-Catania, D. (1998). *Safety planning with battered women*. Thousand Oaks, CA: Sage.
- Dutton, M. A. (1992). *Empowering and healing battered women: A model for assessment and intervention*. New York: Springer.
- Dutton, M. A., & Rubinstein, F. L. (1995). Working with people with PTSD. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 82-100). New York: Brunner Mazel.
- Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner Mazel.
- Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran.
- Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25*, 275-282.
- Galloucis, M., Silverman, M. S., & Francek, H. M. (2000). The impact of trauma exposure on the cognitive schemas of a sample of paramedics. *International Journal of Emergency Mental Health, 2*, 5-18.
- Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health, 2*, 229-240.
- Gilfus, M. E. (1999). The price of the ticket: A survivor-centered appraisal of trauma theory. *Violence Against Women, 5*, 1238-1257.

- Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health and justice*. Washington, DC: American Psychological Association.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Holloway, E. L. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage.
- Hopkins, A., & McGregor, H. (1991). *Working for change: The movement against domestic violence*. Sydney, Australia: Allen & Unwin.
- House, J. S., & Kahn, R. L. (1985). Measures and concepts of social support. In S. Cohen & S. L. Syme (Eds.), *Social support and health* (pp. 83-108). New York: Academic Press.
- Huygens, I. (2001). Feminist attempts at power sharing in Aotearoa: Embarrassing herstory or significant learning towards treaty-based structures? *Feminism & Psychology, 11*, 393-400.
- 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*, 393-412.
- Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection*. New York: Guilford.
- Kanter, R. M. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.
- Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 37-48). Lutherville, MD: Sidran.
- Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Keita, G. P., & Russo, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community*. Washington, DC: American Psychological Association.
- Liang, B., Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., & Miller, J. B. (2002). The Relational Health Indices: A study of women's relationships. *Psychology of Women Quarterly, 26*, 25-35.
- Madsen, L. H., Blitz, L. V., McCorkle, D., & Panzer, P. G. (2003). Sanctuary in a domestic violence shelter: A team approach to healing. *Psychiatric Quarterly, 74*, 155-171.
- McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner Mazel.
- Miller, J. B., & Stiver, I. P. (1997). *The healing connection*. Boston: Beacon Press.
- Moos, R. H. (1988). Psychosocial factors in the workplace. In S. Fisher & J. Reason (Eds.), *Handbook of life stress, cognition and health* (pp. 193-209). New York: Wiley.
- Moos, R. H. (1994). *Work Environment Scale manual* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.
- Munroe, J. F. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 211-229). Lutherville, MD: Sidran.
- Pearlman, L. A., & Maclan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558-565.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist*. New York: W.W. Norton.
- Peled, E., & Edleson, J. L. (1994). Advocacy for battered women: A national survey. *Journal of Family Violence, 9*, 285-296.

- Repetti, R. L., Matthews, K. A., & Waldron, I. (1989). Employment and women's health: Effects of paid employment on women's mental and physical health. *American Psychologist, 44*, 1394-1401.
- Revicki, D. A., Whitley, T. W., & Gallery, M. E. (1993). Organizational characteristics, perceived work stress, and depression in emergency medicine residents. *Behavioral Medicine, 19*, 74-81.
- Rosenbloom, D. J., Pratt, A. C., & Pearlman, L. A. (1999). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 65-79). Lutherville, MD: Sidran.
- 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.
- Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement*. Boston: South End.
- Shepard, M. F. (1999). Advocacy for battered women. In M. F. Shepard & E. L. Pence (Eds.), *Coordinating community responses to domestic violence* (pp. 115-126). Thousand Oaks, CA: Sage.
- Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass.
- Terry, M. J. (1999). Kelengakutelleghapat: An Arctic community-based approach to trauma. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 149-178). Lutherville, MD: Sidran.
- Thomas, J. E. (1999). "Everything about us is feminist": The significance of ideology in organizational change. *Gender & Society, 13*, 101-119.
- Ullman, S. E., & Townsend, S. M. (2007). Barriers to working with sexual assault survivors: A qualitative study of rape crisis center workers. *Violence Against Women, 13*, 412-443.
- Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly, 26*, 120-130.
- Wasco, S. M., Campbell, R., & Clark, M. (2002). A multiple case study of rape victim advocates' self-care routines: The influence of organizational context. *American Journal of Community Psychology, 30*, 731-760.
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). *The PTSD Checklist: Reliability, validity, and diagnostic utility*. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.
- Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 178-208). New York: Brunner Mazel.

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