Organizational Prevention of Vicarious Trauma

Holly Bell, Shanti Kulkarni, & Lisa Dalton

Reprinted with permission from Families in Society (www.familiesinsociety.org), published by the Alliance for Children and Families.

Abstract

For the past 30 years, researchers and practitioners have been concerned about the impact of work stress experienced by social workers. Although research on burnout has been a useful field of exploration, a new concern has arisen about work stresses specifically associated with work with victims of trauma. The concept of vicarious trauma provides insights into the stresses of this particular kind of work. Like the burnout research, early research on vicarious trauma has identified both personal and organizational correlates. In this article, the authors review the growing literature on the organizational components of vicarious trauma and suggest changes in organizational culture, workload, group support, supervision, self-care, education, and work environment that may help prevent vicarious trauma in staff.

WHETHER SHAPING PUBLIC POLICY or providing services to individuals, families, and communities, social workers are fully engaged with today's social problems. This difficult work can take an emotional and psychological toll on the worker (Davies, 1998; Gibson, McGrath, & Reid, 1989). This stress comes not only from responding to people in pain and crisis; characteristics of the organization also contribute to the stress (Sze & Ivker, 1986). This occupational stress has been examined primarily in terms of burnout (Maslach, 1993), but recent research in the field of trauma has identified stresses unique to that work. These stresses have been conceptualized as vicarious trauma (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, 1995b). To date, most research has focused on the individual characteristics thought to contribute to vicarious trauma. There has been less focus on the organizational structures that may contribute. In this article, we draw on the research on organizational correlates of burnout as a background for examining the research on vicarious trauma and then outline various organizational strategies suggested by practitioners working with trauma survivors to prevent vicarious trauma. This discussion is informed by a qualitative study of counselors working with victims of domestic violence (Bell, 1998, 1999) that suggested the importance of the work environment, among other issues, in the development of vicarious trauma. Quotations by counselors from that study will be used to illustrate the discussion.

Organizational Correlates of Burnout

Maslach (1993) described burnout as having three dimensions: (a) emotional exhaustion; (b) depersonalization, defined as a negative attitude towards clients, a personal detachment, or loss of ideals; and (c) reduced personal accomplishment and commitment to the profession. Burnout has been conceptualized as a process rather than a condition or state, and some have theorized that it progresses sequentially through each of these dimensions (Maslach, 1993). Maslach and others have examined the individual, interpersonal, and organizational characteristics that contribute to burnout. Of particular interest to this discussion is the finding that organizations can either promote job satisfaction or

contribute to burnout (Söderfeldt, Söderfeldt, & Warg, 1995). Unsupportive administration, lack of professional challenge, low salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Arches, 1991; Beck, 1987; Himle, Jayaratne, & Thyness, 1986). Individual staff members suffer, and the resulting loss of experienced staff can diminish the quality of client services (Arches, 1991). This research has helped identify organizational supports that could be effective in buffering or mediating burnout and point to workplace characteristics that may also prevent vicarious trauma.

Vicarious Trauma

Recently, the occupational stress of social workers working with trauma survivors has begun to receive attention (Cunningham, 1999; Dalton, 2001; Regehr & Cadell, 1999). Some authors are beginning to suggest that trauma theory has important utility in understanding the burnout experience of social workers working in child protection and with HIV-infected populations (Horwitz, 1998; Wade, Beckerman, & Stein, 1996). Many theorists have speculated that the emotional impact of this type of traumatic material is contagious and can be transmitted through the process of empathy (Figley, 1995; Pearlman & Saakvitne, 1995a; Stamm, 1995), as in this example from an experienced social worker talking about counseling women in a family service agency:

> *Sometimes after a session, I will be traumatized.... I will feel overwhelmed, and I can remember a particular situation with a sexually abused person where I— I just didn't want to hear any more of her stories about what actually happened. She seemed to want to continue to tell me those over and over and I remember just feeling almost contaminated, like, you know, like I was abused. You know? And so I set limits with her after some supervision about that but tracked her in a different way. I think it has an impact. I'm just not sure of what …* (as quoted in Bell, 1998)

In the past 10 years, the emotional impact of working with trauma survivors has been examined under several constructs: compassion fatigue (Figley, 1995), secondary traumatic stress (Figley, 1993; Stamm, 1995), and vicarious trauma (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, 1995b). These constructs have been compared and debated (Pearlman & Saakvitne, 1995a; Stamm, 1995), and a full discussion of them is outside the scope of this article. The majority of the empirical studies in this area have used the vicarious trauma construct. For this reason, the term *vicarious trauma* will generally be used throughout this article unless another term has been used specifically in the research cited.

Vicarious trauma has been defined as "the transformation that occurs in the inner experience of the therapist [or worker] that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995a, p. 31). Vicarious trauma can result in physiological symptoms that resemble posttraumatic stress reactions, which may manifest themselves either in the form of intrusive symptoms, such as flashbacks, nightmares, and obsessive thoughts, or in the form of constrictive symptoms, such as numbing and disassociation (Beaton & Murphy, 1995). It may also result in disruptions to important beliefs, called *cognitive schemas*, that individuals hold about themselves, other people, and the world (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995a, 1995b), as in the following example from a young worker in a battered women's shelter:

> *I think you see the worst of people, working here … the worst of what people do to each other. And I think when you don't have proper resources to process that, to work through it, to understand it or put it in some kind of context, it just leaves you feeling a little baffled about what's going on out there, and the way things work in the world and your role in all of that.* (as quoted in Bell, 1999, p. 175)

Although some of the numbing symptoms of vicarious trauma bear some resemblance to burnout and may in fact result in burnout over time, research on therapists has also begun to establish vicarious trauma as a distinct concept from burnout (Figley, 1995; Pearlman & Saakvitne, 1995a). Unlike the construct of burnout, the construct of vicarious trauma was developed from and is clinically grounded in trauma theory, specifically constructivist self-development theory (McCann & Pearlman, 1990b). In several studies, burnout and general stress levels were not related to exposure to traumatized clients, whereas measures of trauma exposure and vicarious trauma were related (Kassam-Adams, 1995; Schauben & Frazier, 1995). Thus, burnout alone does not appear to capture the effects of trauma as an occupational stressor. Although vicarious trauma may present with elements of emotional exhaustion, depersonalization, and reduced personal accomplishment, it also has effects that are unique and specific to trauma work.

Many professionals risk vicarious trauma through their contact with traumatized people or material that contains graphic images of trauma. Studies have indicated that approximately 38% of social workers experience moderate to high levels of secondary traumatic stress (Cornille & Meyers, 1999; Dalton, 2001). In addition, emergency workers (Leseca, 1996; McCammon, Durham, Allison, & Williamson, 1988; Wagner, Heinrichs, & Ehlert, 1998), nurses (Joinson, 1992), police officers (Follette, Polusny, & Milbeck, 1994), sexual assault counselors (Johnson &

Hunter, 1997; Regehr & Cadell, 1999; Schauben & Frazier, 1995), child protective service workers (Cornille & Meyers, 1999), and trauma therapists (Chrestman, 1995; Follette et al., 1994; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995) have all been documented as developing symptomology quite similar to acute and posttraumatic stress reactions as a result of their second-hand exposure to traumatic material.

Recent studies of trauma therapists have begun to explore some of the factors involved in the development of vicarious trauma. Therapist exposure to traumatic client material has been found to be an important predictor for symptoms of traumatic stress and, in some cases, of disrupted beliefs about self and others. In a survey of 148 counselors, Schauben and Frazier (1995) found that those who worked with a higher percentage of sexual violence survivors reported more symptoms of posttraumatic stress disorder and greater disruptions in their beliefs about themselves and others than did counselors seeing fewer survivors. The researchers tied these symptoms of trauma counselors to a number of factors. Most commonly, counselors said that hearing the trauma story and experiencing the pain of survivors was emotionally draining. Second, many counselors felt that the counseling process was more difficult when working with trauma survivors, who tended to have more problems trusting and working in a therapeutic relationship than clients who were not traumatized. Finally, some counselors found the work more difficult because of the institutional barriers within the legal, and mental health systems that their clients were forced to navigate. Similar findings emerged when researchers compared the stress level of sexual assault counselors with that of counselors who worked with a more general client population (Johnson & Hunter, 1997). Not only did sexual assault counselors show greater evidence of stress, but their work stress also contributed to personal relationship difficulties at home.

The impact of the therapist's own history of abuse on current report of vicarious trauma are unclear. Pearlman and Mac Ian (1995) reported significantly more vicarious trauma symptoms in 60% of the therapists they surveyed who reported a personal history of trauma. However, Schauben and Frazier (1995) found that counselors with a history of victimization were not more distressed by working with survivors than were counselors without such a history. Pearlman and Mac Ian found that therapists without a trauma history were more likely to report intrusive imagery than those with a history. Follette et al. (1994) found that mental health professionals with a significant history of childhood physical or sexual abuse did not experience significantly more negative responses to child sexual abuse survivor clients than those without such a history. They also reported significantly more positive coping strategies. However, the comparison group of law enforcement personnel with childhood abuse histories who also worked with sexual abuse survivors showed significantly more distress than the mental health professionals. The researchers hypothesized that the use of personal therapy by 59.1% of the mental health professionals versus 15.6% of the law enforcement professionals may have accounted for the difference.

Increased time spent with traumatized clients seems to increase the risk of stress reactions in mental health professionals (Chrestman, 1995; Pearlman & Mac Ian, 1995). Furthermore, spending time in other work activities decreases the risk. Having a more diverse caseload with a greater variety of client problems and participating in research, education, and outreach also appear to mediate the effects of traumatic exposure.

Age and experience are inversely correlated with the development of vicarious trauma. Younger and less experienced counselors exhibit the highest levels of distress (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995). They may have had less opportunity to integrate traumatic stories and experiences into their belief systems, as well as to develop effective coping strategies for dealing with the effects of vicarious trauma than have older and more experienced therapists (Neumann & Gamble, 1995). Such was the case of this experienced counselor who worked with battered women in the court system:

> *I think for somebody who doesn't do this type of work it would be extremely stressful, but after twelve years, I've just—I've handled so many cases and dealt with so many people, I know my limitations and the court's limitations and I just don't get as worked up about each case as I used to.* (as quoted in Bell, 1999, p. 117)

Vicarious trauma can be considered a type of occupational hazard in settings where there are high levels of traumatized clients. As a result, organizations providing services to trauma victims have a practical and ethical responsibility to address this risk.

Implications for Agency Administrative Response

The primary focus of discussion about the prevention of vicarious trauma has been on the individual (for a good summary, see Yassen, 1995). However, as with burnout, the organizational context of trauma work has been discussed as a factor in the development of secondary trauma. Several authors have written about their own experiences in agencies that serve traumatized individuals. They have suggested both prevention and intervention strategies in the areas of organizational culture, workload, work environment, education, group support, supervision, and resources for self-care. Each of these will be discussed in turn below.

Organizational Culture

The values and culture of an organization set the expectations about the work. When the work includes contact

with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally. Of primary concern is that organizations that serve trauma survivors, whether rape crisis centers, shelters for battered women, or programs that work with veterans, acknowledge the impact of trauma on the individual worker and the organization. As Rosenbloom, Pratt, and Pearlman (1995) wrote of their work at the Traumatic Stress Institute, "We work together to develop an atmosphere in which it is considered inevitable to be affected by the work" (p. 77). It is not uncommon for feelings and reactions generated by trauma to leave the social worker feeling ineffective, unskilled, and even powerless. An organizational culture that "normalizes" the effect of working with trauma survivors can provide a supportive environment for social workers to address those effects in their own work and lives. It also gives permission for social workers to take care of themselves. Yassen (1995) provided an example of a potentially harmful "norm" that can frustrate workers' attempts at self-care: "In some settings, it may be assumed that if employees do not work overtime, they are not committed to their work, or that clinicians who do not take vacations are more committed to their work than are others" (p. 201). A supportive organization is one that not only allows for vacations, but also creates opportunities for social workers to vary their caseload and work activities, take time off for illness, participate in continuing education, and make time for other self-care activities. Small agencies might signal their commitment to staff by making staff self-care a part of the mission statement, understanding that ultimately it does affect client care. Administrators might also monitor staff vacation time and encourage staff with too much accrued time to take time off. Self-care issues could be addressed in staff meetings, and opportunities for continuing education could be circulated to staff. In social work agencies, which typically operate with inadequate resources and relentless service demands, such commitments, regardless of how small, are not inconsequential.

> Responsible supervision creates a relationship in which the social worker feels safe in expressing fears, concerns, and inadequacies.

Workload

Research has shown that having a more diverse caseload is associated with decreased vicarious trauma (Chrestman, 1995). Such diversity can help the social worker keep the traumatic material in perspective and prevent the formation of a traumatic worldview (Pearlman & Saakvitne, 1995a). Agencies could develop intake procedures that attempt to distribute clients among staff in a way that pays attention to the risk of vicarious trauma certain clients might present to workers. When possible, trauma cases should be distributed among a number of social workers who possess the necessary skills (Dutton & Rubinstein, 1995; Regehr & Cadell, 1999; Wade et al., 1996). In addition, social workers whose primary job is to provide direct services to traumatized people may benefit from opportunities to participate in social change activities (Regehr & Cadell, 1999). Agencies that do not already provide such services might consider providing community education and outreach or working to influence policy. Such activities can provide a sense of hope and empowerment that can be energizing and can neutralize some of the negative effects of trauma work.

Organizations can also maintain an "attitude of respect" (Pearlman & Saakvitne, 1995b, p. 170) for both clients and workers by acknowledging that work with trauma survivors often involves multiple, long-term services. Organizations that are proactive in developing or linking clients with adjunct services—such as self-help groups, experienced medical professionals for medication, in- and out-patient hospitalization, and resources for paying for these services—will support not only clients, but also decrease the workload of their staff (Pearlman & Saakvitne, 1995b). Developing collaborations between agencies that work with traumatized clients can provide material support and prevent a sense of isolation and frustration at having to "go it alone."

Work Environment

A safe, comfortable, and private work environment is crucial for those social workers in settings that may expose them to violence (Pearlman & Saakvitne, 1995b; Yassen, 1995). Some work sites, such as shelters or agencies located in high-crime neighborhoods, are so dangerous that workers may actually experience primary trauma, rather than vicarious trauma. In a sample of 210 licensed social workers, Dalton (2001) found that 57.6% had been threatened by a client or member of a client's family, and 16.6 % had been physically or sexually assaulted by a client or member of the client's family. Being threatened by a client or a member of a client's family was strongly correlated with compassion fatigue. Although it is more of a challenge in certain settings, protecting workers' safety should be the primary concern of agency administration. Paying for security systems or security guards may be a necessary cost of doing business for some agencies that provide services to traumatized individuals.

Failing that, agencies may consider developing a buddy system for coworkers so that if one worker is threatened by a client, another can summon the police.

In addition to attention to basic safety, Pearlman and Saakvitne (1995b) have suggested that workers need to have personally meaningful items in their workplace. These can include pictures of their children or of places they have visited, scenes of nature or quotes that help them remember who they are and why they do this work. One hotline worker described her use of such an item:

> *When it's a real intense call, I kind of hunch over the phone and kind of like focus here on my [computer screen] and I sometimes try to consciously tell myself to sit back and look at one of my pictures that I have up to remind me of happier times.* (as quoted in Bell, 1998)

Agency administrators can encourage staff to make these small investments in their work environment. By placing inspiring posters or pictures of scenic environments (rather than agency rules and regulations) in the waiting rooms, staff meeting rooms, and break rooms, the organization can model the importance of the personal in the professional. In addition, workers also need places for rest at the job site, such as a break room that is separate from clients (Yassen, 1995). With a space such as this, the organization could address the self-care needs of staff by providing a coffee maker, soft music, and comfortable furniture.

Education

Trauma-specific education also diminishes the potential of vicarious trauma. Information can help individuals to name their experience and provide a framework for understanding and responding to it. Training settings, such as schools of social work, have a responsibility to provide this information to field interns entering placements where they will encounter trauma (Pearlman & Saakvitne, 1995b). Dalton (2001) found that social workers with master's degrees had lower levels of secondary traumatic stress compared with those with baccalaureate degrees. This difference suggests that the type of clinical training available in master's programs, such as information about client empowerment, self-care, and recognizing destructive behaviors, may be a missing but important part of training social workers in baccalaureate programs to prevent secondary stress and vicarious trauma.

Efforts to educate staff about vicarious trauma can begin in the job interview (Urquiza, Wyatt, & Goodlin-Jones, 1997). Agencies have a duty to warn applicants of the potential risks of trauma work and to assess new workers' resilience (Pearlman & Saakvitne, 1995b). New employees can be educated about the risks and effects associated with trauma, as new and inexperienced workers are likely to experience the most impact (Chrestman, 1995; Neumann & Gamble, 1995). Ongoing education about trauma theory and the effects of vicarious trauma can be included in staff training (Regehr & Cadell, 1999; Urquiza et al., 1997) and discussed on an ongoing basis as part of staff meetings. Agencies can take advantage of the flourishing number of workshops on vicarious trauma at professional conferences in social work and other disciplines by sending a staff member for training and asking that worker to share what he or she has learned with the rest of the staff. This information provides a useful context and helps social workers to feel more competent and have more realistic expectations about what they can accomplish in their professional role. Preparation for a stressful event, when possible, protects individuals from the effect of stress (Chemtob et al., 1990).

Learning new ways to address clients' trauma may also help prevent vicarious trauma. Theories, such as constructivist self-development theory (McCann & Pearlman, 1990a) on which the theory of vicarious trauma is based, maintain a dual focus between past traumas and the client's current strengths and resources. Working from a theoretical framework that acknowledges and enhances client strengths and focuses on solutions in the present can feel empowering for client and worker and reduce the risk of vicarious trauma.

Group Support

Both the burnout literature and the writings about vicarious trauma emphasize the importance of social support within the organization (Catherall, 1995; Munroe et al., 1995; Rosenbloom et al., 1995). Staff opportunities to debrief informally and process traumatic material with supervisors and peers are helpful (Horwitz, 1998; Regehr & Cadell, 1999; Urquiza et al., 1997). Critical incident stress debriefing (Mitchell, 1983, as cited in Wollman, 1993) is a more formalized method for processing specific traumatic events but may be less helpful in managing repetitive or chronic traumatic material (Horwitz, 1998). Support can also take the form of coworkers' help with paperwork or emergency backup. Time for social interaction between coworkers, such as celebrating birthdays or other events as well as organized team-building activities and staff retreats, can increase workers' feeling of group cohesion and mutual support.

Peer support groups may help because peers can often clarify colleagues' insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of the social worker (Catherall, 1995). Group support can take a variety of forms, such as consultation, treatment teams, case conferences, or clinical seminars, and can be either peer led or professionally led. For example, shelter workers interviewed by Bell (1999) started a reading group and together read and discussed Pearlman and Saakvitne's (1995a) book, *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy With Incest Survivors.* The group met after work on a regular basis. Group members learned about

vicarious trauma and ways to deal with it in their own work and lives. The group cost the agency nothing, did not interfere with work, and provided an opportunity for workers to give each other much-needed support. Regardless of the form group support takes, Munroe et al. (1995) warned that it should be considered an adjunct to, not a substitute for, self-care or clinical supervision.

There are some potential pitfalls of group support. One is the tendency toward "groupthink" and conformity (Munroe et al., 1995). Another is that members hearing about a coworker's distress may use distancing and victim-blaming as a defense mechanism. Peer groups and treatment teams also offer the opportunity for traumatic reenactments, such as splitting the group members into the roles of exploiter and exploited, that are so common in working with trauma survivors (Munroe et al., 1995). When groups are held within agencies, there is also the potential problem generated by conflicting roles in the group, such as a supervisor who is both supporter and evaluator or a coworker/supervisor who is also a friend. Finally, group members may be more rather than less traumatized by the necessity of hearing each other's worst horror stories. Guzzino and Taxis (1995) have suggested a number of ways for members of such groups to talk about their experiences without further traumatizing group members through the use of psychodrama and art therapy. To further minimize the potential for problems in support groups, Catherall (1995) has suggested that group members discuss such a possibility before it happens and normalize the experience of vicarious trauma and its impact on the individual and the group.

Supervision

Effective supervision is an essential component of the prevention and healing of vicarious trauma. Responsible supervision creates a relationship in which the social worker feels safe in expressing fears, concerns, and inadequacies (Welfel, 1998). Organizations with a weekly group supervision format establish a venue in which traumatic material and the subsequent personal effect may be processed and normalized as part of the work of the organization. As one hotline worker said of the value of supervisory support in response to a stressful call: "It's kind of like you have this big sack of rocks and every time you kind of tell someone about it you can, you know, give them a couple of your rocks and your sack gets lighter" (as quoted in Bell, 1998).

In addition to providing emotional support, supervisors can also teach staff about vicarious trauma in a way that is supportive, respectful, and sensitive to its effects (Pearlman & Saakvitne, 1995b; Regehr & Cadell, 1999; Rosenbloom et al., 1995; Urquiza et al., 1997). If at all possible, supervision and evaluation should be separate functions in an organization because a concern about evaluation might make a worker reluctant to bring up issues in his or her work with clients that might be signals of vicarious trauma. Dalton (2001) found that 9% of the variance in her study of social workers and secondary traumatic stress was related to supervision. Her results indicated that the number of times a worker received nonevaluative supervision and the number of hours of nonevaluative supervision were positively related to low levels of secondary traumatic stress. In situations where supervisors cannot separate the supervisory and evaluative functions, agency administrators might consider contracting with an outside consultant for trauma-specific supervision on either an individual or group basis. The cost of such preventive consultation might be well worth the cost savings that would result from decreased employee turnover or ineffectiveness as a result of vicarious trauma.

Resources for Self-Care

Agencies can make counseling resources available for all staff that interact with traumatic material (Regehr & Cadell, 1999; Wade et al., 1996). If there are many employees encountering the same type of trauma in the agency or within the larger community, agencies may consider the feasibility of forming a peer support group, as discussed earlier. Workers also need health insurance that provides mental health coverage (Rosenbloom et al., 1995). Following is a quote from one young shelter worker who was seeing a therapist to deal with some of the challenges of her work:

> *It's nice to be able to talk to another professional person, I think, who understands a lot of the crazy things that can happen working in a shelter. I think when you try to talk with your friends about it or family, they are horrified at some of the stories that you come up with, so it helps to get feedback from another professional who says, "Oh, I know what you're talking about. I've been there, and yes, that is very horrible." And mainly just to vent, just to be able to speak about it. To get it out, so it doesn't disrupt my life in other ways; in my sleep patterns or things like that.* (as quoted in Bell, 1998)

Wade et al. (1996) also recommended that in addition to providing resources for therapy, organizations should provide opportunities for structured stress management and physical activities. Organizations with limited resources might consider exchanging training on areas of expertise with other agencies that have experts in stress management. Again, sending one staff member to a conference or workshop to learn stress management techniques and then asking that person to present what he or she learned to coworkers is a cost-effective way to circulate this information throughout an organization. Organizing something as simple as a walking or meditation group during the lunch hour or after work might also contribute to staff wellness at no cost.

In summary, the physical and cultural environment of work may prevent or predispose social workers to vicarious

trauma. Additional research is needed to understand how and to what degree social workers may be affected by the trauma they come into contact with in the workplace and which workplace variables are most salient. Furthermore, how vicarious trauma impacts the social worker's relationship with clients is another fruitful area for study. Research that helps to clarify the relationship between vicarious trauma and burnout would also be useful in providing a clearer theoretical framework from which to make agency decisions.

Conclusion

Working with clients who have experienced traumatic events challenges many of the beliefs held in the dominant culture about justice and human cruelty. Being personally exposed to these realities can take a toll on social workers' emotional resources and may effect their perceptions and worldviews in fundamental ways. Personal knowledge of oppression, abuse, violence, and injustice can be a difficult and isolating aspect of work for many social workers. As a result, some may become overwhelmed, cynical, and emotionally numb. Some may even leave the profession.

Although for years mental health professionals have understood these reactions to be an aspect of burnout, identification of vicarious trauma as a distinct construct encourages those in the profession to reexamine the relationship between trauma and this type of social worker distress. Social work managers and educators are also challenged to consider the organizational correlates of vicarious trauma. Some responses, such as altering workloads or providing insurance with extensive mental health benefits, may be costly to the organization; however, neglecting such an investment may also be costly to the agency in terms of staff turnover and low morale. Other organizational responses, such as creating an agency culture that acknowledges the potential for vicarious trauma, may be less costly. Simply naming the stress of the work may help workers feel supported and give them permission to seek personal solutions for whatever stress they may experience. In the end, these responses are likely to lead to a healthier environment for both workers and their traumatized clients and a higher and more consistent quality of service.

References

Arches, J. (1991). Social structure, burnout, and job satisfaction. *Social Work, 36,* 202–206.

Arvay, M. J,. & Uhlemann, M. R. (1996). Counsellor stress in the field of trauma: A preliminary study. *Canadian Journal of Counselling, 30,* 191–210.

Beaton, R. D., & Murphy, S. A. (1995). Working with people in crisis: Research implications. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 51–81). New York: Brunner/Mazel.

Beck, D. F. (1987). Counselor burnout in family service agencies. *Social Casework, 68,* 3–15.

Bell, H. (1998). [The impact of counseling battered women on the mental health of counselors.] Unpublished raw data.

Bell, H. (1999). *The impact of counseling battered women on the mental health of counselors.* Unpublished doctoral dissertation, University of Texas at Austin.

Catherall, D. (1995). Coping with secondary traumatic stress: The importance of the professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 80–92). Lutherville, MD: Sidran.

Chemtob, C. M., Bauer, G. B., Neller, G., Hamada, R., Glisson, C., & Stevens, V. (1990). Post-traumatic stress disorder among special forces Vietnam veterans. *Military Medicine, 155,* 16–20.

Chrestman, K. R. (1995). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 29–36). Lutherville, MD: Sidran.

Cornille, T. A., & Meyers, T. W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology, 5,* 1–17.

Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal, 16,* 277–290.

Dalton, L. E. (2001). *Secondary traumatic stress and Texas social workers.* Unpublished doctoral dissertation, The University of Texas at Arlington.

Davies, R. L. (1998). *Stress in social work.* London: Athenaeum.

Dutton, M., & Rubinstein, F. (1995). Working with people with PTSD: Research implications. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 82–100). New York: Brunner/Mazel.

Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/ Mazel.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25,* 275–282.

Gibson, F., McGrath, A., & Reid, N. (1989). Occupational stress in social work. *British Journal of Social Work, 19,* 1–16.

Guzzino, M., & Taxis, C. (1995). Leading experiential vicarious trauma groups for professionals. *Treating Abuse Today, 4,* 27–31.

Himle, D. P., Jayaratne, S. D., & Thyness, P. A. (1986). Predictors of job satisfaction, burnout and turnover among social workers in Norway and the USA: A cross cultural study. *International Social Work, 29,* 323–334.

Horwitz, M. (1998). Social worker trauma: Building resilience in child protection social workers. *Smith College Studies in Social Work, 68,* 363–377.

Johnson, C. N., & Hunter, M. (1997). Vicarious traumatization in counselors working in the New South Wales Sexual Assault Services: An exploratory study. *Work and Stress, 11,* 319–328.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22,* 116–121.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 37–48). Lutherville, MD: Sidran.

Leseca, T. (1996). Symptoms of stress disorder and depression among trauma counselors after an airline disaster. *Psychiatric Services, 47,* 424–426.

Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research.* Washington, DC: Taylor & Francis.

McCammon, S., Durham, T. W., Allison, E. J., & Williamson, J. E. (1988). Emergency workers' cognitive appraisals and coping with traumatic events. *Journal of Traumatic Stress, 1,* 353–372.

McCann, I., & Pearlman, L. (1990a). *Psychological trauma and the adult survivor: Theory, therapy, and transformation.* New York: Brunner/Mazel.

McCann, I., & Pearlman, L. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149.

Munroe, J., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimering, R. (1995). Preventing compassion fatigue: A team treatment model. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 209–231). New York: Bruner/Mazel.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Counter-transference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32,* 341–347.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26,* 558–565.

Pearlman, L. A., & Saakvitne, K. W. (1995a). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Pearlman, L. A., & Saakvitne, K. W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). New York: Brunner/Mazel.

Regehr, C., & Cadell, S. (1999). Secondary trauma in sexual assault crisis work: Implications for therapists and therapy. *Canadian Social Work, 1,* 56–70.

Rosenbloom, D., Pratt, A., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65–79). Lutherville, MD: Sidran.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* 49–64.

Söderfeldt, M., Söderfeldt, B., & Warg, L. E. (1995). Burnout in social work. *Social Work, 40,* 638–646.

Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran.

Sze, W.C., & Ivker, B. (1986). Stress in social workers: The impact of setting and role. *Social Casework, 67,* 141–148.

Urquiza, A. J., Wyatt, G. E., & Goodlin-Jones, B. L. (1997). Clinical interviewing with trauma victims: Managing interviewer risk. *Journal of Interpersonal Violence, 12,* 759–772.

Wade, K., Beckerman, N., & Stein, E. J. (1996). Risk of posttraumatic stress disorder among AIDS social workers: Implications for organizational response. *The Clinical Supervisor, 14,* 85–97.

Wagner, D., Heinrichs, M., & Ehlert, U. (1998). Prevalence of symptoms of posttraumatic stress disorder in German professional firefighters. *American Journal of Psychiatry, 155,* 1727–1732.

Welfel, E. R. (1998). *Ethics in counseling and psychotherapy.* Pacific Grove, CA: Brooks/Cole.

Wollman, D. (1993). Critical incident stress debriefing and crisis groups: A review of the literature. *Group, 17,* 71–83.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 178–208). New York: Brunner/Mazel.

Holly Bell, PhD, LMSW-ACP, *is a research associate at the Center for Social Work Research, The University of Texas at Austin. Her research interests build on over ten years of experience in direct practice as a social worker and focus on violence against women. She has conducted numerous training sessions on the prevention of burnout and secondary trauma.* ***Shanti Kulkarni, MSSW,*** *is a doctoral candidate at the School of Social Work, The University of Texas at Austin.* ***Lisa Dalton, PhD,*** *is assistant professor at New Mexico State University, Las Cruces, New Mexico, with a specialization in psychopathology and trauma. Correspondence concerning this article should be addressed to the first author at the Center for Social Work Research, The University of Texas at Austin, 1 University Station D3500, Austin, TX 78712-0359, or at hbell@mail.utexas.edu.*

Authors' note. We thank Laura Lein, Yolanda Padilla, David Dominguez, Kathleen Murphy, and Jason McCrory for their assistance in the preparation of this manuscript.

Manuscript received: August 27, 2002
Accepted: July 8, 2003