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**VICARIOUS TRAUMATIZATION:
THE DANGER OF THE UNKNOWN
FOR TRANSITION HOUSE WORKERS**

by

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B.Sc., University of Northern British Columbia, 1998

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Abstract

The purpose of this mixed-methods exploratory study is to examine transition house support workers' knowledge of vicarious traumatization. Additionally, this study aims to examine individual and agency level attention/action to this issue. Participants consisted of support workers from seven transition houses located in Northwestern communities along Highway 16 from Prince Rupert, British Columbia (BC) to Prince George, BC. Data were collected in three phases: questionnaires (n=31), face-to-face interviews (n=13), and one focus group (n=8). Descriptive statistics were calculated and content analysis applied to the qualitative data. Research findings indicated the following main themes: vulnerability, impacts, knowledge base, agency response, and strategies for change. Recommendations for policy and practice are also identified. Based on the findings, transition house workers are vulnerable to vicarious traumatization and while their knowledge is limited, what they do know can serve as a baseline to guide the development of effective training programs.

Abstract

The current literature on vicarious traumatization identifies some of the negative effects experienced by professionals who do trauma work. The purpose of this mixed-methods exploratory study is to examine transition house support workers' knowledge of vicarious traumatization. Without understanding what is known about the topic and currently being done within agencies it is difficult to implement the changes needed to protect support workers on the front lines.

Participants in this study consisted of support workers from seven transition houses located in Northwestern communities along Highway 16 from Prince Rupert, British Columbia (BC) to Prince George, BC. This research was carried out between February 2008 and July 2008 through three phases of data collection: questionnaires (n=31), face-to-face interviews (n=13), and one focus group (n=8). Descriptive statistics are calculated and content analysis applied to the qualitative data. Research findings indicate the following main themes: vulnerability, impacts, knowledge base, agency response, and strategies for change. Recommendations for policy and practice are also identified. Based on the findings, transition house workers are vulnerable to vicarious traumatization and while their knowledge is limited, what they do know can serve as a baseline to guide the development of effective training programs.

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Dedication

This thesis is dedicated to the amazing women who provide support and assistance to women and children escaping violence. Thank you for continued compassion and dedication to the issue of violence against women.

Introduction

This thesis focuses on the indirect experiences of trauma on helping professionals as a result of working with trauma survivors and exposure to their traumatic stories, termed vicarious traumatization. Vicarious traumatization is an occupational hazard and is defined by Pearlman and Saakvitne (1995) as “the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material” (p. 31). However, in addition to therapists, any professional who works with trauma survivors and as a result is exposed to trauma stories is susceptible (Pearlman & Mac Ian, 1995). Transition house support workers are one population of workers that work closely with trauma survivors.

Transition houses are emergency safe shelters for women and children escaping violence. The first transition houses in Canada were opened in 1973 and by 2004 there were 543 shelters identified across Canada providing residential services to women experiencing violence (Tutty, 2006). Transition house support workers provide services to trauma survivors and in doing so bear witness to the traumatic stories shared and the brutalities women and children endure. It is through this work that transition house support workers become susceptible to vicarious traumatization, becoming forever changed.

For the last ten years I have been employed as a transition house support worker in two different houses located in Northwestern British Columbia (BC). As a transition house support worker, working with trauma survivors, I know first hand the impact of continually hearing and bearing witness to the traumatic narratives of women. Over the last ten years, I have experienced significant alterations to my cognitive schemas (core beliefs). For example, my sense of safety in the world is altered to the point where I drive with my doors locked, will not walk alone at night, and always make sure the door to my apartment is

locked regardless of the time of day. I experience disturbing dreams related to what I hear from the women with whom I work. I am distrustful and suspicious of people's motivations as well as their interactions with others. However, in my situation, it was not until I learned about vicarious traumatization that I was able to make a connection between my work and what was happening to me. This awareness was not immediate; it took attending second and third training sessions on vicarious traumatization before I was able to start to connect the pieces. Additionally, training provided me with the knowledge and the tools to identify vicarious traumatization and normalized for me that the effects are an aspect of this work, and it is important to seek assistance when needed.

The following mixed-methods exploratory study aspires to listen to and learn from transition house support workers. Through their voices, this research study aims to honour transition house support workers, acquire an understanding of workers' knowledge of vicarious traumatization, as well as examine individual and agency level attention/action to this issue. It is only through understanding current knowledge of and strategies implemented to protect workers in the workplace that we can start to identify additional needs and implement changes.

Chapter One: Building the Foundation

Research Problem and Objectives

Vicarious traumatization is an occupational hazard that requires our immediate attention. Pearlman and Saakvitne (1995) state, “if we do not identify and address the risk of vicarious traumatization, we run the danger of not recognizing its effects on our work” (p. 32). Current literature, while still in its infancy, strives to identify populations affected, predictive factors, preventative strategies, and attempts to measure workers’ levels of vicarious traumatization. However, absent from the literature is an attempt to understand individuals’ actual knowledge about the topic. Without examining professionals’ knowledge and understanding about this occupational hazard, we cannot identify gaps to offer education and strategies to help ameliorate the impacts of vicarious traumatization. Therefore, my research asks the question, “What is transition house support workers’ knowledge of vicarious traumatization?”

In addition to the research question, this thesis aims to meet the following objectives:

- (1) Discover if transition house support workers have received training/information (formally or informally) on vicarious traumatization and examine their knowledge of the topic;
- (2) Explore the work of transition house support workers, the traumatic stories they hear, and any impact on their professional and personal lives;
- (3) Examine prevention/coping strategies utilized when it comes to the traumatic material they hear; and
- (4) Examine the workers’ perceptions of the level of agency response to the issue of vicarious traumatization and identify what workers would like to see put into practice.

The potential outcomes could then be used to support, train, and educate transition house support workers about vicarious traumatization, its effects, and healthy coping strategies. Professional training on vicarious traumatization is needed to protect and arm against this occupational hazard. It is not until workers are provided the opportunity to learn about vicarious traumatization that they will be able to make a connection to what they may be experiencing as a result of the work they do. Training provides workers with the tools to be able to identify vicarious traumatization. Training also teaches workers that it is important and acceptable to ask for help to work through the traumatic material they carry. However, training must be an on-going process. Knowing the effects of vicarious traumatization, how to try and prevent it, or ameliorate its effects, takes a collective effort to care for those who spend their time caring for others.

Continual training will increase not only a worker's knowledge base about vicarious traumatization but an entire agency's overall understanding of the issue and need to implement effective self-care strategies. Through this heightened awareness, I hope that policy and procedures can be written, at the agency level, to support the increased need to recognize, intervene, and lessen the impacts of vicarious traumatization before it compounds to a debilitating level for support workers. Additionally, I hope that the results of this thesis will be used to write a report to the Ministry of Housing and Social Development, the main funder for transition house programs, highlighting the need for additional funding dollars to be allocated to educate staff and provide protective services, such as professional debriefing and clinical supervision. Providing support to survivors of trauma over time can take its toll on workers. How can support workers be expected to identify the impacts of trauma work if they are not given the tools, understanding, and agency support to do so? Pearlman and Saakvitne (1995) state, "unaddressed vicarious traumatization, manifest in cynicism and

despair, results in a loss to society of that hope and the positive action it fuels” (p. 33).

Taking care of workers needs to be a priority. We need to start asking the question, how many more times will workers be able to recover the lost pieces of themselves?

Definition of Terms

Part of the research process is to clearly define the key terms of the research question. According to Taylor-Butts (2007), a transition house is defined as a “facility offering short or moderate term (1 day to 11 weeks) secure housing for abused women with or without children” (p. 3). Transition houses provide: food and other necessities; support and advocacy in accessing financial, medical and/or legal assistance; and emotional help and counselling (Ministry of Community Services, n.d.). Employees are predominately female in emergency shelters for women escaping abusive relationships (Stout & Thomas, 1991). Therefore, I define transition house support workers as adult females employed to provide supportive counselling, advocacy, crisis intervention, and education to women either accessing the transition house or calling the crisis line from out in the community.

The term knowledge can lend itself to several different definitions. For the purpose of my research, knowledge will be defined as the “information and skills acquired through experience or education” (Pearsall, 1999, p. 786). I believe it is important to have a definition that incorporates the possibility of either education or experience for my sample population. Transition house support workers are a diversely educated group of women because their education can come from experience and/or an academic institution. It is important to identify this diversity when selecting the appropriate definition of knowledge to recognize that workers can learn about vicarious traumatization from a variety of sources. It is also important to explore the skills workers employ because for some they may be unable to label what they have experienced as vicarious traumatization. However, without using

formal language, support workers may be able to identify vicarious traumatization and what they do to ameliorate its effects. Furthermore, through their experiences within the workplace, all workers should be knowledgeable on action at the agency level when it comes to dealing with and working to prevent vicarious traumatization.

For the purpose of my thesis research, I draw from the literature to define vicarious traumatization. Vicarious traumatization alters a helping professional's cognitive schemas about themselves and others in the world through continual exposure to traumatic narratives (Zimering, Munroe, & Gulliver, 2003). Cognitive schemas include "beliefs, assumptions, and expectations about self and world that enable individuals to make sense of their experience" (McCann & Pearlman, 1990b, p. 137). Cognitive schemas are not formed or altered overnight, rather they are the result of lifelong experiences and learning that shape the values and beliefs a person holds (McCann & Pearlman). Therefore, vicarious traumatization does not occur after listening to one traumatic narrative. Pearlman and Saakvitne (1995) state:

Vicarious traumatization is a process not an event. It includes our affects and defenses against the affects. That is, it is our strong reactions of grief and rage and outrage which grow over time as we hear repeatedly about the torture, humiliation, and betrayal people perpetrate against others, and also our sorrows, our numbing, and our deep sense of loss which follow those reactions (p. 32).

Furthermore, the level of disruption caused by changes to a professional's cognitive schemas depends upon the degree of discrepancy between an individual's traumatic narrative and the professional's existing schemas (McCann & Pearlman). For example, when listening to the same traumatic material, one professional may experience a dramatic change to his/her cognitive schema, where his/her colleague may only experience a subtle change. Ultimately, vicarious traumatization affects different people in different ways.

Theoretical Framework

Research shows that vicarious traumatization can have a serious impact on the professional, ultimately changing their cognitive schemas. Research also emphasizes strategies that can help to ameliorate the effects of vicarious traumatization. “In the face of trauma, each person will adapt and cope given their current context(s) and early experiences: interpersonal, intrapsychic, familial, cultural and social” (Saakvitne & Pearlman, 1996, p. 27). Vicarious traumatization is conceptualized within constructivist self development theory (CSDT). CSDT identifies that human beings construct their own realities through the development of cognitive schemas (McCann & Pearlman, 1990b). Cognitive schemas include a person’s beliefs, assumptions, and expectations about their self and others. Through a person’s cognitive schemas they are able to make sense of their experience (McCann & Pearlman, 1990b). McCann and Pearlman (1990a) explain,

When the environment presents new information that cannot be assimilated into existing schemas, cognitive schemas are modified, a process called accommodation. The complex interplay and balance between accommodation and assimilation results in the increasing differentiation and maturation of the psychological systems. We refer to this growth as progressive self development (p. 7).

It is through this process that professionals’ cognitive schemas can be altered by the traumatic narratives to which they bear witness. According to McCann and Pearlman (1990a), “because trauma-induced disruptions are...in psychologically central areas, the accommodation process is difficult” (p. 7). Therefore, trauma can hinder one’s psychological growth.

CSDT describes five different components of self that are affected by traumatic events. According to Pearlman and Saakvitne (1995) the first component of self is frame of reference. This includes one’s identity, worldview, and spirituality that shape the lens in which the person interprets the world and their experiences. When a helping professional

experiences vicarious traumatization, one may become cynical and/or distant, may feel confused and/or angry, and may struggle to discover a source of hope (Pearlman & Saakvitne). Moreover, the professional may question their purpose, why they continue to do the work they do, and their vulnerability to abuse (Pearlman & Saakvitne). Alterations to one's frame of reference may be more subtle in nature. If helping professionals experience persistent challenges to their cognitive schemas they may become disoriented and "respond to this with a pervasive and unsettling sense of uneasiness" (McCann & Pearlman, 1990b, p. 142). To ameliorate the impact of vicarious traumatization in regards to frame of reference, one needs to balance work, rest, and play and engage in activities that allow them to experience a dependent role (Pearlman, 1995).

The second component is self capacities. According to Pearlman and Saakvitne (1995), "self capacities allow an individual to maintain a positive sense of self-esteem and a consistent sense of identity and to manage and modulate strong affect" (p. 288). When impairment to this component of self occurs, a professional experiencing vicarious traumatization can feel overly anxious, self-critical, and unlovable (Pearlman and Saakvitne). Helping professionals may also find it difficult to be alone, find themselves on the verge of tears without experiencing a significant trigger or event, and avoid difficult movies and/or news programming (Pearlman & Saakvitne). An important self-care strategy for this component of self involves obtaining emotional support from others (Pearlman, 1995). Emotional support can be in the form of connecting with someone from a professional's support network, talking to a co-worker, or receiving clinical supervision. Although helping professionals know the importance of receiving emotional support, this area is often overlooked.

The third component is ego resources which includes self-awareness, interpersonal, and self-protective skills (Pearlman & Saakvitne, 1995). A professional experiencing vicarious traumatization may experience difficulties making decisions. Most affected by effects of vicarious traumatization are:

the ability to make self-protective judgments, the ability to be introspective, the ability to establish and maintain boundaries, the ability to take perspective, including empathy and sense of humor, the ability to strive for personal growth, and an awareness of one's psychological needs (Pearlman & Saakvitne, p. 288).

Receiving supervision, education, and personal counselling can be extremely helpful to strengthen our depleted ego resources (Pearlman, 1995). Attending training seminars provide both new information and an opportunity for connection with others in the field; allowing helping professionals to feel a sense of renewal and support.

The fourth component is psychological needs and cognitive schemas sensitive to traumatic events which include: safety, esteem, trust, control, and intimacy (Pearlman & Saakvitne, 1995). Depending on which area is affected by vicarious traumatization, a person may become increasingly fearful, devalue oneself or others, experience a loss of trust in oneself, question abilities, and block feelings. Behaviorally, professionals may avoid having people walk behind them, make sure doors and windows are locked, avoid looking in the mirror, avoid social situations, not get out of bed, and try to gain control over another (Pearlman & Saakvitne). McCann and Pearlman (1990b) originally identified specific characteristics associated with psychological needs and cognitive schemas affected by trauma: safety, esteem, trust, intimacy, and power. In regards to safety, helping professionals may become over protective and feel increasingly vulnerable. In addressing esteem, McCann and Pearlman refer to "the need to perceive others as benevolent and worthy of respect" (p. 140). They also identify that professionals may experience a sense of anger towards

others and the world. Trust can be affected when professionals find they are overly suspicious and distrustful of other's motives. A person's sense of intimacy is diminished as a result of bearing witness to the cruel realities highlighted in traumatic narratives. In regards to power, helping professionals may question their own sense of power and purpose in the world (McCann & Pearlman). One's psychological needs and distorted cognitive schemas can be restored by learning new information, consulting with colleagues, and utilizing outside resources by socializing with friends and family (Pearlman, 1995). Helping professionals must remember that it is human to feel vulnerable. However, when those feelings start to dictate their thoughts and behaviours, they need to draw on all of their personal and professional resources for support and help.

The last component of self is the memory system. "CSDT's conceptualization of memory is descriptive. It reflects the understanding that traumatic memory commonly involves the fragmentation or dissociation of aspects of the individual's complex experience" (Pearlman & Saakvitne, 1995, p. 73). According to Pearlman and Saakvitne (1995), experiences are processed and recalled: verbally, visually, emotionally, behaviourally, and sensory. Therefore, a person affected by vicarious traumatization may experience an intrusion of violent imagery or experience similar bodily sensations as described by a trauma survivor. Symptoms associated with memory, such as flashbacks, dreams, or intrusive thoughts are considered central to PTSD (Dunkley & Whelan, 2006a). For this reason, most studies measuring vicarious traumatization also use tools to measure for symptoms of PTSD. McCann and Pearlman (1990b) believe the imagery that causes the most disruption regularly centers on the schemas connected to the professional's principal need areas. For example, those for "whom esteem is more central, may focus in on images involving extreme degradation or cruelty at the hands of others" (McCann & Pearlman, p. 143). Educating

partners, friends, and family is extremely important when a helping professional is dealing with intrusive imagery (Pearlman, 1995). However, the education may be most beneficial for loved ones if it is offered when a person first begins working with trauma survivors. Family support can be vital for a person who may be experiencing intrusive imagery, different bodily sensations, or starting to undertake avoidant behaviours.

The CSDT framework is at the heart of most research examining vicarious traumatization. Therefore, it is the theoretical framework guiding my research. Through using the CSDT to make up the majority of my framework for analysis I am better able to understand what is known about vicarious traumatization, highlight gaps in knowledge, identify if workers and agencies are implementing personal and professional self-care strategies, and what more could be done to protect workers in the future.

Researcher's Personal Standpoint

My topic of research and sample population was ultimately driven by my work experience, overall passion for worker well-being and safety, and my life experiences living in Northwestern BC. As previously identified, I have worked as a transition house support worker for the last ten years. During my employment at one transition house I was given the opportunity to become a staff representative on the agency's Occupational Health and Safety Committee. Initially, the Occupational Health and Safety Committee worked diligently to eliminate any visible hazards in the workplace that could harm staff. However, over time the committee started to examine work related hazards not visible to the human eye and as a result offered staff training on vicarious traumatization. That was the first time I, as well as my fellow co-workers had received training on the topic. Since then, I have continued to be passionate about the issue of vicarious traumatization and the need for education and training for all professionals who are exposed to trauma stories.

Effective service provision for women and children escaping violence is contingent on maintaining the health and safety of staff. It was not until my ninth year working in a transition house, and conducting my research, that I experienced my first formal group debriefing over experiencing the loss of one of our residents. Before that time, I had only experienced less formal debriefings from management, or participated in “debriefings” with other staff members that I now realize were more venting sessions than debriefings. It was not until I attended that formalized group debriefing that I was able to really understand components that debriefing should entail. It was so enlightening to see how a formalized process effectively helped workers process the impacts of the collective loss experienced. Additionally, it is only in the last year that my co-workers and I have been given the opportunity to participate in group clinical supervision sessions. Clinical supervision is not typically a service provided to transition house workers. However, as a part of the process, I have learned that I am not the only one who struggles with doing this work. Processing the stories we hear and the complex situations we deal with is not immediate; rather it takes time, continual reflection, and understanding. In addition, I recognize there is more to learn about the impacts we are vulnerable to before personal awareness allows us to give voice to what we are experiencing. Since experiencing the group debriefing and several clinical supervision sessions, I am even more passionate about the need for the implementation of standardized practices within all agencies.

Being born and raised in northwestern BC also influenced my decision to do this research. Through my work experience, I witnessed the impact that cuts to funding and services have on the women and children trying to free themselves of abusive relationships. Also, living and working in a small community provided many challenges that I, as a professional, continually negotiated in an effort to maintain effective service provision. For

example, working in a community where most people know who you are, what you do, as well as where you live and work, greatly impacts both the worker's and client's confidentiality. Moving to a larger northwestern community, although helpful, still provides several different challenges for workers than they would face living and working in a large urban centre. Therefore, my research has a northern focus because I believe it is one way to truly honor what workers do and deal with on a daily basis and to start to understand how that may amplify any impacts they already experience.

Importance of Reflexivity

Reflexivity is an essential part of qualitative inquiry. In conceptualizing reflexivity, Dowling (2006) identifies that researchers should engage in continuous self-critique and self-appraisal at every stage of the research process. "It involves being aware in the moment of what is influencing the researcher's internal and external responses while simultaneously being aware of the researcher's relationship to the research topic and the participant" (Dowling, p. 8). Rowling (1999) identifies the dilemma of the researcher juggling their various "I's" when conducting qualitative research. From the beginning of the research process I anticipated a dilemma would occur between my "Researcher I" and my "Support Worker I." My personal experiences within a transition house setting, as well as with vicarious traumatization, are ingrained in my values, beliefs, and biases. Therefore, I participated in journaling and wrote my thoughts and feelings down throughout the process. Patton (2002) reminds us that "the quality of qualitative data depends to a great extent on the methodological skill, sensitivity, and integrity of the researcher" (p. 5). The process of self-awareness and self-questioning enhances one's level of integrity. As humans, we are subjective beings, influenced by our values, beliefs, and biases. Reflexivity allows

researchers to identify and understand the impact research has on them, as well as monitor and control the impact they have on the research.

Clinical supervision throughout the research process has been found to aid the reflexivity process (Dowling, 2006; Rowling, 1999). In addition, whether or not supervision is available, Dowling encourages the idea of reaching out to “critical friends” who will challenge the researcher throughout the process. For the purpose of my research, I received supervision from my thesis supervisor, Dr. Glen Schmidt, as well as worked closely with a small group of my peers to form a thesis support group where we openly shared our thoughts and feelings and in return received feedback through critical questioning and the sharing of alternative perspectives. As humans we can often be disillusioned when it comes to recognizing our own beliefs, feelings, assumptions, and biases. Many people fail to fully acknowledge their subjectivity without the help of people they trust. Reflexivity can not be done without critical analysis. Therefore, the process of journaling, supervision, and the input from critical friends helped me as a researcher to keep my values, beliefs, assumptions, and biases in check so as not to work against myself and inappropriately influence the research process.

Chapter Two: Literature Review

Concepts

The concept of vicarious traumatization is often associated and gets confused with burnout, compassion fatigue, secondary traumatic stress disorder (STSD), and posttraumatic-stress disorder (PTSD). However, the literature does identify distinct differences between the concepts. Burnout is defined as “a specific occupational stress syndrome occurring when human service professionals become emotionally exhausted, begin to dehumanize their clients, and lose a sense of personal accomplishment at work” (Maslach, 1982 as cited in Baird & Jenkins, 2003, p. 72). Like vicarious traumatization, burnout is a process that gradually progresses. Nevertheless, burnout is based on physical, emotional, and behavioural symptomatology (Figley, 1995). While vicarious traumatization is directly related to work with trauma survivors, burnout can occur as a result of working with any individual. Furthermore, Suran and Sheridan (1995) identify that unlike burnout, vicarious traumatization is not the result of unmet expectations and diminishing workplace conditions (as cited in Pearlman and Saakvitne, 1995).

Compassion fatigue and secondary traumatic stress are two terms that are used interchangeably and manifest as sudden adverse reactions as a result of working with trauma survivors (Jenkins & Baird, 2002). While vicarious traumatization focuses on meaning and adaptation (Pearlman & Saakvitne, 1995) compassion fatigue focuses on symptoms and emotional responses (Figley, 1995). Compassion fatigue can also occur suddenly and without warning, thus differentiating it from both burnout and vicarious traumatization. Jenkins and Baird identify a clear distinction, “the symptoms of secondary trauma are nearly identical to PTSD symptoms; the main difference being is that the traumatized person may develop PTSD, whereas the one hearing about the trauma may develop STSD” (p. 424). As

with PTSD the foundation of STSD is rooted in ‘symptom-based diagnosis’ (Pearlman & Saakvitne, p. 281). Based on the literature, compassion fatigue, PTSD, and STSD can be clearly differentiated from vicarious traumatization.

Vicarious traumatization is a form of secondary trauma. These two terms are used interchangeably in the literature. However, McCann and Pearlman (1990b) stress that vicarious traumatization is a unique phenomenon distinct from other concepts because the individuals affected experience alterations to their cognitive schemas. While there is overlap between the concepts, research identifies specific differences. Sabin-Farrell and Turpin (2003) emphasize the need to develop clear definitions for each concept because “a number of authors have used the term secondary traumatic stress but also discussed cognitive aspects of the effects of working with trauma, and others have discussed vicarious traumatization while focusing totally on symptomatology” (p. 453). It becomes extremely difficult to attribute the findings to a specific concept when definitions are blurred in the research.

Theoretical Explanations

Countertransference.

Countertransference is a commonly used explanation for how vicarious traumatization occurs. Countertransference is defined as “the process of seeing oneself in the client, of overidentifying with the client, or of meeting needs through the client” (Corey, 1991 as cited in Figley, 1995, p. 9-10). While countertransference is often specific to one individual or therapeutic relationship, vicarious traumatization is based on the traumatic narratives of multiple individuals (Pearlman & Saakvitne, 1995). Sabin-Ferrell and Turpin (2003) explain: “countertransference describes experiences that take place within a therapeutic relationship, whereas vicarious traumatization relates to the changes taking place in the whole of the therapist’s life, including their belief system” (p. 454). Although there are

clear differences between the process of countertransference and the process of vicarious traumatization, the two can interact. Pearlman and Saakvitne propose that unacknowledged countertransference can increase a professional's vulnerability to vicarious traumatization. Similarly, professionals experiencing vicarious traumatization may experience more intense countertransference reactions.

Empathy.

Empathy is central to one's experience of vicarious traumatization. Individuals honor helping professionals by sharing their journeys to reclaim their truth, minds, and bodies. Therefore, workers need to remain open and empathetic, making them vulnerable to emotional pain (Pearlman & Saakvitne, 1995). Empathy permits helping professionals to understand another's subjective world (Jordon, 1997a) through communicated thoughts and feelings (Hetherington, 2001). Palmer (1991) states, "we must be open and willing to listen to what survivors have to say, for they alone know the depth and reality of what they have experienced at the hands of others" (p. 80). Empathic engagements allow professionals to remain open when working with individuals, hearing their stories, and sharing in their physical and emotional experience (Jordon, 1997b). Empathic engagements include listening to detailed narratives, bearing witness to the cruelties of humankind, and participating in reenactments of traumatic events (Pearlman & Saakvitne). However, Rasmussen (2005) states, "vicarious trauma weakens the therapist's capacity to be emotionally flexible and available to the client's emotional needs, that is, to provide a holding environment and to sustain affective attunement through empathic immersion in the client's subjective experience" (p. 26).

Cognitive theories.

Theoretical frameworks provide understanding and knowledge about different issues. CSDT provides a theoretical foundation for vicarious traumatization. However, theoretical frameworks are often susceptible to criticism. In regards to CSDT, two limitations are identified by Dunkley and Whelan (2006b). First, CSDT fails to recognize any positive changes within helping professionals that result from working with trauma survivors. Second, “it does not distinguish between increased awareness and disturbances in cognitive schemas” (Dunkley & Whelan, 2006b, p. 111). Regardless of its limitations, CSDT allows for an increased understanding of this occupational hazard. McCann and Pearlman (1990b) state, “helpers must understand how their own schemas are disrupted or altered through the course of this work and also shape the way they respond to clients” (p. 144). Through understanding which components of self are susceptible to interference, workers can recognize and then transform their experiences of vicarious traumatization (Saakvitne & Pearlman, 1996).

Steed and Downing (1998) conducted a phenomenological study of vicarious traumatization. Professionals participated in semi-structured interviews which looked at their responses in hearing traumatic narratives, perceived effects of vicarious traumatization, and changes in their cognitive schemas. Results showed that therapist responses’ to hearing traumatic client material included anger, pain, frustration (both self and other directed), sadness, shock, horror, and distress. Self-directed frustration centered on the therapists’ knowing they could not change the clients’ situations. Frustration directed at others was identified as directed towards clients, their families, and societal factors. The interviews also produced findings of negative physiological effects, such as fatigue and disturbed sleeping patterns. Furthermore, cognitive schemas were altered; over half of the sample identified

increased feelings of suspicion and distrust outside of the therapeutic session (Steed & Downing).

Professional and Social Costs

There are many professional and social costs to the helping professional as a result of working with trauma survivors. In addition to those listed above, loss is a reality when working in the area of trauma; loss of loved ones, dreams, and innocence (Pearlman & Saakvitne, 1995). Helping professionals are confronted with the reality of loss as they bear witness to traumatic narratives. The recognition that they are not immune can lead to an attack on their self-protective beliefs about safety, control, predictability, and attachment (Pearlman & Saakvitne). Vicarious traumatization not only affects the helping professional, it carries over into their relationships with family, friends, and coworkers. McCann and Pearlman (1990b) emphasize that just as individuals often feel the stigma associated with being a victim, helping professionals who bear witness to their stories can experience an uncomfortable sense of separateness from those closest to them. A critical factor for determining whether the changes to one's cognitive world will become destructive is how the helping professional processes what they are hearing and experiencing. McCann and Pearlman identify that professionals must be willing to engage in a parallel process to that of the trauma survivor, "the process of integrating and transforming these experiences of horror or violation" (p. 139). The effects of vicarious traumatization are cumulative, permanent (can forever change a worker's beliefs about oneself, the world, and others), and emotionally intrusive (Rosenbloom, Pratt, & Pearlman, 1995). However, workers must recognize they are not powerless in the face of vicarious traumatization. Through taking an active role, helping professionals can work to ameliorate the devastating effects of vicarious traumatization.

Contributing Factors

Research finds that aspects of the helping professional contribute to vicarious traumatization. Pearlman and Saakvitne (1995) identify these as a professional's worldview, personal history, and current personal and professional circumstances. Pearlman and Mac Ian (1995) conducted an empirical study on the effects of trauma work on trauma therapists. They examined vicarious traumatization in 188 self-identified trauma therapists. Their study explored "the relations among aspects of trauma therapy, aspects of the therapist, and the therapist's current psychological functioning" (Pearlman & Mac Ian, p. 559). Pearlman and Mac Ian found that therapists new to trauma work experienced the most psychological difficulties, and that trauma therapists with a personal history of experiencing trauma showed increased negative effects. Dunkley and Whelan (2006a) conducted a study examining vicarious traumatization levels in telephone counsellors. The researchers found generally low levels of vicarious traumatization. However, a small number did experience high to very high levels of disruption in their beliefs. When examining coping strategies, the findings showed higher levels of cognitive disruptions for respondents who engaged a non-productive coping style, including worry, self-blame, and keeping to oneself. Additionally, Lerias and Byrne (2003) identified personal factors contributing to vicarious traumatization commonly found in the literature to be psychological well-being, level of social support, age, gender, education, and socio-economic status. Through their examination of the literature, it was highlighted that lower levels of psychological well-being, social support, academic achievement, and socio-economic status have been found to increase an individual's vulnerability to vicarious traumatization (Lerias & Byrne).

Research also highlights a professional's working conditions and environment as contributing to vicarious traumatization (Pearlman & Saakvitne, 1995). Schauben and

Frazier (1995) studied the effects of vicarious traumatization on female counsellors working with sexual violence survivors. The researchers found that counsellors with a greater number of survivors on their caseloads reported more disrupted cognitive schemas, more symptoms of PTSD, and an increased probability that one would identify with experiencing vicarious traumatization. Another study conducted by McLean, Wade, and Encel (2003) examined the contribution of therapists' beliefs to psychological distress and vicarious traumatization in therapists. The study sample consisted of 116 professionals who identified themselves as working with traumatized clients. McLean et al. found that "while therapists function generally well, unhelpful beliefs about therapy, recent significant stress, higher clinical workload and less clinical experience may render them more prone to negative consequences such as secondary traumatization, burnout, and emotional exhaustion" (p. 425).

Unpredictable and high stress work environments can increase a professional's vulnerability to vicarious traumatization. Transition houses, considered safe havens, "have taken the lead in providing not only residential care for women and children fleeing abusive relationships, but also advocacy and counselling for shelter residents, and women and children in the community affected by violence against women" (Tutty, 2006, p. 15). Transition house support workers or anti-violence workers are "one population of workers known for intensive work with victims of physical and sexual abuse" (Jeffrey, 1999, p. 2). Support workers hear stories of abuse which often include survivor stories of child sexual abuse and/or sexual assault. In addition to stories they also observe the survivor's emotions of fear, helplessness, and horror. Zimering, Munroe, and Gulliver (2003) explain how research has found that these occupational duties may lead to psychological symptoms in the trauma worker. "Anti-violence workers know the truth about the atrocities committed against women and children, and probe beyond accepted standards to help shape a new and

better reality” (Richardson, 2001, p. 11). However, although transition house support workers are continually exposed to traumatic material they are not trained in psychotherapy (Jeffrey).

The traumatic material one is exposed to in the course of their work can also increase a professional’s vulnerability to vicarious traumatization. Cunningham (2003) conducted a cross-sectional study to explore the relationship between two different types of trauma; sexual abuse (considered human-induced) and cancer (considered natural) and the impact on a social worker’s cognitive schemas. The study found, “clinicians working with clients who were sexually abused had experienced more evidence of vicarious traumatization as compared to clinicians working with clients dealing with cancer” (Cunningham, p. 456). Specifically a significant difference was found in cognitive schemas of safety (self and other), trust in others, and esteem in others. Stout and Thomas (1991) conducted a survey with 44 domestic violence shelter workers and found that 25 workers reported an increase of concern for their personal safety and 33 workers identified an increase in concern over other people’s personal safety. This study highlighted the fact that “it appears that working with victims of violence increases a person’s feelings of vulnerability or awareness of the prevalence and severity of violence” (Stout & Thomas, p. 83).

Iliffe and Steed (2000) explored the impact of vicarious traumatization on counsellors working with domestic violence clients. Respondents identified experiencing vicarious traumatization and alterations in their cognitive schema. In particular, safety, worldview, and gender power issues were the altered cognitive schemas. Respondents reported experiencing negative feelings; visual imagery of traumatic narratives; and physiological reactions, such as, nausea and a feeling of heaviness. More than half of the participants recognized they felt less secure in the present world. Furthermore, most participants reported an increase in

awareness of power and control issues in their immediate surroundings and in society as a whole (Iliffe & Steed).

Working in northern, rural, remote communities brings with it challenges that may contribute to vicarious traumatization. In northern, rural, and remote communities, several challenges exist to both service provision and access. Coholic and Blackford (2005) identified some of these challenges as: “the lack of local referral opportunities, limited opportunity to share knowledge with others doing similar work, the lack of public support or understanding, insufficient staff numbers, and inadequate funding for transportation and wages” (p. 9). Furthermore, confidentiality can pose a considerable challenge to professionals in the north (Schmidt, 2005). In transition houses, confidentiality is an essential, yet difficult component of service (Iliffe & Steed, 2000). Without confidentiality, women may not feel safe to access the shelter or trust the workers. This challenge is amplified in northern and rural communities due to high visibility (Schmidt, 2005; Helbok, 2003). In a study on vicarious traumatization, Coholic and Blackford (1999) found workers experienced more stress when they “maintained confidentiality about perpetrators of abuse who lived in their community and that their personal and leisure activities were frequently curtailed for reasons of safety and privacy” (as cited in Green, 2003, p. 215). This dilemma is problematic because transition house support workers often are not provided formal clinical supervision or adequate supports (Jeffrey, 1999). Additionally, many transition house support workers are not provided extensive training on vicarious traumatization.

Decisions made at the government level can also increase the stress experienced by professionals. Social policies established under neo-conservative governments continue to work against women, increasing their vulnerability and decreasing their safety in society (Creese & Strong-Boag, 2005). In 2002, the BC Liberal government implemented the

Employment and Assistance Act and the Assistance for Persons with Disabilities Act (Wallace, Klein, & Reitsma-Street, 2006). Such legislation included a two-year time limit rule, a 'two-year independence test', a three-week wait period, and 'alternative service delivery models' which have all contributed to a 40% decrease of people receiving assistance and the increased number of homeless people (Wallace et al., 2006, p. 11). In addition, benefits were significantly reduced, the family maintenance exemption of \$100 was removed, and single parents were deemed employable as soon as their youngest child turned three years old (Creese & Strong-Boag, 2005). In relation to the changes implemented to income assistance, "social policy experts in Canada have found in a number of studies that if adequate levels of social assistance are not available, women do not leave abusive partners, or they return to them because of economic need" (Marrow, 2004 as cited in The Poverty and Human Rights Centre (PHRC), 2005, p. 11). Furthermore, with "the virtual elimination of legal aid for family, poverty, and immigration cases,..., and cuts to community-based victims services programs and women's centres" (Creese & Strong-Boag, p. 16), women have fewer supports and resources to access. The PHRC explains, "the diminishment and elimination of key services for victims of spousal assault, cuts to legal aid and courthouse closures have reduced vital protections for women who are victims of domestic violence, increased their vulnerability and threatened their safety" (p. 13).

Liberal social policies in BC have led to a decrease in people accessing social assistance, an increase in homelessness, and decreased safety measures for women, which affects existing services. Between 2000 and 2006, the number of women and children accessing shelters in British Columbia increased (Taylor-Butts, 2007). In 1999/2000, 14,163 women and children accessed shelters in BC (Locke & Code, 2001). However, in 2005/2006, 18,604 women and children were admitted into shelters in BC, and specifically, 14,370

women and children were admitted into transition houses. These increased numbers mean that support workers have more exposure to women sharing their painful experiences of abuse and this may increase the likelihood of vicarious traumatization among support workers. In addition, many transition house workers are experiencing increased workloads due to the pressure to try to fill gaps in services resulting from the cuts to services and women's centres (Robertson, 1998). According to Tutty (2006),

Across the country, women stay in shelters longer because they cannot secure financial assistance or find affordable housing. Cuts to health and mental health services have led to a reported increase in residents with significant mental health and substance abuse problems. There may be few services in the community that can assist shelter staff in addressing their needs appropriately and these women also have difficulty finding and keeping accommodation after leaving the shelter (p. 19).

Furthermore, the pressure of increased workloads and decreased support may also lead to workers neglecting their self care practices in an effort to do all they can for as many women as possible. Policy changes and budget cuts are impacting women working in transition houses, leaving professionals increasingly susceptible to the impacts of vicarious traumatization.

Prevention Strategies

Self care is an important part of responding to vicarious traumatization. Self care is an essential practice that helps workers to continue to be empathetic, congruent, and effective, in any form of caring work. Pearlman (1995) and Rosenbloom, Pratt, and Pearlman (1995) highlight successful personal self care strategies. On a personal level, engaging in meditation, journaling, creative outlets, exercise, integrating self care time into your day, and socializing with friends and families are identified. In their study with domestic violence shelter workers, Stout and Thomas (1991) identified that shelter workers must "...take regular vacations, obtain better salaries, get involved in community affairs, vent

their fears and frustrations, participate in stress-management workshops..., and, most of all, have lives that are separate from work” (p. 82). The following metaphor of a healthy tree emphasizes what professionals need to prevent or lessen the impact of vicarious traumatization. Meyer and Ponton (2006) state, “what keeps the counselor healthy and well-functioning are the vibrant branches of professional and personal activities, the nurturing soil of professional and personal relationships, and the deep roots of professional and personal ideology” (p. 189).

The level of vicarious traumatization can be impacted by a professional’s approach to practice. Some approaches may work to decrease the likelihood of a professional experiencing vicarious traumatization. Transition house workers generally practice from a feminist, strengths-based approach. Heinonen and Spearman (2006) state, “feminist social work practice, based on a core of principles, is concerned with eliminating domination, subordination, exploitation, and oppression of women” (p. 295). Lockley (1999) explains that a feminist approach in the counselling relationship is based on a person-centered perspective that focuses on individual choice and empowerment. A strengths-based perspective turns the focus from traditional problem-solving to a solution-focused collaborative process that builds on the strengths of an individual (Johnson, McClelland, & Austin, 2000). The strengths-based perspective believes that the individuals we serve are members of a species that we ourselves belong to, who have the ability to overcome adversity while continuing to grow and articulate capacities, knowledge, and insight (Saleebey, 2002).

Organizational prevention strategies are also important. In regards to vicarious traumatization, working at an organization that fosters a strengths-based philosophical

framework proves to be beneficial. A transition house program fosters a strengths-based approach by focusing on a woman's progress. Bell (2003) states,

Such a setting encourages counselors to take the long view, to celebrate small successes, and to see how the work enriches the client's and the counselor's own life. It also takes the counselor's experience seriously and does not prematurely label an individual experience as traumatic or the work as traumatizing, but sees it in the context of all work and life experiences. Furthermore, it does not label or stigmatize counselors who may feel stressed by the impact of work or personal crises, but continues to affirm their contributions to the workplace (p. 520).

Through a strengths-based framework it is hoped that workers will feel supported.

Furthermore, the likelihood of vicarious traumatization can be reduced by a worker's strength to develop creative and resilient ways of dealing with the difficult work they do. In a study conducted by Bell (2003) one counsellor identified the "planting seeds" strategy which "involved disconnecting the value of their effort from the client's response in a way that allowed the counselors to feel hopeful and effective" (p. 518). This strategy helps one to remain optimistic regardless of the lack of immediate positive results. Another strategy is a counsellor's ability to resolve any personally experienced emotional traumas. This strategy provides counsellors with an increase in confidence, as well as a strong belief in a person's ability to heal, which are extremely important in trauma work and buffering work stress (Bell, 2003). All professionals have strengths that can help to alleviate vicarious traumatization. However, when they have the additional support of their employing organization, they may be more likely to tap into these creative and resistant strategies.

Agencies that do not implement preventative strategies to reduce the likelihood of vicarious traumatization and ameliorate its effects set their workers up for psychological injury and one day may be held liable (Sexton, 1999). Therefore, it is important to foster a supportive environment that provides resources such as: consultation, supervision, and daily debriefing practices to workers that help them to process disturbing traumatic material

(Sexton). In workplaces where professionals are faced with a multitude of responsibilities the development of healthy solutions may be hindered. According to Richardson (2001) shelters face this very issue,

A residential environment is unpredictable and it is difficult for shelter counsellors to implement an effective daily routine. Individual support by counsellors is interrupted or shortened to respond to the crisis helpline or to complete a new intake. The daily requirements of providing a home-like environment, including meal preparation, issuing medications, bus tickets and linens, and providing for basic needs, supporting arrangements for school, as well as dealing with illness, communicable diseases, parasites, and a whole host of other compelling problems require a response that challenges a consistent routine or schedule (p. 73).

Bell, Kulkarni, and Dalton (2003) identified that organizations should be supportive; if possible allow for diversity in a worker's caseload, provide a safe, comfortable, and private work environment, and arrange for trauma-specific education (including training on vicarious traumatization).

In conclusion, while the quantitative and qualitative research discussed suggests negative effects of bearing witness to continual trauma narratives, variance is evident among the variables and populations studied. Research studies show that trauma workers experience varying levels of disruptions to their cognitive schemas through hearing stories of traumatic experiences. The literature identifies predictive factors located within the helping professional as well as within working conditions. Additionally, issues faced by helping professionals working in northern, rural, remote communities, as well as ineffective social policies and cuts to services, may contribute to a professional's increased vulnerability to vicarious traumatization. Research also highlights the need for the implementation of preventative strategies at the personal and agency level and all studies consistently emphasized the need for increased education and training. Education is seen as an effective tool for raising awareness on what vicarious traumatization is and preventative strategies that

work to ameliorate its effects (Hesse, 2002). Through examination of the ever growing body of research on vicarious traumatization, one gap has been identified. In all the research, no study specifically asks what helping professionals actually know about this occupational hazard. If workers do not know about vicarious traumatization or understand its impact on their work then they will remain unprepared to protect themselves against its effects.

Chapter Three: Methodology

This exploratory study uses mixed-methods for gathering data and analysis.

Although there is a growing amount of research on vicarious traumatization, no research to date examines what helping professionals actually know about the topic. Rubin and Babbie (2005) identified that exploratory research is needed when a researcher is breaking new ground and looking to gain insight into research topics not yet addressed. In asking, what is transition house support workers' knowledge about vicarious traumatization, insight is gained into what transition house workers actually know, as well as the impacts of the work, and the preventative practices they employ. Furthermore, agency response to this occupational hazard and more importantly, what transition house workers believe can be done, is examined.

A mixed-methods approach employs both quantitative and qualitative methods. Quantitative researchers "emphasize the measurement and analysis of causal relationships between variables, not processes" (Denzin & Lincoln, 2000, p. 8). In contrast, qualitative research attempts to understand a person's lived experience (Yegidis, Weinbach, & Morrison-Rodriguez, 1999). According to Rubin and Babbie (2005),

quantitative measures are always highly structured, tend to use close-ended questions primarily, and may be administered in either an interview or questionnaire format, whereas qualitative measures rely on interviews that are often unstructured and that mainly contain open-ended questions with in-depth probes (p. 228).

My thesis research fulfills the quantitative component through the development of a questionnaire that I used to ask questions regarding demographic information as well as what support workers specifically know about vicarious traumatization. In this study, the quantitative portion is considerably smaller than the qualitative portion. However, from specific close-ended questions, descriptive statistics can be calculated and "the use of

descriptive statistics often can enhance a qualitative study” (Rubin & Babbie, 2005, p. 572). The questionnaire data also proved to be a valuable tool informing subsequent phases of qualitative data collection.

Qualitative methods “attempt to tap the deeper meanings of particular human experiences and are intended to generate theoretically richer observations that are not easily reduced to numbers (Rubin & Babbie, 2005, p. 63). As human beings, we hold values, beliefs, assumptions, and biases based on life experiences that pave the way from objectivity to subjectivity. Qualitative research strives to understand what is being studied by examining peoples’ perceptions, opinions, and experiences. Qualitative researchers “stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry” (Denzin & Lincoln, 2000, p. 8). Therefore, subjectivity is a reality that qualitative researchers embrace and when needed, attempt to control. Within my thesis, qualitative inquiry occurs through open-ended questionnaire responses, in-depth interviews, and a focus group. The purpose of employing two different qualitative methods is to provide rich, quality data about the topic.

Content Analysis

Content analysis is the research method directing my thesis from research design to analysis. Krippendorff (1980) defines content analysis as “a research technique for making replicable and valid inferences from data to their context” (p. 21). Content analysis can be applied to data acquired through both quantitative and qualitative methods (Kondracki, Wellman, & Amundson, 2002). According to Hsieh and Shannon (2005), qualitative content analysis is a “research method for the subjective interpretation of the context of text data through the systematic classification process of coding and identifying themes or patterns” (p. 1278). Boyatzis (1998) defines a theme as “a pattern found in the information that at a

minimum interprets aspects of the phenomenon” (p. 4). Therefore, my thesis aimed to identify themes through the examination of text derived from open-ended questionnaire responses, interview transcripts, and focus group discussion notes.

In content analysis, manifest and/or latent content can be examined. Manifest content is identified as “elements that are physically present and countable” and latent content is “the deep structural meaning” (Berg, 2004, p. 269). According to Holsti (1969), latent content is based on inferences derived from the text. Boyatzis (1998) adds that “a theme may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon)” (p. 4). My thesis examined the manifest and latent content of the text derived from my questionnaire, interviews, and focus groups. I believe that it was important to analyze “the visible or apparent content,” as well as the “underlying aspects of the phenomenon under observation” (Boyatzis, 1998, p. 16).

Content analysis can be approached in a deductive or inductive way. Using a deductive approach, the research question is derived from existing knowledge and theory about a particular issue (White & Marsh, 2006). Coding schemes or frameworks for analysis, which operationalize concepts, are established before coding begins and during analysis, the findings from the coded data are summarized, and patterns and relationships are identified (White & Marsh). In contrast, when taking an inductive approach, the researcher first analyzes the data collected without any preconceived ideas or categories (Kondracki et al., 2002). White and Marsh (2006) identified that compared to a deductive approach,

the text plays a slightly different role in that, as the researcher reads through the data and scrutinizes them closely to identify concepts and patterns, some patterns and concepts may emerge that were not foreshadowed but that are, nevertheless, important aspects to consider (p. 34).

Therefore, such discoveries may move the researcher into another direction asking new questions. During analysis, the content analyst attempts to answer the research questions as well as consider new themes or questions that may have emerged during coding (White & Marsh).

I used a deductive approach for my research. Hsieh and Shannon (2005) identify distinctive strengths and limitations to this approach. The main strength associated with a deductive, directive approach is that existing theory can be supported and extended. However, a limitation identified is that by using theory, a researcher, although informed, may approach the data with a bias. Furthermore, “an overemphasis on the theory can blind researchers to the contextual aspects of the phenomenon” (Hsieh & Shannon, p. 1283).

Before any analysis took place, my framework for analysis (see Appendix A) was developed based on the existing literature on vicarious traumatization and my knowledge of a transition house support worker position. The framework for analysis identifies predetermined coding categories (White & Marsh, 2006). The existing literature on vicarious traumatization helps the researcher during the analysis process to identify what transition house support workers specifically know about the topic. However, I did not want to limit my analysis by solely relying on preconceived ideas. Following the deductive approach, a framework for analysis can either be structured or unconstrained, depending on the research objectives (Kyngas & Vanhanen, 1999, as cited in Elo & Kyngas, 2007). Elo and Kyngas explain, “when using an unconstrained matrix, different categories are created within its bounds, following the principles of inductive analysis” (p. 111). Therefore, I used an unconstrained framework for analysis in my research to allow for additional themes and categories to emerge out of the data. I suggest that to truly honour and give voice to the

women in my study; I needed to remain open to what they have shared about their workplace, vicarious traumatization, and future recommendations.

Content analysis “is a passport to listening to the words of the text and understanding better the perspective(s) of the producer of these words” (Berg, 2004, p. 269). It is for this reason that my research thesis employs content analysis. Furthermore, content analysis has been found to be an effective method in studies measuring knowledge and developing action steps to advance the issue under study (Kondracki et al., 2002).

Research Method and Design

Participants

Transition house support workers are the sample population. Support workers were chosen because they continually bear witness to traumatic narratives, yet they often do not receive clinical supervision. Additionally, due to the confidential nature of domestic violence work, they are often isolated from other helping professionals. This study uses non-probability sampling, which limits its generalizability to the wider population (Rubin & Babbie, 2005). However, I used a purposive sampling method because this study was specifically looking at transition house support workers based on my “knowledge of the population” (Rubin & Babbie, 2005, p. 247). Due to this method of sample selection, the results cannot be interpreted as representative of all women who work in women’s shelters.

Transition houses selected to participate were located in Northwestern communities along Highway 16 East from Prince Rupert, BC to Prince George, BC (see Appendix B). According to BC Stats (2001) the area of study falls within four Regional Districts: Skeena-Queen Charlotte, Kitimat-Stikine, Bulkley-Nechako, and Fraser Fort-George. According to the Government of Canada (2004) the following transition houses are located between Prince Rupert and Prince George and were invited to participate in my thesis research:

- Hope Haven Transition House, Prince Rupert, BC
- Ksan House, Terrace, BC
- Passage House, Smithers, BC
- Eagle's Nest, Burns Lake, BC
- Omineca Safe Home, Vanderhoof, BC
- Amber House (formerly the Elizabeth Fry Shelter), Prince George, BC
- Phoenix Transition House, Prince George, BC

Based on information provided by the management of each of these shelters, I determined that there were 96 transition house support workers. All 96 were invited to participate in all three forms (questionnaires, individual interviews, and focus group) of data collection.

Procedure

Data collection took place during the months of February 2008 and July 2008. Three methods were used: questionnaire, semi-structured interviews, and a focus group. The questionnaire data were collected based on a set time limit between the months of February 2008 and April 2008. Between the months of May 2008 and June 2008, all 13 interviews were conducted with workers from the seven different transition houses in six different communities. The focus group data were collected in the month of July 2008. Collecting the data simultaneously was not feasible as the questionnaire data were used to inform my interview guide and then the data from both of those methods informed my focus group discussion guide.

To identify potential participants and seek agency support for the research study, I sent a letter (see Appendix C) to all seven transition houses. The letter identified the researcher and contact information, purpose of the study, and the responsibilities of agencies and support workers throughout the process. A copy of the questionnaire information sheet

(see Appendix D) was also attached to the letter. Within a couple weeks from sending out the initial letter, a follow-up phone call was placed to each transition house manager/executive director. The follow-up call provided an opportunity to talk with each transition house about the research study, provide any additional information, and answer any questions the agency or support workers had. In one case, I was invited and attended a lunch at a transition house to discuss the research with staff members.

All seven agencies replied back with a letter of consent/support. A total of 96 questionnaire packages, one for each support worker, were then sent out; mailed to all out of town transition houses, and physically delivered to Prince George transition houses. The packages included the questionnaire information sheet, a questionnaire cover letter identifying that through answering the questions participants are consenting to participation (see Appendix E), a questionnaire (see Appendix F), and a participation consent form (see Appendix G) for participants to fill out if they would like to participate in an individual interview and/or focus group. Approximately two weeks after mailing out the research packages, each transition house manager received a follow-up call to ensure the packages arrived and answer any additional questions about the research study. Additionally, a letter of further encouragement (Rubin & Babbie, 2005) was sent to all transition houses approximately a month after all packages were received by the houses.

During the first level of data collection, 96 questionnaire packages were sent out and after three months, 31 completed questionnaires were returned. Of the 31 female respondents, 29 identified themselves as transition house support workers, one as an outreach worker, and another as a Sexual Abuse Intervention Program therapist. However, regardless of their roles, all respondents identified that they work for a non-profit society that manages a transition house program, they provide support and/or advocacy to women accessing those

transition house services, and have the opportunity to listen to many woman's stories and experiences. Thus, all returned questionnaires were used for data analysis.

Of the 96 questionnaire packages sent out, 15 participants identified that they would like to take part in an individual interview and/or a focus group. Potential participants for an individual interview and/or focus group were assessed based on one criterion; employment within their respective agencies for a minimum of six months. This criterion was decided based on existing research that identifies that those new to trauma work experience the most psychological difficulties (Pearlman & Mac Ian, 1995). Therefore, I believe newly employed support workers could provide valuable insight. Additionally, a six month minimum also gives sufficient time for new employees to become acquainted with, and develop a working knowledge of, agency policies and procedures. At the end of the second phase of data collection, 13 out of 15 respondents completed individual interviews. At least one worker from each of the seven transition houses was interviewed.

Due to an overall limited interest in focus group participation, as well as time and travel constraints on the part of the researcher, one agency was selected and all 18 transition house employees fit my study criteria and were invited to participate. In selecting one agency to participate, it was hoped that all participants would have a pre-established rapport with one another and a unified understanding of established policies and procedures within their agency. However, considering that the transition house is staffed 24 hours a day 7 days a week, three support workers were unable to attend due to shift conflicts. Therefore, out of the 15 eligible and available, 8 transition house support workers participated in the focus group.

Data Collection Methods

Questionnaire.

Questionnaires are a form of survey research. According to Rubin and Babbie (2005), “survey research is perhaps the most frequently used mode of observation in the social sciences” and “may be used for descriptive, explanatory, and exploratory purposes” (pp. 282-283). For my study, I developed a self-administered mail out questionnaire. Rubin and Babbie identify the following strengths to employing this mode of data collection: they are both time and cost effective, can be done by one person, are good when dealing with sensitive issues, make having larger samples feasible, and can provide flexibility in your analysis. However, mail out questionnaires can also have weaknesses such as: when you are not face-to-face you are unable to identify important observations, “the survey researcher can seldom develop the feel for the total life situation in which respondents are thinking and acting”, they can be inflexible in that they “typically require that an initial study design remain unchanged throughout”, and they “are subject to artificiality” (Rubin & Babbie, p. 303).

In my research, the questionnaire consisted of 16 open- and close-ended questions. The first six questions were close-ended and ask basic demographic information. The demographic questions were selected based on the literature of vicarious traumatization. The additional 10 questions aimed at exploring what transition house support workers know about vicarious traumatization and if they have ever received any training. Examples included: “have you ever heard of the term vicarious traumatization? If yes, where and in what context did you hear the term? Do you believe that vicarious traumatization is preventable?” At the beginning of the questionnaire, I provided participants with a definition of vicarious traumatization so that all participants have an accurate reference point on which to base their

answers. The questionnaire was pre-tested by 7 people in total (5 of my peers from the Master of Social Work program at UNBC, a BSW graduate, and a family member).

Participants were asked to read the information sheet and the questionnaire cover letter that identified informed consent. If participants chose to continue, they were asked to fill out the questionnaire. After completing the questionnaire, participants were then asked to mail it back to the researcher in the self-addressed stamped envelope provided. Additionally, if participants were interested in participating in a future interview and/or focus group they were encouraged to fill out a participation consent form and mail it back to the researcher in a separate self addressed stamped envelope. It was only through the return of the participation consent forms that any names and contact information were obtained by the researcher.

Interview.

Interviews are the most commonly used qualitative method. Bryman and Burgess (1999) identify that interviews are complex social encounters that provide an in-depth examination of experiences and opinions that are missed through the use of close-ended questions. "The interview is a research-gathering approach that seeks to create a listening space where meaning is constructed through an interexchange/co-creation of verbal viewpoints in the interest of scientific knowing" (Miller & Crabtree, 2004, p. 185). For my research, I conducted in-depth, semi-structured, open-ended interviews. A semi-structured interview uses an interview guide, but also allows "the interviewer to be flexible, informal, and conversational and to adapt the style of the interview and the sequencing and wording of questions to each particular interviewee" (Rubin & Babbie, 2005, p. 228). An interview guide identifies the list of topics or questions that a researcher plans to explore during the interview process (Patton, 2002). My interview guide (see Appendix H) consists of 17 questions with additional probing questions. The original version of the interview guide was

revised based on the data collected through the questionnaires. Initial demographic questions were taken out as basic demographic information: position, agency, and length of employment were provided through the participant consent form. More specific questions examining transition house support work, its impacts, strategies for self-care, and agency response were developed to elicit support workers understanding of vicarious traumatization and preventative practices employed personally or at the agency level.

For this phase of data collection, all interested participants were contacted and asked to participate in an individual semi-structured interview. Before beginning, informed consent and confidentiality were discussed. Each participant was given a copy of the interview information sheet (see Appendix I) to read over and the interview consent form (see Appendix J) was signed. The 13 interviews ranged from 35 minutes to 124 minutes in length with an average length of 65 minutes. All interviews were audio-recorded in an effort to capture verbatim the responses of each interviewee (Patton, 2002). According to Patton (2002), while a recording device may malfunction or stop working, it allows the researcher to be more attentive during the interview process. In addition, “recorders do not ‘tune out’ conversation, change what has been said because of interpretation (either conscious or unconscious), or record words more slowly than they are spoken” (Patton, 2002, p. 380). Each audio-recording was later transcribed verbatim by the researcher.

Focus group.

Interviews can be done individually, as well as in a group setting. Group interviews are commonly known as focus groups. Focus groups occur when a researcher brings a group of people together who have shared a similar experience, and leads the group in a discussion of those experiences (Yegidis et al., 1999). Focus groups can yield quality data that aims to understand the lived reality of individuals. Conducting a focus group provides a cost-

effective opportunity for participants to interact which can enhance the quality of data obtained. Patton (2002) identifies how “participants get to hear each other’s responses and to make additional comments beyond their own original responses as they hear what other people have to say” (p. 386). Additionally Krueger (1988) identifies “the researcher creates a permissive environment in the focus group that nurtures different perceptions and points of view, without pressuring participants to vote, plan, or reach consensus” (p. 18). Therefore, all responses are accepted, whether positive or negative. When people are provided a permissive and nonjudgmental environment to engage in a discussion with others who have had similar experiences, rich and quality data can be produced and collected.

Developing and conducting a focus group is not as simple as putting people in a room and having them talk to one another. Focus groups have specific characteristics. Krueger (1988) identifies the ingredients of a focus group as “(a) people, who (b) possess certain characteristics, (c) provide data (d) of a qualitative nature (e) in a focused discussion” (p. 27). As identified above, my research included one focus group with support workers all employed in the same transition house. Eight support workers participated in the focus group. Focus groups are conducted with typically 7-10 people in each group and “the size is conditioned by two factors: it must be small enough for everyone to have opportunity to share insights and yet large enough to provide diversity of perceptions” (Krueger, 1988, p. 27). The focus group was approximately two hours in length and followed a semi-structured format.

A discussion guide (see Appendix K) was developed and used. According to Patton (2002), “a guide is essential in conducting focus group interviews for it keeps the interactions focused while allowing individual perspectives and experiences to emerge” (pp. 344-345). In addition, researchers use predetermined and sequenced open-ended questions in an attempt to

collect rich qualitative data (Krueger, 1988). Questions asked attempted to elicit information about what support workers know about vicarious traumatization as well as act as a form of member checking for data already collected during the questionnaire and interview phase of data collections. Examples of questions include: “What is vicarious traumatization? Do any thoughts/questions come up for you when you think about the issue of vicarious traumatization? Do you believe that support workers are vulnerable to vicarious traumatization? What are your thoughts about debriefing practices in your work place?” All information shared in the focus group was written on a flip-chart and no recording devices were used.

Prior to holding the focus group, the location was decided, the date set and appropriate accommodations were secured. In addition, financial remuneration (\$10 for one child and \$15 for two or more children) was offered to all workers who required childcare to participate in the focus group. The researcher incurred any cost associated as no funding was accessed throughout the research process. Prior to moderating the focus group, information sheets (see Appendix L) and informed consent forms (see Appendix M) were given to all participants. Informed consent was obtained and confidentiality stressed with all participants. Additionally, prior to commencing, I introduced the focus group, welcomed everybody, gave an overview of the topic, discussed guidelines or ground rules, and explained my role as the moderator (Krueger, 1998). The researcher must not enforce their expectations or perceptions onto the group. The role of the moderator needs to be specified as “the amount of direction provided by the moderator influences the types and quality of the data obtained from the group” (Stewart & Shamdasani, p. 513). Therefore I explained that my role as moderator was not to participate in the discussion but to ask questions, listen, and write responses on the flip chart (Krueger, 1998).

Rationale.

As identified above, this study used three different methods of data collection: a questionnaire, face-to-face interviews, and a focus group. The rationale for this decision is that each method will potentially yield different types of data. Through the use of a questionnaire, the data collected is specific and limited to the questions asked (Rubin & Babbie, 2005). When individual face-to-face, semi-structured interviews were added to the research process an opportunity arose for the collection of more comprehensive data since participants are likely to provide more in depth answers in face-to-face confidential interactions. Additionally, a semi-structured format adds flexibility to use a variety of techniques such as probing questions to draw out more in depth answers (Rubin & Babbie, 2005). Through introducing a focus group as a third data collection technique, participants were given the opportunity to hear from others, interact, and build off what was said by others in the group (Patton, 2002). Therefore, it was hoped that the data produced would be rich, detailed, and include a range of different ideas and strategies.

Ethics

Ethical considerations are a very important part of the research process. Prior to data collection, my research proposal was submitted to the University of Northern BC Research Ethics Board, and was approved on January 15, 2008 (see Appendix N). In regards to the data collection, all participants were given the choice to participate and all gave informed consent. No participant was harmed and no deception was used. As identified previously, no funding was accessed throughout the research process therefore participants were not financially compensated. In the case of emotional distress, numbers for counselling services in each community was available to participants.

Maintaining confidentiality and anonymity are essential to maintaining a participant's sense of safety. Throughout each step of data collection, every effort was made to maintain participant's confidentiality and ensure that no identifying information was exposed. When completing the questionnaire, all participants were asked not to put their names or place of employment on the forms and were provided two envelopes and instructed to mail their participation consent form separate from their questionnaire. Prior to conducting interviews, each participant was given the opportunity to choose a fictitious name to be used for the purpose of documenting quotes in the final report. Also no identifying information was used. Finally, before beginning the focus group, maintaining confidentiality was stressed to all participants and no names were used in the transcripts. In an effort to safeguard confidentiality, returned questionnaires, paper copies of transcripts, and all participant information are stored in a locked cabinet (Mauch & Park, 2003). Additionally, all information, transcripts, and analysis will be kept no longer than one year after completion of my thesis, at which time paper documents will be shredded and digital recordings and computer files erased.

Building Trustworthiness

Triangulation.

As with all types of research, the question of validity needs to be addressed. Validity is defined as "the degree to which the procedure really measures what it proposes to measure" (Krueger, 1988, p. 41). When it comes to content analysis, validity concerns center on sample selection and whether the variables identified actually speak to the research question (Kondracki et al., 2002). Due to the fact that the majority of my study was qualitative and used purposive sampling, one way I addressed rigour was through triangulation.

Regardless of the method, every researcher aims to ensure the dependability of their evidence, as well as the trustworthiness of their conclusions (Avis, 1995). Denzin (1970) as cited in Kimchi, Polivka, and Stevenson (1991) defines triangulation in research as “the combination of two or more theories, data sources, methods, or investigators in the study of a single phenomenon” (p. 364). According to the research, triangulation can have two purposes: confirmability and completeness (Nolan & Behi, 1995). In qualitative research, there is an attempt to understand an individual’s subjective reality; therefore, triangulation is used in an effort to establish completeness, not confirmation. To accomplish this goal, qualitative researchers use multiple methods in the development of a comprehensive understanding of the phenomenon under study (Denzin & Lincoln, 2000). Many researchers see completeness as a way to ensure they will discover a more holistic and contextual picture. Shih (1998) uses the metaphor of a puzzle to explain the expectations following the purpose of completeness. Each data source is not meant to confirm the other, but acts as an additional piece of the puzzle. Therefore, the greater number of puzzle pieces you have, the more the picture will be revealed (Shih).

My research thesis is an exploratory study which uses method as well as data source triangulation to try and accurately convey the reality of transition house support workers and their knowledge of vicarious traumatization. In method triangulation, two or more data collection techniques are used in an attempt to discover different dimensions of the phenomenon under study (Kimchi et al., 1991). For my thesis research, I used a questionnaire, individual interviews, and a focus group to obtain my data. Second, my thesis utilizes data source triangulation, specifically person triangulation. In person triangulation, data is collected from at least two different levels of persons and the findings from one level are used to validate the data from the other level (Kimchi et al.). Therefore, by using three

different methods, I collected data from individuals as well as a collective group of transition house support workers. Through engaging in a variety of strategies, threats to trustworthiness are minimized and research findings authentically represent the meanings as described by participants (Creswell, 1998).

When the decision is made to use a triangulation approach, researchers must follow procedures and protocols to document a systematic account of the triangulation process. Farmer, Robinson, Elliott, and Eyles (2006) identify that the majority of researchers fail to fully detail the appropriate procedural steps that need to be taken in regards to triangulation. Based on protocols established by Farmer et al., in the application of triangulation I organized the findings from each data set in categories that addressed the research question, then identified the themes from each data set, and compared them to those in the other data sets. It is here that any dissonance of findings was documented. Finally, a completeness assessment was conducted. In the completeness assessment, researchers “compare the nature and scope of the unique topic area for each data source or method to enhance the completeness of the united set of findings and identify key differences in scope and/or coverage” (Farmer et al., p. 383).

Pilot tests and verification checks.

To establish validity, qualitative researchers follow established procedures and incorporate strategies such as verification checks (Schoenberger, 1991) and pilot tests (Bryman & Burgess, 1999) in an effort to ensure their results. Therefore, pilot tests and verifications checks were included during the interview and focus group phases of data collection.

Two pilot interviews were conducted, one with a peer from the Master of Social Work program at UNBC, and one with a Canadian Certified Counsellor. The process of

conducting pilot interviews helped the researcher to finalize the sequence and wording of the questions asked, as well as help to identify useful probes needed to elicit information (Miller & Crabtree, 2004). The pilot interviews not only provided valuable feedback, but by going through the entire process twice I was able to practice using transitional sentences and the digital recorder, as well as become more comfortable and familiar with my interview guide.

As identified above, all of the interviews were audio-recorded and transcribed by the researcher. Each participant was then sent a copy of their transcript to read over and verify the accuracy of the transcription. Each participant was also given the opportunity to omit any parts they did not want included in the study. A follow-up call was placed to each participant to assure the transcript was an accurate account of what the participant shared during the interview and to identify what parts, if any, the participant wanted omitted. Only one of the 13 participants requested that some sections of her transcript be omitted. For this participant, a meeting was arranged to go over the transcript together and after the said changes were made, a copy of the revised transcript was sent back so she could be assured that all changes were included.

In regards to the focus group, the discussion guide was pilot tested with peer from the Master of Social work program at UNBC and a Certified Canadian Counsellor to finalize sequence and wording, as well as identify important questions that might be missing. In addition, all collected data was written on a flip chart and verification of its accuracy was obtained throughout the focus group session. Only once was an amendment requested to the written notes.

Testing the reliability of the framework for analysis.

When using a deductive approach, testing the reliability of the framework for analysis, which directs the coding process, is an important step. Boyatzis (1998) defines

reliability as the “consistency of observation, labeling, or interpretation” (p. 144). In addition, Boyatzis refers to reliability as a consistency of judgment “that protects against or lessens the contamination of projection” (p. 146). One way consistency of judgment is achieved is through establishing consistency across viewers. This is attained when “different people observing or reading the information see the same themes in the same information” (Boyatzis, p. 147). For my research thesis to test consistency of judgment it was decided that my thesis supervisor would code an interview transcript based on my framework for analysis. The results were compared, the same themes were identified, and no changes to the framework for analysis were necessary.

Member checks.

Using member checks is another way to try and verify a study’s findings. Schwandt (2001) explains, “also called member or respondent validation, this is a sociological term for soliciting feedback from respondents on the inquirer’s findings” (p. 155). By completing one method of data collection before beginning the next, the opportunity to include member checks was built into the research process. The following are examples of some of the member checks incorporated into the focus group:

- Many respondents said they felt that VT was not preventable and one worker said she believed VT was not a prevention issue but a maintenance issue. Do you have any thoughts about that statement?
- The three emotions identified most often by support workers were frustration, anger, and sadness. Do you have any thoughts/feelings about these emotions? Do you as a worker connect to any of these emotions?
- Most respondents identified the importance of informally debriefing with co-workers. However, many support workers reported the need for more formal

debriefing because it was something they felt was lacking in their agency. What do you think about this?

While there has been some debate about the overall purpose of member checks, “the consensus seems to be that member checking is not profitably viewed as either an act of validation or refutation but is simply another way of generating data and insight” (Schwandt, 2001, p. 156). In regards to my thesis research, the use of member checks has provided validation, as well as, supplementary data and insight.

Data Analysis

Descriptive statistics.

Descriptive statistics identifying frequencies and means were calculated to highlight the results of the demographic questions asked of participants. Information attained from the demographic questions was used to provide detailed information on participants in the study. In addition, frequency of responses and percentages of the remaining close-ended questionnaire items were calculated and used in conjunction with open-ended responses to highlight overall questionnaire results.

Content analysis.

Content analysis guided my entire research study. Specifically, I used a deductive approach that allows themes and concepts to emerge from the data. In conducting a content analysis, I began by transcribing each transcript verbatim. As stated above, before beginning any analysis, I developed a framework for analysis. Due to the unconstrained nature of my framework for analysis, I started my analysis by completing a straight read of all the data from each data source. On the second and third read through, using the framework as well as remaining open to any emerging themes, I began coding by highlighting themes and sub-themes along the margins of each transcript. Schwandt (2001) defines coding as “a

procedure that disaggregates the data, breaks it down into manageable segments, and identifies or names those segments” (p. 26). A fourth read was completed to see if any additional themes would emerge from the data. Throughout the process, I wrote down any thoughts and questions that arose, to aid me in the reflexive practice of knowing how I came to the final analysis of the data. After completing all the coding of the data, I then began to analyze the coded data. Overall themes and sub-themes were counted. All coding and analysis was completed manually and quotes were used to support my findings.

Chapter 4: Research Findings

Demographic Information

Fifty-two participant contacts from seven different transition houses in Northwestern BC were involved in this study. Thirty-one support workers completed the questionnaire, with a response rate of 32.29%. While Rubin and Babbie (2005) identify a response rate of at least 50% as adequate, they also caution that their numbers “are only rough guides; they have no statistical basis, and a demonstrated lack of response bias is far more important than a high response rate” (p. 289). Additionally, 13 workers participated in one-on-one interviews, and eight workers came together for the focus group. Some support workers chose to participate in more than one phase of data collection.

Questionnaire respondents were asked their employment status and the three identified classifications were full-time, part-time, and casual. While full-time and part-time employees have set shifts within the agency, casual employees are called in, often based on seniority, to cover shifts as needed. The length of employment for respondents varied from less than a week to 20 years. The mean length of employment was 5.9 years. One respondent employed less than a week was not included in the calculation of the mean as the exact length of employment was not clear and thus considered an outlier.

Table 1

Questionnaire Participant Demographics (n=31)

Demographic Characteristics	<i>n</i>	%
Employment Status		
Full-time	17	54.8
Part-time	4	12.9
Casual	9	29.0
Info not available	1	3.2
Age		
19-28 years	3	9.7
29-38 years	6	19.3
39-48 years	10	32.3
49-58 years	8	25.8
59-68 years	4	12.9
Level of Education		
Some High School	2	6.5
Graduated Grade 12	3	9.7
Some College	7	22.6
College Diploma	5	16.1
Some University	5	16.1
University Degree	8	25.8
Info Not Available	1	3.2
Relationship Status		
Single	3	9.7
Dating	4	12.9
Common-Law	7	22.6
Married	9	29.0
Divorced	1	3.2
Other	3	9.7
Info Not Available	4	12.9
Past Personal Trauma		
Experienced	30	96.8
Did Not Experience	0	0
Info Not Available	1	3.2

Note. Values are rounded up; therefore, percentages may not equal 100%.

The majority of respondents (54.8%) were employed as full-time workers within their agency, followed by casual (29.0%) and part-time (12.9%) employees.

The age of respondents ranged from 19-68 years and was broken into nine year intervals (i.e. 19-28, 29-38, etc.). The modal, most frequent, age interval was 39-48 years and included 10 (32.3%) respondents. The second most frequent age interval was 49-58 years with eight (25.8%) respondents, and third was 29-38 years with six (19.3%) respondents.

The level of education was identified by all but one respondent, and ranged from some high school to a university degree. The most commonly identified level of education with eight (25.8%) responses was a university degree, followed by seven with some college (22.6%). In addition, some university and a college diploma were identified by five (16.1%) respondents.

With respect to relationship status, married was most frequently identified by nine (29.0%) respondents. Living common-law was the second most identified answer with seven (22.6%) responses, followed by dating with 4 (12.9%) responses. While three people identified "other" on their questionnaire, each respondent identified they were currently separated.

As identified in the literature, a personal history of experiencing trauma can contribute to a worker experiencing the negative impacts of vicarious traumatization (Pearlman & Mac Ian, 1995). Interestingly, 30 (96.8%) respondents identified that they personally experienced trauma in their lives. It is also important to note that one respondent left the answer blank, therefore, whether this person has or has not experienced personal trauma is unknown.

While the questionnaire asked several questions about demographic information, the same questions were not asked of interview and focus group participants. The questionnaire was sent out to all possible participants and asking more detailed demographic questions

allowed me to develop an initial demographic snap shot of the population. However, before moving into the last two phases of data collection, information about employment status, length of employment, and location of transition house that employed each participant, was answered when respondents filled out their participation consent form. There was no plan to analyze the data for any linkages to demographic information. Therefore, the demographic information I focused on was employment status, location of transition house, and whether participants met the selection criteria.

At the end of the second phase of data collection, 13 interviews were completed and they included at least one worker from each of the seven transition houses. Of the 13 participants, seven (53.8%) were full-time, three (23.1%) were part-time, and three (23.1%) were casual employees of the agency. The average length of employment, ranging from seven months to 20 years, was 6.8 years.

The focus group members provided the least amount of demographic information. All of the support workers were employed by the same transition house and all worked longer than six months within the agency. Of the eight transition house support workers who participated in the focus group, three (37.5%) were full-time, three (37.5%) were part-time, and two (25%) were casual employees.

Quantitative Analysis

The quantitative findings in this study were derived from the questionnaire's close-ended questions with fixed response categories. Descriptive statistics were calculated, based on participants' responses to several close-ended questions. The qualitative data derived from the questionnaire's open-ended questions will be described in the next section.

Table 2

Quantitative Findings

	Yes		No		Information Unavailable	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Have you heard the term vicarious traumatization?	26	83.87	5	16.13	0	0
Has your employer ever talked about the impact of hearing traumatic stories?	19	61.29	11	35.48	1	3.23
Have you received training on vicarious traumatization?	10	32.26	20	64.51	1	3.23
Do you believe vicarious traumatization is preventable?	19	61.29	9	29.03	3	9.68
Do you feel personally impacted by the trauma stories you hear?	21	67.74	9	29.03	1	3.23
Do you feel your community's geographic location impacts you as a worker?	21	67.74	10	32.26	0	0

The majority of respondents (83.87%) identified that they heard the term vicarious traumatization prior to completing this research questionnaire. Additionally, 19 (61.29 %) identified that their employer talked to them about the impact of hearing another's traumatic stories. However, only 32.26% (10 out of 30) of respondents reported that they received

training specifically on vicarious traumatization and 19 (61.29%) respondents believed that vicarious traumatization is preventable.

The findings outlined above suggest that the majority of respondents (67.74%) are impacted by continually hearing the traumatic stories of other women. However, an unexpected finding was that 29.03 % of respondents said they felt they were not personally affected by the traumatic stories they heard. Based on this finding a question was incorporated into the interview guide as well as the focus group discussion guide, asking other transition house support workers what they thought about this finding. The opinions shared will be highlighted and discussed further in the qualitative analysis section of this thesis.

As identified in the literature, working in northern communities can provide unique challenges for workers. With respect to northern practice, 21 out of 31 support workers (67.74%) identified that they felt their community's geographic location impacts them and the work they do. Those workers also went on to elaborate in what ways they are impacted which again will be identified in the qualitative analysis of this thesis.

Qualitative Analysis

Qualitative data were derived from open-ended questions in the questionnaire, interview, and focus group. For the purpose of this research, all qualitative data were analyzed using content analysis. While the main themes identified were based on examination of the latent content, some of the subthemes were developed out of clear expressions in the text; the manifest content. In identifying each theme, quotes will be used to add richness to the data. As identified above, three different forms of data collection were used and not all the same questions were asked during each phase of data collection. Therefore, details on which respondents were asked questions related to each theme will be

identified below. It should also be noted that in identifying the main themes and underlying subthemes there were a variety of single responses given, however, only the most frequently identified responses will be highlighted in this section. The following main themes and additional sub-themes were identified through analysis:

Table 3

Research Themes

Theme 1 Vulnerability	Theme 2 Impacts	Theme 3 Knowledge Base	Theme 4 Agency Response	Theme 5 Strategies for Change
Trauma experience	Vicarious traumatization	What is known	Supportive interactions	Debriefing and counselling
Workplace stressors	Physical impacts	What more is needed	Education and training	Professional self-care strategies
Northern context	Positives Workers' rationalizations		Formal versus informal debriefing	

Vulnerability

When looking at the question of what support workers know, it is important to first look at whether workers are at risk for experiencing vicarious traumatization. Throughout each phase of data collection, the vulnerability of support workers was a prominent theme. While an underlying theme throughout the questionnaire and interview responses, all eight of the focus group participants agreed unanimously that they believed support workers are vulnerable to vicarious traumatization. With respect to vicarious traumatization, workers are vulnerable not only to experiencing it, but in their ability to ameliorate its effects. Interviewee Jennifer highlighted her vulnerability by stating, “working in these areas...it just kind of soaks in your arteries and veins and your whole system and you don’t even know that

it's there because it just slowly gets into your system over the years." Whereas May shared, "it's really hard not to become sort of attached to everyone's issues and then you find yourself sort of carrying it with you the whole time." Whether identifying various trauma stories, job demands, and issues to service provision based on their community's geographical location, support worker's vulnerability was highlighted. Therefore, trauma experience, workplace stressors, and northern context were sub-themes raised by respondents that may contribute to a worker's overall vulnerability.

Trauma experience.

Every participant contact ($n = 52$) in every phase of data collection identified that they work with trauma survivors and, therefore, heard stories and/or saw evidence of trauma. Twenty-nine out of 31 (93.55%) questionnaire respondents identified that they had the opportunity to hear the stories of women. As for the two that were left blank, respondents were not actually asked to answer the question if they already identified that they are employed as a transition house support worker, as hearing the stories of women is part of the support work they do. Therefore, it cannot be stated for certain that those two respondents have not had the opportunity to hear another's story. As for the focus group, while participants were not asked directly if they had the opportunity to hear the stories of women, each was asked to recall a traumatic story they heard and to share how the story made them feel. Those findings will be highlighted under the theme titled Impacts.

In the interview phase of data collection all 13 participants identified at least one example of a trauma story they heard. Samantha shared,

There's just lots of stories of women being physically abused by their partners or ex-partners, or being raped, or verbally abused. Pretty much every woman who we see come through these doors has been traumatized in some way. They don't get here because their lives are really going well.

Additionally, Jenny explained, “if we go through the stats in Canada it takes 37 attempts before the woman really decides to leave the abusive relationship...and when they walk in and they tell these horrendous stories it is like ‘oh my god’.” Throughout the interviews the four most frequent trauma stories experienced by support workers were stories of physical assault, sexual assault, psychological abuse, and child sexual abuse.

Hearing stories and seeing evidence of a physical assault was identified by nine out of 13 (69.23 %) interviewees. Jenny identified hearing a woman’s story of seeing her new born son for the first time and seeing the bruises on his face from the physical assault she had endured before giving birth. With respect to seeing the physical signs of an assault on a woman, Betty shared her experience, “there was a woman...who ended up in the hospital and she was so badly beaten, I went to visit her and I almost didn’t recognize her.” Additionally, eight out of 13 (61.54%) support workers identified hearing stories of sexual assault. Arlene identified multiple examples of the traumatic stories she heard during her employment,

I’ve heard stories of adult women who are still being sexually abused by their fathers. I’ve heard stories from a woman who had survived the Robert Pickton farm. I’ve heard stories from a woman who was found in a dumpster in Vancouver and spent six months of her life in hospital without anyone knowing who she was because she was so disfigured that she wasn’t able to be identified and she was in a coma. I’ve heard stories of women who have been raped by multiple men, heard of women working on the street to provide for their family, to provide for their addictions issues, provide for their partner’s substance misuse issue.

Another form of violence that support workers hear about is psychological abuse. Throughout the interviews, six (46.15%) workers identified stories of psychological abuse. Charlotte not only identified that she heard stories of psychological abuse, she also elaborated on different forms of psychological abuse, “we hear a lot of stories about sexual assault and physical abuse and a lot of psychological, like mind games, verbal abuse, and isolation and control.” One other frequently heard story was that of child sexual abuse as

reported by 4 (30.77%) interviewees. To highlight this point, Tracy shared the story of a six year old girl who when they met had already survived multiple incidents with multiple offenders.

Workplace stressors.

Job demands and bureaucracy versus care were the two most frequently identified workplace stressors. When it comes to workplace stressors only those who participated in the interview were asked to identify the work they do and the challenges they face. All 13 interviewees identified that they experience some level of stress in the workplace due to their various job demands. For Arlene, stress comes from the nature of the work, “we can be very high volume, very high crisis.” Meg reiterated the crisis nature of transition house work and stated, “Yeah, some days it’s going to be chaotic, some days you’re just going to want to scream.” Moreover, Charlotte shared,

I’m just flying by the seat of my pants and sometimes we’re all just scrambling and we haven’t really been trained and we don’t really have the resources to deal with...and so we just kind of try and make do and there’s all these different dynamics going on but sometimes there’s a whole bunch of the same issues going on and there’s all this clashing and you just can’t help but have stress when you’ve got that many people in the same house who are trying to pick up the pieces and get their feet back underneath them.

Another job demand shared by Betty that contributed to her stress in the workplace was the shift work involved in keeping the transition house open 24 hours a day, 365 days of the year.

Bureaucracy versus care was another workplace stressor identified by eight (61.54%) interviewees. Bureaucracy versus care was not only identified within the workplace but was also highlighted when talking about working with other systems in the community to provide effective service provision that meets their client’s immediate needs. Meg identified her struggle within the agency,

We have a mandate and to me a mandate is like a little box that somebody has to neatly fit into and people don't always fit into that little box so there are times where I really want to work with a woman who may be referred...and because she doesn't say that key word or fit in the mandate then I can't do anything for her and I don't have any where else to send her. There's nobody else out there so to me that's the most challenging, frustrating part of the work.

For Elizabeth and Jennifer, their struggle lies in high client to staff ratios. Elizabeth shared what she finds challenging as, "sometimes just being spread too thin, having only one staff on. Sometimes you're up to 20 people and you're not being able to help the women individually and give them the right amount of time." Facing the same situation of going over capacity in her transition house Jennifer explained,

Sometimes if there's 20 women at the house we're not going to tell them 'you know what, go out', they're in crisis and need support and...people will be sleeping on couches and mats on the floor, and its okay, and what happens in that crisis is 'yes, we are supporting women...but then the limited workers have to take on all this caseload...I mean there should then be two workers called in to assist.

Jennifer went on to identify how in her experience cost saving measures and high caseloads such as these lead to situations of workers needing to take time off for reasons such as illness. Additionally, two other interviewees identified the challenge they face when trying to create an atmosphere of safety and support while still enforcing house guidelines and agency policies.

Workers also face issues of bureaucracy versus care out in the community when they are trying to support their clients. Rachel identified, "the issues are systemic, if a woman has got a child and she's living on welfare where do we find her a place where she can afford to live and still have money for the kids." Meg reiterated systemic issues in sharing her experience working with a high needs client,

I have a client and she has really, really, really high needs but some of the services that she requires she can't get here so in order for her to get down south to get those services she has to go through a service here. So she has to be on a waiting list for that service here and so each time we try to bridge her to one service to get her down

south to another service she 'slips' and I'm afraid she's going to be a statistic and so that scares me, the lack of services and the red tape...these women have to jump through to get something they need to help them have a better life.

While also identifying the frustration she faces as a worker, when it comes to issues of bureaucracy versus care out in the community, Samantha stated,

You definitely have to be more creative and I think you really have to know what you have control over and what you don't and sometimes you just have to do your best and be okay with the fact that they aren't getting ideal services but you figure out a way.

Northern context.

With respect to northern context, support workers identified both benefits and challenges to working in the Northwestern BC. It is important to note that only questionnaire respondents and interview participants were asked questions about northern practice.

Specifically, interviewees were asked about both the benefits and challenges of working in the north, whereas, questionnaire respondents were only asked to identify in what ways they are impacted by working in the north. When it comes to the benefits, a sense of community was the most frequently identified benefit with seven out of 13 (53.85%) responses.

According to Kelly, "smaller communities here, they do pull together and we draw on one another for different services." For Jennifer, a sense of community comes from good working relationships with other service providers,

When you give referrals they're very supportive...people take time and they even show up at the transition house which in big cities...people are too busy and no time. Being a close knit community people just try to take time for each other, try to take some burden off, and...the fun part is you know every social worker in town because there is only limited staff so you know everybody.

In addition, three support workers identified the smaller size of their communities as a benefit. Samantha highlighted this when she shared,

The north is wonderful because you have a small community and everybody knows each other and you know it is a fairly safe town. I mean my biggest thing is that I

love the fact that I walk everywhere and my partner walks everywhere... everything is so close and when you go to town to get groceries it takes an hour not because of traffic but because you're stopping to talk.

In addition to the benefits, several challenges were identified. While only 21 (67.74 %) questionnaire respondents acknowledged that their community's geographic location impacts them and the work they do, all 13 (100%) interviewees identified challenges to working in the north. The four most frequently identified challenges were a lack of resources, confidentiality, isolation, and racism. Of those respondents that identified challenges to working in the north, a lack of resources was identified by 11 (52.38%) questionnaire respondents and 11 (84.63%) interviewees. A lack of resources included housing, counselling, and healthcare services. One questionnaire respondent wrote, "...there are quite a few social problems and not enough resources for individuals. This makes it frustrating as a transition house worker." May, reiterated this by saying, "one of the biggest issues I find is there are a lot of people who need professional help and where do you refer them to." Jennifer, while identifying the need for more workers, highlighted how workers may feel the pressure to become a 'Jill of all trades,'

Too much caseload...I think there should be more workers, more funding, and especially I find up north, abuse and alcohol is a big one. It seems like sometimes you're a doctor, you're a nurse, you're an alcohol and drug counsellor, you're a teacher, you're a psychologist, you're a counsellor, it seems like you are everything because they expect you to become everything without paying for extra services.

Additionally, in identifying specifically the shortage of safe, affordable housing Samantha shared, "you have women who want to leave but they can't because they have no where to go or they can't afford what apartments or suites are available because they're so exorbitantly priced, so that's definitely a barrier." Another questionnaire respondent reported, "less resources for those who are using the shelters, less services and less shelters for women, thus they cycle through the shelters more often."

Confidentiality and anonymity was another challenge identified by three (14.29%) questionnaire respondents and seven (53.85%) interviewees. Confidentiality and anonymity issues included seeing clients and their abusers in the community, the knowledge workers carry with them, and the workers' inability to seek support for themselves in the community. Tracy shared a recent experience she had at a local restaurant,

I was in Subway a couple months ago and it was late at night but it was fairly full, about three quarters full. I knew something about everyone who was sitting in there, absolutely everyone. There was a fellow in there with a woman, they had just gotten together recently, I had seen the woman's children for years around something that had happened in her family so there's all of that history. The fellow, I had seen a young girl that he had allegedly abused, it was heading into court and that girl became so stressed that she actually killed herself and so here he is sitting with another client with young girls...and I see that whole dynamic.

Jenny also struggled with issues of confidentiality and anonymity,

When we do go out in the community we're more connected...more exposed in ways...it's a struggle keeping your anonymity. I have had experiences where I'm walking through the store and...you know what the other person's capable of and stuff and its like 'okay, I guess I won't be shopping today' and you go outside. That piece is a struggle.

In addition, Samantha shared her struggle with getting support for herself out in the community,

In this town every counsellor has either worked for or is closely linked to our organization. Confidentiality is a huge issue and then we deal with some of the counsellors as well on a professional level so the whole idea of counsellors having counsellors in this town is a bit of a joke.

Isolation and racism were also identified as challenges within a northern context.

Isolation was identified by four (19.05%) questionnaire respondents and two (15.38%) interviewees. One questionnaire respondent wrote, "Isolation from other transition houses and folks that do this type of work and educational opportunities." Meg reiterated this when she identified a "lack of connections to other communities and resources, just the feeling of isolation, and if somebody wants something it's down south."

Racism was identified by one (4.76%) questionnaire respondent and four (30.77%) interviewees. Irene identified racism with helping professionals, “our medical system is terrible and I think it’s even worse for our women who come to the shelter...the racism is just ridiculous what they go through.” Kelly shared her struggle, “discrimination against the native population by the people that are in a position to help, I just end up pulling my hair out, they’re just very frustrating.” Samantha also identified racism in her community, “well it’s a racist town let’s just be honest with that, so there’s these huge barriers to housing right, so people won’t rent to First Nations and a large percentage of our clientele is First Nations and visibly so.”

Impacts

Examining the impacts experienced by support workers can highlight the need to ask workers what they know about the very issue they might be experiencing. Various impacts were identified by the majority of participant responses during all phases of data collection. While all participants who participated in the interview and focus group phase of data collection (n=21) identified various impacts as a result of the work they do, only 21 (67.74%) of the questionnaire respondents said they felt personally impacted. Whether positive or negative, impacts were another prominent theme. According to Jenny,

I think one of the key things of the work we do is getting involved in the other ladies’ issues to the point you are walking through it with them but not actually experiencing it. I don’t know if that makes sense but...I’ve had one recently where they’re fleeing abuse and...well the fear that they exhibit kind of rolls over on to myself.

As identified above, transition houses can be very high volume. Jennifer spoke to the impact of supporting several women throughout her shift,

You sit there, you listen and you kind of absorb everything and it starts...in the morning and you listen to this first person and you try to support her and then by the end of the day it’s the 15th woman that you are sitting there and supporting...They

throw the things on us, we absorb it and by the end of the day its like whoa, too many things running in our mind.

For Samantha, it is the empathic nature of the work that lead her to experience impacts, “I don’t know how you can do this work with compassion and not have it impact you.” Under the theme of impacts: vicarious traumatization, physical impacts, positives, as well as worker rationalizations were determined to be common sub-themes.

Vicarious traumatization.

As identified by the constructivist self development theory, five different components of self that are affected by traumatic events are: frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, and memory and perception (Pearlman & Saakvitne, 1995). At least one impact, as identified by the vicarious traumatization literature, was identified by 11 of the 21 (52.38%) questionnaire respondents that said they felt impacted, 12 of the 13 (92.31%) interviewees, and all eight (100%) of the focus group participants.

Disruptions to one’s frame of reference were most frequently identified by transition house support workers. Specifically, four (19.05%) questionnaire respondents, eight (61.54%) interviewees, and six (75%) focus group participants, identified these kinds of impacts. One questionnaire respondent wrote, “overall, I feel that hearing traumatic stories from women (and the media) affects the way I view the world.” For Meg, feelings of helplessness impacted her frame of reference,

I turn the news off because sometimes I think when I come home and then I see something on the news...I can feel myself feeling frustrated again and helpless and I’ll say things like, ‘what’s the point, why am I trying’ and then I just kind of have to breathe and then I’ll go for a walk.

Charlotte also identified impacts to her frame of reference,

I became more like the world is a really bad place, like nothing is safe and no one is safe...I just kind of felt it was everywhere so I took it and I generalized everywhere. I just felt scared a lot of the time and I just kind of felt it was only a matter of time before it happened to me and it happens to everyone else...people are just cruel and they can be really cruel for no reason.

Avoiding others and not disclosing what one does for a living can also be a frame of reference impact. Arlene identified how her frame of reference has changed to where she does not like telling others what she does for a living,

I find that a lot of my close friends figure, or even strangers...like if you have a hair appointment you usually tell them what you do, and they want to dump their whole life story on you and its just like 'wow' and so I think sometimes I can kind of, I don't know, be cold or shut down where I try and change the subject or I try and make things lighter and not let them share their stories because I'm thinking at the same time, I'm not at work right now and I need to do my own self-care here.

Feeling angry can be another frame of reference impact, and was what the majority of focus group respondents identified.

As a member checking question, focus group participants were also asked if they had any thoughts or feelings around the preliminary finding that frustration, anger, and sadness were the three emotions identified most often by support workers. As a result, workers identified that they were not shocked by it. For three support workers, those emotions are part of the reason they have outside supports and activities. Additionally, one worker posed the question, "even if I have lots outside, why are those emotions still coming up," to which another worker answered, "maybe they come up most because it's easy to go to the negative. When we are working with, dealing in so much negativity, we forget the positive."

With respect to psychological needs and cognitive schemas, five (23.81%) questionnaire respondents, 11 (84.62%) interviewees and one (12.5%) focus group participant identified experiencing various impacts. One questionnaire respondent wrote about experiencing disruptions when it comes to trusting others, "generally I am more wary

of others initially until I get to know them and feel I can trust them. In the general public, I am more cautious of my environment and others around me, keeping safety in mind.” For Arlene, the need to be the one in control was an impact she experienced,

I’m really hypersensitive and I think that it impacts my relationships completely where I want to be almost the one that’s going to be in control because I’m not going to be controlled and so I think I flip it and I just become too focused on the different behaviors or the different things because I don’t want to miss it.

Tracy shared how she has experienced a disrupted sense of safety,

There was yet another disclosure about a fellow around town who was hanging around the schools, he was hanging around our neighborhood where I lived and when I got home that day I realized that I was fighting letting my 2 oldest girls, who were very little at the time,...I was fighting letting them go outside to play and it was from my work and I had to process that and I had to let them go and I had to just sit there with a cup of tea and just face those feelings.

While Charlotte also experienced a disrupted sense of safety, she highlighted the behavioural impacts that can accompany them,

It makes me more suspicious like I used to have no problem walking short distances like when it gets a little dark...but now I’m definitely more likely to look over my shoulder, to even jog a little on my way home or whatever because it does it plays in my mind and I think about, ‘oh wow, look who we’ve got in the shelter now and it happened to them,...just a regular woman and how am I any different,’ and it plays in my mind until I get the door closed behind me.

Additionally, Rachel identified impacts to feelings of intimacy,

I work with a therapist but it’s still hard to hear these stories all day. Who’s doing it? Men are doing it and you’re living with ‘the enemy’ and he’s not understanding what’s going on, he’s just seeing you being cold or angry or frustrated.

When it comes to changes in cognitive schemas, as a form of member checking, focus group participants were told about some of the reported shifts to a worker’s belief system throughout the first two phases of data collection and then asked if they had any thoughts or feelings about the shifts identified. While three workers identified a sense of helplessness,

anger, and changes to their sense of safety respectively, two workers identified the need to get creative to help clients get the services they required.

Impacts to memory system were identified by two (9.52%) questionnaire respondents and six (46.15%) interviewees. While one questionnaire respondent identified dreaming about the stories they heard, the other acknowledged that they experienced haunting memories of things told to them. All six of the interviewees reported dreaming about work, but one also identified smelling scents that were associated with a story she heard. Jennifer shared her experience,

He [her husband] never smokes but then there was discussion about this guy smoking...how his wife never wanted him to smoke. I came home and I feel like there's smoke and...there's nothing it's just that I heard this story then I came home and I'm like, 'I can smell smoke.' He's like, 'nobody's smoking.' I'm like, 'no, I smell smoke'...but I knew I heard the whole thing where this woman is upset because she didn't want smoke around her kids and how her husband was smoking and its bad for you.

In identifying the themes or imagery of their dreams, Kelly talked about experiencing feelings of helplessness. However, for Charlotte, her dreams were more graphic,

I often dream about the stories that I hear...sometimes its me watching it happen and trying to get to it or stop it but not being able to, sometimes its like the violence from the story is happening to me so I'm the victim...or sometimes its taking place at work so I'm working and the abuser has come in and it's like this chaos in the house.

According to Arlene, her dreams can also be very emotional,

I see a lot of bright colors. I always tell myself that's a good thing but they can be really sad dreams too where I actually had a dream, not that long ago...I know it was a very sad dream and I know I woke up crying and it wasn't just a cry-cry, it was you know when you can't even catch a breath cry, that's how I woke up in the middle of the night.

Self-capacities and ego resources impacts were also identified by support workers during the interview phase of data collection. Impacts to self-capacities were highlighted by five out of 13 (38.46%) workers. The most frequently identified impact to self-capacities

was different workers' inability to watch difficult movies such as drama or horror movies.

According to Samantha,

I can't watch movies that have a lot of violence in them unless it's an over the top action movie but if it's you know dramatic and some guy's beating his wife or if there's any violence like that or rape or anything like that I just can't watch it. So I pretty much watch a lot of comedies these days.

This is reiterated by Betty, who shared,

I used to find it really interesting to watch...some of the cutting edge, precedent setting cases of movies to find out, 'okay, so now where has society gotten to on some of these issues,' and...I can't watch those kind of movies any more, any thing that has to do with violence. I have a very low tolerance.

With respect to ego resources, three (23.08%) interviewees identified such impacts, with the majority identifying an inability to take perspective when it comes to a sense of humour.

This was highlighted by Arlene, who shared,

I've become hypersensitive to different issues where some people might think it's a joke and there will be certain times where maybe at one point I might laugh and just kind of brush it off, and then there will be other times where I'll get really sensitive, and I'll get emotional. I'll get angered a little more so than I would have before.

Physical impacts.

Physical impacts were identified by four of the 21 (19.04%) questionnaire respondents that identified they experienced impacts from the work and six (46.15%) interviewees. Some of the physical impacts experienced included tension, headaches, fatigue, vomiting, sleeping and eating problems, and crying. One questionnaire respondent listed the impacts that she experienced as, "anger, frustration, sadness, overeating, personal relationship issues, sleep problems, weight gain, and lack of energy." In describing their physical impacts, Meg and Jennifer both highlighted how physically draining and tiring the work can be. A questionnaire respondent touched on the need for a physical release, "lots of time I go home from work and think about the traumatic stories women have told me and I

can't help but cry because I feel their physical hurt." Tracy also identified the physical impact of the work and a need for a different kind of physical release,

I remember having a client who came in that really just needed to do a play by play of her graphic abuse...a very young little thing, she just wanted to tell me step by step what happened...and when she would leave I'd go and throw up.

Positives.

Support workers also identified experiencing positive impacts. Specifically, three (14.29%) questionnaire respondents, all 13 (100%) interviewees, and three (37.5%) focus group participants identified several positives that come from doing trauma work. The two most frequently identified positives were witnessing the resiliency of women and developing an increased appreciation.

Witnessing the resiliency of women was identified by 10 (76.92%) interviewees and two (25%) focus group participants. For Arlene, the reward is in seeing women make changes in their lives,

Through the work that we do we don't see our clients a lot, or we see them come back through, but we don't see when they are success stories so when we do run into one, which is not very often, and you hear about the work that they've done themselves and the changes in their lives, that's what's rewarding...They make me realize how strong women are and what survivors we can be because a lot of times I think, 'wow, was she ever strong' and I don't know if I could have survived that but I know deep down that I probably could if I wanted to, like if I had that survival, the drive to do that.

Charlotte also identified the resiliency of women as she shared, "it's rewarding because you get to work with women who survive the worst things ever and still come out standing and I think that it gives a lot of hope."

Developing an increased appreciation was a positive impact identified by 12 (92.31%) interviewees and one (12.5%) focus group participant. For Samantha, appreciation for her relationship increased, "I very much appreciate that I have a very healthy relationship

with somebody... he's just considerate and polite and respectful. I think I appreciate him more doing this work than I would if I didn't do this work." Irene appreciated being able to provide for herself,

I appreciate having my bills paid and groceries in my fridge because a lot of times the women will leave and not have anything, they have to start from scratch, and I have started from scratch a couple times so yeah, I appreciate what I have.

An appreciation for family was also identified as Kelly shared, "I appreciate my family so much more and how lucky we are that none of them has ever had to experience what some of these women and children have."

Workers' rationalizations.

In identifying that nine questionnaire respondents reported not feeling personally impacted by the trauma stories they heard, interview and focus group participants were asked how they would interpret those findings. The three most frequently identified rationalizations were a lack of awareness and understanding, the issue of competency, and desensitization. A lack of awareness and understanding was identified by nine (69.23%) interviewees and three (37.5%) focus group participants. Meg highlighted a lack of awareness in her explanation,

Maybe they weren't aware of it, what could be an impact, like change in sleeping, change in diet, maybe being a bit short with their significant other or their family. It could be so minimal or perhaps some people just kind of come home and they kind of zone into TV or kind of keep themselves busy, so that it just isn't there but it would have to impact us all on some level I believe because we're empathetic people.

Charlotte also identified a lack of awareness and understanding,

I think that there's not as much awareness and information about it as there needs to be. Like it's not something we've ever talked about in terms of team meetings or anything so I don't think people realize that some of the stuff, some of the thoughts they have, or some of the fears they have just on a daily basis might be stemming from the work that they do and the things that they hear.

Another common rationalization support workers identified was that workers may fear that admitting they are impacted would be seen as a competency issue. Specifically, six (46.15%) interviewees and three (37.5%) focus group participants identified competency issues. According to Jennifer,

Some people think that ‘what if I write yes, I’m not doing my job properly, I really have to be extra strong and extra human, like super human being to do this job’...if they have been hired they shouldn’t be traumatized.

Betty also identified competency issues and the feeling of not being allowed to admit they are experiencing impacts. Moreover, Tracy presents an argument workers have within themselves that contributes to an increased fear within themselves,

I think though that just as many people if not more would say no approaching burnout or you know even that argument of ‘what you’re letting it bug you then there’s something wrong with you, you must not have the skills in place, you don’t have boundaries.’ All those sorts of accusations which absolutely aren’t true right but that’s the fear and I would wager that quite a lot of people would say no simply out of that...they would be worried that it would look like a competency issue. So I can certainly see certain workers saying no and I can see certain workers in certain workplaces needing to say no.

The other most frequently identified rationalization was that of desensitization, denial, or as some workers worded it, “shutting down.” This rationalization was identified by four (30.77%) interviewees. In highlighting this, Samantha shared a conversation she had with a senior worker,

I’m like, ‘how do you deal with this and she’s like you know what I just don’t care anymore’...and I get that sense from people who haven’t worked or who have been working here a long time that sometimes they just don’t care and I think they just put up that wall

For Arlene, “shutting down” can become a form of self preservation,

A lot of us may not even understand, why did I just jump down that guy’s throat for making eye contact, why did I just do this, why am I constantly doing that...well its because of the impacts and I think there’s some of us that avoid it. I think that some of us can at different points for our own personal survival and self-being, we kind of

shut down and maybe become what people would almost call insensitive to different issues.

Denial, another form of shutting down, also allows workers not to experience the full range of impacts. Rachel shared her experience, “I see denial, that some staff move into their head from the neck up, they’re not looking at their body reactions and they don’t understand that’s part of it.”

Knowledge Base

To understand the impacts, one must first be aware and understand what vicarious traumatization is, what contributes to it, what the costs are, and whether it is preventable. All 13 interviewees and eight focus group participants were asked what they knew about vicarious traumatization. Additionally, questionnaire respondents were asked what they believed contributed to vicarious traumatization and if they believed vicarious trauma was preventable. For Samantha, her response was, “not very much, I am assuming it’s being traumatized by other people’s stories..., but that’s about it, it’s a big fancy term that I didn’t look up in a dictionary.” Whereas, Betty stated, “I know I’d like to know more.” To highlight what more is needed, questionnaire respondents were asked specifically what would they like to know, while interviewees and focus group participants identified the need for vicarious traumatization training.

What is known.

To examine what transition house support workers know about vicarious traumatization they were asked various questions as stated above. While 11 (84.62%) interviewees and five (62.5%) focus group participants were able to provide a definition of vicarious traumatization, only three (18.75%) participants talked specifically about the impact being cognitive shifts in the worker. Arlene shared her definition,

Basically what I know about it is the fact that it is me being impacted or traumatized by somebody else's stories. So...being aware of what they're telling me because I'm actually playing that through my head so it's impacting me as if I'm almost a victim as well...yeah, that's kind of pretty much what I know about it.

When asked what she knows about vicarious traumatization, Jenny responded, "it is trauma that impacts me from somebody else's experience and that's pretty much all I know and when it happens you just really have to be aware of it I guess." Additionally, Elizabeth highlighted shifts to a person's cognitive schemas,

Vicarious trauma in my opinion is somebody who would be fearful to be out in the community after seeing or hearing what they hear, overprotective of their family, friends, probably just more paranoid about what they see and maybe interpreting things in a way that aren't normal.

Contributing factors are important to be aware of so workers can understand how vicarious traumatization may happen. Tracy described the idea of a continuum that contributes to vicarious traumatization,

Kind of the idea of a continuum that starts out with difficult work, moves up into typical stress and difficult work, to stressed out, to...that idea of burnout sort of thing where a worker's saying, 'I'm burnt'...well actually what it is, is they're just carrying a lot of stuff, they're carrying a lot of secondary trauma and they're just very heavy and you know they might look a bit different on how they present.

Twenty-three (74.19%) questionnaire respondents, ten (76.92%) interviewees and four (50%) focus group participants identified what they believed to be contributing factors to vicarious traumatization. The three most frequently identified contributing factors were: hearing traumatic stories and seeing the marks of violence, personal stressors and past trauma, and limited or no coping strategies.

Hearing traumatic stories and seeing the marks of violence was seen as a contributing factor by seven (30.43%) of the questionnaire respondents, seven (53.85%) interviewees, and two (25%) focus group participants. One questionnaire respondent listed the following contributing factors,

Hearing traumatic stories, seeing physical marks caused by violence, continued exposure to family groups with a long history of violence, abuse, and addictions. Lack of opportunities for debriefing and feelings of vicarious trauma being minimized by co-workers/employer.

Jennifer also identified “listening to other people’s stories” as a contributing factor. For one focus group participant, “the perception of repeated ongoing trauma situations, where you may not hear or be exposed to stories on all shifts but just the perception you’re going to hear or experience it” was identified as a contributing factor.

Personal stressors and trauma experiences of support workers were identified as a contributing factor by four (17.39%) of the questionnaire respondents, six (46.15%) interviewees, and one (12.5%) focus group participant. One questionnaire respondent spoke specifically to a worker’s experience of personal trauma,

I think the experience of personal trauma contributes to vicarious trauma. When you are suffering yourself, the suffering of others can ‘build up’ on top of your own pain, causing a heavy load and ‘proof’ that you are not safe and the world is a bad place.

According to Samantha, a contributing factor may be personal stressors experienced by the worker,

I think where the worker is at, so I know that if I have stuff going on in my life or if I am really stressed or not looking after myself, not doing those self-care things, not eating well, not sleeping well, not doing the other things I do...to deal with this work then I find I definitely take on more.

Irene also identified personal stressors as a contributing factor, “stress at home I think leads to it. I think not having support at home for you job to deal with it...keeping stuff inside...and not debriefing with another colleague.”

As already highlighted in some of above examples, limited or no coping strategies, were identified as a contributing factor for vicarious traumatization by four (17.39%) of the questionnaire respondents, six (46.15%) interviewees, and one (12.5%) focus group participant. One questionnaire respondent identified, “not having a strong support system,

not being aware of why this may be happening, and not having a solid sense of who you are.”

Another respondent spoke about unresolved emotions and wrote, “Not feeling your feelings from dealing with this work. For example: suppressing our feelings instead of dealing with them after hearing a woman’s story.” Additionally, Arlene highlighted the importance of having coping strategies in this line of work,

If you don’t have an outlet for dealing with these stories that people are sharing with you or the trauma that you’ve experienced yourself personally I think that it just consumes you until basically whether people want to admit it or not their body just sort of shuts down on them because you’re not taking care of yourself.

Knowing the professional and social costs associated with vicarious traumatization is important so workers can make the necessary connections between their behaviour and impacts of the work they do. Only interview participants were asked if they knew of any costs to a worker experiencing vicarious traumatization. Eleven out of 13 (84.62%) interviewees identified possible costs workers experience. Specifically, seven interviewees (53.85%) identified professional costs and eight (61.54%) interviewees identified social costs. Professional costs can be losing good workers as highlighted by Tracy,

I think you lose good workers. You have good workers who start to mess up on the job in terms of paperwork and things that preoccupy them. They’re tired, they’re messing up on simply bureaucratic things that really have nothing to do with effective counselling. You have people avoiding situations that before they were quite good in or they’re avoiding particular clients or particular client situations or they’re not even avoiding them they’re just not handling them as well as they normally could.

This professional cost is also reiterated by Samantha, who also shared potential social costs to workers,

I think sometimes we’re not the most productive worker so there’s days where you just don’t feel like doing anything so you don’t get the normal level of work done, maybe you don’t go that extra mile for a client, maybe you don’t help them as much as you could right so they could potentially suffer...Socially, I catch myself thinking about work when I’m not at work and maybe I’m not entirely present with the people I’m with. I occasionally make people feel uncomfortable when saying that their joke about incest or pedophilia is not funny.

According to May, “the professional costs I think would be burnout. You lose a lot of good staff...you never realize how ugly, the ugly side can be until you hear about it or experience it.” For Elizabeth and Meg a social cost may also be a diminished social life where you stop going out with friends.

Whether vicarious traumatization is preventable or not is also valuable information for support workers to have. Questionnaire respondents and interview participants were asked if they believed vicarious traumatization was preventable. In addition to the nine (29.03%) questionnaire respondents that said they did not believe vicarious traumatization was preventable, six (46.15%) interviewees also felt it was not preventable. Arlene, when asked, shared her thoughts,

I don't think so. I could be totally wrong but I think that you would have to have basically no heart or soul for it not to impact you, I think there's no way to avoid it as much as we all want to think that different things don't impact us we don't realize until you start thinking about it or talking about it how it has impacted you.

Samantha added, “I think the extent that it runs is preventable. I don't know if it is entirely preventable but I think there's definitely a lot of things you can do to [keep] support workers from experiencing vicarious trauma.” A questionnaire respondent also reiterated this when she wrote,

Vicarious traumatization is a maintenance issue not a prevention issue. The only way to guarantee prevention is to completely control what comes out of a client's mouth before it comes out. Vicarious traumatization is a workplace hazard that must be dealt with after first impact. Otherwise we are in danger of blaming workers for experiencing it [emphasis in the original].

Additionally, the statement, vicarious traumatization is a maintenance issue and not a prevention issue, was presented to the focus group as a form of member checking. As a result, one participant identified that she thought it was both, “awareness before hand and ongoing awareness,” while another argued, “you need to have awareness before hand but it

would not prevent it.” Additionally, three workers liked the idea of maintenance but one questioned where that would leave casuals, as “not much is done with casuals but there are more of them” employed by the agency.

What more is needed.

While it is important to identify what workers know about vicarious traumatization, it is also important to identify what more is needed. Throughout all stages of data collection, only 10 out of 52 (19.23%) support workers identified that they had received training on vicarious traumatization. However, when asked what more could be done, nine out of the 20 (45%) questionnaire respondents that answered the question, eight interviewees (61.54%) and all eight (100%) focus group participants identified the need for training on vicarious traumatization. As Charlotte pointed out, “if you don’t know it could happen then you’re not gonna know to take the steps to not make it happen.” Additionally, in answering what more can be done in the name of prevention, one questionnaire respondent wrote, “education about vicarious trauma, training for skills and tools to lessen the impact, and debriefing/support when needed without judgment and/or consequences.”

Some support workers identified specifically that they believe the training should be mandatory and some identified the importance of training both staff and management.

Arlene highlighted this in her recommendation of training,

Some of the management team might need to be a little more educated on what it is and how it affects people and how it can impact the work and then how it impacts the clients that we work with if it’s not taken care of...and then just doing more information sessions educating staff.

Tracy also identified the need for formalized training and awareness,

Proper training and even just recognition in the workplace for things like vicarious trauma, that they are a workplace hazard absolutely. This isn’t something that happens by accident and it’s not something that can be prevented, I don’t think, it’s a maintenance issue absolutely and to make sure that employers are aware of that and

that they're respectful of that that this just comes with the territory. It's like the fellows who worked at the mill for years and they end up with ruined lungs you know nobody blames them, it's the same thing exactly, it's a workplace hazard. You can do a lot of things to circumvent it, you can do a lot of things to minimize it but the idea of eliminating it or preventing it is absolutely untrue, just wouldn't happen.

During the questionnaire phase of data collection, respondents were asked to identify what, if anything, they would like to know about vicarious traumatization. Of the 31 questionnaires, 22 (70.97%) workers responded to this question. The most common answer, learning how to cope and how other professionals and communities cope with the impacts of vicarious traumatization, was identified by 10 respondents. One respondent wrote,

I would like to know as workers how we can work along with employers to acknowledge and address "VT [vicarious traumatization]" in the workplace. We need more training and workplace strategies to address "VT". It is not talked about enough. Employers should be more aware of it and assist workers in managing "VT" (e.g. more balanced work duties, breaks, time off, training, celebrations).

Other responses included information sessions on vicarious traumatization, warning signs, short and long term effects, prevention, prevalence, how to support others, as well as more emphasis on the responsibility of the employers.

Agency Response

Agency response was another main theme highlighted throughout the data. Agency response to vicarious traumatization is important because often it is the agency that sets the tone that workers follow when addressing different issues. When it comes to the issue of vicarious traumatization, Tracy emphasized,

...the workplace is crucial for making people aware and also making them aware that it's okay, this really is one of the dangers of the job, one of the realities of the job, and there's ways that people can process and lighten their load and there's skill they can build to minimize the impact initially.

To look at agency response, data from the questionnaires, interviews, and focus group were analyzed.

Supportive interactions.

One aspect of agency response is whether staff felt that they are supported in their workplace. All 13 (100%) interviewees identified that they felt their workplace was supportive. When asked if her agency has been responsive to vicarious traumatization, Tracy stated,

They have and they haven't. I mean we don't do any training on it but we certainly have an employer that if we're dealing with a worker who was presenting as burnt that there would definitely be a fairly genuine and empathetic response to that. They wouldn't be looking at firing them or getting rid of them, they'd be looking at trying to get help and get it resolved...so we're blessed in that.

Kelly also identified that she felt supported by management when she shared, "in this workplace it's supportive, open, honest...we do have a staff meeting once a month and any issues that are on our minds or anything you feel needs to be addressed gets addressed at that time." However, seven (53.85%) workers identified that more could be done to provide a more supportive environment for staff. According to Irene,

I don't think we're supported by management...as much as they should be. We have our staff meetings every six weeks but really nothing gets accomplished, really all that happens is the question gets turned on us; there's no leadership.

Additionally, six out of 13 (46.15%) interviewees identified that they felt there was good interaction between staff and management. Arlene pointed out, "I think for any staff that do go to management, I think management's always very open." Whereas, Charlotte felt more could be done when it came to staff-management interaction,

I also don't feel that there is as much open, and I don't think it's as supportive and as attentive maybe as it needs to be. I think that a lot of the stuff just kind of gets shoved under the carpet and I understand that they have a lot of responsibility, that they are busy, but sometimes it seems like there's a huge disconnect.

To further explore agency response, a member checking question was used and focus group participants were asked how they felt about workers identifying feelings of disconnect

between staff and management and the need for management to check-in with all staff on a more regular basis. As a result, two focus group participants agreed absolutely that staff would feel more supported. Another participant pointed out that “the agency values empowering women, management should use the same values in responding to supporting staff.” After sharing her view, five other participants agreed with her and identified that they felt what was said was very important.

Education and training.

Providing education and training on vicarious traumatization can take the form of informal conversations or more formalized training sessions. As identified above, when asked, “has your employer ever talked to staff about the impact of hearing another’s traumatic stories,” 19 out of 31 (61.29%) questionnaire respondents said yes. When asked about the content of these discussions, respondents reported that their employers highlighted the importance of self-care, self-awareness, debriefing, and avoiding personalizing another’s trauma. One respondent described that her employer stressed the importance of “acknowledging that working with trauma survivors will affect you. It is important to be aware of the warning signs and to find a healthy balance to cope with the effects.” Another support worker stated that her employer discussed “strategies for self-care and [the need to be] mindful of how even debriefing can cause vicarious traumatization in co-workers.” However, it is important to note that 11 out of 31 (35.48%) respondents identified that their employers have not talked to them about the impacts of hearing traumatic stories. Additionally, seven out of 13 (53.85%) interviewees reported they have not received training on or had discussions with management about vicarious traumatization.

Informal versus formal debriefing.

Debriefing in the workplace is an important part of an agency's response to vicarious traumatization. Eight out of 13 (61.54%) interviewees identified that they have participated in a more formalized debriefing session with management. Seven (53.85%) interviewees identified they can access their Employee Assistance Program (EAP) for outside debriefing and counselling. Elizabeth acknowledged that she has both options available to her when she shared, "I have debriefed with management and we do have the EAP...for counseling. So yeah, we can debrief with management plus we have an on-call that we can debrief with."

When asked if she ever debriefed with management, Charlotte stated,

I rarely do, well once; no she didn't even call me, no. I would if they called me and said I heard this went on, you know, what happened but I have never approached the employer and said look I need to talk about you know this happened on the weekend.

When it came to group debriefing practices not one of the 13 interviewees identified that they had participated in a formal group debriefing session.

Additionally, 12 (92.31%) interviewees identified they regularly debrief informally with co-workers. According to May, "one tool that we do use here for coping is we have a 15 minute shift overlap...so that's a good way to do it [debriefing] too, so you can leave it here and not take it home with you." When talking about debriefing with her co-workers, Arlene shared, "I don't think that I do it very formally, I think it comes off more as bitching and complaining sometimes then actually debriefing and talking about the actual issues that your suppose to be debriefing." Jennifer also highlighted her concerns with debriefing with her co-workers,

I don't know how much it is helpful when it comes to your co-worker because they go through the same thing as what you go through and unwinding your feelings and your emotions by the end of the day it means you are kind of loading everything on them before they even start the work."

Focus group participants were also asked what they thought about the debriefing practices in their workplace and one participant felt they were less than satisfactory. Whereas, another worker said they need debriefing in their workplace. The conversation then turned to possible reasons why people do not identify the need for debriefing which included lack of trust, competency issues, and fear it won't be followed through by management. Additionally, each focus group participant was asked what they thought about the following member checking question: most respondents identified the importance of informally debriefing with co-workers. However, many support workers reported the need for more formal debriefing because it was something they felt was lacking in their agency. In response, one worker shared they have both but it is up to her to call the Employee Assistance Program. At which time workers discussed the limited amount of sessions allotted to workers accessing the program. Another worker then identified they "need more formal debriefing and it needs to be accessible to casuals," at which time the entire group agreed. Finally another participant identified how with formal debriefing, "you know you're being heard without having to take on someone else's stuff," whereas debriefing with co-workers is "good but they also have their own stuff."

Strategies for Change

Strategies for change were a prominent theme based on data collected during all phases of the research. The strategies came out of discussions with support workers on what can be done, and how agencies can become more responsive to vicarious traumatization and encourage professional self-care practices. When asked how management could encourage self-care practices in the workplace, Tracy highlighted the importance of asking staff in each worksite,

I don't think it's a heavily researched area and I imagine workers on the job are really where the information's at and if you put that out there to people that that's a normal part of workplace conversation, I would wager that individual worksites could come up with some really neat awareness programs on their own.

Twenty-four (77.42%) questionnaire respondents, and all 13 (100%) interviewees and eight (100%) focus group participants identified strategies for change. As identified above training on vicarious traumatization was identified as one strategy for change. The other two most frequently identified sub-themes were debriefing and counselling and professional self-care strategies.

Debriefing and counselling.

Formalized debriefing and counselling for support workers was identified by 11 (45.83%) of the questionnaire respondents, 10 (76.93) interviewees, and two (25%) focus group participants. Not only did workers identify the need for debriefing, counselling and clinical supervision, some workers felt that developing group debriefing practices would also be beneficial. The need for debriefing was identified as Irene shared,

If somebody did up an incident report of a serious incident I think management should take responsibility and do some counseling or do something for that person. For instance, if somebody gets threatened at the shelter and gets scared and has to call the RCMP then instead of just faxing off an incident report and be done with it...it needs to be dealt with after the fact and I think management needs to take a step and have somebody specific to do debriefing or counseling for that person because they're gonna go home and be freaked out.

Additionally, Jennifer shared, "there should be some extra money out there where employers should look into totally a different system of debriefing because debriefing each other is just...over loading each other and it's not helping in the end." Arlene while identifying her recommendation for a more formalized debriefing session also highlighted how clinical supervision could be beneficial,

Clinical supervision, I think would be a benefit and I think just maybe trying to open the lines of communication a little more, trying to figure out how we can do that so

that staff can debrief a little more effectively and maybe having a more formalized debriefing session set up.

Debriefing can also be done within a group setting. For Samantha, establishing group debriefings has more to offer than is already established,

I would love to see group debriefs...get everybody together or get small groups together and just be like okay what's going on, what about this client and just talk about the frustrations instead of talking with somebody on shift change briefly...it would also give you a bigger picture, what's going on for everybody.

Throughout the interviews, a few support workers identified how they once had an outside counselling option, but for whatever reason the contract was let go. As Betty shared, her recommendation would be for her employer to once again establish an outside counselling option for staff,

To have it[counselling services] more available and that people felt like they could use it more too because I think sometimes people don't feel like they could use it, and I think there's so much stuff around mental health that has to be normalized. It is stigmatized and I think it's sad.

Jennifer also identified the need to break down the stigma attached to workers admitting they are impacted,

I think it is so important that all of us as workers should realize that it's okay to say that it's too much. It's okay to say that you know what, I need a break, I need to do some self-care here. It's okay to say that...at this point, this particular incident is just too much for me to take, I need support, I need back up.

Professional self-care strategies.

A variety of professional self-care strategies were identified by 10 (76.92%) interviewees and five (62.5%) focus group participants. The most commonly identified strategies were encouraging self-care and connecting and checking in with staff. Some ways support workers identified for management to encourage self-care practices included: sending emails or memos with self-care ideas, encouraging and supporting workers to take breaks, providing books on self-care, setting up a corporate rate for group membership at the

local gym, supporting staff when they need to take time off, sharing success stories, and providing positive reinforcement to staff. Keeping it simple, Jenny identified how management could encourage self-care practices,

A little thing is having our managers just say, 'hey, when was the last time you did a self-care activity' and 'how did that go for you,' that little initiative or putting out a memo, 'its self-care week today and make sure everybody has something in there because we value each and every one of you.'

When it comes to taking breaks, Meg shared,

Something has to change at the transition house because apparently you get breaks there but I don't see them. Workers don't get breaks and they need them. I'm told you're not allowed to take a break off site, that's got to change.

For Irene, encouraging self-care can be done through sharing success stories,

Maybe have guest speakers...like having someone come in that's gone through a horrible thing in her life and has changed her life for the better and through being at shelters and stuff...I think that we need to see that there are benefits that come from what we do because we see so much repeat.

Positive reinforcement is another way to encourage self-care. Jennifer explained how encouragement helps to balance the positive with the negative,

The other thing is encouragement..."you did a good job"...it gives a little boost to our workers to keep going. When there's too much negativity..."you didn't do this part well, you didn't..." you're already stressed and have this trauma going on and tons of things and then it just adds up and you feel like you're not a good worker and it just doesn't help. A lot of negative comes in; we need to generate some really good positive stuff in that building to balance it all.

Management checking in and connecting with staff was also identified as a professional self-care strategy by four (30.77%) interviewees and three (37.5%) focus group participants. In speaking to current debriefing practices in their agency, three of the focus group participants recommended that there should be an automatic check-in with staff member(s) involved after an incident has happened in the transition house. However, regardless of an incident occurring, Elizabeth felt management should,

Just touch one on one with each staff just to see how they are and where they're at and maybe if the management could recognize the trauma, sometimes it would be helpful to have management say, 'I'm seeing that you're not dealing with this'...having more compassion, that would probably be able to nip things in the bud faster.

Charlotte also identified the need for management to check-in with all staff members,

I think the employer should make more of an attempt to connect individually with their staff...even if it's just a 'how's it going? Oh great, I'm glad everything's good'...at least you'd have your chance to...voice your opinion or bring up any issues and not just feel like you were just kind of a shelter worker so you just put in your shift and go home.

Chapter 5: Discussion, Limitations, and Recommendations

Discussion

I think one of the things that I've learned over the years is I don't think I really look at it anymore that this is just a small piece of society and there's this other whole huge percent of society that's untouched by this sort of thing. I now realize that everybody has secrets, not that I'm saying absolutely every family in town...but generally speaking this is all about closed doors. This is about being privy to people's worst secrets and sharing the worst moments of their lives with them which I think everyone carries in one fashion or another...so I look at it differently now. I look at it very much like we're all in this together, we all have our journeys and I'm just a person that gets in behind closed doors. (Tracy).

Vicarious traumatization is an occupational health and safety concern. Transition house support work is rewarding, yet extremely difficult. While workers have the opportunity to meet women and bear witness to their strength and resiliency, they also are exposed to horrific trauma stories of human cruelty. In addition to trauma stories, support workers are faced with the impacts of having to cope with workplace stressors and challenges that arise out of working in communities located in Northwestern BC. Support workers are vulnerable to experiencing vicarious traumatization. Impacts identified by support workers in this research included: shifts to their cognitive schemas; changes to how they view the world; issues with personal relationships; dreaming about the work; various physical impacts; as well as positive impacts such as developing a greater appreciation for the loved ones in their lives. Although workers identify their employers as generally supportive, most have a limited knowledge base when it comes to vicarious traumatization, and many are not afforded education or formal debriefing practices within their respective agencies. Vicarious traumatization may not be preventable but many professional coping strategies can be implemented in an effort to educate, support, and ameliorate the impact of vicarious traumatization.

Examining a worker's vulnerability is important because it highlights the need to ask what workers know about vicarious traumatization and what more is needed. While it is the exchange of trauma stories that leads one to experience vicarious traumatization, there are many factors that influence susceptibility, as well as the extent to which workers will have the support and tools to ameliorate its effects. Research, as identified in the literature review, identifies such factors as personal trauma history (Pearlman & Mac Ian, 1995), type of trauma stories heard (Cunningham, 2003; Iliffe and Steed, 2000; Stout and Thomas, 1991), work environment (Pearlman & Saakvitne, 1995; Schauben and Frazier, 1995), and issues related to working within a northern context (Coholic and Blackford, 2005; Helbok, 2003).

Trauma experience is a contributing factor to support workers' experiencing vicarious trauma. As shown by the data, trauma experience can include direct (a worker's past experience of trauma) and indirect (hearing other people's trauma stories) exposure. While dealing with one or the other can be difficult, most transition house support workers have both direct and indirect trauma experiences. In examining direct exposure, based on my knowledge of this population, it was not surprising that 96.8% of questionnaire respondents identified that they had experienced personal trauma in their lives. Tutty (2006) points out, "in the early shelter days, the staff were often women who had themselves been abused" (p. 65). While today, the minimum educational requirement for employment is anywhere from Grade 12 to a Social Service Worker Diploma, there are still many workers that identify as survivors of abusive relationships. In regards to this research, I did not ask workers to specify what kind of trauma they personally experienced. My aim was not to qualify each trauma experience, but to honor each worker's perception of experiencing trauma. It is one's perception of an event that leads them to identify a personal history and classify it as traumatic.

Indirect exposure to trauma leaves support workers vulnerable to experiencing vicarious traumatization. With the average length of employment for questionnaire respondents being 5.9 years and 6.8 years for interviewees, one can only imagine how many trauma stories workers have been exposed to. As Jennifer shared,

The place I work is a place where hundreds of women on average, sometimes more than 500 people access that service. [They] walk into the building with some serious stories to tell and you sit there, you listen, and you kind of absorb everything.

High numbers of survivors of trauma accessing services each year further highlights the increased vulnerability of support workers (Schauben & Frazier, 1995). Additionally, as identified from the data, transition house support workers from all seven of the participating agencies have heard a wide range of graphic and horrifying stories of violence and human cruelty from the women accessing their services. However, often it is more than just hearing the stories; it is also bearing witness to the survivor's physical and emotional responses to trauma that may cause professionals to experience greater impacts (Knight, 2004; Herman, 1997). This was highlighted through Meg's experience,

In hearing the details of what she was saying I felt that she felt she was unsafe that she had this knowledge, when she was finished, I felt unsafe that I had this knowledge and I didn't want it anymore. I kind of went back and went, 'oh my god she's so terrified' and that's the thing, it was when she was telling me her story like her whole body was consumed with terror, you know the woman was so frightened and she had been carrying this story around for two years too terrified to tell anybody.

Therefore, it was alarming to learn that workers not only had a limited knowledge base about vicarious traumatization, but for many they have not had anyone talk to them about the possible impacts of hearing traumatic stories or received any additional training. Coupled with workers' limited knowledge on the subject is the issue that most workers identify; they are only provided with limited time and opportunity to debrief the traumatic stories they hear, and often it is informally with another co-worker.

Transition house support workers are not only hearing stories of trauma, but they are seeing and hearing about another form of human cruelty; racism towards those marginalized in society. Alexander (2008) also found racism to be an issue in the North. Support workers value being non-judgmental in their work with individuals. In fact, “the key to their being good shelter workers is an ability to connect with residents in a warm and non-judgmental manner...” (Tutty, 2006, p. 65). Racism can challenge the values workers hold dear and witnessing such cruelty can increase workers’ feelings of anger and helplessness.

Crisis intervention work combined with maintaining a safe and secure communal living environment within the transition house were workplace stressors identified by support workers. Support workers juggle a variety of tasks throughout their shifts (Richardson, 2001). For example, support workers have to manage providing individual support to women and children in the house, answering the door and/or crisis line, maintaining the general maintenance of the house, and assisting with various issues that often arise for individuals during crisis times and/or in a communal living environment. This is important to highlight because while it may increase a worker’s level of stress, it might also impede a worker’s ability to process the traumatic stories they hear and effectively debrief with a co-worker and manager. Shelter environments are different than being in a clinical or office setting where you have the ability to book appointments with clients and allow for sufficient breaks in between to process the information heard, write file notes, and psychologically regroup before the next session. Thus, Sexton (1999) emphasizes fostering a supportive environment that offers resources for workers to engage in processing what they are seeing and hearing from others.

One finding under the theme of workplace stressors that warrants attention is how Charlotte gave voice to feeling like she was inadequately trained, ‘flying by the seat of her

pants,' and thus ill equipped to deal with crisis and conflicts that arise within a shelter environment. This is a significant statement that leaves me asking, 'how many other workers would admit feeling the same way?' Trauma literature highlights how such feelings may be "because of the conflicting requirements for flexibility and boundaries" (Herman, 1997, p. 151). The need for flexibility, while maintaining boundaries, is paramount when working in transition houses.

Another interesting workplace stressor was bureaucracy versus care. Dealing with the challenges of navigating different systems while still trying to ensure that women and children are receiving the best support possible can increase a worker's stress level.

Schauben and Frazier (1995) found,

...many counselors mentioned that there were several larger systemic issues that made working with survivors difficult, such as inadequate funding for counselling (e.g., limits on mental health coverage), the injustice of the legal system, and public apathy about violence against women (p. 57).

Additionally, for workers already experiencing feelings of helplessness and frustration, struggling with issues of bureaucracy can amplify those feelings. One finding of particular interest was workers who identified having to navigate high client to staff ratios. Typically, transition houses are funded for a certain number of beds, yet often the need is so great that many transition houses go over capacity to provide safety and shelter to women and children. However, workers are then faced with trying to support and assist in upwards to 20 plus women and children, with no additional staff called in to help. With high numbers of women and children accessing the shelter, exposure to trauma stories increases which can contribute to higher levels of vicarious traumatization.

The impacts associated with working in a northern context can leave support workers more vulnerable to experiencing vicarious traumatization. Dealing with a lack of resources,

issues of confidentiality and anonymity, as well as isolation are all findings that correspond with the literature on working in northern communities (Coholic and Blackford, 2005). While the challenge of having to deal with a lack of resources was identified by most participants, it was issues of confidentiality and anonymity that proved concerning. In northern communities, professionals are often faced with juggling multiple roles and relationships (Schmidt, 2005). On top of being the professional, they are often a neighbor, community member, employee, friend, or acquaintance. However, when you are well known professionally as well as personally, this can affect a worker's overall feeling of safety out in the community as well as their interaction with the individuals they serve (Green, 2003). As identified in the results section, several support workers shared that they have experienced a disrupted sense of safety in the world. Due to issues of high visibility (Helbok, 2003), support workers have to deal with seeing their clients with their abusive partners in the community. Workers may also face the reality that many community members may know that they work at the transition house. Therefore, support workers may never really feel like they able to escape their work.

Pre-established working relationships with other professionals may limit the options support workers have when it comes to receiving counselling or formal debriefing in the community. It is important for agencies to ask the question, 'do workers have outside options that provide a safe place to talk about the impacts of the work?' Agencies need to examine what they offer support workers, and if it is something all classifications of workers can access. While transition house workers are paid relatively low wages, benefits may not be included (Tutty, 2006). Therefore, if not offered by the employer, many support workers may not have the financial means to access other options. However, in smaller communities, there might not be any appropriate outside options available. Therefore, creative strategies

need to be developed. Possible suggestions may include telephone or video conferencing with professionals in larger communities.

Support workers experience a variety of impacts, including vicarious traumatization. Surprisingly, nine out of 31 support workers, who completed the questionnaire, identified that they do not feel personally impacted by hearing trauma stories. Additionally, two interviewees also stated they did not feel impacted, however, during further discussion did identify experiencing some impacts. With support workers deny experiencing any impacts, it was important to try and understand why, so the question was posed to workers in the interviews and focus group. Workers came up with several rationalizations that highlighted issues staff may struggle with such as: a lack of awareness, issues of competency, and desensitization or shutting down emotionally. As a transition house worker, none of these surprise me as I have experienced each one at one point or another throughout the last 10 years in the field. According to Pearlman and Saakvitne (1995), “emotional numbing is both a response to painful feelings, such as horror, grief, outrage, shock, and rage, and a sign of vicarious traumatization” (p.287). It is important to examine the rationalizations to better understand the thoughts and fears of workers. This new understanding can guide policy writing and generate dialogue aimed at normalizing worker impacts. Normalizing the impacts of trauma work helps to overcome the stigma associated with experiencing distress and in some cases impairment so that appropriate interventions can be sought if necessary (Brady, Guy, Poelstra, & Brokaw, 1999).

Throughout the entire research process, workers identified impacts that are associated with vicarious traumatization. This is important to highlight because support workers were not assessed for overall levels of vicarious traumatization. The focus of this research was to emphasize their vulnerability while examining what they knew about this occupational

hazard. Experiencing impacts associated with vicarious traumatization and agency response further supports their overall vulnerability, as well as the recommendation that workers need training and education on this topic.

Impacts to all five components of self that are affected by traumatic events were identified. Disruptions to workers' frame of reference, as well as psychological needs and cognitive schemas, were most frequently identified. Through providing support to trauma survivors, workers are experiencing issues of trust, sense of safety, intimacy, and control. For many, their view of the world has changed and they have started to see the world as a bad place. In addition, the most frequently experienced emotions were helplessness, anger, and sadness. Herman (1997) found that trauma workers share their client's experience of helplessness, identify with a victim's anger, and experience profound grief. These impacts highlight the large cost to support workers. They can also shed light on the reason workers identify the need to shut down emotionally in an attempt at self preservation. However, without a solid knowledge base, some workers might not have the understanding or foresight to recognize what might be happening for them. Ultimately, without recognition and education, we risk the chance of losing good workers that do this work not for the money, but because they are passionate about doing their part in the fight to end violence against women and children.

Support workers also identified several positive impacts they experience. This is extremely important to highlight because positives work to balance out the negatives. For support workers the rewards are usually small in nature and can include: finding inspiration in seeing the amazing strength and resiliency of women, developing a greater appreciation for their lives and the people in them, and feeling like they are making a difference. Trauma literature also highlights the importance of experiencing positive impacts such as witnessing

resiliency and being part of another's healing journey (Schauben & Frazier, 1995). Just like negative impacts, positive impacts can also cause shifts to workers' beliefs about themselves and others. This was highlighted by Jenny when she shared,

I am definitely impacted because I find what I hear and what I learn from the women in the safe home helps me be a better human being,...be more understanding of women's issues, be more understanding of people who are oppressed, so it impacts me on how I lead my life everyday.

Recognizing the positive impacts helps workers to go to work everyday and effectively engage with women and children accessing transition houses.

Support workers identified a limited knowledge of vicarious traumatization.

Surprisingly, there are still workers who acknowledge that they have never even heard the term vicarious traumatization and even more who identified that they have never received training on the topic. One reason for this may be that vicarious traumatization is a relatively new term which only dates back to the 1970s (Iliffe & Steed, 2000). Another reason, with respect to working in a northern context, is that a lot of professional training takes place in larger urban centers. For some support workers, they identified that they learned about the term vicarious traumatization when it was 'touched on' during Transition House Module Training offered by the BC/Yukon Society of Transition Houses (BCYSTH), a provincial umbrella organization. Unless transition houses in northern communities can cover the associated costs to offer module training in their own community, rarely is training offered in the North. Therefore, the cost of travel and training is too expensive for many agencies to afford. Even when opportunities arise for subsidized training through the BCYSTH, they usually only cover one or two workers from each worksite and usually those receiving training are full- or part-time employees. Casuals are not normally offered opportunities for

training past their initial training shifts and any in-service training. However, as one worker pointed out, there are often more casual employees than full-time staff.

Interestingly, the word ‘burnout’ was mentioned several times throughout data collection. Generally when talking about the cost of doing this work people use the word burnout. This may be because burnout is highly recognized in the literature as an occupational hazard. This highlights the need for workers to not only be educated on issues of vicarious traumatization, but also burnout, compassion fatigue, and post-traumatic stress disorder. Workers need to be educated on each of these occupational hazards so that they are informed because just as each hazard has different signs, symptoms, contributing factors, and impacts, they may have different strategies for ameliorating its effects on a worker.

While knowledge was limited overall, support workers had varying levels of knowledge of vicarious traumatization. As identified above, some have never heard the term. Others had a more basic understanding of vicarious traumatization than others, while a couple of participants demonstrated a good working knowledge. During the interviews and focus group most support workers were able to define vicarious traumatization. It should be noted, that at the onset of this research study, every support worker was given questionnaire packages that provided workers with the definition. While some workers only identified that they did not know much more than the definition of vicarious traumatization, many workers were able to identify some contributing factors, as well as some of the professional and social costs to workers. When it came to identifying costs to workers, several answers corresponded with already identified impacts. Therefore, workers may have identified professional and social costs based on prior knowledge, their own experience, or witnessing them in their co-workers. Finally, when asked about prevention, the majority of workers felt that vicarious traumatization is preventable. However, as Tracy explained, “if you’re

working with trauma you cannot guard against that, you cannot control everything that comes out of a client's mouth before it comes out, you just can't." The information shared by workers provides the start of a baseline to which we can build off of when developing training sessions on vicarious traumatization.

Transition houses are usually under the umbrella of services for non-profit agencies and it is no secret that they receive limited funding. Tutty (2006) explains, "the funding that most shelters receive from their provincial/territorial governments has never covered the total costs of providing shelter" (p. 19). Specifically, government funding often only covers 65 to 80% of the shelter's expenses (Tutty). Therefore, it is understandable that employers may not have sufficient funds to allocate to staff training. However, agencies should review their training policies and procedure, talk to their employees, identify what is missing, work together to develop creative cost-effective solutions, and lobby for better funding.

Generally, agency response to vicarious traumatization is limited. While all interviewees identified that their workplace was supportive, more than half felt more could be done. One third of questionnaire respondents identified that they have never had their employer talk about the impacts of hearing traumatic stories. There is often debate surrounding whose responsibility it is to make sure workers are okay. Some staff felt that it was their responsibility to inform management if they require debriefing and support after hearing traumatic material or experiencing a traumatic incident within the house. Whereas others such as Charlotte felt the responsibility should be placed on the employer,

I think it definitely rests with the employer to make sure that they keep on top of it and know what's going on with their employees and that people are okay because if your staff's not okay then your clients can't be okay.

In actuality responsibility has to be shared. Employers need to be responsible for talking to employees at the time of hire about the possible impacts they may experience. They need to

make a point to check in with staff on a regular basis and debrief when necessary. Agencies also need to be aware of reasons why workers may not seek out debriefing, such as a lack of trust and fear they will be seen as incompetent. Brady et al. (1999) state, “organizations and agencies whose staff members treat a significant number of trauma survivors also must take responsibility for reducing the likelihood of vicarious traumatization in the workplace” (p. 390). Staff, on the other hand, need to give voice to what they are experiencing and seek out support because often they are the only ones who know something is bothering them. If both management and staff take responsibility, hopefully, no one will fall through the cracks and be left to feel unsupported in the workplace. This can also work to facilitate supportive dialogue and normalize any impacts experienced. Policy and procedures may not address the fact that workers sometimes experience difficulty and require supports for assistance. Participating in conversations, developing policies, and collaborating with all stakeholders can show workers that the agency is committed to workers’ overall well-being. As well, they hold both management and support workers accountable for being active participants in the search for solutions. Until we start bringing the issue of vicarious traumatization to the table we continue to foster an environment of silence.

Formal versus informal debriefing was an important theme to highlight. As Herman (1997) states, “no one can face trauma alone” (p. 153). While several staff identified that they had the opportunity to more formally debrief with management, the majority of support workers identified that they regularly debrief with their co-workers. Most debriefing between staff is done informally and is also referred to as peer support. None of the support workers in this study identified that they had received any training on how to debrief others. Support workers acknowledged that debriefing with their co-workers was more about venting, unloading, and in some cases, receiving validation. However, peer support cannot

be overlooked (Brady et al., 1999). Fullerton, Ursano, Vance, and Wang (2000) identify, “the protective effects of peer support include the sense of control and personal efficacy that are gained from the reciprocal helping process” (p. 261). It is important to honour and support what staff have established and the strong working relationships they have created to facilitate debriefing with one another.

Formalized debriefing goes beyond venting and validation. According to Fullerton, Ursano, Vance, and Wang (2000), “debriefing is the systematic process of education, emotional expression and cognitive reorganization accomplished through the provision of information and fostering meaningful integration and group support through identifying shared common experience” (p. 260). Unfortunately, for some workers they felt debriefing in the workplace was almost non-existent and more was needed. For others, they were not provided with outside options such as an Employee Assistance Program (EAP). Additionally, no interviewee identified that they had the opportunity to participate in a formal group debriefing session within their agency. However, the literature emphasizes the benefits of processing traumatic experiences through debriefing (Fullerton et al., 2000; Sexton, 1999). Therefore, agencies need to examine their current debriefing practices, to see where there might be gaps and aim to create more options for staff.

Support workers identified several strategies for change within their agencies. While training and debriefing has already been highlighted, the other theme to emerge was creating an environment that encourages self-care titled, Professional Self-Care Strategies. Ideas that were presented included: being supportive of a support worker’s need for time off, role modeling and encouraging effective self-care, management connecting with staff, and supporting staff to take regular breaks. Not surprisingly, staff did not recommend unattainable self-care strategies. Support workers are aware of the fiscal constraints non-

profit agencies have to work under and were considerate of that fact when making their recommendations. Clearly, they care about the agencies they work for and that needs to be recognized. Through their recommendations, support workers show there are creative cost effective strategies that can be implemented, that will make a big difference to staff in the workplace.

Limitations

One limitation of this study was that it studied a specific population in a specific geographical area. Transition house support workers may experience different impacts and have different levels of knowledge of vicarious traumatization than other professionals doing trauma work. Additionally, no comparison sample was used to see if similar findings would be found with transition house support workers from larger urban centers in Southern BC. It would have been interesting to see if Southern workers experienced the same type of impacts as workers in the North. Also, with respect to vicarious traumatization, do workers in the South have a higher level of knowledge and more opportunity to attend specialized training? Therefore, while some of the findings of this research study may be transferable to other populations and other geographical areas, they are not generalizable.

Another limitation lies in the unequal distribution of voices heard from the seven different transition houses. While every attempt was made to encourage workers to participate in one or all phases of data collection, there was a limited response to participating in the interviews and even more limited was those interested in being part of a focus group. In addition, time and travel constraints limited my ability to return to some communities in the north more than once. In the end, although there was at least one support worker from each transition house participating in the one on one interview, I would have liked to see more of an equal representation.

While the focus was not to measure support workers' level of vicarious traumatization, not assessing workers could also be a limitation. Having workers complete different measures to assess for vicarious traumatization could have strengthened the argument that not only are support workers susceptible, they are in fact vicariously traumatized. Furthermore, assessing workers would give further proof that education and training is needed.

Recommendations for Policy and Practice

This research study attempted to highlight the issue of vicarious traumatization within a transition house setting and give support workers an opportunity to share their voice, experiences, knowledge, and recommendations. Recommendations for policy and practice come out of examining the pre-existing literature on vicarious traumatization as well as the data generated from all three phases of this research study. The four main recommendations for policy and practice were: generating supportive dialogues, offering debriefing and clinical supervision, educating and training, and prioritizing the health and safety of workers.

Supportive Dialogue

Generating dialogue with workers is essential. Iliffe and Steed (2000) also highlight, "the need for an open dialogue between DV [domestic violence] counsellors and their managers to discuss the impact of this work and to accommodate counselors' varying needs" (p. 410). One of the hardest things to do as professionals is to recognize we need help to deal with the effects of our work and to feel secure in the belief that seeking help is a strength not a weakness. Agencies need to ask the questions, 'how do we foster an environment where support workers feel safe to start to have a conversation about the impacts of doing trauma work? How do we help workers to shift their thinking away from denial of impacts based on the fear of being seen as incompetent to one of acceptance and confidence they will be

supported within the workplace? Brady et al. (1999) stress the importance of agencies working to establish “an emotionally supportive, physically safe, and consistently respectful work environment” (p. 390). To begin conversations on the impacts of trauma work, all stakeholders need to feel safe and supported. Support workers are vulnerable to the negative impacts of continually hearing about human cruelty, and opening themselves to engage in conversations with management, ultimately places them in an extremely vulnerable position.

Debriefing and Clinical Supervision

Debriefing and clinical supervision are critical tools that assist in maintaining the health and well-being of workers. Herman (1997) supports the need for ongoing support for those working with traumatized people. Through these professional coping strategies, support workers are given the tools and support to talk about the work, process the stories, identify what is impacting them, and how to ameliorate its effects. Fullerton et al. (2000) state, “much like an analgesic medication can allow for increased movement of an injured arm, debriefing may allow the individual to avoid withdrawal and decrease stigma assuring a more rapid return to work and loved ones even if symptoms persist” (p. 262). Debriefing can be done individually or as a group. Group debriefing offers the opportunities for workers to see others identify and share the impacts they are experiencing, build trust, and also see that opening oneself up to share does not result in judgment from management or co-workers. Therefore, there needs to be more opportunity for formal debriefing.

Clinical supervision incorporates many similar aspects as debriefing but goes further to educate workers on issues such as vicarious traumatization. According to Saakvitne and Pearlman (1996), “everyone working with survivor clients needs supervision and consultation. Interpersonal relationships with survivors of interpersonal trauma are compelling and complicated. There are many potential pitfalls as we negotiate our clients’

powerful needs and our own responses” (p. 79). As with debriefing, clinical supervision can be done individually or with a group of workers.

To assist workers, and break down the walls of fear and mistrust that maintains worker silence, debriefing and clinical supervision need to become regular practice within agencies. As identified earlier, non-profit agencies consistently deal with financial constraints. However, this does not need to be the end of the conversation; creative and cost effective solutions can be identified and implemented. One option is offering group debriefings and/or clinical supervision. Since completing data collection, one transition house has implemented regular group clinical supervision sessions for their support workers. Sessions take place every six weeks and workers are encouraged to attend. Although it is not mandatory, workers who attend are paid wages for their time. Additionally, the transition house manager attends the sessions and actively engages in the discussion and shares the impacts she experiences as a result of the work she does. Through the inclusion of management, workers see that managers too are impacted and this may also work to normalize and reduce stigmas associated with talking about the impacts of the work.

Another option may include training workers on formal debriefing techniques. Through offering this training, agencies honor the informal debriefing practices staff have created, as well as provide workers with additional skills to effectively support each other. Again, a creative cost-effective strategy may include bringing in a qualified trainer into the agency and offering in-service training to all employees.

Education and Training

Educating management and workers on vicarious traumatization as well as other occupational hazards is crucial. Vicarious traumatization has numerous impacts that many may not be aware of. In addition, workers need to learn more about the signs, contributing

factors, professional and social costs, as well as effective personal and professional coping strategies. Training does not have to be offered on a large scale, it can be information sessions at staff meetings or it can be a one or two day in-service training. If agencies pay into an EAP, they may be able to arrange for a counsellor to present on the issue. As well, in smaller communities, workers know and often collaborate with their community partners. These relationships could also allow for creative training opportunities that are cost effective. However, training needs to be continuous, it cannot just happen once. As already identified, it was not until I had received additional training on vicarious traumatization that I was able to start to make connections to the impacts I was experiencing. In addition, high turnover rates of staff are also a common occurrence in transition house work.

Transition house support workers have varying levels of education. Over the years educational requirements to work in a transition house have changed. For some, support workers need to have a social service worker diploma. As shown in the questionnaire demographic information, the majority of respondents have college and/or university education. Therefore, education and training on the impacts of trauma work and professional well-being needs to be offered not only at the agency level, but at the college and university level. More time and attention needs to be given to training workers before they even go out into the field. Classes could be developed devoted to professional health and well-being, providing students with formal education on vicarious traumatization, burnout, compassion fatigue, and the development of effective personal and professional coping strategies. If started early, normalization of the impacts of trauma work may be obtained and support workers sharing openly without fear of judgment, may become common practice.

Prioritizing the Health and Safety of Workers

The last recommendation calls for a collaborated effort. Transition house workers, management, and non-profit agencies across BC need to rally together and gather our allies in the BCYSTH as well as other provincial umbrella organizations such as the Ending Violence Association of BC (EVA BC). In doing so, we can present a strong collective voice to Provincial Government funding bodies and send the message that taking care of workers needs to take priority. The Provincial Government continues to declare that violence against women and children is a serious social issue and they are committed to helping in the fight to end violence. However, there is no provision in funding contracts to take care of the women who are working on the front lines. If we do not take care of the front line workers how can we expect them to provide the most effective service to women and children. Support workers advocate everyday to improve services for their clients, is it not time to also advocate for workers, so they too can receive services that help to protect them from occupational hazards such as vicarious traumatization.

Conclusions

Vicarious traumatization is a clear and present danger to transition house support workers and an occupational hazard of the profession. This research study aimed to examine what worker's know about vicarious traumatization. In attempting to answer the research question, worker's vulnerability to vicarious traumatization, the impacts they experience, agency response, and strategies for change were also identified. Through sharing the voices of support workers across Northwestern BC, it is hoped that changes will start to happen at a personal, agency, and provincial level. Speaking freely about the impacts of trauma work needs to be normalized, debriefing and supervision needs to be implemented, training sessions need to be developed, and government funding bodies need to financially support

agencies to work towards prioritizing the health and safety of workers. Transition house workers provide safety and support to women and children escaping violence with often no thought about the costs of doing such important work. This needs to change. As identified by an anti-violence worker, “the women change us forever. To honour their courage, we must honour ourselves and commit to self-preservation, self-renewal and self-care”

(Richardson, 2001, p. 5).

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Appendix A

Framework for Analysis

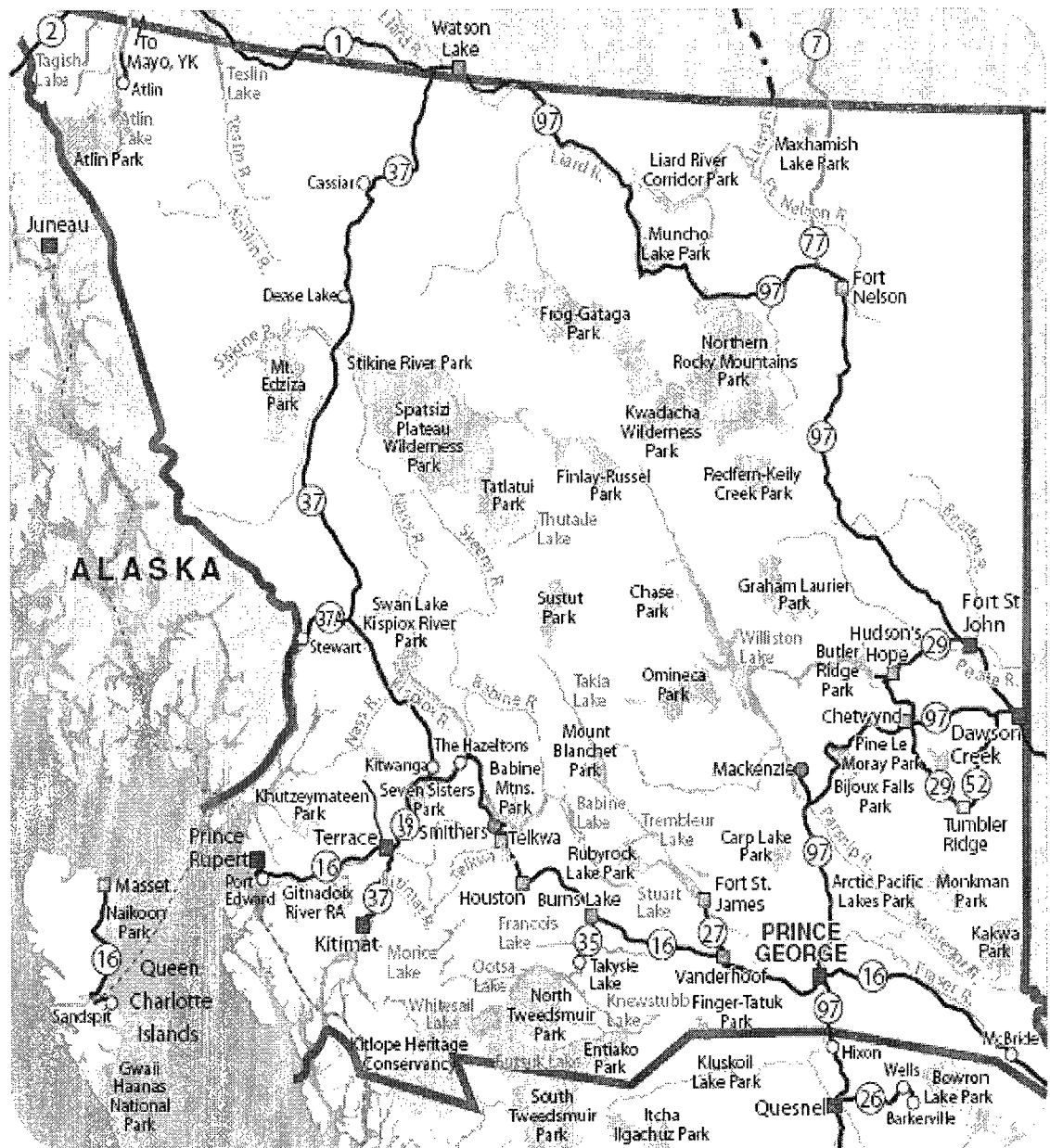
This framework for analysis not only incorporates the information and research findings found in the literature, but aims to utilize the existing theoretical framework that conceptualizes vicarious traumatization to identify the impacts workers experience and any coping strategies that have been found to be beneficial. The aim of this research is to explore support workers' knowledge of vicarious traumatization. Although this research does not attempt to measure a worker's level of vicarious traumatization, it is believed that through identifying the reported impacts support workers experience, the need for training and self-care work practices will be highlighted. While this framework outlines all of the identified research objectives, the opportunity for new topics and issues to emerge from the data through the process of content analysis is welcomed.

Topics to be explored:

1. Transition House Support Work
 - Benefits/positive impacts
 - Challenges
 - Traumatic stories heard
2. Transitional house support workers' knowledge of vicarious traumatization.
 - Knowledge through education/training, personal awareness, and/or experience
 - Contributing factors of vicarious traumatization – aspects of the professional (worldview, history, length of employment, coping style), work environment (stress, workloads, availability of support/supervision), northern challenges (limited resources, lack of support, confidentiality issues)
 - Social and professional costs – experiencing loss, recognizing not immune, feelings of separateness, impacts on relationships, isolation
 - Prevention – is vicarious traumatization preventable? Activities and practices to decrease the effects of vicarious traumatization.
3. Vicarious traumatization as conceptualized by the Constructivist Self Development Theory (CSDT). According to Pearlman and Saakvitne (1995), this theory describes five different components of self affected by traumatic events and identifies possible impacts and effective coping skills under each component:
 - 1) Frame of reference – one's identity, worldview, and spirituality
 - Impacts: become cynical and/or distant, may feel confused and/or angry, may question purpose and why they continue to do the work they do, loss of optimism and hope, helplessness, become suspicious of others, and avoid telling others what they do for a living.
 - Coping: balancing work, rest and play, partake in activities that allow them to experience being in a dependent role

- 2) Self-capacities – maintaining a positive sense of self-esteem and a consistent sense of identity
 - Impacts: feel overly anxious, self-critical, and unlovable, find themselves on verge of tears without experiencing a significant trigger or event, avoid difficult movies or the news, grief, and anger.
 - Coping: obtaining emotional support
 - 3) Ego Resources – self-awareness, interpersonal, and self-protective skills
 - Impacts: experiences difficulties making decisions, problems establishing and maintaining boundaries, difficulty taking perspective including empathy and sense of humor, limited awareness of one's psychological needs
 - Coping: supervision, education and training, personal counselling
 - 4) Psychological needs and cognitive schemas – safety, esteem, trust, control, and intimacy are those that are sensitive to traumatic events
 - Impacts:
 - Control: diminished sense of self control and attempt to exercise greater control over others
 - Safety: disrupted sense of safety, hyper vigilance, and increased sense of vulnerability.
 - Trust: experience a loss of trust, no longer trust their own perceptions of others, and become suspicious of people's motives.
 - Esteem: devalue oneself or others.
 - Intimacy: sense of intimacy diminished and emotionally distant.
 - Behavioral impacts: become self-critical, avoid having people walk behind them, lock doors and windows, avoid social situations, try to gain control over another, and 'shopping therapy,' avoid looking in mirror
 - Coping: learning new information, consulting with colleagues, utilizing outside resources by socializing with friends and family
 - 5) Memory System – how experiences are processed and recalled
 - Impacts: may experience intrusion of violent imagery, similar bodily sensations as described by trauma survivor, avoidance behaviors, and sensitivity to certain sounds and smells
 - Coping: Educating partners, friends, and family, family support
4. Agency response
 - Talks about impact of hearing trauma stories
 - Debriefing practices
 - Supports provided.
 5. What more can be done? Transition house support workers give voice to ideas around protecting workers and implementing self-care practices in the workplace.

Map of Highway 16 British Columbia



worker's onsite mailbox. **All participation is completely voluntary and individuals are welcome to withdraw from the study at any time.**

Each research package will contain a questionnaire, informed consent form, information sheet, and a form asking each participant if they would be willing to participate further in an individual interview and/or attend a focus group on the same topic. For those willing to participate further, their name and contact information will be required so confidential arrangements can be made for a face-to-face interview and/or to provide a date and time for the focus group. Included in the package will be a self addressed stamped envelope so each support worker can choose confidentially to participate in the research study or not. All participants will be assigned fictitious names to protect their identities and confidentiality will be maintained.

The participant information sheet has been included with this letter for you and your staff to look over before making a decision. If you have any additional questions or concerns, please feel free to contact me via phone or email. For those agencies located outside of Prince George, please feel free to phone me collect.

In follow-up to this letter, I will be contacting your agency by phone within the next two weeks.

Thank you for you time and consideration.

Respectfully,

Sheri Bishop
MSW Student, UNBC

Appendix F**Participant Questionnaire**

The following questions have been designed to collect demographic information and examine your existing knowledge of vicarious traumatization. Vicarious traumatization alters a helping professional's cognitive schemas (beliefs, assumptions, and expectations) about themselves and others in the world through continual exposure to traumatic narratives (Zimering, Munroe, & Gulliver, 2003). Please answer the following questions to the best of your knowledge.

- 1) How long have you worked in a transition house setting? _____
- 2) What is your employment status?
 - ☐ Full-time
 - ☐ Part-time
 - ☐ Casual
- 3) What age category do you fall under?
 - ☐ 19-28 yrs
 - ☐ 29-38 yrs
 - ☐ 39-48 yrs
 - ☐ 49-58 yrs
 - ☐ 59-68 yrs
- 4) What level of education have you accomplished?
 - ☐ Some High School
 - ☐ Graduated Grade 12
 - ☐ Some College
 - ☐ College Diploma
 - ☐ Some University
 - ☐ University Degree
 - ☐ Other _____ (please specify)
- 5) What is your relationship status?
 - ☐ Single
 - ☐ Dating
 - ☐ Living Common-Law
 - ☐ Married
 - ☐ Divorced
 - ☐ Widowed
 - ☐ Other _____ (please specify)
- 6) Have you personally experienced trauma in your life?
 - ☐ Yes
 - ☐ No

7) Have you ever heard of the term vicarious traumatization?

☐ Yes

☐ No

If yes, where and in what context did this take place?

8) Have you ever received training on vicarious traumatization?

☐ Yes

☐ No

9) Has your employer ever talked to staff about the impact of hearing another's traumatic material?

☐ Yes

☐ No

If yes, what was said? _____

10) What do you feel contributes to vicarious traumatization?

11) Do you believe vicarious traumatization is preventable?

☐ Yes

☐ No

If yes, what could be done to aid in the prevention of vicarious traumatization?

12) What strategies do you use to deal with all the traumatic material you hear when working with women accessing transition house services?

13) In relation to what you know about vicarious traumatization, do you think your community's geographic location impacts you and the work you do?

☐ Yes

☐ No

If yes, in what ways?

14) What would you like to know about vicarious traumatization?

Thank you for your time. Your participation is greatly appreciated!

Zimering, R., Munroe, J., & Gulliver, S.B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times*, 4. Retrieved March 9, 2006, from <http://www.psychiatrictimes.com/p030443.html>

Appendix G**Participation Consent Form**

I, _____ would be interested in participating in:
Please print full name

☐ An individual interview

☐ A focus group

I am a transition house support worker who works ☐ full-time ☐ part-time ☐ casual
hours for _____ in _____, BC. I have worked
Name of transition house Location
as a transition house support worker for _____.
Length of employment

I give permission for Sheri Bishop (thesis researcher) to contact me at:

Day time number Evening number Email address

(The best time to contact me by phone is _____)

Signature of Participant

Date

Appendix H

Interview Guide

1. Can you please describe for me the work you do?
2. What brought you into this line of work?
3. What about this work do you find rewarding? Challenging?
4. Have there been women you have worked with in the transition house that you have felt a connection with? Without giving any identifying information could you share an example?
5. Are there some stories you have found inspiring? Without giving any identifying information could you share an example?
6. Have you heard stories of trauma during the course of your employment? Without giving any identifying information could you share some examples?

Possible Prompts: Do those types of stories impact you? Stay with you? In what ways? If not, are there certain strategies you employ to keep yourself from being impacted? In completing the questionnaire some people said they are not personally affected by the stories they hear or did not respond to the question, why do you think other support workers did not respond or identify any impacts?

7. Has all that you have seen and heard changed the beliefs you hold and the way you think about yourself and others in the world?

Possible Prompts: Can you explain? Give some examples (if clarification is requested I will provide the following examples: seeing old scars on women's faces or necks and always thinking that these are about past abuse and then also being more careful [suspicious] of male partners).

8. Have any of your personal relationships (colleagues, friends, partners, children, etc) been affected by the work you do?

Possible Prompt: Do you find yourself appreciating anything more as a result of this work?

9. Do you ever dream about your work? If so, what are the themes and imagery in these dreams?
10. How do you cope with hearing and seeing other people's pain and suffering?

Possible Prompt: How do you "turn off" work when you go home?

11. What do you do for self-care? Do you regularly make time for self-care?

12. Please tell me what you know about vicarious traumatization.

Possible Prompts: What do you think are some signs? Contributing factors? Professional and social costs? Prevention?

13. What do you feel are the issues you face as a worker in a transition house in a northern community? Do you feel these issues could contribute to vicarious traumatization?

Possible Prompts: Benefits to living in the north?

14. Can you please describe your work environment?

Possible Prompts: Do you experience stress in your work environment? Where does it come from? What is done to alleviate stress in the workplace? Would you consider your work environment supportive? Is there flexibility? Is there effective communication? Do you feel one's work environment could play a role in vicarious traumatization?

15. Do you regularly practice debriefing in your workplace?

Possible Prompts: With whom does this usually occur with? Do you feel enough time and opportunity are given to debrief with others? Does your workplace offer the opportunity for group debriefing and do you feel it would be a beneficial practice? If no, do you have the option to access debriefing outside of the workplace?

16. Has your agency been responsive to the issue of vicarious traumatization? How?

17. What would you like your employer to do that has not already been done?

Possible Prompts: Do you have any thoughts on how your employer could implement/encourage self-care practices in work place?

What will participants be asked to do: Participants are asked to participate in an individual interview. All interviews will be arranged at a time that is convenient for the participant. The interview will take approximately one hour. Again, participants will be asked to answer some demographic questions, discuss aspects of the work you do, and share your knowledge of vicarious traumatization. The interview will be audio-recorded and later transcribed by the researcher. If at anytime participants feel uncomfortable they are welcome to stop the interview or request that certain sections not be recorded. Transcripts of the interviews will be made available to participants to read over and verify the accuracy of what was shared during the interview. **Quotes and demographic information shared in the interviews will be used in my final research report.**

★All data collected will be kept in a locked file cabinet in the office of my home. I will be the only one who has access to the locked cabinet. All information will be shredded and tapes destroyed once I have successfully defended and completed my thesis research.★

Who will have access to respondents' responses: Sheri Bishop (researcher), and Dr. Glen Schmidt (thesis supervisor).

How confidentiality and anonymity is addressed: As transition house support worker's you know that confidentiality is extremely important. Therefore, confidentiality will be maintained throughout the entire research process. All participants are asked to sign the attached informed consent form.

Fictitious names will be used to protect your identity and all information will be kept in a secure location. However, I can not guarantee that particulars and personal experiences shared will not appear familiar to someone who knows you.

How to get a copy of research results: To ensure that all transition house support workers have access to the results of my study, all transition houses who participated will receive a copy of my completed thesis.

If you have any questions or concerns please contact myself or my thesis supervisor, Glen Schmidt at the above contact numbers or via email.

Any complaints about the project should be directed to the Office of Research, (250) 960-5820 or by email: reb@unbc.ca

Appendix J

Interview Consent Form

I, _____ understand that I have been asked to participate in a research study examining what transition house support workers know about vicarious traumatization.

I have read the attached information sheet. ☐ Yes ☐ No

I understand that my participation is strictly voluntary and I have the right to withdraw from the study at any time and my information will be destroyed and no longer used. ☐ Yes ☐ No

I understand the risks and benefits involved in participating in this research study. ☐ Yes ☐ No

I understand that the research interviews will be recorded and that I can stop at any time or request that certain sections not be recorded. ☐ Yes ☐ No

I have been given the opportunity to ask questions and discuss this research study with the researcher. ☐ Yes ☐ No

I give permission for the researcher to use quotes provided I am not named. I understand that I will be given a fictitious name to protect my real identity. However, I recognize that particulars and shared personal experiences may appear familiar to someone who knows me.

I understand the importance of confidentiality and that confidentiality will be maintained throughout the research process. I also understand that only the researcher and her thesis committee members will have access to the information I provide.

I give permission for the information I share to be used for the researcher's thesis and any presentations or publications of her research study. I know that if I have any questions or concerns that I can contact the researcher at any time.

I agree to take part in this study:

Signature of Research Participant

Printed Name of Research Participant

Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator

Date

Appendix K

Focus Group Discussion Guide

Introduction:

- Greet participants
- Explain the purpose of focus groups and identify some ground rules: role of the moderator, confidentiality, individual opinions (no right or wrong), and the importance of speaking one at a time.
- Ice Breaker: Please share your name, position, and one thing you like to do when you are not at work.

1. What is vicarious traumatization (VT)?

Prompts: Do any thoughts/questions come up for you when you think about the issue of vicarious traumatization? What do you think about having mandatory training?

2. Do you believe that support workers are vulnerable to VT?

Prompt: How does that make you feel as a worker?

3. **Member checking:** Many respondents said they felt that VT was not preventable and one worker said she believed VT was not a prevention issue but a maintenance issue. Do you have any thoughts about that statement?

4. Please take a moment and think about a traumatic story a woman has shared with you. What, if any, emotions and/or thoughts did you experience during her disclosure?

Prompt: Explore what was behind the emotions and thoughts shared.

5. **Member checking:** The three emotions identified most often by support workers were frustration, anger, and sadness. Do you have any thoughts/feelings about these emotions? Do you as a worker connect to any of these emotions?

6. Out of 31 support workers answering the questionnaire, 9 said they do not feel personally affected by all the trauma stories they have heard and 2 left the question blank. How do you interpret these answers?

7. Have any of the beliefs you hold about yourself and others in the world shifted?

8. **Member checking:** Respondents in both stages of data collection identified shifts to their belief systems such as: becoming more protective, suspicious, or hypersensitive; feeling a sense of helplessness; and experiencing a loss of trust and/or safety. Do you have any thoughts/feelings about those shifts identified? Do you as a worker connect to any of these responses?

9. What are your thoughts about debriefing practices in your workplace?

10. **Member checking:** Most respondents identified the importance of informally debriefing with co-workers. However, many support workers reported the need for more formal debriefing because it was something they felt was lacking in their agency. What do you think about this?

11. If you were the program manager, what kind of changes would you implement to address the issue of vicarious traumatization in the work place?

12. **Member checking:** Most interviewed participants felt that overall, their agency has not been responsive to the issue of vicarious traumatization. For some respondents, they identified feelings of disconnect between management and staff and felt if management more actively tried to check in with all staff on a more regular basis, staff may feel more supported in the workplace. Do you have any thoughts/feelings about this?

What will participants be asked to do: Participants are asked to participate in a focus group. The focus group will be approximately two hours in length and will also follow a semi-structured format. Questions asked will elicit information about what support workers know about vicarious traumatization. The information obtained in the focus group will be written on a flip chart and verification of its accuracy will be obtained during the focus group session. Financial remuneration for transportation costs will be provided to all women who agree to participate in the focus group. **Quotes and information shared in the focus group will be used in my final research report.**

★All data collected will be kept in a locked file cabinet in the office of my home. I will be the only one who has access to the locked cabinet. All information will be shredded and tapes destroyed once I have successfully defended and completed my thesis research.★

Who will have access to respondents' responses: Sheri Bishop (researcher), and Dr. Glen Schmidt (thesis supervisor).

How confidentiality and anonymity is addressed: As transition house support worker's you know that confidentiality is extremely important. Therefore, confidentiality will be maintained throughout the entire research process. All participants are asked to sign the attached informed consent form.

Fictitious names will be used to protect your identity and all information will be kept in a secure location. However, I can not guarantee that particulars and personal experiences shared will not appear familiar to someone who knows you.

All support workers participating in a focus group will be reminded of the importance of maintaining confidentiality within the group process to ensure that everyone feels safe to speak openly and honestly. However, all participants must be aware that whenever there is a group of people involved, confidentiality may be compromised by another participant in the group.

How to get a copy of research results: To ensure that all transition house support workers have access to the results of my study, all transition houses who participated will receive a copy of my completed thesis.

If you have any questions or concerns please contact myself or my thesis supervisor, Glen Schmidt at the above contact numbers or via email.

Any complaints about the project should be directed to the Office of Research, (250) 960-5820 or by email: reb@unbc.ca

Appendix M

Focus Group Consent Form

I, _____ understand that I have been asked to participate in a research study examining what transition house support workers know about vicarious traumatization.

I have read the attached information sheet. ☐ Yes ☐ No

I understand that my participation is strictly voluntary and I have the right to withdraw from the study at any time and my information will be destroyed and no longer used. ☐ Yes ☐ No

I understand the risks and benefits involved in participating in this research study. ☐ Yes ☐ No

I have been given the opportunity to ask questions and discuss this research study with the researcher. ☐ Yes ☐ No

I give permission for the researcher to use quotes provided I am not named. I understand that I will be given a fictitious name to protect my real identity. However, I recognize that particulars and shared personal experiences may appear familiar to someone who knows me.

I understand the importance of confidentiality and that confidentiality will be maintained throughout the research process. However, I understand that my confidentiality could be compromised by another in the group. I also understand that only the researcher and her thesis committee members will have access to the information I provide.

I give permission for the information I share to be used for the researcher's thesis and any presentations or publications of her research study. I know that if I have any questions or concerns that I can contact the researcher at any time.

This study was explained to me by: _____
Print Name

I agree to take part in this study: _____
Signature of Research Participant

Printed Name of Research Participant

Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator

Date

Appendix N

UNBC Research Ethics Board Approval

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Sheri Bishop
CC: Glen Schmidt

From: Greg Halseth, Acting Chair
Research Ethics Board

Date: January 15, 2008

Re: **E2007.1017.120**
Vicarious Traumatization: The Danger of the Unknown

Thank you for submitting the above-noted research proposal and requested amendments to the Research Ethics Board (REB). Your proposal has been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Good luck with your research.

Sincerely,

Greg Halseth