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The Relationship between Organizational Trauma-Informed Care and Secondary Trauma Symptoms in Staff Members of Kentucky Domestic Violence Programs

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THE RELATIONSHIP BETWEEN ORGANIZATIONAL TRAUMA-INFORMED CARE AND SECONDARY TRAUMA SYMPTOMS IN STAFF MEMBERS OF KENTUCKY DOMESTIC VIOLENCE PROGRAMS

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This study evaluated secondary traumatic stress (STS) levels in 89 employees from Kentucky's 15 regional domestic crisis programs to determine whether certain demographic variables predicted STS levels (as measured by the Secondary Traumatic Stress Scale©) and whether employee perception of organizational trauma-informed care practices (as measured by the Ticometer©) reduced levels of STS. Results of a multiple regression analysis indicated that personal trauma history severity did significantly impact STS levels. In this way, the current study rejected the null hypothesis. Results also indicated that the more the employee perceived the organization to adopt and execute trauma-informed care practices, the lower the employee's levels of STS. Specifically, Domain Four of the Ticometer© (fostering trauma-informed service delivery) contributed significantly to reduction in STS levels, thereby rejecting the null hypothesis. While the study was limited due to the specificity of the sample as well as its small size and limited gender diversity, it is rich with practical application for leaders of human services organizations charged with caring for trauma survivors and staff member likely exposed to high levels of trauma content. Since much of the research on STS is confined to only licensed, direct service providers, this study offers critical information on the effects of STS on all agency employees and sheds light on the responsibility organizations have to both understand and practice trauma-informed care.

Chapter I: Introduction

The health and human service fields have become increasingly aware of disturbingly high rates of traumatic stress and its potentially devastating impact on the individuals who experience it. A national study reported that almost 90% of nearly 3,000 respondents reported at least one exposure to a traumatic event in their lifetimes with multiple exposures within the range of normal experience (Kilpatrick et al., 2013). Unfortunately, research suggests that 51% to 97% of women who have been diagnosed as severely mentally ill (SMI) report lifetime exposure to physical attack or sexual assault with a significant portion reporting multiple victimizations. One sample of women with SMI suggested 98% of those surveyed experienced some sort of trauma within their lifetime (Butler, Critelli, & Rinfrette, 2011).

As the awareness of the prevalence of trauma increases, and as our understanding of the effects of trauma grows, our understanding of the effects of indirect exposure to traumatic material should also expand. According to Knight (2013), the term *indirect trauma* refers to the range of negative effects working with survivors has on providers. Over time, the manifestation of these negative symptoms has been conceptualized by researchers as secondary traumatic stress (STS) and is analogous to symptoms of post-traumatic stress disorder (PTSD). STS continues to garner the attention of researchers and is now considered to be a tangible occupational hazard for those who devote their careers to helping victims of traumatic exposure on their road to recovery. (Knight, 2013; Nelson, 2015). So what are organizations to do in response to both the demand for specialized intervention services for survivors and the need to protect those who provide care to them?

Over the past two decades, government agencies and communities have begun to examine the role that systems such as juvenile justice, behavioral health, child welfare, housing, health care settings, and others play in facilitating recovery from exposure to traumatic events. The impetus for the development of a trauma-informed care perspective came in part from increased attention over the past 20 years to the wide prevalence of early traumatic events and their connections with later psychological and physical difficulties and disorders (Butler, et al., 2011). Likewise, this movement toward developing non-traditional response systems demonstrates a paradigm shift toward practically applying what is known about trauma exposure and incorporating that knowledge into every aspect of service delivery (Harris & Fallot, 2001).

This paradigm shift of trauma-informed care (TIC) has emerged as a framework grounded in an understanding of the impact of trauma, and commitment to allow that understanding to inform the organization's responsiveness to trauma for both the providers and service users (Harris & Fallot, 2001; Hopper, Bassuk, & Olivet, 2010). Since the majority of the literature is focused on how service users (clients) benefit from receiving trauma-informed services, this study is focused on how the service providers benefit from working for trauma-informed organizations. To fully grasp the need for both trauma-specific services and trauma-informed organizations, it is imperative that we review the origin of trauma treatment, the effects of primary trauma exposure and the impact on those secondarily exposed as they provide care to those in need following traumatic events. Likewise, due diligence must also be given to the effects of trauma exposure on organizational operations and climate.

Chapter II: Review of the Literature

History

Since the early fathers of psychology first began documenting the elements of human behavior, traumatic experience has found its way into the scientific literature as a focus of psychological treatment (Van der Kolk & Van der Hart, 1991). Early foundations of modern psychology were laid more than a century ago with the study of consciousness and the disruptive effects of trauma on the human experience. Psychologists such as Pierre Janet, Henri Elenberger and Sigmund Freud all strived to make sense of the human reaction to unspeakable events of horror and fear. Early contributions centered on research and theory of "consciousness" and "subconsciousness" and paved the way for work on memory storage, retrieval and reactions to traumatic events.

According to Van der Kolk and Van der Hart (1991), founding psychologists as early as 1904 coined the term "subconscious" and described it as a collection of memories stored automatically that serves as a guide for interaction with the external environment. Scholars of that day noted that the more frightening or novel the experience, the more difficult it is to integrate into conscious awareness; therefore, it becomes dissociated from awareness under voluntary control and can later manifest as unwanted recollections or behavioral reenactments (Van der Kolk, & Van der Hart, 1991). History records that it was Pierre Janet's observations that helped to lay the foundations of our understanding of the differences between ordinary and traumatic memories. According to Van der Kolk and Van der Hart (1991), Janet's understanding of the effects of trauma on the memory and subsequent behavioral and psychological

experiences, helped to pave the way for future work on helping clients deal with the negative and often times overwhelming responses to trauma including flashbacks, dissociation, and symptoms of re-experiencing (Van der Kolk & Van der Hart, 1991). Modern psychologists believe that it was Janet's work that was instrumental in helping us to understand that actual memories may form the center of psychopathology and continue to influence current experience by way of dissociation (Van der Kolk & Van der Hart, 1991). Janet made it possible to understand that proper integration of intensely emotional experiences into the memory system must occur in order to prevent dissociation and the development of traumatic memories. His work was pivotal in the building blocks of what is now understood about traumatic stress, dissociative disorders and the disrupting effects of traumatic experiences on overall adaptive functioning (Van der Kolk & Van der Hart, 1991).

Traumatic experiences are still disruptive today. Hundreds of years of the study of psychology and the complexities of human behavior have only underscored the resiliency of the human mind to adapt to the most difficult of experiences. Just like in the times of Janet, the study of trauma is still critical to our field and to those we serve. And while we understand much more about direct exposure to trauma, we are only recently beginning to see the effects on those who are indirectly exposed (e.g., clinicians, advocates, and first responders). The purpose of this review is to both highlight the existence of secondary trauma exposure and to explore its effects and the mitigating factors that may help to prevent or reduce the negative consequences of such exposure.

Trauma Defined

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), and for the purpose of this review, the term "trauma" refers to "experiences that cause intense physical and psychological stress reactions" (SAMHSA, 2012 p. 2). It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing" (SAMHSA, 2012, p. 2). In her book, *Trauma and Recovery*, Judith Herman (2015) describes psychological trauma as experiences that are accompanied by feelings of intense fear, helplessness, and threat of annihilation and loss of control. She further elaborates by adding that traumatic events are not extraordinary because of how rarely they occur, but instead are difficult because they so overwhelm the ordinary human experience. Sadly, the research literature on the topic of trauma supports this. According to Layne et al. (2011), nationally, psychological trauma in child and adolescent populations is becoming part of the normal human experience with some studies showing 68% of youth experience one or more traumatic event before the age of 16 (Copeland, Keeler, Angold, & Costello, 2007; Layne et al, 2011). Modest estimates suggest between 60% to 80% of adults in the United States and Europe have experienced a minimum of one traumatic event in their lifetime, including child abuse, interpersonal violence, and natural disasters (Simiola, Neilson, Thompson, & Cook, 2015).

Prevalence

Research evidence is mounting regarding the normality of traumatic experiences. General population estimates suggest that gender increases the risk of interpersonal

victimization with women more likely to be affected. According to Stappenbeck and colleagues (2016), 13% to 45% of women experience some sort of sexual assault in their lifetime. Moreover, the younger a woman is when child sexual abuse occurs, the more likely he or she is to be sexually assaulted in adulthood (Stappenbeck et al., 2016).

As disturbing, according to Alhabib, Nur and Jones (2010), domestic violence is as serious as cancer in the likelihood to cause death and incapacity among women aged 15–49 years old, and a greater cause of poor health than traffic accidents and malaria combined worldwide. Sadly, prevalence studies indicate that domestic violence has reached epidemic proportions in most societies making it a global health concern (Alhabib et al., 2010).

According to the Substance Abuse and Mental Health Administration (SAMHSA, 2014), trauma was once considered an abnormal experience. However, the first National Comorbidity Study underscored how common traumas were in the lives of the general population of the United States. In the study, more than 60% of men and 50% of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, experiencing a natural disaster, and/or experiencing a life-threatening accident being listed among the most common events (Kessler et al., 1999; SAMHSA, 2014). So whether the trauma is sexually-specific in nature or more broadly defined as in the SAMHSA study, the likelihood of traumatic experience occurring is high. In light of the prevalence of traumatic experiences in the general population, the knowledge of the effects of trauma has also grown. It is important to give a broad review of it here so that we can fully understand the serious nature of trauma on both those directly and indirectly exposed.

Effects of Trauma

Advancement in research has also increased our understanding of the effects (both short and long-term) of traumatic experiences on the overall psychological functioning of survivors. This deeper understanding has helped us to see more clearly the negative effects of interpersonal trauma (e.g., sexual assault, domestic violence) compared to non-interpersonal trauma (e.g., natural disasters, accidents)(Bennett, Crosby, Modrowski, Chaplo & Kerig, 2016; Van der Kolk, 2014). Interpersonal trauma results in higher levels of posttraumatic stress symptoms, especially those that are considered betrayal traumas. Betrayal trauma is defined as incidents of trauma that are committed by someone with whom the individual has had a trusting and close relationship (Bennett et al, 2016). Specifically, 62% of attacks on women occur within the context of an intimate relationship compared to 37% of the attacks on males (Van der Kolk, Roth, Pelvocitz, Sunday & Spinazzola, 2005). Therefore, the majority of interpersonal trauma is betrayal trauma: the most damaging type of abuse (Bennett et al., 2016).

According to Van der Kolk et al. (2005), abuse and neglect of children is extremely common. Also, based on the definition of betrayal trauma cited above, most abuse and neglect would fall within this definition and therefore be categorized as among the most harmful type. Given the vulnerability of children, these incidents of trauma and abuse are most likely repeated (Van der Kolk, et al., 2005). National reports estimate that nearly 300 million children are reported as abused and neglected annually (Van der Kolk, et al., 2005). Histories of physical and sexual abuse in childhood are associated with other physical and psychiatric problems later in life. These problems may include substance abuse, personality disorders, eating and dissociative disorders, cardiovascular

disease, metabolic and immunological disorders, as well as mood disorders (Brown et al., 2009; Van der Kolk, 2014). Yet, only recently has consideration been given in the clinical literature on how to properly diagnose and care for victims of trauma since many do not meet diagnostic criteria for Post-Traumatic Stress Disorder (PTSD) - a diagnostic criteria developed primarily in response to a single traumatic experience (Briere & Elliot, 1997; Simiola, Neilson, Thompson & Cook, 2015; Van der Kolk et al., 2005).

Recent literature is clear that those who experience interpersonal trauma(s) are more likely to experience difficulties with emotional regulation, dissociation (alteration in awareness of the present moment, self or environment), and emotional numbing in addition to a host of physical, social and cognitive struggles (Stappenbeck et al., 2016). Since the prevalence rates suggest that a significant portion of the general population may experience one traumatic event, researchers have focused on effects of cumulative traumatic events to see if that helped to explain symptoms that seemed to plague individuals for which a diagnosis of PTSD was not appropriate. Cumulative or complex trauma is described in the literature as the effect of multiple traumatic experiences on a single individual. Briere, Agee and Dietrich (2016) found that 4% of the general population met criteria for PTSD when only one traumatic event was identified. However, that number increased to 12% when the individual had six or more traumatic events. Numerous studies also suggest that PTSD consistently co-occurs with other disorders, and that 84% of persons with diagnosed PTSD had another life-time diagnosis (Van der Kolk et al., 2005).

Effects of Working with Traumatized Clients

As a field, much has been learned about the cost of trauma to individual victims and even to society as a whole. Much less has been learned about the cost to those who offer to respond to societal ills such as child abuse, sexual assault, and domestic violence. A review of the literature supports some distinctions in how researchers have characterized the negative effects of trauma on individuals who provide care to victims. These distinctions include symptoms associated with PTSD (i.e., intrusion, avoidance, and arousal), self-efficacy, social functioning and overall job satisfaction among others (Butler et al., 2011; Ludick & Figley, 2017; McMurray, Islam, Sarros, & Perola-Merlo, 2012). This is noteworthy since while the research is clear that working with trauma survivors may cause negative effects; the research is not consistent in its conclusion of which symptoms are most likely to occur.

According to Hesse (2002), a traumatic event usually involves the actual or threatened injury or death to one's self or others. This event or threat produces feelings of fear, helplessness or horror. No person is immune to experiencing traumatic events, and most agree that working with individuals who have suffered traumatic events may also face inevitable, long-lasting and far-reaching effects (Harris & Fallot, 2001; Hesse, 2002; Ludick & Figley, 2017). Fortunately, Knight (2013) noted that organizations, supervisors and institutions of higher learning can effectively intervene in helping reduce the negative effects of indirect trauma exposure.

Relevance

It may seem logical to conclude that the relevance of the study of trauma can be understood by understanding the effects alone. It is clear that persons who suffer from trauma may also suffer short- and long-term effects in overall psychological functioning. Yet, the literature indicates that this conclusion alone may be short-sighted. Trauma does not just involve the psyche it also involves the physical and neurobiological domains.

For example, Brown, Anda, Tiemeier, Felitti, Edwards, Croft and Giles (2009) found that adverse experiences in childhood (ACEs) are associated with an increased risk of premature death. Further, that same study found associations between the number of categories of ACEs and prevalent cases of disease that underlie many of the leading causes of death in the U.S., specifically correlating with at least five of those leading causes. This is relevant to the understanding of trauma because, if prevalence rates are high and many people who are victimized once are at a greater risk to be re-victimized, it is critical for providers to understand the broad-stroke implications for providing care to clinical populations that are likely to have experienced one or more traumatic events. It is paramount that we have a certain level of mastery as to the prevalence and relevance of this issue as we attempt to mitigate negative effects and reduce factors that may lead to premature death and impaired functioning of survivors. To minimize or simply fail to calculate the effects of traumatic experience in the lives of our clients is to miss critical opportunities to provide ethical and specialized care to those that seek our help (Harris & Fallot, 2001).

For example, the presence of a PTSD diagnosis may be indicative of other co-occurring disorders that may be the focus of clinical treatment. It seems paramount to

understand that those individuals who are traumatized may develop a range of maladaptive patterns and pathologies depending on their social support, developmental stage and relationship to the origin of trauma (Van der Kolk et al., 2005). Therefore, it is likely that caregivers in a variety of settings (e.g., healthcare, academics, and mental health) will encounter individuals who need assistance and also possess histories of single and multiple traumas. Counselors in most settings will likely work with clients who are survivors of trauma based on prevalence of the issue alone. Alarmingly, some experts have now concluded that virtually all clients receiving community mental health or substance abuse services have histories of trauma (Butler, Critelli, & Rinfrette, 2011; Trippany, White Kress & Wilcoxon, 2004). The body of literature that is devoted to explaining and understanding the effects of trauma on those who are directly exposed is not the focus of this review; however the findings are consistent in suggesting the vast number of ways in which trauma may disrupt the physical, neurobiological, psychological, emotional, social, spiritual, behavioral, and cognitive functioning of those who experience it (Van der Kolk, 2014).

Indirect Trauma Terminology

First, it is important for the reader to understand that there are several different terms that describe the negative effects of indirect trauma exposure on the helping professionals that respond. The literature primarily recognizes three main terms: burnout, secondary trauma and compassion fatigue (Hesse, 2002; Knight, 2013; Nelson, 2017). Knight (2013) notes that researcher's lack of precision in the use of terminology to describe the impact of working with trauma survivors in the empirical and conceptual literature only proves problematic to the evidence base we seek to establish. Therefore,

because each term has similarities and key differences, additional but brief explanation is needed if we are to accurately focus this study.

Burnout. According to Kulkarni and Bell (2013), burnout as it relates to provision of trauma-specific services is best described as an overload that develops over a period of time. It has three primary components: emotional exhaustion, depersonalization or cynicism, and reduced feelings of professional efficacy (Green, Albanese, Shapiro & Aarons, 2014). Burnout has been cited as a primary reason for reduced optimal work performance, decreased employee morale, and increased absenteeism. Similarly, burnout is associated with increased negative physical symptoms (i.e., gastroenteritis), increased substance abuse, anxiety, and depression (Green et al., 2014). Across the literature, burnout usually indicates an overall sense of exhaustion and low satisfaction (Green et al. 2014; Ifrach & Miller 2016; Kulkarni & Bell, 2013; Tyler, 2012).

Compassion Fatigue. In the early 1970s, compassion fatigue was used interchangeably with burnout and secondary trauma, and some may argue it still is (Ifrach & Miller, 2016; Kulkarni & Bell, 2013; Tyler, 2012). For the purpose of this review, compassion fatigue is described as having sudden onset and is specifically related to exposure to traumatic material and is more closely aligned with secondary trauma than burnout. Additionally, compassion fatigue may not be accompanied by such feelings of depression and exhaustion as identified in burnout; but instead, compassion fatigue is better characterized by symptoms of numbing and intrusive symptoms (Ifrach & Miller, 2016; Kulkarni & Bell, 2013).

Secondary Trauma. The term secondary trauma refers to a body of literature that proposes that helping professionals who work with trauma survivors are at risk to

develop a type of work-induced PTSD (Bell, 2003). The term refers to what is now considered a widespread experience of indirect exposure to various kinds of traumatic material and is postulated to be an inherent characteristic of occupations like mental health worker, health care worker, advocate, or social worker, especially those involved in providing clinical services to traumatized individuals or groups (Bell 2003; Cieslak et al., 2013; Hesse 2002; Knight 2013). Characterized by emotional numbing, dissociation, intrusive experience, withdrawal, fear, anger, anxiety, depression, and a host of negative physical symptoms (i.e., sleep disturbance, fainting, and changes in neurobiological processes), secondary trauma is now seen as a real occupational hazard to those who work with trauma-exposed populations (Ghahramanlou & Broadbeck, 2000; Hesse, 2002; SAHMSA, 2014; Ting, Jacobson, Sanders, Bride & Harrington, 2005; Tyler, 2012). Alarmingly, studies also suggest that transformations in worldview of mental health professionals exposed to trauma are likely permanent (Ting et al., 2005).

Other researchers have examined characteristics of secondary traumatic stress under several constructs: vicarious trauma, burn-out and compassion fatigue. All constructs seek to explain the negative reactions of helping professionals specific to their work with those who have suffered trauma (Bell, 2003). Over the years, there is some empirical support for distinction between burn-out and secondary trauma, and some have hypothesized that that secondary trauma may be a contributing factor to burnout. Most agree that symptoms of compassion fatigue (understood as more of exhaustion due to empathy) come on more suddenly and can be ameliorated more quickly than burnout, as burnout is characterized as an overall state of emotional exhaustion (Kulkarni & Bell, 2013; Ting et al., 2005).

Conversely, secondary trauma usually denotes an alteration in cognitive schemas (Bell, 2003). This alteration would be congruent with the alteration of worldview often seen in trauma survivors. Affected schemas usually include safety concerns, disruptions in the sense of self and others, and disruptions in relationships and intimacy (Bell, 2003). Simply stated, trauma exposure changes the way one sees and experiences the world (Fallot & Harris, 2001). Secondary trauma is seen more as a traumatic reaction to specific client-presented information that causes profound changes in the helping professional's sense of self; whereas burnout seems to better address the result of the general psychological distress of working with difficult client populations. As such, it is not simply working with difficult populations that may cause secondary trauma, but rather specific to the repeated exposure of the professional to client-specific traumatic experiences (Trippany et al., 2004).

Additionally, seven major schema have been identified as the most likely to be altered by exposure to traumatic experiences: 1) sense of self; 2) sense of trust; 3) sense of safety; 4) sense of power and control over one's circumstances; 5) independence; 6) sense of self-esteem; and 7) sense of intimacy (Hesse, 2002; Ifrach & Miller, 2015; Nelson, 2015; Trippany et al., 2004). These alterations can be detrimental to the helping professional and directly affect the quality of care being provided. For example, the professional may struggle with feelings of incompetence or lose optimism in overall humanity. He or she may feel isolated and create distance from others. He or she may feel emotionally numb or overwhelmed with a strong sense of grief at the plight of the victim. Secondary trauma may manifest itself in a variety of ways, but most of which may alter

the professional's sense of identity, spirituality and world view (Hess, 2002; Trippany, White Kress & Wilcoxon, 2004).

Dagan, Itzhaky, and Ben-Porat (2015), refer to secondary traumatization as an event that occurs when the traumatic experiences affect not only the survivors themselves, but also the people in their environment. When this occurs, the individuals helping the survivors also experience emotional distress related to the empathy they share with the survivors. Additionally, professionals helping survivors show various levels of secondary traumatic stress symptoms related to different variables (e.g., organizational and personal factors).

The effects of secondary trauma can range from mild to severe. Physical symptoms may include sleep disturbance, fatigue, or change in appetite; while psychological symptoms may include feelings of anger, irritability, powerlessness, and emotional dysregulation. Other symptoms include preoccupation with thoughts of clients outside of sessions, re-experiencing details of trauma narratives, increased startle response and hyper-vigilance (Knight, 2013).

Secondary trauma theories. Secondary trauma finds its roots in conservation of resources theory (COR) (Dagan et al., 2015). This theory was developed by Hobfoll in the late 1980's, and assumes that people strive to keep, preserve, and build resources (Hobfoll, 1989). According to this theory, anything that threatens those resources is defined as stress and can lead to psychological distress (Bell, 2003; Dagan et al., 2015; Goldfarb & Ben-Zur, 2016; Hobfoll, 1989). Stated another way, this model relates to two types of stressors: Current/Chronic and Personal Trauma History. The first type relates to those things that are found in the environment, personal or social demands of the

individual that may make him or her vulnerable to secondary traumatization. The second type refers to the care-giver's personal trauma history. The more demands on an individual's resources, the more susceptible he or she will be to suffer the negative effects specific to his or her work with trauma survivors (Dagan et al., 2015).

Another leading theory in the development of secondary trauma comes from a model known as the constructivist self-development theory (CSDT) (Hesse, 2002; Trippany et al., 2004). This theory states that humans construct their own personal realities. From those realities, we go on to develop complex cognitive structures known as schemas. Schemas, a term introduced by Piaget (Hesse, 2002), include beliefs, assumptions and expectations about the self and the world. Schemas allow us to make sense of both of those domains (Hesse, 2002; Trippany et al., 2004). According to this theory, the development of secondary trauma is explained by the repeated exposure to traumatic material and the subsequent alteration to the schemas that govern the professional's sense of self and the world. The level of alteration depends primarily on two factors: the work and personal characteristics intrinsic to the professional (Hesse, 2002). For example, work factors might include organizational factors, specific nature of the content shared by the victims, or cultural issues. Factors intrinsic to the professional may include personality, circumstances, or level of professional development (Hesse, 2002). Regardless of the theoretical underpinning, the empirical support for the reality of secondary trauma is worthy of additional attention and clarification.

Personal Risk And Protective Factors

Personal Risk Factors. The nature of the helping profession is one characterized by empathy and open engagement. These qualities may be at the very root of the development of secondary trauma. According to Trippany, White Kress and Wilcoxon (2004), the counseling relationship requires an empathic response to the pain of others. This position of openness makes the helping professional more vulnerable to alterations in his or her sense of safety, trust, intimacy, and intrusive imagery that are foundational to secondary trauma. Likewise, occupations that require an increased level of sensitivity and compassion like those of advocates and mental health workers also increase susceptibility to the development of secondary trauma (Nelson, 2017).

As such, the personal qualities that are often evaluated and elevated by supervisors, such as empathy, openness, and compassion may actually be occupational hazards for those working with trauma (Nelson, 2017). Other personal risk factors such as a personal trauma history (especially sexual trauma), increased personal stress, and temperament or personality traits may also increase one's risk. Individuals who possess increased reactivity, inflexibility, and perfectionism, and low frustration tolerance may be at increased risk (Nelson, 2017). Additional risk factors including inadequate social support, poor coping styles or avoidance are also believed to increase vulnerability to the development of secondary trauma symptoms (Knight, 2013; Merchant & Whiting, 2015; Nelson, 2017).

Personal Protective factors. According to Cieslak et al. (2013), the self-efficacy level of the professional may serve as a protective factor in negative symptom development. Specifically, years of experience likely increase self-efficacy and

subsequently provide the professional with a sense of control over his or her environment and reactions (Cieslak et al., 2013). Strong self-efficacy may also be a contributing factor in willingness to seek out emotional support and improve an individual's overall cognitions about both self and the world. These qualities would be consistent with having the opposite effect on schema alterations, feelings of powerlessness and isolation (Cieslak et al., 2013). Similarly, adequate training for professionals that boosts competency of practice; adequate peer and supervisory support, reasonable case-loads, good self-care (including diet and exercise), and general work-life balance are all important components in the consideration of prevention of secondary trauma (Hesse, 2002; Ifrach & Miller, 2016; Nelson, 2017; Trippany et al., 2004).

The research on individual risk and protective factors has adequate breadth but limited consistency (Cieslak, et al., 2013). One isolated finding that appears in the literature requires additional exploration. Specific cognitive constructs and the interplay between positive and negative cognitions of individuals indirectly exposed to trauma is understudied (Cieslak et al., 2013). Likewise, closer examinations of the organizational climate in which helping professionals operate is of equal importance since services are not offered independent of external factors.

Organizational Risk and Protective Factors

It is important to establish an operational definition of organizational climate when both studying and reviewing the literature on organizational factors that contribute to development and reduction of secondary traumatic stress. The study by Green et al. (2014) examined correlates of burnout and provider demographics, leadership and organizational characteristics. Green et al. (2014) defined organizational climate as

shared worker attitudes and perceptions of the work environment. In general, findings from that study showed a strong positive correlation regarding the impact of organizational climate and transformational leadership style. While the Green et al. (2014) study does not address secondary trauma symptoms specifically, the more generalizable nature of the conceptualization of burnout does allow extrapolations to the study of secondary trauma development and steps organizations can take to provide adequate support for workers.

Organizational Risk factors. In addition to repeated exposure to traumatic content, other risk factors for secondary trauma symptoms may be present within organizational environments. Specifically, symptoms of secondary trauma are the focus of this review, and are being examined in the organizational context. Risk factors for secondary trauma may include excessive caseloads; cumbersome documentation requirements; little or no supervision or peer support; lack of proper training; little recognition or appreciation from management; poor boundaries with clients and colleagues; and excessive number of clients who are demeaning, aggressive, or hostile (Bell, 2013; Knight 2013; Nelson, 2017).

Unfortunately, despite reducing risk factors within organizations, providers can still remain at substantial risk due to factors outside of the control of the organization. For example, rarely do helping professionals who work within greater systems have the benefit of only working with survivors alone. The nature of social justice work often requires advocates or mental health/social workers to operate within larger systems on behalf of clients. Those systems may include the criminal justice or civil justice systems, military networks, and even local community systems. When those systems that are in

place to offer support for victims cause additional real or perceived violations, the helping professionals suffer as well. These instances can lead to increased feelings of helplessness and disillusionment for the helper that can increase risk of secondary traumatization and contribute to alterations in worldview (Nelson, 2017).

Organizational Protective factors. The literature on organizational factors that may help to mitigate secondary trauma symptoms in staff who work for service organizations is limited; however, what is available does provide some insight into the role of the organizational environment in mitigating the effects of trauma exposure on service providers. According to Green et al. (2014), organizational characteristics should be considered when designing programs to reduce risk to providers and improve quality services to clients. Hesse (2002) examined secondary trauma and its effects on therapists concluding that steps can be taken by organizational leaders to prevent the occurrence of secondary trauma in employees. At the most basic level, Hesse (2002) noted that providing mental health professionals with safe, private and comfortable work areas and allowing them some control over the decoration of those spaces is an important protective factor. Other prevention and coping strategies include creating a warm and supportive environment that promotes support, value, and respect through activities that show appreciation for staff and clients. These activities could include honoring staff birthdays or allowing staff time to socialize at times throughout the week or month. These types of activities promote identity and self-esteem restoration and thereby combat secondary trauma development. In addition, organizations that accept the reality of secondary trauma and actively educate employees of this reality offer an element of protection for providers. Environments characterized by strong social support and interpersonal

relationships serve as a buffer to the negative effects associated with chronic exposure to traumatic material.

Ivicic and Motta (2016) noted this same trend. Notably, their research contributed to the extensively studied relationship between secondary traumatic stress and adequate supervision. Specifically, employees who had the empowering, engaging, and authentic supervision fared better when exposed to traumatic content than those who did not have supervision. Findings suggest that supervision is more critical for the less experienced provider.

Similarly, organizations that seek to understand trauma populations may also benefit from implementing models that foster organizational practices that reduce negative effects of trauma on both clients and staff. For example, a paper published by Madsen, Blitz, McCorkle and Panzer (2003) explained the process of implementing the Sanctuary Model in a domestic violence shelter in New York City. The paper discusses the role of teamwork, empowerment and trust-based relationships organization-wide. The work discusses methods of operation founded upon theories of trauma and attachment and a broad understanding of behavioral responses to danger and the need for safety (Madsen et al., 2003). While types of in-depth models, like the Sanctuary Model, are not as prevalent, there are some basic practices consistently observed across the literature. Basic practices include limiting the caseloads of providers, or studies examining personal characteristics of employees such as age, gender, tenure with organization (Dagan et al., 2015; Green et al., 2014; Hesse 2002).

All aspects of services need to be organized in a way that reflects the pervasiveness of trauma, its impact on survivors, and the complex journey to recovery

(Harris & Fallot, 2001). Within the past decade, research has been much more focused on developing common language and practices to aid organizations and providers in developing consistent, informed responses to the issue of trauma: trauma-informed care (Butler et al., 2011).

Organizational Trauma-informed Care

One potential approach that may be central to furthering the understanding of secondary trauma while helping to provide consistency in organizational responses is described in the literature with terms such as "trauma-informed" or "trauma-informed care" (Harris & Fallot, 2001). In the summer of 2012, national experts identified three key elements of a trauma-informed approach as those that: (1) realize the prevalence of trauma; (2) recognize how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) respond by implementing practices that reflect this knowledge (SAMHSA, 2012).

Bassuk, Unick, Paquette & Richard (2017) describe the trauma-informed care framework as one in which all services are offered through a trauma lens with healing occurring through respectful relationships. Environments that are described as trauma-informed emphasize physical, psychological, and emotional safety for both the helper and the survivor, and create chances for survivors to re-establish a sense of empowerment and control. Essential to the trauma-informed framework is the focus on ensuring that treatment environments and practices do not re-traumatize or re-trigger clients (Bassuk et al., 2017; Butler, Critelli, & Rinfrette, 2011; Harris & Fallot, 2001). While many studies examine organizational climate or characteristics, the study of trauma-informed care utilizes a much more comprehensive organizational approach. This approach describes a

level of organizational care that responds to trauma by fully integrating knowledge about trauma into operating procedures, practices, and culture while avoiding any institutional practices that may re-traumatize individuals who already have trauma histories (Fallot & Harris, 2001; Harris & Fallot, 2001).

Harris and Fallot (2001) identify five key Principals of trauma-informed environments as they relate to the clients who are accessing those services. Those components are described as safety, trustworthiness, choice, collaboration and empowerment. According to Butler, Critelli, and Rinfrette, (2011), practical application of these Principles is central to building trauma-informed organizations.

Safety denotes both physical and emotional safety. This can be as simple as allowing clients a sense of predictability of when services are offered or choosing their seat near the door during sessions. Trustworthiness only builds on a sense of safety and denotes strong rapport between the client and the provider by the fostering of informed consent and confidentiality. This quality is also modeled by pacing treatment appropriately to the client's window of tolerance. Similarly, the Principles of choice and collaboration denote partnership in the therapeutic process and overt respect for client's rights and responsibilities to both choose and collaborate on treatment priorities and goals. Lastly, empowerment is practiced when clients are given education about trauma and its possible effects on their current presenting problem. Empowerment is integrated into treatment through focus on a strengths-based approach where the provider is encouraged to build on the client's resiliency as a key ingredient to healing and recovery (Butler et al., 2011).

Benefits of organizational trauma informed care. These aspects of philosophy and organizational commitment to trauma-informed operations and practices have been well-studied with regards to the tandem work of the service provider and the service user. Little research has been conducted to examine how that very same organizational commitment and practice of trauma-informed care impacts employees with regards to the tandem work of the employee and the employer in organizations that provide trauma specific services. Cultivating a culture of knowledge about the reality of secondary trauma and an understanding that the organization is committed to reducing its occurrence may offer an additional layer of protection to employees (SAMSHA, 2014). Similarly, a study conducted by Slattery and Goodman (2009) found that, of the 148 domestic violence advocates who were surveyed, workers who felt empowered by the organization and were offered a level of autonomy were able to reduce the impact associated with secondary trauma on both their professional and personal lives.

Findings across the literature on trauma-informed care practices further support that the path to prevention of secondary trauma is to reduce risk and enhance protective factors (SAMSHA, 2014). This may include normalizing secondary trauma across all levels of the organization; diversifying case-loads where possible; increasing supportive professional relationships through activities such as team-builders, staff meetings, retreats and increased supervision; providing trauma-informed clinical supervision where applicable; providing adequate training; and actively engaging providers in the decision-making processes at all-levels of the organization. This helps to inform trauma-informed policy-making and contributes to an overall development of trauma-informed

organizational climate, and thus benefits both service providers and users (SAMSHA, 2012; SAMSHA 2014).

Kentucky's Domestic Violence Programs

Kentucky Coalition Against Domestic Violence. Kentucky's 15 state-funded regional domestic violence programs are governed through the Kentucky Coalition Against Domestic Violence (KCADV) whose mission seeks to mobilize and support member programs and allies to eradicate intimate partner violence (Member Service Standards, 2015).

Member programs contract with the Cabinet for Health and Family Services (CHFS) to provide services to victims of domestic violence and their children. These services include: a 24-hour, staffed crisis line; emergency shelter; residential and nonresidential advocacy; mental health services; comprehensive case management services; children's services; professional and public educational programming; community involvement; and prevention and awareness efforts (KCADV Member Service Standards, 2015).

In 1993, at the request of the Cabinet for Health and Family Services, the Kentucky Coalition Against Domestic Violence developed and promulgated standards for providing services to victims of domestic violence through Kentucky's state-funded regional domestic violence programs. Consequently, all 15 KCADV member programs adhere to these quality standards to ensure that Kentucky's victims receive quality services. In addition to establishing minimum service standards, the expectations also provide guidance on program administration, including program governance, staff and volunteer management, general administration, documentation, financial management,

contract requirements, and facility safety and security. The standards also cover program policy issues such as eligibility for services, ethical considerations, and client confidentiality. Recently, the standards have been revised to demonstrate KCADV's mission to creating more trauma-informed organizations (KCADV, 2015).

The mission of KCADV is fulfilled in part through its commitment to ensure all staff members are adequately trained prior to interfacing with victims of domestic violence. As such, staff members of all 15 member programs must complete a minimum of 20 hours of training specific to intimate partner violence prior to providing any direct services including answering agency telephones (KCADV, 2015). Additionally, all member program staff statewide must complete Level 1 certification through KCADV within the first year of employment. This certification process consists of completion of six training modules conducted on-site at KCADV's training institute in Frankfort, Kentucky covering specific content developed by the National Center on Substance Abuse, Trauma and Mental Health. These training modules cover content areas such as Kentucky history of the domestic violence movement, the neurobiology of trauma, mental health, trauma-informed advocacy, the intersection of domestic violence and substance abuse, diversity and more. Once staff members are Level 1 certified, staff members must complete 12 hours of continuing education per year to maintain active certification status if hired as full-time staff and six hours if hired as part-time staff.

Present Study

Over hundreds of years, the theories have taken many forms, but the observable negative consequences have remained steadfast (Van der Kolk, 2014). Unfortunately, traumatic experiences are no longer considered rare or abnormal (Kilpatrick et al., 2013). Instead, the prevalence of trauma is now considered within the range of normal human experience. As such, the likelihood of professionals being called on to respond to those who have been traumatized is increasing (Butler et al., 2011; SAMSHA, 2014). .

A large majority of the research literature has been devoted to the study of trauma on the primary victim. Yet, a growing body of research now demonstrates negative effects on those providing treatment and care to trauma survivors. Trauma effects the victim physically, psychologically, emotionally, and spiritually. Therefore, researchers have theorized and observed similar effects on those indirectly exposed to trauma and secondary trauma is now the focus of scientific research. And while much is being learned about the symptoms of secondary trauma, more needs to be learned about both risk and protective factors. Further, the majority of the work that has been done on secondary trauma has only included mental health professionals. There is a significant gap in the studies examining the effects on service providers that may not be considered mental health professionals (i.e., advocates, front-line workers).

Leaders in the trauma field now understand that both personal and organizational characteristics should be considered when examining secondary trauma, and contributing factors. Recent research now defines this area of study as trauma-informed care. This construct emphasizes a more comprehensive response to trauma not only clinically between client and clinician, but collectively between and among clients, staff, and

leadership organization-wide. This type of organizational environment may help reduce employee turn-over and absenteeism, improve service delivery, and reduce the health-risk to employees engaged in trauma work (SAMSHA, 2012). By understanding how to better care for the providers, we will only be better equipped to provide more excellent care to clients who suffer from traumatic events. It is also likely that those providing care may have trauma histories their own.

What is the personal cost to those who stand ready to respond to interpersonal violence and how can the organizations for which they work function in a way that mitigates the negative effects of repeated exposure to the traumatic experience of others? To help answer this broad question, this study examined the role of organizational trauma-informed care practices in mitigating secondary trauma symptoms in staff members of Kentucky domestic violence shelter programs. This study helped to bridge the gap that exists in the effects of trauma exposure on individuals that may not be mental health professionals, but who are exposed daily to traumatic material or crisis environments. This study focused on the less studied issue of the effects of trauma on individuals who provide care to the victims and on the organizations that employee them-specifically, the staff members of Kentucky's regional domestic violence programs.

The following research questions will be explored in this project:

1. What factors predict level of secondary trauma symptoms in organization employees?
2. What organizational trauma informed care factors predict reduction of secondary trauma symptoms in organization employees?

For the purpose of this study, the following hypotheses (stated in the null form) will be tested:

Research question one hypothesis:

There is no impact on secondary trauma symptoms based on employee demographics or personal life events.

Research question two hypothesis:

There is no impact of level of organizational trauma informed care on employee secondary traumatic stress level.

Chapter III: Method

In an attempt to answer the questions of whether a relationship exists between the level of secondary trauma symptoms of employees and their demographics, and whether a relationship exists between the level of trauma informed care and secondary trauma symptoms, the following methods and procedures were implemented.

Sampling Design

Participants in the current study included staff from Kentucky's 15 regional domestic violence programs that are members KCADV. KCADV member programs provide shelter and outreach services to domestic violence survivors and their children in each Area Development District across the Commonwealth. These organizations offer many services including, but not limited to: 24-hour crisis line access; 24-hour emergency shelters; legal advocacy; relocation services; support groups; financial assistance; economic justice services; transportation services, micro-loan programs; housing stabilization services; youth services; mental health services; and comprehensive case management. Due to the specific focus on Kentucky's network of domestic violence providers, an availability sampling strategy was utilized.

. All staff members employed by KCADV Member Programs (N = 275) were contacted by and invited to participate in the research via the individual agency Executive or Program Directors. Participant email addresses were provided to the Principal Investigator by a program representative and were checked for accuracy prior to emailing the survey. Participants were given the option to request a paper survey, but no paper surveys were requested. All participants participated using a Qualtrics (June, 2020) web-based survey. Participants were asked to answer a series of questions about their life

events, symptoms of traumatic stress and level of organizational trauma-informed care. Each participant was notified that participation indicated implied consent (See Appendix B); but participants were asked to begin the study by checking the appropriate box to indicate understanding of consent during the on-line survey (See Appendix A). For any participant who did not provide consent, the survey automatically discontinued. All participation was completely voluntary, and the survey could be discontinued at any time.

Measures

The research literature suggests that secondary trauma may be impacted by both personal and organizational factors (Dagan et al., 2015; Green et al., 2014; Hesse, 2002). These factors include those that are considered chronic and current (environmental factors such as social demands or occupational demands), those that are personal to the caregiver such as personal trauma history, and those that may help to explain level of self-efficacy, such as tenure with the organization, or that may pre-dispose one to secondary trauma development, such as gender, (Bell, 2003; Dagan et al., 2015; Goldfarb & Hasida Ben-Zur, 2016; Hobfoll, 1989). In an effort to examine the role demographics may play, a combination of environmental, personal, and demographic information was gathered by using basic survey questions created by the Principle Investigator.

Non-organizational related demographic variables collected included: age and gender (Appendix A). Organizational-related person variables collected included: employment status (full-time or part-time status), placement within the organization, role within the organization, and length of time with the organization. Age was measured as a categorical variable as prior research studies utilized this method. Prior to analysis, dummy variables (k -1) were created as follows: 18-20; 21-29; 30-39; 40-49. Individuals

in the 50+ served as the reference category. Gender was not included in the analysis due to lack of variability as only two males responded to the survey. Employment status was measured using a categorical variable, where 1 = *part-time*, 2 = *full-time*, 3 = *PRN*, and 4 = *other*. For analysis purposes, any response of part time as needed (PRN) or "other" that was under 32 hours per week was considered "part time". Placement within the organization was excluded from analysis because it seemed redundant when the variable of organizational role was considered. Role within the organization was measured as a categorical variable, where 1 = hotline *worker* 2 = emergency *shelter worker*, 3 = *adult residential advocate*, 4 = *adult non-residential advocate*, 5 = *housing/economic justice advocate*, 6 = licensed mental health worker, 7 = child/youth advocate, 8 = food services worker, 9 = *community educator*; 10 = *volunteer coordinator/manger*, 11 = *administrative worker*, 12 = *Executive Director*, 13 = *other*. Prior to analysis, the variable of role within the organization was re-coded into dummy variables (*k*-1) as follows: direct service and admin. Individuals in non-direct service served as the reference category. The length of time with the organization was assessed using a continuous variable rounded to the nearest month.

In addition to demographics, it was also necessary to obtain information that the literature supports as relevant to the understanding of secondary traumatic stress and organizations. For example, the literature suggests that employees who work for organizations in which they feel empowered, and in which they have some level of autonomy may benefit from an additional layer of protection (SAMSHA, 2014; Slattery & Goodman, 2009). Therefore, the Ticometer© was used in the present study as many of the foundational principles of Trauma Informed Care (TIC) are based on a degree of both

staff and client autonomy. Similarly, personal factors, such as personal trauma history, may increase an employee's risk for the development of secondary traumatic stress (Nelson, 2015). As such, the Life Events Checklist-5 (LEC-5)(Weathers et al., 2013) was utilized to collect personal trauma history information.

Ticometer©. The level of organizational trauma-informed care was measured using the Ticometer© (Bassuk, Ellen L., Unick, George J., Paquette, Kristen, Richard, Molly K., 2017). Participants were given the Ticometer© (Bassuk et al., 2017) to measure the level of trauma-informed care of the organization. The Ticometer© provides domain-level scores based on respondents' ratings of individual items. The five domain-level scores can be combined into an overall score. While the psychometrics are strongest at the domain level, organizations may find the overall score useful for tracking progress over time. The overall score was most appropriate in answering the proposed research questions; although domain-level scores would be best to use if determining specific areas for improvement (Bassuk et al., 2017).

According to Bassuk et al. (2017), each item is rated on a four-point scale, indicating the extent to which respondents agree that their organization complies with the specific items (1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Agree*; 4 = *Strongly Agree*), with higher scores indicating better adherence and practice of trauma informed care principals. This 35-item questionnaire representing organizational trauma-informed care across five domains has strong reliability and validity properties. Domains are as follows: Build trauma-informed knowledge and skills (alpha = .82); Establish trusting relationships (alpha = .73); Respect service users (alpha = .86); Foster trauma-informed service delivery (alpha = .86); Promote trauma-informed procedures and policies (alpha = .78);

and Full Scale for all domains (alpha = .92). The Ticometer© may be completed by all staff at all levels of an organization, including administrators/leadership, clinicians, and direct care staff, and asks questions about the organization's written policies or specialized training for staff (Bassuk et al., 2017). Since the hypotheses being tested examined the level of participant's perception of organizational trauma-informed care and its relationship to secondary traumatic stress, the domain scores were the most appropriate scores to use. These scores help inform what aspects of the organization's trauma-informed practices may be most beneficial to the employee and which may need improvement from the employee's perspective. Overall scores are best utilized when an organization wants to track improvement over time (Bassuk et al., 2017). Therefore, while this index is helpful in extrapolating the individual employee's assessment of the organizations adherence to best practices related to trauma informed care, this study does not allow for measurement over time. According to Bassuk et al. (2017), the item-level scores can be averaged (sum 35 item scores and divide by 35).

Life Events Checklist (LEC-5). Personal trauma history was measured by the Life Events Checklist for the *DSM-5* (LEC-5)(Weathers et al., 2013). The LEC-5 screens for exposure to 16 events known to possibly result in disorders of traumatic stress (e.g., PTSD) or distress and includes one additional item assessing any other extraordinarily stressful event not listed in the first 16 items (Weathers et al., 2013). Weathers et al. (2013) noted that the LEC was originally developed contemporaneously with the CAPS to determine if criterion A was met for a diagnosis of PTSD. The original LEC demonstrated adequate psychometric properties as a stand-alone measure of traumatic exposure, especially when measuring consistency of events that actually happened to a

respondent (mean k= .61; r = .82, p < .001) (Gray, Matt J., Litz, Brett T., Hsu, Julie L., & Lombardo, Thomas W., 2004).

The current study examines whether exposure to potentially traumatic events might increase one's risk to develop secondary traumatic stress, but does not examine whether the exposure event results in symptoms that meet diagnostic criteria for PTSD. Since the LEC is considered unique measure of multiple types of trauma with varying levels of severity (Gray, et al., 2004; Weathers et al., 2013), it is useful in the current study to assess whether participants have been exposed to a single potentially traumatic event or multiple traumatic events, and the level of exposure (e.g. happened to me, witnessed it, etc.). The current study is not concerned with whether the exposure meets diagnostic criteria for PTSD, but rather if the exposures themselves may help to predict whether an individual goes on to develop symptoms of secondary traumatic stress when placed in the context of an organization that exists to respond to those who have experienced trauma. In order to obtain a severity score, the Principle Investigator ranked the participant's endorsement of items as follows: *Happened to Me* = 5; *Witnessed It* = 4; *Learned It* = 3; *Part of My Job* = 2; *Not Sure* = 1; *Doesn't Apply* = 0. The items are listed in this order on the LEC-5 measure and provide an implied severity rank. Therefore, the Principle Investigator assigned the number only (0-5), not the order of the event itself. As such, the higher the participant's score, the higher the level of trauma severity (See Appendix A).

Secondary Traumatic Stress Scale©. The dependent variable was the level of secondary trauma symptoms present in staff members, was assessed using the Secondary Traumatic Stress Scale© (STSS)(Bride, 1999). The STSS© is a 17-item instrument

designed to measure frequency of intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events via one's professional relationships with clients who have experienced trauma (Bride, Robinson, Yegidis & Figley, 2004). Respondents endorse how frequently an item was true for them in the past seven days, with possible responses ranging from 1 (*never*) to 5 (*very often*). Scoring is obtained by summing the endorsed frequency for each subscale as well as the total STSS©. No reverse scoring is used (Ting et al., 2005). Strong psychometric properties indicate that the measure is both reliable and valid. Alpha levels for the STSS© and subscales are as follows: Full Secondary Traumatic Stress Scale© (FSTSS) ($\alpha = .93$), Intrusion ($\alpha = .80$), Avoidance ($\alpha = .87$), and Arousal ($\alpha = .83$). Cut off scores of at or above 38 on the FSTSS© should be used to indicate presence of symptoms associated with PTSD (Bride, 2007). Cut off scores were not used in this study since this study did not explore symptoms associated with PTSD.

Procedure

The study submitted to Western Kentucky University's Institutional Review Board for approval. Once approval was obtained (reference # 20-024) (See Appendix C), the data collection process was begun utilizing an electronic survey that was created using the Qualtrics Survey Software (June, 2020). Study inclusion required consent of the participant. Specifically, the survey notified participants that, by continuing the survey, the participant was giving consent to participate in the study. The survey was completed online as a part of the research packet that included a demographics survey, and three standardized measures (i.e., STSS; TICOMETER©; LEC-5). A minimum of two reminder emails that were created in and generated by Qualtrics Survey Software (June,

2020), were sent out to member programs of KCADV prior to the completion of the study. Reminder emails simply invited participants to take part in the research study.

An email was sent to Executive/Program directors of the 15 KCADV member programs and individual staff emails were compiled by program directors and submitted back to the Project Director. Those email addresses were entered into the Qualtrics (June, 2020) database and emails were disseminated directly to program staff. All staff who participated did so voluntarily and with no compensation. All responses were anonymous. Program Directors were asked to make the survey available to all staff members.

Once the data collection period closed, data was entered into SPSS for analysis. Surveys were considered invalid and discarded if the participant began the survey but did not answer any questions or if the participant failed to complete the standardized measures. The cleaning processes resulted in 46 surveys being discarded.

Statistical Analysis

Descriptive statistics, such as frequency and measures of central tendency (e.g., mean, standard deviation) were conducted in order to determine the demographic makeup of the sample (Tables 1-2).

Multiple regression analyses were conducted to determine the effect demographic variables and other predictors (life events) have on the dependent variable (DV) of STS (Tables 3-4). The software used to conduct the proposed analyses was IBM's Statistical Package for the Social Science (SPSS) Statistics 26.

Chapter IV: Results

Descriptive Statistics

The current sample of 89 participants was drawn from a total of 135 participants who completed any part of the on-line survey out of 275 staff members. Participants were excluded if they did not complete all of the measures on the survey (e.g., only completed demographics) (*n* = 46). Of the final sample of 89 participants included for analysis, 2.2% were male (*n* = 2), 96.6% were female (*n* = 86), and 1.1% of respondents identified as "other" (*n* = 1). Participant age ranged from age 21 to 60+ years (Table 1) The majority of participants were employed full-time (a minimum of 32 hours per week) (*n* = 78, 87.6%), while a much smaller sample of participants were employed part-time (less than 32 hours per week) (*n* = 7, 7.9%) (Table 2). The majority of participants were in roles that required that they provide some type of direct client service (Table 2). To assess longevity within individual agencies, participants were asked to provide information on how many months he or she has served the organization (Table 3). Any participant who did not make this entry clear (e.g. putting a single number with no specifier of months or years) was not included (*n* = 67). Time of service ranged from as little as two months to as long as 300 months (25 years) with an average length of service of 6 years (*M* = 72.27; *SD* = 78.63) (Table 3). Tenure with the organization as not normally distributed with right skewness of 1.145 (*SE* = .293) and kurtosis of .207 (*SE* = .578). Participant's score on the Secondary Traumatic Stress Scale© (STSS) placed symptom levels currently being experienced by participating employees in the "mild" range (*M* = 36.85; *SD* = 12.39) and were non-normally distributed with skewness of .496 (*SE* = .255) and negative kurtosis of -.543 (*SE* = .506) (Jacobs, Charmillot, Martin &

Horsch, 2019). To assess participant's level of exposure to traumatic life events, the Life Events Check List – 5 (LEC-5) was used and scores were ranked to provide a total trauma severity score *(M* = 61.29; *SD* = 34.27) (Table 3). Severity scores were non-normally distributed with skewness of .545 (*SE* = .258) and negative kurtosis of -.219 (*SE* = .511). To assess participant's perceived level of trauma informed care, the full-scale score of the Ticometer© was used (*M* = 96.41; *SD* = 12.04) (Table 3). Ticometer© scores were non-normally distributed with skewness of .487 (*SE* = .255) and kurtosis of -.202 (*SE* = .506).

Table 1

Sample Demographics (Personal)

Variable	Frequency	Percent
Gender		
Male	2	2.2
Female	86	93.5
Other	1	1.1
Age		
18-20	0	00.0
21-29	20	21.7
30-39	22	23.9
40-49	28	30.4
50-59	15	16.3
60+	4	4.3

Table 2

Sample Demographics (Organizational)

Variable	Frequency	Percent
Employment Status		
Full Time	78	84.8
Part Time	7	7.6
PRN/Other	3	3.3
Organizational Role		
NR Advocate[a]	20	21.7
Administrative	19	20.7
Other	11	20.0
Emergency Shelter	9	9.8
Housing/EJ[b]	8	
Executive Director	6	6.5
Hotline Worker	4	4.3
Residential Advocate	4	4.3
Youth/Child Advocate	3	3.3
Clinician	2	2.2
Community Educator	1	1.1
Food Services	1	1.1

[a]NR = Non-Residential. [b]EJ = Economic Justice.

Table 3

Descriptive Demographics for Tenure and Instruments

Variable	Mean	Standard Deviation	Range
Tenure	72.27	78.63	0-300
STSS© Score	36.85	12.39	19-71
LEC-5 Severity	61.29	34.27	0-150
TICFSS	96.41	12.04	73-124

Note. Tenure is shown in months. Variable STSS Score = Secondary Traumatic Stress Scale©; LEC-5 Severity = Life Events Checklist – 5; TICFSS = Ticometer© Full Scale Score.

A multiple linear regression analysis was conducted to determine the effect the predictor variables of demographics, organizational trauma-informed care, and life events (personal trauma history severity) had on the outcome variable of secondary traumatic stress. Results of the analysis indicated that there was a collective, significant effect between total trauma severity, as measured by the LEC-5, and the employee's perceived level of organizational trauma informed practices, as measured by the Ticometer©, and the dependent variable of level of secondary traumatic stress, as measured by the STSS©. Explained differently, results suggest that 28.8% of the variance in secondary traumatic stress scores of employees can be explained by the employee's personal trauma history severity and the perceived level of organizational trauma informed care ($R^2 = .288$, F (9, 53) = 2.377, ($p < .024$) (Table 4).

More practically stated, for every increase in the severity of personal traumatic events reported by an employee, the level of secondary traumatic stress also increased by

0.11 points on the STSS©. Fortunately, results also suggest that as the organization's level of trauma informed care increases by one unit, employee's level of symptoms of secondary traumatic stress decreases by 0.28 points (Table 4).

Table 4

Summary of Multiple Regression Analysis of Predictor Variables on STS Levels

Variable	*b*	SE *B*	B
Constant	50.516	14.940	
Full-time Status	-1.218	5.713	-.027
Age			
21-29	9.801	5.383	.347
30-39	4.123	4.887	.146
40-49	1.075	4.545	.037
Direct Service	3.647	4.406	.145
Administrative	.705	4.955	.024
Tenure	.045	.024	.276
Severity	.108	.046	.293*
TIC Score	.-285	.130	.-276*
R^2		.288	
F		2.37*	

Note. Dependent Variable: STS Total Score. Total Demographics = Status: full-time (32+ hours) (with part-time/PRN = reference category); Age: ranged from 21-49 (with 50+ = reference category); Role: direct service or administrative (Non-direct service = reference category); Tenure: length of time in months; Severity = Total Trauma Severity Score on the LEC-5; TIC Score: Full Scale Ticometer© Score.
*$p < .05$.

In order to more specifically determine which area(s) of the Ticometer© may inform where organizations should focus their attention to yield the most immediate impact on the organization's level of TIC, a second regression analysis was conducted. It found that 12.6% of the variance in secondary traumatic stress scores of employees can be explained by the organization's level of fostering trauma-informed service delivery as measured by domain four of the Ticometer© (R^2 = .126, F(5, 83) = 3.526, p < .006) (Table 5). No other domains were significant predictors of STS. Said more practically, results indicate that for every one unit of increase in organizational TIC service delivery, the level of STS the employee feels decreases by 1.07 points (Table 5). Participant scores on domain four were normally distributed (M = 30.01; SD = 4.08) with skewness of .306 (SE = .255) and kurtosis of .119 (SE = .506).

Table 5

Summary of Multiple Regression Analysis on Impact of Ticometer© Domains on STS

Variable	*b*	SE B	B
Constant	66.507	11.14	
Knowledge and Skills	-.615	.972	.091
Trusting Relationships	.860	.619	.214
Respect Service Users	-.299	.524	-.075
Service Delivery	-1.069	.418	-.352*
Policies & Procedures	-.493	.588	-.116
R^2		.126	
F		3.52**	

Note. Dependent Variable: STS Total Score. Each of the variables represents Ticometer© domains from 1-5. *$p < .05$. **$p < .01$.

Chapter V: Discussion

As the awareness of the prevalence of trauma increases, and as our understanding of the effects of trauma grows, our understanding of the effects of indirect exposure to traumatic material should also expand. The current study was conducted in an effort to further contribute to the ever-growing body of research regarding the construct of secondary traumatic stress and to further inform our understanding of the role organizational trauma-informed care may play in ameliorating this damaging occurrence.

Early research suggested that the most important aspect of preventing secondary trauma was to acknowledge that it is a normal part of doing trauma work (Hesse, 2002). Yet, as time passes, it seems to only be the starting point. Hesse's (2002) review of the literature suggests that the best way to reduce secondary trauma is to limit trauma exposure. However, with research evidence mounting regarding the normality of traumatic experiences, the sheer demand for services makes this approach seem less plausible than originally suggested (Stappenbeck et al., 2016). To this end, the current study examined not only the role of personal and professional factors in secondary traumatic stress (STS), but also whether the concept of organizational trauma informed care contributes to its reduction. To review, the hypotheses of this study were as follows:

Research question one hypothesis:

> There is no impact on secondary trauma symptoms based on employee demographics or personal life events.

Research question two hypothesis:

> There is no impact of level of organizational trauma informed care on employee secondary traumatic stress level.

The hypothesis stating that there would be no effect on STS by demographic variables (excluding personal trauma history) was confirmed. However, results from the study indicated that severity of personal trauma history (counted here as a demographic variable) impacted an employee's level of STS to a statistically significant degree. In that way, the current study rejected the null hypothesis. Results of the current study reaffirmed other findings in the literature related to the presence of STS in human services fields. Participants in the present study were employees from across Kentucky's 15 regional domestic crisis programs and included both direct and non-direct service providers. While cut-off scores on the STSS© were not used for inclusion into the study, scores were categorized by severity for the purpose of discussion. Participants, on average, scored in the "mild" range for STS symptoms regardless of their role at the organization (Jacobs, et al., 2019) indicating that Kentucky program workers are experiencing low levels of STS symptoms. This is consistent with results from multiple research studies indicating that working in a field where exposure to traumatic content is prevalent, STS is also likely (Knight, 2013; Merchant & Whiting, 2015; Nelson, 2015; Trippany et al., 2004).

However, it should be noted that much of the research literature examines traditional direct service providers such as mental health professionals. In this study, employees vary across multiple positions (administrative, direct and non-direct services). Since the base line for Kentucky domestic violence workers shows some level of STS, the current study is relevant to the broader discussion on ways to both understand the factors contributing to STS while also understanding key factors to both preventing an increase or, better yet, reducing the symptoms all together.

Demographics and Personal Factors

Results from the current study suggest that age and length of time with the organization had no statistically significant impact on employee level of STS. However, the results from the regression analysis involving these two demographic variables did merited closer examination. Specifically, only the variable of age for one group of participants (participants aged 21-29) (p = .074) and the variable of tenure with the organization (p = .071) showed a trend towards significance. Further research is needed to determine whether an increase in sample size might have made the impact of age and organization tenure on STS statistically significant. In prior research, these variables showed a significant relationship to STS levels, in part, because the younger the employee, the more novice he or she is likely to be thus making him or her more likely to quit work due to STS symptoms (Bercier, 2013; Dagan et al., 2015; Ivicic & Motta, 2016). As such, the noted trend is consistent with previous research findings. Conversely, the findings on gender are unclear in this study. As stated earlier, due to the lack of variability in the current study with regards to gender, this variable was not used in the multiple regression analysis. Still, the issue of gender merits mentioning. According to Ivicic and Motta (2019), women tended to experience higher rates of Post-Traumatic Stress Disorder (PTSD) and higher levels of STS than men, despite similar trauma experiences as reported on the Life Events Checklist (LEC-5). Prior research supports the effect of gender on STS, and the primarily all female study here may explain, at least in part, the overall "mild" level (Jacobs et al., 2019) of STS in the current sample.

In the current study, trauma severity was a significant predictor of the development of STS in Kentucky workers. According to Briere, Agee and Dietrich

(2016), the likelihood of developing PTSD symptoms following a traumatic event depends on many variables of which personal trauma history is only one. This is consistent with findings by Ghahramanlou and Broadbeck (2000), who found that mental health professionals who were primary victims of sexual assault had increased psychological distress when they, in turn, worked with survivors of sexual assault as a part of treatment. So, what about those providers who have experienced multiple forms of trauma both personally and through other means?

Research suggests that exposure to multiple traumas or cumulative trauma increases one's risk of PTSD development (Briere et al., 2016). Since STS is conceptualized on the same spectrum as PTSD, research into personal factors that contribute to PTSD development is relevant here and even more so, the concept of cumulative trauma exposure. Through this lens, the results of the current study help to further shed light on the development of STS even when the exposure to trauma does not match the actual experience of the provider (e.g., hearing about domestic violence, but never personally experiencing it) or when the provider has experienced varying degrees of severity around trauma exposure (e.g., happened to me versus learned about it).

In short, the current study affirms the notion that having a personal trauma history may not make one at higher risk for developing STS, but the more severe the exposure to multiple traumatic experiences, the more likely one is to develop symptoms of secondary traumatic stress. Without question, however, the results of this study are consistent with past findings implicating personal trauma history as a significant predictor of STS development (Bercier, 2013; Briere et al., 2016; Dagan, et al., 2015, Ghahramanlou & Broadbeck, 2000).

Organizational Trauma Informed Care

At the center of the current study was the question whether the level of organizational trauma informed care (TIC) impacted the level of STS in employees of Kentucky's 15 domestic crisis programs. The results of the current study rejected the null hypothesis. Specifically, the results suggested that, as the level of TIC went up, the symptoms associated with employee STS went down. The factor that contributed most to the decrease in STS was domain four on the Ticometer©, which is a measure of how the organization fosters TIC service delivery (Bassuk et al., 2017). Since domain four assesses broad themes of client and staff control, predictability, and sense of "voice" into agency operations, it may be that this domain is contributing to the sense of safety, trustworthiness and collaboration- three key principles of a trauma-informed framework. Domain four assesses the participant's knowledge about how the organization addressed things like client's confidential information (e.g., "service users are informed about how information is shared between agencies"), feedback from clients (e.g., "process for raising organizational concerns"), flexibility regarding program expectations (e.g., "program is flexible about changing rules based on individual circumstances"), consistency and predictability of services (e.g., "Provider meetings are predictable and consistent"). Since the Ticometer© is the first psychometrically tested measure that assess the degree of organizational TIC, these findings contribute significantly to the information we have about this more nuanced concept.

While the research literature continues growing around TIC as a framework, the idea that an organization can possess a score delineating how sufficient or insufficient its TIC practices may be, may significantly alter how organizations can improve in this area.

Practically speaking, this may include normalizing secondary trauma across all levels of the organization by regularly assessing TIC levels via the Ticometer©; diversifying case-loads where possible; increasing supportive professional relationships through activities such as team-builders, staff meetings, retreats; increased supervision; providing trauma-informed clinical supervision where applicable; providing adequate training; and actively engaging providers in the decision-making processes at all-levels of the organization. (SAMSHA, 2012; SAMSHA 2014).

Study Limitations

While the current study found some statistically significant results that will contribute to the growing body of research literature, it was not without limitations. For example, readers should be careful in generalizing findings outside of the state of Kentucky, since the sample only reflects employees from Kentucky's 15 regional domestic crisis programs. Further, the sample was largely female, rendering the results narrow. Also, age was captured as a categorical variable, limiting the analysis. Future research should capture this as a continuous variable. Likewise, the sample-size, while sufficient, was still small in comparison to the hundreds of service providers employed by Member Programs.

Another limitation is the use of the trauma severity score developed by the Principle Investigator. While the LEC-5 has strong psychometric properties, the measure use deviated from its original intention for scoring purposes. Consequently, findings should be interpreted cautiously. Another limitation is the limited use of the Ticometer©. While the instrument is psychometrically tested, the development of the measure is relatively new. Finally, there were several demographic variables not measured in the

current study but that are supported in the literature as leading to minimizing STS. Variables such as level of training, size of provider caseloads, and number of caseloads with high trauma severity were not explored here. While it is expected that these findings would remain consistent with prior studies, it is unclear what role those variables may have on STS levels and organizational TIC. Given the mixed and narrow nature of the current literature on STS and organization TIC, this should be considered when interpreting the current findings.

Practical Application of Research

For more than 27 years, the KCADV has served as the governing and technical support body for Kentucky's 15 Member Programs. This role provides the Coalition with both resources and influence to advance real change in the level of organizational TIC of each Member Program. The results of the current study lay the foundation for more discussion around both STS and TIC. By bringing these topics to the forefront of state-wide strategy, as well as policy and resource development, KCADV is well-positioned to lead the state's domestic crisis providers in further exploration of these very important issues. In a more limited way, the results of this study remind both administrative and clinical leadership of the importance of raising awareness of the existence and potential threat of STS to its workforce and, indirectly, to the quality of services provided to survivors of domestic violence. Further, findings suggest that, by identifying STS in employees and elevating protective factors, such as fostering trauma informed service delivery, organizations are able to successfully contribute to reduction in this very real occupational hazard. By so doing, each organization is better positioned to truly facilitate

change in the lives of those it serves while protecting its most valuable of all resources - human resources.

Findings from the current study can be utilized to inform current practice, practical application and future research. First, by operationally defining STS and measuring it, organizations are encouraged to consider STS as a real, occupational hazard (Ghahramanlou & Broadbeck, 2000; Hesse, 2002; SAMHSA, 2014) and begin to identify symptoms in personnel, as well as educate staff members on the subject of STS. Further, organizations, such as KCADV member programs, should consider requesting funding from federal, state and local grants, private foundations, and individual donors to begin to prioritize the assessment of organizational trauma informed care and the implementation of practices to reduce the effects of STS. Simple and immediate application can begin through already existing practices, protocols and procedures. For example, findings from this study can be used to inform new employee onboarding orientations, professional development opportunities, and reflective supervision training requirements for supervisors (SAMSHA, 2014). These methods provide a good starting point for building cultures of trauma-informed care within organizations. For organizations that require continuing education units, requiring topics on STS and organizational trauma informed care might help to additionally incorporate this knowledge into the fabric of the organization, and generate employee input into how to practically apply the knowledge to daily work practices (SAMSHA, 2014).

To that end, organizations created to facilitate healing, health, and wholeness of others will inspire those same qualities within itself. Organizations charged with caring for traumatized populations will better protect those employees in its charge. Finally, this

study challenges every human services program, like Kentucky's domestic crisis centers, to prioritize expertise, time, and resources to the understanding of and reduction in STS.

The current study calls on organizational leaders, who are entrusted with overseeing operations of agency staff providing care to traumatized individuals to intentionally assess and score the level of organizational trauma informed care present in the agency and to actively pursue reduction in STS across all levels of the organization.

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Appendix A

Demographics Questionnaire

The Relationship between
Organizational Trauma-Informed Care and Secondary Trauma Symptoms in Staff of Kentucky Domestic Violence Programs

Survey Instruction

Organizational Trauma Informed Care and Secondary Traumatic Stress - This project seeks to gather information on organizational trauma informed care, and secondary traumatic stress information from Kentucky's 15 regional domestic violence programs in partnership with the Kentucky Coalition Against Domestic Violence (KCADV).

This survey should take between 15-30 minutes to complete and is completely voluntary. Questions about the project should be directed to Mary E. Foley, M.S., at maryf@merrymanhouse.org;

Project Title: The Relationship between Organizational Trauma-Informed Care and Secondary Trauma Symptoms in Staff Members of Kentucky Domestic Violence

Programs Investigator: Mary E. Foley, Applied Clinical Psychology, 270-448-8056;

maryf@merrymanhouse.org

You are being asked to participate in a project conducted through Western Kentucky University and Kentucky Coalition Against Domestic Violence.

The University requires that you give your signed agreement to participate in this project.

Taking part in this project is voluntary. By completing the on-line questionnaire, you agree to take part in this research study and acknowledge that you are at least 18 years old. You do not have to answer any questions that make you uncomfortable. If you decide to participate in this study, you may stop taking part at any time. If you decide not to participate in this study, or if you stop participating at any time, there will not be any repercussions. The remainder of this informed consent, including the purpose of the project, the procedures, and the potential benefits and possible risks of participation are included below.

You may direct any questions you have to Mary E. Foley at maryf@merrymanhouse.org or via phone at 270-448-8056.

1. **Nature and Purpose of the Project:** This project aims to identify and describe qualities of trauma-informed organizations and the effect those qualities may have on secondary trauma symptoms in direct service providers of domestic violence programs. It will employ a quantitative research design in which self-report questionnaires will be completed by employees of domestic violence organizations in Kentucky.

2. **Explanation of Procedures:** Researchers will begin the data collection process by emailing all Executive and/or Program directors of the 15 member programs affiliated with the Kentucky Coalition Against Domestic Violence. Those directors will be asked to make the on-line survey link or paper research packet available to all employees of the organization. On-line questionnaires and paper packets will be made available once informed consent forms have been received by the research team. The interview questions include topics, such as whether the participant has experienced a traumatic life event and whether his/her organization possesses certain characteristics commonly associated with trauma-informed care. The entire process is expected to last between 15-30 minutes.

3. **Discomfort and Risks:** Participants in this study will take part in a brief, 15-30 minute survey/questionnaire. Survey questions will focus on the participant's perception of his/her organizational culture and questions about secondary symptoms of trauma and potentially traumatic life events. The researchers anticipate minimal negative risks or side effects resulting from participation in this study. However, if you are a victim of domestic violence or sexual assault and would like to speak to someone, you may reach the National Domestic Violence hotline at 800-799-7233 or the National Sexual Assault hotline at 800-656-4673.

4. **Benefits:** The researchers anticipate no direct benefit to participants in this study and are not offering any form of incentive for participation.

General benefits of this study could include an increased self-awareness negative symptoms that may affect the participant's quality of life and/or work performance. Additionally, input gathered from participants will significantly contribute to research that explores secondary traumatic stress and organizational trauma-informed care. While the research literature is robust regarding secondary trauma, the study of organizational trauma-informed care is
limited.

5. **Confidentiality:** Data, in the form completed research packets/on-line surveys, will be stored on a University password-protected computer, or in a locked filing cabinet. This computer and filing cabinet will be located in a locked faculty office. Packets/surveys will not include any identifying information in order to help ensure participants' anonymity and confidentiality. Additionally, all data will be kept for a minimum of three (3) years. 6. **Refusal/Withdrawal:** Refusal to participate in this study will have no effect on any future services you may be entitled to from the

University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.
You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

- oI consent to participate in the study (1)
- oI do not consent to participate in the study (2)

Q3 What is your age?

- o18-20
- o21-29
- o30-39
- o40-49
- o50-59
- o60 and older

Q4 What is your gender?

- oMale
- oFemale
- oOther

Q5 Which best describes your employment status?

- oFull-time (32 hours or more per week)
- oPart-time (less than 32 hours per week)
- oPRN (Called in as needed; no guaranteed schedule
- oOther

Q6 Which best categorizes your placement within the organization?

- oResidential Services (Emergency Shelter)
- oNon-residential Services (Outreach)
- oHotline/Crisis Line
- oFacilities/Maintenance
- oFood Services
- oCommunity Education
- oVolunteers
- oAdministration
- oExecutive Director
- oOther

Q7 Which best describes your role within the organization?

- oHotline Worker
- oEmergency Shelter worker
- oAdult Residential advocate
- oAdult Non-residential advocate
- oHousing/Economic Justice advocate
- oLicensed mental health worker
- oChild/Youth advocate
- oFood services worker
- oCommunity educator
- oVolunteer Coordinator/Manager
- oAdministrative worker
- oExecutive Director
- oOther

Q8-Q30 are from the Secondary Traumatic Stress Scale © and are copyrighted.

Q31-Q65 are questions taken from the Ticometer© and are copyrighted.

Q66 Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.
Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Natural disaster (for example, flood, hurricane, tornado, earthquake)

- ☐Happened to me
- ☐Witnessed it
- ☐Learned about it
- ☐Part of my job
- ☐Not sure
- ☐Doesn't apply

Q67 Fire or explosion

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q68 Transportation accident (for example, car accident, boat accident, train wreck, plane crash)

- Happened to me
- Witnessed it
- Learned about it
- Part job
- Not sure
- Doesn't apply

Q69 Serious accident at work, home, or during recreational activity

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q70 Exposure to toxic substance (for example, dangerous chemicals, radiation)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q71 Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q72 Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q73 Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q74 Other unwanted or uncomfortable sexual experience

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q75 Combat or exposure to a war-zone (in the military or as a civilian)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q76 Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q77 Life-threatening illness or injury

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q78 Severe human suffering

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q79 Sudden violent death (for example, homicide, suicide)

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q80 Sudden accidental death

- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q81 Serious injury, harm, or death you caused to someone else
- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Q82 Any other very stressful event or experience
- Happened to me
- Witnessed it
- Learned about it
- Part of my job
- Not sure
- Doesn't apply

Appendix B

Implied Consent Form

Project Title: The Relationship between Organizational Trauma-Informed Care and Secondary Trauma Symptoms in Staff Members of Kentucky Domestic Violence Programs

Investigator: Mary E. Foley, Applied Clinical Psychology, maryf@merrymanhouse.org

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your agreement to participate in this project. **You must be 18 years old or older to participate in this research study.**

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have. You should keep a copy of this form for your records.

1. **Nature and Purpose of the Project:** This project aims to identify and describe qualities of trauma-informed organizations and the effect those qualities may have on secondary trauma symptoms in direct service providers of domestic violence programs. It will employ a quantitative research design in which self-report questionnaires will be completed by employees of domestic violence organizations in Kentucky.

2. **Explanation of Procedures:** On-line questionnaires and paper packets will be made available once informed consent forms have been received by the research team. The survey questions include topics, such as whether the participant has experienced a traumatic life event and whether his/her organization possesses certain characteristics commonly associated with trauma-informed care. The entire process is expected to last between 15-30 minutes.

3. **Discomfort and Risks:** Survey questions will focus on the participant's perception of his/her organizational culture and questions about secondary symptoms of trauma and potentially traumatic life events. The researchers anticipate minimal negative risks or side effects resulting from participation in this study. However, if you are a victim of domestic violence or sexual assault and would like to speak to someone, you may reach the National Domestic Violence hotline at 800-799-7233 or the National Sexual Assault hotline at 800-656-4673.

4. **Benefits:** General benefits of this study could include an increased self-awareness negative symptoms that may affect the participant's quality of life and/or work performance. Additionally, input gathered from participants will significantly contribute to research that explores secondary traumatic stress and organizational trauma-informed care.

5. **Confidentiality:** Data, in the form completed research packets/on-line surveys, will be stored on a University password-protected computer, or in a locked filing cabinet. This computer and filing cabinet will be located in a locked faculty office. Packets/surveys will not include any identifying information in order to help ensure participants' anonymity and confidentiality. Additionally, all data will be kept for a minimum of three (3) years.

6. **Refusal/Withdrawal:** Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

Your continued cooperation with the following research implies your consent.

THE DATED APPROVAL ON THIS CONSENT FORM
INDICATES THAT THIS PROJECT HAS BEEN
REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Robin Pyles, Human Protections
Administrator TELEPHONE:
(270) 745-3360

Appendix C

Institutional Review Board Approval Letter

DATE: August 26, 2019

INSTITUTIONAL REVIEW BOARD OFFICE OF RESEARCH INTEGRITY

TO: Mary Foley, M.S.
FROM: Western Kentucky University (WKU) IRB

PROJECT TITLE: [1305046-1] THE RELAIONSHIP BETWEEN ORGANIZATIONAL TRAUMA- INFORMED CARE AND SECONDARY TRAUMA SYMPTOMS IN STAFF MEMBERS OF KENTUCKY DOMESTIC VIOLENCE PROGRAMS
REFERENCE #: 20-024
SUBMISSION TYPE: New Project

ACTION: APPROVED APPROVAL
DATE: August 26, 2019

REVIEW TYPE: Exempt Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit
ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Exempt Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by an *implied* consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Robin Pyles at (270) 745-3360 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Western Kentucky University (WKU) IRB's records.