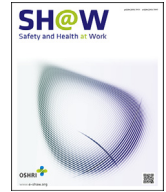




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## Original Article

## Supporting Those Who Provide Support: Work-Related Resources and Secondary Traumatic Stress Among Victim Advocates

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## ABSTRACT

**Background/Aims:** Victim advocates are at risk of developing secondary traumatic stress (STS), which can result from witnessing or listening to accounts of traumatic events. This study investigated the relationship between victim status, years of experience, hours of direct contact with victims, and availability of workplace supports in the development of STS.

**Results:** Of the 142 victim advocates, 134 were women. Regression analyses revealed that the only significant predictor of STS was the number of direct hours of victim services provided.

**Conclusion:** The findings from this study found that women have high rates of STS and that more workplace support needs to be implemented.

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## 1. Introduction

Burnout is the emotional exhaustion, depersonalization, and feelings of professional insufficiency [1,2] that results from an emotionally demanding work environment [2]. When burnout occurs, the helping professional (e.g., social worker, victim advocate, and therapist) may no longer be able to fulfill their personal and professional responsibilities and/or duties [1,2]. Burnout has been associated with physical and mental health problems, lower productivity, and lower organizational commitment [2–4]. Moreover, burnout can impact compassion satisfaction and/or the positive feelings (i.e., gratification on their ability to help others) helping professionals have regarding their ability to help others, both of which act as protective factors against burnout [5].

When the helping professional is exposed to repeated secondary trauma, a more severe form of burnout can arise: secondary traumatic stress (STS). STS results from witnessing or listening to accounts of traumatic events or disturbing experiences [6,2]. The symptoms of STS are similar to those of post-traumatic stress disorder, where after exposure to the traumatic account, the individual experiences rumination, flashbacks, fear, hypervigilance, nightmares, sleeplessness, agitation, or fatigue and other physiological responses [6]. The effects of STS can cause a variety of issues such as hopelessness, avoidance, fear, guilt, and low compassion

satisfaction for individuals, which can impact the helping professional's level of interaction with their clients [2]. The preponderance of the research on STS is focused on social workers, specifically social workers who work with trauma victims. Most social workers tend to experience at least one symptom of STS in relation to their interactions with their clients [6].

With regard to risk factors in the development of STS, Hensel et al [7] found (via meta-analysis) that the helping professionals' experiences, caseloads, and lack of work support were all significant risk factors for STS. The individual's caseload or the proportion of time spent working with trauma survivors produced the strongest effect size. Conversely, protective factors include compassion satisfaction [8]; access to strategic information (e.g., participation in decision-making and setting goals [7]); and support from coworkers, supervisors, and work teams [9]. Indeed, Choi [9] examined the organizational risk and protective factors for STS among social workers who assist family violence or sexual assault survivors. The findings highlight the importance of social support provided at the organizational level as a protective factor for STS. Access to strategic information (e.g., participation in decision-making and setting goals) was also found to be a protective factor to STS. In addition to these risk factors, Slattery and Goodman [10] examined the workplace risk and protective factors for STS among domestic violence advocates. Support from coworkers, good

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quality clinical supervision, and shared power was significantly correlated with STS; the more support an advocate received, the less likely she/he was to develop STS.

Victim status (i.e., whether the advocate had a history of being victimized) was also linked to the development of STS. Wasco et al [11] also explored the different levels of support made available to victim advocates by their organizations. Advocates varied substantially in terms of reported organizational support and listed being able to talk to others within their agency, having more services available to victims, and sharing duties and working with others as helpful organizational contexts.

As noted previously, most research on STS has used social workers as participants, although other helping professionals may be at risk of developing STS. Victim advocates represent a unique population as their role includes, but is not limited to, enhancing the safety of victims and survivors of abuse (e.g., finding emergency shelter and filling for a temporary protection order), providing medical and legal advocacy (e.g., coordinating doctor appointments and information on court proceedings), and providing victims with emotional support (e.g., normalizing feelings and referring the victim to individual and group behavioral services). The limited research that does exist on victim advocates suggests that victim advocates are also an at-risk population with regard to STS [10].

As mentioned previously, there is some research that supports that organizational factors can act as protective factors against the development of STS; despite this emerging body of literature, there has been an explicit call for further research on the protective factors of STS [13]. Despite victim advocates representing an at-risk population for the development of STS, given the nature of their work, they have been largely neglected in the STS literature, especially female victim advocates. Owing to the research supporting that organization factors can act as a protective (or risk) factor in the development of STS, that victim advocates have been largely neglected in the research arena, and that victim advocates are at risk of developing STS, given the nature of their work, we examined how organizational factors may act as protective (or risk) factors against the development of STS among primarily female victim advocates. Specifically, we were interested in identifying workplace support victim advocates have available to them and the relationship between STS and workplace support. We also examined nonorganizational factors that have been identified in the literature as potential risk factors as potential confounders in the investigation of the relationship between workplace supports and the development of STS.

## 2. Materials and methods

### 2.1. Procedure

Participants were recruited from a comprehensive web search of United States agencies employing victim advocates using the search term "victim advocate." From this search, a list of possible agencies ( $N = 75$ ) was generated, and each of these agencies was contacted and sent an e-mail with information about the study and a link to the study (hosted on SurveyMonkey Inc.). The link provided the participants with a consent form, a demographic survey, and the study instruments along with a request that the recipient of the e-mail forward the survey on to other victim advocates. Data were collected from February 2016 to February 2017. Of the 142 victim advocates to participate, ten surveys were omitted from final data analysis because of missing data that exceeded 5%. All study procedures were approved by the Institutional Review Board at the University of Nevada, Reno.

### 2.2. Measures

#### 2.2.1. Demographic questionnaire

Participants were asked information regarding their gender, age, ethnicity, education, income, and victim status. Furthermore, the participants were asked to provide information pertaining to their professional activities (i.e., years of experience, type of victims/trauma, hours worked per week, and services provided).

#### 2.2.2. Work support questionnaire

A list of questions regarding organizational support was developed for the purpose of this study. The list was based on the relevant literature that examined the relationship between organizational support provided by work settings where individuals may be at risk of developing STS. The extant literature has indicated that professional trainings [14] and emotional support [10,15] can act as protective factors against the development of STS. Moreover, recently, there has been an increase in the implementation of mindfulness-based interventions in workplace settings [16], and individual therapy and group therapy have been noted to be used with populations who experience STS [17]. Thus, the participants were asked to indicate what work supports their organization provides including trainings/workshops, support to attend conferences, mindfulness-based interventions (e.g., yoga, and meditation), support groups, or counseling. The participants were also given the option to list other supports provided by their organization. The list of questions had answer choices of "yes" or "no" regarding their organizational support.

#### 2.2.3. Secondary traumatic stress scale

Bride et al [18] created a 17-item self-report questionnaire with the aim of detecting experiences of STS. The participants were instructed to rate items on a five-point Likert scale, indicating how frequently true each item is for them in the past week. In addition, the scale detects the occurrence of intrusion (e.g., my heart started pounding when I thought about my work with clients), avoidance (e.g., I felt emotionally numb), and arousal (e.g., I had trouble sleeping) symptoms of STS, resulting from trauma-related work environments. These three subscales are made up of 5 and 6 questions of the secondary traumatic stress scale (STSS) and all load above .58. The STSS has shown high levels of internal consistency (coefficient alpha = .94) and has demonstrated good discriminative, convergent, and factorial validity among social workers [18].

### 2.3. Participants

A sample of 142 participants (134 women) ranging from 21 to 72 years participated in this prospective study. The sample was predominantly Caucasian (77.5%), Hispanic/Latino (14%), mixed (4.2%), and American Indian (1.4%). Of the 142 participants, 96 (68.1%) participants reported that they have experienced some form of trauma. In addition, 96% of the sample was paid victim advocates. There was a large variability in years of experience, ranging from their first year of working as a victim advocate to thirty-five years of experience. The mean score for the STSS was 39.81 [standard deviation (SD) = 13.2].

## 3. Results

To address the first research question, *Do advocates who are provided with workplace support have lower levels of STS than advocates who are not provided with workplace support?* four independent sample *t* tests were conducted to compare STSS scores (intrusion, avoidance, and arousal subscales and STSS total score) in victim advocates who indicated that their workplace does provide

support compared with those who indicated that their workplace does not provide support. There were no significant differences in STSS intrusion, avoidance, and arousal subscales or the STSS total score (see Table 1).

To answer the second research question, *What types of work supports do victim have available to them?* descriptive statistics were run using the variables from the work support questionnaire. Table 2 depicts workplace supports available to participants. The majority of participants (83%) reported that trainings were available to them as a form of support, and more than half (55%) of the participants reported that their workplace provided support to attend conferences. To a lesser degree, counseling (25%), mindfulness-based interventions (11%), and support groups (8%) were provided to the participants through their work. Several participants listed other supports available to them including time off as needed, support from coworkers, weekly supervision and/or the ability to speak with supervisors, mental health days, and access to local recreation centers.

To adequately answer the final research question, *What is the relationship (if any) between the types of workplace supports provided to victim advocates and STS?* numerous analyses were run. First, only those cases where the advocate indicated that their work provided support were selected ( $n = 109$ ). Second, it was important to determine possible confounders so as to control for them in the regressions. Because the extant literature has cited victim status [10,19], years of experience [20,21], and direct hours of victim services [20] as being related to STS, the relationship between each of these and the outcome variables and total score on the STSS was examined. An independent sample  $t$  test was run to determine whether or not victim status was related to the total score on the STSS. The results of the independent sample  $t$  tests showed that victim advocates who were victims themselves ( $M = 38.87$ ,  $SD = 12.60$ ) did not differ with regard to the STSS total score from victim advocates who were not victims themselves ( $M = 37.88$ ,  $SD = 10.95$ ) ( $t = -.44$ ,  $df = 70$ ,  $p = .3805$ , 95% confidence interval for mean difference  $-.99$ ,  $2.40$ ). Two Pearson product-moment correlation coefficients were computed to assess the relationship between the STSS total score and (1) years of experience and (2) direct hours of victim services. There was a significant relationship between the STSS total score and the number of direct hours of victim services provided each week only ( $r = 0.263$ ,  $n = 109$ ,  $p < .001$ ).

Finally, four separate multiple regressions were run, where the STSS total score and each of the three subscale scores were the outcome variables. The three-predictor variables were trainings/conferences/workshops, mindfulness-based interventions, and support group/counseling in all four regressions, whereas in the workplace support questionnaire, trainings/workshops were listed as a separate variable from support to attend conferences; we collapsed these into a single variable as they all fall under the broader category of educational support. Similarly, we collapsed

**Table 1**  
Results of  $t$  test and descriptive statistics for STSS subscales

| STSS        | Workplace support |       |                   |       | 95% CI for mean difference | $t$   | df |
|-------------|-------------------|-------|-------------------|-------|----------------------------|-------|----|
|             | No ( $n = 23$ )   |       | Yes ( $n = 109$ ) |       |                            |       |    |
|             | M                 | SD    | M                 | SD    |                            |       |    |
| Intrusion   | 10.61             | 4.21  | 11.04             | 3.52  | -2.34, 1.50                | -0.45 | 29 |
| Avoidance   | 17.61             | 6.48  | 15.61             | 5.47  | -.97, 4.96                 | 1.38  | 29 |
| Arousal     | 12.43             | 4.33  | 11.92             | 1.17  | -1.50, 2.53                | 0.53  | 31 |
| Total score | 40.65             | 14.31 | 38.57             | 12.08 | -4.46, 8.63                | 0.65  | 29 |

CI, confidence interval; SD, standard deviation; STSS, secondary traumatic stress scale.

**Table 2**  
Workplace supports available to advocates

| Supports                        | No (n) | Yes (n) | Yes (%) |
|---------------------------------|--------|---------|---------|
| Trainings                       | 33     | 109     | 77%     |
| Conferences                     | 68     | 73      | 48%     |
| Counseling                      | 108    | 33      | 22%     |
| Support group                   | 130    | 11      | 8%      |
| Mindfulness-based interventions | 127    | 14      | 10%     |
| Other                           | 112    | 30      | 21%     |

support group and counseling into a single variable as they both fall under the broader category of emotional support. The results from the multiple regressions can be seen in Table 3 through 6. Although work-related supports were not found to be significant across all four regressions, it was found that number of direct hours worked with victims per week predicted STSS scores as a total score and in the three subscales ( $p < .05$ ).

#### 4. Discussion

Victim advocates represent an at-risk population for the development of STS, given the nature of their work; however, they have been largely neglected in the STS literature. Past research has indicated that organizational factors can act as protective (or risk) factors in the development of STS among other helping professionals, such as social workers [6,9], nurses [15,22,23], and forensic interviewers [12]. Therefore, the aim of this study is to understand how organizational factors relate to STS among primarily female victim advocates. This study found that the only significant predictor of STS was the number of direct hours spent providing the victim with services. Furthermore, we examined what work supports victim advocates have available to them and found that most participants receive educational support. To a lesser extent, advocates reported having emotional support available to them (in the form of counseling or support groups), and a small minority of advocates reported that mindfulness-based interventions were available to them through their work. The STS has been usually examined with social workers, with Bride et al [18] finding a mean rate of STS of 29.49 ( $SD = 10.76$ ), which is a quite lower endorsement of STS than this study with victim advocates ( $M = 39.81$ ;  $SD = 13.2$ ).

##### 4.1. Risk factors

The main goal of this study was to establish the extent to which workplace supports acted as protective factors against the development of STS. However, before examining that data, it was first necessary to investigate the risk factors that may act as confounders to these workplace supports. While an extensive discussion on risk factors that are not related to the organizational context is beyond the scope of this article [24], it is worth noting that our results add to the equivocal body of literature on whether or not victim status

**Table 3**  
Summary of linear regression analysis for variables predicting STSS total score

| Variable                        | B      | SE B  | $\beta$ |
|---------------------------------|--------|-------|---------|
| Mindfulness-based interventions | -0.03  | 3.556 | -0.001  |
| Educational support             | -3.222 | 4.545 | -0.071  |
| Emotional support               | -0.638 | 2.552 | -0.025  |
| Direct hours***                 | 0.295  | 0.104 | 0.28    |

\*\*\* $p < .001$ .

STSS, secondary traumatic stress scale.

**Table 4**

Summary of linear regression analysis for variables predicting STSS intrusion subscale

| Variable                        | B      | SE B  | $\beta$ |
|---------------------------------|--------|-------|---------|
| Mindfulness-based interventions | -0.436 | 1.032 | -0.042  |
| Educational support             | -1.429 | 1.319 | -0.107  |
| Emotional support               | 0.226  | 0.741 | 0.03    |
| Direct hours***                 | 0.088  | 0.03  | 0.288   |

\*\*\* $p < .001$ .

STSS, secondary traumatic stress scale.

and years of experience predict STS [7]. Our findings aligned with research that supports that victim status [25,26] and years of experience [20,21,27] are not related to STS. We did find that the number of direct hours worked was related to higher STS scores, which is consistent with the extant literature. This may not be related to exposure to secondhand trauma per se. Instead, this finding is congruent with the literature on the negative repercussions of working in an emotionally demanding work environment [2]; working directly with victims is by its nature emotionally demanding. While this finding is not related to workplace supports, the findings do suggest that organizations should be mindful of the number of hours that victim advocates work directly with victims. Although the aforementioned information addresses the potential confounders in our data set, interestingly, we did not find that the availability of workplace supports was related to (and acted as protective factors against the development of) STS.

#### 4.2. Protective factors

The aforementioned information highlights how potential confounders (risk factors for the development of STS as per the extant literature: [27]) are related to STS. The main aim of the present study was to investigate how workplace supports were related to STS as the current literature is lacking with regard to investigation of protective or mitigating factors of STS among victim advocates. Yet, they play a prominent role in the victim's life. Therefore, structured approaches to decrease susceptibility to burnout and STS for victim advocates were warranted. The literature has shown that educational and/or skill trainings, with a focus on self-care, have decreased burnout and STS; organizational approaches encompassed alterations in the work process, which increased and improved supervision and increased autonomy and control at work [28]. While such approaches can help with burnout after it has occurred, there is a need for prevention of burnout from occurring in the first place [2]. Thus, examining which workplace supports may mitigate the development of STS was important. This study did not find that the availability of formal emotional supports (support groups or counseling), educational supports, or mindfulness-based interventions reduced the rates of STS.

**Table 5**

Summary of linear regression analysis for variables predicting STSS avoidance subscale

| Variable                        | B      | SE B  | $\beta$ |
|---------------------------------|--------|-------|---------|
| Mindfulness-based interventions | -0.69  | 1.637 | -0.043  |
| Educational support             | -1.57  | 2.092 | -0.076  |
| Emotional support               | -0.468 | 1.175 | -0.04   |
| Direct hours***                 | 0.111  | 0.048 | 0.231   |

\*\*\* $p < .001$ .

STSS, secondary traumatic stress scale.

**Table 6**

Summary of linear regression analysis for variables predicting STSS arousal subscale

| Variable                        | B      | SE B  | $\beta$ |
|---------------------------------|--------|-------|---------|
| Mindfulness-based interventions | 1.096  | 1.217 | 0.09    |
| Educational support             | -0.223 | 1.555 | -0.014  |
| Emotional support               | -0.396 | 0.873 | -0.045  |
| Direct hours***                 | 0.096  | 0.036 | 0.265   |

\*\*\* $p < .001$ .

STSS, secondary traumatic stress scale.

While the current literature supports the hypothesis that workplace supports are related to lower levels of STS [10], the current literature is limited because of the small sample sizes and few number of studies investigating victim advocates. Interestingly, our findings did not converge with the existing literature with regard to workplace support and STS. This led us to examine the literature that is focused on workplace supports and STS across other populations. Among the STS literature with other populations, it has been noted that workplace supports (e.g., trainings and conferences) have small negative effect sizes [7], suggesting that such structured and organizational approaches are ineffective.

Other types of supports (e.g., social support) and coping strategies may play a larger role in mitigating the risk of STS. One of the most robust findings in the trauma literature is that post-traumatic stress disorder and social support have an inverse relationship [29,30]. Thus, future researchers should examine whether helping victim advocates to increase social supports is an effective mechanism for reducing STS. Peer support also emerges as a significant predictor for reducing risk of developing STS in the extant literature [9–11,15,30], although the literature is mixed [7]; therefore, future researchers should examine peer support as a potential protective factor against STS.

With regard to formal emotional support, it may be the case that formal emotional support systems are artificial or forced and thus do not attenuate the impact of trauma-related work to the same degree. Moreover, having support systems that are outside of the workplace may also be more effective in assuaging STS. Therefore, a more individualized approach may be warranted. Interestingly Bercier and Maynard [17] conducted a systematic review of the literature on interventions for STS with mental health workers and did not find any literature to support how to intervene most effectively with mental health workers who experience STS. Future researchers should seek to establish evidence-based treatment guidelines for STS. Finally, our results did not converge with the growing body of literature that supports mindfulness-based interventions as mechanisms for stress relief (i.e., [31]). It is important to note that it cannot be ruled out that the availability of supports may not be sufficient to protect against the development of STS. One of the key limitations of this study is that we examined the availability of supports as opposed to the actual use of supports.

#### 4.3. Limitations and future directions

In addition to our examination of the *availability* of supports (as opposed to the actual available supports) as a limitation to our study, the sample size and the possibility of recruitment bias (as participants self-selected to be in the study) also represent limitations to the present study. In addition, future research studies should extend their examination of workplace supports (as there are many other types) in addition to more naturalistic forms for support (e.g., family, friends, participation in a certain membership, or activities) as past research has indicated the importance of social support in the work environment [9,10], emphasizing the social



aspects. Thus, examining advocates' support outside of work and its possible link to STS warrants investigation.

This study adds necessary information regarding the development of STS in victim advocates and relevant risk and protective factors. Victim advocates play an incredibly important role in the victim's recovery and quest for justice [32], hence ameliorating STS in this population is paramount. In addition, our findings showed that the availability of educational support was not significantly related to STSS scores, but that the subscales were all trending toward significant, which may indicate that a larger sample size is needed or that certain types of trainings (i.e., those that engender social bond) are more beneficial than others. Future research investigating how to foster social supports in work environments, what natural types of support are *protective* against STS, and what type(s) of coping strategies victim advocates use is needed to establish buffers and create interventions against.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.shaw.2019.04.001>.

## Conflicts of interest

All authors have no conflicts of interest to declare.

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