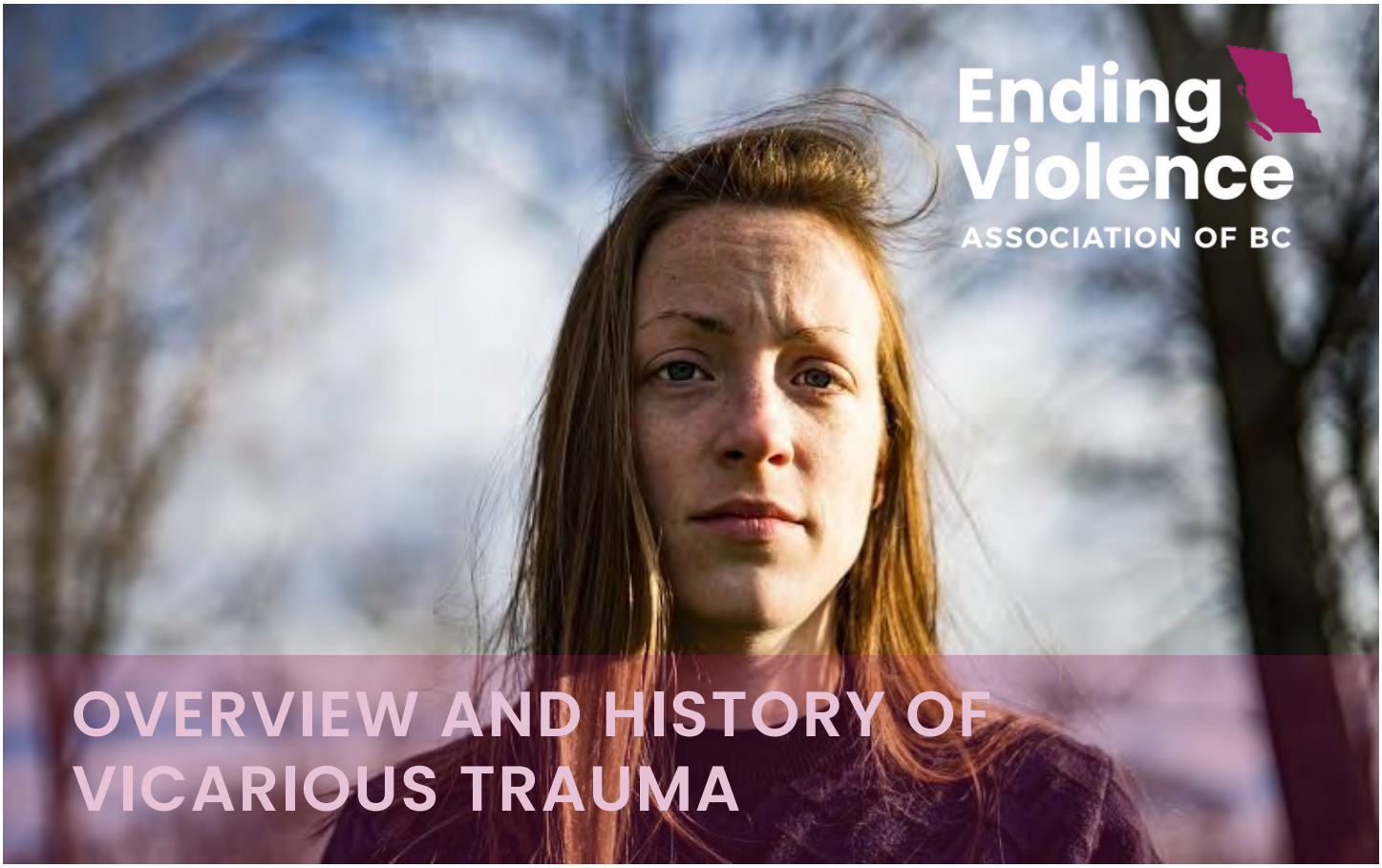


OVERVIEW AND HISTORY OF VICARIOUS TRAUMA

Since the early nineties, research has been emerging documenting the changes that occur in workers who support primary trauma survivors. Over the two decades of research, various concepts have been developed to describe the impacts on workers: secondary traumatic stress (Stamm, 1997), compassion fatigue (Figley, 1995), vicarious traumatization (Pearlman & Saakvitne, 1995), post-traumatic stress (term often employed in research on first responders) and burnout (Freudenberger, 1974). Initially, these concepts were put forward with unique presentations, such as secondary traumatic stress having a presentation of intrusive imagery and hyperarousal, accompanied with avoidance directly related to a client's traumatic narrative (Branson, 2019). Compassion fatigue develops over time for caretakers, helping professionals, family, and friends of anyone needing ongoing support and care, resulting in a sense of helplessness and overwhelm and an accompanying disconnection from self and one's sense of compassion (Branson, 2019).

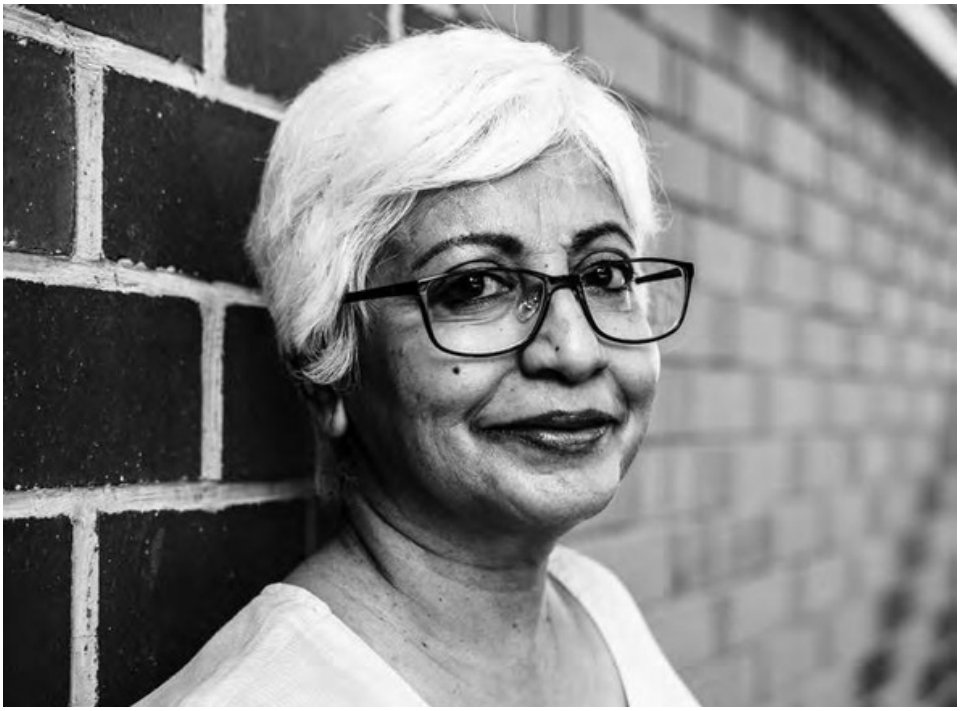
Burnout was originally conceptualized as "becoming exhausted by making excessive demands on energy, strength, or resources" in the workplace (Freudenberger, 1974, p. 159). It is helpful to recognize its presentation as a reaction to an organizational systems impact – namely poor working conditions, including low wages, poor morale, lack of organizational support and appreciation, and high turnover (Branson, 2019). For more descriptions of the similarities and differences within these terms, please refer to EVA BC's 2020 report, Community-Based Anti-Violence Worker Wellness: A Review of the Literature (see references).

Over the 30 years that these terms have been discussed and researched, their unique characteristics have been blurred, and the concepts are now often used interchangeably. The use of various concepts to describe the same process – the transformation of professionals due to their exposure to suffering within

their work – has been problematic, as it can become unclear what researchers are measuring and comparison of studies is compromised. Interchangeable terms have also confused those within the field, leaving many to wonder how to accurately name what they are experiencing.

In the feminist anti-violence field, the term vicarious trauma, first coined by McCann and Pearlman (1990) has been adopted. It is McCann, Pearlman and Saakvitne who began to study the impacts on workers within feminist organizations who were responding to survivors of interpersonal violence, marking a shift in the research, which had been mostly focused on health care professionals.

In 1995, Tedeschi and Calhoun coined the term post-traumatic growth to refer to the positive growth that can occur after a traumatic experience. Over time this concept has been applied to the helping professions, in particular to those supporting survivors, with the understanding that strategies can be employed to foster vicarious resilience and growth rather than traumatization. Pearlman has identified that engaging deeply in our work and work recovery, expanding our resources, and examining our beliefs fosters post-traumatic growth. Additionally, various researchers have confirmed that organizational support is a key factor in promoting post-traumatic



growth (Linley & Joseph, 2007; Linley et al., 2005).

It is interesting to note that the bulk of research on post-traumatic growth in professionals who support trauma survivors has been on professionals who occupy a counselling role. Most therapist respondents report that their growth has been rooted in the relational experience of providing therapy and witnessing the transformation of clients. Specifically, the literature repeatedly reveals that counsellors report "...gains in relationship skills, increased appreciation for the resilience of the human spirit, the satisfaction of observing clients' growth and being part of the healing process, personal growth, and spiritual well-being." (Howard, 2010, p. 21). Given that outreach workers, sexual assault centre workers and community-based victim service workers are actively involved with survivors in crisis (sometimes without necessary safety systems), and later intersecting with the criminal justice system (which systemically does not prioritize the needs of survivors), it could be that these roles do not experience the same access to post-traumatic growth that counsellors do. Research on post-traumatic growth in outreach and advocacy roles is needed.

Definition of Vicarious Trauma

Throughout the early nineties, McCann, Saakvitne and Pearlman, along with the staff of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, defined vicarious traumatization as "the transformation of the therapists' or helpers' inner

experience as a result of empathetic engagement with survivor clients and their trauma material." (Saakvitne and Pearlman, 1996, p. 279). This transformation was defined as emerging in domains of meaning making, causing profound changes in how anti-violence workers saw themselves and the world, thus re-shaping their beliefs and expectations. The areas of meaning that were transformed by anti-violence work were: dependency/trust, safety, power, independence, esteem and intimacy.

Risk Factors for Vicarious Trauma

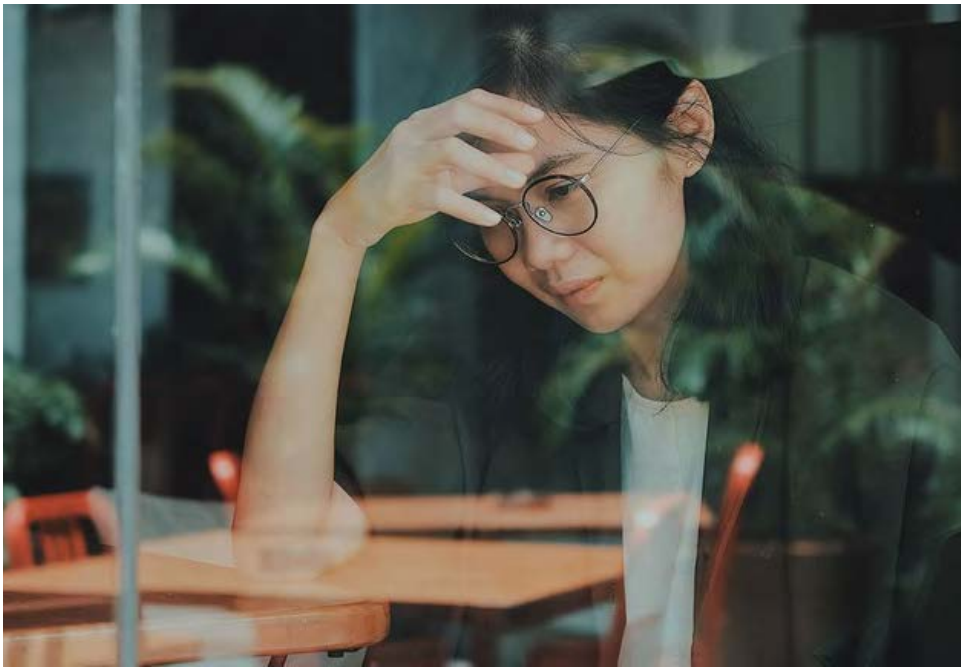
Research has documented both individual and systemic or environmental risk factors for vicarious trauma. Individual risk factors include gender, personal history of trauma, (Baum et al., 2014; Bishop & Schmidt, 2011; Choi, 2011; Dworkin et al., 2016; Killian, 2008; Klinic Community Health Centre, 2013; Silard, 2018; Wood et al., 2017) and age – specifically, younger workers are more at risk (Dworkin et al., 2016; Klinic Community Health Centre, 2013; Wood et al., 2017). Social isolation is a risk factor for vicarious trauma (Killian, 2008), and can be both an individual and environmental risk factor. Social isolation may be a personal choice due to introversion or needing non-interactive time in one's personal life to recover from the highly interpersonal aspect of one's work. However, this risk factor may be environmental when one considers the reality of working within a small community either geographically, or within culturally identified groups. A worker may isolate themselves within that community as a protection against overlapping roles and encountering clients or their families in one's personal time. These choices are undertaken as a protective mechanism, and yet may increase the worker's vulnerability to vicarious trauma. A worker who experiences isolation within their agency as the only Indigenous worker or the only trans worker for example, is experiencing a risk factor due to the lack of diversity and inclusion in their agency, rather than their own choices. While further research is needed, anecdotal evidence indicates that if a worker is primarily working with members of a community with which they personally share experiences of oppression and/ or discrimination, their risk of impact is increased.

Other environmental risk factors include a longer tenure of work in the anti-violence field resulting in cumulative exposure to witnessing trauma, and the failure of systems to adequately protect survivors (Cummings et al., 2018; Klinic Community Health Centre, 2013; McKim & Smith-Adcock, 2014). Supporting survivors who return to abusive partners can also take a toll on workers, who may feel helpless, hopeless, or that they have failed to provide needed support to their clients (Fusco, 2013; Merchant & Whiting, 2015).

Weighted workplace risk factors are a high number of direct contact hours with survivors, and lack of control over one's caseload (Anderson & Overby, 2020; Benuto et al., 2019; Jirek, 2020; Klinic Community Health Centre, 2013; Kulkarni et al., 2013; McKim and Silard, 2018; Smith-Adcock, 2014; Wood et al., 2017). One report (Wood

et al., 2017) indicated that the risk of secondary traumatic stress was higher among staff who spent more than 40% of their work time providing direct service to victims of violence, while another (McKim & Smith- Adcock, 2014) indicated that exposure to clients with more serious trauma experiences was associated with increased risk of compassion fatigue. Benuto et al. (2019) examined the significance of risk factors such as length of time in the anti-violence field, availability of workplace supports, and types of victims supported, and found the only significant predictor of impact on the worker was the number of direct hours spent with survivors.

Workers perceiving that they are not adequately supported in their workplace by supervisors and colleagues and/or that they are receiving too infrequent or poor quality supervision are also significant risk factors (Babin, Palazzolo & Rivera, 2012; Dworkin et al., 2016; Killian, 2008; Silard, 2018). This was aptly identified in one worker's reflection, "I think one of the most overwhelming aspects of this work is that you are constantly moving from one crisis situation to another with little or no time to think or breathe in between. Fellow workers are overwhelmed as well so there is little if no time to debrief, and what debriefing there is is often rushed and tense. It is hard to debrief with individuals who are as overwhelmed as you are."

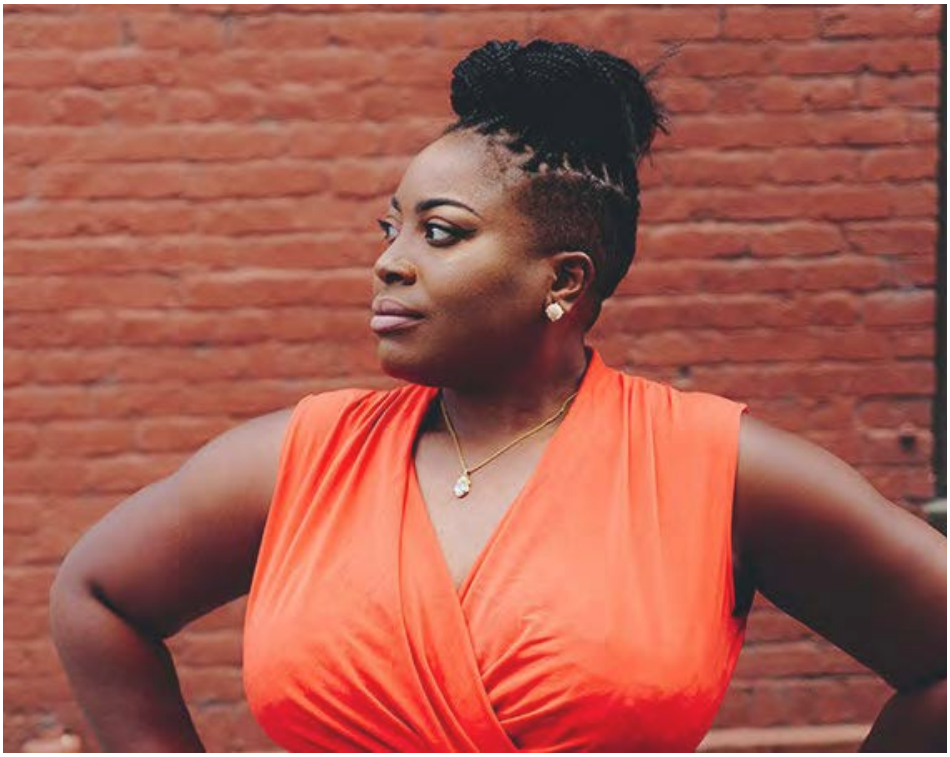


(Richardson, 2001, p. 18). Inadequate training may leave advocates feeling unprepared to deal with trauma and crisis work, and ill-equipped to recognize and respond to vicarious trauma when it emerges – furthering their vulnerability to vicarious trauma (Anderson & Overby, 2020; Ashley-Binge & Cousins, 2020; Merchant & Whiting, 2015; Bishop & Schmidt, 2011).

Research has also examined the impact of workplace culture in fostering risk factors for vicarious trauma. Organizational cultures that promote "selflessness and sacrifice" in which staff are recruited to volunteer to take on additional tasks and work long hours, creating "an institutional badge of honor, necessary for full inclusion" (Jury et al., 2018, p. 321; Jirek, 2020) is a significant risk factor. Another cultural risk factor is defining a good staff member as someone who is unphased by exposure to trauma (Jury et al., 2018) and seeing a staff member who is open about their experience of vicarious trauma as not resilient enough. Staff who disclose impacts of the work were "somewhat ostracised as a result, as they did not comply with the collective expectation of toughness" (Jury et al., 2018, p. 323).

Anecdotal evidence not yet fully reflected in the research suggests experiencing cumulative losses at work such as the death or disappearance of client(s), the loss of a beloved co-worker or supervisor, or significant changes within the workplace also increase the risk of vicarious trauma.

Many anti-violence agency workers in intake or administrative roles are at risk of vicarious trauma through indirect exposure via review of case files, images of injury in court, and fielding inquiries or requests for service from survivors who are overwhelmed



and in crisis. One worker reflected on the risks in her role in this way, "I work in administration. The counselling staff tell us all the time about a difficult crisis call, a horrible story they have just heard.... We only hear about the danger, the high-risk alerts and the problems...It breaks my heart." (Richardson, 2001, p. 78).

Systemically, feminist anti-violence workers and leaders of feminist-based organizations work in a context of higher risk for vicarious trauma due to lower pay, limited or no access to extended health benefits, lack of mental health supports including trauma-informed clinical supervision, and limited access to paid time off compared to health-based organizations and first responders. Other system impacts include the ongoing witnessing of the failure of health, justice and income support systems to provide needed resources to survivors to assist them in increasing their safety and provide viable choices in their lives (Klinic Community Health Centre, 2013; Merchant & Whiting, 2015).

Protective Factors for Vicarious Trauma

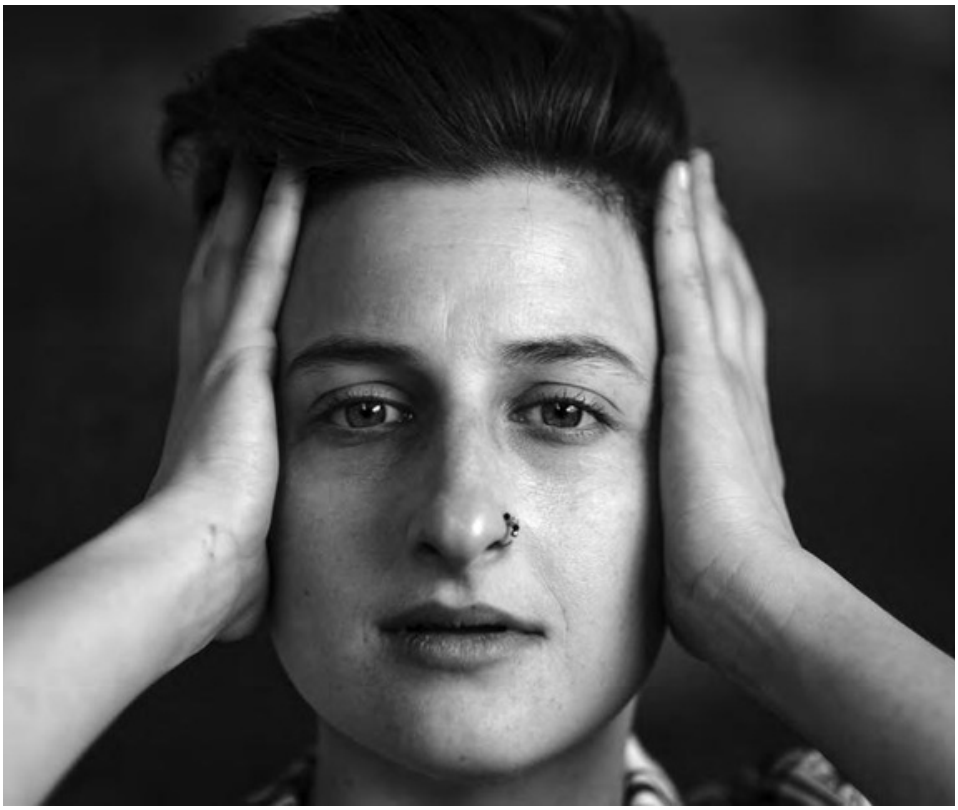
Early in the development of a body of knowledge regarding vicarious trauma, researchers focused on individual protective factors such as various forms of robust and regular self-care and wellness practices as protective factors against vicarious trauma. Although self-care, personal boundaries and work/life balance are protective factors (Butler et al., 2019; Lipsky & Burk, 2009; Molnar et al., 2017; Trippany et al., 2004), the most prominent protective factors are situated in the organizational response to vicarious trauma and the supports available to staff (Ashley-Binge and Cousins, 2020; Backe, 2018; Bober and Regehr, 2006). Staff perception of both their supervision and overall organization as supportive is a critical protective factor against vicarious trauma (Bell et al., 2003; Jansen, 2004). A sense of control within one's workplace, opportunities to have input and make decisions at work, having one's own workspace, a lower caseload, higher quality of supervision, and emotional support are all documented to be protective factors against vicarious trauma (Bemiller & Williams, 2011; Benuto et al., 2019; Frey et al., 2017; Kulkarni et al., 2013; McKim & Smith-Adcock, 2014; Rose and Palattiyil, 2020; Sommer, 2008; Wachter et al., 2020; Wood et al., 2017; Wood et al., 2019). Additionally, professional training – specifically including information on how to recognize vicarious trauma and ways to mitigate it – were significant protective factors (Anderson & Overby, 2020; Molnar et al., 2017; Pack, 2014; Sommer, 2008).

Impacts of Vicarious Trauma

Vicarious trauma can impact or create change in emotional, cognitive, physical, interpersonal, meaning-making and spiritual domains of one's being (Pearlman, Saakvitne,1995; Yassen, 1995). Yassen developed tables listing 67 personal impacts in these domains, and 30 impacts on professional

functioning in the domains of work performance, morale, interpersonal relations at work and workplace behaviours (Richardson, 2001). Workers may experience changes in mood (such as becoming more anxious and impatient), or changes in the body (including tension, headaches, difficulties with concentrating and/or sleeping, and chronic exhaustion) (Killian, 2008; Klinic Community Health Centre, 2013). Vicarious trauma may create change in a worker's ability to tolerate strong emotion from others and/ or to manage their own emotion activation, often leading them to employ avoidance tactics in the presence of strong emotion and/or to experience numbing or activation in response to emotion.

Vicarious trauma may lead to cognitive impacts such as impaired memory, cynicism, intrusive thoughts and nightmares (Branson, 2019). It may impact one's ability to maintain healthy professional boundaries and to make decisions, increase absenteeism, lower staff retention, and reduce the quality of services provided to victims (Branson, 2019; Klinic Community Health Centre, 2013). One sexual abuse counsellor reflected on the impact of vicarious trauma on her boundaries in this way, "Her [counsellor's client] situation seemed so desperate that I became more and more involved. I gave her my home phone number and accepted calls

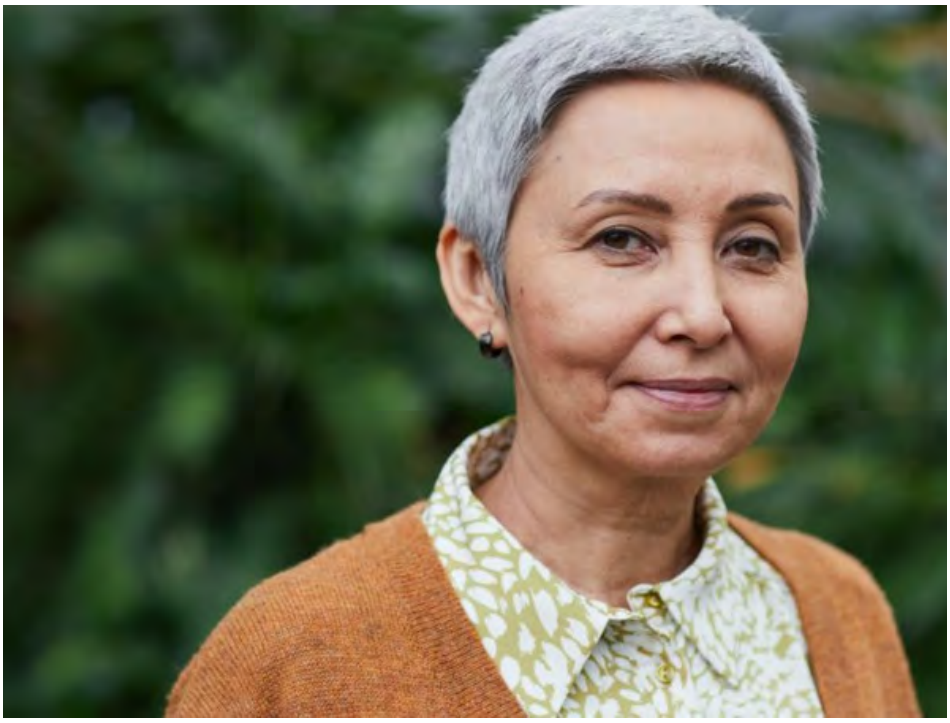


at any time. My fellow counsellors and advocates questioned me about my lack of boundaries; other agencies providing support were frustrated by my need to be present. It didn't matter what anyone told me, I couldn't stop. I became angry and exhausted. I don't know what made me stop, I only know that I jeopardized so many important personal and professional values." (Richardson, 2001, p. 23).

Vicarious trauma may erode or transform a worker's self-esteem, sense of safety, and worldview, including creating an overall sense of disillusionment with society (Cummings et al., 2018; Silard, 2020). A sexual assault advocate reflected on the impact on her sense of safety from exposures in her role, "I put myself in a position where I had to teach self-defense so I had to learn it. And I'm constantly looking for new strategies to deal with the situations. But I think that's how I compensated for it, because that was borne out of fear. I was, I lived alone when I first started this job. I'm a woman with a disability...a fairly obvious one to most people and I knew that I was in a pretty high- risk category there. So I really actively went out and made myself stronger, physically and emotionally." (Wasco & Campbell, 2002, p. 12).

Considerations for Anti-Violence Programs

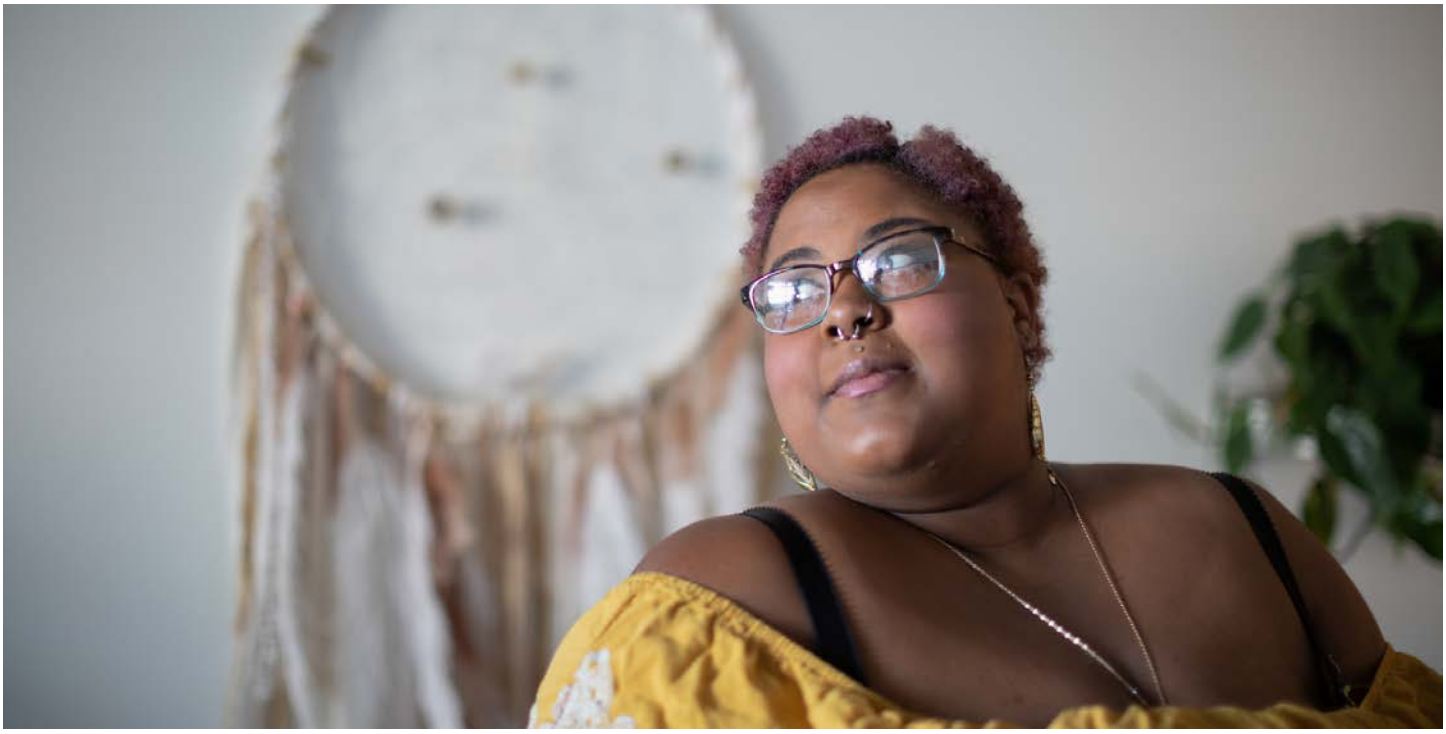
Although the risk and protective factors apply broadly throughout the anti-violence sector and the impacts identified above have been confirmed by research to be consistent across various



helping professionals – social workers, sexual assault workers, domestic violence workers and counsellors – there are unique exposures and protective factors aligned with various roles. Anti-violence workers (such as community- based victim services workers, sexual assault workers and outreach workers) who provide direct support to survivors within the criminal justice system, and to a lesser degree, within the family court system, encounter specific impacts. Both of these legal systems are structured hierarchically, and are conducted with limited sensitivity to a trauma survivor. Legal processes limit the amount of active support the anti-violence worker can provide within the court room, thus relegating the worker to a passive witness role while being exposed to specific traumatic detail. Legal concepts such as the presumption of innocence and burden of proof, and the priority of involving all parents in the lives of their children often result in a survivor's safety and sense of justice being compromised. Repetitive exposure to survivors and their families not receiving a sense of justice and thus closure through our systems' responses, plus a lack of viable resources for survivors, may lead to moral distress in exposed workers. Moral distress can occur when a worker witnesses repeated behaviours that contradict their values and morals, which can lead to feelings of powerlessness, cynicism, anger, anxiety and depression.

In addition to the acknowledgement of moral distress, the concept of soul pain has been theorized by Jirek, which encapsulates well the pain anti-violence workers and leaders of anti-violence organizations experience when individuals or systems repeatedly dispossess and oppress survivors. Soul pain is defined as "a deep, gut-wrenching ache that pierces the core of one's being...it is a spiritual pain, a sorrow born of seeing the cruelty that human beings inflict on one another and of feeling powerless to stop it" (Jirek, 2015, p. 1).

Leaders of anti-violence organizations are exposed directly to the failure of systems to protect and to resource survivors and the organizations that support survivors. Carrying the responsibility for the safety and well-being of workers and clients in a society that continues to devalue and under-fund front-line feminist services fosters both burnout and moral distress or soul pain. Research has demonstrated that differing impacts can co-exist and that experiencing one impact – for example, burnout – increases the vulnerability to multiple impacts (burnout accompanied by vicarious trauma and/or secondary traumatic stress) (Cummings et al., 2018). In smaller and remotely located organizations, managers often carry caseloads of direct work with survivors, leaving them vulnerable to vicarious trauma in addition to burnout from the administrative responsibility. All of these impacts are profound and can be significantly taxing to recover from, and these injuries are often invisible and/or minimized for leadership.



Sexual assault centre workers and Stopping the Violence counsellors with caseloads of a high number of sexual abuse and assault survivors face unique impacts. Workers who are providing telephone crisis support and/or hospital accompaniment are often interacting with a survivor at the height of their trauma. The intensity of these interactions, and the possibility of observing first hand visible evidence of the assault they have endured, is absorbed by the worker's nervous system and may elicit a fight, flight or freeze response within them. Cumulative exposure to details of sexual intrusion and violence may over time effect a worker's connection to their body and/ or openness for sexual intimacy (Branson et al., 2014). Workers may discover that their bodies are storing automatic responses to initiations of physical intimacy or sexual expression that does not match their emotional, mental or relational state.

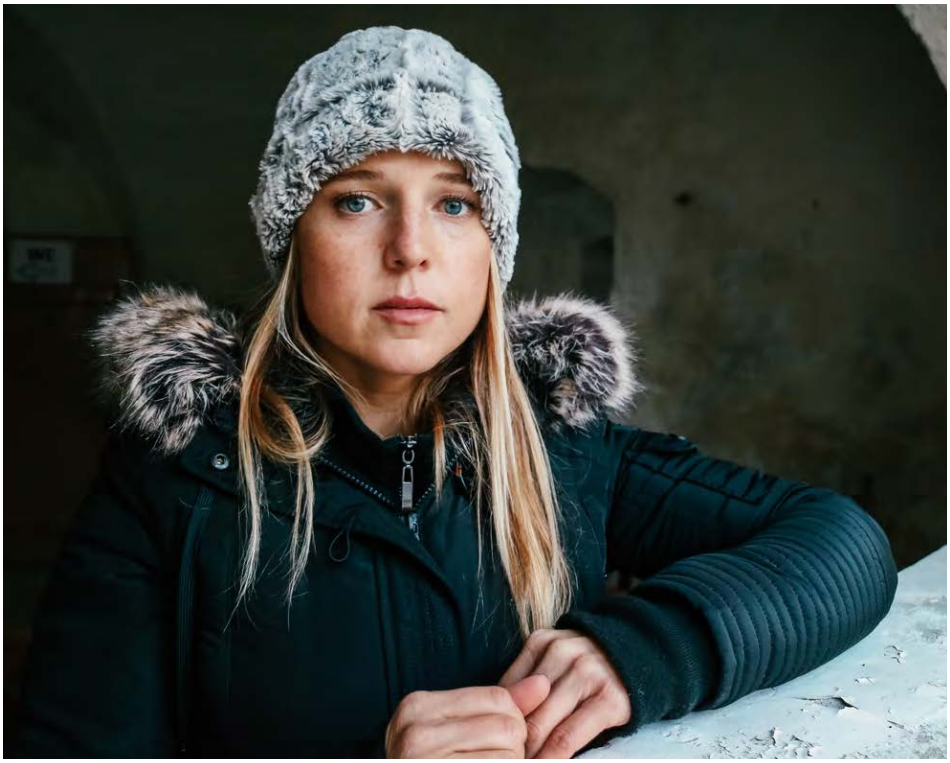
In 2016, BC declared a public health emergency due to the sharp increase of drug overdose deaths due to a poisoned drug supply. Unexpected deaths of clients have impacted all anti-violence programs, with Outreach workers – who work closely with survivors who are unhoused and under resourced – especially exposed to these losses. BC has been faced with a steady increase of overdoses for the last six years, with the numbers doubling in some of these years, and disproportionately effecting Indigenous peoples (Nathoo et al., 2018, Gates, 2020). This increase has surged during the COVID-19 pandemic due to increased supply of tainted drugs, isolation of people who use drugs and lack of accessibility to safe injection centres and health services. Outreach workers, who are intimately connected with the vulnerability of survivors falling between the cracks of our support systems, have also been limited in their ability to physically reach out to their clients during the pandemic, and unable to offer transportation and accompaniment. Many are experiencing compounded and complicated grief at the news of yet another loss of a client due to poisoned drugs.

Mitigating Vicarious Trauma - Individual Anti- Violence Workers

Consistent attention to personal self-care practices in which a balance is struck between work, play and rest through a combination of connection, creativity and physical activity has been shown to offset impacts of

exposure to trauma (Jirek, 2020; Lipsky & Burk, 2009; Sansbury et al., 2015; Trippany et al., 2004). Another level of repair is within spirituality as "...the damage of vicarious traumatization is often related to the counselor's sense of spirituality..." and can be improved by finding a sense of "...meaning and connection... [through] organized religions, meditation, and volunteer work... (Trippany et al., 2004, p. 36). Sansbury et al. (2015) wrote that writing a personal plan of action that holds the intent of offsetting vicarious trauma and creating a behavioural change in oneself is beneficial. The plan could include daily coping skills to employ at work, and enlisting a colleague to assist with holding themselves accountable to implementing their plan. They recommended "...finding a trusted colleague where, together, you actively 'check in' with each other about the action plan for self-care" and also take the opportunity to reflect on "the positive impacts of trauma work...[as this] can be enormously rewarding, restorative, and fulfilling" Sansbury et al., 2015, p. 118).

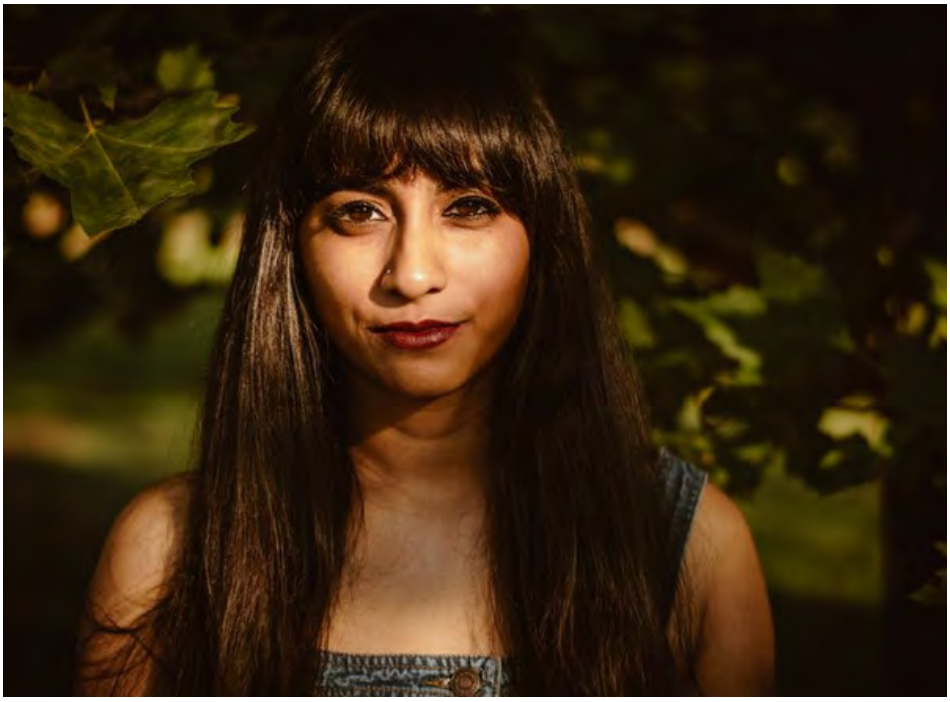
Although regular participation in self-care activities is helpful to mtigate vicarious trauma, implementation of self-care within the workplace with a specific focus on modulating nervous system activation is highly beneficial. Discharging tension and absorption of impact from traumatic detail and calming any activation from exposure is a potent form of self-care to offset impact.



Working within an organization that teaches and promotes these techniques and provides space in a workday to implement them is an important organizational contribution.

As a weighted risk factor for vicarious trauma is a high number of direct service hours with survivors, anti-violence workers may benefit from balance within their workloads by participating in research, policy work, and "big picture" initiatives that seek to address systemic problems and prevent violence and trauma within their communities (Kulkarni et al., 2013).

Knowing that isolation in the workplace is a risk factor for vicarious trauma, it follows that increasing social support within the workplace is a powerful antidote to vicarious trauma. One qualitative research study of 20 therapists engaged in trauma work confirmed previous preliminary findings suggesting that social support was vitally important for a healthy workplace (Killian, 2008). "Individuals in the helping professions who reported greater social support suffered less psychological strain, had greater job satisfaction, and greater compassion satisfaction" (Killian, 2008, p. 40). This includes regular debriefing meetings and clinical supervision to process challenging client material (Babin et al., 2012; Bemiller & Williams, 2011; Bell et al., 2003; Bishop & Schmidt, 2011; McKim & Smith-Adcock, 2014). Regular access to high quality trauma-informed clinical supervision is critical to prevent the negative impacts of trauma work (Dworkin et al., 2016; Richardson, 2001;



Sommer, 2008; Wood et al., 2019). When outsourcing clinical supervision is not viable, it is recommended by one researcher that "...a clear separation of supervision and evaluation functions to allow workers to feel comfortable sharing..." assists in increasing the effectiveness of internal supervision (Bell et al., 2003).

Given that many anti-violence roles lack access to funding for clinical supervision, workers may be reliant on informal supports in the workplace. Peer support meetings could provide essential structured processes and space to mitigate the impacts of the work, particularly if these gatherings are trauma-informed and attend to safety and inclusion. Having a rotating leader for peer support meetings enhances the intentionality and focus of meetings. Processing relevant losses (global, community, client, staff), engaging in activities for deactivating stress responses, and sharing of relevant work resources increase the potential benefit of these meetings.

Mitigating Vicarious Trauma - Management

Management and leadership have an essential role to play in evaluating the processes and procedures in the workplace environment that may be contributing to vicarious trauma. The specific risk factors of lacking control over one's caseload, too many direct service hours with survivors, isolation, and lacking knowledge about vicarious trauma and resources within the workplace to respond to it are all domains that management has influence in. An overall guiding principle for leadership is ensuring that "workers needs are prioritized as highly as clients' needs..." (Jirek, 2020, p. 224).

Leadership style is also important, as workers' well-being increases when they sense their leaders are approachable, trauma-informed and committed to them (Wood et al., 2017). One study wrote "[S]atisfied advocates had supervisors and executive staff with a vision that unified and provided direction... Shelter visions promoted teamwork by providing a common goal while also allowing advocates to identify their niche in the vision...." (Merchant and Whiting, (2015, p. 474). Providing staff with access to information about external factors that impact the work of the organization and opportunities to participate in the development of the organization's strategic priorities and decision-making processes may also enhance wellness (Choi, 2011; Klinic Community Health Centre, 2013; McKim & Smith-Adcock, 2014).

With regards to caseloads, management could develop "... intake procedures that attempt to distribute clients among staff in a way that pays attention to the risk of vicarious trauma certain clients might present to workers" (Bell et al., 2003, p. 466). Ensuring that communication channels are open between staff and management for staff to identify areas of concern regarding their caseloads (i.e., a preponderance of clients in active crisis or a cluster of certain behavioural presentations) so that

reassignment or pausing on more intakes is possible to reflect the ebbs and flows of heightened stress within caseloads is beneficial to staff's resiliency and empowerment (Trippany et al., 2004; Wachter et al., 2020).

Actively supporting practices of self-care within the workplace is important through holding structured self-care activities within work time, regular peer support meetings, inclusion of therapy animals in the workspace, and paid time to attend mental health care appointments (Anderson and Overby, 2020; Babin et al., 2012; Bell et al., 2003; Bemiller and Williams, 2011; Benuto et al., 2019; Parnes et al., 2020; Trippany et al., 2004; Wachter et al., 2019; Wood et al., 2017; Wood et al., 2019).

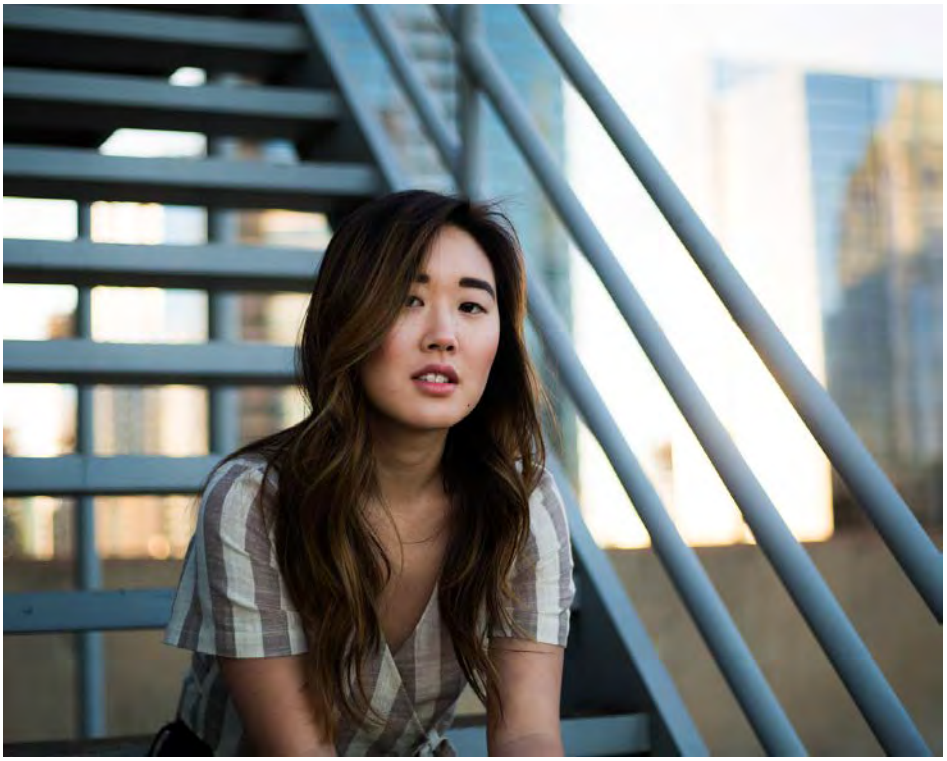
Providing access to extended health benefits and trauma-informed counselling for all employees is highly beneficial (Bell et al., 2003; Trippany et al., 2004). If possible, adding trauma-based supports to the organization's Employee Family Assistance Plan coverage (an extra cost) provides access to a higher calibre of therapist, and to a higher number of allowable sessions for the employee. Research has demonstrated that access to externally based and trauma-informed clinical supervision is more effective for offsetting vicarious trauma compared to internally provided supervision (Ashley-Binge & Cousins, 2020; Sommer, 2008). If funds are not available for this, all efforts should be made to separate internal

supervision from evaluation (Bell et al., 2003).

Efforts to reduce isolation within the workplace could include staff wellness activities, team-building exercises and mentoring programs. Formalized mentorship programs may be helpful in mitigating the risk newer and younger workers face for vicarious trauma, as more experienced staff can serve as role models, share insights, and provide social support to their less experienced colleagues (Babin et al., 2012; Jirek, 2020; Kulkarni et al., 2013).

Regular training on vicarious trauma, how to recognize its signs, and remedies for it has been shown to assist in mitigating its impact (Pack, 2014). One recommendation would be to include training on vicarious trauma in all onboarding of staff and volunteers. In addition to training, scheduled assessment of staff for vicarious trauma and review of the assessment to improve self-care strategies within the organization can assist the organization in monitoring trauma impacts on their staff and proactively set the tone for organizational-level support (Sansbury et al., 2015)

Attention to work spaces that provide staff safety and comfort is important. One study suggests that organizations should provide a "safe, comfortable, and private work environment" where workers feel safe in the area inside and outside of their work space and have the ability to display "meaningful items in their workplace" to find comfort and inspiration (Bell et al., 2003, p. 466-7; Jirek, 2020).



Mitigating Vicarious Trauma - Organizational Leadership

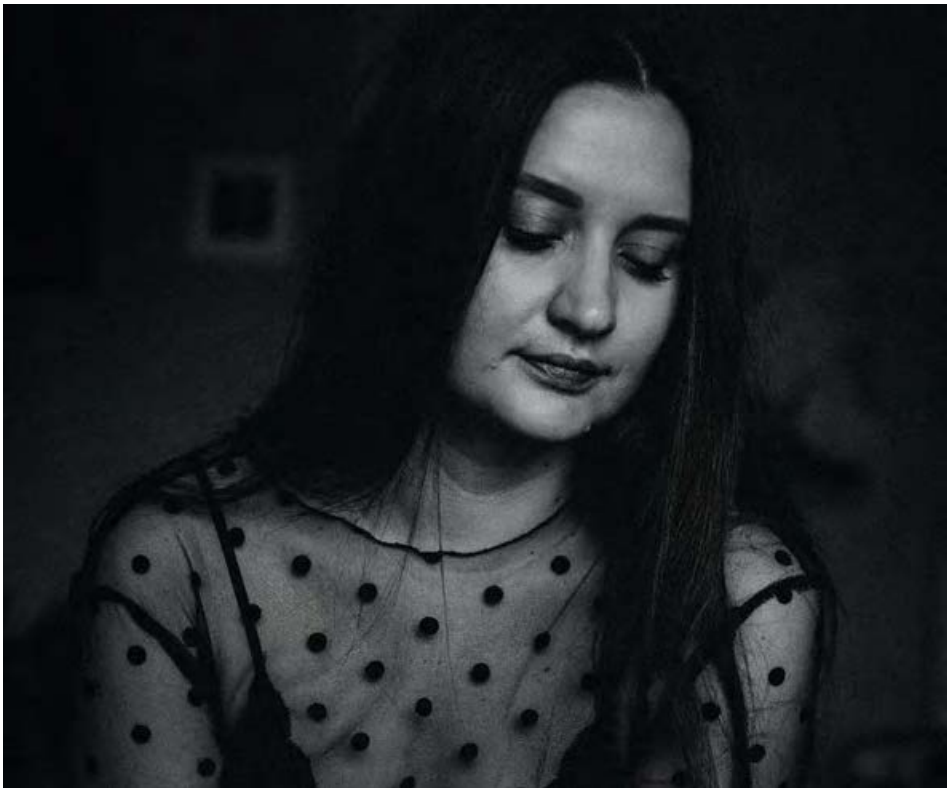
Boards of directors and advisory committees are responsible for ensuring that an organization is sufficiently resourced and has policies and procedures in place for the strategies identified within the management section of this paper to take place. In collaboration with management and staff, an organization would highly benefit from undertaking an overall organizational assessment to ensure its work is being conducted within a trauma-informed lens at all levels (see assessment resources below) (Sansbury et al., 2015). One organization reported that, "We spent a year answering the question: how would we know that the organization is running well and that the staff are happy? We developed reporting requirements for the executive director and set up an annual calendar to hear about different programs and the evaluation criteria and review certain policies and practices of particular interest such as finance and extended health care benefits." (Richardson, 2001, p. 70).

Staff having meaningful input on strategic direction and vision of an organization has been shown to improve worker wellness (Choi, 2011). Leadership could invite frontline workers to directly participate in the agencies' decision-making process when establishing annual goals and strategic information (O'Brien, 2006). Staff "...having an organization's strategic information means having a clear understanding about work flow, productivity, and external environmental factors that interact with the organization and impact the organization and its future direction" (Choi, 2011, p. 235).

In terms of protecting staff safety and well-being, and meeting WorkSafeBC requirements, policies and training on anti-oppressive practice and strategies to prevent and address microaggressions and bullying in the workplace are important (Wood et al., 2017; Wood et al., 2019).

Mitigating Vicarious Trauma – Funders

In order for organizations to both retain staff and ensure they have the personal and professional resources to mitigate vicarious trauma, they need to adequately compensate them for their work (Jirek, 2020). Research has shown that workers who are adequately compensated are able to engage in self-care activities in a more substantial way (Ashley- Binge & Cousins, 2020). It has been common knowledge for years that anti-violence workers earn substantially less than their counterparts in the mental health and substance use field, and lack comparable access to sufficient health care benefits. In a recent poll of anti-violence workers in BC, 29% of those polled did not have access to clinical supervision, and 19% did not have access to Employee and Family Assistance Plan services due to the under resourcing of their agencies. Given that access to external trauma- informed clinical supervision is a



weighted protective factor against vicarious trauma, it is strongly recommended that all anti-violence roles be funded for regular externally provided clinical supervision.

Vicarious Trauma Assessment Tools

There is no standardized assessment tool that measures vicarious trauma. A number of standardized tools exist that measure secondary traumatic stress and compassion fatigue. The Professional Quality of Life Measure (ProQoL) offers three measures: compassion satisfaction, burnout and secondary trauma. Various assessments have been developed that provide anti-violence workers measures to reflect on the balance they have in their lives, and the level of self- care and resilience they hold. is recommended that workers participate in an assessment on an annual basis in order to create better awareness of the impacts they are carrying, and to assist in developing a care plan to address them.

Numerous assessments have been developed for organizations to examine how trauma-informed their organization is and how well positioned they are to support their staff in mitigating vicarious trauma. A good initial assessment is the Trauma-Informed Practice Guide developed by the BC Centre of Excellence for Women's Health. It provides an organizational checklist in eight areas of function: Overall Policy and Program Mandate, Leadership, Hiring Practices, Training for Staff, Support and Supervision of Staff, Screening and Assessment, Policies and Procedures, and Monitoring and Evaluation.

If an organization sees that they would benefit from a deeper review and guidance of how to move their organization into greater strength in mitigating vicarious trauma, The Vicarious Trauma Toolkit: Blueprint for a Vicarious Trauma-Informed Organization, developed by the Office for Victims of Crime is strongly recommended. This online document offers tools to assess the organization's readiness to address vicarious trauma, and highlights strengths and areas that need improvement. Hallinan et al. researched the validity of this organizational tool, used within 13 first responder and victim assistance organizations, and found it to have excellent internal consistency, and that the assessment was able to predict and measure "... turnover intention, compassion satisfaction, and organizational resilience...." (. Hallinan et al.,2019, p. 481).

Assessment Resources

Personal Assessment Tools for Vicarious Trauma

Professional Quality of Life Measure (2009) – compassion satisfaction, burnout and secondary trauma. http://www.proqol.org/ProQol_Test.html

Burnout self-test https://www.mindtools.com/pages/article/newTCS_08.htm

Silencing Response Scale (Baranowsky, 1996, 1998) impact of communication with trauma survivors on our ability to be present and emotionally resourced http://www.compassionstrengths.com/Silencing_Response.html

Secondary Traumatic Stress Scale (Bride et al., 2004) https://theacademy.sdsu.edu/wp-content/uploads/2019/09/STSSwithscoreinterpretation.pdf

Compassion Fatigue/ Satisfaction Self Test (Stamm, 2013) https://nwdrugtaskforce.ie/wp-content/uploads/2013/01/Compassion-Fatigue-Handout-6.pdf

Mental Health Continuum Model for First Responders https://bcfirstrespondersmentalhealth. com/wp-content/uploads/2017/06/MentalHealthContinuumModel-1.pdf

Personal Assessment Tools for Self Care, Resilience and Post Trauma Growth Self-care Patterns Scale (SCPS-R) (Gonzalez, Leeds & Knipe, 2012) http://www.intra-tp.com/wp-content/uploads/2017/02/SELF-CARE-SCALE-with-Interpretation.pdf

Self Care Assessment based on the work of Saakvitne, Pearlman, & Staff of TSI/CAAP (1996) https://socialwork.buffalo.edu/content/dam/socialwork/home/self-care-kit/self-care-assessment.pdf

Self care and resilience wheels created by Olga Phoenix https://olgaphoenix.com/wp-content/uploads/2020/12/SCWsWDmin.pdf https://olgaphoenix.com/wp-content/uploads/2020/11/Resilience-Wheel-Toolkit.pdf

Post-traumatic growth inventory https://www.careinnovations.org/wp-content/uploads/Post-Traumatic-Growth-Inventory.pdf

Organizational Assessment Tools for Trauma Safety The Vicarious Trauma Toolkit: Blueprint for a Vicarious Trauma-Informed Organization, 2013. Office for Victims of Crime, Department of Justice. https://ovc.ojp.gov/program/vtt/ what-is-the-vt-org

Trauma-Informed Workplace Assessment, Crisis & Trauma Resource Institute, 2021. https://ca.ctrinstitute.com/workplace-assessment-2021/#

Trauma-Informed Practice Guide, BC Centre of Excellence for Women's Health, 2013. https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Trauma-Informed Organizations/Systems–Organizational Self Assessment, Manitoba Trauma Information and Education Centre, 2021. https://trauma-informed.ca/trauma-informed-organizationssystems/organizational-self-assessment/

Developing Trauma-Informed Organizations: A Tool Kit (Second Edition), Institute for Health and Recovery, 2012. http://www.healthrecovery.org/publications/detail.php?p=30

Policy Guidance for Trauma-informed Human Resources Practices, Missouri Trauma Roundtable through the Department of Mental Health, 2017. https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/victims/hrpolicyguidancetraumainformed.pdf

Strategies for Encouraging Staff Wellness in Trauma-Informed Organizations, Menschner & Maul, 2016. https://www.traumainformedcare. chcs.org/wp-content/uploads/2018/11/Brief-Trauma-Informed-Care-Staff-Wellness.pdf

Vicarious Trauma Assessment Toolkit for the Violence Against Women Sector, van Veen, 2012. https://www.yumpu.com/en/document/read/14975385/vicarious-trauma-assessment-toolkit-for-the-violence-against-

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