How do we Heal the Healer?

Understanding the Health and Wellbeing of Staff and Building Capacity to Provide Safe and Supportive Working Environments

MAY 1, 2020

CALGARY DOMESTIC VIOLENCE COLLECTIVE

Contents

Executive Summary

Background

This project aimed to explore options for applying the concepts of *Heal the Healers* to the work of the Capacity Building Working Group (CBWG) of the Calgary Domestic Violence Collective (CDVC). This research recognizes that individuals who work with domestic violence (DV) survivors are exposed to traumatic events that can leave staff feeling overwhelmed, distressed and susceptible to experiences of trauma themselves. **A survey conducted by the CDVC, identified that 68% of people who work in the DV field in Alberta, have personal experience with or have witnessed DV.** Personal experience with violence and trauma increases risks and exacerbates the need to respond appropriately.

Methods

The research questions guiding this project were: How does working in the domestic violence sector affect the health and wellbeing of staff and how can we build capacity to create healthy workplace cultures and provide safe and supportive working environments?

To examine the research questions, several methods were utilized: a literature review, a focus group with CDVC members, and two surveys, one for supervisors and one for front-line staff. The literature review included 55 articles and identified distinct definitions and impacts of compassion fatigue, vicarious trauma and burnout, barriers and facilitators.

To add context and to 'localize' the literature review results, a focus group was held with 40 CDVC members and two surveys were administered, one to 35 supervisors, Directors and Executive Directors and one to 26 front-line staff'. In total, 101 people participated. Questions in each survey were similar, and focussed on awareness of, and suggestions for changes to organizational policies; perceived barriers to organizational support/healing and suggested strategies for CDVC to reduce barriers and build capacity.

Results

Results from the review highlighted primary barriers to supportive and safe organizational cultures including the work environment, leadership, supervision, resources, transparency and autonomy. A number of facilitators or solutions grounded in *trauma-informed supervision* were also identified in the literature. They include:

1. Supervisors who inspire, teach, support, model and challenge, evaluate, collaborate and advocate;
2. Solid and healthy organizational structure;
3. Self-care that is modelled and embedded in organizational culture;
4. Education and clinical training for mitigating the damaging effects of trauma work;
5. Policies that acknowledge the risks of trauma work while protecting workers;
6. Safety and security measures

Results from the surveys and focus group supported the literature review in many ways. However, there were subtle differences in how issues/solutions were prioritized.

Front-line staff prioritized barriers in the following way:

1. Inadequate funding
2. Inadequate resources (e.g. limited training, high caseloads)
3. Lack of effective supervision to deal with burnout
4. Lack of organizational time/support for debriefing/mentorship/peer support
5. Lack of training/education for leaders
6. Lack of organizational policy to respond to burnout/secondary trauma
7. Vicarious trauma (VT) support is not prioritized

Supervisors ranked barriers like this:

1. Lack of training/education for leaders
2. Inadequate resources (e.g. limited training, high caseloads)
3. Inadequate funding
4. Lack of organizational policy to respond to burnout/secondary trauma
5. Lack of organizational time/support for debriefing/mentorship/peer support
6. Lack of effective supervision to deal with burnout
7. Lack of autonomy
8. VT support is not prioritized

Both frontline staff and supervisors were asked what CDVC could do to reduce barriers and enhance healthy organization culture.

Frontline staff said (in order of importance)

1. Advocate for funding
2. Provide training/capacity building
3. Develop organizational policies and encourage agencies to follow them
4. Host events/opportunities for self-care

Supervisors said (in order of importance)

1. Provide training/capacity building
2. Advocate for funding
3. Host events/opportunities for self-care
4. Develop organizational policies and encourage agencies to follow them

Recommendations

To summarize, DV workers are vulnerable to stress, trauma and burnout due to their ongoing exposure to DV survivors' traumatic stories, and often, personal experiences with violence. Participants felt that primary responsibility for self-care was on individuals but that leadership/executive staff had an important role to play in creating and sustaining organization cultures (supported with policy) that promote health and wellness.

Results from all sources of data informed several recommendations for CDVC.

1. Embedded Trauma-Informed Supervision

CDVC could develop and/or leverage partnerships to deliver a series of capacity building sessions for supervisors. Suggested content could include specific strategies on:

A. Trauma-informed supervision – what is it – how we do it;
B. Boundary setting, conflict resolution and problem solving;
C. How to share personal experiences in a safe and constructive way;
D. How to build rapport, relieve anxiety, provide a 'safe space' for grievances and build supervisee's self-awareness and insight through reflective questioning and dialogue;
E. Share current research/evidence on 'best-practices';
F. Reduce power differences while balancing corrective feedback and reviewing and assessing staff performance;
G. "Provide a voice" on behalf of staff through collective advocacy efforts meant to ensure adequate resources are available for organizational responses;
H. Create shared decision-making and staff input into organizational decisions.

2. Organizational Structure and Policy

Considerations for healthy organizational structures and polices are guided by the principles of trauma- informed practice, which is a strengths-based approach grounded five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity.

CDVC could develop and encourage organizational polices and practices that include:

A. Identifying clear roles and responsibilities for each team member;
B. Transparent lines of decision making and accountability;
C. Established work hours and schedules with options for time away from direct client contact;
D. Manageable case loads;
E. Values or principles-based hiring strategies;
F. Formal measures of informed consent with staff regarding risks of trauma work at time of hiring;
G. Vigilance in creating and implementing 'best practices' and strategies to protect staff;
H. Opportunities for staff to participate in social change activities such as work towards influencing policy;
I. Build knowledge of system navigation into staff training.

3. Self-Care Strategies

Self-care strategies should be modelled by supervisors and offered during work hours and could include:

A. Peer support groups, counselling services, debrief sessions;
B. Pairing newly hired staff and practicum students with more experienced staff in a 'buddy' system;
C. Stress management sessions, yoga classes, a walking or a meditation group, artistic activities;

D. Team retreats (hosted by organizations with resources).

4. Advocacy and Funding

The Policy Working Group of the CDVC could prioritize advocacy for funding for the sector, in response to the number one recommended action by front line staff in the survey. This will be particularly important within the context of COVID-19, which may affect funding at a time when rates of domestic violence are on the rise, as are stress levels for staff.

5. Future Research and Evaluation

Future research

A. Examine the impact of the recommendations and include a‘re-administration’ of the supervisor and staff surveys to assess changes in understandings of and responses to vicarious trauma and burnout.
B. Assess the impact of the recommendations on supervisors and staff with diverse backgrounds. “How do the dynamics of supervisory power play out in supervision for trauma-informed practice when the supervisor and supervisee have different social identities?
C. The impact of strategies should be reported annually to CDVC members including generative discussions to ‘tweak’ the work moving forward.

Evaluation

A. Evaluative surveys should be included in each capacity building session.
B. CDVC conduct a scan of partner organizations and their current capacity to participate in shared resource allocation to implement sector wide strategies to *heal the healer*.
C. CDVC encourage partner agencies to use organizational assessment tools to assess how ‘trauma-informed’ an organization is.

Background

This project aimed to explore options for applying the concepts of *Heal the Healers* to the work of the Capacity Building Working Group (CBWG) of the Calgary Domestic Violence Collective (CDVC). The CBWG believes that in addition to creating learning opportunities related to best practice programming and collective impact, we have a responsibility to provide opportunities for learning about and responding to the impact on staff of working in a high stress field. We also believe there is a need for tools, strategies and supports to recognize and process through those impacts.

Purpose and Research Questions

This research is intended to inform the work of the CBWG in recognizing that individuals who work with domestic violence (DV) survivors are exposed to traumatic events and stories that can leave workers feeling overwhelmed, distressed and susceptible to experiences of trauma themselves (secondary or vicarious trauma). Prevalence rates for secondary or vicarious trauma for front-line staff vary due to differing definitions and different sectors being surveyed, but rates range from 15-70%. Meaning, as many as 70% of people working in organizations that support clients with trauma will experience secondary or vicarious trauma themselves (Bride, 2007; Newell & MacNeil, 2010). There are several risk factors for secondary trauma and they described as personal and organizational.

Personal risk factors:

- Personal experience with trauma (e.g. violence and/or abuse)
- Insufficient time and support to recover from personal trauma
- Lack of choice of interventions and strategies to cope
- How workers experience client stories
- How workers interact with clients

Organizational risk factors:

- Direct work with clients who have trauma
- Heavy caseloads including with children
- Long tenure in the field
- Working more than 40 hours per week
- Social or organizational isolation
- Inadequate training

(Collins, 2012; Conrad, 2012; Figley, 2012).

A survey conducted by the CDVC, identified that **68% of people who work in the DV field in Alberta, have personal experience with or have witnessed DV.** Personal experience with violence and trauma increases risks and exacerbates the need to respond appropriately.

Organizational policy and leadership approaches often place the responsibility of mitigating secondary/vicarious trauma on individuals instead of actively acknowledging the role that workplace culture and leadership can play in reducing or exacerbating secondary or vicarious

trauma. The purpose of this report is to summarize results from multiple methods of data collection led by the CBWG and conducted over 12 months and to summarize that evidence into several recommendations for learning and capacity building to respond to the impact of highly stressful work on individuals in the DV sector with a priority on collective impact solutions.

The research questions guiding this project were: How does working in the domestic violence sector affect the health and wellbeing of staff and how can we build capacity to create healthy workplace cultures and provide safe and supportive working environments?

To examine the research questions, several methods were utilized: a literature review, a focus group with CDVC members, and two surveys, one for supervisors and one for front-line staff.

1.0 Literature Review

Methods for Literature Review

An initial review of academic literature was conducted using the following search terms: "vicarious trauma", "secondary trauma", "burnout", "compassion fatigue", "domestic violence", "risk factors", "protective factors", "organizational culture", "counselor education", "counselling", "mental disorders", "self-evaluation", "psychotherapy", "Aboriginal", "Indigenous". Out of a total of 64 articles reviewed, 55 articles were reviewed. Databases included were Social Work Abstracts, JSTOR, Social Services Abstracts, Gale: Health & Wellness Resource Center, Web of Science, Taylor & Francis Online, Therapeutic Recreation Resources, Nursing Reference Centre Plus, Nursing & Allied Health, Therapeutic Recreation, and PsychINFO. All reviewed documents were published between 2000 and 2019 with studies conducted in the United States, Israel, Western Countries and non-Western Countries in transition from dictatorship to democracy, and the United Kingdom. The review did not yield appropriate journals within Indigenous and Women/Gender Studies databases.

Introduction

The purpose of this summary of the literature is to define terms, explore the effects of trauma on DV workers, discuss the relationship between organizational culture and employee burnout, and identify how organizations can better support and protect their workers from harms associated with secondary/vicarious trauma.

Terminology

Terms describing the psychological effect of trauma on individuals who work with trauma survivors is often referred to as secondary traumatic stress (STS), compassion fatigue (CF) or vicarious trauma (VT). Burnout is often the outcome. STS, CF, VT and burnout have been defined in the literature as follows:

- *Secondary traumatic stress* refers to the physical and psychological trauma and emotional distress in workers exposed to stories from trauma survivors. Symptoms of this distress may include re-experiencing the survivor's traumatic event, avoiding any reminders of the event and arousal or hypervigilance, with presenting psychological symptoms similar

to post traumatic stress disorder (PTSD) such as exhaustion, avoidance and numbing (Baird & Kracen, 2006; Baird & Jenkins, 2003).

- *Compassion fatique* "is a condition that is the cumulative result of the strong, authentic, empathetic feelings experienced by a healthcare professional while continuously caring for and meeting the emotional and medical needs of patients and/or their families" (Mennella, 2018, p.1). Several articles describe symptoms of CF as:

    - emotional numbness or apathy
    - avoidance of particular clients
    - over-identification or preoccupation with clients OR, inability to connect with clients
    - inability to stop thinking about work
    - anger and/or emotional outbursts
    - anxiety and depression
    - guilt
    - sleep disturbances
    - powerlessness or helplessness
    - physical health problems like, stomach upset, muscle tension, dizziness, headaches
    - sick days or absenteeism
    - substance use

(Abendroth, 2011; Billhartz, 2012; Carpenter, 2013; Hooper et al, 2010; Jenkins & Warren, 2012)

- *Vicarious trauma* refers to a harmful shift or inner transformation in an individual's beliefs about themselves, others, and the world around them due to their empathetic engagement with client trauma. Individuals who work with DV and sexual abuse survivors are extremely vulnerable to developing symptoms of VT which may include flashbacks, nightmares, numbing, disassociation, emotional exhaustion, depersonalization, reduced personal accomplishment, interpersonal difficulties and difficulty controlling negative emotions. It is important to note that although there is some resemblance to the symptoms of burnout, VT is a distinct concept and highly unique to workers who deal with trauma survivors (Peled-Avram, 2017; Cunningham, 2003; Jenkins & Baird, 2002; Bell, Kulkarni & Dalton, 2003). Vicarious trauma is often also referred to as secondary trauma.

- *Burnout* refers to feeling emotionally exhausted, having a negative attitude towards clients, and experiencing a reduced sense of accomplishment, meaning and commitment to one's job. Health service workers are extremely vulnerable to burnout due to the emotional expectations of the work and may also include a lack of recognition for one's work, conflict between one's values and the values of the organization they work for, and

a lack of input into organizational decisions (Bell, Kulkarni & Dalton, 2003; Tarshis & Baird, 2018; Newell & MacNeil, 2010).

Effects of STS, CF and VT on DV Workers

Staff who work with DV survivors are often deeply affected by the stories they hear and may experience unique emotional reactions that impact several aspects of their personal and professional lives. Researchers suggests four themes: hypervigilance, personal life, shift in worldview, and coping methods (Beckerman & Wozniak, 2018).

- *Hypervigilance*: DV workers reported feelings of fear of being harmed and immediate/imminent threats due to their proximity with a DV survivor. Additionally, DV workers reported a fear of being identified by an abuser, becoming a potential target of an abuser, and of leaving a workplace in fear that an abuser would find them.

- *Impact on personal life*: DV workers reported intrusive and pervasive feelings transferred over from work into their personal life resulting in nightmares, poor sleep, lack of enjoyment, fear of being followed, emotional numbing and questioning their own relationships with others in their lives, specifically men.

- *Shift in worldview*: DV workers reported a shift in how they viewed the world, resulting in a negative transformation in their worldview and challenges with trying to find and maintain a positive outlook on life.

- *Methods of Coping*: DV workers reported the most challenging aspect of working with DV survivors was how to empathetically engage with a client without becoming emotionally invested. DV workers reported a lack of training and supervision was contributing to burnout, with some responding to their feelings of vulnerability by trying to control clients and/or withdrawing and becoming distant. Staff reported the importance of finding creative outlets for self-care such as meditation, exercise, team activities with coworkers, culture, community, religion, family, and spirituality.

A study conducted by Iliffe and Steed (2000) found that DV workers reported feeling drained, upset, and horrified by the stories they heard, resulting in feeling less safe, more wary and fearful, isolation from friends, family and coworkers, powerlessness and being distrustful of others. Furthermore, individuals who work with trauma survivors may experience a heightened awareness of the reality and occurrence of traumatic events making them more aware of their vulnerability, experiencing a loss of control and unsafe or insecure feelings, difficulty with intimacy and feelings of avoidance, anger and guilt (Trippany, White Kress & Wilcoxon, 2004). Accumulation and/or sustained feelings can result in physical illness, rage, diabetes, hypertension, apathy, depression, insomnia, and weight gain with impacts to organizations including absenteeism, tardiness, poor client care, inadequate communication, decreased quality of client care, increased staff turnover, lack of engagement and lost dollars in revenue (Mattioli, Walters, & Cannon, 2018; Newell & MacNeil, 2010).

Barriers: Organizational Culture

Organizational culture can contribute to employee well being and includes characteristics of the work environment, leadership approaches, supervision, adequacy of resources, transparency and employee autonomy.

Work Environment

Several studies revealed that low levels of organizational support are correlated with higher levels of burnout, suggesting organizations must prioritize the establishment of support systems in the workplace, with workers themselves reporting higher levels of emotional exhaustion when organizational support is missing. Staff have confirmed the need for peer support groups and debriefing sessions to help them cope and mitigate the harmful effects of working with trauma survivors (Babin et al., 2012; Slattery & Goodman, 2009; Iliffe & Steed, 2000). Inadequate wages and low staff to client ratios also increased stress and burnout (Hole & Karakashian, 2018). Unpaid vacation, excessive overtime and paper work and difficult relationships with the team also contribute to stress and burnout (Schub, 2018). Finally, organizations without a mentorship program where newly hired workers are paired with more experienced workers can lead to feelings of isolation and burnout in new employees (Babin et al., 2012).

Leadership

Pross (2014) suggests that support organizations are often founded by advocates and professionals that are passionate and enthusiastic fighters; however, these leaders also sometimes portray self-importance, reject structure, show a lack of tolerance for critique or doubts, and fail to practice self-care or encourage it in others. This type of leadership fosters an unpredictable environment built on chaos and fear with high levels of stress resulting in failures to maintain boundaries, lack of professional management and inspired leadership, informal leader conflict, lengthy decision making processes, diffusion of roles and competence, insufficient training, insufficient supervision, no coaching or mentoring, workaholism, and a lack of boundaries and self-care among all staff.

Supervision

A lack of effective supervision can have detrimental effects on employee well-being. Individuals who are exposed to trauma often work without quality supervision are more likely to experience symptoms of burnout, STS and VT with workers feeling isolated and alone, unable to process their feelings about their trauma work, struggling to find creative ways to cope, experiencing very high or unmanageable caseloads, having no access to appropriate training and overall, experiencing symptoms of burnout very quickly (Beckerman & Wozniak, 2018; Baird & Jenkins, 2003; Peled-Avram, 2017; Newell & MacNeil, 2010).

Resources

A lack of organizational resources significantly interferes with the ability of staff to provide quality services to trauma survivors as staff are often placed in difficult and vulnerable situations with no options for support. In addition to resource issues that create heavy workloads (Epp, 2012) and unmanageable caseloads (Mohamed, 2016), poor agency training is associated with

increased levels of STS, VT and burnout. Staff have re-iterated the importance of needing proper training in providing culturally competent care across ethnicities, religions, sexual orientation, gender and abilities (Kulkarni, Bell, Hartman & Herman-Smith, 2013; Newell & MacNeil, 2010; Kulkarni, Bell, & Rhodes, 2012). Researchers suggests a lack of resources means staff are more susceptible to experiencing STS, VT and burnout (Beckerman & Wozniak, 2018; Baird & Jenkins, 2003; Cunningham, 2003; Kulkarni, Bell, Hartman & Herman-Smith, 2013).

Transparency

A lack of transparency with employees in an organization has been reported to significantly contribute to employee burnout. Without effective communication channels between administrators and staff to relay strategic information, or without inviting workers into the organizational decision-making process, staff are not given the opportunity to understand the organization's goals, vision, and strategies, which can result in burnout (Choi, 2011).

Autonomy

Unfair organizational hierarchy and a lack of staff autonomy also significantly contributes to employee burnout. Studies suggests a rigid hierarchical structure results in lower job satisfaction, higher turnover and feelings of disempowerment (Thomas, 1999; Slattery & Goodman, 2009; Kulkarni, Bell, Hartman & Herman-Smith, 2013).

Solutions: Implementing Trauma-Informed Supervision

A crucial factor identified in the literature for prevention of STS and VT in trauma work is the importance of effective supervision (Beckerman & Wozniak, 2018; McCann & Pearlman, 1990; Ben-Porat, 2015; Bell, Kulkarni & Dalton, 2003; Peled-Avram, 2017; Walker, 2004; Trippany, White Kress, & Wilcoxon, 2004; Schub, 2018; Winning et al, 2017). Elements of effective supervision include:

- supervision that is supportive, accessible, informative and reciprocal
- practicing strong active listening skills, self awareness and boundary-setting
- creating authentic, engaging and empowering relationships with all supervisees to encourage openness and support
- monitoring and limiting supervisee caseloads
- establishing regular check-ins and weekly meetings while watching for potential symptoms of STS and VT in each supervisee
- scheduling group discussions/peer support for DV workers where trauma is acknowledged and normalized
- encouraging staff to take care of themselves by utilizing vacation days, wellness days, employee assistance program, etc.
- providing ongoing training, workshops and professional development opportunities and support that is psychoeducational and psychoanalytic.

Supervision is extremely important in facilitating an environment where DV staff feel they can share their own experiences, build cohesion and togetherness, reduce isolation, share coping strategies, validate and support each other, have an opportunity to debrief, alleviate countertransference issues and reaffirm confidence.

It has been established so far in this report that there is a high risk for VT for those working in the DV field and the effects of VT are concerning. Compounded by high rates of personal experiences with trauma as reported in our survey, it is critical to present practical solutions within a framework of ***trauma-informed supervision***.

Trauma-informed supervision is an approach that recognizes that trauma is part of the day-to-day work (and day-to-day lives for many), seeks to build safety and trust and that addresses staff health and wellbeing while maintaining appropriate boundaries. Trauma-informed supervisors help build self-awareness, choice, collaboration, and empowerment while encouraging transparent, open and honest discussions (the same components as trauma-informed care). Several studies argue that, supervisors who 'take up' a trauma-informed approach means reducing power imbalances in the workplace, which means encouraging staff feedback, having clearly defined expectations and responsibilities, and creating a workplace culture of mutual respect (Kreider, 2014; Tromski-Klingshirn & Davis, 2007; Walsh, Gillespie, Greer, & Eanes, 2003).

Berger and Quiros's (2016) study described trauma-informed supervision as "[creating] an oasis within the chaos… [balance] being very attentive, gentle, supportive, and nurturing, while also nudging workers to challenge themselves, hold them accountable, and yet create a safe place to struggle toward professional growth" (p. 149)." They also argue the need for supervisors to model "vulnerability and their… own encounters with trauma" (p. 151) as a way of helping staff work through the pain that their work triggers.

While reducing power imbalances is key in trauma-informed supervision, Jernigan et al (2010) argue that supervision is not egalitarian. There is a need for power differences between supervisors and supervisees as supervisors need to assign responsibilities and assess employee performance. Further, sociodemographic characteristics or social identities, like age, spiritual/religious affiliation, status, race, ethnicity, gender, and sexual orientation, also influence divisions of power (Beddoe, 2010). So, if self-awareness, choice, collaboration, and empowerment are key elements of trauma-informed supervision, the role of the supervisor is to ensure that staff feel that power is shared (as much as is possible), that their ideas matter and their decisions are honored and/or made collaboratively, rather than dictated from the 'top down' (Berger, Quiros & Benavides-Hatzis, 2017). These authors further argue that it is very important for supervisors and staff to explore their social identities and related positions of privilege and power to help build open and trusting relationships through ongoing dialogue.

Trauma-informed supervisors are teachers and counselors as well as supervisors. Done well, the impact of trauma-informed supervision better prepares staff to identify and develop strategies to cope with their own 'triggers' and to help ensure they are able to continue to provide effective support to clients (Berger & Quiros, 2016). To do this, supervisors require their own mechanisms

for capacity building and support, including knowledge of trauma and its effects on clients, knowledge of vicarious trauma and its effects on staff, self-care and clinical and supervision skills, (Berger & Quiros, 2016; Courtois & Gold, 2009; Mattar, 2011; Gray, Ladany, Walker, & Ancis, 2001; Mehr, Ladany, & Caskie, 2015).

A skilled trauma-informed supervisor needs to be adaptive to a variety of situations depending on what is needed. Peterson (2015) argues that supervisors need to be able to inspire, teach, support, model and challenge, evaluate, collaborate and advocate. Meaning they need to

- create conditions that instill hope and promote adherence to the mission and goals of the organization
- use innovative methods to communicate knowledge such as modeling and role playing (boundaries and conflict resolution)
- provide encouragement, empathic responses, examples from personal experience
- build rapport, relieve anxiety, and build supervisee's self-awareness and insight
- foster open learning environments and promote risk-taking
- demonstrate how knowledge translates into practice through applying evidence-based techniques
- provide corrective feedback
- point out discrepancies between staff goals and actions and review and assess performance
- encourage problem-solving skills
- facilitate professional development
- "provide a voice" on behalf of staff through advocacy efforts
- Encourage staff input into organizational decisions
- provide a "living wage" and good benefits
- provide safe space for grievances

List was adapted from Peterson, 2015.

In addition, to trauma-informed supervision, organizational structure, a culture of self-care, capacity building and training, organizational policies and workplace safety are important to discuss as solutions.

Organizational Structure

Pross (2014) suggests one of the keys in preventing work-related stress in employees is by establishing a solid and healthy organizational culture as follows:

- delegating tasks and responsibilities
- clearly defining roles, procedures, job descriptions
- opening transparent lines of decision making and accountability
- establishing working hours, service schedule and time management for all employees
- managing and limiting case loads
- carefully selecting new staff and new leadership teams
- ongoing training, coaching and management

- having the Board of Directors actively monitor the organization and its leaders
- hiring practices that seek out staff who are equipped, prepared and able to undertake trauma work

Self-care

Self-care has been associated with lower levels of STS and VT and is crucial to the well-being of DV workers; thus, it must be conveyed as an agency expectation to protect workers from harm (Kulkarni, Bell, Hartman & Herman-Smith, 2013; Beckerman & Wozniak, 2018; Bell, Kulkarni & Dalton, 2003; Trippany, White Kress, & Wilcoxon, 2004). Self-care as an agency expectation could include:

- providing resources to staff such as peer support groups, counselling services, debrief sessions, etc.
- creating structured self-care opportunities in the work environment such as stress management, yoga classes, a walking or a meditation group, art therapy
- scheduling team retreats and weekend trips for staff
- establishing diverse schedules for workers that allow for taking breaks from high trauma work (e.g. two days of client contact balanced with two days of no client contact)

Ongoing Training and Education

Studies reveal education and clinical training are critically important in mitigating the potentially damaging effects of trauma work (Beckerman & Wozniak, 2018; Bell, Kulkarni & Dalton, 2003; Ben-Porat, 2015; Cunningham, 2003; Knight, 2018). Education and training may include:

- informing staff about the potential risks of undertaking trauma work starting in the job interview
- providing ongoing workshops to increase knowledge around STS and VT and mitigate the potential impacts on staff
- move beyond ‘awareness’ training to include practical strategies and tools

Tarshis & Baird (2019) have identified a framework for supervisors working with practicum students, a crucial step to mitigating the effects of trauma at the start of an individual’s education and career path.

Supervisors should:

- recognize a student’s vulnerability to vicarious trauma, consider past traumatic experiences and address the potential ‘shattering’ of the student’s worldview
- create a relationship in which students feel open and comfortable discussing trauma, with support that is accessible, informative and reciprocal
- set boundaries between professional and personal relations with the student and discuss countertransference
- arrange weekly or biweekly training and encourage students to voice their needs and concerns

Policies

Agency policies that acknowledge the risks of trauma work while protecting workers are imperative to mitigating the experiences of STS and VT in DV workers (Beckerman & Wozniak, 2018; Bell, Kulkarni & Dalton, 2003; Trippany, White Kress, & Wilcoxon, 2004; Mennella, 2018). Agency policies and subsequent practices may include:

- utilizing formal measures of informed consent with staff regarding risks of trauma work at time of hiring
- remaining vigilant in creating and implementing 'best practices' and strategies to protect staff
- providing opportunities for staff to participate in social change activities such as community education and outreach or work towards influencing policy
- being proactive, not reactive when supporting staff experiencing STS and VT
- building knowledge of system navigation into staff training, this helps DV survivors get the holistic support they need while decreasing demands and workload on staff

Workplace Safety

The safety of DV workers should be prioritized (Bell, Kulkarni & Dalton, 2003; Slattery & Goodman, 2009). Safety and security measures could include:

- installing security systems
- utilizing a buddy system
- allowing staff to have personal objects such as pictures and quotes to help them stay grounded through trauma work
- providing break rooms that promote self-care such as couches, music, coffee and tea
- having access to a counselor or therapist (Hole & Karakashian, 2018).

2.0 Heal the Healer Focus Group

40 people participated in a generative group discussion to examine barriers and gaps to *healing the healer* as well as strategies to respond. The following is a summary of key themes that emerged.

Organizational Support

Participants consistently spoke of the role organizations must play in preventing employee burnout by acknowledging, understanding and removing systemic barriers. Participants suggested organizations need to stop blaming individuals for burning themselves out and noted organizational support is about creating a work environment that is safe and supportive. Participants described a safe and supportive work environment as follows:

- establishing daily and weekly debrief meetings

- creating support networks within the agency for workers to reach out to
- having a carefully selected, strong leadership team in which supervisors continually check in with staff and are available to discuss emotional impacts of trauma work
- creating supportive space for workers to deal with the process of grieving and frustration in trauma work
- asking each staff member what they need to be successful

"*Burnout does not come from clients – it comes from hitting our heads against the wall and not moving forward."*

"It is on us to take care of ourselves but responsibility lies within organizations to create supports and safety."

"Hold leadership accountable to support."

"Choose your team wisely – pick people who you know can build a strong team that works well to support each other."

Organizational Self-Care

Participants identified the need for active and ongoing self-care to be embedded within the organization so that taking care of oneself becomes a normalized process. Some participants reported not knowing how to take care of themselves, while others felt that wellness was not embedded in their work role. Participants discussed the importance of having the management team "on board" with making self-care a daily responsibility. This was decirbed as:

- establishing a wellness committee to create scheduled self-care activities at work such as weekly yoga sessions, self-care workshops and humor
- encouraging activities that are work appropriate such as clothing swaps and building a library
- empowering staff to have difficult conversations as self-care may be hard for some
- promoting a culture the focuses on rest, response and learning
- developing a sense of community with other agencies to bring people together and collaborate with each other
- finding innovative ways to support and encourage self-care
- modifying work hours to encourage a healthy work-life balance

"I just don't know what to do – counselor says I need a hobby – I end up helping others… that is my hobby. I like helping people, it is hard to get away from that."

"Self care should be part of daily responsibility of your day – need to empower and support staff to engage in self-care"

"We don't perceive our own wellness as part of the work – it is done on the side or after work."

"Set aside time to support each other – we have to be creative."

Training and Policies

Participants discussed the need for ongoing training about trauma and burnout to help mitigate the potential triggers associated with working with DV survivors. Training included safety awareness training, psychological health and safety standards, and vicarious trauma training. Participants also spoke about needing HR policies and procedures that are trauma-informed so that workers are not re-traumatized through their work.

"*It can be a small circle and we may know the abuser… may be a trigger for staff."*

"We bring our own stuff with us…. how can we create policies and procedures that do not further traumatize?"

"HR policies knowing it is okay [for staff] to access counselling."

"Guiding principles are voice, trust and collaboration."

Workload and Expectations

Participant discussion revealed workload and expectations are among the biggest barriers they face when trying to access healing strategies within the DV sector. Participants described these barriers as follows:

- small agencies with limited number of employees results in workers being extremely busy and having no time for healing strategies
- workers being asked to do more with less as funding gets cut, leaving no funding for culture and wellness
- staff are encouraged to heal people, meet unrealistic expectations and work under high pressure

"Small agency with 3 full time employees – hard to develop culture because there is work to be done."

"Sometimes there is just too much work – made to feel guilty if there is waitlist."

"Society encourages us to wear exhaustion as a badge of honor… the harder you work, the more tired you are, the busier you are – the better employee you are."

"They see us as a white knight – that is way too much pressure."

3.0 Survey Results

"The issue is not about self care or understanding vicarious trauma. The issue is about creating structures and systems that empower staff to deal with vicarious trauma and burn out. Self care is a shaming way of addressing this issue (which is why it is only mildly effective). Trauma and burnout come from hitting the same barriers over and over again as employees', either with our clients or within our organization, the antidote is not a warm bath, it is the ability to feel empowered to address these barriers. "(Supervisor survey)

To add context and to 'localize' the literature review results, two surveys were administered to CDVC members. One to supervisors, directors and executive directors and one to front-line staff'. In total, 61 people participated (35 supervisors and 26 front-line). Questions in each survey were similar, the data are presented here to show where similarities and discrepancies occur between the two groups. Questions in the surveys focussed on personal experiences with violence (to understand potential 'risk' for VT); awareness of and suggestions for changes to organizational policies; perceived barriers to organizational support/healing and suggested strategies for CDVC to reduce barriers and build capacity. A summary of the results are presented here.

When asked about personal experiences, 68% said they had experienced or witnessed violence in their own lives. When asked what type of violence the following was reported (check all that apply)

- 28% emotional/psychological
- 25% verbal
- 21% physical
- 11% financial
- 8% sexual
- 3% spiritual
- 3% neglect

Most of these experiences were in youth or childhood. When asked how long it lasted, the range was from one month, 1 year, 3 years, 17 years, 20 years to still ongoing, the number of violent relationship ranged from 1-7 and most people told their mothers or a friend first. 88% said they felt heard and understood when they disclosed and 56% did not seek formal supports. Of those who did seek support:

- most sought counselling
- 1 person went to a shelter
- 1 went to police
- 1 went to a school counselor
- 1 went to counseling and peer support

Reasons for not seeking support: most said it was because they were children or because it was a long time ago, 1 said because of cultural reasons, 1 was afraid to ask for help, 1 said their work provides an avenue to ensure they are able to deal (training and a core ability to cope) and 2 said they didn't think they needed it until much later when they struggled to cope.

37% of frontline staff are aware of organization policies while 63% are very aware. This compares with 19% of supervisors being aware and 71% being very aware. Interestingly, 10% of supervisors were only slightly aware or not at all aware of organizational policies.

Supervisors were asked if they had formal or informal training in leadership skills:

- 48% have 'formal' education in leadership ranging from certificates to degrees

- 93% have attended workshops and seminars on leadership including coaching and certificates

When asked to prioritize the barriers that emerged in the literature review in order of importance, there were slight differences between the groups. Front-line staff identified the following:

1. Inadequate funding
2. Inadequate resources (e.g. limited training, high caseloads)
3. Lack of effective supervision to deal with burnout
4. Lack of organizational time/support for debriefing/mentorship/peer support
5. Lack of training/education for leaders
6. Lack of organizational policy to respond to burnout/secondary trauma
7. VT support is not prioritized

Supervisors ranked barriers like this:

1. Lack of training/education for leaders
2. Inadequate resources (e.g. limited training, high caseloads)
3. Inadequate funding
4. Lack of organizational policy to respond to burnout/secondary trauma
5. Lack of organizational time/support for debriefing/mentorship/peer support
6. Lack of effective supervision to deal with burnout
7. Lack of autonomy
8. VT support is not prioritized

Other barriers identified by front-line staff were:

1. Elder support, cultural awareness and understanding of Indigenous peoples
2. Victim mentality of staff not just clients

Other barriers identified by supervisors were:

1. Mindset – *"we serve clients first not staff"*
2. No relief workers for respite
3. Misunderstanding the solution – which falls to self-care

"Most organizations don't have a lot of redundancy across roles so if someone is burnt out or has to go on leave it impacts their team. This can create an environment of frustration when someone isn't taking care of themselves because we all know what it will lead to. I think respecting people's personal boundaries around their health and wellness creates difficult grey areas for employers in the context of burnout and secondary trauma." (*Supervisor survey*).

Frontline staff were asked questions about whether or not they felt supported by their organization's leadership team to deal with stress and burnout.

- 50% feel somewhat supported
- 42% feel very supported
- 8% do not feel supported

"I find that often we put the responsibility of staff mental health on the staff themselves but don't really look at how the agency treats staff, or look at improving communication process or the culture of the organization. I think these are extremely crucial to address staff mental health." (Supervisor survey)

25% of front-line staff agree or strongly agree with the following statement: "*My organization has strategies in place to help me deal with stress and burnout"*
42% somewhat agree, 12.5% neither agree nor disagree and 17% disagree or strongly disagree.

65% of frontline staff agree or strongly agree with the following statement: *"I feel safe at work".*
30% somewhat agree, 5% somewhat disagree.

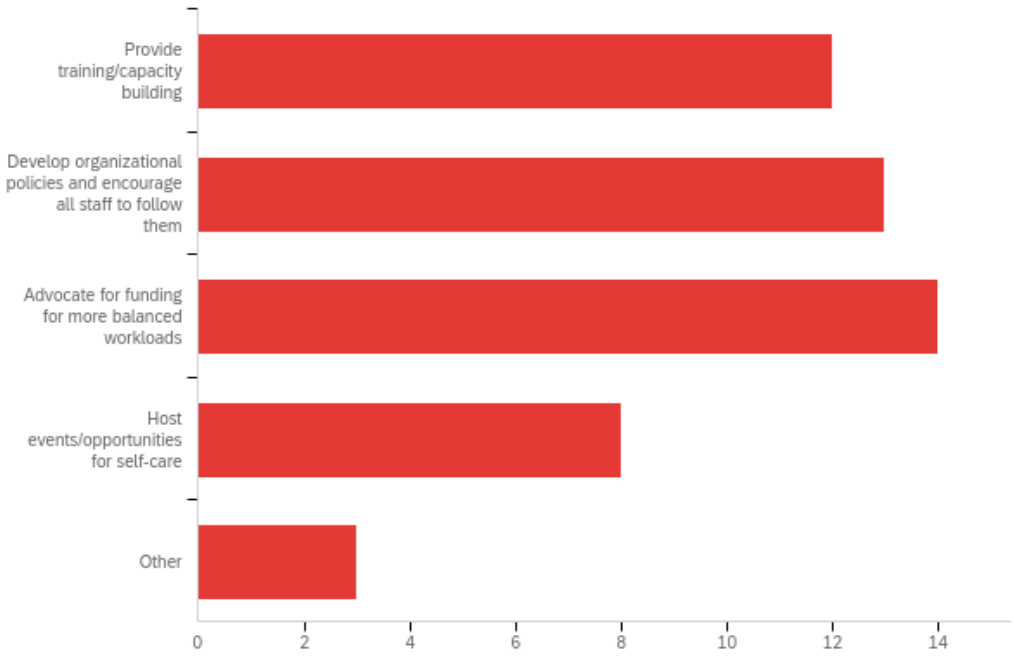
79% of front-line staff have developed their own strategies for self-care, while 17% agree somewhat to that statement and 4% disagree. Identified self-care strategies included, mental health days, exercise and meditation, reaching out to personal support networks.

"I avoid working and checking emails in evenings, weekends and holidays, except in emergencies. Ensure there is time for my health and spiritual needs during time off". (Frontline staff survey)

"I do a lot of outdoor activities to help me with burnout, I take time to myself so I do not bring it home to my own family… I sit with my Elders or talk to them when needed." (Front-line staff survey)

"When feeling overwhelmed or burned out I try to make time (30-60 minutes) to tackle a task or research a topic that gets me inspired. This could be professional or personal development goals." (Front-line staff survey)

When asked for solutions from their supervisors/organizations to reduce burnout, front-line staff suggested:



Both frontline staff and supervisors were asked what CDVC could do.

Frontline staff said (in order of importance)

5. Advocate for funding
6. Provide training/capacity building
7. Develop organizational policies and encourage agencies to follow them
8. Host events/opportunities for self-care

"Advocate to governments and service providers on the importance of self-care. Collect and publicize statistics on prevalence and effects of burnout (effects on staff, absences and on service delivery)." (Front-line staff survey)

"I think everyone working in frontline work is doing amazing and they do need to be compensated for their hard work and praised…Be open and aware of what your staff may be experiencing. Talk on the regular about self care and how important it is, if our managers follow this model then the frontline staff will see that self-care is important too." (Front-line staff survey)

Supervisors said (in order of importance)

5. Provide training/capacity building
6. Advocate for funding
7. Host events/opportunities for self-care
8. Develop organizational policies and encourage agencies to follow them

Examples of other suggestions included:

"More wellness days. We have three per year. It's not enough and often it isn't meant to address burnout, stress, or mental health-related issues." (Front-line staff survey)

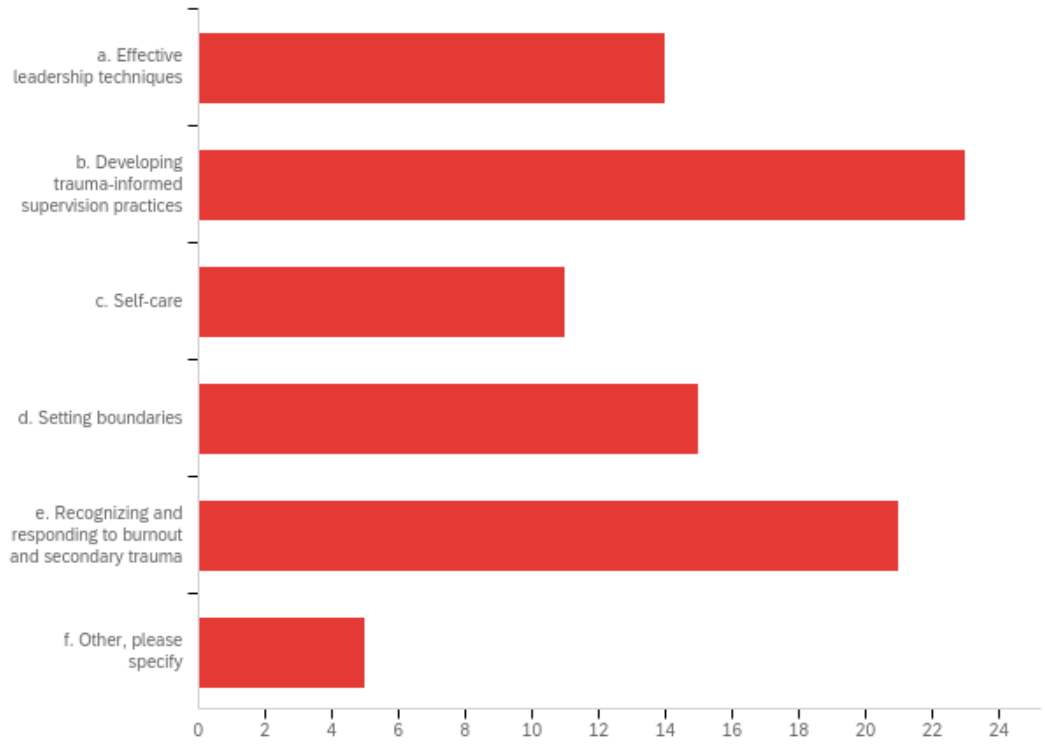
"Organizational day- staff attend a day of sessions on self care, burn out, etc to build capacity and team cohesion. These sessions can occur in one hour time slots, and following a learning session there could be some self care exercises scheduled like yoga, adult crafts, art exercises, meditation, cooking a small meal in community kitchen setting, etc." (Front-line staff survey)

"Organizations need to learn how to ensure that staff are the product they need to survive and make sure they are put first - introducing the concept of the inverse hierarchy." (Supervisor survey)

"I believe it really comes down to effective leadership where staff and supervisors feel safe to communicate their experiences and needs without feeling shame or worry of being seen as incompetent. Relationship based leadership and building high trust cultures is essential." (Supervisor survey)

Education for all staff and leadership to better understand the signs of CF and VT. I believe it is important for staff to have the information, be aware of signs and be self-aware enough to know when they are experiencing symptoms. If it is more normalized and validated staff might feel less shame and judgement surrounding the issue. Stigma is getting in the way of preventative conversations." (Supervisor survey)

Specific ideas for CDVC capacity building sessions included:



Specific ideas for organizational policies included:

1. debriefing sessions, case consultations
2. onsite self care opportunities
3. access to counselling
4. maximum caseloads
5. extended mental health days
6. policies that empower staff to *"feel connected to the bigger WHY of the work we do as an antidote to vicarious trauma and burn out"*
7. policies on how change is communicated, who is included in change processes, how to make change and policy development more of a collaborative process with staff rather than a top down process

"If staff have been affected by a client passing or being severely abused then provide them with more support, debrief the situation but also ensure your staff are okay, Provide them the time to grieve… build relationships with them." (Front-line staff survey)

4.0 Summary and Recommendations

To summarize, DV workers are vulnerable to STS, VT and burnout due to their ongoing exposure to DV survivors' traumatic stories, and often, personal experiences with violence and abuse resulting in significant negative impacts to their own lives. In many ways the results from the group discussion and surveys support the results from the literature review. Participants felt that primary responsibility for self-care was on individuals but that leadership/executive staff had

an important role to play in creating and sustaining organization cultures (supported with policy) that promote health and wellness.

Supervisors and organizational culture play a significant role in contributing to employee health and wellness. There is an increased importance on the role that senior/executive staff must take in protecting their staff from trauma-related harms which includes focusing on trauma-informed supervision, structure, self-care, education and training, agency policies and the safety of the work environment.

Recommendations for CDVC

Mediating and responding to the impact of vicarious trauma in DV organizations is a leadership and an organizational responsibility. The effects of trauma work should be discussed openly and often between supervisors and staff and should include discussions about social identities, power and privilege to truly build self-awareness and transparency and reduce power hierarchies.

Understanding of the trauma that DV supervisors face and staff capacity to work in DV should be assessed in the interview process before new staff are hired. Action plans should be developed collaboratively and reflect available resources to ensure they can be sustained.

The following are considerations for CDVC to respond to barriers and facilitate solutions that emerged in the research. Recommendations are grounded in collective impact solutions that are collaborative and coordinated and focused on high impact opportunities for change. Recommendations are organized under the themes of organizational culture (that is grounded in trauma-informed supervision), organizational structures and policies and future research/evaluation.

Trauma-Informed supervision

To be truly trauma- informed, supervisors need to inspire, teach, support, model and challenge, evaluate, collaborate and advocate. **Trauma-informed supervision should be embedded within an organizational culture that prioritizes the health and wellbeing of staff as well as DV survivors.**

CDVC could develop and/or leverage partnerships to deliver a series of capacity building sessions for supervisors. Suggested content could include specific strategies on:

1. Trauma-informed supervision – what it is – how we do it
2. Boundary setting, conflict resolution and problem solving
3. How to share personal experiences in a safe and constructive way
4. How to build rapport, relieve anxiety, provide a ‘safe space’ for grievances and build supervisee’s self-awareness and insight through reflective questioning and dialogue
5. Share current research/evidence on ‘best-practices’
6. Reduce power differences while balancing corrective feedback and reviewing and assessing staff performance

7. “Provide a voice” on behalf of staff through collective advocacy efforts meant to ensure adequate resources are available for organizational responses (e.g. living wage and benefits, balanced caseloads)
8. Create shared decision making and staff input into organizational decisions

Organizational Structure and Policy

Considerations for healthy organizational structures and polices are guided by the principles of trauma- informed practice, which is a strengths-based approach grounded five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity. Policies should be proactive, not reactive when supporting staff experiencing or at risk of vicarious trauma.

CDVC could develop and encourage organizational polices and practices that include identification of clear roles and responsibilities for each team member (including job descriptions); transparent lines of decision making and accountability; established work hours and schedules with options for time away from direct client contact; manageable case loads and values or principles based hiring strategies.

Further:

- Formal measures of informed consent with staff regarding risks of trauma work at time of hiring;
- Vigilance in creating and implementing ‘best practices’ and strategies to protect staff;
- Opportunities for staff to participate in social change activities such as work towards influencing policy;
- Build knowledge of system navigation into staff training.

Self-care strategies should be encouraged and offered during work hours and could include:

- Peer support groups, counselling services, debrief sessions;
- pairing newly hired staff and practicum students with more experienced staff in a ‘buddy’ system for bi-weekly check in for the first six months of employment;
- Stress management sessions, yoga classes, a walking or a meditation group, artistic activities;
- Team retreats (could be hosted by organizations with resources).

Advocacy and Funding.

The Policy Working Group of the CDVC could prioritize advocacy for funding for the sector, in response to the number one recommended action by front line staff in the survey. This will be particularly important within the context of COVID-19, which may affect funding at a time when rates of domestic violence are on the rise, as are stress levels for staff.

Future Research and Evaluation

Evaluative surveys should be provided for each capacity building session. Examples include pre and post surveys to assess changes in knowledge and confidence to implement new strategies and any resources that need to be advocated for.

CDVC could conduct a scan of partner organizations and their current capacity to participate in shared resource allocation (staff and financial) to implement sector wide strategies to heal the healer. Examples could be to identify organizations that could offer shared HR staff, and counselling, mentorship, retreats, existing policies and practices for self-care.

CDVC could encourage partner agencies to use organizational assessment tools to assess how 'trauma-informed' an organization is (See Appendix A for examples). Following this, CDVC should host sessions for organizations to share their results in a judgement free way and strategize ways to build capacity across the sector.

Future research could examine the impact of the recommendations and could include a're-administration' of the supervisor and staff surveys to assess changes in understandings of and responses to vicarious trauma and burnout. Results could help inform the development of needed 'new' strategies and recommendations.

Future research could also assess the impact of the recommendations on supervisors and staff with diverse backgrounds. For example, are there different barriers and/or solutions when supervisors and staff come from different genders, cultures, ages, orientations, abilities etc.) Sample research question could be "how do the dynamics of supervisory power play out in supervision for trauma-informed practice when the supervisor and supervisee have different social identities?

The impact of strategies should be reported annually to CDVC members including generative discussions to 'tweak' the work moving forward.

Appendix A

Organizational Assessment Tools

1. The Trauma-Informed Care Project - Agency Self-Assessment for Trauma-Informed Care

http://www.traumainformedcareproject.org/resources/Trauam%20Informed%20Organizational%20Survey

_9_13.pdf

2. National Center on Domestic Violence, Trauma, & Mental Health; Boston College; and Michigan State University. Trauma-Informed Practice Scales (TIPS) is a tool that can be used by agencies to identify areas of strength and weakness, improve their practices, and "demonstrate to funders and other key stakeholders that they are incorporating trauma-informed principles into their work."

http://vaw.msu.edu/wp-content/uploads/2015/02/Tips_Using_TIPS_Sullivan_Goodman_2015.pdf

References

Abendroth, M. (2011). Overview and summary: Compassion fatigue: Caregivers at risk. *Online Journal of Issues in Nursing, 16(*1), 1-3.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18,* 71-86.

Baird, K., & Kracen, A. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counseling Psychology Quarterly, 19*(2), 181–188.

Beckerman, L. N., & Wozniak, D. F. (2018). Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support. *Social Work in Mental Health, 16*(4), 470-490.

Beddoe, L. (2010). Surveillance or reflection: Professional supervision in "the Risk Society" *British Journal of Social Work, 40*, 1279–1296

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational Prevention of Vicarious Trauma, *Families in Society: The Journal of Contemporary Social Services, 84*(4), 463-470.

Ben-Porat, A. (2015). Vicarious post-traumatic growth: Domestic violence therapists versus social service department therapists in Israel. *Journal of Family Violence, 30*(7), 923–933.

Berger, R., Quiros, L. & Benavides-Hatzis, J.R. (2017). The intersection of identities in supervision for trauma-informed practice: Challenges and strategies. *The Clinical Supervisor, 37*(1), 122-141.

Billhartz Gregorian, C. (2012). Nurses take steps to battle compassion fatigue. *Utah Nurse, 21*(1), 13. (GI)

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63-70.

Carpenter, H. (2013). Health, safety, & wellness. When caring hurts: Compassion fatigue. *American Nurse Today, 8*(3), 54.

Choi, G.Y. (2011) Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work, 35*(3), 225-242.

Collins-Camargo, C. (2012, Spring). Secondary traumatic stress and supervisors: the forgotten victims. CW360, 8-9.

Conrad, D. (2012, Spring). The secondary trauma prevention project: a multilevel systems approach to protect child welfare staff from secondary trauma. CW 360, 23. 4-5.

Courtois, C. (2018). Trauma-informed supervision and consultation: Personal reflections. *The Clinical Supervisor, 37*(1), 38-63.

Cunningham, M. (2003). The impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*(4), 451–459.

Epp, K. (2012). Burnout in critical care nurses: A literature review. Dynamics, 23(4), 25-31.

Figley, C. (2012, Spring). Helping that hurts: child welfare secondary traumatic stress reactions. CW360,

Garcia, M., Kosutic, I., McDowell, T., & Anderson, S. A. (2009). Raising critical consciousness in family therapy supervision. *Journal of Feminist Family Therapy, 21*(1), 18–38.

Hernandez, P., & Rankin, P. (2008). Relational safety and liberating training spaces: An application with a focus on sexual orientation issues. *Journal of Marital and Family Therapy, 34*(2), 251–264

Hole, M.N. & Karakashian, A.L. (2018). Burnout in Critical Care Nursing Staff. *CINAHL Nursing Guide,* Evidence- Based Care Sheet

Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 36*(5), 420-427. doi:10.1016/j.jen.2009.11.027

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15,* 393-412.

Jenkins, S.R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5), 423–432.

Jenkins, B., & Warren, N. A. (2012). Concept analysis. Compassion fatigue and the effects upon critical care nurses. *Critical Care Nursing Quarterly, 35*(4), 388-395.

Jernigan, M. M., Green, C. E., Helms, J. E., Perez-Gualdron, L., & Henze, K. (2010). An examination of people of color supervision dyads: Racial identity matters as much as race. *Training and Education in Professional Psychology, 4*, 62–73.

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. *The Clinical Supervisor, 37*(1), 7-37.

Kulkarni, Bell, & Rhodes. (2012). Back to basics: Essential qualities of services for survivors of intimate partner violence. *Violence Against Women, 18(*1), 85-101.

Kulkarni, S., Bell, H., Hartman, L. J. & Herman-Smith, L. R. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers, *Journal of the Society of Social Work and Research, 4*(2), 114-130.

Mattioli, D., Walters, L. & Cannon, J. E. (2018). Focusing on the caregiver: Compassion fatigue awareness and understanding, *MedSurg Nursing, 27*(5), 323-328.

Mennella, H. (2018). Compassion fatigue in nursing: an Overview. *CINAHL Nursing Guide*, Evidence-based Care Sheet.

Mohamed, F. R. (2016). Relationship among nurses role overload. Burnout and managerial coping strategies at intensive care units. *International Journal of Nursing Education, 8*(2), 39-45.

Newell, J. M. & MacNeil, G.A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventative methods for clinicians and researchers. *Best Practices in Mental Health, 6*(2), 57-68.

Peled-Avram, M. (2017). The role of relational-oriented supervision and personal and work-related factors in the development of vicarious traumatization. *Clinical Social Work Journal, 45*(1), 22-32.

Pross, C. (2014). Cultural competence and trauma in the organizations: Sources and prevention of stress and dysfunction. *Clinical Neuropsychiatry, 11*(1), 7-19.

Schub, T. (2018). Burnout in hospice and palliative nursing staff. *CINAHL Nursing Guide*, Evidence- Based Care Sheet

Slattery, S. M., & Goodman, L. A. (2009). Secondary traumatic stress among domestic violence advocates: Workplace risk and protective factors. *Violence Against Women, 15*(11). 1358 – 1379.

Tarshis, B., & Baird, S. (2019). Addressing the indirect trauma of social work students in intimate partner violence (IPV) field placements: A framework for supervision. *Clinical Social Work Journal, 47.* 90-102.

Trippany, L. R., White Kress, E. V. & Wilcoxon, A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors, *Journal of Counseling and Development, 82*(1), 31-37.

Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: Counter transference, secondary traumatization and terror. *Psychodynamic Practice, 10*(2), 173–193.

Winning, A. M., Merandi, J. M., Lewe, D., Stepney, L. M. C., Liao, N. N., Fortney, C. A., & Gerhardt, C. A. (2017). The emotional impact of errors or adverse events on healthcare providers in the NICU: The protective role of coworker support. *Journal of Advanced Nursing, 74*(1), 172-180

Hensel, Ruiz, Finney, & Dewa, 2015; Sprang, Ross, Miller, Blackshear, & Ascienzo, 2017). https://www-tandfonline-com.ezproxy.lib.ucalgary.ca/doi/full/10.1080/07325223.2017.1413607

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. The Clinical Supervisor, 37(1), 7-37.

Berger, R., & Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. Traumatology, 22, 145–154

Best, D., White, E., Cameron, J., Guthrie, A., Hunter, B., Hall, K., & Lubman, D. I. (2014). A model for predicting clinician satisfaction with clinical supervision. Alcoholism Treatment Quarterly, 32, 67–78.

Courtois, C., & Gold, S. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. Psychological Trauma: Theory, Research, and Practice, 1, 3–23.

Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. Journal of Counseling Psychology, 48, 371–383.

Knight, C. (2013). Indirect trauma: Implications for self-care, supervision, the organization, and the academic institution. The Clinical Supervisor, 32, 224–243.

Kreider, H. (2014). Administrative and clinical supervision: The impact of dual roles on supervisee self-disclosure in counseling supervision. The Clinical Supervisor, 33, 256–268.

Mattar, S. (2011). Educating and training the next generations of traumatologists: Development of cultural competencies. Psychological Trauma: Theory, Research, Practice, and Policy, 3, 258–265

Mehr, K. E., Ladany, N., & Caskie, G. L. (2015). Factors influencing trainee willingness to disclose in supervision. Training and Education in Professional Psychology, 9, 44–51.

Petrila, A., Fireman, O., Fitzpatrick, L. S., Hodas, R. W., & Taussig, H. N. (2015). Student satisfaction with an innovative internship. Journal of Social Work Education, 51, 121–135.

Sommer, C. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. Counselor Education and Supervision, 48, 61–71.

Tromski-Klingshirn, D., & Davis, T. E. (2007). Supervisees' perceptions of their clinical supervision: A study of the dual role of clinical and administrative supervisor. Counselor Education and Supervision, 46, 294–304

Walsh, B. B., Gillespie, C., Greer, J. M., & Eanes, B. E. (2003). Influence of dyadic mutuality on counselor trainee willingness to self-disclose clinical mistakes to supervisors. The Clinical Supervisor, 21(2), 83–98