Evaluating an Organization's Response to Vicarious Trauma in Staff and Multidisciplinary Team Members

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EVALUATING AN ORGANIZATION’S RESPONSE TO VICARIOUS TRAUMA IN
STAFF AND MULTIDISCIPLINARY TEAM MEMBERS

A Dissertation

Presented to the Faculty of
Antioch University Seattle
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In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By
Molly O’Neil
June, 2015
Evaluating an Organization’s Response to Vicarious Trauma in
Staff and Multidisciplinary Team Members

This dissertation, by Molly O'Neil, has been approved by the Committee
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ABSTRACT

EVALUATING AN ORGANIZATION’S RESPONSE TO VICARIOUS TRAUMA IN
STAFF AND MULTIDISCIPLINARY TEAM MEMBERS

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Seattle, WA

Program evaluation method was utilized to examine the relationship between vicarious trauma (VT) and organizational policies and practices. VT and secondary traumatic stress (STS) refer to the impact of hearing explicit accounts of people being directly traumatized. Indirect exposure to a traumatic events can cause traumatic stress and changes in the person’s way of experiencing the self and the world. The focus of this evaluation was developed collaboratively with the Clinical Director of Monarch Children’s Justice and Advocacy Center (MCJAC), the site of the program evaluation. The question of study was How effectively is MCJAC addressing vicarious trauma in staff, volunteers, and multi-disciplinary team members? MCJAC provides free services to victims of childhood sexual abuse and their families through forensic interviewing, psychotherapy, and family advocacy programs. Additionally, MCJAC houses and facilitates multidisciplinary team (MDT) meetings (a case consult group of Child Advocacy Center partners, such as law enforcement, medical examiners, etc.). The purpose of this program evaluation included identifying current levels of VT/STS distress and cognitive changes in current staff, volunteers, and MDT members; and exploring the participants’ perceptions and experiences of how MCJAC addressed VT. The evaluator conducted four interviews, developed and administered a qualitative and quantitative
measure unique to this site, and administered the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003) and the Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis, & Figley, 2004) to 16 participants. The quantitative results indicated low to average levels of VT/STS in participants. Qualitative data revealed more VT symptoms and both negative and positive impacts of working with the families. This program evaluation found most of the participants experienced most of the practices and the MCJAC culture as intended. Participants reflected trust, respect, and gratitude toward supervisor, team members, and team meetings. Although participants wanted to maintain the supportive and respectful atmosphere that allows them to get much-needed support, some experienced MDT as a point of exposure to material that increased their VT/ST symptoms. Recommendations included continuing current practices, creating a way to gather and implement new suggestions, and ongoing evaluation of VT/STS. The electronic version of this dissertation is at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLink ETD Center, http://etd.ohiolink.edu
For Clover
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This project truly could not have happened if Monarch Children’s Justice and Advocacy Center had not opened their doors to me. The professional community there was welcoming and kind throughout this evaluation. Thank you for collaborating with me and participating in this project. I hope that the process and results have been as useful to you as they were to my learning.

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Chapter I: Introduction

Formal evaluation can help people make informed decisions about their programs or interventions based on systematically collected data. Informal evaluation can provide information important to daily functioning within an organization. However, more formal evaluative process is often needed for making broader decisions about the program or specific interventions, understanding how well a program is meeting its goals overall, or having clarity about the organization’s purposes, structures, workflow, communication, or collaborative relationships. Funders of non-profit organizations are also requiring more stringent and systematic self-evaluation (Fitzpatrick, Sanders, & Worthen, 2011). For example, the National Children’s Alliance (NCA) accredits Child Advocacy Centers nationwide. Monarch Children’s Justice and Advocacy Center (MCJAC), as an accredited advocacy center, is now required to provide self-monitoring data based on the NCA standards (Jackson, 2012, National Institute of Justice, 2004).

As a Child Advocacy Center, MCJAC provides free services to victims of childhood sexual abuse and their family members. The clinical director of MCJAC supervises and facilitates the following services: forensic interviewing; psychotherapy; family advocacy; and a multi-disciplinary team meeting, which includes law enforcement and other investigative agents, victim and family advocates and therapists, special prosecutors, and medical health professionals. Please see Appendix A for specific information about MCJAC’s grant funding and clients they have served (Community Action Council, 2011, 2012).

Front-line workers in helping and first-responding professions may have both positive and negative reactions to their work. Research has demonstrated that those
helpers who work with people who have been exposed to traumatic stresses are at risk for suffering psychological distress and trauma symptoms (Bride, 2007; Figley, 1995; Follette, Polusny & Milbeck, 1994; McCann & Pearlman, 1990). The terms used for this phenomenon reflect separate but related lines of both theory and inquiry. Figley, together with colleagues (e.g., Adams, Boscarino, & Figley, 2006; Figley, 1995, 2002), developed and researched the concepts related to compassion fatigue and secondary traumatic stress (STS) disorder, drawing on Maslach’s (1982/2003) concepts of burnout and Rosenheck and Nathan’s (1985) concept of secondary traumatization. Stamm (2010) reconceptualized these terms, describing compassion fatigue as an umbrella term including the two constructs of STS and burnout.

Separately, McCann and Pearlman (1990) and Pearlman and Saakvitne (1995a, 1995b) described the more enduring changes in belief structures and imagery memory that can happen for professionals working with survivors of trauma, which they termed vicarious trauma (VT). These scholars developed the constructivist self-development theory (CSDT) (McCann & Pearlman, 1990). CSDT integrates concepts of belief structures and schemas from cognitive theory, psychodynamic concepts of transference/countertransference, and constructivist ideas of self-development as a dialogue between internal belief structures and a meaningful environment. McCann and Pearlman used this framework to conceptualize the trauma-like symptoms occurring for therapists working with trauma-survivors, symptoms such as numbing, intrusive imagery and thoughts, and the changes in world-views and self-concepts. Pearlman and her colleagues (e.g., McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b) have focused their research particularly on therapists working with victims of sexual violence.
Possibly for this reason, the term vicarious trauma is the one used most often within MCJAC programs and meetings. Vicarious trauma will be the term primarily used for this program evaluation, except when citing and discussing an article using different terms. Although some differences exist between the constructs (please see the Literature Review), many in the field use the terms interchangeably. Additionally, because the overarching purpose of this evaluation is to support MCJAC’s efforts to mediate the impacts of working with traumatized clients on their workers and MDT members, research for all indirect trauma constructs will be considered, as well as burnout peripherally.

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) did not include these indirect forms of exposure in the diagnosis of posttraumatic stress disorder (PTSD). However, the DSM-5 (American Psychiatric Association, 2013) Criterion A4 reads,

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: . . . 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (p. 271)

These changes happened during the course of this program evaluation. Thus, these changes will be included in the analysis and discussion of this program evaluation, but will be used alongside the older diagnostic criteria in the research, literature, and data.

Bride (2007) studied prevalence of secondary traumatic stress symptoms (as measured by the secondary traumatic stress scale (STSS) (Bride et al., 2004). (For a detailed description of the STSS, please see the Measures subsection in the third chapter of this program evaluation). The STSS is based directly on three criteria for post-
traumatic stress disorder (PTSD) in the *DSM-IV* (American Psychiatric Association, 1994): intrusion, avoidance, and arousal. In a sample of 282 social workers (47% response rate), Bride found 55% met at least one criterion, approximately one-fifth met two criteria, and 15.2% met all three core diagnostic criteria for PTSD. Nearly 98% of respondents reported their client population is at least mildly traumatized, and 81.7% reported a moderately to very severely traumatized client population. Fear, helplessness, or horror in response to the traumatic experiences reported by their clients was reported by 86.7% of respondents. Bride found the most frequently reported individual symptoms were intrusive thoughts, avoidance of reminders by clients, and numbing responses. Among the least reported were distressing dreams and a feeling of reliving clients’ traumas.

Using the definition given by the *DSM-5* (American Psychiatric Association, 2013), every one of MCJAC’s workers and MDT members are exposed to traumatic material as a regular part of their jobs. Thus, the workers and professional partners are all in positions that make them vulnerable to trauma symptoms and impacts. Based on the primary researcher’s experience, MCJAC has a culture that takes vicarious trauma seriously (please see the Internal v. External Evaluation subsection of the third chapter for a full discussion of the primary researcher’s relationship with MCJAC). For example, the incoming interns are trained to be aware of vicarious trauma. It is also considered a natural consequence of the work, and steps are taken to maintain it at a manageable level and to care for people who are showing more severe signs. The topic is discussed with regularity in the context of group case consult meetings, as well as in individual supervision. Dr. Donohue asked to focus the program evaluation on this topic in order to
examine and explore two dimensions. The purpose of this evaluation was to establish a baseline of current levels of vicarious trauma/STS distress and cognitive changes in the workers (staff, volunteers, and interns) and MDT members at this time, and to explore workers’ and MDT members’ perceptions of how MCJAC addresses vicarious trauma.
Chapter II: Literature Review

This literature review covers theory and empirical data related to vicarious trauma, secondary traumatic stress, and briefly touches on burnout. This review has had two practical goals: to increase utilization of the recommendations in this report by MCJAC, and to support the development of the MCJAC Questionnaire used for this evaluation. The empirical data and theoretical support for the recommendations and conclusions can be used for psycho-education while implementing the recommendations, for funding applications, and for the public. Thus, the material presented here is directly relevant to MCJAC’s programs, missions, and practices related to vicarious trauma; and to the constructs and items included in the questionnaire.

The questionnaires gathered data related to the following variables:

- Personal, team, and leadership awareness and psychoeducation about vicarious trauma (VT)
- Personal and peer support
- Organizational support, including autonomy, staff participation, and strategic information, workplace safety and comfort
- Organizational culture, such as attitudes toward clients, impact of VT, and self-care
- Meetings impact on VT, such as the interplay between both risk and protective factors present
- Personal and peer impacts of VT
- Compassion satisfaction; and impact of having Astro, the Courthouse Dog, working at MCJAC.
These variables were drawn from the literature and from consultation with the clinical director, Dr. Tambra Donohue. Further details on how the questionnaires were developed can be found in the Questionnaire Development subsection of the Methodology chapter of this dissertation.

The following sections first place the scholarly work on vicarious trauma (VT) and secondary trauma (ST) in historical and social contexts. The next sections describe the research related to risk and mediating factors; and organizational and treatment guidelines and suggestions for mitigating vicarious trauma, particularly for this population (professionals with a variety of roles serving survivors of childhood sexual abuse and their family members).

Dr. Donohue was interested in examining client outcomes, both in general and in relation to vicarious trauma. However, studying client outcomes was outside the scope of this evaluation for several reasons. In addition to practical and ethical issues, the relationship between client outcomes and vicarious trauma among mental health workers is complicated and difficult to study.

It is often assumed in the literature and in the field that a clinician suffering the impacts of vicarious trauma, at the very least, will have decreased professional effectiveness or capacity. Yael Danieli (1980, 1982) has made one of the only empirical links between the countertransference of therapists working with traumatized clients and a negative affect on their clients’ healing process. Through qualitative study, Danieli (1980) described a common experience of survivors of the Holocaust and their families, which she called a conspiracy of silence. Survivors and their families experienced awkwardness, changing of subject, inappropriate humor, denying, or shaming when
sharing their stories with family, friends, colleagues, and healthcare professionals, including therapists. Danieli (1980) posited, based on her research, that professionals were both worried about bringing up painful memories for the survivor, but also silencing out of self-protection. Danieli (1980) argued this silencing only worked to further isolate, alienate, and paralyze the healing process for survivors and their families. Baranowsky (2002), drawing from Danieli’s work, identified the silencing response as significantly positively correlated with compassion fatigue in a pilot study of a measure, the Silencing Response Scale. This correlation offers support for the hypothesis that as clinicians become more severely impacted by their work with traumatized individuals, their work with those individuals becomes compromised. Baranowsky provided practical steps to identify and work with this particular impact of vicarious trauma.

Theoretical support for clinicians’ work with clients being affected by vicarious trauma and secondary traumatic stress symptoms was discussed by Munroe (1999), who considered the American Psychological Association’s (1992) ethical guidelines in light of STS. He posited that organizations have a responsibility to warn and train their employees in high-risk settings, and that as part of their responsibility to clients’ welfare, clinicians also have a duty to care for themselves. Munroe suggested avoidant or intrusive symptoms in the clinician could negatively affect therapeutically appropriate work (e.g., timing of disclosures).

Studying client outcomes is a difficult and risky endeavor. The risk of harm is great, asking clients to provide feedback after receiving free services could feel coercive, particularly to traumatized, young clients, and could trigger traumatic or negative memories. For these reasons, it might be more meaningful to the clients to create a
participatory research project for the clients to explore how they themselves are moving through their healing process. However, linking that process with clinicians, advocates, or interviewers could be leading or intrusive, and linking any client data with the professionals’ current levels of VT/STS is tenuous at best. However, if the purpose of gathering data on client outcomes was not to examine the relationship between professionals’ current mental health and clients’ healing process, then participatory research could provide incredibly rich documentation of clients’ experiences. Studying client outcome is out of the scope and focus of this project; however, based on Danieli’s (1980, 1982) work and Munroe’s (1999) theory, client outcomes were included in the logic model of the program evaluation question of study (see Appendix B).

**History and Definitions**

The idea that caring professionals working with traumatized individuals may exhibit similar distress is far from a new one. Much of the current research and theoretical work discussing this phenomenon is founded on scholarship and research in the field of countertransference, and the early work identifying the impacts of the Holocaust seen in the children and other family members of the victims (Danieli, 1980, 1982; Freyberg, 1980). Danieli’s (1980) qualitative research resulted in descriptions of the most prevalent countertransference experiences therapists were likely to have when working with Holocaust survivors and their families. Among the twelve thematic reactions identified were bystander’s guilt, rage, dread and horror, shame, murder versus death, me too, and victim and hero. Danieli (1980) considered the source of these reactions to be the Holocaust rather than the encounter with its survivors and their families.
This early work identifying the impacts of the Holocaust on the children of survivors (intergenerational transmission) contributed to Rosenheck and Nathan (1985) to coin the phrase *secondary traumatization*. Building on this concept and Danieli’s (1980) concepts of countertransference, Figley (1989) brought in the *DSM-III* (American Psychiatric Association, 1980) definitions of PTSD and began discussing this phenomenon as secondary traumatic stress disorder. The development of his ideas through time by a variety of authors and researchers has created a somewhat confusing combination of terms. Initially, Figley (1995) used the term secondary traumatic stress and considered it a form of burnout specific to working with victims of trauma. Maslach’s (1982/2003) construct definition of burnout has been the most accepted, and includes three content domains: emotional exhaustion, depersonalization, and loss of personal accomplishment. Figley (2002) then changed the term to compassion fatigue in an effort to depathologize the phenomenon.

Figley (1995) defined secondary traumatic stress disorder (STSD) as a disorder nearly identical with post-traumatic stress disorder (PTSD), which is now reflected in the *DSM-5* (American Psychiatric Association, 2013) changes in PTSD criteria. According to Figley in 1995, the person who experienced a primary trauma may develop PTSD, whereas the person caring for the traumatized person could develop STSD. This disorder could apply to anyone exposed to the traumatic material of someone else’s life (e.g., family members and helping professionals). Jenkins and Baird (2002) argued Figley should drop the term compassion fatigue since the measure he initially developed involved no content related to compassion or fatigue, but had a subscale related to his construct of STS. The most recent version of that measure is the Professional Quality of
Life Scale (ProQOL) (Stamm, 2010), which retained the theoretical construct of compassion fatigue; however, it remained absent from the subscales. Stamm reconceptualized compassion fatigue as an umbrella term containing both STS and burnout. Figley was also involved in a collaborative effort to develop and validate the secondary traumatic stress scale (STSS), directly based on PTSD criteria (Bride et al., 2004).

McCann and Pearlman (1990) reviewed the literature going back to the 1970s describing countertransference experiences of therapists working with clients who have been traumatized. This literature included descriptions of a parallel process of trauma symptomology, such as intrusive images, nightmares, recurring unwelcome thoughts, avoidance and numbing, as well as changes in attitudes toward life and beliefs about oneself, the world, and others (McCann & Pearlman, 1990). These changes often involve a loss of faith in humanity, loss of a sense of basic security of oneself and/or loved ones, or an inability to trust others, with resulting increases in fear, pessimism, helplessness, and hopelessness. Pearlman and Saakvitne (1995b) stated the primary theoretical difference between the terms vicarious trauma and secondary traumatic stress is one of emphasis rather than experience. Vicarious trauma emphasized the changes in cognitive schemas (beliefs) and imagery memory, whereas STS has been directly based on the DSM-IV (American Psychiatric Association, 1994) in its emphasis on trauma symptomology (Figley, 1995; McCann & Pearlman, 1990).

In an extensive review of literature related to adaptation to trauma, McCann, Sakheim, and Abrahamson (1988) identified five basic psychological needs that are particularly vulnerable to disruption by trauma. Through continued research and theory
development, the following aspects of self have been found to be particularly vulnerable to the effects of trauma: self-capacities (affect management, object constancy, self-worth), frames of reference (identity, worldview, spirituality), and five psychological needs (safety, trust, esteem, intimacy, and control) (Saakvitne, 2002). Cognitive schemas are also affected, and have been defined as “the conscious and unconscious beliefs and expectations individuals have about self and others that are organized according to central psychological need areas” (Pearlman & Saakvitne, 1995a, p. 68). How these changes manifest in an individual depends on that person’s history, temperament, and other unique psychological factors. McCann and Pearlman (1990) viewed these changes in cognitive schemas as enduring, cumulative, and likely permanent. Although these authors acknowledged the changes are likely permanent, they held hope for people to find a balanced and realistic belief structure through fully processing both the horror of the traumatic material and the personal reactions – similar to treatment of primary trauma.

Jenkins and Baird (2002) examined the validity of an empirical relationship between an early measure of compassion fatigue/secondary stress, the Compassion Fatigue Self-Test for Psychotherapists (CFST) (Figley, 1995), and the TSI-Belief Scale, Revision L (TSI-BSL) (Pearlman, 1996) (an earlier version of the Trauma and Attachment Belief Scale, Pearlman, 2003). Jenkins and Baird (2002) compared these two measures with the well-established measures Maslach Burnout Inventory (MBI) (Maslach, 1996, as cited in Jenkins & Baird, 2002) and Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1983). The MBI (Maslach, 1996) measures burnout and the SCL-90-R (Derogatis, 1983) measures general psychological symptoms of distress over the past seven days. Jenkins and Baird (2002) found strong concurrent validity with
moderate discriminant validity between the two measures, CFST (Figley, 1995) and TSI-BSL (Pearlman, 1996). The CFST (Figley, 1995) and TSI-BSL (Pearlman, 1996) both correlated highly with the general distress scale, SCL-90-R (Derogatis, 1983), higher than would allow for good differentiation; however, the trauma-related scales were more strongly correlated with each other than each was with the SCL-90-R (Derogatis, 1983). In a very interesting finding, the TSI-BSL (Pearlman, 1996) and the burnout scale were less well differentiated than had been expected based on their conceptual divergence (Jenkins & Baird, 2002). However, some of that shared variance seemed to represent positive intrinsic job satisfaction. The TSI-BSL (Pearlman, 1996) had a moderate negative correlation with the burnout subscale related to positive experiences of working with clients. There was less support for the burnout construct being included in the CFST (Figley, 1995). Jenkins and Baird (2002) conducted two studies on the same data set and contributed important initial empirical data for several variables to a relatively new area of research at the time. Because this article is cited often throughout the VT/STS literature, examining the validity of the research is especially important.

Jenkins and Baird’s (2002) and Baird and Jenkins’s (2003) research examined the responses for 99 and 101 participants respectively as part of the same data set. Participants were both volunteers and paid staff from agencies providing services to survivors of domestic violence (DV) and sexual abuse/assault (SA). All measures used for this research, except the demographics questionnaire, had published psychometric qualities, with two measures having well-established psychometric qualities, the MBI (Maslach, 1996) and SCL-90-R (Derogatis, 1983). These researchers collected demographic information for all the participating agencies and compared the research
sample demographics and test scores with the demographics and mean scores reported in the literature, as well as the total demographics of the agencies. No notable demographic differences were found, increasing generalizability to primarily White, heterosexual, and female service providers in fields of DV and SA. Jenkins and Baird (2002) reported their sample was “a little less symptomatic on the CFST-BO, MBI, and SCL-90-R GSI, the latter compared to Derogatis’ nonpatient sample (Derogatis, 1983)” (p. 428). Research procedures were reported carefully and in detail. This research had very solid construct validity by providing a thorough literature review of previous findings in the areas of question.

The data set used for these two studies contained the weaknesses inherent in correlational, cross-sectional, and self-reported data (correlation not causation, and possibly self-report bias – although measures were anonymous). Jenkins and Baird’s (2002) and Baird and Jenkins’s (2003) research also suffered from a sample size too small for the number of analyses and variables explored (particularly when combining the two published studies). This imbalance made the research vulnerable to both Type I and Type II errors, in that as the number of statistical tests increases, as does the chance of finding something that is not really there, and having low power can decrease the chance of finding a significant result when it really exists. However, these authors also reported three levels of significance error rate (.05, .01, and .001), which does strengthen the statistical validity of their claims by addressing the Type I error risk. They also clearly articulated hypotheses and used methods common in social science research (Grimm & Yarnold, 1995/2009). Overall, these studies were conducted carefully and thoroughly, with strong construct validity, moderate generalizability, and moderate statistical validity.
Results from both of these studies will be discussed in later sections of this literature review.

**Synthesizing definitions.** The various terms and definitions of indirect traumatization have often been synthesized or essentially ignored (e.g., authors often use the terms vicarious trauma and secondary traumatic stress interchangeably). Additionally, most, if not all research and theory about VT/STS was born from research and theory about primary trauma. In their review of vicarious trauma research, Lerias and Byrne (2003) included more research about direct trauma exposure than from secondary/indirect/vicarious trauma. Research such as Bride’s (2007), examining the prevalence of STS in a population of 282 social workers, lent support to a diagnosable pathology meeting PTSD criteria based on someone’s indirect exposure to accounts of traumatic events. A view that has now been integrated into the diagnosis of PTSD in the *DSM-5* (American Psychiatric Association, 2013). Thus, the conversation about the difference between direct and indirect trauma may be one of emphasis, duration, critical mass, and the quality of symptom differences, similar to other differences between types of trauma and patterns of responses.

For the purposes of this program evaluation, the research on indirect trauma exposure will be the focus of the literature review. This research is more directly relevant to the population and site of the evaluation and the measures developed are appropriately worded for service providers. Additionally, many providers have impacts that do not reach diagnosable levels. Again, the purpose of this evaluation is not to diagnose PTSD, but rather give MCJAC further information about how this type of exposure has been
found to affect people, and what actions have been found helpful for workers that organizations and agencies can take.

**Ecological Perspective of Vicarious Trauma**

This evaluation is focusing on the individual and the organizational level of function, action, and impacts related to vicarious trauma. Nelson and Prilleltensky (2010) described the reaction against psychology’s extreme focus on the individual psychological processes as a need to understand the pathogenic or oppressive qualities of human environments. Much of the research available and presented in this literature review has explored the individual psychological processes related to vicarious trauma. However, utilizing Bronfenbrenner’s (1977) ecological perspective (see Figure 1), on the meso-system level, organizations can have pathogenic and oppressive qualities which may contribute to vicarious trauma as well as burnout (Choi, 2011; Maltzman, 2011; Pross & Schweitzer, 2010; Townsend & Campbell, 2009).

*Figure 1. Bronfenbrenner's (1977) Ecological Approach*
On the microsystem level, interpersonal trauma dynamics can be transferred into the work place. Herman (1997) described intense conflict and bitter debates occurring in work environments and professional relationships among those working with traumatized clients. Herman explained that professionals’ countertransference responses can become fragmented, with one provider taking on the role of rescuer, as another takes on a doubting or punitive stance toward a difficult client. Countertransference feelings of anger, helplessness, despair or skepticism and avoidance can also be projected onto colleagues.

The mesosystem level speaks to the interaction between microsystems, such as between work and home. The combination of confidentiality issues and loved ones often not wanting to hear about the daily sorrows of child welfare work, or domestic violence counseling further isolate mental health and investigative workers from social support outside the agencies and departments (Iliffe & Steed, 2011; Maltzman, 2011). Workers in social services agencies sometimes perceive potential consequences, such as shaming, blaming, or being viewed as weak for being open about being impacted by client material or for taking time off or using other self-care measures (Maltzman, 2011). The negative coping strategies (such as excessive drinking) employed by workers at times (Follette et al., 1994) can also negatively affect social networks.

On the exosystem level, Wolff (2010) depicted our helping industry in crisis, highly competitive, and often focused more on funding than on solutions and social change. Though usually staffed with caring individuals who often truly want to help improve people’s lives, the helping industry, systematically, often does not act to empower clients, and agencies that do are sometimes sabotaged by other local helping
agencies (Wolff, 2010). Systems dysfunction can contribute to the alienation of the client as well as the vicarious trauma of the helper/worker (Iliffe & Steed, 2000).

Viewing vicarious trauma within the exosystem and macrosystem perspective of sociopolitical structures and dominant beliefs leads to a discussion of the link between systemic oppression and personal violence (van Dernoot Lipsky, 2009). Poverty, racism, sexism, and other forms of oppression increase rates of personal violence, thus increasing the levels of trauma exposure in our society, and thus increasing the primary and secondary impacts of trauma (van Dernoot Lipsky, 2009). The cultural attitudes toward sexual assault and the legal systems in place to address child abuse and sexual assault can create macro-level system impacts to vicarious trauma, in that these attitudes and legal systems often encourage victim-blaming, individual-level framing of the problem, and continued victimization by the legal system (Iliffe & Steed, 2000; van Dernoot Lipsky, 2009). Although these macro-system factors are well out of the scope of this project, this brief discussion of the ecological systems and relationships grounds this research and data within the larger context in which MCJAC exists and acknowledges the political nature of vicarious trauma. These larger social contexts can inform the interpretation and reporting of the data gathered from MCJAC and the MDT.

**Risk and Mediating Factors**

This section explores demographic and individual characteristics as well as organizational characteristics and culture. The empirical data on the risk and mediating factors and predictor variables are somewhat difficult to parse out. The data have been collected through widely varying measurements (e.g., level of detail and depth, level of measurement, psychometric qualities, etc.) and thus are not easily compared. Because
none of the studies found for this literature review were longitudinal studies, all research presented on the risk and mediating factors of vicarious trauma are correlational. Therefore, we cannot surmise from any of these data whether these factors contribute to increased impacts, or are in fact symptoms of vicarious trauma. For example, social support has one of the most consistent negative relationships with symptoms of vicarious trauma – the question remains whether workers will face more severe or frequent symptoms when they do not have social support, or if they become socially isolated when they are suffering more severe or frequent symptoms – or both. Additionally, most variables have conflicting findings related to the level or quality of impact on vicarious trauma symptoms. Social support stands out as a variable with a great deal of empirical support for a negative relationship with VT/STS symptoms (Ozer, Best, Lipsey, & Weiss, 2003) and will be threaded throughout all three categories.

**Demographics and individual characteristics.**

**Personal history of abuse.** The relationship between a personal history of abuse and later vicarious trauma is complicated. The prevalence of personal abuse histories in samples of clinicians has been found to be relatively high, with a large range. The range in prevalence rates could be related to the gender make-up of the samples in the different studies. Victims of sexual assault are overwhelmingly female (https://rainn.org/get-information/statistics/sexual-assault-victims). The rates by gender are not quite as dramatically different for domestic violence; however, when looking at intimate partner abuse women are far more likely to be killed by an intimate partner than men (http://www.ncadv.org/learn/statistics). For these reasons, the gender of the samples has been included for the following prevalence studies. Approximately 73% of Schauben
and Frazier’s (1995) total sample of female psychologists and sexual assault counselors reported at least one form of sexual victimization (which included rape, attempted rape, sexual abuse, sexual harassment, and other sexual assault), and 37% of the total sample reported more than one type of victimization. On the other end of the scale, Follette et al. (1994) found that overall, 29.8% of mental health professionals (n = 225) and 19.6% (n = 46) of law enforcement officers reported experiencing some form of physical or sexual abuse as children. Follette et al.’s sample was 53% female mental health professionals, and 89% male officers. Ghahramanlou and Brodbeck (2000) stated 53% of the 89 sexual assault trauma counselors who participated in their study indicated they had “experienced any extremely stressful, life-threatening, or traumatic event such as serious physical injury, rape, assault, combat, or seeing someone badly hurt or killed” (p. 232). Ghahramanlou and Brodbeck’s sample was 98% female. VanDeusen and Way (2006) reported 76% of the total sample of clinicians reported experiencing any form of childhood maltreatment, with over 50% reporting two or more forms of maltreatment. The percentage of clinicians reporting different types of abuse ranged from 25% reporting physical abuse to 51% reporting emotional abuse.

Conflicting literature suggests a complicated relationship between history of abuse and later vicarious trauma symptoms. For example, Follette et al. (1994) found in their sample of mental health and law enforcement professionals that a personal history of childhood abuse was not predictive of increased trauma symptoms in the therapists, but it was in the officers. Using multiple regression analysis, Schauben and Frazier (1995) found a personal history of rape or incest was not significantly correlated with symptom measures (either by itself or when interacting with percentage of survivors
seen; whereas, percentage of survivors seen was significant in all three analyses). Ghahramanlou and Brodbeck (2000), on the other hand, found positive trauma history (see above for definition) was significant in stepwise multiple regression analyses of variables predicting higher scores for general distress and secondary trauma intensity.

Three studies were published examining contributing factors to two vicarious trauma impact constructs, such as avoidance and intrusions (Way, VanDeusen, Martin, Applegate, & Jandle, 2004); trust and intimacy (VanDeusen & Way, 2006); and self-esteem and self-intimacy (Way, VanDeusen, & Cottrell, 2007). All three studies were based on one large, national survey of clinicians providing treatment to both survivors and offenders of sexual abuse. Survey packets were mailed to 1,754 clinical professionals from the mailing lists of two organizations (excluding unusable and undeliverable surveys, 409 packets were returned for a response rate of 23%, n = 383 total). The total sample was approximately 60% female and 94% Caucasian.

The national survey included the Traumatic Stress Institute Belief Scale (TSIBS-R-L) (Pearlman, 2003) [an early version of the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003)]; the Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979); the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998); and a question asking respondents to indicate types of coping strategies they have employed in the last six months with a list of 24 possible strategies (e.g., “one-to-one supervision,” “used alcohol to relax or get away from the day,” Way et al., 2004, p. 56).

The use of the CTQ (Bernstein & Fink, 1998) provided one of the most in-depth looks into prevalence and relationships of personal history of abuse broken down by type and intensity of childhood maltreatment (sexual abuse, physical abuse, physical neglect,
emotional abuse, and emotional neglect). The TSIBS-R-L (Pearlman, 2003) has multiple subscales which cover five psychological needs found by the scale developers to be particularly vulnerable to disruption by trauma. The TSIBS-R-L (Pearlman, 2003) has been relatively well researched, and moderate to strong psychometric qualities have been demonstrated, including construct, concurrent, and discriminant validity, reliability, and internal consistency. Way et al. (2004) reported both the IES (Horowitz et al., 1979) and CTQ (Bernstein & Fink, 1998) have been found to have adequate psychometric qualities and demonstrated validity as well. Way et al. (2004) only analyzed the factor of having any maltreatment history and found no significant relationship between maltreatment history and either intrusion or avoidance symptoms with either category of clinician in the sample.

For those working with survivors, VanDeusen and Way (2006) found emotional neglect history was significantly associated with greater disruption in cognitions about trust and intimacy with others, and histories of any and multiple forms of maltreatment were associated with disruption in intimacy with others. For those clinicians who worked with offenders, the following types of maltreatment history were significantly associated with higher levels of disruption in both trust and intimacy: any maltreatment, multiple maltreatment, physical abuse, neglect, and emotional neglect. Emotional abuse was only significantly associated with greater disruption in cognitions about intimacy with others. History of sexual abuse was not found significant for either group or either disruption type in this study. Way et al. (2007) found history of emotional neglect predicted greater levels of disruption in self-intimacy.
These three studies have many strengths, including well documented measures for all but one variable (coping strategies); appropriate statistical tests for analysis; a large, national sample pool; and clear, detailed reporting of the research procedures, including weaknesses. Two major weaknesses affected all three studies (in addition to the common weaknesses of cross-sectional, self-report research). First, the response rate was low at 23%. Second, these researchers decided to increase the chance of Type I errors and kept their significance error rate at 0.05 rather than risk not finding a predicting variable. If all three studies are combined, the number of analyses done on this data set was quite large. These last two weaknesses decrease the overall statistical validity of the research. All findings should be viewed as exploratory and in need of further research.

Follette et al. (2004) found mental health professionals who reported being abused as children did not differ from their nonabused colleagues on the following measures: the percentage of their current caseload reporting an abuse history, the percentage of their clients actively working on sexual abuse issues, and the number of negative responses to child sexual abuse survivors. Furthermore, therapists with their own history of abuse reported using significantly more positive coping behaviors to deal with sexual abuse cases than did nonabused therapists. Law enforcement officers who reported a history of childhood abuse reported significantly higher proportions of their caseloads involving child sexual abuse investigation, and greater use of both negative and positive coping strategies than their nonabused counterparts. Negative clinical or investigative response to sexual abuse cases was defined as total number of the following behaviors: inattentiveness or dissociation during clinical or investigative work, lack of empathy, and feelings of guilt related to one’s limitations as a professional. No differences were found
between abused and nonabused officers in the number of reported negative responses to investigating sexual abuse cases (Follette et al., 1994).

Based on all these findings, as well as Collins and Long’s (2003) literature review, we could conclude that when workers have explored and worked through their own trauma histories, they might be approaching work with trauma survivors less naively, and might bring stronger coping skills for handling the impacts. Thus, understanding how far a worker is in their own recovery is important when assessing for vulnerability to impacts of vicarious trauma (Collins & Long, 2003).

**Personal loss and personal stress.** Personal stress and trauma symptoms were found to have a significant positive correlation by Follette et al. (1994) in both mental health professionals and law enforcement. It is hard to parse out the direction of causation with personal stress, since it could be an impact from vicarious trauma. Personal loss, though, cannot be viewed as being caused by vicarious trauma, and was found by Bonach and Heckert (2012) to be the most predictive variable of higher levels of STS among Children’s Advocacy Center forensic interviewers. These researchers asked 257 participants whether or not they had suffered a significant loss in the previous year as a control variable (the researchers did not define loss for the participants). Forensic interviewers who had suffered one or more significant losses in the last year were predicted to have six points higher on the STSS than those who did not. Although this variable will not be measured in this evaluation, this research could be very useful for supervisors and team members in supporting workers with recent loss. What organizations can do to support their staff will be expanded upon later in this literature
review; however, Bonach and Heckert made several key recommendations worth mentioning now.

Bonach and Heckert (2012) suggested supervisors validate and educate forensic interviewers throughout the process of hiring and training about the difficult aspects of the work, as well as positive coping strategies. They recommended that in addition to debriefings, support training, and peer support, that supervisors and agency administrators become trained in how to prevent STS. Bonach and Heckert’s study supported organizations providing adequate supervision, continuing education, consultation, staffing, insurance for personal counseling, paid vacations, and limiting caseloads. These authors emphasized the organization’s role in preventing and addressing STS rather than placing the burden of self-care on the individual (Bonach & Heckert, 2012).

**Demographic factors.** This section briefly covers the factors age, experience, gender, and level of education. In 2004, Bride found the majority of studies reviewed had found no relationship between age or experience and STS/VT. When a relationship was found, it trends toward an inverse relationship with younger and less experienced workers having higher levels of symptoms (Bell, Kulkarni, & Dalton, 2003; Bride, 2004; McLean, Wade, & Encel, 2003; Way et al., 2004). This relationship could be because those who are more vulnerable to higher levels of vicarious trauma leave the profession, and/or those practitioners who remain in the field learn coping skills that help to decrease trauma symptoms. However, more experienced practitioners have also been found to have more severe VT/ST symptoms (Baird & Jenkins, 2003).
Gender also seems to have little to no relationship with severity of symptoms (Bride, 2004; McLean et al., 2003; Way et al., 2007). Bride again found in his literature review that the majority of studies found no relationship, though two studies in his review found more severe symptoms in women, and two studies have found male and female participants articulated or endorsed different forms of impact. McLean et al. found no gender differences between any of the subscales, or the means of two out of the three dependent variable measurements they used (one for burnout, an early version of the TABS, and an intrusion and avoidance symptom scale). Only the mean of the scale measuring intrusion and avoidance showed a difference, with men scoring an average of 3.5 points lower than women’s scores. On the other hand, Way et al. found male gender predicted greater disrupted cognitions about self-intimacy and self-esteem.

The general trend in the research suggests less education might be associated with higher symptoms; however, this relationship is not a strong one. Nelson-Gardell and Harris (2003) failed to find a relationship, though they acknowledged their sample had a small range of level of education and thus may not have had the statistical size needed to find an actual relationship. Other researchers have found higher levels of education associated with lower levels of symptoms or distress (Baird & Jenkins, 2003; Townsend & Campbell, 2009). However, this could reflect a self-selected sample, in that only those who are either less vulnerable to vicarious trauma or have learned successful coping strategies will stay and become further educated in professions with high levels of vicarious trauma exposure.

Baird and Jenkins (2003) also looked at the differences between paid staff and volunteers. They found no differences between these two groups for trauma symptoms or
general distress; however, paid staff had significantly higher levels of emotional exhaustion, depersonalization, and positive accomplishment subscale scores, though the total score for burnout was not significantly different. Only emotional exhaustion was significantly higher in paid staff when other factors were controlled (such as education level and client exposure). Ghahramanlou and Brodbeck (2000) also failed to find an association between type of client contact (such as emergency/crisis work or individual therapy) and level of distress.

**Empathy and emotional distance.** Professionals’ ability to bond with and understand other people’s suffering has been linked to resilience, professional satisfaction, as well as vulnerability to burnout and VT/STS (Figley, 1995, 2002; Harrison & Westwood, 2009). Figley (1995) posited empathy could be a conduit for the transmission of trauma from the traumatized individual to the helping professional. Although this idea of “transmission” is theoretical and difficult to study, there does seem to be a strong, though complicated relationship between levels and types of empathy and the impacts – both negative and positive – of working with traumatized individuals on helping professionals.

Davis (1980) argued for an integrated, multidimensional approach to the definition and study of empathy. Through his development of a new empathy scale, Davis found items consistently loaded on four factors, which he termed fantasy, perspective-taking, empathic concern, and personal distress. Fantasy and perspective-taking are both related to the cognitive aspects of understanding and relating to others’ experiences, either in fantasy or in real-life. Empathic concern is the other-oriented warmth and compassionate feelings one might have toward those having trouble, and
personal distress describes the self-oriented anxiety and discomfort one might have in emotionally laden interpersonal settings (Davis, 1980, 1983). These four factors have become the four subscales of the final 28-item, self-report Interpersonal Reactivity Index (IRI). Each subscale has seven items. The IRI has been used in multiple studies relating empathy to compassion fatigue, professional satisfaction, and vicarious trauma, thus some description is warranted. Davis (1980) reported finding acceptable internal consistency with alphas ranging from .71 to .77 and test-retest reliabilities ranging from .62 to .71. Davis (1983) has also found expected results when comparing the IRI to similar or related measures providing further construct validity. The four subscales allow for these different dimensions of empathy to be studied as separate but related constructs.

In Deutsch and Madle’s (1975) review, they found most definitions of empathy included some form of self-other differentiation. However, most empathy scales, including the IRI, do not specifically address self-other differentiation. Additionally, although the empathic concern and personal distress scales are differentially oriented to self and other, one is intentionally measuring the positive emotions one might have in relation to others having trouble, while the other assesses the negative emotions one might have in response to a myriad of interpersonal situations, including emergencies and others having difficult emotions. These two constructs do not capture emotional separation as one could feel warmth or anxiety with low or high emotional separation.

Corcoran (1982, 1983, 1989) explored the self-other differentiation quality of empathy through several studies while developing an emotional separation measure, the Maintenance of Emotional Separation (MES). Self-other differentiation was defined by Corcoran (1983) as asserting a separation in the emotional experiences of the client and
therapist. The MES is a seven item unidimensional measure with acceptable construct validity, including internal validity with an alpha of .71 and factor loadings of > .35 from the original 16 items, and discriminant validity with no correlation with social desirability items. Low scores indicate a loss of emotional separation.

Interestingly, Corcoran (1982) found a curvilinear relationship between empathy, as measured with the Empathic Tendency (ET) scale (Mehrabian & Epstein, 1972), and emotional separation. Davis (1980) argued the ET was imprecise in that it combined cognitive and affective qualities of empathy, even though it was intended to measure only emotional empathy; however, as a measure of an overarching empathy construct it showed moderate to strong internal reliability, and discriminant and predictive qualities (Mehrabian & Epstein, 1972). Corcoran (1982) pointed out this instrument is not concerned with self-other differentiation, in that 10 items on the face seemed to tap into the loss of separation between the respondent and another. Corcoran (1982) used these 10 items to test construct validity of the MES with a negative correlation predicted and found. Additional testing was done on the ET scores minus those 10 items to explore further the relationship between empathy and emotional distance.

The curvilinear relationship Corcoran (1982) found between empathy and emotional separation showed that as people increased in empathy they were less able to maintain emotional separation (see Figure 2). Further study has consistently shown loss of emotional separation to be moderately to strongly correlated with higher symptoms of burnout (Corcoran, 1989; Thomas, 2011), compassion fatigue (Thomas, 2011), and STS (Badger, Royse, & Craig, 2008). All three of these studies found emotional separation to have a stronger correlation with higher levels of impacts than empathy alone. Thomas
(2011) found the personal distress dimension of empathy also correlated with compassion fatigue. Although the personal distress scale of the IRI does not specifically address emotional separation, of the four IRI scales personal distress had the most overlap with the MES (Thomas, 2011).

![Figure 2. Curvilinear relationship between emotional separation and empathy. MES = Maintenance of Emotional Separation. Copyright © 1982 by the American Psychological Association. Reproduced with permission. The official citation that should be used in referencing this material is: Corcoran, K. (1982). An exploratory investigation into self-other differentiation: Empirical evidence for a monistic perspective on empathy. *Psychotherapy: Theory, Research, and Practice, 19*(1), 63–68. The use of APA information does not imply endorsement by APA.]

The picture emerging from these studies is one of balance. It is well known that empathic responses from professionals are a cornerstone of building trust and rapport with those we serve. However, when empathic responses become very high, people often begin to lose emotional separation. This loss of emotional separation seems to be more problematic than the empathic responses. Thus, tools to increase or maintain emotional separation and perspective could allow professionals to feel and show higher levels of empathy with less risk to themselves. Thomas (2011) found both mindfulness and emotional separation to be correlated with both lower levels of compassion fatigue and
with higher levels of compassion satisfaction, as measured by the ProQOL (Stamm, 2003). Compassion satisfaction was defined as the pleasure one derives from being able to do one’s work (http://www.proqol.org). Thomas defined mindfulness as focusing in a nonjudgmental or accepting way one’s attention on the experience occurring in the present moment, and used the 5-Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Kriete, & Toney, 2006). Mindfulness and emotional separation appeared to be related but different concepts in Thomas’s regression analysis. A weaker but significant positive relationship was found between empathic concern and compassion satisfaction. A significant negative relationship was found for personal distress and compassion satisfaction, with higher personal distress predicting lower compassion satisfaction. Interestingly, Thomas found a possibly moderating effect of the variables mindfulness and emotional separation on empathic concern and compassion satisfaction. Empathic concern became significant only after mindfulness and emotional separation were added in a hierarchical regression (Thomas, 2011).

Iliffe and Steed (2000) interviewed 18 counselors working with victims and perpetrators of domestic violence (DV) in Australia. They found themes that support this emerging view of empathy being protective, as long as adequate boundaries and emotional separation is present. As an example, one theme found was ‘taking on too much responsibility’, especially for clients’ safety and particularly early in the counselors’ careers. Clinicians discussed having to find a balance by not becoming too involved in their clients’ experiences while remaining connected to their clients in session.
Harrison and Westwood (2009) qualitatively researched vicarious trauma prevention. They interviewed six Master’s or doctoral level therapists with at least ten years professional experience. These therapists self-identified as having managed well in this work, and had scored below average on the burnout and compassion fatigue subscales of the Pro-QOL R-III (Stamm, 2003). Harrison and Westwood found nine major themes in and across the participants interviews:

- countering isolation (in professional, personal and spiritual realms)
- developing mindful self-awareness
- consciously expanding perspective to embrace complexity
- active optimism
- holistic self-care
- maintaining clear boundaries and honoring limits
- exquisite empathy
- professional satisfaction
- creating meaning

Harrison and Westwood (2009) came to regard these themes as integrally interrelated as a fractal, with the overall pattern occurring in each part. Mindfulness awareness (the practice of attending to minute, ongoing shifts in mind, body, and the surrounding world) integrated into daily life was found to help these therapists to be able to access and engage in the other protective practices described in the other themes. These clinicians maintain clear and consistent boundaries and limits. They all acknowledge their vulnerability to VT, and they maintain clarity about the limits of their sphere of influence. The participants hold realistic expectations of self, other, and the
world, and do not confuse the ideal with reality. One participant described self-other differentiation. He described that although he is often deeply touched by clients’ stories, “It’s still their story. It’s not my story. [It] doesn’t get painted on my wall, you know. It passes through. I don’t lose myself in it. I don’t have to. I can care [but] I’m not in [the trauma story]. I didn’t have that thing happen to me” (Harrison & Westwood, 2009, p. 212). Most of the clinicians also described how intimate, empathic work with clients sustains them, as long as they maintain clarity about interpersonal boundaries. Harrison and Westwood termed this experience exquisite empathy:

[Exquisite empathy] requires a sophisticated balance on the part of the clinician as s/he simultaneously maintains clear and consistent boundaries, expanded perspective, and highly present, intimate, and heartfelt interpersonal connection in the therapeutic relationship with clients, without fusing, or losing sight of the clinician’s own perspective. (Harrison & Westwood, 2009, p. 214)

The authors go on to report efforts to avoid or resist the intensity of the client’s stories are often counterproductive. Exquisite empathy may be a way for clinicians to meet the needs of their clients without having to sacrifice their own. Both clinician and client may ethically benefit from the clinician’s clear boundaries and caring attunement to the client (Harrison & Westwood, 2009).

**Social support.** Researchers have studied both personal and organizational forms of support and how they contribute to vicarious trauma. A positive relationship has consistently been found between social support and well-being (Chronister, Chou, Frain, & Cardoso, 2008; Chu, Saucier, & Hafner, 2010). Whereas a small to moderate negative relationship has been consistently found between symptoms of trauma and social support, with those reporting higher levels of perceived social support also reporting lower levels of symptoms, with this relationship strengthening over time (Ozer et al., 2003). The
same inverse association has been found for the relationship between vicarious trauma symptoms and social support both internal and external to the job place for forensic interviewers (Bonach & Heckert, 2012), therapists and law enforcement professionals (Follette et al., 1994), child protective services workers (Bride et al., 2007), social workers assisting survivors of domestic violence or sexual assault (Choi, 2011), and sexual assault nurse examiners (Townsend & Campbell, 2009). Although a causal relationship has not been established, social support is clearly an important factor in helping people mitigate VT/ST and generally increase their well-being.

**Organizational characteristics and culture.** Although much of the research studying vicarious trauma has focused on individual characteristics, the following section reviews empirical and theoretical scholarship exploring relationships between aspects of organizations and VT/STS symptoms of the workers. Because burnout is a construct specifically related to work, much more research is focused on the relationship between workplace characteristics and burnout. However, burnout is peripherally related to the question of study. Thus, this section focuses on research particular to trauma workers or VT/STS. Some studies look at burnout alongside VT/STS; in those cases findings regarding burnout will be discussed as well.

Individual organizational characteristics are numerous, diverse, complicated, and sometimes vague in nature. Often studies look at many organizational factors simultaneously. These characteristics will not be explored individually here, but rather the studies found to have most relevance to MCJAC and the question of study will be described and integrated throughout the following sections.
Organizational structure and culture. Pross and Schweitzer’s (2010) comparative qualitative study of international organizations working with survivors of extreme trauma shed light on how formal and informal structures in organizations might contribute to worker stress and conflict. Although this article did not study vicarious trauma in particular, the authors noted many of the participants described symptoms and experiences which mirrored those described in the literature as VT. For this grounded theory study, Pross and Schweitzer (2010) interviewed 72 caregivers, supervisors, and experts from 13 institutions. Fifty-seven of the participants were from Western institutions and 15 were from non-Western countries transitioning from dictatorship to democracy. Further data were collected and analyzed from existing organizational documentation, such as annual reports, publications, charts, external organizational evaluations and capacity assessments, and through observations (the authors did not specify how many clinics were observed, or even whether these observations happened at the clinics in the study).

The authors found organizations that show a high level of stress and conflict also showed significant structural deficiencies. Using models of group development as a framework, Pross and Schweitzer (2010) proposed that when organizations move past the early “honeymoon” phase, they face serious challenges. Tuckman’s (1965) storming stage is characterized by conflict and polarization around interpersonal issues. According to Pross and Schweitzer (2010), how an organization navigates this phase will predict whether its workers remain in conflict and stress or move into a stable, predictable structure, which was found to produce less stress and conflict. Key conditions were described for the successful functioning of an organization. These included a board that
has independence from staff and leadership, which allowed decisions to hold; a leadership that has clearly entitled authority (the style can be more authoritarian or more democratic, as long as the leadership is clearly defined); and a staff that has clear definition of role, authority, responsibility, and accountability. When these conditions were not met, stress and conflict levels rose within the organizations. Other characteristics found in organizations with low stress and conflict included clearly articulated strategic concept and long-term planning, shared treatment philosophy and therapeutic concept, strong supervision and consultation, well-maintained boundaries with clients and within the organization, a balance of empathy and professional distance, encouragement and opportunity for staff to get ongoing and extensive professional training and for leadership to have coaching, and support and encouragement for protective self-care strategies (Pross & Schweitzer, 2010).

Pross and Schweitzer (2010) described organizations with high levels of stress and conflict as being in a permanent storming phase. Without the transformation to stable functioning, power struggles created divisive cliques or camps with informal leaders vying for position. This authority vacuum created unclear roles, boundaries, responsibilities, and accountability often in all levels in the organization. Pross and Schweitzer found a bonding pattern among workers in the trauma field was the belief in equality and consensus decision-making. Pross and Schweitzer posited that this decision-making style may work for organizations in the small, pioneer, honeymoon phase. However, in their study, they found this style of decision-making became dysfunctional when the organization grew and became more diverse in task, aim, and human capital. Although Pross and Schweitzer framed this issue as a style of decision-making that
cannot work on a particular scale, it could be that just as clinicians and leaders within dysfunctional organizations were found to lack training and competence for other necessary tasks, the capacity held by staff and leaders for consensus-building was too low for it to work beyond small groups. More research is needed into whether consensus-building training for staff and leadership would help organizations meet their egalitarian goals as they grow and make the transformation into stable, functioning structures.

Within the organizations Pross and Schweitzer (2010) studied, these egalitarian ideals were often coupled with a lack of clarity of role, responsibility, and accountability with chaotic results. Either decisions were not made and problems postponed, or they were made by informal leaders and could be changed at any time. Pross and Schweitzer found trauma dynamics were often recreated within staff dynamics creating a shaming, hostile atmosphere filled with suspicion and mistrust. Supervision and consultation occurred rarely, if at all. Overidentification with clients, and caregiver isolation also characterized these organizations. Boundaries were crossed regularly, with caregivers overworking and providing extra services for clients within a culture of caregivers as martyrs who self-sacrifice. When handled properly, Pross and Schweitzer point out trauma enactments among caregivers working with trauma can often give clinicians more understanding of the client’s problem. Thus, they suggest caregivers and organizations must tolerate partial enactment while simultaneously maintaining reflective thought, giving room for the interaction to be explored, such as in supervision or consultation. Pross and Schweitzer also observed symptoms similar to VT and STS almost disappeared when organizations were functioning well structurally and culturally. They suggested that, due to this observed relationship, the concepts of VT, STS, and compassion fatigue
should be reconsidered. However, when mild to moderate depression is successfully treated through changes in diet and exercise, and/or psychotherapy, the concept of depression does not need to be reconsidered. Rather, Pross and Schweitzer’s important study pointed to valuable treatment and prevention of vicarious trauma at the level of organizational structure and function.

Support does exist for Pross and Schweitzer’s (2010) suggestion that organizational factors may cause more stress than exposure to trauma. Hart, Wearing, and Headey (1995) found organizational factors were more important to police well-being than operational factors in their study of hassles and uplifts for police. (Hassles and uplifts were the terms these authors used to describe the negative and positive impacts of police work). Experiences such as being exposed to danger or dealing with victims, which were often believed to be the source of serious police distress actually made the least contribution to police hassles. Similarly, assisting victims and successfully dealing with offenders made the least contribution to police uplifts. The findings of Hart et al. suggested the organizational context had more impact on police officers’ responses to their work. This study was not looking directly at VT/STS and thus might not have captured the more extreme negative responses that can happen in response to trauma exposure. However, the larger point of both articles is important, as it indicates organizational factors might be as critical, if not more so, in how service providers respond to exposure to trauma.

Empowerment. Dr. Donohue, the director of Monarch Children’s Justice and Advocacy, reported following a feminist model of empowerment as supervisor and director of MCJAC and as the facilitator of the MDT (see Appendix C). This is
consistent with Spreitzer’s (1995a, 1995b, 1996) studies developing and validating a theoretical model of intrapersonal empowerment within the workplace. The four dimensions of this model of psychological empowerment are a sense of meaning, competence, self-determination, and having impact. Spreitzer (1995a) suggested multiple organizational characteristics that create an environment conducive to workers having a sense of empowerment. These characteristics included role ambiguity (inverse relationship expected), access to information and resources, sociopolitical support, and organizational culture. The model predicts that when the environment contains adequate support, access, and role clarity within an atmosphere of valuing the people working in the organization, workers are better able to perceive themselves as competent, self-determined people doing work that is meaningful and has impact. These perceptions of empowerment then mediate innovation and effectiveness outcomes. The complicated relationships between the many constructs within the theory were partially supported by Spreitzer’s (1995a) study with participants working in middle management in a Fortune 50 company.

Although Spreitzer’s (1995a) theory drew from multiple disciplines, the study and emphasis was on corporate management. Thus, this study is peripherally relevant to the current program evaluation, in that it provides a framework for evaluating whether Dr. Donohue’s intentions of empowerment are being perceived by the staff, volunteers, and MDT members. Spreitzer (1995b) found support for reliability, and convergent and discriminant validity for the four dimensions and an overall gestalt of the experience of empowerment in the work-place. Also, although Spreitzer’s (1995b) model described a relationship with outcomes (increased innovation and effectiveness) that most would
argue are positive, it could also be argued that workers feeling valued and competent while doing meaningful and impactful work are valuable outcomes in and of themselves. Spreitzer (1995a) found role ambiguity and empowerment to have a significant inverse relationship as expected. Sufficient strategic information was found to be significantly correlated with empowerment. Spreitzer (1995b) also found a construct combining access to information and resources together with sociopolitical support to be highly correlated with empowerment, more than for any of the three constructs separately. Spreitzer (1995a, 1996) pointed out all the organizational antecedents are mutually reinforcing elements.

Choi (2011) studied the relationship between the organizational characteristics Spreitzer (1995a) identified as organizational antecedents for empowerment and secondary traumatic stress. The participants in Choi’s study were 154 social workers, who provided direct services to family violence or sexual assault survivors on a regular basis within an organization-setting. Participants took Spreitzer’s (1995a) Social Structural Scale with items capturing sociopolitical support, access to strategic information, access to resources, and organizational culture. Choi also used the STSS and a work conditions and demographics survey developed for that study. A major weakness of this study was the small response rate (29%), which might have skewed results. The study’s strengths included a simple design and established measures. Using a multivariate regression model, Choi found social workers who had more sociopolitical support and more access to strategic information experienced significantly lower levels of STS. “Sociopolitical support is defined as endorsement, approval, and legitimacy from various organizational constituencies” (Spreitzer, 1995a, p. 608). Sociopolitical support
was thought by Spreitzer (1995a) to encourage a sense of task interdependence, which would then enhance a sense of personal power. Access to strategic information was described by Spreitzer (1995a) as making more information available throughout the levels of an organization. Spreitzer (1995a), coming from the corporate management field, included types of information that may or may not be relevant to a small non-profit agency; however, data about work flow and overall strategies for achieving mission could be relevant for workers in this setting, and could potentially increase motivation or clarity of role if well understood by people in all levels.

**Organizational characteristics.** Townsend and Campbell (2009) studied the relationships between organizational variables and STS and burnout among sexual assault nurse examiners (SANEs). A sampling frame was created by searching for SANE programs serving adult survivors of sexual assault across the United States of America. Out of 288 programs identified, 144 programs were randomly selected. A total of 110 programs participated (89% response rate). Data was then collected at each program from the SANE nurse with the most experience (as defined by the number of years doing SANE work). For the majority of programs, the most experienced SANE practitioner was the director of the program. Data was collected through phone interview with answers recorded by hand and coded in real time. A path analysis tested the relationship between organizational, demographic, and outcome variables. The 11 organizational variables measured in this study were case load, role ambiguity, goal diffusion, prosecution orientation, facilities, compensation structure, continuing training, interagency team, compensation satisfaction, peer support, and organizational support. The interview protocol was developed through a four-step process, which included
reviews of current literature and guides, previous surveys, and a review by five SANE nurses. It was unclear whether the interview protocol used for this study was based on open-ended questions, which were then coded based on previously developed Likert-scaled items and dichotomous codes or if the participants were actually asked to rate items directly.

Townsend and Campbell (2009) found higher levels of STS were predicted by greater prosecution orientation, higher caseloads, more diffuse goals, more organizational support, and more continuing training. Lower levels of STS were predicted by more education, more SANE-only facilities, older age, higher compensation (salary) satisfaction, and greater peer support. Higher levels of burnout were predicted by greater prosecution orientation, whereas lower levels were predicted by higher compensation satisfaction, more education, greater peer support, and older age. The variables that were not significant for either outcome included ‘compensation structure,’ ‘role ambiguity,’ ‘interagency teamwork,’ and ‘experience as a SANE nurse.’

Townsend and Campbell (2009) took significant steps to ensure the validity of this study, including training provided to interviewers, weekly discussions to increase intercoder reliability, creating a national sampling frame with random selection, reviewing various external sources for the interview protocol development, and having five SANE experts assess the protocol for relevancy and understandability. However, the constructs themselves, although relevant and understandable, often captured the most general level, and at times did not have construct validity. An example of a very general construct is organizational support, which was scored as the mean of two items (“I have enough organizational support” and “My supervisors show me that they appreciate the
work I do.”) with a five-point Likert-scale of agreement. As is described by Spreitzer (1995a), organizational support can include many levels and types of support. An example of unclear construct measurement was goal diffusion. Goal diffusion was the sum of scores pertaining to how important six goals were to the program on a four-point Likert scale (prosecution, high quality medical care, attending to survivors’ emotional needs, supporting feminist ideas and values, empowering victims/survivors, and changing how the community responds to rape survivors). The higher the summed score, the more goal diffusion. On the surface, this seems an innovative way to operationalize goal diffusion; however, many of the goals listed could be met by SANE nurses using the same action. For example, nurses carefully respecting the patients’ self-determination could meet four of the six goals listed above. Even with that confusion, the researchers did find high goal diffusion to predict STS symptoms. It would be interesting to have a more specific understanding of the inter-relationships between each individual goal and between each goal and STS in future research.

Townsend and Campbell’s (2009) study is important in that it addressed organizational correlates related to STS and burnout when not many were focusing on what organizations could be doing to prevent and treat VT in staff. The study had strong methods in many ways; however, the construct validity was somewhat weak – not in relevance, but in how they operationalized the constructs. Therefore, results should be viewed as tentative or suggestive and as pointing toward areas for future research into organizational factors related to VT/STS. It identified areas of interest and relevance to SANE nurses, and possibly others providing services to sexual assault survivors. The study provided exploratory data regarding those areas of interest. Although the item
construction seemed weak at times, the research design was innovative, rigorous, and careful in other ways.

**Organizational prevention.** Based on an extensive literature review, Bell et al. (2003) made recommendations for organizational actions that could prevent and support staff with burnout, vicarious trauma, and secondary traumatic stress. Bell et al. suggested organizations can set the tone, atmosphere, and expectations around how staff experience and handle exposure to trauma. Organizational leaders, together with staff, can create a culture that normalizes impacts and encourages staff to take care of themselves. These suggestions go against some often deeply ingrained attitudes toward work in the helping professions – commitment and dedication are often shown by working overtime, not taking vacations or leave, etc. Thus, supportive organizations not only allow leave, they encourage it by monitoring and suggesting leave when too much vacation time has accrued, for example.

Bell et al. (2003) also suggested agencies collaborate with other service providers in the community, as connection with others can decrease isolation, better serves clients, and potentially decreases the workload for any one provider. Safe, comfortable, and private workspaces are crucial for trauma-workers. For agencies in high-risk, violent areas, employing a security guard or a co-worker buddy system can increase basic safety for staff. In addition to basic safety, agencies can model creating an inspirational, meaningful environment by putting up art and posters, creating a break room separate from clients with self-care items such as comfortable furniture, soft music, coffee and tea maker. Organizations have a duty to inform workers during hiring and training, as well as
provide opportunities and encouragement for trauma-specific training and education (Bell et al., 2003).

Peer/group support has been overwhelmingly established in the research as helpful in the treatment and prevention of VT/STS, thus Bell et al. (2003) suggested encouraging informal debriefing if needed, critical incident debriefing, team-building activities, and staff retreats. One example given in the article was a shelter where the workers started a reading group focused on Pearlman and Saakvitne’s (1995a) book, *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. However, group support meetings can also provide further exposure to traumatic material, as well as opportunities for role ambiguity and enactments of trauma dynamics, which could increase stress. Bell et al. suggested groups discuss these possibilities openly and come up with ways to limit exposure while maintaining support for the team members. Supervision can also provide an opportunity for processing difficult cases and responses, as well as time for psychoeducation and training about vicarious trauma for staff; however, Bell et al. recommended supervision be separated from evaluation, if possible, in order to decrease the possibility of a worker not sharing a difficulty due to fear of negative evaluation. These authors also recommended organizations provide health insurance that includes mental health coverage, as well as resources and structural opportunities for self-care (Bell et al., 2003).

Maltzman (2011) described an applied project in which a model of organizational self-care was implemented in 2006 in the second largest county child welfare services system in the state, and included roughly 800 staff, including protective services workers, interns, their direct supervisors, and adjunctive administrative staff. The purpose of the
self-care model was to provide psychoeducation to direct service and support personnel and direct support at the individual and unit levels after critical incidents. The goals were to prevent and mitigate ST and VT by providing proactive support and acute symptom relief. Long-term goals were to promote staff well-being and maintain successful organizational functioning (Maltzman, 2011).

An example of organizational culture affecting the responses to traumatic material was a common theme expressed by staff when the self-care model was introduce. Staff believed they were expected to be unfeeling and nonreactive when traumatic events occurred and any expression of anxiety, sadness, or horror was perceived as a sign of weakness (Maltzman, 2011). Staff in this organization were observed to have the common perception that overwork and self-deprivation were normal and honorable. Staff worried colleagues would view them negatively if they were unwilling to sacrifice (Maltzman, 2011). As described above, Bell et al. (2003) suggested these attitudes and fears are common in social services workplaces.

The self-care model Maltzman (2011) described was based on six assumptions. These assumptions were based on literature and organizational constraints. The six assumptions are:

- Staff are competent, psychologically healthy, and able to perform job functions satisfactorily.
- The experience of ST or VT is an inherent risk in the workplace.
- Experiencing ST or VT is not the “fault” of the individual staff person.
- The self-care model must be organizationally supported, from top management on down, to be successful.
- The self-care model must be built into the organizational structure to be successful.
- The self-care model has two primary goals: supporting staff and supporting the continuity of organizational functioning. These goals are inherently congruent and compatible. (Maltzman, 2011, pp. 308–309)
Implementing this self-care model required changes in practice, policy, and culture at the organization. Maltzman (2011) described the self-care model carefully and in enough detail to be utilized and tailored to other situations. Practical suggestions will be drawn from this article for the recommendation section of this program evaluation.

In conclusion, research into VT/STS has primarily focused on individual characteristics; however, in recent years more information has become available giving guidance and suggestions for organizations to prevent and treat VT/STS in staff. Understanding individual correlates can be important for supervision and peer consultation; however, the burden of care can be viewed from a systems perspective that includes an organizational responsibility, as well as an individual’s responsibility for self-care. The research described in this chapter has been used to develop the MCJAC Questionnaire, as well as provide best practices recommendations. The following chapter provides more detail on the MCJAC Questionnaire development and the methods used for gathering data for this program evaluation.
Chapter III: Method

The method used for this study was program evaluation (PE). According to Fitzpatrick et al. (2011), PE utilizes the same systematic quantitative and qualitative methods used for research. Evaluators often use mixed methods as well as tools specific to PE, such as logic models and review of existing source documentation (Fitzpatrick et al., 2011; Renger, 2011). However, PE differs from traditional research in a few key ways. Although traditional researchers often provide some conclusions based on data analysis, these conclusions are limited and judgments or decisions regarding the subject of study are not expected and are rarely given. Whereas, the purpose of PE is to make a judgment (Fitzpatrick et al., 2011). PE can be a collaborative process between the evaluator and the people implementing the program or intervention being studied. Greater utilization often occurs when stakeholders are included at every stage of the evaluation. At times, the evaluation question is developed by the funders in order to deem a program effective, efficient, or functioning well in some specific capacity. Sometimes an organization wants better to understand a difficulty internally, or to clarify their philosophy or goals. PE can also have process benefits, often related to the collaborative nature of gathering input and data. Examples of benefits arising from the evaluative process include strengthened dedication to missions and goals created by the act of thinking out clear goals together, or increased morale and coworker appreciation born from learning more about what others are doing in the organization (Fitzpatrick et al., 2011).

This study evaluated an informal set of interventions at Monarch Children’s Justice and Advocacy Center (MCJAC). MCJAC is a small, complex organization with
multiple funding sources. MCJAC functions somewhat autonomously within an umbrella organization, the Community Action Council, which has financial and policy oversight. The stakeholders included clients and their families; management staff; service providers, who were further categorized by contract and professional status and roles; funders and accrediting organizations; multidisciplinary team members (i.e., professionals from organizations and agencies who are in collaborative relationships with MCJAC); staff in other programs within Community Action Council; board members; organizations that are providing services to the same population; organizations that are in direct competition for funds; and other community members. As was explained above, the decision-making process for this program evaluation was limited, by necessity, to collaboration with the program director, Dr. Donohue. Existing organizational documentation was reviewed and incorporated into the summary of current practices and policies (please see Appendix C). Data was gathered at team meetings and in interviews with staff, including employees, volunteers, interns, and contract workers; and from MDT members, a group that often includes law enforcement personnel, child protection workers, victim advocates, medical professionals, and prosecutors. A full report will be given to MCJAC after this dissertation is approved by committee. Two summary reports including initial results were presented at two stakeholder meetings during regularly scheduled clinic and MDT meetings. Suggestions made by stakeholders at those meetings were incorporated in the recommendations.

Logic Models

Logic models are often used in PE for visual representation of the theory of the program or intervention. They are used to clarify causal relationships, program
Rogers (2008) outlined the limitations of using linear logic models for complicated and complex programs and interventions. She differentiated between complicated (multiple components) and complex (emergent) program constructs with different structure, purpose, and evaluation needs. Rogers summarized the literature and practical application of nonlinear use of logic models and program theory.

Complicated and complex programs and interventions often require a qualitative or mixed method approach, relying on interviews and focus groups to establish deeper understanding and meaning rather than well-defined and narrow outcomes. Many programs have aspects or interventions that are relatively simple and causal in nature, as well as complicated relationships and emergent processes (Fitzpatrick et al., 2011; Patton, 2011; Rogers, 2008).

MCJAC’s interventions and programs can be described as simple, complicated, and complex. Aspects of MCJAC’s interventions can be defined in simple terms, easily conforming to single causal strands (e.g., number of families served in a month through advocacy, therapy, and forensic interviewing activities); whereas, some aspects can be defined as complicated, or involving multiple agencies or multiple causal strands (e.g., the complicated organizational hierarchy of Community Action Council involving multiple programs with very divergent, though often complementary goals). Yet other aspects are more emergent, or complex (e.g., the MDT process of staffing cases, which can develop creative or innovative responses to complex family situations involving multiple service providers and/or legal paths). Rogers (2008) included several suggestions for developing logic models for interventions which address complicated and complex aspects: differentiating between causal theory and implementation theory;
creating a very broad and general logic model which allows sufficient room for changing particulars; using network theory to represent hierarchical relationships between organizations and between projects and overall program goals; and rather than represent a causal model, articulate the common principles or rules that will be used to guide emergent and responsive strategy and action (Rogers, 2008).

This program evaluation attempted to provide information and interpretation with all three levels of program construct in mind. Appendix A provides simple strand organizational information regarding number of clients served, as well as organizational charts illustrating the complicated relationships within the Community Action Council and the Children’s Advocacy Center. Appendix B Table B1 contains the formative logic model developed to describe MCJAC’s activities and outcomes. This logic model uses broad terms to allow change in particulars, encompasses the Child Advocacy Center partners’ activities as well as MCJAC’s programs’, and articulates common goals. The second logic model in Appendix B Table B2 is based on the question of study, and is meant to illustrate the complex relationships between addressing and caring for vicarious trauma, workers and MDT members maintaining manageable levels of vicarious trauma, and their satisfaction, effectiveness, and overall functioning.

Another methodological consideration is time and scope. The project timeline did not allow a researcher to be embedded, for example, in the workings of the program for two or three years in order to complete a developmental evaluation (Patton, 2011). Although this is a method particularly recommended for complex interventions, it was beyond the scope of this project, and might not have been feasible for MCJAC. This PE was mixed method with quantitative and qualitative measures administered and
interviews conducted. The measures were a combination of established, published measures and questionnaires developed for this PE.

**Internal Versus External Evaluation**

The relationship of the evaluator to the object of evaluation is another area in which PE differs from research. Partly due to the costs of hiring external consultants, organizations will often either hire an internal evaluator or assign these evaluation tasks to an existing employee. Nonprofits, in particular, rely heavily on internal evaluators. An example of this is MCJAC implementing standardized evaluation tools for accreditation compliance, administered and analyzed by Dr. Donohue (Fitzpatrick et al., 2011).

There are risks and benefits to both internal and external evaluations. Considerations for using internal evaluators include a possible lack of training in either evaluation or research methods, and staff might be overworked and overwhelmed by adding tasks for an evaluation. Participants might be less likely to be honest in self-reports with an internal evaluator. These factors have implications for use, validity, accuracy, and credibility of evaluation reports. While external evaluators likely bring field and research expertise, they will not know or understand the specifics of the company or agency (Fitzpatrick et al., 2011).

Implementation of recommendations is a serious concern for evaluators (Fitzpatrick et al., 2011). Maltzman (2011) reported external agents or evaluators might be viewed with wariness when agencies have a closed culture. Some elements that might contribute to a closed culture are providing services that are often considered psychologically difficult (such as child welfare services) or that require confidentiality.
Internal evaluators might have greater trust built with the team implementing recommendations; however, external evaluators might be able to see elements of the workplace culture that could impede utilization.

Both internal and external evaluators bring biases to their studies (as in all research), though the biases tend to be of a different nature. For example, internal evaluators may have interpersonal relationships with the people who implement or manage the program. Often, which hierarchical tier the evaluator works influences issues of trust, credibility, and use of reports within the organization. Conflicts of interest can arise when an internal evaluator is directly impacted by the report (i.e., their program could lose funding). Both internal and external evaluators bring cultural and individual values to their research. These values will necessarily shape the focus, emphasis, and decisions made during the evaluation (American Evaluation Association [AEA], 2004; Fitzpatrick et al., 2011).

Ethical and professional guidelines (AEA, 2004) require evaluators to disclose roles and relationships they have that could pose a conflict of interest, and be explicit about their own, their clients’, and other stakeholders’ interests and values concerning the conduct and outcomes of an evaluation, as well as disclose all sources of financial support and the source of the request for an evaluation. Reporting should be impartial and communications should have adequate scope, and guard against biases, distortions, misconceptions, and errors. Evaluators are expected to maintain credibility in the evaluation context (AEA, 2004; Fitzpatrick et al., 2011)
The researcher’s disclosure of roles and relationships. I worked at MCJAC from September 2011 through September 2012 as a therapist while working on pre-internship clinical hours for licensure. I then sought MCJAC as a site at which to conduct my dissertation. In the last stages of dissertation, after presenting initial findings, I became an intern therapist at MCJAC again while working on a secondary internship for completing hours for licensure. Although I was not working for MCJAC throughout the program evaluation process, my relationship with MCJAC is closer to an internal evaluation than external. For instance, I have interpersonal relationships with some of the staff at MCJAC. I also care about the program and have personal values that support its mission and purpose. I had positive experiences with the staff and the clinical director, Tambra Donohue, Ph.D, who has been my primary contact at MCJAC, facilitating the evaluation process internally. Although many of the therapists with whom I worked during my year there have left, some have not. I have maintained personal friendships with several of them. Some of the pros to these relationships are an established familiarity, and trust of my skill in handling a study involving sensitive material. Another way in which I fit the internal evaluator is my lack of evaluation experience. I do bring the strength of a doctoral-level education in research and evaluation methods, including working with a team of students to conduct a program evaluation of a non-profit in the Seattle area.

Although I do not have any current financial stake in the results of the evaluation, I do have personal and professional stakes in the organization. My friendships and the professional ties one has with internship sites (e.g., the need for letters of reference, potential future volunteer position or employment, etc.) could cause bias, or create
tension or stress if I am in the position of giving negative feedback to people I know and like. These are all aspects of the political nature of program evaluation.

Fitzpatrick et al. (2011) pointed out that program evaluation involves itself in political situations in a way that traditional research often remains detached. Furthermore, Vestman and Conners (2006) described three positions in which evaluators may interact within political contexts: a) Evaluator as value-neutral (evaluators are rational methodologists who collect data and provide it to stakeholders. Judgments are then made by stakeholders), b) Evaluator as value-sensitive (the evaluator works to maintain the technical aspects of the evaluation, the provision of information as separate from politics, though recognizes that other aspects of the evaluation such as providing judgments, and considering ethical issues require the evaluator to learn of and become involved in the political environment), and c) Evaluator as value-critical (it is critical for the evaluator to become actively involved in politics and to actively articulate those values). Fitzpatrick et al. (2011) argued that the first position is unrealistic, and the third position can create problems with validity—or perceived validity, and thus advocated for taking the second position—evaluators as value-sensitive. As such, evaluators balance the technical aspects of their study with a need to understand how their evaluation may be useful to at least some stakeholders within the political context. This area is one in which internal evaluators may have a superior knowledge or understanding of the political context of their judgments, which could both create reports more relevant to stakeholders or less accurate due to either blindness or fear. Within my role as value-sensitive evaluator, I had to carefully consider confidentiality in this small agency while reporting results.
Knowing some of the participants allowed me to better recognize potentially identifying information.

An important job of any evaluator, but particularly an internal evaluator is to notice one’s biases, and to reflect on how those biases could affect analysis and recommendations. I continually reflected on decisions throughout the project development, data gathering and analysis, and recommendation phases of this project. This reflection process occurred in discussions with my dissertation committee, together and individually, as well as through notes and memos taken throughout the process.

Sample

In this study, the primary researcher administered several paper-and-pencil measures to staff and MDT members. The measures were administered at two separate meetings that meet weekly. The MCJAC therapists and family advocate staff cases in the clinic. The second meeting is the MDT, which any service provider in the community involved in a particular case related to sexual abuse or assault has a standing invitation to attend. For example, a Child Protective Service worker may only attend once or twice in a six-month period, whereas the special prosecutors may attend three out of four weekly meetings.

The director of MCJAC and facilitator of the MDT, Tambra Donohue, sent an email to the regular email lists of both groups (approximately 120 people emailed for MDT, and 13 emailed for the clinic meeting, including some duplicated emails). The email was written by the primary researcher and included a brief description of the project and a request for participation in both the surveys and interviews, with contact information. The informed consent forms for surveys and interviews were attached to the
emails. Three participants contacted the primary researcher for interviews, which was the number of interviews planned. A brief email was sent to three contract therapists offering individual administration due to possible scheduling conflicts.

Providers who had not attended MDT at least once per month for the previous three months were excluded from the study. This inclusionary criterion was used in order to best capture those who have had an opportunity to experience MCJAC’s culture and activities regarding vicarious trauma while gathering data from as many participants as possible.

It was assumed that the number of participants would include only those service providers who were in attendance the day of the administration, minus any who declined to participate. A total of seven people participated from the clinic meeting (all who attended), and a total of nine people participated from the MDT after those who declined to participate left the meeting. One protocol from the MDT was not eligible to be used in the study based on inclusionary criteria.

**Informed Consent**

All participants were informed of the possible risks and benefits of this study prior to consenting to participate. Two informed consent documents were developed to address both survey participation and interviews. At the times of administration and interviewing, the primary researcher verbally explained the informed consent and hard copies were signed. In the informed consent, and again at the stakeholder meetings, a debriefing session was offered, and mental health resources were provided. In order to provide as much confidentiality as possible, the demographics and informed consent forms were collected separately from the other measures. No identifying information
was collected in the second packet of measures. For this reason, participants were told
withdrawal from the survey portion of the study would be impossible once they turned in
the second packet of measures, which were anonymous.

All informed consent forms stated this data could be used for future research and training development. All paper materials gathered for this study have been and will continue to be kept in locked cabinets in the primary researcher’s house (identifying information is kept separately from the other research materials). All electronic data was saved on an encrypted storage device. All materials – paper and electronic – will be destroyed no later than January 1, 2020, approximately five years after the completion of this study. In the event of the death or incapacitation of the primary researcher before that date, a plan is in place for all materials to be destroyed immediately by a colleague.

**Measures**

**Demographics.** A brief questionnaire (Appendix F) was given to all survey participants that asked open-ended questions about age, race, ethnicity, gender, length of time in current position and in professional field, and position held in relation to MCJAC (i.e., volunteer, community partner, etc.).

As described above, this questionnaire was collected with the signed consent and separately from the rest of the measures. This information was gathered in case this study is published in the future rather than for relevance to the program evaluation. These data will be reported as descriptive statistics in the most general terms possible to protect identity. Most of the questions are asked in an open-ended way to allow participants to use the wording and labels with which they feel most comfortable.
**Trauma and Attachment Belief Scale.** The TABS (Pearlman, 2003) is an 84-item paper-and-pencil measure based on the areas of psychological needs found to be affected by trauma (McCann & Pearlman, 1990; also see Literature Review section of this study for further detail). Ten subscale scores reflect beliefs about self and beliefs about others for each of the following five areas: Safety, Intimacy, Trust, Control, and Esteem. Items are rated on a 6-point Likert scale of agreement. The items are brief, requiring a minimum of 15 minutes for administration time. The following statements are the first three items on the protocol, drawn from a sample form provided by the publisher and available to the public: “I believe I am safe,” “You can’t trust anyone,” and “I don’t feel like I deserve much” (Pearlman, 2003, p. 1).

The first version of this measure was generated by gathering statements related to the six areas of normal psychological need identified as particularly vulnerable to disruption from trauma. These statements were collected from trauma survivor clients, and then independently assigned to the areas of need by clinical psychologists with expertise in treating trauma survivors. Items were discarded if not every expert reviewer assigned that item to the same need area. After the first version was published in 1988 (called the McPearl Belief Scale), data were collected on the scale, both by the authors and other interested researchers. Through this process of empirical refinement, additional items were added to establish reliability of some subscales, and to reconceptualize some of the subscales (e.g., the original High-Power and Low-Power subscales turned into Control Subscale). Then, with the 1994 publication of the Traumatic Stress Institute (TSI) Belief Scale Revision L (Pearlman, 1996, as cited in Pearlman, 2003) the dual subscales for self and other were established. All of these changes and developments
were supported by empirical data. The primary changes between the TABS and the TSI Belief Scale Revision L were done to improve readability and strengthen the subscale psychometrics. Through this process four items were added. All of the psychometric properties reported in the manual were calculated on either Revision L or on the current form of the TABS. The total Revision L and TABS are highly correlated with each other. The total correlation coefficient was .95 for a group of 260 college students took both forms twice with a one- to two-week interval. The median correlation between subscale scores is .87 (ranging from .71 for Other-Safety to .97 for Self-Esteem). Additionally, for every subscale the correlation between the two forms was higher than the Revision L internal consistency and retest reliability estimates. For these reasons, Revision L and the current form of the TABS should be considered equivalent, though the author did suggest all future research should use the TABS (Pearlman, 2003).

Standard scores for the TABS were generated with a sample of 1,743 adults aged 17 to 78 years. The sample was a nonclinical population, 68% of which fell in the age range of 17–29 years, 73% were female, and 49% were Caucasian (38% Unspecified Race/Ethnicity). The manual for this measure provided T-score means and standard deviations (SD) compared by gender, age, and race/ethnicity. Through other research samples, T-score comparisons are provided for outpatient, inpatient, prisoner populations, and trauma therapists for interpretation purposes and for criterion validity analysis. As would be expected, populations that generally have a high level of trauma exposure (e.g., prison population) scored higher on the TABS than a nonclinical population (Pearlman, 2003).
The estimates of internal consistency and test-retest reliability for the final version of the TABS are high, .96 and .75 respectively for total score. Subscale estimates range from .67 for Self-Intimacy to .87 for Other-Intimacy for internal consistency, and .60 for Other-Intimacy to .79 for Other-Trust for retest reliability. Items are face-valid in that they are asking directly about individuals’ beliefs to be self-reported. For the most part, the intercorrelations of a given subscale with other subscales are well below its estimated internal consistency coefficient, suggesting the subscale constructs are at least partially independent of one another. The factor structure also supports the subscales scored on the TABS, showing interesting relationships, with clear distinctness between the subscales and factor structure (Pearlman, 2003).

The TABS also has reasonable correlation with the Trauma Symptom Inventory (TSI) (Briere, Elliott, Harris, & Cotman, 1995). Because these scales are meant to measure similar but somewhat different constructs (the purpose of the TSI is to identify PTSD symptoms rather than disrupted schemas as with the TABS), the pattern of correlations between scores on the different measures is complex, though for the most part support the TABS constructs. For example, the TABS self-oriented scores are more highly correlated with the TSI subscales that reflect the internal rather than interpersonal processes and experiences, whereas, other-oriented scores are more highly correlated with the interpersonal-oriented subscales (Pearlman, 2003).

The TABS has solid empirical and psychometric properties, with very strong internal consistency, and strong retest reliability. This measure has moderate to strong construct and criterion validity properties. The population used for establishing norms
had clear demographic imbalances, though the developer made an effort to establish interpretation guidelines based on normative differences found.

The purpose of this measure is to capture changes in schemas. Most other measures focus on symptomology based on post-traumatic stress disorder (PTSD) criteria in the *DSM* (American Psychiatric Association, 1994, 2000, 2013). The TABS has been used in research for measuring the effects of both primary and vicarious trauma (Williams, Helm, & Clemens, 2012). This measure was chosen for this program evaluation in order to give MCJAC useful information about what areas of people’s lives have been or are being affected by the work they do, and to shed light on any areas that need to be addressed organizationally. This measure is also sensitive for identifying disrupted schemas in people who do not necessarily meet criteria for PTSD. The purpose of this program evaluation was not to diagnose or screen for PTSD, but rather to assess current levels and areas of distress, and relate those to both current activities and possible actions for the future for addressing that distress organizationally. Thus, the TABS fit the purpose of this project by providing in-depth and sensitive information regarding major areas of psychological functioning as they relate to vicarious trauma.

**Secondary Traumatic Stress Scale.** The STSS (Bride et al., 2004) is a 17-item paper-and-pencil, self-report measure based on the diagnostic criteria for PTSD in the *DSM-IV* (American Psychiatric Association, 1994). Designed to assess frequency of symptoms, five point Likert scale items were developed for the PTSD criteria B (intrusion), C (avoidance), and D (arousal). Based on item analysis from two samples (a convenience sample of 37 participants, and a sample of 200 alumni of a school of social work) the items were reduced from 65 to one item for each of the 17 individual
symptoms in the *DSM-IV* (American Psychiatric Association, 1994). Bride et al. (2004) did give rationale drawn from outside research for some questions. Five experts in the area of secondary traumatic stress reviewed the original 65 questions for content validity. The final 17-item scale was found to have a coefficient alpha of .93, with three subscale alphas ranging from .80 to .87. The scores for the three subscales and the total score are obtained by summing the items assigned to each. Survey respondents are asked to indicate how often an item has occurred in the last seven days *1 – never to 5 – very often*. Examples of items are, “I wanted to avoid working with some clients,” “I expected something bad to happen,” and “My heart started pounding when I thought about my work with clients” (Bride et al., 2004, p. 33). Dominguez-Gomez and Rutledge (2009) found Cronbach alpha coefficients of .92 for all three subscales and .91 for the total STSS in a sample of 67 emergency nurses. Ting, Jacobson, Sanders, Bride, and Harrington (2005) also found strong internal consistency ranging from .79 to .87 for the subscales, and .94 for the total score.

The psychometric qualities of the STSS were examined with a sample of 287 social workers from one southeastern state, with a 48% return rate (Bride et al., 2004). In addition to the STSS, participants were asked to complete an additional 23-item survey asking professional and personal information, including single-item questions asking the extent to which they have experienced anxiety and depression, to what extent their current client population is traumatized, and the frequency with which their work addresses traumatic stress. This survey was not an established measure, but rather created specifically for this study.
Although Bride et al. (2004) used appropriate and conservative statistical analysis, and found expected and statistically significant relationships between convergent and discriminant variables and the STSS, these measures of validity were somewhat questionable. As expected, STSS scores were significantly correlated with the convergent variables of anxiety, depression, the extent to which respondents’ clients are traumatized, and the frequency with which their work addressed traumatic stress. Discriminant validity was also supported in that no significant correlations were found between the STSS and the demographic variables of age, ethnicity, and income. However, using these variables to establish validity provides only weak support, particularly those variables used for discriminant validity. Age has been found by some to be significantly correlated with STS/VT (see Bell et al., 2003, and Bride, 2004, for review of literature on age as risk factor). In addition, although race and/or ethnicity are often included in demographic analyses to explore factors related to STS/VT, few studies include a large enough sub-sample of nonwhites to give power to analyses of race/ethnicity. In fact, the one study cited in Bride et al. (2004) supporting ethnicity as a discriminant variable used a sample that was 96% Caucasian (Knight, 1997). Additionally, Dominguez-Gomez and Rutledge (2009) reported significant correlations between both age and race with the STSS. In order to establish convergent and discriminant validity for the STSS, more research is needed, including comparisons with established measures of well-researched factors or constructs thought to be conceptually related or different.

Bride et al. (2004) supported the three factorial structure of subscales Intrusion, Avoidance, and Arousal with adequate model fit indices .90 or above. Factor loading
was expected and statistically significant for each item, ranging from .58 to .79, with
$t$-values ranging from 10.13 to 15.68. Sufficient variance was accounted for by the
factors to which individual items were assigned ranging between 33% and 63%. Bride et
al. are careful to point out these structural analyses say nothing about whether alternative
models would fit better, only that the three structure model was supported by their data
analysis. Ting et al. (2005) found evidence of a unidimensional factorial model.
Although all items loaded significantly on the factors identified by Bride et al., all three
factors were also highly correlated with each other (Intrusion-Avoidance $r = .96$,
Intrusion-Arousal $r = .96$, Avoidance-Arousal $r = 1.0$). Ting et al. (2005) reported the
same multiple fit indices as strong (ranging from .88 to .92) again supporting the three
factor model. However, when further analysis was done with two other models, a single
factor model, and a primary factor (STS) with three secondary factors model both models
were found to have similar fit indices. Thus, in keeping with using the most
parsimonious fit, the STSS should be considered a unidimensional instrument.

Overall, the STSS has strong evidence of internal consistency reliability and
factorial validity, mild to moderate convergent validity, and some suggestion of
discriminant validity. The STSS needs more research to establish convergent and
discriminant validity, and to further explore the factorial structure. This measure was
chosen for this study to provide additional information about the baseline symptoms from
STS/VT suffered by the participants. Although the TABS will also give baseline
information, the TABS is published privately and thus will cost the agency money to re-
administer at a later date; the TABS is meant to capture long-term changes rather than
more immediate symptoms; and the STSS is brief. For these reasons, the STSS can be
used relatively easily in the future by the agency to self-monitor STS. Adding it to this study will establish a baseline for future comparison.

**MCJAC Questionnaire.** Please see Appendix E for a full copy of the questionnaire. The primary researcher developed this questionnaire with four sections for the purpose of exploring how effectively MCJAC is addressing vicarious trauma in its staff, volunteers, and MDT members. Section I contains qualitative questions. Sections II and III are quantitative. Sections I and II focus on experiences and aspects of individual, team, and leadership functioning related to vicarious trauma and work. Section II has 19 items structured as statements with a five-point Likert scale (1 – Disagree Strongly to 5 – Agree Strongly). The first two sections were given to both groups. Two copies of Section II were provided for those participants who regularly attend both clinic and MDT to provide data for both teams. Section III was only given to those who work for MCJAC as staff, contract worker, or volunteer/intern (not to co-located partners) and concentrates on issues related to workplace, such as physical comfort, safety, autonomy, and strategic support. It has 16 items structured the same way as Section II. Section IV has one qualitative question asking respondents to make any further comments.

The variables included in the questionnaire were drawn directly from the interview with Dr. Donohue and the research literature. Dr. Donohue’s interview provided data regarding her goals, practices, perceptions, and concerns regarding vicarious trauma in the organization (please see Appendix C for a summary of the interview). The research literature provided the individual, team, and organizational characteristics found to contribute to vicarious trauma. The primary researcher formed
initial questions or items based on these variables. Then each variable (or set of variables) was assessed for the following:

1. How potentially harmful will answering questions about this variable be for the participants?
2. How appropriate is it for a participant to answer questions about this variable for their employer or professional partnering organization?
3. How potentially helpful will knowing aggregate information about this variable be for the stakeholders?
4. Is aggregate information from participants directly relevant for the organization’s response and practices in addressing vicarious trauma?
5. Will best practices or empirical data drawn from the literature for this variable be directly relevant for addressing vicarious trauma organizationally?

As an example, gathering information from participants on personal history of abuse has a high potential of harm and low potential of help, yet this variable is directly relevant to both organizational and personal processes of handling the impacts of VT. Based on prevalence rates found in the literature ranging from 29–83% in therapists working with sexual abuse cases (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Schauben & Frazier, 1995), some level of personal history of abuse can be assumed and addressed in broad and general terms for psychoeducation. Additionally, an understanding of the empirical data and best practices drawn from the literature would be more helpful if an individual decided to confide a personal history of abuse in coworkers or supervisors. Thus, this variable is included in the literature review but not in the questionnaire.
The following variables were included in the questionnaire: psychoeducation and awareness about vicarious trauma; various forms of support (e.g., organizational support, team/coworker support, personal social support, etc.); team structure; strategic information; safety; physical space; and organizational culture. In addition, during the course of this program evaluation, MCJAC was approved for having a courthouse dog (http://www.courthousedogs.com, please also see Appendix C for a detailed description of Astro, MCJAC’s courthouse dog). The formal interview with Dr. Donohue took place the week before she was to bring Astro to the center. During the interview Dr. Donohue described witnessing a positive effect the idea of Astro was having on the staff and MDT members in relation to vicarious trauma. For that reason, a qualitative question was included in the questionnaire to capture this phenomenon.

The MCJAC Questionnaire was reviewed and edited by colleagues and professionals, including the dissertation committee, and approved by Dr. Donohue and the MCJAC Board of Trustees. The purpose of this questionnaire was to capture respondents’ experiences of how VT is addressed, the organizational culture as it relates to VT, and respondents’ experience of vicarious trauma in this organization. No psychometric properties have been tested on this measure as a whole. It is common practice for program evaluators to create surveys to seek information about unique organizational issues (Fitzpatrick, 2011). This practice does decrease the validity of the data collected by these surveys; however, it increases the relevance of the data to the organization’s needs and utilization.
Procedures

**Measures.** The primary researcher administered pencil-and-paper measures to the two groups during the regularly scheduled weekly MDT and clinic meetings. Dr. Donohue briefly introduced the primary researcher and the project, then left the room and was not present during administration of any measures.

Group administration was done for the convenience of the busy professionals being asked to participate. Administration began in the second half of the meetings in order to allow the non-participants to leave. Only half the meeting was taken up by this project, and was done at a time when the members were not handling extreme, acute cases (and thus needing all the time to staff cases). Group administration has a higher risk of loss of confidentiality (and thus a possible loss of honesty) as other people are physically near and might be able to see an individual’s answers. Participants were asked to spread out as much as physically possible in order to give privacy.

**Interviews.** In addition to the interview with the program director, three other interviews were conducted. Dr. Donohue’s interview also included more in-depth questions and explored the program director's personal experience, which was analyzed with the other participants’ qualitative data. The interviews were semi-structured, and were audio-recorded and transcribed. The interview protocols were also based on literature review and information gathered from Dr. Donohue.

**Data Analysis**

Data analysis decisions were based on the combination of the small number of participants, the goals of program evaluation to provide the organization direct information, and the need to maintain participants’ confidentiality in this small agency.
setting. For example, although descriptive statistics were used for the demographics, the rich details revealed in the data from the other measures was lost when reducing the scores to means. The Results chapter details how data was analyzed and presented and why.

**Stakeholder Meetings**

Two stakeholder meetings were held after data collection. The purpose of these meetings was to provide initial findings to the agency and provide an opportunity for stakeholders to contribute to the recommendations in order to increase utilization and relevance. These contributions are different than the suggestions that arose during data collection, but both have been integrated into the recommendations.
Chapter IV: Results

This chapter describes the results of the interviews and surveys with staff, volunteers, and multidisciplinary team (MDT) members. In addition to the survey administrations and three interviews conducted with the study participants (staff, volunteers, and MDT members), existing organizational documents were reviewed and both informal conversations and a formal interview took place with the director of Monarch Children’s Justice and Advocacy Center (MCJAC). Copies and summaries of the organizational documents and the formal interview with the director can be found in the Appendices.

An email inviting staff, volunteers, and MDT members to participate in both the surveys and the interviews was sent to both regular email lists for the therapy clinic and the MDT. The primary researcher attended the second half of the weekly clinic and MDT meetings, administered and collected packets mostly on site the same day. Three interviews were conducted (a detailed description of informed consent and procedures can be found in Chapter III: Methods).

Sixteen participants completed the survey packets that included the demographics survey (collected separately from the other measures for confidentiality), the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003), the Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004), and the questionnaire developed for this program evaluation, the MCJAC Questionnaire. Group administrations took place on November 12, 2014 for the clinic team (n = 7) and January 16, 2015 for the MDT (n = 9). All but one participant finished and turned in all measures at the same meeting. One participant ran out of time and turned in the packet one week later. All packets were fully
completed. One participant was excluded from the primary data analysis due to not meeting the inclusionary criterion of having attended MDT at least once a month for the previous three months. That participant’s data was included in the global observations.

Two copies of the MCJAC Questionnaire Section II were provided, which allowed participants to provide responses regarding team meetings they regularly attended even if that was not the meeting at which they filled out the packets. Participants’ demographics, TABS, and STSS are reported together with the group with which they completed the packets. For the MCJAC Questionnaire, the number of participants who completed each section of the questionnaire is reported separately.

Missing quantitative data was minor and handled by either following recommendations by the published manual (TABS), using the mean of the participant’s responses for that subscale (STSS), or presenting the missing data gap directly (MCJAC Questionnaire). No completed instruments were deemed invalid due to missing data.

Due to the very small number of participants, the quantitative data are presented primarily visually. Quantitative data is often presented as means; however, means flattened the data of this tiny sample and gave very little meaningful information. Every participant’s individual scores are given; however, the scores are organized from smallest to largest, unlinking individual scores from any others (i.e., no individual participant’s response patterns can be identified). With the addition of color coding, a visual representation of the overall score card of the group can be easily viewed. This was found to be the simplest and clearest way to report the data while also maintaining confidentiality. The TABS scores and STSS scores are in color-coded tables with keys near them explaining what the colors represent. The quantitative items from the MCJAC
Questionnaire were included in tables with tallied scores and means. Interpretation of these scores can be found in Chapter V: Discussion.

**Demographics**

A brief questionnaire was given to all survey participants asking open-ended questions about age, race, ethnicity, gender, length of time in current position and in professional field, and position held in relation to MCJAC (i.e., volunteer, community partner, etc.).

**Clinic team.** Seven participants completed survey instruments from this team. The mean age of this sample was 36.4 years (25–55 range), 86% identified as Caucasian/White American, 14% identified as Asian/Korean American, 100% of this sample identified as female, 71% as Volunteer/Unpaid Intern, and 29% as paid employee. The mean for years working in current position was 2.69 (0.25–8.25 range), the mean for years working in the field was 4.81 (0–14 range).

**Multidisciplinary team.** Nine participants completed survey instruments from this team. Demographic data was collected separately from the other measures. One participant’s packet was excluded from the primary data analysis; however, it was not possible to identify that participant’s demographic data, thus demographics for all nine participants are included here. The mean age was 47.9 years old (33–66 range), 100% identified as White/Caucasian in the question about race, whereas, 56% responded to the question asking for ethnicity as White/Non-Hispanic, 33% did not respond to the ethnicity question and 11% identified as Hispanic. Fifty six percent of participants identified as female, while 33% identified as male, and 11% of responses were unclear. Community partners made up 78% of the sample, with 11% paid contract workers and
11% paid employees. Mean years in current position was 8.2 (.08–25.08 range), mean years reported in field was 19.18 (6–36.08 range).

**Trauma and Attachment Belief Scale Results**

The TABS (Pearlman, 2003) measured beliefs and worldviews based on self-report. The items are based on psychological needs found to be particularly vulnerable to disruption by trauma (McCann & Pearlman, 1990; McCann et al., 1988; Pearlman, 2003; Pearlman & Saakvitne, 1995a). Lower scores indicate less distress or disruption. Table 1 provides a list of the subscales of the TABS and the corresponding psychological need. The descriptions of subscales are drawn directly from two sources. Pearlman and Saakvitne (1995a) included brief descriptions of the psychological needs, which Pearlman (2003) then repeated in the manual for the TABS breaking them into self and other categories. The scores and means for each team are provided with a common key in Tables 2 and 3.

**Clinic team.** The MCJAC clinic team’s scores fell mostly in the low-average to average range on the TABS subscales and total and mean scores (Table 2). The two subscales of the TABS that had the largest number of scores falling in the high average range or above (more distress/disruption) were Other Intimacy and Self Control. Most of the subscales of the TABS had large numbers of scores falling in the low average range or below (less distress). The subscale that had the largest number of very low scores was Self-Safety.
Table 1.

*Psychological Needs Associated With TABS Subscales*

<table>
<thead>
<tr>
<th>TABS Subscale</th>
<th>Reflected Need</th>
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<tbody>
<tr>
<td>Self-Safety</td>
<td>To feel secure and reasonably invulnerable to harm inflicted by oneself or others</td>
</tr>
<tr>
<td>Other-Safety</td>
<td>To feel that loved ones are reasonably protected from harm inflicted by oneself or others</td>
</tr>
<tr>
<td>Self-Trust</td>
<td>To have confidence in one’s own perceptions and judgment</td>
</tr>
<tr>
<td>Other-Trust</td>
<td>To depend or rely on others</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>To feel valuable and worthy of respect</td>
</tr>
<tr>
<td>Other-Esteem</td>
<td>To value and respect others</td>
</tr>
<tr>
<td>Self-Intimacy</td>
<td>To feel connected to one’s own experience</td>
</tr>
<tr>
<td>Other-Intimacy</td>
<td>To value and respect others</td>
</tr>
<tr>
<td>Self-Control</td>
<td>To manage one’s feelings and behaviors</td>
</tr>
<tr>
<td>Other-Control</td>
<td>To manage interpersonal situations</td>
</tr>
</tbody>
</table>

*Note.* These descriptions were drawn directly from Pearlman and Saakvitne, 1995a, p. 62. For descriptions broken into self and other categories see Pearlman, 2003, p. 16.
Table 2.

Clinic Scores and Means for the TABS Subscales and Total

<table>
<thead>
<tr>
<th>Self Safety</th>
<th>Other Safety</th>
<th>Self Trust</th>
<th>Other Trust</th>
<th>Self Esteem</th>
<th>Other Esteem</th>
<th>Self Intimacy</th>
<th>Other Intimacy</th>
<th>Self Control</th>
<th>Other Control</th>
<th>Total</th>
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</table>

Mean Scores

40.0 47.4 51.1 42.9 49.7 48.0 47.6 53.1 52.6 43.1 48.1

TABS Color-Code Key

- Very Low or Below
- Low Avg.
- Average
- High Avg.
- High
- Extremely High

Table 3.

MDT Scores and Means for the TABS Subscales and Total

<table>
<thead>
<tr>
<th>Self Safety</th>
<th>Other Safety</th>
<th>Self Trust</th>
<th>Other Trust</th>
<th>Self Esteem</th>
<th>Other Esteem</th>
<th>Self Intimacy</th>
<th>Other Intimacy</th>
<th>Self Control</th>
<th>Other Control</th>
<th>Total</th>
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</tbody>
</table>

Mean Scores

45.0 51.1 41.3 40.6 45.1 43.4 48.9 44.1 48.8 44.6 46.0
**Multidisciplinary team.** Overall levels of vicarious trauma were found to be low to average on all scales for the TABS among MDT members. The two subscales that had the largest number of scores falling in the high average range or above (more distress/disruption) were Other Safety and Self Intimacy. Most of the subscales of the TABS had large numbers of scores falling in the low average range or below (less distress/disruption). The subscale that had the largest number of very low scores was Other Trust.

**TABS Critical Items.** Pearlman (2003) identified items on the TABS as Critical Items, which could indicate a higher or more concerning level of distress. The TABS was primarily developed as a tool in clinical work. These items were developed as a specific assessment tool for psychological concerns that might need particular therapeutic attention or that could have the potential for physical danger to self or others. Therapeutic follow-up was expected for these items. In this research context the TABS protocols were anonymous and separated from any identifying paperwork. Many (though not all) of the critical items also could be seen as normal responses to vicarious trauma at times. However, these items could indicate risk of self- or other-harm. Thus, in the summary reports given to each team for feedback during stakeholder meetings, the primary researcher provided additional resources for all survey participants and a paragraph asking participants to seek help if they feel overwhelmed or at risk.

The clinic team endorsed three Critical Items related to being able to do serious damage to someone, not being able to stop worrying about others’ safety, and physically hurting people in the past.
The MDT endorsed seven Critical Items. Four items were related to other-safety, such as never thinking anyone is safe from danger, being able to do serious damage to someone, not being able to stop worrying about others’ safety, and not being able to control harm to others. Three items were related to self-harm, such as not being able to keep one’s self safe, and two items disagreeing to never hurt self.

One participant approached the primary researcher after the administration of the TABS. During the informal conversation, the participant mentioned some confusion about how to answer a few of the questions. One confusion that was mentioned was difficulty knowing which direction to endorse at times (such as disagreeing with an item stated as “never,” creating a double negative). This participant also described answering the questions very literally (i.e., being able to do damage to others could be related to a car accident). This is a good example of why follow-up would be important in a clinical setting, and why these items should be viewed within the research context as having multiple possible meanings.

Secondary Traumatic Stress Scale Results

The STSS (Bride et al., 2004) measured three DSM-IV (American Psychiatric Association, 1994) criteria (intrusion, avoidance, arousal) for posttraumatic stress disorder for those who work with traumatized people, with lower scores indicate fewer symptoms. The STSS does not have published cutoff scores (Bride et al., 2004). The scores are based on a 5-point Likert scale of frequency. Table 5 provides a key associated with Tables 4 and 6. The key gives ranges of scores that are based on the number of questions in the scale multiplied by the Likert numbers, with the difference between columns split in the middle, thus giving a rough idea of where on each scale a
score falls. This method does make the middle bins larger than the scores on either end of the scale due to the outside limits of the lowest and highest scores (i.e., unless a participant does not answer a question, the lowest score for a subscale consisting of five items is 5, the highest possible score is 25). Tables 4, 5 and 6 are all color coded as with the tables for the other measures in this study. The subscale scores for the participants from both teams are similar in range – all three subscales indicate a range from one to three (Never to Occasionally) on the Likert scale. Note the scores are again sorted from lowest to highest. No two scores are related to each other in any way. The numbers on the bottom of the graph are simply the number of scores and do not correspond to any one participant.
Table 4.

*Clinic Team Scores for Secondary Traumatic Stress Scale*

<table>
<thead>
<tr>
<th>Intrusion</th>
<th>Avoidance</th>
<th>Arousal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>13</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>11</td>
<td>14</td>
<td>12</td>
<td>38</td>
</tr>
<tr>
<td>12</td>
<td>14</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>13</td>
<td>16</td>
<td>13</td>
<td>42</td>
</tr>
<tr>
<td>14</td>
<td>16</td>
<td>15</td>
<td>46</td>
</tr>
<tr>
<td>15</td>
<td>20</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>16</td>
<td>21</td>
<td>16</td>
<td>51</td>
</tr>
</tbody>
</table>

Table 5.

*Key for Interpreting STSS Scores With Likert Scale*

<table>
<thead>
<tr>
<th></th>
<th>Never 1</th>
<th>Rarely 2</th>
<th>Occasionally 3</th>
<th>Often 4</th>
<th>Very Often 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusion</td>
<td>5-7</td>
<td>8-12</td>
<td>13-17</td>
<td>18-22</td>
<td>23-25</td>
</tr>
<tr>
<td>Avoidance</td>
<td>7-10</td>
<td>11-17</td>
<td>18-24</td>
<td>25-31</td>
<td>32-35</td>
</tr>
<tr>
<td>Arousal</td>
<td>5-7</td>
<td>8-12</td>
<td>13-17</td>
<td>18-22</td>
<td>23-25</td>
</tr>
<tr>
<td>Total</td>
<td>17-25</td>
<td>26-42</td>
<td>43-59</td>
<td>60-76</td>
<td>77-85</td>
</tr>
</tbody>
</table>

*Note.* These bins were created by multiplying the number of items in a scale (the smallest number in the Never column) with the number of the score. The difference between each column was then split in the middle. This method creates larger bins in the middle by necessity due to the outside limits of the top and bottom scores.

Table 6.

*MDT Scores for Secondary Traumatic Stress Scale*

<table>
<thead>
<tr>
<th>Intrusion</th>
<th>Avoidance</th>
<th>Arousal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>7</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>10</td>
<td>13</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>11</td>
<td>14</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>12</td>
<td>15</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>12</td>
<td>17</td>
<td>14</td>
<td>46</td>
</tr>
<tr>
<td>15</td>
<td>18</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>16</td>
<td>18</td>
<td>18</td>
<td>48</td>
</tr>
</tbody>
</table>
**STSS individual items.** The STSS has a total of 17 items, which were analyzed to find the items with the highest and lowest means for each team.

**Clinic team.** The two items the clinic team rated as the most frequent were #10 (3.3 mean), which was related to thinking about work with clients when not intending to, and #9 (3.0 mean), which was related to being less active than usual. The clinic team rated as least frequent, #17 (1.3 mean), which was related to noticing gaps in memory about client sessions, and #16 (2.0 mean), which related to expecting something bad to happen. Two items had 2.0 means. The item presented had no scores 4 or above.

**Multidisciplinary team.** The MDT rated the following two items as the most frequent, #4 (3.4 mean), which related to having trouble sleeping, and #10 (3.1 mean), which was related to thinking about work with clients when not intending to. The following two items were rated as least frequent by the MDT, #13 (1.3 mean), which related to having disturbing dreams about work with clients, and #8 (1.6 mean), which related to feeling jumpy.

**MCJAC Questionnaire Section II Results**

Monarch Children’s Justice and Advocacy (MCJAC) Questionnaire Section II measured various aspects of personal, team, and leadership functioning particularly related to vicarious trauma. This section has 19 items with a five-point Likert scale (1 – Disagree Strongly to 5 – Agree Strongly). The tallied scores and means for both teams are found in Table 7. Because these teams had very similar results, the the team results are combined for this section.

**Combined results.** Seven participants completed MCJAC Questionnaire Section II for the clinic team. Ten participants completed MCJAC Questionnaire Section II for
the MDT. Overwhelmingly, the teams and leaders were found to provide support in multiple ways for both MDT and clinic teams. Participants reported they could talk to their team and leader. The meetings were reportedly supportive in tone and left most members feeling energetic and interpersonally connected. Many participants had learned about work impacts from the team members and leaders, though a minority did not agree or were neutral. All but participants (except one missing data) agreed the team laughs together.

Nearly all participants reported they knew what vicarious trauma was and how to identify vicarious trauma in themselves. Although the majority of participants agreed they knew how to give support to others who could be struggling with vicarious trauma, a minority reported they did not or were neutral. Although friends and family were not reported to understand the work by some clinic participants and the majority of MDT participants, almost all the participants agreed they could talk to friends and family when upset about work. All participants indicated they understood and were not annoyed by discussions of VT and negative impact.
Table 7.

*Clinic and MDT Scores and Means for Questionnaire Section II*

<table>
<thead>
<tr>
<th>Full Item</th>
<th>Team</th>
<th>Tallied Responses and (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree Strongly</td>
<td>Disagree</td>
</tr>
<tr>
<td>1  Other members of the team have helped me understand how my work affects me.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>2  I feel support from the team when I am feeling sad, angry, or worried about a case.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>3  I feel annoyed when people talk about the negative impact of this work.</td>
<td>Clinic</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>3</td>
</tr>
<tr>
<td>4  When I see a team member showing signs of vicarious trauma, I know how to give them support.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>5  I can tell when I am being impacted by my work.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>6  The leader(s) of the team has helped me understand my own vicarious trauma.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>7  I leave the meetings feeling that I’m not alone.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
<tr>
<td>8  My friends and/or family don’t understand my work – they just don’t get it.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>1</td>
</tr>
<tr>
<td>9* The team laughs together.</td>
<td>Clinic</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note.* One MDT participant did not answer question #9.
Table 7 (continued).

*Clinic and MDT Scores and Means for Questionnaire Section II*

<table>
<thead>
<tr>
<th>Full Item</th>
<th>Team</th>
<th>Tallied Responses and (Mean)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>(Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I leave the team meetings feeling more sad, worried, angry, or numb than before.</td>
<td>Clinic</td>
<td>5 1 1 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1.4)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>6 3 1 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1.5)</td>
</tr>
<tr>
<td>I can talk to team members about difficult feelings I have about a case.</td>
<td>Clinic</td>
<td>0 0 0 2 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.7)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 1 1 3 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.2)</td>
</tr>
<tr>
<td>I trust the leader(s) of the team to maintain a supportive tone in the meeting.</td>
<td>Clinic</td>
<td>0 0 0 1 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.9)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 0 0 2 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.8)</td>
</tr>
<tr>
<td>I feel confident I know what <em>vicarious trauma</em> means.</td>
<td>Clinic</td>
<td>0 0 1 5 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.0)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 0 1 0 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.8)</td>
</tr>
<tr>
<td>Members of my team have taught me a lot about how my work affects me.</td>
<td>Clinic</td>
<td>0 1 0 3 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.1)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 1 1 4 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.1)</td>
</tr>
<tr>
<td>I leave the team meetings with more energy than before.</td>
<td>Clinic</td>
<td>0 1 2 2 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(3.7)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 1 1 4 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.1)</td>
</tr>
<tr>
<td>I can talk to the leader(s) of the team about difficult feelings I have about a case.</td>
<td>Clinic</td>
<td>0 0 0 1 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.9)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 0 0 3 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.7)</td>
</tr>
<tr>
<td>Even though I can’t talk to my friends/family about details of cases, I can talk to them about how I’m feeling about work.</td>
<td>Clinic</td>
<td>0 0 1 5 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.0)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 0 0 8 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.2)</td>
</tr>
<tr>
<td>I don’t understand why we talk about vicarious trauma at all.</td>
<td>Clinic</td>
<td>4 3 0 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1.4)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>8 2 0 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1.2)</td>
</tr>
<tr>
<td>I trust the team members to maintain a supportive tone in the meeting.</td>
<td>Clinic</td>
<td>0 0 1 0 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.7)</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>0 0 1 1 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(4.7)</td>
</tr>
</tbody>
</table>
MCJAC Questionnaire Section III Results

Nine participants completed Section III of the MCJAC Questionnaire. This portion of the Questionnaire was limited to those who work for MCJAC programs in some capacity. Section III measured various aspects of workplace practices that could have an effect on levels or quality of vicarious trauma. It has 16 items with a five-point Likert scale (1 – Disagree Strongly to 5 – Agree Strongly). Table 8 provides the tallied scores and means obtained for Section III.

These questions were answered overwhelmingly positively. Participants agreed they feel physically safe, their ideas are asked for and listened to, and they have control over their jobs and schedules. One participant disagreed with feeling physically safe. The culture at MCJAC was reported as warm, welcoming, compassionate, and supportive with leave and training encouraged. Most participants agreed they have a comfortable place to take a break, with one participant disagreeing with that. All participants agreed VT training is provided, and most, but not all, participants reportedly understood the plan to achieve the agency’s mission.
Table 8.

*Scores for Questionnaire Section III*

<table>
<thead>
<tr>
<th>Full Item</th>
<th>Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Agree Strongly</th>
<th>(Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have control over how my job gets done.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>(4.1)</td>
</tr>
<tr>
<td>My workplace encourages me to take leave when I need to.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>(4.7)</td>
</tr>
<tr>
<td>My co-workers ask me how I’m doing when I’m feeling upset.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>(4.4)</td>
</tr>
<tr>
<td>I feel physically safe at work, including coming and going.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>(4.6)</td>
</tr>
<tr>
<td>My supervisor(s) asks me my opinion.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>(4.9)</td>
</tr>
<tr>
<td>My co-workers think taking leave is selfish or weak.</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1.0)</td>
</tr>
<tr>
<td>When I need a break at work, I have a comfortable place to go.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>(4.1)</td>
</tr>
<tr>
<td>My co-workers are compassionate toward clients.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>(4.8)</td>
</tr>
<tr>
<td>My workplace is decorated in a warm and welcoming way.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>(4.6)</td>
</tr>
<tr>
<td>I understand my agency’s plan of action to achieve our mission.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>(4.2)</td>
</tr>
<tr>
<td>My supervisor(s) encourages taking time off for training.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>(4.8)</td>
</tr>
<tr>
<td>My workplace provides training about vicarious trauma.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>(4.7)</td>
</tr>
<tr>
<td>My ideas are listened to at staff meetings.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>(4.6)</td>
</tr>
<tr>
<td>I feel like my co-workers and I belong to a supportive team.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>(4.8)</td>
</tr>
<tr>
<td>I feel hassled at work.</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1.0)</td>
</tr>
<tr>
<td>I make my own schedule at work.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>(4.4)</td>
</tr>
</tbody>
</table>

*Note.* One participant did not answer question #9.
Qualitative Data Results

Three interviews were conducted with participants, one interview was conducted with the director, and the MCJAC Questionnaire Sections I and IV were composed of qualitative questions. Tambra Donohue, Ph.D., the Program Director of the Child Advocacy Center within MCJAC, specifically requested this study to emphasize and value the participants’ confidentiality over specificity of data. The MDT is made up of professionals who work within different agency and organizational settings with different work cultures, values, and practices. In order for the members of the MDT to safe and comfortable answering questions about personal experiences and sensitive information, confidentiality needed to be very strong. That need combined with the small numbers of people on each team, identification of participants through the data was a high risk. In order to accommodate the stakeholders, this evaluator chose to present the data in ways that purposefully created vague statements at times and necessarily lost detail in the data.

For these reasons, the qualitative findings from all data sources are presented in an integrated form. Information that could not be de-identified was not included. Qualitative information was analyzed in multiple ways. Primarily, responses were summarized and reported as directly as possible without identifying participants. Additionally, in this qualitative data analysis, patterns and themes were examined, working hypotheses developed and confirmed or rejected. The analysis was iterative, conducted with multiple types of information and alternative themes explored (Fitzpatrick et al., 2011).

The qualitative analysis was within the context of the goals of the program evaluation. The primary goals for presenting data to the organization were to provide as
much information as possible to answer the questions of the evaluation, while maintaining strict confidentiality. Due to the distinctive way people speak, even short quotes could have identified the participants. During the analysis, the primary researcher summarized the answers to the survey questions and analyzed the interviews for themes. However, reporting data from these sources separately would also likely identify participants. Often, themes mirrored information found in the survey answers. Therefore, the themes are incorporated into the summaries of the survey answers. This method of presenting data did not provide as much transparency about the methods of analysis and the richness of the qualitative analysis was lost; however, this presentation of data did afford a high level of care in maintaining confidentiality, while providing as much data as possible to the organization for future use. Information from all data sources was also used to create lists of coping strategies and negative impacts (see Appendix G), current practices (see Appendix C), and suggestions.

**Clinic team.** The most common responses described the clinic team and director as safe and supportive. This group of participants reported that the support felt in the team and from the supervisor was freeing and helped with both working with clients and addressing vicarious trauma. These participants also reported experience at MCJAC affected their lives in the following ways: decreased tolerance of rape culture, changed sense of what is important in life, increased hope and faith in community, and increased sense of commitment and empowerment to be part of the solution.

Some of the common descriptions of the team and team members were words such as supportive and strong. The less common terms used were intelligent, compassionate, committed, outstanding, caring, and full of laughter. Some participants
reported having difficulty feeling heard in the clinic meetings, primarily due to people talking over each other during discussions. Participants reported feeling pride and gratitude for the clinic team.

The clinic team is reportedly low in conflict. Stress was reportedly present. Both were reportedly handled with open communication and the identified practices (described later in this chapter). Whenever conflict and stress were discussed for this team, this was the consensus answer from participants.

Astro, the Courthouse Dog working at Monarch, was described as a calming and healing presence that helped both clinicians and clients feel comfortable. Astro reportedly helps build trust, makes people smile, brings joy and excitement, and helps clients and clinicians address trauma.

Difficulty with systems vicarious trauma was a common theme. The few participants who did want to know more about vicarious trauma wondered about how better to understand and process, address, or manage the impacts of both general and systems vicarious trauma. Participants reported witnessing and experiencing systemic barriers increased their stress and vicarious trauma symptoms.

The responses about negative impact could be categorized into the following groups:

- Physiological symptoms of stress (i.e., increased problems with sleep and fatigue, increased irritability, more jumpy, upsetting dreams).
- Changes in awareness/sensitivity to sexual abuse and the systemic contributors (more aware of hidden wounds, more suspicious, feeling defeated or overwhelmed by sexual abuse as epidemic and by broken system).
• Self-care and self-protection actions (more time for self-care, less social, spending more time with grounded, happy people and less time with people who require a lot of energy, no violent shows, eating more chocolate).

Participants were reportedly handling the negative impacts with a great number of coping strategies (see Appendix G). The strategies most frequently named by all participants were regular exercise, family and social time, and reading and watching light or unrelated material. Having the space and time to take care of oneself at work was found to be very important for clinic participants, and not always available or used when available.

The clinic participants described loving the process of being a part of and witness to healing, resilience, and transformation. These aspects of the work were also reportedly helpful in managing vicarious trauma.

Practices identified. Participants were varied and disparate in their answers. Some were unable to identify any direct practices, while others identified the following:

• Vicarious trauma is identified
• Ongoing conversation takes place with a lot of opportunities to talk about it
• Small, regular practices such as “gratitude’s” at meetings
• Stress is acknowledged
• Freeing and supportive atmosphere
• Supervision

Multidisciplinary team. The participants reported gaining a great deal of support and help with their jobs from the MDT meetings and members. Participants described MDT members as people who care, work hard, understand the difficulties of
this work, and have common goals of working to make the world better and safer. The MDT meetings were described as supportive and helpful for doing good work by providing teamwork with diverse perspectives, a better understanding of others’ jobs and roles, and a place to process and cope with experiences, clients, and vicarious trauma. MDT was found to successfully build capacity, hope, and strong working relationships among its members.

Astro was described as being a highlight of the workday and that he brings smiles and joy. He reportedly helps with cases and helps the participants address their vicarious trauma. Participants were reportedly proud of the facility for being on the cutting edge of best practices for having Astro work throughout the entire legal and healing process for both clients and staff.

Participants reported the level of detail discussed in cases could be overwhelming and painful at times; however, this sentiment was coupled with a strong desire to maintain the support and understanding found in the meetings. Please see suggestions section below for ideas about how to maintain a better balance between supporting members/staffing cases and sharing fewer details about cases during meetings.

The mutual respect of members was a common theme. Respectful tone and atmosphere was reported as being maintained even if tension or conflict arose between members. Although some MDT members tend to speak more than others, participants reported this was, for the most part, due to differences in roles and personality and did not in any way impede anyone’s input. Everyone’s voice was reportedly welcomed and held with respect. An egalitarian stance was reportedly maintained throughout meetings. Participants reported feeling pride and gratitude for the MDT.
Participants reported noticing that cases were more in number and intensity/severity recently. Participants reported witnessing and experiencing systemic barriers increased their stress and vicarious trauma symptoms.

Negative impacts were primarily related to having difficulty with cases staying in thoughts. Knowing details of crimes reportedly changed participants’ behavior and choice of activities at times. Also described were feeling overwhelmed with responsibility to community; an increase in being cynical, suspicious, and judgmental; feeling ineffective; and decreased physical and social activity. A common theme was difficulty with knowing/learning how to deal with information about crimes against children as a parent.

Participants were reportedly handling the negative impacts with primarily positive coping strategies (see Appendix G). The strategies most frequently named by all participants were regular exercise, family and social time, and reading and watching light or unrelated material.

MDT members reportedly love helping children and families become empowered, be safe, and get the resources and care they need for growth, healing, and justice, and educating community members about how crime and trauma impact children. Focusing on work well done reportedly helped mitigate vicarious trauma symptoms for some participants.

**Practices identified.** Participants were varied and disparate in their answers. Some were unable to identify any direct practices or reference to vicarious trauma in the meetings, while others identified the following:

- Vicarious trauma is identified
• Meeting is safe for people to share anything
• Everybody understands the difficulty of the work
• Collaboration increases sense of efficacy
• Common/Unified mission
• Self-distraction during meeting is viewed as acceptable if not disruptive

Suggestions

Participants’ suggestions and ideas for improvement were collected throughout data collection. Suggestions for the clinic team included coming up with a way to decrease speakers interrupting each other during meetings, and having more space for clinicians to play or garden during breaks. Suggestions made by participants for MDT included the following:

• Provide community resources at meetings
  o Encourage everyone to take one/hand them out

• Have facilitator moderate level of detail discussed in cases more directly
  o Reminder at beginning of meeting
  o Interrupt speaker if details become less relevant to staffing case
  o Encourage members to handle details/impact in other ways (see Global List of Coping Strategies)

• More frequent, direct (non-joking) discussions about vicarious trauma impact
  o More serious comments about vicarious trauma
  o VT training
- Education about signs and symptoms, including physical complaints (i.e., head and neck pain, etc.)
- Time left at the end of meeting to check in with people about impact of cases

**Global Observations**

In this section, overarching questions, observations, and impressions are described. These observations came from the data as a whole, including all quantitative, qualitative, formal, and informal information from the entire program evaluation process. A question that recurred throughout the data was how to better manage negative impacts. Although participants named many negative impacts, the one that stood out was having intrusive thoughts outside of work about cases and clients. The quantitative measures and the qualitative data indicated a mild discrepancy. The quantitative data showed overall very low to average levels of vicarious or secondary trauma; however, the qualitative data indicated people were struggling with the negative impacts of the work. What this discrepancy means, if anything, will be explored further in the Discussion chapter. The overarching impression repeated throughout all data was how supported people feel in this agency.
Chapter V: Discussion

The question of study for this program evaluation was, “How effectively is Monarch Children’s Justice and Advocacy Center addressing vicarious trauma in staff, volunteers, and Multi-Disciplinary Team members?” The purpose of this evaluation was to make recommendations to the organization based on defining what the current practices and policies are regarding vicarious trauma, establishing a baseline of current levels of vicarious trauma/STS distress and cognitive changes in the workers (staff, volunteers, and interns) and MDT members, and exploring workers’ and MDT members’ perceptions of how MCJAC addresses vicarious trauma. Recommendations are based on best practices found to be supported in research literature. The following sections provide baseline data, practices and policies, perceptions of participants, and discussion and summary of limitations of this study.

Baseline Levels of Vicarious Trauma/Secondary Traumatic Stress

The results of this study indicated relatively low to average levels of vicarious trauma symptoms and secondary traumatic stress occurring in MCJAC staff and MDT members at this time. An interesting note to discuss is a discrepancy found between the quantitative measures of vicarious trauma and the descriptions found in the qualitative data. One way to interpret these results is within the normalization framework. Some level of impact is considered a normal response to working with traumatized individuals (Bell et al., 2003; Danieli, 1980; Pearlman & Saakvitne, 1995a). Thus, we should trust both sets of results, in that most of the participants are not experiencing PTSD, but that most of them also experience negative affects at times, which need various levels and types of attention (i.e., maintaining self-care daily, or critical event debriefing).
Summary of Current Practices

Tambra Donohue, Ph.D., provided a description of how she approaches vicarious trauma within the MCJAC programs as the director and clinical supervisor, and within the MDT as facilitator, and how vicarious trauma is approached within the larger organizational structure of the Community Action Council. The full summary of the interview can be found in Appendix C.

As a child advocacy center, MCJAC is accredited by the National Children’s Alliance (NCA) and must meet their ten standards (included in Appendix D). Although those standards do not address VT in any way, they require a level of structure and collaboration which can help stabilize non-profits and individuals working with traumatized individuals (Bell et al., 2003; Pross & Schweitzer, 2010). Bell et al. suggested collaboration decreases isolation, better serves clients, and potentially decreases the workload for any one provider. Pross and Schweitzer found organizational structure has a dramatic impact on the levels of stress and conflict in non-profits working with traumatized individuals that it led them to question the concepts of VT and STS.

Practices and policies of any kind have underlying values that influence the way they are implemented and emphasized. Dr. Donohue described taking a feminist, empowerment leadership approach while recognizing the hierarchical system within which everyone works. Dr. Donohue reported the empowerment approach she uses includes an egalitarian and transparent management style. This approach and style translate practically into bidirectional feedback and induction of staff and MDT members into strategic planning. For example, the MDT discusses systems issues, protocols, and team culture at a monthly Task Force Meeting (T. Donohue, personal communication,
August 23, 2013). Choi (2011) found staff who had access to strategic information had lower levels of STS.

As related to vicarious trauma, Dr. Donohue stated she has an ethical responsibility to inform prospective interns, employees, and MDT members of both positive and negative impacts of vicarious trauma. She reported she considers these initial conversations informed consent for folks coming into work or meetings to be able to make an educated choice about whether or not to be exposed to trauma. Dr. Donohue stated she always discusses these impacts as well as her intention to work with people to lessen the negative impacts by intervening to address the impacts when needed and preventing them when possible (T. Donohue, personal communication, August 23, 2013). This approach is supported and recommended in the literature (Bell et al., 2003; Munroe, 1999). Munroe posited organizations have a responsibility to warn and train their employees in high-risk settings, and that as part of their responsibility to clients’ welfare, clinicians also have a duty to care for themselves. This duty to care for oneself is then extended to organizations to provide necessary support for that care (Bell et al., 2003; Maltzman, 2011).

Dr. Donohue reported that, based on the empowerment model, people have the right to decide how to address their own vicarious trauma. As a supervisor, Dr. Donohue empowers her staff and interns by giving them control over their schedules and jobs, providing training and time for training, and supporting and prioritizing self-care by providing and encouraging leave time. Dr. Donohue identified close working and trusting relationships, space to talk, humor, and a common mission as positively impacting or decreasing vicarious trauma for the MDT and staff. For staff in particular,
some factors Dr. Donohue identified that lessen the impacts are the organizational support, such as providing mental health and medical benefits, encouraging staff to take vacation and to engage in self-care activities, providing and encouraging both job training and vicarious trauma training. These practices are rooted in creating and maintaining a culture of openness and normalization about the impact of the work (T. Donohue, personal communication, August 23, 2013).

Bell et al. (2003) described the need for organizations to create supportive cultures, and made several practical suggestions on how to do so. The literature mostly supported and encouraged organizations to provide opportunities for training, and to encourage leave when needed (Bell et al., 2003; Maltzman, 2011; Pross & Schweitzer, 2010). Not all research suggested organizational support will decrease symptoms, though. Townsend and Campbell (2009) found higher levels of STS were predicted by (among other things) more organizational support and more training in sexual assault nurse examiner (SANE) nurses. The factor ‘organizational support’ was measured by two questions asking how supported the nurses felt; however, other forms of organizational support, such as higher satisfaction with compensation were found to predict lower levels of STS.

Ultimately, Dr. Donohue reported that developing trusting relationships provides the space and opportunity for her to address vicarious trauma organizationally both internally and externally, and on an individual level with staff and MDT members. She described relying on this trust when she realizes a worker or MDT member is suffering a level of vicarious trauma high enough to affect their work (T. Donohue, personal communication, August 23, 2013).
Astro, the Courthouse Dog, has also added to the formal and informal support of staff and MDT members. The mission of Courthouse Dogs Foundation includes providing emotional support to everyone in the justice system (http://www.courthousedogs.com). Dr. Donohue reported seeing Astro make a difference in people’s VT (T. Donohue, personal communication, August 23, 2013), such as people asking after and connecting with Astro when they were having a difficult time with cases. Please see Chapter IV: Results for further information on how Astro was experienced by participants. Overall, Dr. Donohue described practices, policies, and organizational culture that follows recommendations and suggestions found in the research literature.

**Participants’ Perceptions**

One of the goals of formative evaluation is to learn if a program is actually doing what it means to do. This program evaluation found that most of the participants generally experienced the formal and informal practices and the MCJAC culture as Dr. Donohue described them. The participants who work for the MCJAC programs reportedly experienced support, normalization, mostly clear roles, and egalitarian and clear leadership structure. Participants reflected trust, respect, and gratitude toward supervisor, team members, and team meetings.

MDT was experienced by some participants as a point of exposure to material that increased their VT/ST. These comments were always coupled with a desire to maintain the supportive and respectful atmosphere that allows people to get much needed support. However, a need for greater sensitivity to details being revealed unnecessarily was also identified. Participants in the MDT were less likely to perceive any or much direct addressing of VT. However, some indirect practices identified by Dr. Donohue were
described, such as using humor to release tension, and the development of a trusting, respectful atmosphere where people feel comfortable talking about negative impacts. Astro was identified as helping with clients, especially children clients, as well as helping mitigate vicarious trauma for many participants. Participants described much love and gratitude toward Astro.

Recommendations

All of these recommendations are made with the assumption that all decisions and actions taken based on this report will be developed for and by the teams to be flexible and responsive to the complicated, complex, and emergent activities and relationships within and around this agency.

The first recommendation is for the organization as a whole, and each of its parts, to continue the numerous activities they have been engaging in to address vicarious trauma. Study results indicated the staff and MDT members seem to be responding well, and for the most part, have levels of distress or disruption well within manageable levels. The following recommendations are made to build on the existing foundation built by the attention already given to the health and well-being of the staff and MDT members.

The second recommendation is to create a way to gather and implement new suggestions. Although both teams described a trusting and respectful atmosphere, some people could still feel uncomfortable making suggestions at all, or giving less popular or potentially sensitive suggestions and feedback (this idea was not presented in the data collection phase, but was brought up in the stakeholder meetings when the primary researcher was reporting initial findings and stakeholders were brainstorming for recommendations that would fit for them). Thus, finding a way for anonymous
suggestions to be regularly collected and discussed could open avenues to further address vicarious trauma not previously explored or acknowledged. Developing a structure to handle new suggestions will help the agency utilize the feedback from this report. This structure will likely be most useful if it remains ongoing and adds to the established conversation and culture.

The third recommendation is for the organization to continue discussing how to maintain a safe environment for all workers. Although this was not a recurring theme, due to the importance of safety to the health and well-being of service providers, a data indicating that any participants feel unsafe warrants discussion and a call for suggestions for how the organization can maintain a safe environment for staff, volunteers, and MDT members.

The fourth recommendation is to continue evaluating levels of vicarious trauma/secondary traumatic stress. Gathering more than one data point could give a larger, ongoing view of how the groups are doing. The evaluation could be done in multiple ways. Two measures are available at no cost, the Secondary Traumatic Stress Scale (STSS), and the Professional Quality of Life Scale (ProQOL) (Stamm, 2010). The STSS was used for this study, so baseline information is now available for this measure for MCJAC participants. However, due to MCJAC being a learning facility, intern clinicians change every one to two years, making this baseline less relevant in a short time. The STSS is focused totally on PTSD criteria. The ProQOL does have some conceptual confusion with the term compassion fatigue, in that the questions do not address compassion or fatigue; however, aside from that issue, it does provide a more rounded measurement tool. The ProQOL studies compassion fatigue/STS, burnout, and
compassion satisfaction. This tool has been used in research extensively, and does have some moderate to strong psychometrics (Stamm, 2010). Including the compassion satisfaction component can provide some process benefits, in that the act of taking the test could remind people of the positives of their job rather than only the negative. Additionally, due to the subclinical levels of STS found in this report, having a more complete snapshot of functioning might also be useful. How this continued evaluation is implemented depends on each team, the purpose of the evaluation (i.e., individuals monitoring themselves, or the organization monitoring the workers for which it is responsible), and issues of confidentiality/anonymity in this small agency setting.

Each team had a brief brainstorming session at the stakeholder meetings held after initial data analysis. These meetings generated the following discussion points and suggestions.

**Clinic stakeholder meeting.** It was noted that the general focus of caring for and addressing vicarious trauma is starting to shift in the field from an individual focus to an organizational one. The role and responsibility organizations have in addressing and managing the stress and trauma of their workers is becoming more recognized.

A stakeholder noted suggestions and recommendations should have space and room for the organization to implement specifics as they see fit, rather than specific prescriptions that could feel imposing. A rich discussion ensued related to the burden self-care can add to an already stressed or traumatized professional.

The following ideas were generated by the clinic team for themselves to dream or think about:

- Rooftop garden
• Comfortable space for just us – away from clients
• Regular opportunities for physical movement and play
  o Toys, games
• Time for enjoying each other socially with no talk about work
  o Camping
  o Parties
  o Picnics
  o Group walks
• Connecting with nature

**Multidisciplinary team stakeholder meeting.** The discussion in this group was raucous and filled with laughter. People here seemed to have a lot of fun generating ideas. Discussing the topic of vicarious trauma more seriously could be challenging. The humor was found in the data to both feel supportive and avoidant by participants. This team might do well to have an agenda item related to vicarious trauma on a time-scale that allows for both the serious conversations to take place, as well as the light, supportive, tension-relieving atmosphere.

Most of the ideas generated by this team focused on enjoyable team-building activities. It was noted the activities need to be fun and safe for everyone. Some stakeholders noted some specific ideas were too much like work (i.e., laser tag for law enforcement). The following ideas were generated by the clinic team for themselves to dream or think about:

• Organize team-building retreats
  o Disneyland
o Beach

o Laser tag

o Horse race tracks

- Watch movies for a meeting
- Play games (e.g., Family Feud)
- Dress in costume themes for meetings
- Place a suggestion box for anonymous suggestions/ideas

**Limitations**

Participants in this study self-selected and self-reported all data. These forms of data collection are inherently limited in that participants with higher levels of VT/STS may have chosen not to participate, or those with lower levels may not have been interested in the project. A disadvantage of self-reported data is the vulnerability of it to distortions for many reasons, such as more socially desirable (Heppner, Wampold, & Kivlighan, 2008). This limitation was addressed in part by having the survey packet anonymous; however, in a small agency setting, anonymity is questionable. The self-report bias might at least partially explain the responses to the qualitative question about negative coping strategies. Many participants left that question blank or answered with no detail. This could also be explained as participants are not using many negative coping strategies.

Most questions appeared to be answered straightforwardly in ways that made sense; however, the TABS measure was problematic in a couple of ways. Several questions were confusing for participants, based on questions and comments made during or after administration. These confusing items might have skewed TABS results in either
direction. Due to anonymity, follow-up was not possible for endorsed items that were more concerning. Therefore, TABS scores and critical items should be viewed with caution.

Finally, the primary researcher fits best in the role of internal evaluator as a former and current intern. Both internal and external evaluators bring biases to their studies (as in all research), though the biases tend to be of a different nature (Fitzpatrick et al., 2011). As an internal evaluator, the primary researcher has interpersonal relationships with the people who implement and manage the programs. Both internal and external evaluators bring cultural and individual values to their research. These values will necessarily shape the focus, emphasis, and decisions made during the evaluation. The friendships and professional ties the primary researcher has with people at this site may have caused bias, or created tension or stress. These ties also offered a greater level of trust between the evaluator and the director and participants, which might have allowed participants to give a greater amount of information, or it could have increased their self-report bias. These are all aspects of the political nature of program evaluation (AEA, 2004; Fitzpatrick et al., 2011).

This study was small, with only 16 participants, split between two teams. Thus neither causative or correlational statements can be made based on these samples. Continued evaluation could provide more data points which will sharpen the image; however, the sample is simply too small for any conclusive inferences to be drawn from it. While this limitation is inherent in small program evaluations, the purpose of the evaluation is not to provide data to better understand the particulars of MCJAC. The
trends, themes, and direct responses reported in the results appear to give the agency valuable information for responsive and tailored practices to address VT/ST.

**Conclusion**

This program evaluation clarified practices, policies, and intentions about how the organization is addressing vicarious trauma. The evaluation produced several logic models related to the question of study and of MCJAC’s activities and goals as an agency. The study data supported the implementation of practices and intentions, and it made recommendations based on all those elements as well as stakeholder input and research literature. The evaluation found MCJAC had clearly articulated intentions and actions based on current research and well-articulated values for addressing the health and well-being of their staff and partners. These actions were found mostly to be perceived and experienced as intended. The primary researcher hopes to use this PE as the first step in creating a model for organizations to address VT/ST at a systems level.

One of the more interesting findings in this PE was the positive impact of Astro, the courthouse dog, on participants’ experience of vicarious trauma both because of how much he helps the participants do well in their work with victims and families, and also how he helps people feel good when he is present. Unfortunately, this study is so small no generalization can be made, but this together with the anecdotal stories of other programs having similar experiences with courthouse dogs certainly points a direction for future research of animals and VT/ST outcomes with providers of services.
References


Appendix A: Organizational Information of
Monarch Children’s Justice and Advocacy Center

Table A1.

Monarch Children’s Justice & Advocacy Center’s Annual Report

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<th>Reporting Period</th>
<th>Sex</th>
<th>Age</th>
<th>Type of Abuse</th>
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Funding Sources

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Figure A1. Community Action Council Line of Authority Organizational Chart. Agency archival document reproduced with permission. (Personal communication, Tambra Donohue, Program Director, Monarch Children’s Justice and Advocacy Center).
Figure A2. Monarch Children's Justice and Advocacy Center Organizational Chart. See below for text outline.
Text Outline of Figure A2

- Organizational structure
  - Community Action Council
    - Umbrella organization
      - Fiscal oversight and personnel policies
  - Child Advocacy Center (Monarch Children’s Justice and Advocacy Center)
    - Accredited by National Children’s Alliance
    - Tambra Donohue, PhD is director
      - In charge of:
        - NCA accreditation standards for all programs and MDT
        - Policies and procedures
        - Staffing
  - MCJAC Programs
    - Therapy Program
    - Family Advocate Program
    - Forensic Interviewing Program
  - Multidisciplinary Team (Tambra Donohue, PhD facilitates)
  - Co-located partners
    - Providence St. Peter Hospital Sexual Assault Clinic
    - Thurston County Attorney General’s Special Victims Prosecution Unit
  - Community Partners
    - See NCA standards for MDT above for a list of partners required to be represented
Appendix B: Logic Models

Figure B1. Formative Logic Model for Monarch Children’s Justice and Advocacy Center. This formative model provides the logical steps between what MCJAC does and the hoped for results. MDT = multidisciplinary team; NCA = National Children’s Alliance; CSA = childhood sexual abuse; VT = vicarious trauma; tx = treatment
Figure B2. Addressing Vicarious Trauma at MCJAC. This is a model of the philosophy and logic guiding MCJAC’s approach to addressing vicarious trauma, and how these elements were studied in this program evaluation.
Appendix C: Summary of Interview With

MCJAC Director

Current Practices and Policies Addressing Vicarious Trauma

The following information was gathered from an interview with Tambra Donohue, Ph.D., Director of Monarch Children’s Justice and Advocacy Center (MCJAC) on August 23, 2013; existing agency documents (such as brochures and policy forms); and organization websites.

Organizational structure. Understanding the practices and policies of MCJAC must start with a more detailed understanding of the organizational structures in place (please see Appendix A for organizational charts). Monarch Children’s Justice and Advocacy Center is a Children’s Advocacy Center that is accredited by the National Children’s Alliance (NCA). The NCA has ten standards (included in Appendix D). The Advocacy Center includes the MDT, to which certain community partners must be represented per the NCA’s standards. Thus, the partners are included within the Children’s Advocacy Center’s accreditation. Two of those community partner agencies, the Providence St. Peter Hospital Sexual Assault Clinic and the Thurston County Attorney General’s Special Victims Prosecution Unit, are co-housed within the same building as MCJAC’s programs. Dr. Donohue is the managerial supervisor and clinical supervisor for the clinicians and staff who work within the therapy, family advocacy, and the forensic interviewing programs within MCJAC. Dr. Donohue is also the director of the Children’s Advocacy Center and, within that role, facilitates the MDT. As director of the Children’s Advocacy Center and supervisor of MCJAC’s programs, Dr. Donohue is in charge of accreditation standards, policies and procedures, and staffing.
As an agency, MCJAC is placed within the umbrella organization, Community Action Council of Thurston County, which provides financial and policy oversight of MCJAC. Community Action Council contains several anti-poverty programs, such as WIC (please see Appendix A for organizational chart). Thus, MCJAC’s organizational structures are complicated and complex as a small agency with multiple levels of oversight by different entities, with complex and emergent relationships with community and co-housed partners, and with Dr. Donohue’s multiple hats within those structures.

**Organizational values.** Having clearly defined values help organizations maintain a “north star” when making decisions about what programs to provide and how to develop and implement policies. Organizational values will also contribute to how that agency approaches topics such as vicarious trauma in their workers. For example, if an organizational value of an agency or department is to have the most clients seen no matter the cost to workers, then workers’ self-care is less likely to receive much attention or support. Thus, having a clear picture of the organizational values influencing MCJAC’s practices will help this program evaluation achieve a depth of analysis and establish the foundation for MCJAC’s practices and policies regarding vicarious trauma (Fitzpatrick et al., 2011).

During Dr. Donohue’s interview, a constant dance took place in trying to untangle her personal and professional values from the values represented organizationally. According to Dr. Donohue, she is given a lot of leeway to manage and supervise MCJAC’s programs and the Children’s Advocacy Center because of the trust she has built with Community Action Council and agency partners. Thus, the values Dr. Donohue relies on for her leadership roles are implemented on an organizational level
within those programs. However, as she described, her leadership role is less well defined within the MDT, thus the values influencing and contributing to that group are more diverse and Dr. Donohue’s influence is more diffuse as the facilitator. “…With many of the partners I don’t have any supervisory relationship, so it’s operating all by relationship and facilitation of those relationships, and their… interrelationships. So, a lot of what I do is by facilitation and relationship building, and community building, and cross-education over systems” (T. Donohue, personal communication, August 23, 2013).

Then also, the Children’s Advocacy Center and the Community Action Council have clearly defined missions and organizational values that are reflected in policies and procedures. In general, MCJAC, the MDT, and Community Action Council are centered on doing work that is contributing in a positive way to healing and to development of staff.

**Leadership values.** Dr. Donohue described taking a feminist, empowerment approach while recognizing the hierarchical system within which everyone works. “The more power and control people have within trauma environments, the more that they are able to address vicarious trauma, and also increase their happiness and well-being in their position… within, you know, certain restraints that we have to operate under, and within certain safety precautions” (T. Donohue, personal communication, August 23, 2013). Dr. Donohue reported the empowerment approach she uses includes an egalitarian and transparent management style. This approach and style translate practically into bidirectional feedback and induction of staff and MDT members into strategic planning. For example, the MDT discusses systems issues, protocols, and team culture at a monthly Task Force Meeting. “So I try to get regular feedback from the team about how they’re
experiencing the culture and what’s working for them” (T. Donohue, personal communication, August 23, 2013).

As related to vicarious trauma, Dr. Donohue stated she has an ethical responsibility to inform prospective interns, employees, and MDT members of both positive and negative impacts of vicarious trauma. She reported she considers these initial conversations informed consent for folks coming into work or meetings to be able to make an educated choice about whether or not to be exposed to trauma. Dr. Donohue stated she always discusses these impacts as well as her intention to work with people to lessen the negative impacts by intervening to address the impacts when needed and preventing them when possible (T. Donohue, personal communication, August 23, 2013).

Missions.

Children’s Advocacy Center and Multidisciplinary Team. According to the National Children’s Alliance website:

The primary goal of all National Children's Alliance Children’s Advocacy Centers (CAC) is to ensure that children disclosing abuse are not further victimized by the intervention systems designed to protect them. CACs are child-focused, facility-based programs with representatives from many disciplines working together to effectively investigate, prosecute, and treat child abuse. CAC locations are not only child-focused, but designed to create a sense of safety and security for child victims. (http://www.nationalchildrensalliance.org/)

The MDT has widely differing sets of values influencing the group. The members come from independent partner organizations and agencies, which all have their own cultures and sets of values, in addition to members’ personal values. However, “the mission of the MDT is to provide a place for collaboration all in agreement of reducing trauma in children” (T. Donohue, personal communication, August 23, 2013). The
purpose of the MDT is to prevent cases from falling through the cracks due to a lack of coordination or even communication between agencies – public and private.

So [the MDT] gives us ways to, in a confidential meeting, provide innovative ways to address really complex cases, and everybody at the table with mission to reduce the trauma to the children. It’s also an empowerment-based model. The idea being that when there’s trauma and when kids have been victimized, a lot of their power has been taken from them and the families. And so the empowerment model kind of flows through the entire process. The more we can empower victims to have choices, and educate them in what the… systems can and can’t do - the better outcomes for kids, as well as cases. (T. Donohue, personal communication, August 23, 2013)

Community Action Council.

In recognition that poverty impacts all members of our community, our mission is to identify and facilitate the use of resources toward the reduction of the hardships associated with poverty; to promote self-sufficiency; to strengthen family and improve the quality of life for all residents of Lewis, Mason and Thurston Counties. (Community Action Council Employee Handbook, September 2011)

Community Action Council values include providing a “positive working environment and solid economic foundation for their employees” (Community Action Council Employee Handbook, September 2011). In practice, Dr. Donohue reported this goal is met through fair wages to staff; merit increases; policies of leave; and general care toward staff, which includes providing trainings, open communication, and support about vicarious trauma and other impacts of the work on their staff (T. Donohue, personal communication, August 23, 2013).

Vicarious trauma defined. One result of this program evaluation will be a working definition of vicarious trauma by MCJAC, for MCJAC. This section begins that evolving definition by including Dr. Donohue’s definition.

I would describe vicarious trauma as the impact on individuals who are working in cases that involve traumatic events, and ours specifically are mostly related to child trauma, child physical abuse, sexual abuse, child fatalities and criminal neglect. But many of our team also work with the adult cases of sexual assault
and other cases that tend, because our team works with lots of different, so now I’m talking about the MDT… vicarious trauma is that impact of working directly with individuals who’ve been traumatized. And many people typically have an empathetic response to the clients that they’re working with and so I think that part of it is through that empathetic responding that people have, they’re own emotional reactions to the traumatic material. Vicarious trauma can look a lot of different ways for different people and can impact them in, I think, in every domain in their lives. In some ways similar to PTSD, is a way, one way to think about it. Not that it is PTSD, but I’ve known cases that have reached the clinical level of PTSD. But vicarious trauma can affect people in emotional responding, social responding, physical responses, in really, I think in every arena of their lives. (T. Donohue, personal communication, August 23, 2013)

As was discussed in the Literature Review, the DSM-5 (American Psychiatric Association, 2013) included secondary exposure to traumatic material in the diagnosis of PTSD. At the time of this interview, the DSM-5 (American Psychiatric Association, 2013) had not yet been fully integrated into clinical application.

Current practices and policies. Dr. Donohue stated, “We have a responsibility to provide – at minimum – education on vicarious trauma, opportunities to talk about it, and to debrief cases as people want to, and to share their vicarious trauma as they wish, to talk about how you can identify, prevent vicarious trauma” (T. Donohue, personal communication, August 23, 2013). Based on the empowerment model, people have the right to decide how to address their own vicarious trauma. As a supervisor, Dr. Donohue empowers her staff and interns by giving them control over their schedules and jobs, providing training and time for training, and supporting and prioritizing self-care by providing and encouraging leave time (T. Donohue, personal communication, August 23, 2013).

Thus, the practices addressing vicarious trauma are rooted in creating and maintaining a culture that fosters openness and normalizes the impacts: Whenever we have group meetings, whether it’s clinic, intern meetings, or MDT meetings, I will bring, almost invariably will bring it up, just to keep normalizing it, bring it to the surface, giving opportunities to talk about it… I’ll share some of
my own experiences with vicarious trauma to normalize it even more. Point it out when I see it happening… We use a lot of humor, so I can use humor, upstairs with the MDT. I can use humor to point that – what may seem inappropriate sometimes is really vicarious trauma – and I think pointing that out can also help address the fact that sometimes it appears inappropriate, dark, like morbid humor that you might see in emergency rooms and things. So that’s a phenomena we see in lots of different trauma environments, where the people who work in those environments develop a humor around their work. (T. Donohue, personal communication, August 23, 2013)

Ultimately, Dr. Donohue reported that developing trusting relationships provides the space and opportunity for her to address vicarious trauma organizationally internally and externally, and on an individual level with staff and MDT members. She described relying on this trust when she realizes a worker or MDT member is suffering a level of vicarious trauma high enough to affect their work. Dr. Donohue reported she has handled that situation in the past with direct communication and normalization about how the impacts of this work often contribute to staff issues. This normalization, she noted, is often appreciated by the person being impacted.

**Astro, the courthouse dog.** During the time this evaluation was taking place, MCJAC was approved as a site for housing a dog from the Courthouse Dogs Foundation. The following is a description from the Foundation’s website:

Since 2003, courthouse dogs have provided comfort to sexually abused children while they undergo forensic interviews and testify in court. These dogs also assist treatment court participants in their recovery, visit juveniles in detention facilities, greet jurors and lift the spirits of courthouse staff who often conduct their business in an adversarial setting… The mission of Courthouse Dogs Foundation is to promote justice with compassion through the use of professionally trained facility dogs to provide emotional support to everyone in the justice system. (http://www.courthousedogs.com)

Monarch Children’s Justice and Advocacy Center went through an extensive evaluation in order to receive a courthouse dog at their facility. This evaluation included a site evaluation, extensive interviews with co-housed and community partners, and
board approval in order to ensure MCJAC would be able to maintain the dog’s well-being and priorities as a working animal. Dr. Donohue was chosen as the primary handler with four co-handlers, including the forensic interviewers, a therapist, and a nurse practitioner. Dr. Donohue described anecdotal stories from other Children’s Advocacy Center directors at facilities that have courthouse dogs. These directors have remarked to her about the positive impacts on the children and the cases, as well as on their staff. Dr. Donohue was scheduled to leave for a week-long training required of primary handlers the week after the date of the interview for this evaluation. The following week she would be bringing Astro, a two-year old dog specially trained and bred for temperament to MCJAC. Dr. Donohue stated she had noticed a positive difference in her staff with just the idea of Astro coming soon.

**Vicarious Trauma Resources Used.** Dr. Donohue specifically identified Laura van Dernoot Lipsky’s trainings (http://traumastewardship.com) and book, *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others* (2009) as resources the Children’s Advocacy Center accesses. Van Dernoot Lipsky has provided trainings for the Children’s Advocacy Center and for Providence Saint Peter’s in the past. Otherwise, Dr. Donohue reported she reads current research regarding vicarious trauma.

**Factors that Impact Vicarious Trauma for Staff and MDT Members.**

Dr. Donohue identified primarily systems factors as having a negative impact on vicarious trauma, or increasing the impacts. She reported they have seen a general increase in number and severity of cases, particularly with military returning home as well as current economic factors decreasing basic supports for families. Dr. Donohue reported she notices throughout the agency that witnessing systems failing families when
basic needs are not being met increases vicarious trauma responses. For staff in particular, the large list of clients waiting to be seen for therapy increases the negative impacts of the work. In addition, MDT members are coming from very diverse professional settings and backgrounds.

Dr. Donohue identified close working and trusting relationships, space to talk, humor, and a common mission as positively impacting or decreasing vicarious trauma for the MDT and staff. For staff in particular, some factors Dr. Donohue identified that lessen the impacts are the organizational support, such as providing mental health and medical benefits, encouraging staff to take vacation and to engage in self-care activities, providing and encouraging both job training and vicarious trauma training.

**Hopes for Outcomes of Current Practices and Policies.**

Dr. Donohue articulated her hope that workers and MDT members feel free to talk about vicarious trauma impacts, and even be able to point it out in each other when it is happening. She hopes workers and MDT members are able to recognize vicarious trauma in themselves and others, and are more capable of addressing it and acknowledging it. She hopes they have some choices about what to do about vicarious trauma impacts, and that folks will support each other and work as a team.

As Dr. Donohue articulated blocks to addressing vicarious trauma organizationally, these became general hopes for the future. She hopes for more funding and personnel to meet more need, and more resources for clients. “It would be great to have things on site that people could – retreats and more funding, more room, more things that address well-care would be great” (T. Donohue, personal communication, August 23, 2013).
Appendix D: National Children’s Alliance (NCA) Accreditation Standards

1. Multidisciplinary Team (MDT). A multidisciplinary team for response to child abuse allegations includes representation from the following:
   - Law Enforcement
   - Child Protective Services
   - Prosecution
   - Medical
   - Mental Health
   - Victim Advocacy
   - Children's Advocacy Center

2. Cultural Competency and Diversity. Culturally competent services are routinely made available to all Children Advocacy Center clients and coordinated with the multidisciplinary team response.

3. Forensic Interview. Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact finding nature, and are coordinated to avoid duplicative interviewing.

4. Victim Support and Advocacy. Victim support and advocacy services are routinely made available to all Children Advocacy Center clients and their nonoffending family members as part of the multidisciplinary team response.

5. Medical Evaluation. Specialized medical evaluation and treatment services are routinely made available to all Children Advocacy Center clients and coordinated with the multidisciplinary team response.
6. Mental Health. Specialized trauma-focused mental health services, designed to meet the unique needs of the children and non-offending family members, are routinely made available as part of the multidisciplinary team response.

7. Case Review. A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis.

8. Case Tracking. Children’s Advocacy Centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.

9. Organizational Capacity. A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.

10. Child Focused Setting. The child-focused setting is comfortable, private, and both physically and psychologically safe for diverse populations of children and their non-offending family members.

(National Children’s Alliance, http://www.nationalchildrensalliance.org)
Appendix E: Permissions for Copyrighted Material

Table E1.

American Psychological Association Permission Information

Title: An exploratory investigation into self-other differentiation: Empirical evidence for a monistic perspective on empathy.

Author: Corcoran, Kevin J.

Publication: Psychotherapy: Theory, Research and Practice

Publisher: American Psychological Association

Date: Jan 1, 1982

Copyright © 1982, Division of Psychotherapy (29), American Psychological Association

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Note. See https://s100.copyright.com/AppDispatchServlet#formTop

Kevin Corcoran gave permission through email for Molly O’Neil to use Figure 2:

κ <mypalkevin@aol.com> 6/19/14

to me

You may. Would you send me the abstract once you are finished?

Best of luck w your studies.

Kevin Corcoran
Emails giving permission to identify MCJAC and publish organizational information:

Molly O'Neil <mollyoneil22@gmail.com>  Feb 18

to tambra

Hi, Tambra,

Hope all is well. I'm wondering if we can say definitively yet whether I need to de-identify Monarch, now that you've gotten a chance to see the more in-depth organizational information I include.

Thanks,
Molly

tambra donohue <tambrad.monarch@caclmt.org>  Feb 18
to me

No, I don’t see any need to de-identify—thanks!
Appendix F: MCJAC Questionnaires and Interview Protocol

Demographics Questionnaire

1. What is your
   a. Age?_______________________________
   b. Race?_______________________________
   c. Ethnicity?_______________________________
   d. Gender?_______________________________

2. Please circle the position you hold in relation to Monarch Children’s Justice and Advocacy Center (please circle only one):
   a. Volunteer/Unpaid Intern
   b. Paid Employee
   c. Paid Contract Worker
   d. Community Partner

3. How long have you been working in your current position? _________years
   _________months (if applicable)

4. How long have you been working in your professional field? _________years
   _________months (if applicable)
Questionnaire for Staff, Volunteers, and Multidisciplinary Team Members

**Definition**

**Vicarious trauma**: refers to the impact on others from hearing the explicit accounts of the directly traumatized individual’s experiences, traumatic stress which develops from the knowledge of a traumatizing event, and indirect exposure to a traumatic event(s) causing changes in the person’s way of experiencing the self and the world (Lerias & Byrne, 2003).

1) MDT members, please mark how often you have attended MDT on average over the last 6 months.

1 time/month  2 times/month  3 times/month  4+ times/month

**Section I**

1) Please describe how Astro, the courthouse dog, has affected you and/or your work.

2) How has your experience at Monarch Children’s Justice and Advocacy Center (MCJAC) or in the MDT affected your life outside of MCJAC/MDT?

3) Is there something you wish you knew or understood about vicarious trauma?

4) Please describe what you like and/or love about your work.

5) How does your work affect you in ways you do not like?

6) Do you do any activities to help you handle the stress in your life? If so, what activities do you do and how frequently (ex. “exercise, 3x/week” or “drink alcohol 3x/week”)

7) Are there activities that help you handle your stress, but you would not want others to know about?

   If so, what activities do you do and how frequently (ex. “smoke pot, 3x/week” or “use porn 3x/week”). (If you can not be explicit, please follow this example: “activity 1, 3x/week, activity 2, 3x/week”)

---

1 In the original questionnaire, space was left after each qualitative question for handwritten answers.
**Section II – 1st Team**

This section includes questions about your experiences with the team meetings. **If you attend both regularly, please fill out one for each team meeting. Please circle which team your answers are for on this page:**

<table>
<thead>
<tr>
<th>Multi-Disciplinary Team (MDT)</th>
<th>Therapy Program Clinical Team</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disagree</strong></td>
<td><strong>Disagree</strong></td>
<td><strong>Neither Agree nor Disagree</strong></td>
<td><strong>Agree</strong></td>
<td><strong>Agree Strongly</strong></td>
</tr>
<tr>
<td>1</td>
<td>Other members of the team have helped me understand how my work affects me.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I feel support from the team when I am feeling sad, angry, or worried about a case.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I feel annoyed when people talk about the negative impact of this work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>When I see a team member showing signs of vicarious trauma, I know how to give them support.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I can tell when I am being negatively impacted by my work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The leader(s) of the team has helped me to understand my own vicarious trauma.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I leave the meetings feeling that I’m not alone.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>My friends and/or family don’t understand my work – they just don’t get it.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The team laughs together.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I leave the team meetings feeling more sad, worried, angry, or numb than before.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I can talk to team members about difficult feelings I have about a case.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I trust the leader(s) of the team to maintain a supportive tone in the meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>13</td>
<td>I feel confident I know what <em>vicarious trauma</em> means.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Members of my team have taught me a lot about how my work affects me.</td>
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<tr>
<td>15</td>
<td>I leave the team meetings with more energy than before.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I can talk to the leader(s) of the team about difficult feelings I have about a case.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Even though I can’t talk to my friends/family about details of cases, I can talk to them about how I’m feeling about work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I don’t understand why we talk about vicarious trauma at all at the meetings.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td>I trust the team members to maintain a supportive tone in the meeting.</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section II – 2\(^{nd}\) Team\(^2\)**

\(^2\) In the original questionnaire, a second copy of Section II was included.
**Section III**

Do you work for Monarch Children’s Justice and Advocacy Center (MCJAC) as either staff, contract worker, or volunteer?

Yes  No

**If yes**, please answer the following questions based on your experiences at MCJAC.  
**If no**, please skip this section.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Agree</td>
<td>Agree Strongly</td>
</tr>
<tr>
<td>1</td>
<td>I have control over how my job gets done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>My workplace encourages me to take leave when I need to.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>My co-workers ask me how I’m doing when I’m feeling upset.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I feel physically safe at work, including coming and going.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>My supervisor(s) asks me my opinion.</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>My co-workers think taking leave is selfish or weak.</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>7</td>
<td>When I need a break at work, I have a comfortable place to go.</td>
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<tr>
<td>8</td>
<td>My co-workers are compassionate toward clients.</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>My workplace is decorated in a warm and welcoming way.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>I understand my agency’s plan of action to achieve our mission.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>My supervisor(s) encourages taking time off for training.</td>
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<td></td>
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<td></td>
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<td>---</td>
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<td></td>
</tr>
<tr>
<td>12</td>
<td>My workplace provides training about vicarious trauma.</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>13</td>
<td>My ideas are listened to at staff meetings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I feel like my co-workers and I belong to a supportive team.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I feel hassled at work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I make my own schedule at work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section IV**

Do you have any other questions, thoughts, or comments?

**Thank you for your participation!**
Interview Protocol

1. How do you manage to sustain your personal and professional wellbeing, given the challenges of your work with seriously traumatized clients?

2. Please describe current practices in this organization that specifically address VT.

3. How do you experience stress and conflict [in the clinic] [in the MDT]?

4. How do you describe the formal and informal power structure [in the clinic] [in the MDT]?

5. What do you witness happening in your team that contributes positively (then negatively) to overall levels, or to the quality of VT among staff/MDT?

6. What steps would you or do you take if it becomes clear a co-worker’s responsibilities are being compromised possibly due to VT?

7. How do you identify VT in yourself?

8. Is there anything you wish you could do to address VT, but can’t?
Appendix G: MCJAC’s Coping Strategies and Impacts

Table G1.

**MCJAC’s Coping Strategies**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise/gym</td>
<td>Personal therapy</td>
</tr>
<tr>
<td>Physical activities (such as walking,</td>
<td>Take time off</td>
</tr>
<tr>
<td>swimming, golfing, etc.)</td>
<td>Control news input</td>
</tr>
<tr>
<td>Yoga</td>
<td>Spend time with happy, grounded people</td>
</tr>
<tr>
<td>Light/different reading or watching</td>
<td>Moderate alcohol use</td>
</tr>
<tr>
<td>Have fun/laugh/play games</td>
<td>Moderate distraction during meetings</td>
</tr>
<tr>
<td>Eat well</td>
<td>Maintain balance in life</td>
</tr>
<tr>
<td>Cook</td>
<td>Alone/social time</td>
</tr>
<tr>
<td>Travel and vacations</td>
<td>Work/family time</td>
</tr>
<tr>
<td>Talk to colleagues/team meetings</td>
<td>Maintain perspective</td>
</tr>
<tr>
<td>Supervision</td>
<td>Clients’ lives are their path, not mine</td>
</tr>
<tr>
<td>Connect with nature/beauty</td>
<td>Doing all I can, then letting go</td>
</tr>
<tr>
<td>Play with pets/animals</td>
<td>Many people doing incredible work</td>
</tr>
<tr>
<td>Sleep</td>
<td>More good happens than bad</td>
</tr>
<tr>
<td>Pampering self</td>
<td>Remember successful outcomes</td>
</tr>
<tr>
<td>Write</td>
<td>Leave workplace for breaks</td>
</tr>
<tr>
<td>Prayer/meditation/spiritual reading</td>
<td>Ask for support when needed</td>
</tr>
<tr>
<td>Hugs/handholding</td>
<td>Training</td>
</tr>
<tr>
<td>Family/social time</td>
<td>Maintain boundaries</td>
</tr>
<tr>
<td>Alone time</td>
<td>Between work and personal life</td>
</tr>
<tr>
<td>Sing/play music</td>
<td>Separation with people we serve</td>
</tr>
</tbody>
</table>

**Negative strategies**

- Alcohol and Substance use/overuse
- Too much (eating, sweets, TV, etc.)

*Note.* This list was generated from all data sources and generalized to maintain confidentiality of participants.
Table G2.

Specific Negative Impacts

<table>
<thead>
<tr>
<th>Increased irritability</th>
<th>Playing trauma stories over and over in mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased insomnia</td>
<td></td>
</tr>
<tr>
<td>Physical symptoms (i.e., neck pain)</td>
<td>Not enjoying/loving what I do as much</td>
</tr>
<tr>
<td>Upsetting dreams</td>
<td>Not feeling effective</td>
</tr>
<tr>
<td>Increased suspicion and fear</td>
<td>Sadness, horror, and confusion</td>
</tr>
<tr>
<td>Increased cynicism and judgment</td>
<td>World seems dark and scary</td>
</tr>
<tr>
<td>More jumpy</td>
<td>Decreased activity/health</td>
</tr>
<tr>
<td>Jealousy about others’ simple lives/innocence</td>
<td>Feel drained/overwhelmed at the end of the day</td>
</tr>
<tr>
<td>Do not want to do self-care</td>
<td>Defeated/hopeless about sexual abuse as epidemic and by broken system</td>
</tr>
<tr>
<td>Thinking about loved ones in trauma stories</td>
<td>More aware of hidden wounds</td>
</tr>
<tr>
<td>Delayed reaction to stories</td>
<td>Less social</td>
</tr>
</tbody>
</table>

Note. This list was generated from all data sources and generalized to maintain confidentiality of participants.