

DISSERTATION

TRAUMA-INFORMED ORGANIZATIONAL CULTURE: THE PREVENTION,  
REDUCTION, AND TREATMENT OF COMPASSION FATIGUE

Submitted by

Joni Handran

School of Education

In partial fulfillment of the requirements

For the Degree of Doctor of Philosophy

Colorado State University

Fort Collins, Colorado

Spring 2013

Doctoral Committee:

Advisor: Gene Gloeckner

Co-Advisor: Victoria Buchan

John Gandy

Carole Makela

## ABSTRACT

### TRAUMA-INFORMED ORGANIZATIONAL CULTURE: THE PREVENTION, REDUCTION, AND TREATMENT OF COMPASSION FATIGUE

Caregivers who provide services to trauma survivors are at high risk of developing secondary traumatic stress and burnout. Researchers and practitioners in the field of traumatology emphasize the role organizational culture has on individuals who provide services to trauma survivor's well-being. Although there is a considerable amount of theoretical literature on organizational culture and its effects on trauma-workers' well-being, there is a lack of empirical research. The purpose of this exploratory study was to identify what organizational characteristics influence trauma caregivers' compassion fatigue and compassion satisfaction and to construct and provide validation for a measure of the role organizational culture has on caregivers. The measure is entitled the Trauma-Informed Organization Culture (TIOC) Survey. This study used data from a sample of 282 individuals who provide services to survivors of trauma including 67 animal control officers, 102 child, youth, and family service workers, and 113 individuals who work with the homeless. This research supports the literature and found several significant relationships between the independent and dependent variables. Burnout and secondary traumatic stress were negatively correlated with perceived level of organizational support and trauma-informed caregiver development with effect sizes of medium to large. A correlation was found between percentage of time providing direct services to survivors of trauma and secondary traumatic stress. As the percentage of direct trauma services increased so did the level of secondary traumatic stress. Organizational support and trauma-informed caregiver development were found to be strong predictor variables for burnout and secondary

traumatic stress. Practical implications are provided addressing the roles that organizational support, supervisory support, peer support, and trauma-informed caregiver development have in the implementation of a trauma-informed system of care.

## DEDICATION

This work is dedicated to my dogs Charlie and Maddy the Moose. Thank you for keeping me mindful of what is most important in life.

## ACKNOWLEDGEMENTS

This research would not have been possible without the help and guidance of many people. First and foremost I would like to express my deepest gratitude to the people and organizations who made this study possible. You have dedicated your lives to lessening the stress of people and animals who have experienced trauma. Your hard work and devotion has not gone unrecognized.

I want to give a heart-felt thanks to my committee members Dr. Vicky Buchan, Dr. John Gandy, Dr. Gene Gloeckner, and Dr. Carole Makela. I am forever grateful for your patience and the direction you gave me during my PhD program. I want to specifically thank Dr. Carole Makela for her countless and invaluable revisions and feedback. You challenge me to be a better writer and critical thinker. I want to also thank Dr. Gene Gloeckner for providing me with boundless guidance throughout my entire doctoral program. You took the time out of your busy schedule to support me with weekly meetings while I was analyzing and writing up my data. Your positive and supportive emails are what kept me going when I wanted to quit. I want to thank Dr. Vicky Buchan for creating and building my passion for research ever since I attended the MSW program nine years ago. Your passion for research and teaching ignited a desire in me that continues to grow. I want to thank Dr. John Gandy for being a great leader, mentor, and teacher to me that started when I was in the MSW program. Your help has continued through my PhD program. Dr. Vicky Buchan and Dr. John Gandy recommended that I pursue a PhD and I am so glad that I followed their advice!

I want to acknowledge my friends at the Empowerment Program, many of whom still feel like family to me. Joyce Kennedy, LCSW, for introducing me to the concept of trauma-informed care and for being patient with me while I was growing and learning as a new social worker. I reflect on what you taught me every day in my social work practice. Thank you Tracy Gano, LCSW, for willing to be a support to individuals who may have felt distress from participating in the study. Finally I want to thank my family who always supported me and my decisions and my friend Caitlin Lindquist who sat countless hours with me at the coffee shop writing our dissertations. I could not have done it without any of you.

# TABLE OF CONTENTS

	<b>Page</b>
Abstract.....	ii
Dedication.....	iii
Acknowledgements.....	iv
Table of Contents.....	vi
List of Tables.....	x
List of Figures.....	xii
Chapter 1. Introduction.....	1
Emotional Contagion.....	5
Statement of the Problem.....	11
Purpose of the Study.....	13
Conceptual Framework.....	13
Research Question.....	17
Definition of Terms.....	19
Researchers Assumptions.....	23
Limitations.....	24
Chapter 2.Literature Review.....	26
Professional Quality of Life.....	27
Who is at Risk for Compassion Fatigue?.....	27
Child, Youth, and Family Workers.....	28
Individuals Who Work with Homeless Populations.....	29
Non-Human Animal Care/Animal Control Workers.....	31

Organizational Culture.....	33
Trauma-Organized Organizational Culture .....	34
Trauma-Informed Systems and Organizational Culture: Components of a Trauma-Informed Organizational culture .....	38
Safety .....	40
Support.....	41
Trauma Awareness.....	47
Trauma Training .....	48
Trauma Responsiveness.....	49
Chapter 3. Methodology .....	51
Research Questions.....	52
Research Design.....	54
Sampling .....	54
Instrumentation .....	55
TIOC .....	56
Demographics .....	58
ProQOL.....	58
Data Collection .....	59
Data Analysis .....	60
Ethical Issue .....	65
Chapter 4. Data Analysis .....	67
Data Screening and Testing and Assumptions.....	67
Participant’s Profile .....	67
Validity and Reliability of Research Instruments.....	70
New Research Questions and Data Analysis .....	73



Chapter 5. Discussion .....	98
Trauma-Informed Organizational Culture .....	98
Trauma-Informed Organizational Culture Survey .....	100
Research Highlights .....	101
Important Findings and Conclusion.....	102
Strongest predictor Variables of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction .....	104
Individual Items on the TIOC .....	107
Trauma-informed systems of care .....	109
Limitations .....	111
Future Research .....	112
Researcher’s Reflection .....	114
References.....	117
Appendix A.....	129
Appendix B .....	134
Appendix C.....	139
Appendix D.....	141
Appendix E .....	142
Appendix F.....	143

## LIST OF TABLES

Table 1. Highest Level of Education (N = 278), Percentage of Direct Trauma Service (N = 282), and Years Working in the Field of Trauma (N=283).....	69
Table 2. Factor Loadings for the Rotated Factors.....	71
Table 3. Levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction, Descriptive Statistics.....	75
Table 4. Levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction.....	75
Table 5. Animal Control Officers, Child Welfare Youth and Family Services, and Individuals Who Work with the Homeless, Means and Standard Deviations .....	78
Table 6. One-Way Analysis of Variance for the Effects of Groups—ACO, CYFW, and Homeless on Levels of Supervisory Support, Peer Support, Organizational Support and Trauma-informed Caregiver Development.....	79
Table 7. Means, Standard Deviations, and Correlations of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction and the Variables Supervisory Support, Peer Support, Organizational Support, Trauma-Informed Caregiver Development and Years Working in the Field of Trauma.....	81
Table 8. Means, Standard Deviations, and Correlations of Burnout, Support, Peer Support, Organizational Support, Trauma-Informed Caregiver Development and Years Working in the Field of Trauma.....	82
Table 9. Predictor Variables for Burnout, Means, Standard Deviations, and Intercorrelations (N = 256) .....	83
Table 10. Simultaneous Multiple Regression Analysis Summary for Burnout, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N = 256) .....	84
Table 11. Predictor Variables for Secondary Traumatic Stress, Means, Standard Deviations, and Intercorrelations for (N = 258) .....	85

Table 12. Simultaneous Multiple Regression Analysis Summary for Secondary Traumatic Stress, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N = 258).....	86
Table 13. Predictor Variables for Compassion Satisfaction, Means, Standard Deviations, and Intercorrelations for (N = 258) .....	87
Table 14. Simultaneous Multiple Regression Analysis Summary for Compassion Satisfaction, Supervisory Support, Peer Support, Organizational Support, and Trauma Education (N = 256).....	88
Table 15. Pearson Correlations Between Levels of Burnout and TIOC Individual Items, Not Included in Inferential statistics .....	92
Table 16. Pearson Correlations between Levels of Secondary Traumatic Stress and TIOC Individual Items, Not Included in Inferential Statistics .....	94
Table 17. Pearson Correlations between Levels of Compassion Satisfaction and TIOC Individual Items, Not Included in Inferential Statistics .....	96

## LIST OF FIGURES

Figure 1. Researchers Conceptualization of a Trauma-Informed System of Care .....	39
Figure 2. Histograms Demonstrating Distribution of Data for the Levels of Burnout, Secondary Traumatic Stress, and Compassion fatigue .....	76
Figure 3. Researchers New Conceptualization of a Trauma-Informed System of Care .....	110

## CHAPTER 1

### INTRODUCTION

Individuals who provide services to survivors of trauma are at heightened risk of becoming traumatized themselves (Figley, 1995; Saakvitne & Pearlman, 1996; Stamm, 2002). Social workers, counselors, child, youth, and family workers, nurses, clergy, and other caregivers work closely with individuals who have lived through horrendous experiences. Hearing story after story of terror may take a toll on caregivers and lead to feelings of stress, exhaustion, and burnout.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2000) describes trauma as either direct experiences of traumatic events such as physical assaults, torture, military combat, sexual assault, sexual abuse as a child, accidents, natural disasters, or witnessing or perceiving trauma including death of a loved one, learning a loved one has a serious illness, or has been in a serious accident. Saakvitne, Gamble, Pearlman, and Tabor (2000) claim

An event or situation creates psychological trauma when it overwhelms the individual's perceived ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual feels emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss (p. 5).

Trauma is a subjective experience and although an event may be not be traumatizing to one person, the event may be extremely traumatizing to another person. Today, crisis and traumatic events occur far too often. Millions of people are affected every year by problems associated with trauma that they cannot resolve on their own. Van Der Kolk and McFarlane (1996) claim "trauma is an essential part of being a human" (p. 3). Reynolds and Turner (2008)

found in their trauma study of 1,986 individuals, over 1,600 of the sample experienced some sort of traumatic crisis event during their lives, only 372 of their sample reported no traumatic event. These findings are not unique. In a sample of 2,181 individuals living in the Detroit area during 1996, Breslau et al. (1998) examined the prevalence of trauma event history and the onset of post-traumatic stress disorder (PTSD) and found 89.6% of the sample had experienced at least one traumatic event in their life prior to data collection and approximately 11.4 percent of women and 19.7 percent of men reported experiencing at least three traumatic events prior to data collection.

The number of individuals in the general population with exposure to trauma is high, but it is even higher in populations who seek the services of social workers and other caregivers (Bride, 2007; Knight, 2004). Many individuals who seek the services of social workers have suffered from more than one traumatic experience and deal with complex trauma from multiple ongoing traumas throughout the life span. Complex trauma usually instigates a series of difficult issues and many trauma survivors suffer from multi-occurring illnesses including mental illness, substance abuse, and homelessness (Christensen, Hodgkins, Garces, Estlund, Miller, & Touchton, 2005; Kim, Ford, Howard, & Bradford 2010; Milford, 2008; Padgett, Hawkins, Abrams, & Davis, 2006). Individuals with trauma histories also have high rates of criminal justice involvement (Bride, 2007) and may be incarcerated in detention centers, jails, or prisons. Trauma is also correlated with involvement in other risky behaviors, such as prostitution or injection drug use, that may lead to HIV or Hepatitis C (Medrano, Hatch, Zule, & Desmond, 2003) or further violence and victimization.

The Adverse Childhood Experiences Study (ACEs) funded by Kaiser Permanente and the Center for Disease Control and Prevention is the largest epidemiological study to date that

looked at the connection between childhood trauma, adverse childhood experiences (ACE), and adult behavioral and health outcomes (Anda & Felitti, 2003). These ACEs include physical, emotional, and sexual abuse, and household dysfunction including violence, substance abuse, an incarcerated parent, a parent with a severe and persistent mental illness, or the loss of one biological parent regardless of cause. The researchers asked 26,000 individuals to participate in this study and had a response rate of 71% (Felitti, 2002), and of those in the sample, 75% of the participants reported having experienced at least one ACE. Of the participants who reported experiencing at least one ACE, 87% reported at least one other ACE with 70% reporting two or more others, and more than 50% of the sample experiencing three or more ACEs (Anda & Felitti, 2003, p.1).

Since the 1970s multiple crisis intervention organizations and programs were developed in the United States including battered women shelters, hospital emergency rooms, suicide prevention hotlines, environmental and national disaster response teams, and other trauma centers. These organizations provide crisis services to individuals suffering from accidents, crime victimization, violence, abuse, and psychiatric emergencies (Roberts, 2000). It is essential for caregivers of these organizations to provide unbiased assessments, incorporate best practices, and show compassion and empathy toward clients (Figley, 2002). To continuously provide a model of excellent service can be very taxing on workers. Valent (2002) claims “attunement and effort needed to help others in trouble may provide great rewards for caregivers when they are met with success, but when they are strained, or worse, when they fail, helpers may be the next dominoes who follow primary victims in suffering themselves” (p. 17).

Trauma survivors have complex issues that often prevent them from receiving comprehensive care and it is these complex issues that create barriers for the caregivers and

organizations that provide care. Trauma survivors are over-represented among those seeking support and often treatment providers are ill-prepared and lack needed training to provide appropriate and effective treatment (Henry, Richardson, Black-Pond, Sloane, Atchinson, & Hyter, 2011; Knight, 2004).

Caregivers who provide counseling, crisis alleviation, and other needed services to severely traumatized people often work in highly stressful situations and are at high risk of developing burnout and secondary traumatic stress, collectively known as compassion fatigue (Stamm, 2009). Caregivers plagued with burnout or secondary traumatic stress may become flooded with negative feelings such as hopelessness, exhaustion, and frustration. Often these individuals find a shift in their view of others; usually from being a caring person of others to a non-caring person of others. Individuals plagued with burnout often start to view people as negative, focus on problems, and are unable to provide positive feedback (Maslach, 1982).

Bride (2007) found in his study of compassion fatigue among social workers ( $n = 294$ ) who provided services to trauma survivors that 55% of caregivers experienced some diagnostic criteria for Post-Traumatic Stress Disorder (PTSD), 20% met two diagnostic criteria, and over 15% met all three core diagnostic criteria for a PTSD. These outcomes indicate that caregivers, who work directly with traumatized people, are twice as likely as the general population to experience symptoms of PTSD. One interpretative phenomenological qualitative study completed by Iliffe and Steed (2000) looked at compassion fatigue among 18 clinicians who provided services to perpetrators and survivors of domestic violence. These researchers found in addition to clinician's personal impact from hearing the traumatic stories their clients experienced, particularly with children, over half of the sample experienced changes to their world view and cognitive schemas including feeling less secure and safe in the world.



## **Emotional Contagion and the Spread of Compassion Fatigue**

Caregivers are affected by others and the emotions of other individuals in their environment, including disturbing emotions, can be contagious (Cozolino, 2006).

Trauma always creates a ripple effect, the same as when someone throws a stone in a pond. The shock-waves soon move beyond individual caregivers to influence the organizations and systems in which we work and, ultimately the society as a whole (Dernoot Lipsky & Burk, 2009, p. 17).

Caregivers can be collectively affected by the direct work provided to suffering clients, leading to a traumatized system (Bloom, 2006). Mental abilities decrease when caregivers are under distress (Goleman, Boyatzis, & McKee, 2002), and these feelings can be contagious to other caregivers in the environment, affecting an entire organizational culture (Hatfield, Cacioppo, & Rapson, 1994; Hormann & Vivian, 2005). Organizational systems may actually start experiencing the same symptoms such as changes in world view or identity and, like individuals, may become traumatized. Eventually, individual's stressful emotions can take a toll on an organizational climate, become part of the embedded system and contagious to all workers (Hormann & Vivian, 2005).

Although working with traumatized clients can create stress on trauma workers, organizational dynamics play a large role in generating worker stress (Ross, Altmaier, & Russel, 1989). Helpers who work with survivors of trauma are at high risk for feeling the pressures of their clients, especially if they work in an environment that is not supportive of their needs. Program administrators often overlook the impact of the environment on compassion fatigue and time and again it is the social environment, such as the workplace, that is the main contributor to employee's burnout (Maslach & Leiter, 1997; Ross, Altmaier, & Russel, 1989).

When compassion fatigue hits critical mass in the workplace, the organization itself suffers. Chronic absenteeism, spiraling worker's compensation costs, high turnover rates, friction between employees, and friction between staff and management are among some

of the organizational symptoms that surface, creating additional stress on workers (Compassion fatigue Awareness Project, 2008, n.p.).

Caregivers and organizations are unable to provide effective treatment and other trauma services when plagued with burnout and secondary traumatic stress and, ultimately, it is the people seeking help, the caregiver, and the entire organization that suffer. Traumatized systems may occur for various reasons including direct or indirect experiences, may arise suddenly or over time, and be the result of external or even internal dysfunctions (Bloom & Farragher, 2011).

Literature exists on the importance of leadership in business, government, and military sectors, but there is very little empirically based research on the role of leadership in non-profit organizations and in the field of social work (Mary, 2005; Riggio & Smith-Orr, 2004; Rowold & Rohmann, 2009), specifically in trauma-work. The social work and mental health literature does not provide adequate guidance to organizational leadership. Many agencies must turn to other fields like business or organizational performance and change (Bloom, 2006) for leadership education. Although the helping professions can learn from existing empirical literature, individuals providing services to trauma survivors have unique leadership needs that may be different from other professions. Sole reliance on this literature is problematic.

While the literature provides information on what supervisors and organizations can do to prevent and lessen compassion fatigue, such as self-care education, case load size management, and time for reflection, there is a lack of empirical evidence to validate the effectiveness of these approaches. In addition, most information is on what individual helpers must do to prevent such problems and frequently this information does not include organizational strategies for the prevention, reduction, and treatment of compassion fatigue (Richardson, 2001). Although self-care is crucial, agencies must look at the role organizational culture has on employee well-being

because it is often the workplace environment that increases worker stress and makes caregivers more susceptible to developing compassion fatigue.

Often helpers work in environments that do not recognize, understand, or validate the existence of compassion fatigue. To provide adequate trauma-informed care to survivors of trauma, agencies must address the organizational and leadership factors that may strengthen or worsen worker compassion fatigue thus leading to organizational accomplishment or decline and the delivery of inadequate services. Compassion fatigue must be looked at from an organizational and systems perspective because when workers become burned out or fatigued from their work it not only affects the workers but the entire system.

There are certain organizational components found throughout the related literature that trauma scholars assert are crucial for preventing or reducing the effects of compassion fatigue in the workplace. This list includes the components

- safety, both physical and emotional safety ( Bell, Kulkarni, & Dalton, 2003; Pearlman & McCay, 2008; Traumatic Stress Institute, 2008),
- support, which includes organizational support, supervisory support, and peer support (Harrison & Westwood, 2009; Knight, 2004; Maslach, 1982; Pearlman & McKay, 2008; Perry, 2003) and,
- trauma awareness, which includes trauma training and trauma responsiveness (Harris & Falot, 2001; Jansen, 2004; Pearlman & McCay, 2008; Rosenbloom, Pratt, & Pearlman, 1995; Saakvitne & Pearlman, 1996).

**Safety.** At first glance human services jobs may appear safe, but according to the Occupational and Safety Health Administration (OSHA), health care and other social service workers are at increased risk for employment-related violence (OSHA, 2004). One study conducted by the National Association of Social Workers (NASW) and the Center for Health Workforce Studies (N = 4,940) found 44% of the social workers who responded faced safety

issues in their primary place of employment and 30% felt their employers did not address these safety concerns appropriately (Whitaker, Weismiller, & Clark, 2006).

Because trauma workers are at heightened risk for experiencing violence or other dangerous situations, staff and client safety should be a top priority in a trauma-informed system. Safety is crucial for human growth and individuals who work with victims of trauma must feel both physically and emotionally safe to thrive and take risks at the workplace. If a human being does not feel safe, they are continuously experiencing the mammalian visceral response to fight, flight, freeze, or fold (Levine, 2010). When an individual senses danger their parasympathetic nervous system goes into a state of hyper-arousal and if the threat is continuous a person nervous system will stay in an agitated and unbalanced state.

Chronic stress and traumatic events can destroy a person's sense of safety in the world. One of the signs of traumatic stress and secondary traumatic stress is a change in a person's perception of the world from a safe place to a dangerous place of pain and suffering. Kees (2009) cites Abraham Maslow and states "Second only to physiological needs on Maslow's hierarchy of needs, a sense of safety and security is an important, if not vital, step toward human beings fulfilling their higher-level needs of self-esteem, love and belonging, and self-actualization" (p. 15). Timpson (2009) states "A climate of trust and personal safety is important for self-exploration and openness to other areas and experiences" (p. 254). It is impossible for individuals to provide effective trauma-informed services if they are constantly feeling threatened and their nervous systems are not in a balanced state. A safe workplace will allow caregivers to flourish and provide comprehensive and effective treatment and other services to trauma survivors.

**Support.** A supportive environment is also central to ensure caregivers have the assistance and sustenance needed to provide effective treatment services. Trauma workers must feel support from their co-workers, supervisors, and organizations. Harrison and Westwood (2009) recommend, based on the findings of their qualitative study, that organizational support, supervisory support, and peer support helped reduce compassion fatigue. These authors found such practices stabilized practitioners in the professional community and reduced feelings of anxiety, despair, distress, and feelings of isolation.

**Organizational support.** Organizational support is the collective elements or Gestalt of an agency that make it trauma-informed. Organizational leaders possess the most power in an organization and have the highest responsibility to ensure a workplace culture increases employee well-being and reduces stress and institutional trauma. Leaders must develop, implement, and follow through with programs, policies, and procedures that prevent, lessen, and treat the effects of compassion fatigue. Although empirical evidence is limited on what these practices entail, the theoretical literature provides a solid foundation on what organizations can do for staff. A trauma-informed system is not just about hiring trauma experts and implementing a trauma-specific intervention, but encompasses all of the characteristics of an organization including how staff are supported and treated. These practices, policies, and procedures include

- adequate training and professional development (Harris & Fallot, 2001; Jansen, 2004; Pearlman & McCay, 2008; Rosenbloom, Pratt, & Pearlman, 1995; Saakvitne & Pearlman, 1996);
- ongoing and sufficient supervision to process counter-transference issues in a confidential and respectful environment (Goleman, Boyatzis, & Mckee, 2002; Roche, Todd, & O'Connor, 2007; Ross, Altmaier, & Russel, 1989);
- opportunities to voice their concerns and provide feedback on the organization and practices that affect their jobs through empowerment (Bloom, 2006; Bloom & Yanosy-Sreedhar, 2008);
- variance in workday activities including supervision, group work, research, grant writing, and training (Saakvitne & Pearlman, 1996);

- health care plans that include affordable and confidential mental health services (Bell, Kulkarni, & Dalton, 2003; Harrison & Westwood, 2009; Pearlman & McCay, 2008; Saakvitne & Pearlman, 1996); and
- paid time off and encouragement to use this time for vacations or illness (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

***Supervisory support.*** Supervision is essential for individuals who work with trauma survivors to provide effective client care (Knight, 2004) and prevent or reduce the effects of compassion fatigue (Goleman, Boyatzis, & Mckee, 2002; Ross, Altmaier, & Russel, 1989). Individuals, despite educational level or professional affiliation, who provide trauma services at an agency, should receive ongoing and adequate supervision. This supervision should focus more on the caregiver as opposed to mere client case consultation. Trauma-informed supervision should be separate from administrative supervision (Roche, Todd, & O'Connor, 2007) and may be in modes of individual, group, case conferences, seminars, and informal consultation. The supervision culture must nurture a safe and respectful environment for helpers working with complicated issues (Pearlman & McKay, 2008).

***Peer support.*** Positive relationships within the workplace provide professional, social, and emotional support for trauma service providers (Bahraini, 2008) and have been found to be more effective than supervisory support in combating compassion fatigue (Schwartz, 2008). Figley and Roop (2006) claim supportive colleagues help trauma professionals bounce back from negative emotional experiences

A positive work environment includes workers who care about each other and show it. They genuinely like one another, and they may joke around and/or pitch in when needed and often without being asked to do so. They pick up on subtle mood changes of fellow workers and ask them in a caring and supportive manner (p. 10).

Co-worker relationships reduce isolation and provide a safe and supportive environment for individuals to process negative feelings associated with burnout and secondary traumatic stress.

If unsupportive or unstable, these relationships may create stress and may be a major cause for burnout.

**Trauma awareness.** In addition to safety and support, trauma awareness is crucial in the prevention and reduction of compassion fatigue in individuals who provide services to survivors of trauma. Trauma awareness includes agency-wide training on at least basic introductory information about trauma (Bloom, 2006, Harris & Fallot, 2001) and education on the importance of self-care (Saakvitne & Pearlman, 1996). Many organizations send contradictory messages to staff about self-care. One example of this inconsistency is a supervisor who encourages self-care activities, but schedules mandatory meetings during the lunch hour.

On top of providing important training for staff, a trauma-informed agency fosters an environment that is responsive to trauma and does not deny worker's compassion fatigue. Trauma responsive organizations promote a culture that is conducive to the prevention, awareness, and treatment of compassion fatigue (Saakvitne & Pearlman, 2006) by creating policies and procedures and implementing them with trauma-responsive practices.

### **Statement of the Problem**

Although working with trauma survivors may place heavy stress on workers, it is often the workplace environment and working conditions that generate most pressure for trauma workers. An online anonymous survey, conducted by the National Association of Social Workers (NASW) in 2007, reported it was the work environment, not clients, that caused most of the stress with social workers (N = 3,653). Many of those who completed the survey felt they had too high of a workload and did not have enough time to finish their work each day. Many

experienced psychological distress and almost three quarters of the respondents felt they suffered from fatigue on the job (Dale, 2008).

Agencies may become cumulatively affected by the direct work provided to clients. When staff experience compassion fatigue from working with trauma survivors it can damage organizations in numerous ways and may lead to organizational issues such as low employee morale, high staff turnover, and, ultimately, delivery of inadequate services. Agencies become a trauma-organized system where “The internal atmosphere remains stressful, and stress becomes an organizing framework, a lens through which the work is experienced. The interplay of atmosphere and organizing framework results in a culture partially defined by its stress” (Hormann & Vivian, 2005, p. 164). Traumatized systems breed high rates of caregiver burnout and secondary traumatic stress. These trauma-organized agencies ultimately provide ineffective services and may re-traumatize the person accessing services.

Creating a trauma-informed work culture may lead to lower levels of compassion fatigue; improved compassion satisfaction, and ultimately more effective client care and positive treatment outcomes. Due to the already demanding nature of working with trauma survivors, a trauma-informed organizational culture is crucial for employees to thrive and provide trauma informed services to clients in need. The goal of trauma-informed services is to lessen stress to the person receiving services (Harris & Fallot, 2001). Therefore, the goal of a trauma-informed organizational culture would be to provide a workplace environment that does not create more distress to workers providing the services to trauma survivors. If workers are traumatized as caregivers, how will they be compassionate and provide effective services?



## **Purpose of the Study**

The goal of this research is to improve culture in organizations that provide services to trauma survivors. This exploratory research aims to begin to bridge the gap between the theoretical literature and empirical research by identifying relationships among the variables of safety, support, and trauma awareness and worker's compassion fatigue and compassion satisfaction. This researcher provides over 12 years of experience providing services to individuals who have experienced ongoing developmental trauma (Bloom & Farragher, 2011) and supervision of case managers and clinicians who provided front-line services to trauma survivors. It is the intent of this research to connect the theoretical knowledge in the field of trauma work with empirical research to validate if what the literature claims actually reduces compassion fatigue in helpers providing services to trauma survivors.

This study will expand the understanding of how caregiver's perception of safety, support, and trauma awareness affect their level of compassion fatigue and compassion satisfaction. This research will help contribute to the literature of social work leadership, particularly in the field of trauma. The research seeks to increase dialogue on improving organizational cultures in agencies that work with trauma survivors to prevent and reduce caregivers' compassion fatigue, increase caregivers' compassion satisfaction, and ultimately improve the effectiveness of trauma-informed care to trauma survivors.

## **Conceptual Framework**

### **Systems theory and the trauma-organized versus trauma-informed system.**

According to Kast and Rosenzweig (1972) organizational systems theory should serve as a foundation for understanding organizations and leadership. Schein (1996) claims that

organizations have focused solely on an individual's psychology and ignored the organization's collective psychology. "It is these norms or 'shared, tacit ways of perceiving, thinking, and reacting' embedded in an organization's culture and psychology that are perhaps the most powerful force operating in organizational systems" (Schein, 1996, p. 3).

Systems theory is the central theory needed to understand a trauma-informed and a trauma-organized system. Systems theory allows the researcher to view compassion fatigue from a larger systemic perspective, the organization level, as opposed to the individual level. As stated earlier, it is the collective components or culture that makes a system trauma-informed. Systems theory helps us understand the complexities of organizations and how the interconnected relationships within these living systems may promote caregivers' well-being or increase stress and compassion fatigue.

A person cannot be understood without examining his/her environment. The system's perspective helps us understand how caregivers' perception of their work environment affects their well-being. Group or collective psychology cannot be examined without understanding the role of emotional contagion and how groups of individuals transfer feelings. Hatfield, Cacioppo, and Rapson (1992) define emotional contagion as "the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person's and consequently, to converge emotionally" (pp. 153-154). Emotional contagion often occurs at an unconscious level (Hatfield, Cacioppo, & Rapson, 1994) and is a primitive process that humans share with other animals. Levine (2010) claims the human body's natural survival response, like other animals, is to evaluate other bodies and to immediately and unconsciously take action when we perceive threats in the environment. It is during stressful or threatening

experiences when “rational deliberation could compromise survival by confusing and slowing us down” (p. 44).

Levine asserts that although this reaction is important for survival it can be counterproductive. “We should not underestimate how compelling instinctual fear reactions are and how readily they can become maladaptive” (p. 46). Levine uses the example of a fire in a theatre and “As each person mirrors the fear posture of those nearby, he or she simultaneously senses fear and transmits that fear posture to others in the group. Transmittance of fear through postural resonance creates an escalating situation, a positive feedback loop (with negative consequences). Panic contagion can spread to the whole group almost instantly” (p. 46).

Under stress our perceptions are extremely impaired and we often resort to immediate action instead of thinking about the situation and making planned actions (Bloom, 1999). The way we develop memories is impaired when dealing with stress. People tend to focus more on negative information or emotions than positive emotions (Barsade, 2002), and this focus makes the spread of compassion fatigue more likely for individuals who work with trauma survivors and work in chronic stressful environments.

Habitually, stress is dealt with by creating rigidity. At the organizational level when something traumatic happens, organizational reactions often parallel individual’s responses to trauma. When tension takes over a workplace it is human nature to create more rules and regulations to prevent further problems, these knee-jerk reactions may actually diminish quality of care and leave staff and clients confounded (Richardson, 2001). Bloom and Yanosy-Sreedhar (2008) state

Organizations committed to working with troubled individuals all face enormous stresses. Unfavorable financial, regulatory, social, and political environments can adversely impact organizational functioning and, under these circumstances, it is relatively easy to lose sight of the mission, goals and values that should guide work.

Over time, stressed systems can become reactive, change-resistant, hierarchal, coercive and punitive. Traumatized organizations may begin to exhibit symptoms of collective trauma similar to those of their clients, creating a trauma-organized culture (p. 41).

The priority of a trauma-informed system is to promote openness. Sheafor and Horejsi (2008) explain that the word niche is used in ecological systems theory to describe certain environments where organisms flourish. For example, a plant needs proper soil, water, drainage, and sunlight to thrive. Different species have different needs and certain environments promote prosperity. In trauma-informed practice settings certain conditions or niches are needed to promote safety and growth for workers. The workplace environment may either prevent or ameliorate stress and burnout or may be a major contributing factor. If individuals feel safe, connected, and supported by their agency and are provided with the tools to work effectively with trauma survivors, they too will flourish. This prosperity will ultimately lead to lower levels of compassion fatigue and increased levels of compassion satisfaction and quality of client care. The goal of creating a trauma-informed organization is to enhance organizational resilience to trauma, improving overall organizational health and functioning (Hormann & Vivian, 2005), and increasing the effectiveness of care to trauma survivors (Harris & Falot, 2001; Sharp, 2013).

Cameron's (2008) work on virtuous systems, positive leadership, and positive climate in the organizational literature resembles that of a trauma-informed system. Cameron, Bright, and Caza (2004) claim moral goodness, human impact, and social betterment are the main attributes of a virtuous system and "virtuousness does not stand in opposition to concepts such as citizenship, social responsibility, or ethics, of course, but it extends beyond them" (p. 770). In virtuous organization behaviors such as compassionate or courageous acts are acknowledged and appreciated. "Virtuousness become self-reinforcing and fosters resilience against negative and challenging obstacles" (Cameron, Bright, & Caza, 2004, p. 770). Virtuousness emphasize that the two greatest characteristics of a virtuous system are "its amplifying qualities, which can

foster escalating positive consequences, and its buffering qualities, which can protect against negative encroachments” (p. 770), thus increasing performance and treatment or service outcomes. As explained earlier in systems theory, a caregiver’s environment, including the employing organization, plays a major role in his/her well-being. A virtuous system may prevent or reduce stress and compassion fatigue while a trauma-organized system may increase stress and compassion fatigue among caregivers who provide services to trauma survivors.

Following are the research questions for this study. Please note that these research questions changed after factor analysis was completed on the Trauma-Informed Organizational Culture survey and new constructs identified.

### **Research Questions**

Following are the six research questions that guide this study:

1. What are the levels of compassion fatigue and compassion satisfaction in the research sample?
  - a. Animal Protection
  - b. Child Protection
  - c. Individuals who work with the homeless
  
2. Are there differences in the demographics and self-reported levels of compassion fatigue and compassion satisfaction?
  - a. Type of trauma work
    - i. Animal protection
    - ii. Child protection
    - iii. Individuals who work with the homeless
  - b. Job Responsibility
  - c. Agency Size

- d. Years working in the field of trauma
  - e. Education Level
  - f. Type of Social Work Degree (If applicable)
3. Are there differences in the following demographics and perceived levels of trauma-informed organizational culture?
- a. Type of trauma work
    - i. Animal protection
    - ii. Child protection
    - iii. Individuals who work with the homeless
  - b. Job Responsibility
  - c. Agency Size
  - d. Years working in the field of trauma
  - e. Education Level
  - f. Type of Social Work Degree (If applicable)
4. Is there an association between levels of compassion fatigue and the following three variables?
- a. Perceived level of safety at the workplace?
  - b. Perceived level of support at the workplace?
  - c. Perceived level of trauma awareness at the workplace?
5. Is there an association between levels of compassion satisfaction and the following three variables?
- a. Perceived level of safety at the workplace?
  - b. Perceived level of support at the workplace?
  - c. Perceived level of trauma awareness at the workplace?

6. What are the predictor factors for compassion fatigue and compassion satisfaction?

- a. Type of trauma work
  - i. Animal protection
  - ii. Child protection
  - iii. Individuals who work with the homeless
- b. Job Responsibility
- c. Agency Size
- d. Years working in the field of trauma
- e. Education Level
- f. Type of Social Work Degree (If applicable)
- g. Perceived level of safety at the workplace?
- h. Perceived level of support at the workplace?
- i. Perceived level of trauma awareness at the workplace?

### **Definition of Terms**

Certain key terms must be defined to establish an understanding of trauma-informed organizational culture specific to this research. Following is a list of these key terms.

**Compassion Fatigue.** Compassion fatigue can be broken down into two components, secondary traumatic stress and burnout. Secondary traumatic stress is the negative emotions brought on by working with trauma survivors. Burnout is the feelings of hopelessness or exhaustion a person feels that prevents a person from doing his or her job effectively (Stamm, 2011).

**Compassion Satisfaction.** Compassion satisfaction is the contentment and pleasure one gets from helping others (Stamm, 2002).

**Emotional Contagion.** Hatfield, Cacioppo, and Rapson (1992) define emotional contagion as “the tendency to automatically mimic and synchronize expressions, vocalizations, postures, and movements with those of another person’s and consequently, to converge emotionally” (pp. 153-154).

**Emotional Safety.** For the purpose of this study, emotional safety includes moral safety, psychological safety, and social safety. “The first and most essential assumption must be the human need for safety. Our definition of safety however includes not just physical safety, but psychological, social, and moral safety as well” (Bloom, 1999, p. 12). Bloom defines these types of emotional safety as: Moral Safety “the maintenance of a value system that does not contradict itself and is consistent with healthy human development as well as physical, psychological, and social safety” (p. 12); Psychological Safety: Being able to feel safe with oneself (p. 12); and Social Safety: Ability to feel safe with other people.

**Organizational Culture.** Organizational culture is “the shared learning experiences that lead to shared, taken for granted basic assumptions held by the group or organization” (Schein, 2010, p. 21).

**Organizational Support.** Employees’ perceptions concerning the extent to which the organization values their contributions and cares about their well-being. Perceived organizational support has been found to affect employee performance and well-being (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Organizational support can be characterized into two categories including supportive tangibles and supportive empowerment. Organizations take care of their staff by offering supportive tangibles including adequate



compensation, vacation, and health benefits that include mental health services. In addition, agencies provide adequate and ongoing supervision, diversity in work duties, and realistic workloads or caseloads. Supportive empowerment is recognizable in agencies that adopt structures that empower employees, including shared governance, endorse practices that increase communication, trust, information sharing, mutual respect, and inclusive decision making (Moore, 2007). Supportive and empowering organizations value their employee's ideas and give them a voice to provide feedback and influence decision and policy making.

**Peer Support.** “The availability and quality of an employee's relationships with supervisors, coworkers, and the amount of positive consideration and task assistance received from them” (Spielberger, Vagg, & Wasala, 2003, p.192).

**Physical Safety.** People feel secure at the work place and do not feel threatened with violence toward themselves or others by staff or clients. Policies and procedures are followed to prevent work place violence including threats and physical/sexual violence.

**Professional Quality of Life.** Professional Quality of Life (ProQOL) website defines professional quality of life as “the quality one feels in relation to their work as a helper. Both the positive and negative aspects of doing one's job influence ones professional quality of life” (Professional Quality of Life, 2011, para 7).

**Safety.** Safety is characterized by two categories including physical safety and emotional safety.

**Supervisory Support.** Guidance and consultation are provided on a consistent basis by a competent staff member who is approachable, trustworthy, and authentic.

**Trauma Awareness.** Is the ability to provide a healthy workplace environment that does not re-traumatize clients or traumatize caregivers by providing services to the workers providing trauma services. Trauma awareness includes trauma training and trauma responsiveness.

**Trauma-Informed Care.** According to the Substance Abuse and Mental Health Services Administration (SAMHSA) and their National Center for Trauma-Informed Care “Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives and requires a change in paradigm from one that asks, ‘What’s wrong with you?’ to one that asks, ‘What has happened to you?’” (2011, para 3). SAMHSA claims that a trauma-informed workplace incorporates staff and survivor empowerment and both staff and survivor well-being are top priority. The National Center for Trauma Informed Care (n.d.) maintains many individuals who receive services from human service organizations suffer from histories of trauma including physical and sexual abuse. Trauma-informed care is a comprehensive collective approach that starts when the trauma survivor first contacts the agency or enters the door to receive services. Agencies committed to becoming trauma-informed must modify every aspect of their system including leadership, administration, and service delivery to prevent re-traumatization and provide supportive services to individuals requesting services.

**Trauma-Informed Organizational Culture.** A workplace that promotes compassion satisfaction while lessening the effects of compassion fatigue on workers who provide services to trauma survivors by fostering safety, empowerment, support, and trauma awareness.

**Trauma-Organized.** Bloom and Yanosy-Sreedhar (2008) describe a trauma-organized system as a system that is reactive, change-resistant, hierarchal, coercive and punitive and state

“Traumatized organizations may begin to exhibit symptoms of collective trauma similar to those of their clients, creating a trauma-organized culture (p. 41)”.

**Trauma Responsiveness.** Trauma responsiveness is described as an organization’s ability to prevent compassion fatigue, recognize when employees may be at risk for compassion fatigue, and provide treatment for staff who are affected. In a trauma-responsive workplace staff are encouraged to engage in self-care activities including physical (e.g., eating right), psychological (e.g., saying no to additional responsibilities when appropriate), emotional (e.g., spending time with others whose company one enjoys), spiritual (e.g., spending time with nature, workplace and professional (e.g., taking a break during the work day), and balance e.g., balancing of life-including work, family, relationships, play and rest) (Saakvitne & Pearlman, 1996). A trauma-responsive workplace fosters an environment that enhances empowerment for employees at all levels.

**Trauma Training.** Staff is provided with at least basic information about trauma and is given information and training on the importance of self-care and the prevention, awareness, and treatment of burnout and compassion fatigue. Trauma training is characterized by three elements

- basic education including symptoms and effects of trauma (Harris & Fallot, 2001);
- how to effectively help and empower trauma survivors using client-centered and client empowerment approaches; and
- importance of self-care to help prevent and lessen the effects of compassion fatigue.

### **Researcher Assumptions**

This researcher assumes that caregivers who work in more trauma-informed organizations will report higher levels of perceived safety, support, and trauma awareness on the Trauma-Informed Organizational Culture (TIOC) survey. These individuals will exhibit higher levels of compassion satisfaction and lower levels of compassion fatigue. Conversely, this

researcher assumes that individuals who work in a more trauma-organized agency will report lower levels of perceived safety, support, and trauma awareness at the organization and exhibit higher levels of compassion fatigue and lower levels of compassion satisfaction.

### **Delimitations**

There are limitations to this study that may threaten the validity of results including potential instrumentation, sampling, and generalizability. Currently there is no instrument that completely captures perspectives of agency levels of trauma-informed culture. The Trauma-Informed Organizational Culture (TIOC) survey (Appendices A and B) was created for this research and may not be the most reliable instrument to measure trauma-informed organizational culture. This researcher ran a pilot study to explore the introductory efficacy and increase some assurance of validity and reliability of the TIOC instrument. Cronbach's alphas were completed using the pilot study data showing strong internal reliability with construct alphas ranging from .80-.91. In the pilot test a factor analysis was not completed to establish instrument validity and the theoretical constructs the researcher intended to measure in the larger study did not end up being the same after a factor analysis was completed.

The convenience sample of agencies were used to reach three distinct types of trauma providers including individuals who work with the homeless, children, youth and family workers, and animal control officers.

## **Summary**

Using organizational systems theory and the works of Kim Cameron's organizational virtuousness framework (Cameron, Bright, & Caza, 2004), this research builds on the organizational literature for agencies that provide services to trauma survivors. Also, this research helps to strengthen the connection between the neuro-science of stress and human interaction of caregivers within organizational systems.

The goal of this study was to begin the integration of the theoretical literature with empirical research and practice implications to identify organizational factors that may lead to lower levels of compassion fatigue for individuals who work in the trauma field. Using an exploratory quantitative survey design this study sought to assist in the formation of a solid foundation for development of the Trauma-Informed Organizational Culture (TIOC) survey and determine if the constructs of safety, support, and trauma awareness had an influence on caregiver levels of compassion fatigue and compassion satisfaction.

## CHAPTER 2

### LITERATURE REVIEW

When trauma workers become overwhelmed by hearing story after story of horrific experiences they may start to feel emotionally exhausted, stressed, and burned out. This stress is not without repercussions and can lead to poor quality of professional life (Figley, 2002). Negative emotions become contagious to others (Barsade, 2002) thus having destructive effects on teams and organizations. Traumatized organizations experience the same symptoms as individuals who have experienced trauma (Bloom, 2006). If individuals and organizations become traumatized from their work, then it is less likely for them to provide effective services to individuals in need. In fact, these systems can actually cause harm to the client.

There are specific organizational components trauma scholars assert are crucial to promote an organizational culture that is conducive to the prevention and reduction of compassion fatigue. These features include the caregivers' perceptions of their organizations level of safety, support, and trauma awareness. The literature review begins with the definitions of compassion satisfaction and compassion fatigue and explains the risks caregivers face. The theoretical foundation of a trauma-informed organizational culture is then supported by the literature trauma scholars suggest supports such a workplace environment. Lastly, this literature review provides explanations and supporting research for the three components found in trauma-informed organizations that supposedly lessen the risk of compassion fatigue and increase the chance of compassion satisfaction among trauma workers including safety, support, and trauma awareness.

## **Professional Quality of Life: Compassion Satisfaction and Compassion Fatigue**

As stated in the first chapter, Stamm (2011) describes professional quality of life as the positive and negative parts of one's job and how these experiences affect the caregiver. Stamm's Professional Quality of Life (ProQol) is a tool that is often used to measure a trauma worker's professional quality of life (Stamm, 2011). It measures the two constructs; compassion satisfaction and compassion fatigue. Compassion satisfaction is the satisfaction one gains from his or her work with trauma survivors. This may include feelings of gratitude, fulfillment, and other positive emotions. The opposite of compassion satisfaction is compassion fatigue. Although there are different terms and theoretical meanings to this phenomenon, including vicarious trauma or secondary trauma, for the purpose of this study, compassion fatigue will be used. According to Stamm (2011), compassion fatigue has two components, secondary traumatic stress and burnout. Secondary traumatic stress is defined as the negative emotions brought on by working with survivors of trauma and burnout is defined as the feelings of hopelessness or exhaustion that prevents one from doing an effective job. Burnout includes emotions of exhaustion and hopelessness and the inability to deal with work or do one's job successfully. Burnout and secondary traumatic stress will be the variables measured in this study and although these two variables will be measured separately, collectively they will represent compassion fatigue.

### **Who is At Risk for Compassion Fatigue?**

Often, individuals who work with trauma survivors experience negative emotions and these feelings may lead to compassion fatigue. Caregivers at high risk for developing compassion fatigue including social workers (Bride, 2007; Horwitz, 1998), counselors who

provide services to traumatized children (Etherington, 2000; Perry, 2003), child protection case workers (Conrad & Kellar-Guenther, 2006; Friedman, 2002), nurses (Frandsen, 2010), individuals who provide services to the homeless (Olivet, McGraw, Grandin, & Bassuk, 2010), mental health workers (Newell & MacNeil, 2011), substance abuse counselors (Oyefeso, Clancy, & Farmer, 2008), clergy (Ferguson, 2007; Mandziuk, 1997), and nonhuman-animal care professionals including people who work in animal control, clinics, hospitals, the humane society/shelter, volunteers, and rescue groups (Rank, Zaparanick, & Gentry, 2009). This is not an exhaustive list as many professions provide services to trauma survivors and are at high risk of experiencing trauma directly or compassion fatigue vicariously.

**Child, Youth, and Family Workers.** A population at increased risk for developing compassion fatigue is child, youth, and family workers. Rakoczy (2011) believes one of the reasons for such high stress is that child, youth, and family workers have to assess abuse, confront the alleged perpetrator, and work closely with and maybe even testify against their clients in court. Every year over 5 million children experience trauma and abuse in the United States (Perry, 2002). In 2010, over 3.3 million suspected child abuse/neglect referrals were made to child protection agencies in the United States (U.S. Department of Health and Human Services, 2011). Child, youth, and family workers have a high-demand job and often have to work more than 20 hours over the 40 hour work week to complete all of their job requirements. These demands leave many child, youth, and family workers feeling that they are given too much responsibility (Nolan, 2005). Child, youth, and family workers often have to go into dangerous home environments and witness horrific abuse or neglect of vulnerable children, an experience that can be traumatizing. Moreover, Nolan (2005) found that 90% of child, youth,



and family workers had been involved in a traumatic event on the job and 35% had been involved in a work-related death.

Jankoski (2010) found that child, youth, and family workers displayed some of the same symptoms as their clients in her qualitative research with a sample of 305 child welfare workers. Many of the study participants' trauma symptoms were actually worse than the standards of compassion fatigue defined by Figley (1995). The participants reported feelings of hopelessness, increased cynicism, lack of personal worth, inability to talk to or disconnect from loved ones, fear for personal and family safety, and a lack of trust with others. Other trauma symptoms that resembled those of Post-Traumatic Stress Disorder (PTSD) included re-occurring thoughts, depression, and avoiding public places or activities.

Due to such high stress working conditions, the average length of employment in the area of child welfare is approximately one year (Rakoczy, 2011). In Jankoski's (2010) study, poor leadership was reported as a major factor that lead to compassion fatigue as many participants reported that they did not feel supported by their supervisors. Many of the study participants discussed how supervision was punitive and shame based, administrators and supervisors appeared standoffish, and there was a lack of consistency and understanding of government regulations. Other contributions to compassion fatigue included professional shame by the media, territory issues among units and programs, and the vast amount of paperwork often viewed by leaders as more important than self-care. Nolan (2005) found that child, youth, and family workers often did not feel supported by their supervisors or their organization as leadership did not allow employees to voice their opinions or concerns.

**Individuals who provide services to homeless populations.** Another community of helpers at high-risk of developing compassion fatigue are individuals who provide services to

homeless populations. Finding affordable, adequate, and safe housing for individuals, couples, and families who are homeless is a challenge in itself, but often these populations do not suffer homelessness alone. Many individuals who are homeless suffer from multiple-occurring issues including but not limited to trauma, mental, and physical health disparities, criminal justice involvement, engagement in risky behaviors, and concurrent mental health and substance abuse concerns.

According to the Colorado statewide Point-In-Time Study (2007), conducted in winter 2007 and released that year, found that 27.5% of the population's primary reason for being homeless was due to substance abuse (27.5%) and 21.5% due to mental illness. Individuals who are homeless and who suffer from mental illness are at extremely high risk for addiction to illicit drugs (Gearon & Bellack, 1999). Being homeless may be extremely stressful and individuals who are homeless might be more likely to rely on "avoidant coping styles" such as alcohol or substance abuse (Stump & Smith, 2008).

Most women who are homeless have experienced serious ongoing trauma, including child abuse, sexual abuse, and physical abuse (Pilon, 2008). One qualitative study conducted at New York University found 70% of previously homeless women suffered from serious traumatic life experiences, 75% had been raped, most of whom had been raped multiple times (Padgett, Hawkins, Abrams, & Davis, 2006). Drug use may be a coping mechanism to deal with the harsh realities faced in their daily lives, especially in the absence of adequate support services.

Other risks many homeless individuals and families face are financial problems, family problems, suicide, violence, sexual and physical victimization, incarceration, increased diagnosis of HIV/AIDS and Hepatitis B and C, as well as early death (SAMHSA, 2003). Individuals who are homeless face numerous barriers when accessing medical care, mental health care, and

substance abuse treatment (Wen, Hudok, & Hwang, 2007). Caregivers have to help the homeless navigate multiple systems to ensure their clients' receive adequate comprehensive care or they may be part of the systems that unconsciously create these barriers.

Olivet, McGraw, Grandin, and Bassuk (2010) claim in their article *Staffing Challenges and Strategies for Organizations Servicing Individuals Who Have Experienced Chronic Homelessness* that many of the participating sites struggled with providing both comprehensive yet flexible services to meet the complex and ever-changing needs of people they served, many of whom had been turned away from the major systems of care. Many of these organizations found it difficult to support staff and prevent compassion fatigue and turnover.

**Non-human animal care workers.** One population at extremely high-risk for compassion fatigue and often overlooked is the non-human animal care community. Animal care workers include individuals who work in animal shelters and emergency animal hospitals, and animal control officers. One study conducted by the Humane Society of the United States (2003-2004) found in their sample of 1,000 animal control workers that over 56% self-reported extremely high risk for compassion fatigue. Despite the Disney produced vilified image of the evil dog catcher, non-human animal workers are drawn to the profession due to their passion and love for animals. These workers are at high risk for developing compassion fatigue for a multitude of reasons and often deal with animal suffering at the hands of humans including abuse, neglect, overpopulation with limited resources, and euthanasia.

Possibly the most stressful duty a non-human animal care worker has to perform is euthanasia. Although some of the animals have health problems that may justify euthanasia, many are healthy but simply unwanted. "The magnitude of pet overpopulation in the United States appears to make animal euthanasia a tragic and necessary reality" (Reeve, Rogelberg,

Spitzmüller, & DiGiacomo, 2005, p. 120). Reeve et al. (2005) found in their sample of non-human animal workers that euthanizing animals led to feelings of anxiety, depression and low self-worth, lack of concentration and sleep, and a disruption of daily activities. Compared to those who did not perform euthanasia, individuals who were directly involved reported significantly higher levels of work stress, somatic complaints, work-to-family conflict, and lower levels of work satisfaction. These authors found that as the number of hours engaged in euthanasia per week increased so did alcohol and other substance use. These outcomes indicate that euthanasia related work has a significant negative impact on animal protection caregiver's well-being. One animal control worker stated "You don't have to kill your patients" in the qualitative reporting of this research. These authors claim that euthanasia "creates a professional landscape that is fraught with danger and pain for many employees and volunteers" (p. 40).

The organizational factors that increase the risk for compassion fatigue for non-human animal care workers are similar for individuals providing services to trauma survivors. According to Figley and Roop (2006) these risk factors include work load, staffing levels, volume of animals, hours of operation, adoption rates, nature of the work, and the financial health of the shelter. Other factors that increase risk for compassion fatigue that resemble human trauma workers include poor leadership particularly the mentality of indispensability and relationships with co-workers.

Little research exists on the effects compassion fatigue has on animal control workers and what organizational characteristics may prevent or reduce the onset of compassion fatigue. What is known is that compassion fatigue is affected by interactions among colleagues, clients (pet owners), and social support (Figley & Roop, 2006). Risley-Curtiss, Holley, and Wolf (2006)

recommend that the social work profession team up with other disciplines to build its knowledge base regarding the animal-human connection as there is a lack of research showing the stress non-human animal care workers experience every day because of their work. A positive work environment may help prevent or reduce the effects of compassion fatigue but a negative work environment can put these workers at higher risk. Supportive colleagues can be a buffer against developing compassion fatigue and a tool to help lessen its effects.

### **Organizational Culture**

An organization's culture must be examined to understand the influence it has on employees and their levels of compassion fatigue and compassion satisfaction. As stated earlier, Schein (2010) defines organizational culture as "the shared learning experiences that lead to shared, taken for granted basic assumptions held by the group or organization" (p. 21).

Joanne Martin (2002) describes organizational culture

as the stories people tell to newcomers to explain 'how things are done around here' the ways in which offices are arranged and personal items are not displayed, jokes people tell, the working atmosphere (hushed and luxurious or dirty and noisy), the relations among people (affectionate in some areas of an office and obviously angry and perhaps competitive in another place), and so on. (p. 3)

Hormann and Vivian (2005) claim "Culture supports the experience of belonging, understanding, and acceptance, defining insiders and outsiders: it provides sense of 'home' and bounds the organizational identity" (p. 160). Organizational culture determines an organization's priorities, how the work is carried out, and who and what behaviors get acknowledged, rewarded, or reprimanded. This culture influences the psychological impact the work environment has on trauma workers (Glisson, 2007).

Organizational culture strongly affects staff's well-being, job satisfaction, morale, retention, and service quality. Glisson (2007) claims service quality outcomes are strongly correlated with organizational culture.

The norms, expectations, perceptions, and attitudes can encourage or inhibit the adoption of best practices; strengthen or weaken fidelity to established protocols; support or attenuate the relationships between service providers and consumers; and increase or decrease the ARC (availability, responsiveness, and continuity) of services (p. 737).

Culture "is an astonishingly powerful force that affects all who function within organizational settings all of the time, but it is the most overlooked force because it works indirectly and frequently at the level of nonverbal communication" (Bloom, 2006, p. 27). Hormann and Vivian (2005) believe that culture affects every part of an organization and according to Schein (1992) culture is an instrument used for "social control and can be the basis of explicitly manipulating members into perceiving, thinking, and feeling in certain ways" (pp. 19-20). Schein claims cultures often are

nonconfrontable and nondebateable because to question such underlying assumptions can bring about anxiety and rather than tolerating such anxiety levels, we tend to want to perceive the events around us as congruent with our assumptions, even if that means distorting, denying, projecting, or in other ways falsifying to ourselves what may be going on around us. It is in this psychological process that culture has its ultimate power (pp. 28-29).

### **Trauma-Organized Organizational Culture**

Bloom (1999) defines trauma as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (p. 7). Agencies that provide services to trauma survivors are at high risk of becoming collectively traumatized. These organizational systems can actually start experiencing the same symptoms as individuals who have experienced trauma, a concept known as trauma-organized (Bloom, 2006). "The empathetic skill of tuning into the emotion is a great gift to offer women and children as they

work through complicated feelings. It can also be a liability as these emotions reverberate through offices and residential spaces of shelters” (Richardson, 2001, p. 55). Trauma-organized systems may develop for various reasons including direct or indirect experiences, may arise suddenly or over time, and may be the result of external or even internal dysfunctions.

Agencies may become cumulatively affected by the direct work provided to suffering clients. Hormann and Vivian (2005) claim that eventually stressful emotions may take a toll on the organizational climate and become part of the embedded system. Workers are susceptible to their colleagues’ stress, a phenomenon known as emotional contagion. Hormann and Vivian explain that in a trauma-organized agency “The internal atmosphere remains stressful, and stress becomes an organizing framework, a lens through which the work is experienced. The interplay of atmosphere and organizing framework results in a culture partially defined by its stress” (p. 164).

Tyler (2012) proposes in her paper *The Limbic Model of Systemic Trauma* that the limbic system of caregivers are at risk of psychological and neurobiological changes when working with survivors of trauma. “Clients will project unwanted, unbearable feelings into the worker and over time the personality of the professional will become invaded as neurobiological changes occur (p. 130). Tyler asserts these changes not only affect the individual trauma caregiver but also the organization and both may adapt defense mechanism to help cope with the trauma.

The limbic model proposes that traumatised clients involved in the system are experiencing raw, unprocessed emotions of trauma. This results in activation of their amygdala which holds powerful primitive emotions associated with trauma such as fear, rage, shame and dissociation. These feelings are projected outwards into professionals working with them. It is proposed that professionals are then bombarded by these powerful projections from multiple clients and start to ‘catch’ these emotions (p. 131).

Higher level thinking diminishes as individuals and systems experience trauma and the automatic visceral response is to go into the fight (rage), flight (avoidance/fear), or freeze

(dissociation) (Tyler, 2012). The fight response of trauma is a system that is conflict ridden and uses punitive measures to help sustain control of the situation and environment. Rules and rigidity become the overlying framework to cope with the trauma of both clients and staff. The flight response is another means of coping with trauma. Individuals and systems who use the flight response to trauma are full of fear and often avoid dealing with the trauma by calling in sick and avoiding the workplace all together. Freeze, also known as paralysis or dissociation, is another instinctual response to trauma. Trauma caregivers experiencing the freeze response check out and lose all connection to their organizations, colleagues, and clients. Systems that experience the fight, flight, or freeze response can become organized by the trauma response. Trauma-organized agencies services become fragmented and ultimately systems of care suffer.

Staff exhibit high levels of burnout, secondary trauma, and low levels of compassion satisfaction in trauma-organized systems. According to the Compassion Fatigue Awareness Project (2008), some of the struggles organizations with high levels of compassion fatigue face include personnel issues such as constant changes in co-workers relationships, inability for teams to work well together, and a desire among staff members to break organizational rules. Another struggle trauma-organized agencies face include outbreaks of aggressive behaviors among staff, inability of staff to complete assignments and tasks, failure to respect other staff, and meet deadlines. Ultimately compassion fatigue leads to lack of flexibility among staff members, negativism toward management, strong reluctance toward change, inability of staff to believe improvement is possible, and lack of a vision for the future. In addition, trauma-organized agencies experience high absenteeism, high employee turnover, and professional misconduct, such as violating boundaries (Bloom, 2006).

When organizations experience trauma and make decisions under stress, their perceptions are extremely impaired and they often resort to immediate action instead of thinking about the



situation and making planned actions (Bloom, 1999). Cameron (2008) describes a positive climate as an environment that fosters positive emotions as opposed to negative emotions of stress, worry, and lack of trust. When people experience positive emotions they are more likely to take in new information, learn, increase creativity, change, and grow. These positive emotions reduce the senses that activate a person's nervous system putting them into the fight, flight, or freeze mode.

Through his research, Cameron has found that high performing positively deviant (organizations that go above expectations and show higher outcomes) organizations have different communication patterns than low performing agencies. Cameron believes virtuousness may be due to the connectivity that positive communication brings among people as opposed to the disconnect people feel when confronted or spoken to in a negative manner. Cameron's idea of virtuousness makes sense on a biological level as a human's visceral response is to attack, run, or shut down when confronted with a threat or danger whether experiencing danger in a jungle or in an unsafe work environment (Tyler, 2012). Cameron explains that because of our visceral survival instinct it is easier to remember or pay attention to negative threats or experiences than positive ones. To ignore life threatening signals can be dangerous to a person's survival. Therefore, human beings have learned to continuously evaluate their environments for danger and a human system is continuously in a state of hyper-arousal in the presence of constant perceived danger.

The way we create memories is also impaired when dealing with stress. Unlike normal memories, traumatic memories, including images, feelings, and physical sensations of the trauma, do not go away easily. Bad emotions, impressions, and memories are harder to change than good ones. Baumeister, Bratslavsky, Finkenauer, and Vohs (2001) explain from an

evolutionary perspective that individuals who are more in-tune with their environment are more likely to sense danger, thus increasing survival. Negative experiences are harder to forget than positive experiences and individuals may go on to develop negative memories about their work. These negative memories can become part of the organizational framework and create a culture that is punitive, reactive, and actually exacerbates stress instead of reducing it (Bloom & Farragher, 2011; Tyler, 2011).

Cameron (2008) claims that positive and healthy relationships provide support, learning opportunities, and enrich strength and vitality for both individuals and organizations. “Positive communication occurs in organizations when affirmative and supportive language replaces negative and critical language” (p. 51). Feeling support from one’s organization, supervisory, and colleagues (peers) provide positive effects on the hormonal, cardiovascular, and immune systems and increases physical, psychological, and emotional health. Working on people’s strengths as opposed to deficits is at the fundamental core of trauma-informed care. Promoting strengths also helps build positive supportive relationships among staff. In a trauma-informed and positive system leaders focus and celebrate the positives and strengths of the people and organization as opposed to focusing primarily on the negative. The goal of a trauma-informed organization is to promote positive well-being of individuals and organizations.

### **Trauma-Informed Systems and Organizational Culture: Components of a Trauma-Informed Organizational Culture**

The purpose of a trauma-informed organizational system is to enhance organizational resilience to trauma and improve overall organizational health and functioning (Hormann & Vivian, 2005). Trauma-informed organizations are systems that promote positive well-being for

the trauma survivors receiving services, the clinicians, and the organizational leaders. “In a trauma-informed system the human dimension should always be at the forefront, with consideration given to the whole person, regardless of whether the person is a consumer, a clinician, or a program administrator” (Arledge & Wolfson, 2001, p. 91).

Individuals must feel secure, supported and work in an environment that is conducive to well-being in order to provide effective services to trauma survivors. There are specific components crucial for an organization to promote the well-being of workers who provide services to trauma survivors. These components include safety, support, and trauma awareness. Following are complete descriptions of the factors that create a trauma-informed organizational culture. Figure 1 provides the researcher’s conceptualization of a trauma-informed system of care.

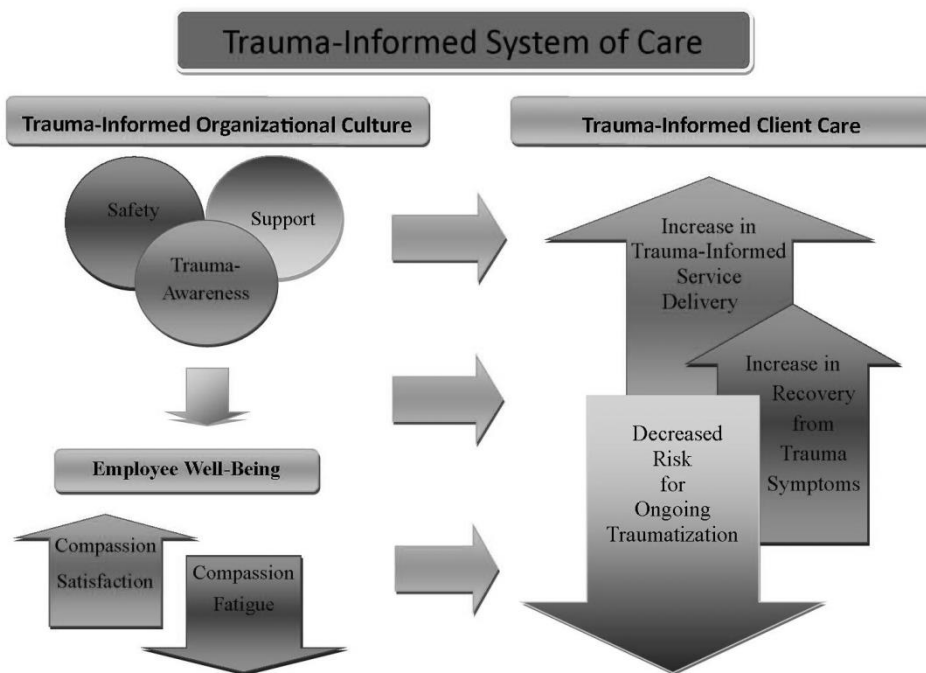


Figure 1. Researchers Conceptualization of a Trauma-Informed System of Care

**Safety.** Safety, both physical and emotional safety, are crucial in a trauma informed system (Bell, Kulkarni, & Dalton, 2003; Bloom & Farragher, 2011; Pearlman & McCay, 2008). “Second only to physiological needs on Maslow’s hierarchy of needs, a sense of safety and security is an important, if not vital, step toward human beings fulfilling their higher-level needs of self-esteem, love and belonging, and self-actualization” (Kees, 2009, p. 15). As stated earlier, safety includes both physical and emotional safety. If workers feel physically and emotionally safe at the workplace they are more likely to take risks and thrive; but what if they feel vulnerable and threatened?

Trauma is the suffering someone feels from experiencing physical, emotional, or mental pain (Cooper, Masi, Dababnah, Aratani, & Knitze, 2007), and often an individual’s sense of safety is questioned after experiencing a traumatic event. When an individual experiences trauma or a sense of danger the body activates the sympathetic nervous system and the entire system is compromised. During a traumatic experience, individuals may experience the fight, flight, or freeze response. Chronic states of stress can lead to unhealthy physical and emotional issues (Sapolsky, 1998). Bloom, an expert in the work of trauma and the originator of the Sanctuary Model, states

a traumatic experience impacts the entire person--the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people and the way we make sense of the world are all profoundly altered by traumatic experience. (1999, p. 2)

Just as victims of trauma can feel hyper-vigilant and unsafe after experiencing a horrifying event, which they had no control over; workers and entire organizations can confront parallel emotions. Once an individual or an organization experiences trauma, it sets people into a state of hyper-arousal. Individuals continuously seek other threats of danger and this state of

hyper-arousal can actually become transmittable to others sharing the same environment. Even if the potential for danger is low, individuals may perceive harmless situations as unsafe.

Threat-perceived or real-invariably induces vigilance among those who feel they are potential victims. Once vigilant, these persons, more so than others, may look for additional signs of potential danger. Thus vigilance can become a self-reinforcing process or at least one that is difficult to extinguish since in many settings, one can find what one seeks (Yang, 2009, p. 267-268).

Maslow (1943) claims if a person is consistently worried about their safety then

Practically everything looks less important than safety, (even sometimes the physiological needs, which being satisfied, are now underestimated). A man, in this state, if it is extreme enough and chronic enough, may be characterized as living almost for safety alone” (p. 376).

Individuals who have a history of trauma often experience feelings of powerlessness and helplessness (Gunn, Richburg, & Smilstein, 2007). Caregivers may feel powerless and helpless particularly if they work in an environment that lacks employee’s empowerment and support. If caregivers feel powerless and helpless, they are at risk of passing these feelings to the individuals accessing services. In addition to safety in the workplace, caregivers must feel supported by their co-workers, supervisors, and organizations so they provide effective services to trauma survivors.

## **Support**

**Organizational support.** To thrive in the workplace it is crucial for caregivers to feel supported by their organizations. Perceived Organizational Support (POS) refers to employees’ perceptions concerning the extent to which an organization values their contribution and cares about their well-being (Eisenberger, 2008). Organizations may support their employees through providing tangibles or financial support such as adequate pay and benefits and by providing non-

tangibles or non-financial support including opportunities for professional development and allowing employees to voice their concerns through structural empowerment.

POS has been found to influence employee performance and well-being (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Riggle, Edmondson, and Hansen (2009) in their meta-analysis of research, published from May 1986 to August 2006, of the relationship between POS and the job outcomes (organizational commitment, job satisfaction, performance, and intention to leave) found a strong positive association between perceived organizational commitment and job satisfaction, a moderate positive association between POS and organizational commitment, and a strong negative association between POS and intention to leave a job.

Not only does POS lead to more favorable organizational outcomes, but Shanock and Eisenberger (2006) found supervisors' perceptions of their organizations' level of support was positively associated with their subordinates' level of perceived supervisory and organizational support. Supervisors who felt supported by their organization tended to respond by being more supportive of their staff. This finding confirms the notion of emotional contagion and suggests organization support at the top permeates down to the front-line workers (N = 248).

There are specific tangible rewards that organizations should provide their employees particularly if they work with trauma survivors. These include offering ample compensation, paid leave or vacation time, and affordable comprehensive health insurance that includes confidential psychotherapy services (Saakvitne & Pearlman, 1996). In addition to material resources such as compensation and benefits, Eisenberger (2008) claims organizations must provide "socioemotional resources" such as personal value and encouragement. He states

Being regarded highly by the organization helps to meet employees' needs for approval, esteem, and affiliation. Positive valuation by the organization also provides an indication that increased effort will be noted and rewarded. Employees

therefore take an active interest in the regard with which they are held by their employer (n.p.).

These socio-emotional resources represent a variety of practices that help reduce levels of compassion fatigue including work load management, diversity in job duties, and opportunities for professional growth. Training opportunities, professional development, and mentorship practices have been found to stabilize practitioners in the professional community and reduce feelings of anxiety, despair, and isolation (Harrison & Westwood, 2009).

Organizations are obligated to support their staff by monitoring work load so it is realistic to complete responsibilities. Iliffe and Steed (2000) found in their interpretative phenomenological qualitative study that working long hours and holding a high number of domestic violence cases led to higher levels of burnout and compassion fatigue. Harrison and Westwood found in their qualitative study lack of diversity in professional roles for caregivers was a main factor in secondary traumatic stress and burnout prevention (2009). These authors stress that workers should have diverse work duties instead of non-stop direct client contact all day. Other work duties may include supervising, teaching, administration, or research (Saakvitne & Pearlman, 1996).

Trauma scholars assert that a strong component leading to compassion fatigue is high caseloads with a large percentage of the caseload being victims of severe and complex trauma (Bell, Kulkarni, & Dalton, 2003; Harrison & Westwood, 2009; Pearlman & McCay, 2008; Saakvitne & Pearlman, 1996). Organizations and supervisors must pay attention to staffs' workload and the intensity of the clients. Caregivers are at higher risk for developing compassion fatigue if they have all high-acuity, suicidal individuals with extensive histories of trauma on their case load. Burnout and secondary traumatic stress levels can be lowered through changes in organizational practices.

In addition to maintaining realistic workloads and work intensity for trauma workers, organizations must include employees in the decision making processes that affect their work and the clients through structural empowerment. Components of structural empowerment should be present in a trauma-informed organization to promote safety, trust, and invite democratic decision making among all members of an organization. Laschinger (2001) noticed in a sample of 600 caregivers that structural empowerment of staff not only reduced job strain and increased job satisfaction but also resulted in increased levels of psychological empowerment. Structural empowerment at the workplace has been found to significantly influence patients' perception of the quality of care they received and lowers risk of harm toward patients (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

Organizational leaders may think they know what is best for staff, but without feedback from employees changes may do more harm than good. Administration has the responsibility to invite staff and participants into the development of this new model of practice. Pearlman and McKay (2008), leaders in the field of trauma work, believe open lines of communication and decision making (democracy) among all levels of staff are crucial in providing an organization culture that is trauma informed. In addition to organizations, supervisors and co-workers are central in reducing the risk for compassion fatigue and increasing employee satisfaction as these key players often provide the social support for employees.

**Social support: supervisor and peer support.** Spielberger, Vagg and Wasala (2003) define social support as “the availability and quality of an employee’s relationships with supervisors, coworkers, family, and friends and the amount of positive consideration and task assistance received from them” (p. 192). These authors argue that social support, especially support by a supervisor, has a positive effect on workers’ well-being and efficiency. Adequate



and ongoing supportive supervision is fundamental in preventing burnout and compassion fatigue (Goleman, Boyatzis, & Mckee, 2002; Ross, Altmaier, & Russel, 1989) increasing self-awareness, self-care efforts (Harrison & Westwood, 2009), and reducing high staff turnover (Smith, 2005), a negative consequence of compassion fatigue.

In their qualitative study on secondary trauma among mental health therapists, Harrison and Westwood (2009) determined that supportive supervision was crucial for diminishing the risks of compassion fatigue including the emotion of feeling shameful of compassion fatigue. In addition, these authors found supportive supervision increased self-awareness and bolstered self-care efforts of the therapists. Rääkkönen, Perälä, and Kahanpää (2008) discovered in their study of long-term care workers that individuals who perceived they had low supervisory support viewed their own professional skills to be low and those who viewed their supervisors as empowering and adequate self-reported they personally felt they provided better care to their patients.

Supportive supervision focuses more on the clinician and the relationship as opposed to focusing solely on the client (Etherington, 2000). A supportive supervisor listens, solicits feedback on how to solve problems, validates experiences, and encourages open dialogue to change. Supervisors who are supportive can actually help reduce feelings of shame associated with compassion fatigue (Harrison & Westwood, 2009). Supervisors need to model effective communication and provide support, feedback, and assist helpers in maintaining boundaries with clients. Supervisors must be genuine and authentic. If staff senses their leader is fake or dishonest, distrust and the groups' productivity will falter. It is the supervisor's responsibility to be easily approachable and available to the staff. Work with victims of trauma can be

challenging both mentally and emotionally and the more demanding a job, psychologically, the more understanding and supportive a leader must be (Goleman, Boyatzis, & McKee, 2002).

Supervision can be in forms of group, individual, case conferences, seminars, and informal consultation. The supervision culture must cultivate a safe and respectful environment for helpers working with complicated issues (Traumatic Stress Institute, 2008). Some scholars argue that there is a difference between administrative supervision and clinical supervision Pearlman & McKay, 2008; Saakvitne & Pearlman, 1996). Roche, Todd, and O'Connor state this distinction is "often blurred in resource-strapped" organizations (p. 242). These authors argue there are fundamental differences between the two not only in the function and purpose but as to the relationships and interactions as well. They assert while there may be overlap between the two, it is the goal to "strive for a model of clinical supervision that minimizes power issues, ensures that skill development is not neglected in busy agencies, and accentuates the capacity for clinical supervision as a professional development tool" (p. 243). These authors believe agencies that fail to employ such practices run the risk of not providing optimal care to clients in need.

In addition to feeling supported by their supervisors, trauma workers must feel supported by their peers. Peer support in the work place provides professional, social, and emotional support to help prevent or reduce compassion fatigue (Bahraini, 2008). Maslow (1943) maintains once a person's basic and safety needs are met they yearn for a sense of belonging. Organizations should never doubt the strength of positive co-worker relationships as they are an invaluable resource in the prevention and treatment of burnout (Maslach, 1982) and secondary traumatic stress (Saakvitne & Pearlman, 1996; Schwartz, 2008).

**Trauma awareness.** Trauma awareness, which includes trauma training and trauma responsiveness (Harris & Fallot, 2001; Jansen, 2004; Pearlman & McCay, 2008; Rosenbloom, Pratt, & Pearlman, 1995; Saakvitne & Pearlman, 1996), is critical in a trauma-informed system to help caregivers provide effective services to trauma survivors. Vicarious trauma hurts organizations especially if an organization views such feelings as unprofessional. Although it is crucial for social workers and other helpers to feel safe at the workplace, a trauma-informed organizational culture does not stop at safety, but fosters a trauma-responsive environment conducive to preventing and diminishing the influences of worker burnout and compassion fatigue.

As discussed earlier, organizations that provide services to trauma survivors are at risk of becoming collectively traumatized. When people are under stress their perceptions become impaired. They often make rash decisions and act immediately instead of taking time to think about the situation and making planned decisions (Bloom, 1999). These trauma-organized agencies experience high absenteeism, high employee turnover, and professional misconduct (Bloom, 2006). In contrast, if an agency embraces trauma awareness, the opposite can occur.

As agencies validate the impact of trauma work and subsequently the need for clinician self-care, they create an atmosphere of empowerment, which is likely to foster greater staff satisfaction, less staff turnover, and the provision of more effective services for consumers” (Harris & Fallot, 2001, p. 97).

Systems theory tells us that organizations encompass many symbiotic relationships, and the entire system is affected to some extent by the other parts (Sheafor & Horejsi, 2008). “So much of our sense of safety is dependent on the maintenance of our social safety net which depends on communication among all team members” (Bloom & Farragher, 2011, p. xxiii). As a result, it is not just the role of administrators to ensure staff feels safe and supported, but also the responsibility of managers, supervisors, and individuals (peer). Co-workers, supervisors, and

organizations must understand that the impact of distress on caregivers and this distress should be expected of those who provide trauma services (Horwitz, 1998). Organizations, including administrators, supervisors, and front-line workers must validate and understand the impact of compassion fatigue.

**Trauma training.** Trauma training is crucial for prevention of burnout and secondary traumatic stress (Bloom & Farragher, 2011, 2005; Figley, 2002; Harris & Fallot, 2001; Harrison & Westwood, 2009; Saakvitne & Pearlman, 1996). Bloom (2006) states “studying and understanding concrete information about the impact of trauma on individuals, families, and systems is vital for creating a trauma-informed system” (p. 11). Harris and Fallot (2001) believe it is more important to provide a general trauma introduction to all staff than an in-depth training to some of the clinical staff.

In a trauma-informed system all clinical staff should be trained on trauma-sensitive screening and assessment, evidence based curriculum, and interventions to ensure those seeking services are provided the most effective care and are not being re-traumatized by services. In addition, working with trauma survivors can be challenging and often overwhelming for both the clinician and the trauma survivor (Saakvitne, Gamble, Pearlman, & Tabor, 2000). Knowledge of trauma-informed evidence-based practices provides better care for the individual receiving services and helps clinicians feel more confident in the treatment they provide.

In addition to knowledge on helping survivors of trauma, staff should be provided with training on the importance of self-care and the prevention and treatment of compassion fatigue. Although it is vital that individuals who work with victims of trauma receive training on compassion fatigue (Figley, 2002), we cannot rely solely on training alone. Research has shown trainings can increase enthusiasm and change results in a workplace, unfortunately too often

these changes do not continue over time (Campbell, Dunnette, Lawler III, & Weick, 1970). Because the longevity of single training effectiveness is unknown, agencies must promote an organizational culture that is conducive to self-care. Staff should be encouraged to engage in self-care activities (Saakvitne & Pearlman, 1996).

**Trauma responsiveness.** At the organizational level when something traumatic happens, organizational reactions often parallel individuals' responses. The priority of a trauma-informed system is to promote openness, but often stress is dealt with by creating more rigidity. When tension takes over a workplace it is human nature to create more rules and regulations to prevent further problems. These knee-jerk reactions may actually diminish quality of care and leave staff and clients confounded (Richardson, 2001). It is incongruent to social work values for agencies to provide services that are ineffective and harmful. Traditional systems of care have continued the abuse cycle through not recognizing, validating, or providing trauma-sensitive treatment (Harris & Fallot, 2001; National Center for Trauma-Informed Care, n.d.; Sharp, 2013).

There should be organizational and individual standards of practice when working with traumatized populations to ensure clients are receiving superior services and staff are not feeling traumatized or burned out. Saakvitne and Pearlman (1996) believe one of the largest components that leads to compassion fatigue is "the situation", which includes the work environment, case load number, percentage of case load who are victims of trauma, trauma type, as well as cultural contexts.

Organizational tragedy can occur if systems:

1. do not provide respite for the staff (e.g., shared coverage, adequate time off),
2. require staff to have unrealistically high caseloads,
3. fail to provide enough qualified supervision,

4. deny the severity and pervasiveness of clients' traumatic experiences and their after-effects,
5. fail to work with staff to identify and address signs of vicarious traumatization,
6. do not provide opportunities for continuing education,
7. do not provide sufficient vacation time, and
8. do not support personal psychotherapy for clinicians (e.g., health insurance acknowledgement of the value and important of personal therapy for all clinicians (Saakvitne & Pearlmann, 1996, p. 43).

Trauma-responsive organizational cultures encourage trauma awareness, prevention, and acceptance. Organizations must validate and understand the impact of vicarious trauma. Studies suggest organizations that view such feelings as unprofessional are at higher risk of becoming burnt out or trauma organized (Bloom, 2005; Figley, 1995; Jansen, 2004; Maslach, 1982; Pearlman & McCay, 2008; Rosenbloom, Pratt, & Pearlman 1995). Agencies have the responsibility to provide time and space for self-reflection and to foster environments that promote the discussion of compassion fatigue in a non-judgmental environment. This will promote staff well-being and ultimately provide effective care to trauma survivors.

## **Summary**

Little empirical research exists on the effects organizational components have on caregivers' level of compassion fatigue and compassion satisfaction. This chapter provided the theory, research, and practice that may have an influence on compassion fatigue and compassion satisfaction. Currently there is no instrument that measures the collective organizational factors that influence workplace culture in agencies that provide services to trauma survivors. The next chapter, Methodology, describes the process this researcher has taken to create an instrument that measures caregivers' perceptions of their organizational culture to begin to bridge the conceptual assumptions with empirical knowledge.

## CHAPTER 3

### METHODOLOGY

Individuals who provide services to trauma survivors are at heightened risk for developing burnout and secondary traumatic stress, collectively defined as compassion fatigue. Working closely with trauma survivors can be extremely taxing on caregivers, particularly if they work in an environment that is not supportive to trauma workers' unique needs. Often organizations place the sole responsibility of preventing and reducing compassion fatigue on the caregivers providing services. It is also the organizations' responsibility to ensure that all staff feels safe and supported at the workplace. In addition, trauma workers must be given the appropriate tools effectively to work with trauma survivors.

The purpose of this quantitative research design was to help lessen the gap between the theoretical literature and the empirical research on the impact organizational culture has on workers who provide services to survivors of trauma. Subsequently the goal of this research was to gain an understanding of what practices might increase employee's well-being and ultimately lead to a trauma-informed culture for all trauma workers and individuals receiving care. This knowledge may help advance the knowledge in the growing field of traumatology and the promotion of trauma-informed care practices. This chapter provides an explanation for the chosen quantitative survey research methodology. The specific framework for this study is described and includes the research design, study sample, instrumentation, data collection, limitations, and ethical issues.

## Research Questions

Following are the six research questions that guided this study:

1. What are the levels of compassion fatigue and compassion satisfaction in the research sample?
  - a. Animal protection
  - b. Child protection
  - c. Individuals who work with the homeless
  
2. Are there differences in the demographics and self- reported levels of compassion fatigue and compassion satisfaction?
  - a. Type of trauma work
    - i. Animal protection
    - ii. Child protection
    - iii. Individuals who work with the homeless
  - b. Job responsibility
  - c. Agency size
  - d. Years working in the field of trauma
  - e. Education level
  - f. Type of social work degree (If applicable)
  
3. Are there differences in the following demographics and perceived levels of trauma-informed organizational culture?
  - a. Type of trauma work
    - i. Animal protection
    - ii. Child protection



- iii. Individuals who work with the homeless
  - b. Job responsibility
  - c. Agency size
  - d. Years working in the field of trauma
  - e. Education level
  - f. Type of social work degree (If applicable)
4. Is there an association between levels of compassion fatigue and the following three variables?
- a. Perceived level of safety at the workplace?
  - b. Perceived level of support at the workplace?
  - c. Perceived level of trauma awareness at the workplace?
5. Is there an association between levels of compassion satisfaction and the following three variables?
- a. Perceived level of safety at the workplace?
  - b. Perceived level of support at the workplace?
  - c. Perceived level of trauma awareness at the workplace?
6. What are the predictor factors for compassion fatigue and compassion satisfaction?
- a. Type of trauma work
    - i. Animal protection
    - ii. Child protection
    - iii. Individuals who work with the homeless
  - b. Job Responsibility
  - c. Agency Size
  - d. Years working in the field of trauma

- e. Education Level
- f. Type of Social Work Degree (If applicable)
- g. Perceived level of safety at the workplace?
- h. Perceived level of support at the workplace?
- i. Perceived level of trauma awareness at the workplace?

## **Research Design**

This study was exploratory in nature; therefore, using a non-experimental, non-randomized sample survey design provides an effective approach to begin to understand the connection between trauma-informed organizational culture and its effects on burnout, secondary traumatic stress, collectively known as compassion fatigue and compassion satisfaction. In addition, this approach allowed the researcher to examine the individual constructs of a trauma-informed organizational culture including safety, support, and trauma awareness, the concepts this researcher defined as integral to a trauma-informed organizational culture, to determine which of these concepts appeared to have an influence on worker burnout and secondary traumatic stress, collectively known as compassion fatigue and compassion satisfaction.

## **Sampling**

The population for this study consisted of three different professional groups who provided services to people or animals who have experienced trauma including child, youth, and family workers, individuals who work with the homeless, and animal protection. A sample size was expected of approximately 150 participants. The researcher contacted organizations that provides child protection, services to the homeless, and services to traumatized animals to establish a connection and find out if they were interested in having the caregivers participate in

the study. These organizations included a county child protection department, a non-profit organization that provides services to homeless individuals, and a non-profit organization that provides support to animal control officers. The researcher submitted the research methods to each organization to gain approval. All three organizations agreed to participate in this research.

Although some research exists on the three populations, little, if any research exists on the role these caregivers' organizations play in their levels of compassion fatigue and compassion satisfaction. These three groups were chosen because they represent three unique groups who work with survivors of trauma and may provide interesting outcomes to help enhance the literature on burnout and secondary traumatic stress. All individuals who work at the agencies were allowed to participate in the study, including front line workers, middle management, and upper-level management.

### **Instrumentation**

The online survey consisted of three sections including the Trauma-Informed Organizational Culture (TIOC), a short demographic section, and the Professional Quality of Life (ProQOL, 2011). See appendices A and B. The TIOC was used to measure a caregiver's perception of the level of safety, support, and trauma awareness available at his or her agency. The demographic section measured professional affiliation, agency size, agency type, type of trauma work, and years working in the field of trauma. The ProQOL measured burnout and secondary traumatic stress, collectively known as compassion fatigue, and compassion satisfaction.

**Trauma-Informed Organizational Culture (TIOC) survey.** Currently there is no instrument that captures workers' perspectives of their agency's level of trauma-informed culture. The Trauma-Informed Organizational Culture Survey (TIOC) is a researcher created survey developed to measure caregivers' perception of the organizational culture where they work and whether or not they perceive it to be trauma informed. After conducting an extensive literature review, three concepts were consistently found across the trauma literature that prevent or lessen the effects of burnout and secondary traumatic stress, collectively known as compassion fatigue, on trauma workers. These three concepts included a caregivers' perception of safety (physical and emotional), support (organizational, supervisory, and peer), and trauma awareness (trauma training and trauma responsiveness) at the workplace.

The draft version of the TIOC was initially constructed in an attempt to measure both individually (caregiver) and collectively (organization) the three constructs: safety, support, and trauma awareness. The draft instrument was designed on a 5 point Likert scale with the responses to the 24 items anchored at Strongly Disagree, Disagree, Undecided, Agree, and Strongly Agree.

To explore the introductory efficacy of the TIOC, a preliminary pilot study (N = 25) was conducted at two unique non-profit organizations that provide services to individuals who have experienced trauma. The appropriate gatekeepers at each agency were contacted and granted permission to allow interested staff members participate in the study. The draft instrument was administered through Qualtrics and an email with the research survey link was sent out to the gatekeepers who were then asked to forward the email to individuals who were interested in participating.

The researcher provided a follow-up meeting with the organization of the participating agency and presented results of the pilot study. Feedback was solicited from the pilot study participants and their opinions were used to make appropriate changes to the instrument. The pilot study revealed the following: The overall internal consistency of the 24-item TIOC was .857. These Cronbach alphas' indicated that the TIOC instrument exhibits a high level of internal consistency. The 7-item Perceived Organizational Support factor had an alpha of .815. The 7-item Perceived Supervisory Support factor had an alpha of .846, and the 5-item Peer Support had an alpha of .829.

After the pilot study, the researcher received constructive feedback from two experts in the field of trauma and mental health (Dillman 2007; Dillman, Smyth, & Christian, 2009). This feedback was taken to improve the instrument by revising, adding, and deleting items, and changing word use and format. For example, the piloted version of the TIOC had one item in regards to safety. One of the trauma experts pointed out that physical safety was different than emotional safety and perhaps the TIOC should include statements in regards to emotional safety. After reviewing results of the pilot study, it was decided the TIOC was missing vital statements that differentiated it from other surveys on organizational culture. The original survey appeared to disregard the underlying theme of this research purpose. Therefore, appropriate changes were made to the survey to be used in the larger research study.

The revised TIOC used for this study consisted of 30 items and these items fit into 7 constructs including a caregiver's perception of the levels of safety, including physical and emotional safety; support, including organizational, supervisory, and peer support; and trauma awareness including trauma training and trauma responsiveness available at his/her agency. The revised version used a 5 point Likert scale with the responses anchored at Strongly Disagree (1),

Disagree (2), Undecided (3), Agree (4), and Strongly Agree (5). It was presumed that the 30 items of the instrument would fit into the seven domains or constructs as follows: Physical Safety—Items 1- 3; Emotional Safety—Items 4-5; Organizational Support—Items 6-13; Supervisory Support—Items 14-19; Peer Support—Items 20-24; Trauma Training—Items 25-27; and Trauma Responsiveness 28-30. Exploratory Factor analysis was used to help verify the different domains the TIOC aims to measure. For more detail on the exploratory factor analysis please see Chapter 4 Results.

**Demographics Questionnaire.** Participants were asked to complete a short 6-item demographic questionnaire, to help describe the sample and answer research questions. These demographic variables included: (a) professional affiliation, (b) agency size, (c) agency type, (d) type of trauma work, and (d) years working in the field of trauma. These variables were selected based on prior research on compassion fatigue and interest of the researcher.

**Professional Quality of Life instrument.** The Professional Quality of Life (ProQOL) (2011) was used to measure worker burnout, secondary traumatic stress, together defined as compassion fatigue, and compassion satisfaction and help establish validity for the TIOC survey. The ProQOL instrument, now in its fifth version, is a 30-item self-administered survey originally created by Figley and then transferred to Hudnall Stamm (2009). The ProQOL looks at compassion satisfaction, burnout and secondary traumatic stress, the latter two collectively defined as compassion fatigue. The ProQOL has been extensively used in trauma research for various populations who work in the field of trauma including, child, youth, and family workers (Azar, 2000), social workers (Bride & Figley, 2007), nurses (Lauvrud, Nonstad, & Palmstierna, 2009) and non-human animal workers (Rank, Zaparanick, & Gentry, 2009). According to Stamm (2009) the ProQOL has been used in over 200 published papers and over half of the published literature on compassion fatigue uses the ProQOL or one of its earlier versions. In the

most recent version, researchers found the following alphas with caregiver populations: secondary traumatic stress alpha .88, burnout .75, and compassion satisfaction .81 (Stamm, 2009). The ProQOL fits into this study because it is used to measure caregivers levels of compassion fatigue and compassion satisfaction. This information will be used to answer the research questions and assist the researcher in understanding more about organizational culture and its effects on caregiver well-being.

### **Data Collection**

Using a tailored design survey method (Dillman, Smyth, & Christian, 2009), the research methodology attempted to increase responses through topic salience, incentives, and ensure the perceived benefits of taking the time to participate in the study outweighs the perceived costs (Edwards, Roberts, Sandercock, & Frost, 2004). The entire survey contained 69 items and took less than ten minutes for participants to complete.

The appropriate gatekeepers at each organization were contacted to set up an initial meeting to discuss the research project, research objectives, process, and how it may benefit the organization if they decided to participate. The study's intent and procedures were discussed and permission to ask employees to voluntarily participate was requested from the appropriate leaders.

Participants who chose to take part in the study completed two self-reported measurements including the Professional Quality of Life (ProQOL) and the researcher created Trauma-Informed Organizational Culture (TIOC) survey. Participants were asked to complete a short demographic questionnaire at the end of the survey. The ProQOL and TIOC were combined with the demographic questionnaire using Qualtrics.

Organizations did not feel comfortable giving out employee or member's email addresses. Using Qualtrics, a link to the survey was emailed out to potential participants by the gatekeepers at each agency. This email described the intent of the study, incentives provided, information on how to complete the survey with a link to the survey, and an explanation of why participation was needed. One week following the introductory email, the gatekeepers were asked to send a follow-up email with the link to the survey to remind individuals of the study and increase response rates.

The introductory email that contained a link to the survey ensured participant anonymity and individual organizational results remained confidential. As an incentive, participants were given the opportunity to enroll into a drawing for \$50.00 gift cards. A total of six \$50.00 gift cards were awarded to those who completed the survey and were willing to separately give their name and email or other contact information. To ensure participant anonymity, no contact information was given to any employer. The recipients of the gift cards remained confidential. A private email address was created for this purpose and the email address was given at the end of the survey. Individuals who wished to enter the drawing could send a contact phone number or email to this private email address. This email was not connected to the survey in any way and all email contacts were destroyed by the deletion of the email account at the end of the research.

## **Data Analysis**

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 20. Descriptive statistics were performed to describe the demographics of the participants to accurately depict the sample including participant's professional affiliation, agency size, agency type, type of trauma work, and years working in the field of trauma.



Some factors or variables cannot be measured by using just one item on a questionnaire because they are too complex. Often these factors require more than one item to fully measure the variable in question and these composite measures (factors), meaning multiple questions or items on a survey, are called scales (Rubin & Babbie, 2011). Often in exploratory research the results of these composite variables may be very different than the theoretical constructs a researcher intends to measure by creating a new scale. Factor analysis is an effective method to determine patterns in a large number of items and was used to look for patterns among the variations in the values of the responses to the multiple variables on the TIOC (Babbie, 2004). To determine the factors composing the measure an exploratory factor analysis on the responses on the TIOC was conducted. The TIOC intended to measure the three theory-based constructs including safety, support, and trauma awareness. The sub-constructs the TIOC aimed to measure under safety included emotional safety and physical safety. The sub-constructs under support included organizational, supervisory, and peer support, and the sub-constructs under trauma awareness included trauma training and trauma responsiveness. An exploratory factor analysis helped increase measurement validity (factorial validity) by demonstrating internal structure for these complex constructs with underlining sub-constructs (Gliner, Morgan, & Leech, 2008; Royse, Thyer, & Padgett, 2010; Rubin & Babbie, 2011).

To measure internal consistency and determine if individuals were responding consistently across items on composite variables, including safety (emotional and physical), support (organizational, supervisory, and peer), and trauma awareness (trauma-training and trauma responsiveness) in the TIOC instrument, this researcher ran Cronbach's alpha to determine composite scales. The Cronbach's coefficient alpha is frequently used in the behavioral sciences to measure internal consistency reliability for items because it can obtain a

measure of reliability in a single administration of the instrument (Gliner, Morgan, & Leech, 2008). Alpha measures the internal consistency reliability of a summated scale and can help identify the composite variables in the TIOC. A single overall alpha was conducted to identify a summated scale for overall trauma-informed organizational culture.

Analysis was completed to see if there are any differences between participants by ages, years in the field, levels of education, professional affiliations, and type of trauma work. The major constructs that the TIOC attempted to measure include safety, support, and trauma-awareness. These constructs were broken into sub-constructs with safety including both physical and emotional safety, support including organizational, supervisory, and peer support, and trauma awareness including trauma training and trauma responsiveness. The major constructs measured by the ProQOL included compassion fatigue, which is the collective score of burnout and secondary traumatic stress, and compassion satisfaction. Following is a list of the research questions. Please note that these research questions changed after factor analysis was completed on the Trauma-Informed Organizational Culture survey and new constructs were identified.

### **Research Questions and Data Analysis**

1. What are the levels of compassion fatigue and compassion satisfaction in the research sample populations?
  - a. Animal Control Workers
  - b. Child, youth, and family workers
  - c. Individuals who work with the homeless

Analysis: Basic descriptive statistics were used to determine the levels of compassion fatigue and compassion satisfaction for the sample.

2. Are there differences in the following demographics and their self- reported levels of compassion fatigue and compassion satisfaction?

a. Professional affiliation

b. Agency size

i. Small

ii. Medium

iii. Large

c. Agency type

i. Non-profit

ii. Government

d. Type of trauma work

i. Animal control worker

ii. Child protection worker

iii. Individuals who work with the homeless

d. Years working the field of trauma

Analysis: To determine if there are differences among the variables professional affiliation, agency size, agency type, type of trauma work, and years working in the field of trauma and the self- reported levels of compassion fatigue and compassion satisfaction One-Way ANOVA's were used.

3. Are there differences in the following demographics and perceived levels of trauma-informed organizational culture?

a. Professional affiliation

b. Agency size

- i. Small
  - ii. Medium
  - iii. Large
- c. Agency type
- i. Non-Profit
  - ii. Government
- d. Type of trauma work
- i. Animal control worker
  - ii. Child protection worker
  - iii. Individuals who work with the homeless
- e. Years working the field of trauma

Analysis: To determine if there are differences among the variables professional affiliation, agency size, agency type, type of trauma work, and years working in the field of trauma and perceived levels of trauma-informed organizational culture One-Way ANOVA's were used.

4. Is there an association between levels of compassion fatigue and the following three variables?
- a. Perceived level of safety at the workplace?
  - b. Perceived level of support at the workplace?
  - c. Perceived level of trauma awareness at the workplace?
  - d. Years working in the field of trauma?

Analysis: Pearson product moment correlations were used to determine if there was a correlation between levels of compassion fatigue and perceived levels of safety, support, trauma awareness, and years working in the field of trauma.

5. Is there an association between levels of compassion satisfaction and the following variables?

- a. Perceived level of safety at the workplace?
- b. Perceived level of support at the workplace?
- c. Perceived level of trauma awareness at the workplace?
- d. Years working in the field of trauma?

Analysis: Pearson product moment correlations were used to determine if there was a correlation between levels of compassion satisfaction and perceived levels of safety, support, trauma awareness, and years working in the field of trauma.

6. What are the predictor factors for compassion fatigue and compassion satisfaction?

Analysis: Simultaneous multiple regression was used to determine the predictor factors for compassion fatigue and compassion satisfaction.

## **Ethical Issues**

Prior to initiating this study, an application and summary of the research design was submitted to the Institutional Review Board (IRB) at Colorado State University. Individual involvement in this study was strictly voluntary. Individual results remained anonymous and organizational results shall remain confidential. This researcher did not foresee any significant

risks to physical or psychological safety but followed the IRB's recommendation and requirements to ensure the ethical treatment of participants.

### **Summary**

An exploratory, non-randomized, survey research design was selected as the most feasible method to answer the research questions. This chapter begins with the statement of the problem, research questions, and potential limitations. Also, the chapter provides the research design, sampling, instrumentation, data analysis, and potential ethical issues.

## CHAPTER 4

### DATA ANALYSIS

This chapter provides a description of the findings of the statistical analysis conducted for the current study. The analysis and results presented address the 9 research questions.

#### **Data Screening and Testing of Assumptions**

From the total sample of 975 animal control officers, individuals who provide services to the homeless, and child, youth, and family services workers 301 individuals completed the full or partial survey. Data were imported from Qualtrics to Statistical Package for the Social Sciences (SPSS) version 20 and were examined prior to analysis. A total of 301 individuals responded to the survey but 18 participants' responses were removed from the final analysis due to incomplete survey responses. Therefore, 283 valid cases were used in the data analysis with a response rate of 29 percent. Individuals with only a couple missing responses were not removed from the data analysis to answer certain research questions. Data were checked for normality and all variables were approximately normally distributed with no items or variables markedly skewed.

#### **Participant's Profile**

A total of 282 participants' data were analyzed including 67 animal control officers (23.7%), 102 child, youth, and family services workers (36.2%), and 113 individuals who work with the homeless (40.1%). Two hundred and seventy eight individuals reported their education level. Altogether 79 participants (28%) reported having a Bachelors of Social Work (BSW) degree or Masters of Social Work (MSW) degree with 35 participants (12.4%) reporting a BSW degree and 44 participants (15.5%) reported having a MSW degree. In the sample, 282 (96%)

reported that they provided direct services to people or animals who had experienced trauma. Thirty percent worked 51-75% of their time and over thirty percent spent 76-100% of their time in direct trauma services.

A categorized open-ended question asked years working in the field of trauma. The data were condensed into ordinal level data for this reporting and for data analysis. The majority (54.1 percent) had worked in the trauma field 10 years or less. Some responses were not valid and not used in the analysis. Subsequently 49 of 272 individual responses were omitted from this analysis due to lack of response or invalid response. Table 1 summarizes the highest level of education, percentage of time spent in direct trauma services, and years of experience that individuals reported working in the field of trauma



Table 1

*Highest Level of Education (N = 278), Percentage of Direct Trauma Service (N = 282), and Years Working in the Field of Trauma (N=283).*

Characteristic	N	%	Cumulative
<b>Highest Level of Education</b>			
GED/High School Graduate	34	12.0	12.0
Associate of Arts	19	6.7	18.7
Bachelor's Degree	105	37.1	55.8
Graduate Degree	94	33.2	89.0
Professional Certificate	26	9.2	98.2
Missing	5	1.9	1.9
Total	283	100.0	100.0
<b>Direct Service</b>			
25% or Less	60	21.3	21.3
26-50%	52	18.4	39.7
51-75%	84	29.8	69.5
76-100%	86	30.5	100.0
Total	282	100.0	
<b>Years Working in the Field</b>			
1-5	73	25.8	25.8
6-10	80	28.3	54.1
11-15	44	15.5	69.6
21-25	26	9.2	78.8
26+	11	3.9	82.7
Missing	49	17.3	
Total	283	100.0	

## **Validity and Reliability of Research Instruments**

**Factor Analysis.** Exploratory factor analysis with varimax rotation was conducted to assess the underlying structure for the 30 items on the Trauma-Informed Organizational Culture survey. The varimax rotation was used to maximize the sum of the variances of the squared loadings help minimize the complexity of the components (Morgan, Leech, Gloeckner, & Barrett, 2010). The assumption of independent sampling was met. The assumptions of normality and linear relationship between pairs of variables were checked. Five factors were requested which were named employee's perception of safety, organizational support, supervisory support, peer support, and trauma awareness. Exploratory factor analysis helps test for the validity of the instrument and helped the researcher see if the survey items actually fit the predicted constructs. Factor analysis identified four constructs in the TIOC. The constructs were labeled supervisory support, peer support, trauma-informed caregiver development, and perception of organizational support. Eight items were dropped from the survey for additional statistical analysis but descriptive data will be presented for all items. The goal is to eventually refine the TIOC so that factor loadings are consistent to measure each construct.

After rotation, the first factor, supervisory support, accounted for 14.8% of the variance, the second factor, peer support, accounted for 9.8%, the third factor, trauma-informed caregiver development, accounted for 9.5%, and the fourth factor, organizational support, accounted for 5.6% of the variance. Table 2 displays the items and factor loadings for the rotated factors, with loadings less than .40 omitted to improve clarity.

Table 2  
*Factor Loadings for the Rotated Factors*

Item	Factor Loading				Communality
	1 Supervisory Support	2 Peer Support	3 Caregiver Dev.	4 Org. Support	
My supervisor supports my decision	.83				.73
I trust my supervisor	.80				.75
My supervisor Encourages self-care	.73				.70
I feel comfortable talking To my supervisor about work-related problems.	.71				.59
My supervisor asks me for suggestions or about my opinions	.70				.57
I receive regularly scheduled supervision for my job	.50				.40
I feel comfortable discussing work related problems with my co-workers.		.71			.54
I generally like my co-workers		.70			.53
I trust my co-workers		.69			.65
My co-workers know at least a few personal things about me.		.67			.45
I feel comfortable discussing personal problems with co-workers		.63			.46
My organization values me as a person			.70		.70

My organization values people who have different types of skills			.65		.62
I feel like my organization does not support me.			.62		.67
I work in an organization that supports my self-care efforts			.53		.80
My organization encourages me to take care of myself			.52		.73
I have received information at my current job on the importance of self-care.				.77	.64
I have received training at my current job to help me effectively work with individuals who have experienced trauma				.68	.49
I have received information at my current job on compassion fatigue				.67	.52
Cronbach's Alpha	.88	.82	.90	.82	

---

**Trauma-Informed Organizational Culture Survey.** To assess whether the data from the four factors formed reliable scales, Cronbach's alphas were computed. Cronbach's coefficient alpha is the most common test of reliability (Morgan, Leech, Gloeckner, & Barrett, 2010) and is reported like a correlation coefficient with a numerical value between 0 and 1. Alpha levels should typically range between .70-.90 to show modest to high levels of internal consistency (Royse, Thyer, & Padgett, 2010). The alpha for supervisory support (six items) was .88, which indicates that the items form a scale that has good internal reliability. The alpha for perceived level of peer support (5 items) was .82, the alpha level for perception of organizational support was .90 (5 items), and the alpha level was .82 for the trauma-informed caregiver development (3 items), all of which indicated good internal consistency. The overall internal

consistency for the entire TIOC (30 items) was .91 and the overall consistency for the 19 items used in the data analysis was .87.

*ProQol.* The Professional Quality of Life (ProQOL) was found to be reliable. Each of the three subscales had 10 items with the burnout subscale ( $\alpha = .80$ ), the secondary traumatic stress subscale ( $\alpha = .82$ ), and the compassion satisfaction ( $\alpha = .83$ ). These alphas were consistent with previous studies of caregiver populations (Stamm, 2009).

### **New Research Questions**

After the data were cleaned and factor analysis completed there were certain research questions that could not be answered but many new research questions that emerged from the findings. The research questions that contained the variables of job responsibility and agency size could not be answered due to incomplete data. As a result, the research questions were accommodated to fit the new constructs identified versus hypothesized. Following are the new research questions created after the factor analysis and identification of these new constructs.

**Research question # 1.** What are the levels of burnout, secondary traumatic stress, and compassion satisfaction in the research sample?

**Research question # 2.** Are there differences on work type and self-reported levels of burnout, secondary traumatic stress, and compassion satisfaction?

**Research question # 3.** Are there differences in work type and perceived levels of trauma-informed organizational culture?

**Research question # 4.** Is there a correlation between levels of burnout and supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

**Research question # 5.** Is there correlation between levels of secondary traumatic stress and supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

**Research question # 6.** Is there a correlation between levels of compassion satisfaction and the variables supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

**Research question # 7.** How well can we predict each burnout, each secondary traumatic stress, and each compassion satisfaction from a combination of supervisory support, peer support, organizational support, and trauma-informed caregiver development?

**Research question # 8.** Is there a correlation between percentage of time spent at work providing direct trauma services and individuals levels of burnout, secondary traumatic stress and compassion satisfaction?

**Research question #9.** Do individual's levels of burnout, secondary traumatic stress, and compassion satisfaction differ between individuals who have a Bachelor of Social Work (BSW) degree and Master of Social Work (MSW) degree and those who do not?

### **Levels of Burnout Secondary Traumatic Stress, and Compassion Satisfaction**

**Research question #1.** What are the levels of burnout, secondary traumatic stress, and compassion satisfaction in the research sample?

Descriptive statistics were used to identify the levels of burnout, secondary traumatic stress, and compassion satisfaction. Levels were determined by using the *Concise ProQOL Manual* (Stamm, 2009). According to the *Concise ProQOL Manual* and Stamm's research sample, the average scores on the burnout and secondary traumatic stress scales are 50 with a

standard deviation of 10. Approximately 25% of caregivers score above 57 and about 25% of caregivers score below 43. The average score on the compassion satisfaction scale is 50 with a standard deviation of 10 and approximately 25% of caregivers score higher than 57 and about 25% of people score below 43. Table 3 summarize the raw scores for burnout, secondary traumatic stress, and compassion satisfaction of the trauma caregivers who participated in this study.

Table 3  
*Levels of Burnout, Secondary Traumatic Stress (STS), and Compassion Satisfaction (CS)*  
*Descriptive Statistics*

	N	Mean	Std Dev.	Median	Mode	Range
Burnout	283	23.64	5.5	23	23	10-39
STS	273	23.55	5.82	23	22	11-40
CS	275	38.91	5.91	39	40	18-50

Table 4 summarizes how these scores may be interpreted using the *Concise ProQOL Manual*.

Table 4  
*Levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction*

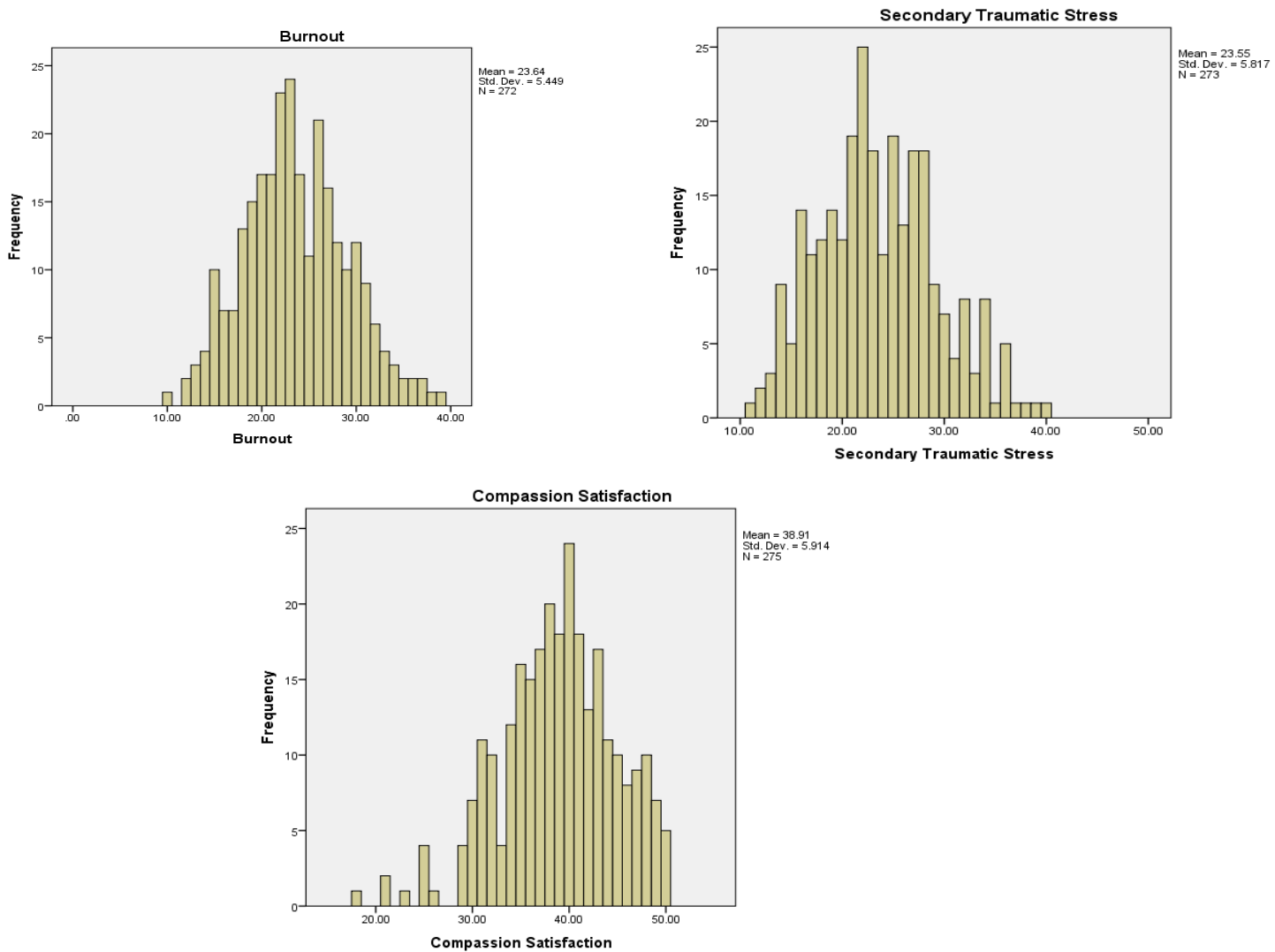
Level	Low		Average		High		
Raw Score	22 or Less		23-41		42 or More		
ProQol Score	43 or Less		Around 50		57 or More		
	n	Number	%	Number	%	Number	%
Burnout	272	119	42	153	54.1	--	
STS	273	127	44.9	146	51.6	--	
CS	275	3	1.1	182	64.3	90	31.8

Levels of burnout and secondary traumatic stress were low to average for the research sample. Levels of compassion satisfaction were average to high with only 3 people reporting low levels of compassion satisfaction.

Figure 2 provides a histogram to summarize the distribution of data for the levels of burnout, secondary traumatic stress, and compassion satisfaction

Figure 2

*Distribution of Data for the Levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction.*





## **Work Type and Levels of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction**

**Research Question #2.** Are there differences on work type and self-reported levels of burnout, secondary traumatic stress, and compassion satisfaction?

To see if there was a difference among the three groups of animal control officers, child, youth, and family service workers, and individuals who work with the homeless, an analysis of variance was conducted. There were no significant differences among the three groups on levels of burnout  $F(2, 268) = 1.91, p = .151$ , secondary traumatic stress  $F(2, 269) = 2.01, p = .136$ , and compassion satisfaction  $F(2, 272) = 2.34, p = .099$ .

## **Work Type and Organizational Culture**

**Research question #3.** Are there differences in work type and perceived levels of trauma-informed organizational culture?

To see if there was a significant difference among work type and perceived levels of supervisory, peer, organizational support, and trauma-informed caregiver development, four one-way ANOVA tests were computed (tables 5 and 6). A statistically significant difference was found among the three groups of work type on perceived level of supervisory support,  $F(2, 275) = 5.09, p = .007$ , perceived level of peer support  $F(2, 269) = 3.72, p = .025$ , on perceived level organizational support  $F(2, 278) = 25.55, p < .001$ , and trauma-informed caregiver development,  $F(2, 277) = 3.677, p = .027$ .

If a significant difference in means exists among three groups it is helpful to know exactly which means are different. Post hoc Tukey HSD Tests are helpful in determining where this difference lies (Morgan, Leech, Gloeckner, & Barrett, 2007). Post hoc Tukey HSD Tests indicate that animal protection and individuals who work with the homeless differed significantly

in their perceived level of supervisor support ( $p = .006$ ,  $d = .23$ ), which was a smaller than typical effect size. Table 5 summarizes the means and standard deviations of the three groups.

Table 5

*Animal Control Officers, Child Welfare Youth and Family Services, and Individuals Who Work with the Homeless Means and Standard Deviations*

Work Type	<i>n</i>	Supervisory		Peer		Personal		Trauma-Ed.	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>S</i>
Animal Control Officer	66	21.84	5.05	19.20	4.00	18.12	4.72	9.00	3.00
Child Welfare Youth and Family Services	101	22.82	4.80	18.52	3.39	16.40	4.01	9.50	2.80
Individuals Who Work with the Homeless	109	24.30	5.30	19.90	3.45	20.25	3.4	10.54	2.90
Total	276	23.15	5.13	19.23	3.60	18.34	4.3	10.03	2.90

Table 6

*One-Way Analysis of Variance for the Effects of Groups—Animal Control Officer, Child, Youth and Family Workers and Individuals who Work with the Homeless on Levels of Supervisory Support, Peer Support, Organizational Support and Trauma-informed Caregiver Development*

Source	<i>df</i>	SS	MS	F	<i>p</i>
<i>Supervisory Support</i>					
Between groups	2	260.13	130.06	5.09	.007
Within groups	275	7028.83	25.56		
Total	277	7289.00			
<i>Peer Support</i>					
Between groups	2	94.33	47.17	3.72	.025
Within groups	269	3408.08	12.67		
Total	271	3502.41			
<i>Organizational support</i>					
Between groups	2	813.21	406.60	25.55	<.001
Within groups	278	4423.67	15.91	25.55	
Total	280	5236.88			
<i>Trauma Education</i>					
Between groups	2	60.62	30.31	3.67	.027
Within groups	277	2285.15	8.25		
Total	279	2345.77			

Individuals who worked with the homeless felt more supported by their supervisors than animal control officers. Individuals who work with the homeless and child and family workers differed significantly in their perceived level of peer support ( $p = .019$ ,  $d = .90$ ), which was a larger to much larger than typical effect size. Individuals who worked with the homeless felt more supported by their peers than child and family workers. Each of the three groups significantly differed on their perceived level of organizational support including animal control

officers and individuals who work with the homeless ( $p = .002$ ,  $d = .22$ ), smaller than typical effect size, individuals who work with the homeless and youth and family workers ( $p < .001$ ,  $d = .56$ ), medium or typical effect size, and animal control officers and youth and family workers ( $p = .015$ ,  $d = .19$ ), smaller than typical effect size. Individuals who work with the homeless reported higher levels of supervisory support, peer support, and organizational support than child, youth, and family workers or animal control officers.

### **Correlations Between the Dependent Variables and the Independent Variables**

**Research question #4.** Is there a correlation between levels of burnout and the variables supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

**Research question # 5.** Is there correlation between levels of STS and the following variables including supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

**Research question #6.** Is there a correlation between levels of compassion satisfaction and the variables supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma?

To investigate if there were statistically significant associations between the dependent variables burnout, secondary traumatic stress, and compassion fatigue, 15 Pearson Product Moment Correlations were computed. Several statistically significant relationships were found among the variables and Table 7 provides the means, standard deviations, and correlations of these variables.

Table 7

*Means, Standard Deviations, and Correlations of Dependent Variables and Independent Variables*

Independent V.	M	SD	Dependent Variables		
			Burnout	STS	CS
Supervisory Support	23.16	5.12	-.33**	-.19*	.34**
Peer Support	19.24	3.60	-.21**	-.07	.25**
Organizational Support	18.35	4.32	-.49**	-.26**	.36**
Caregiver Development	10.01	2.90	-.33**	-.28**	.45**
Years Working in Trauma	11.06	7.87	-.09	-.11	.16*

\* $p < .01$  \*\* $p < .001$

Table 8 provides the results of the Pearson Product Moment Correlations that found statistically significant relationships between the dependent variables burnout, secondary traumatic stress, and compassion satisfaction and the independent variables supervisory support, peer support, organizational support, trauma-informed caregiver development and years working in the field of trauma. Effect sizes are provided in Table 8 using Cohen’s (1988) guidelines. Cohen provides effect size examples to indicate the strength of a relationship to help researchers make decisions on the practical significance of a relationship between two variables (Morgan, Leech, Gloeckner, & Barrett, 2007).

Following are the guidelines for r family effect sizes  $>$  or  $=$ .

- .70 (Much larger than typical)
- .50 (Larger or larger than typical)
- .30 (Medium or typical)
- .10 (Small or smaller than typical) (Cohen, 1988)

Table 8

*Correlations of Dependent Variables Burnout, Secondary Traumatic Stress, and Compassion Satisfaction and Independent Variables Supervisory Support, Peer Support, Organizational Support, Trauma-Informed Caregiver Development and Years Working in the Field of Trauma*

Variables	N	r	p	Effect Size	% of Variance
<b>Burnout</b>					
Supervisory Support	268	-.33	p < .001	Typical	11
Peer Support	265	-.21	p = .001	Smaller than Typical	4
Organizational Support	271	-.49	p < .001	Larger than Typical	24
Caregiver Development	270	-.33	p < .001	Typical	11
<b>Secondary Traumatic Stress</b>					
Supervisory Support	270	-.19	p = .002	Typical	4
Organizational Support	271	-.26	p < .001	Larger than Typical	6
Caregiver Development	270	-.28	p < .001	Typical	8
<b>Compassion Satisfaction</b>					
Supervisory Support	271	.34	p < .001	Typical	12
Peer Support	265	.25	p < .001	Small to Medium	6
Organizational Support	273	.36	p < .001	Medium	13
Caregiver Development	272	.45	p < .001	Medium to Large	20
Years Working in Trauma Field	262	.16	p = .008	Smaller than Typical	3

## Predictor Variables of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction

**Research Question # 7.** How well can each burnout, each secondary traumatic stress, and each compassion satisfaction be predicted from a combination of the four variables supervisory support, peer support, organizational support, and trauma-informed caregiver development?

**Predictor Variables of Burnout.** Simultaneous multiple regression was conducted to investigate the extent to which levels of burnout can be predicted. The means, standard deviations, and intercorrelations for the predictor variables are found in Table 9. The combination of variables to predict burnout from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development (caregiver development) was statistically significant,  $F(4, 251) = 22.98, p < .001$ .

Table 9

*Predictor Variables for Burnout, Means, Standard Deviations, and Intercorrelations (N=256)*

Variable	<i>M</i>	<i>SD</i>	Supervisor Support	Peer Support	Organizational support	Trauma-Informed Caregiver Development
Burnout	23.85	5.42	-.34**	-.20*	-.48**	-.40**
Peer Support	19.18	3.58	--	--	.499**	.42**
Supervisory Support	23.18	5.15	--	.41**	.64**	.42**
Organizational Support	18.27	4.32	--	--	--	.52**
Trauma-Informed Caregiver Development.	9.93	2.86	--	--	--	--

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

The beta coefficients are presented in Table 10. Organizational support and trauma-informed caregiver development significantly predict burnout when all four variables are included. The adjusted  $R^2$  value was .26 and the effect size was .52. This indicates that 26% of the variance in burnout was explained by the model. According to Cohen (1988), this is a large or larger than typical effect size.

Table 10

*Simultaneous Multiple Regression Analysis Summary for Burnout, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N=256)*

Variable	<i>B</i>	<i>SEB</i>	<i>B</i>
Supervisory Support	-.03	-.08	-.02
Peer Support	.13	.10	.09
Organizational support	-.51	.10	-.41**
Trauma-informed caregiver development	-.39	.12	-.20*
Constant	35.07	1.78	

*Note.*  $R^2 = .52$ ;  $F(4, 251) 22.98$ ,  $p < .001$

\* $p < .01$     \*\* $p < .001$

***Predictor Variables of Secondary Traumatic Stress.*** Simultaneous multiple regression was conducted to investigate the extent to which levels of secondary traumatic stress can be predicted. The means, standard deviations, and intercorrelations can be found in Table 11. The combination of variables to predict secondary traumatic stress from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development was statistically significant,  $F(4, 253) = 7.57$ ,  $p < .001$ .



Table 11

*Predictor Variables for Secondary Traumatic Stress, Means, Standard Deviations, and Intercorrelations for (N=258)*

Variable	<i>M</i>	<i>SD</i>	Supervisor Support	Peer Support	Organizational support	Trauma-Informed C.D.
Secondary Traumatic Stress	23.60	5.83	-.19**	-.07	-.28**	-.25**
Supervisory Support	23.07	5.16	--	.40**	.42**	.64**
Peer Support	19.20	3.60	--	--	.50**	.37**
Organizational support	18.27	4.33	--	--	--	.53**
Trauma-Informed C.D.	9.96	3.00	--	--	--	--

\*p = .01 \*\*p<.001

The beta coefficients are presented in Table 12. Organizational support and trauma-informed caregiver development significantly predict secondary traumatic stress when all four variables are included. The adjusted  $R^2$  value was .09 with an effect size of .33. This indicates that 9% of the variance in burnout was explained by the model. According to Cohen (1988), this is a medium or typical effect size.

Table 12

*Simultaneous Multiple Regression Analysis Summary for Secondary Traumatic Stress, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N=258)*

Variable	<i>B</i>	<i>SEB</i>	<i>B</i>
Supervisory Support	-.02	.088	-.01
Peer Support	.20	.11	.13
Organizational support	-.34	.12	-.25*
Trauma-informed caregiver development	-.33	.14	-.16**
Constant	29.46	2.10	—

*Note.*  $R^2 = .12$ ;  $F(4, 253) = 7.57$ ,  $p < .001$   
 \* $p < .01$  \*\* $p < .05$

***Predictor Variables of Compassion Satisfaction.*** Simultaneous multiple regression was conducted to investigate the extent to which levels of compassion satisfaction can be predicted. The means, standard deviations, and intercorrelations can be found in Table 13. The combination of variables to predict compassion satisfaction from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development (caregiver development) was statistically significant,  $F(4, 253) = 17.08$ ,  $p < .001$ .

Table 13

*Predictor Variables for Compassion Satisfaction, Means, Standard Deviations, and Intercorrelations for (N=258)*

Variable	<i>M</i>	<i>SD</i>	Supervisor Support	Peer Support	Organizational support	Caregiver Development
Compassion Satisfaction	38.81	5.91	.34**	.24**	.44**	.34**
Supervisory Support	23.21	5.02	--	.37**	.62**	.41**
Peer Support	19.30	3.51	--	--	.44**	.34**
Organizational support	18.36	4.25	--	--	--	.53**
Caregiver Development	9.97	2.86	--	--	--	--

\*\*p<.001

The beta coefficients are presented in Table 14. Organizational support and trauma-informed caregiver development significantly predict compassion satisfaction when all four variables are included. The adjusted  $R^2$  value was .20 and the R effect size was .46. This indicates that 20% of the variance in burnout was explained by the model. According to Cohen (1988), this is a medium to large effect size.

Table 14

*Simultaneous Multiple Regression Analysis Summary for Compassion Satisfaction, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N=256)*

Variable	B	SEB	B
Supervisory Support	.10	.09	.09
Peer Support	.02	.11	.01
Organizational Support	.42	.113	.30**
Trauma-Informed Caregiver Development	.30	.14	.14*
Constant	25.45	2.01	--

Note.  $R^2 = .21$ ;  $F(4,253) = 17.08$ ,  $p < .001$ .

\* $p < .05$ ; \*\* $p < .001$

### **Direct Service and its Effects on Burnout, Secondary Traumatic Stress, and Compassion Satisfaction**

**Research Question # 8.** Is there a correlation between percentage of time spent at work providing direct trauma services and individuals levels of burnout, Secondary Traumatic Stress, and Compassion Satisfaction?

To assess if there was a significant correlation between the percentage of time spent providing direct services to trauma survivors and burnout, secondary traumatic stress, and compassion satisfaction a Spearman's Rho's were conducted. Spearman's Rho, a non-parametric statistic, was used because the independent variable, percentage of time spent providing direct trauma services was ordinal level data. There was not a statistically significant association between percentage of time providing direct trauma services and burnout,  $r(280) = .05$ , between percentage of time spent providing direct trauma services and compassion satisfaction,  $r(280) = .07$ . There was a positive correlation between the two variables of

percentage of time providing direct trauma services and secondary traumatic stress,  $r(271) = .19$ ,  $p = .002$ . As the level of direct trauma services provided increased so did the level of STS. Using Cohen's (1988) guidelines, the effect size is smaller than typical.

## **Social Work Degree and Burnout, Secondary Traumatic Stress, and Compassion**

### **Satisfaction**

#### **Research Questions #9.**

Do levels of burnout, secondary traumatic stress, and compassion satisfaction differ between those individuals who have a Bachelors of Social Work (BSW) degree or Masters of Social Work (MSW) degree and those who do not?

A statistically significant difference was found between the two groups of individuals who have a BSW ( $n = 35$ ) and those who do not ( $n = 247$ ) on levels of compassion satisfaction  $F(1, 196) = 8.40$ ,  $p = .004$ . Individuals who possessed a BSW reported significantly higher levels of compassion satisfaction ( $M = 41.21$ ), than those individuals who did not have a BSW,  $M = 38.09$ . Although this was a statistically significant difference, the effect size was  $.10$ , which is smaller than typical. The two groups did not differ on levels of burnout  $F(1,196) = 1.61$  ( $p = .20$ ) or secondary traumatic stress  $F(1, 195) = .61$  ( $p = .44$ ), as determined by one-way ANOVA.

There was not a significant difference between the two groups of individuals who have a MSW and those who do not on levels of burnout  $F(1, 189) = 1.68$ , ( $p = .20$ ) secondary traumatic stress  $F(1,190) = .57$ , ( $p = .45$ ), or compassion satisfaction  $F(1,190) = .63$ , ( $p = .43$ ), as determined by one-way ANOVA. Also, once BSW and MSW were combined as the same group ( $n = 79$ ) and compared with individuals who did not possess either degree ( $n = 203$ ), the two groups did not differ significantly on levels of burnout  $F(2,197) = .86$ , ( $p = .43$ ), secondary

traumatic stress  $F(2,197) = .95$ , ( $p = .39$ ), or compassion satisfaction  $F(2, 198) = 2.30$ , ( $p = .10$ ) as determined by one-way ANOVA.

### **Remaining Items Not Included in Inferential Statistics**

After a factor analysis was completed and constructs from the Trauma-Informed Organizational Culture Survey were defined, the following items were deleted from the TIOC. Inferential statistics were not completed on these items.

- I feel safe at my job.
- I witness violence at my job.
- My organization has policies and procedures in place to ensure my safety.
- I am asked to do things at my job that I do not feel safe doing.
- My organization offers adequate health insurance to employees that include confidential mental health services.
- My organization compensates me or provides comp time when I work long hour or overtime.
- My work day is filled with different types of activities.
- When something upsetting happens at my agency workers are given time to process and heal.
- I feel like I do not have enough work time to do get my job done during a normal business day.
- I feel like I do not have enough resources to succeed at my job.
- I work in a stressful environment.

Descriptive analysis was conducted using the individual items listed above to identify patterns between each individual item on the TIOC and the variables including burnout, secondary traumatic stress, and compassion satisfaction. Tables 15, 16, and 17 summarize the results of the Pearson Product-Moment Correlation Coefficients computed on the items not included in the overall TIOC instrument. Table 15 summarizes the correlations between burnout and the individual 11 items from the TIOC instrument. Positive correlation ( $r$ ) means that as the independent variable goes up so does the level of burnout. Levels of burnout should remain low in a trauma-informed organization.

Table 15

*Pearson Correlations Between Levels of Burnout and TIOC Individual Items Not Included in Inferential Statistics*

Independent Variable-Individual Items from the TIOC Survey	N	r	Effect Size Level	% of Variance
I feel safe at my job.	270	-.40 **	Medium to Large	16.0
I witness violence at my job.	270	.20	No Significant Difference	4.0
My organization has policies and Procedures in place to ensure my safety.	269	-.31**	Medium or Typical	10.0
I am asked to do things at my job that I do not feel safe doing.	270	.30**	Medium or Typical	9.0
My organization offers adequate health insurance to employees that include confidential mental health services.	270	-.30**	Medium or Typical	9.0
My organization compensates me or provides comp time when I work long hours or overtime.	281	-.27**	Medium or Typical	7.3
My work day is filled with different types of activities.	269	-.24**	Small to Medium	6.0
When something upsetting happens at my agency workers are given time to process and heal.	269	-.44**	Medium to Large	19.0
I feel like I do not have enough work time to do get my job done during a normal business day.	269	.40**	Medium to Large	16.0
I feel like I do not have enough resources to succeed at my job.	270	.45**	Medium to Large	20.0
I work in a stressful environment.	268	.26**	Small to Medium	7.0

\*\* p<.001

Table 15 provides the results of correlations and the strengths of these relationships between individual items not included in the four constructs determined by the factory analysis and the dependent variable burnout. Several statistical associations with p values less than .001 and medium to large effect sizes were found indicating the importance of these individual factors



in the prevention, reduction, and treatment of burnout in caregivers who provide services to trauma survivors.

Table 16 summarizes the correlations between levels of secondary traumatic stress and the individual items from the TIOC instrument. Positive correlation means that as the independent variable goes up so does the level of burnout. Levels of secondary traumatic stress should remain low in a trauma-informed organization.

Table 16

*Pearson Correlations between Levels of Secondary Traumatic Stress and TIOC Individual Items Not Included in Inferential Statistics*

Independent Variable-Individual Items from the TIOC Survey	N	r	Effect Size	% of Variance
I feel safe at my job.	271	.32**	Medium or Typical	10.0
I witness violence at my job.	269	.13*	Smaller than Typical	2.0
My organization has policies and procedures in place to ensure my safety.	280	-.25**	Small to Medium	6.0
I am asked to do things at my job that I do not feel safe doing.	271	-.30**	Medium or Typical	9.0
My organization offers adequate health insurance to employees that include confidential mental health services.	271	-.21**	Small to Medium	4.0
My organization compensates me or provides comp time when I work long hours or overtime.	271	-.15**	Smaller than Typical	2.0
My work day is filled with different types of activities.	270	-.02	No Significant Difference	
When something upsetting happens at my agency workers are given time to process and heal.	270	-.28*	Medium or Typical	8.0
I feel like I do not have enough work time to do get my job done during a normal business day.	270	.29**	Medium or Typical	8.0
I feel like I do not have enough resources to succeed at my job.	271	.32**	Medium or Typical	10.0
I work in a stressful environment.	269	.14*	Smaller than Typical	2.0

\*p<.05 \*\*p<.001

Table 16 provides the results of correlations and the strengths of these relationships between individual items not included in the four constructs determined by the factory analysis and the dependent variable secondary traumatic stress. Several statistical associations with p

values less than .001 and medium to large effect sizes were found indicating the importance of these individual factors in the prevention, reduction, and treatment of secondary traumatic stress.

Table 17 summarizes the correlations between levels of compassion satisfaction and the individual items from the TIOC instrument. Positive correlation means that as the independent variable goes up so does the level of compassion satisfaction. Levels of compassion satisfaction should remain high in a trauma-informed organization.

Table 17

*Pearson Correlations between Levels of Compassion Satisfaction and TIOC Individual Items Not Included in Inferential Statistics*

Independent Variable-Individual Items from the TIOC Survey	N	r	Effect Size	% of Variance
I feel safe at my job.	273	.26**	Medium or Typical	7.0
I witness violence at my job.	273	-.04	No Significant Difference	
My organization has policies and Procedures in place to ensure my safety.	273	.23**	Small to Medium	5.0
I am asked to do things at my job that I do not feel safe doing.	275	-.18*	Smaller than Typical	3.0
My organization offers adequate health insurance to employees that include confidential mental health services.	273	.25**	Small to Medium	6.0
My organization compensates me or provides comp time when I work long hours or overtime.	273	.25**	Small to Medium	6.0
My work day is filled with different types of activities.	280	.32**	Medium or Typical	10.0
When something upsetting happens at my agency workers are given time to process and heal.	272	-.34**	Medium or Typical	12.0
I feel like I do not have enough work time to do get my job done during a normal business day.	272	-.23	Smaller to Medium	5.0
I feel like I do not have enough resources to succeed at my job.	273	.27**	Medium or Typical	7.0
I work in a stressful environment.	271	-.10	No Significant Difference	

\*p&lt;.05 \*\*p&lt;.001

Table 17 provides the results of correlations and the strengths of these relationships between individual items not included in the four constructs determined by the factory analysis and the dependent variable compassion satisfaction. Several statistical associations with p values

less than .001 and medium to large effect sizes were found indicating the importance of these individual factors and increasing compassion satisfaction in trauma caregivers.

## CHAPTER 5

### DISCUSSION

This chapter provides a summary of the study and discusses the highlights of the research findings and conclusions drawn from the findings. Practical and clinical interpretation of what these findings might mean for organizations that provide services to survivors of trauma is provided. Limitations of the study are addressed, followed by recommendations for further study.

#### **Summary of the Study**

This research study had two purposes 1. To explore the relationship of organizational factors and the role these factors have on employee levels of burnout, secondary traumatic stress, and compassion satisfaction and 2. To develop an instrument that would measure the organizational characteristics that define a trauma-informed organizational culture.

The role of leadership and organizational culture in the field of trauma work has not been thoroughly researched. Although working with traumatized clients can create stress on trauma workers, organizational dynamics also play a role in generating worker stress (Ross, Altmaier, & Russel, 1989). Traumatized systems breed high rates of caregiver burnout and secondary traumatic stress (Bloom, & Farragher, 2011; Tyler, 2012).

#### **Trauma-informed organizational culture**

The literature review builds the case that individuals and organizations that provide services to survivors of trauma are at high-risk of developing burnout and secondary traumatic stress, collectively known as compassion fatigue. People are affected by their work

environment. Tyler (2011) explains how organizations are in danger of becoming collectively traumatized in her article “The Limbic Model of Systemic Trauma”. Tyler argues that psychological and physiological changes can be transferred from the clients who experienced trauma to professional trauma caregivers. Lack of organizational support and resources to provide effective trauma-informed services exacerbate these problems leading to high rates of burnout and secondary traumatic stress. When professional caregivers experience these problems, it is impossible for them to provide adequate and effective trauma-informed services. In the last 10 years, organizational trauma scholars have started to identify how traditional systems of care may have actually done more harm than good to clients. Although traditional treatment systems were meant to ameliorate distress, often these systems of care have created more traumas.

Organizational culture has a profound influence on employee well-being because it is often the workplace environment, not the clients, which increases worker stress and makes caregivers more susceptible to developing compassion fatigue. Trauma-informed care is a complete paradigm shift and requires that every person take an active role in ensuring that systems of care do not re-traumatize the clients, staff, organizations, and community. Well-being of staff and members is top priority in a trauma-informed system and when organizations experience financial stress often the resources that promote staff well-being are diminished. This study supports previous research on the responsibilities organizations have to provide supportive resources to their staff to reduce the risks of compassion fatigue and apply the benefits of employee compassion satisfaction.

The population for this study consisted of three different professional groups who provide services to people or animals who have experienced trauma including child, youth, and family

workers, individuals who work with the homeless, and animal protection workers. Of the 975 individuals who were asked to participate in the study 301 responded and 283 participants, a 31% response rate, were used in the data analysis.

**Trauma-informed organizational culture survey.** This study provided an adequate start in the development of the TIOC and continued research efforts will help improve reliability and validity of the instrument. Through an extensive review of the literature, the Trauma-Informed Organizational Culture survey was created to measure the concepts of caregiver's perception of safety, support, and trauma awareness. Support was broken down into the sub-constructs of organizational support, supervisory support, and peer support. The researcher conducted a pilot study to test the instrument for reliability before the larger study with a relatively small sample size. Although the pilot instrument was found to be reliable, certain items were changed to address the initial research questions. In the larger study the data did not support the hypothesized five factor structure. A factor analysis identified four constructs including the trauma caregiver's perceptions of supervisory support, peer support, organizational support, and trauma-informed caregiver development rather than the original five constructs. A total of 11 items of 30 were not included in the inferential statistical analysis for this study, but were analyzed and results were provided in chapter 4. Although these individual 11 items did not load up as planned, most of these items were significantly correlated with levels of burnout, secondary traumatic stress, and compassion satisfaction. These findings strongly suggest that these items are important but will need to be re-worked to provide a valuable scale measurement of the constructs this study was unable to measure.

The Professional Quality of Life (ProQOL) instrument may be used in conjunction with the TIOC to help measure concurrent validity. The ProQOL has been shown to be a valid and



reliable measure for compassion fatigue and compassion satisfaction (Stamm, 2009).

Theoretically, trauma caregivers working in a trauma-informed system will report lower levels of burnout and secondary traumatic stress (compassion fatigue) and higher levels of compassion satisfaction than individuals who work in a trauma-organized system of care. This theory was supported by this research study. This study found several statistically significant relationships between the independent variables (organization characteristics) and the dependent variables (levels of burnout, secondary traumatic stress, and compassion satisfaction). These findings suggest that the TIOC has several valid constructs including organizational support, supervisory support, peer support, and trauma-informed caregiver development. Further refinement of the instrument will increase validity for the two theoretical constructs of safety and trauma responsiveness not found in the data after the factor analysis was completed.

### **Research Highlights**

This study produced several statistically significant findings that support the researcher's premise of what might constitute a trauma-informed organizational culture. Participants of the study who felt more supported by their organizations, supervisors, and peers tended to be at lower risk for developing burnout and secondary traumatic stress. Also, lack of organizational support and trauma-informed caregiver development were significant predictors of burnout and secondary traumatic stress. Individuals with higher percentage of time working with survivors of trauma exhibited higher rates of secondary traumatic stress, and years working in the trauma field were positively correlated with higher levels of compassion satisfaction. Following is a detailed description of these findings with explanations of what these findings might mean for the field of trauma work.

## Important Findings and Conclusions

This study contributes to the literature regarding professional quality of life for professional trauma caregivers by investigating organizational culture as a predictor of burnout, secondary traumatic stress, and compassion satisfaction. Although other researchers have found significantly high levels of burnout and secondary traumatic stress in child-protection (Conrad, & Kellar-Guenther, 2006; Sprang, Craig, & Clark, 2011) and animal welfare (Humane Society of the United States, 2003-2004), the results of this study were not consistent with previous studies. The average burnout score in the sample was 23.64, the average secondary traumatic stress score was 23.55, and the average compassion satisfaction score was 38.91. When compared to the average scores of a sample of 1,182 providers described in Stamm's (2010) *Concise Professional Quality of Life Manual*, the sample for this study reported low to average levels of burnout and secondary traumatic stress, and average to high levels of compassion satisfaction. Three percent of the participants reported low risk for compassion satisfaction and no respondents were at high risk for burnout or secondary traumatic stress (compassion fatigue).

One difficulty that arose from comparing the findings of this study with previous studies is that many researchers use different instruments to measure burnout and secondary traumatic stress. Several studies used previous versions of the ProQOL or used a completely different instrument to measure burnout and secondary traumatic stress. This prevented making direct comparisons of burnout, secondary traumatic stress, and compassion satisfaction with previous studies.

While the research sample reported low to average levels of burnout and secondary traumatic stress, this research discovered significant findings that should be recognized in the field of trauma work. Following are the study's findings that support the importance of

incorporating a trauma-informed culture for the prevention, reduction, and treatment of trauma caregivers at risk for compassion fatigue.

Although the three groups of professionals did not differ on their levels of burnout, secondary traumatic stress, or compassion satisfaction, individuals who work with the homeless reported significantly higher levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development than child and family workers and animal control officers. The homeless services agency that participated in this study received a grant in 2011 to support system-wide implementation of a trauma-informed treatment approach. This opportunity provided the agency with access to resources and training including education on trauma-informed care, non-violent crisis interventions, and trauma screening for clients. Also, this organization uses an appreciative inquiry approach for employee performance evaluation that endorses a self-care component emphasizing the importance of self-care as part of the overall organizational culture. This situation may have posed a threat to internal validity of the study as this group of participants may have had an advantage to the other two groups.

Burnout was negatively correlated with perceived level of organizational support and trauma-informed caregiver development with effect sizes of medium to large. Burnout was negatively correlated with perceived level of peer support ( $p = .001$ ) and supervisory support ( $p < .001$ ), but these associations were not as strong as organizational support and trauma-informed caregiver development. Interestingly, burnout was not correlated with number of years working in the field of trauma.

Secondary traumatic stress was negatively correlated with perceived level of organizational support and trauma-informed caregiver development with effect sizes of medium to large. Secondary Traumatic Stress was negatively correlated with supervisory support ( $p =$

.002), but the strength of association was not as strong as organizational support and trauma-informed caregiver development. This does not negate the importance of supervisory support as this study found supervisory support to be significantly associated with higher levels of compassion satisfaction ( $p < .001$ ) and the strength of this relationship was medium when effect sizes were calculated. Countless other researchers have found lack of supervisory support to be a strong predictor of burnout and secondary traumatic stress (Harrison & Westwood, 2009; Jankoski, 2010; Tehrani, Osborne, & Lane, 2012) and correlated with trauma caregiver perceptions of client care (Räikkönen, Perälä, & Kahanpää, 2008).

**Strongest predictor variables of burnout, secondary traumatic stress, and compassion satisfaction.** Although supervisory and peer support were found to be significantly important buffers for burnout and secondary traumatic stress in this study, surprisingly these two variables were not as strongly correlated as organizational support and trauma-informed caregiver development based on the effect sizes that were considered. Interestingly secondary traumatic stress was not correlated with perceived level of peer support or number of years working in the field of trauma.

Although the effect size was smaller than typical, years working in the field of trauma was positively correlated with compassion satisfaction. Individuals who worked in the field of trauma longer tended to have higher levels of compassion satisfaction. Many researchers have found that compassion satisfaction may help diminish the negative effects of compassion fatigue (Conrad & Kellar-Guenther, 2006, Stamm, 2002). This finding is consistent with Craig and Sprang (2010) who found years of experience to be a predictor of burnout and secondary traumatic stress with more experienced providers showing higher levels of compassion satisfaction. Laschinger (2001) found that providers who felt more confident that the trauma

services they provided were effective had lower rates of compassion fatigue and higher levels of compassion satisfaction. This may suggest that caregivers who have more trauma experience perceive they are being more helpful to trauma survivors.

When the four variables of supervisory support, peer support, organizational support, and trauma-informed caregiver development were combined and analyzed in relation to burnout, secondary traumatic stress, and compassion satisfaction, multiple regressions discovered that perceived levels of organizational support and trauma-informed caregiver development significantly predicted the variables of burnout, secondary traumatic stress, and compassion satisfaction. For example, if we wanted to predict burnout for a similar group knowing only organizational support, we could use the regression equation to estimate an individual's level of burnout; *predicted burnout score = 35.07 + -.51\*(Organizational Support)*. Thus if the trauma caregiver had an individual organizational support score of 23, his or her predicted burnout score would be 12.58 which is considered to be low. This regression equation formula may also be used to predict burnout for a similar group based on scores of trauma-informed caregiver development. We could use the regression equation to estimate an individual's level of burnout; *predicted burnout score = 35.07 + -2.34\*(Trauma-Informed Caregiver Development)*. Thus if the trauma caregiver had a trauma-informed caregiver development score of 6, his or her predicted burnout score would be 32.7, an average level of burnout. These regression equation formulas must be used with caution as the percentage of variance that can be explained by these variables was 24% and 11%, respectively.

In their sample of behavioral health and trauma caregivers (N = 532), Craig and Sprang (2010) found specialized trauma training was a negative predictor of compassion fatigue and that individuals who received lower levels of training tended to be at higher risk for compassion

fatigue. Acker (2011) found in a sample of 460 mental health workers that workplace support and opportunities for professional development were significant and negatively correlated with compassion fatigue. Discovering these two predictor variables of burnout and secondary traumatic stress was probably the most important finding of the study because predicting individuals who are at higher risk for developing burnout or secondary traumatic stress may lead to organizational practices that focus on prevention or early intervention for those caregivers at risk.

Although there was not a correlation between percentage of time spent providing direct trauma-related services and levels of burnout or compassion satisfaction, there was a correlation between percentage of time providing direct services to survivors of trauma and secondary traumatic stress. As the percentage of direct trauma services increased so did the level of secondary traumatic stress. This finding has strong practical implications and is supported across the trauma literature. Many trauma experts believe that trauma caregivers are at higher risk for secondary traumatic stress if their entire caseload consists of individuals or animals who have experienced trauma (Bell, Kulkarni, & Dalton, 2003; Harrison & Westwood, 2009; Pearlman & McCay, 2008; Saakvitne & Pearlman, 1996). This finding supports the idea that trauma caregivers continuously providing services to survivors of trauma are at higher risk of developing secondary traumatic stress. Organizations should give trauma caregivers opportunities to maintain balanced work duties instead of meeting with client after client. Other opportunities for staff may include training, supervision, research, policy, and/or program development (Saakvitne, & Pearlman, 1996).

**Individual Items on the TIOC.** Other items included on the TIOC were correlated with levels of burnout at significant levels ( $p < .001$ ). The two statements, “I feel safe at my job” and

“When something upsetting happens at my agency workers are given time to process and heal”, were negatively correlated with burnout. These findings supported previous research on compassion fatigue. The National Council for Community Behavioral Healthcare (2012) contends that safe and secure environments are crucial in a trauma-informed organization and “regular examination of an organization’s environment, policies, practices, and relationships prevent increased distress, stigma, and reactions that are experienced as re-traumatizing”. Additionally, Abendroth and Flannery (2006) who found that nurses who did not receive support after a patient died were at higher risk for developing compassion fatigue (N = 166). The two statements, “I feel like I do not have enough work time to get my job done during a normal business day” and “I feel like I do not have enough resources to succeed at my job” were positively correlated with burnout. All four of these had strong associations with medium to large effect sizes and are supported by multiple studies on compassion fatigue prevention (Maslach, 1982; Pearlman & McKay, 2008;).

**Implications for the field of trauma.** Henry, Richardson, Black-Pond, Sloane, Atchinson, and Hyter (2011) discovered that lack of sustained consultation to workers and significant child welfare worker turnover, many of whom had not received adequate training, were the main obstacles that prevented child welfare agencies from adopting a trauma-informed approach. Often workers did not stay in child welfare positions long enough to receive adequate training. These authors recommend “trauma-informed consultation” be optimized to help reduce burnout and secondary traumatic stress, a common theme they found with the child welfare staff. Staff reported they felt as if they were in “survival mode and had little energy to implement trauma-informed casework practices” (p. 183). These authors highly recommended that welfare

staff receive lower workloads and more work time devoted to caregiver development including specialized trauma training starting with information on compassion fatigue.

Professional caregivers have experienced a significant reduction in organizational support and caregiver development due to limited funding and financial deficits in many systems of care (Whitaker, Weismiller, & Clark, 2006). It has become increasingly more difficult to provide effective care to survivors of trauma because of cost control, increased demand for services, and limited available resources (Scheid, 2003). Lack of organizational support and opportunities create additional stressors to the work environment.

When professional caregivers are experiencing the stress response it is virtually impossible for them to provide effective trauma-informed services.

The more that can be done to support caregivers and their emotional needs, the sooner the negative impact of emotional imbalances can be minimized for patients, organizations, and the individuals themselves (Douglas, 2012, p. 417).

Douglas (2012) recommends that organizations acknowledge the existence of compassion fatigue and create structures that support self-care. He states “Delivering care without caring is simply wrong” (p. 419) and validates that survivors of trauma should not have to receive services under such conditions, caregiving professions should not accept traumatized systems as the status quo, and organizations should invest in development to help reduce the effects of compassion fatigue. Trauma-specific training can be used as an adaptive strategy to address compassion fatigue and provide support for professional development that goes beyond educating trauma caregivers (Craig & Sprang, 2010).

The decrease in opportunities for caregiver development and organizational support has also become a challenge that trauma caregivers must face as a result of limited funding and financial deficits of mental health care organizations (Acker, 2011; Scheid, 2003). Changes in

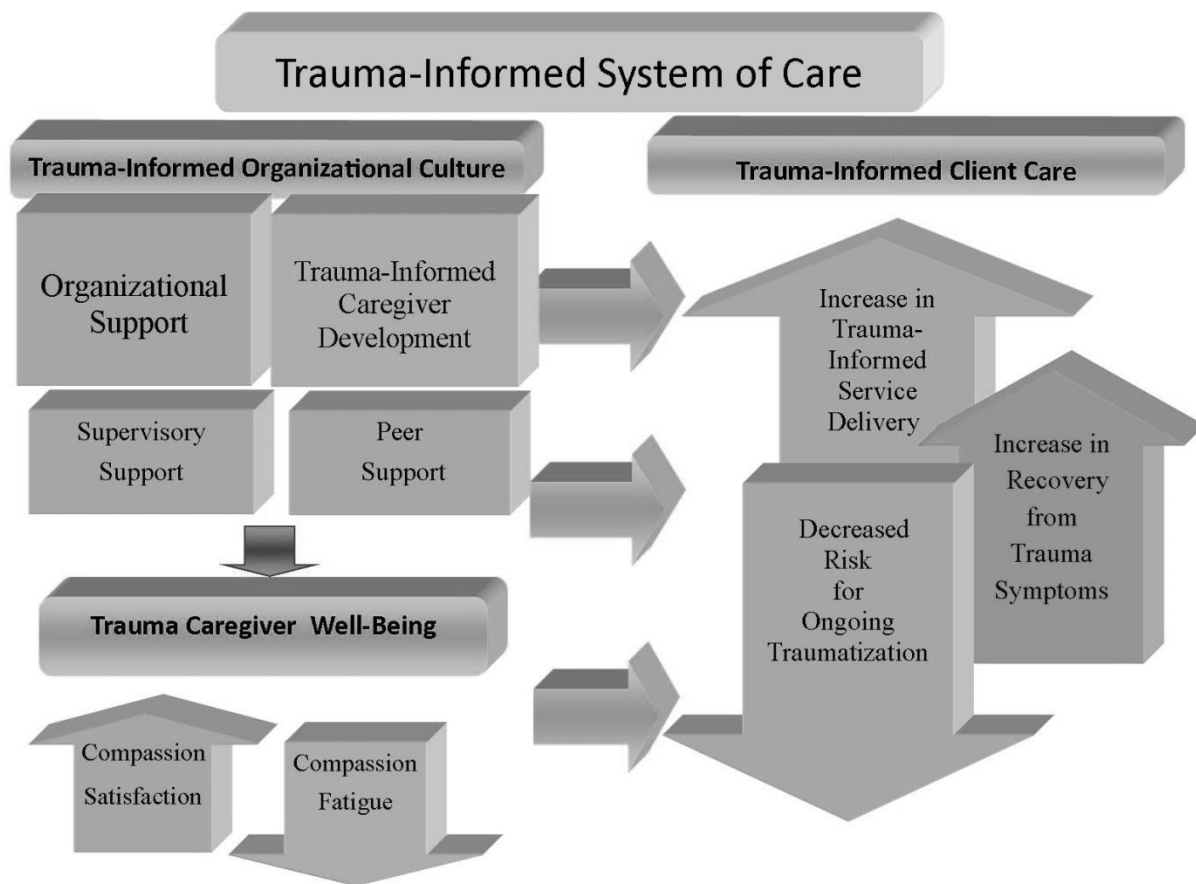


funding structures in many organizations have resulted on less emphasis to professional caregiver development and more on achieving the monthly billable hours to ensure organizational funding. Researchers have found compassion fatigue linked with intent to quit (Jankoski, 2010). This may have implications as mental health and other systems of care attempt to provide efficient quality care at lower cost, but it is usually at the detriment of the workers and ultimately the clients receiving care. Providing opportunities for trauma caregivers to develop skills associated with trauma work including self-care and effective therapies for survivors of trauma may show powerful results in the prevention of compassion fatigue and the increase of compassion satisfaction. Cost-benefit analysis may show that high turnover actually costs more than investing in workers to ensure they have the tools available to provide adequate services while still balancing work and self-care (Arledge, & Wolfson, 2001).

**Trauma-informed systems of care.** The implementation and change toward a trauma-informed system of care may seem overwhelming and often trauma-informed change agents may feel their efforts are not being heard. Henry, Richardson, Coryn, Henry, and Black-Pond (2012) claim that systems theory explains that simply changing one entity of a system may not have a strong enough systemic effect.

As system theory predicts, other system forces (i.e., within the agency, from other agencies, from individuals in the system) will be in play to keep the change from happening in order to maintain equilibrium. If the forces for change are strong enough and come from enough entities within the system, especially entities with strength (power to change systems), the point of equilibrium can shift further in the direction of change to the new paradigm shift (p. 182).

Using systems theory as a lens to understand this study's results, Figure 3 provides a revised conceptualization of a trauma-informed system of care.



*Figure 3. Researcher’s New Conceptualization of a Trauma-Informed System of Care*

Implementation of a trauma-informed organizational culture is an organization-wide endeavor that starts at the top. Administration and funders must be invested in a trauma-informed system and the agency mission and values must reflect a trauma-informed approach (Harris & Fallot, 2001). If the organization’s values are closely tied to the helping process of trauma clients, professional caregivers may feel that their trauma-informed work is supported more by the organization (Ga-Young, 2011). This in turn may help professional caregivers feel more confident in their work with survivors of trauma, which may decrease feelings of helplessness and hopelessness; strong emotions for higher risk of developing compassion fatigue.

Professional caregiver development must be a top priority for trauma-informed systems of care. “Every larger system has an obligation to the people who make it work, as well as to the people it serves” (Dernoot Lipsky & Burk, 2009, p. 17). Douglas (2012) found that even though interest was high for trauma-informed programs among nursing staff, executives were hesitant to invest in such programs. Organizations and supervisors of professional caregivers must have the knowledge of the risks and costs of compassion fatigue (Tehrani, Osborne, & Lane, 2012) and agencies that ignore these requirements are at risk for engaging in unethical behavior. Often when agencies experience budget cuts, training and proper supervision are the first to be slashed. The need for research to support such endeavors is critical so leadership recognize benefits of such programs outweigh the costs (Douglas, 2012).

### **Limitations**

There were limitations that may reduce the internal and external validity of this study. One limitation may have been non-response error or response bias. Non-response error occurs when people who respond to the survey are different than those people who do not respond. Those recipients of the survey who chose to participate in the study may differ in systematic ways from those who did not. Individuals who were experiencing high rates of burnout and secondary traumatic stress might have felt too overwhelmed or did not have enough time to participate in the survey. Also, because the organizations did not release staff email information to the researcher, the emails containing the survey were sent out via an internal employee. Although anonymity was explained and assured, people who did not respond on the survey may not have felt safe responding (Dillman, Smyth, & Christian, 2009).

There is always error in measurement particularly measurement of mental or emotional states (Keller & Casadevall-Keller, 2010). Instrumentation produced threats to internal and external validity in this study. As stated earlier, the original theoretical construct did not load as planned with the factor analysis. Eleven items from the survey were dropped from the overall survey. Even though descriptive data and significant correlations were presented for the items removed from the survey, further research must be done to improve factorial validity on the entire instrument.

This study also did not take into effect personal factors and participants may have responded based on how they were feeling due to external factors not related to the organizational culture. Although this research provided some important findings about the roles organizational support, supervisory support, peer support, and trauma-informed caregiver development have on compassion fatigue, there are many more questions that research may explore. Qualitative or mixed-methods studies done in the future may yield more detailed, rich descriptions of the lived experiences of this exemplary group of professionals.

### **Future Research**

Further research is recommended to increase the validity of the TIOC , understand the role organizational culture has on systems and workers who provide services to survivors of trauma, and ultimately determine the effectiveness of a trauma-informed system of care. The continued refinement of the Trauma-Informed Organizational Culture survey will help increase validity and reliability of the instrument. Dillman, Smyth, and Christian (2009), leaders in the field of instrumentation, recommend the use of feedback from experts and cognitive interviews to help increase instrument validity. Obtaining feedback from multiple trauma experts who have

specialized knowledge of the instrument content will increase the validity of items and identify items that may be inappropriate. Cognitive interviewing will help decipher if respondents are interpreting the individual items as the researcher interprets them. Continued research will increase content validity of the instrument to measure trauma-informed organizational culture in organizations that provide services to survivors of trauma. Reworking the instrument to attain greater predictive validity is vital to understanding the construct of being trauma informed. The use of this survey with other populations who provide trauma-informed services will increase validity of the instrument and inform discussion as to whether certain items on the instrument need to be changed, added, or deleted.

More research needs to be completed on the cost, effectiveness, and advantages of implementing a trauma-informed system. The Trauma-Informed Organizational Culture survey can be used to help organizations identify how they might improve the agency culture and ultimately reduce costs of care. High turnover rates produce high costs to organizational systems and create more stress for the remaining staff. “If not recognized and responded to, compassion fatigue may derail the primary mission of child welfare—to identify and assist abused and neglected children and their families” (Conrad & Kellar-Guenther, 2006, p. 1079).

## **Summary**

The purpose of this study was to identify the organizational characteristics that influence trauma caregivers’ levels of compassion fatigue and compassion satisfaction and to construct and provide validation for an instrument that measures the role organizational culture has on trauma caregivers. The question of what constitutes a trauma-informed organizational culture inspired me to explore the existing research in the growing field of trauma-informed care.

This study found several significant relationships between lack of support and higher risk of burnout and secondary traumatic stress, collectively known as compassion fatigue. The two strongest predictor variables for burnout and secondary traumatic stress were lack of organizational support and trauma-informed caregiver development. Based on these findings we can predict that individuals who feel less supported by their organizations and are given lower levels of education on trauma and how to provide effective trauma services are at higher risk for developing burnout and secondary traumatic stress. The results of this study provide strong evidence that organizations and the support they provide have a large impact on trauma caregiver's health and well-being. Organizations must be mindful of these factors when implementing a system-wide change toward a trauma-informed care approach.

### **Researcher's Reflection**

I first learned about the trauma-informed approach to care when I worked for over eight years at an organization that provided services to women from marginalized populations who suffered from co-occurring illnesses, homelessness, and involvement in the criminal justice system, and/or prostitution. The majority of these women had experienced severe ongoing trauma throughout their lives. I noticed that many of these women were actually being re-traumatized by the institutions in which they received services. I experienced other professionals engaging in punitive practices toward individuals with histories of significant trauma. Although I am very fortunate I received this life-learning experience, I too suffered from compassion fatigue. I know when I wasn't feeling well I was not providing effective trauma-informed services to my clients. When I wasn't feeling well it would take every ounce of energy for me to get out of bed in the morning and show up to work.

Van Dernoot Lipsky and Burk (2009) state in their book *Trauma Stewardship* that “The kind of tired that results from having a trauma exposure response is a bone-tired, soul-tired, heart-tired kind of exhaustion-your body is tired, your mind is tired, your spirit is tired, your people are tired. You can’t remember a time when you weren’t tired” (p. 81). There were times during my trauma work where I felt this level of tiredness on my soul. These authors also state “When we contend with trauma exposure, however, we often find ourselves craving more structure and less creativity. We may resist change even when existing structures are out of date and detrimental to us personally and professionally” (p. 68). I became flooded by feelings of helplessness and hopelessness and questioned if I was actually helping the people I sought out to help. I found myself engaging in knee-jerk reactions to create more structure when I was feeling traumatized by my work. Some of these responses included behaving in a passive-aggressive manner with colleagues and supervisors and calling in sick to work. This response only made me feel worse because these coping skills were not healthy and an approach that was not consistent with my values.

I am fortunate to have experienced great mentors throughout my journey who allowed me to grow and change and taught me about the trauma-informed approach to treatment. A trauma-informed approach to social work is at the very core of my personal values and to see the ever-expanding trauma-informed literature provides me with a new found sense of hope and inspiration.

This study provides strong support on the importance of implementing trauma-informed organizational support, supervision, and training for professional caregivers providing trauma services. Trauma-informed care is a system-wide approach that must include the workers providing the trauma-services. Trauma-informed care is not about providing a trauma-specific

intervention to survivors of trauma but incorporates a system-wide paradigm shift (Harris & Falot, 2001, SAMHSA, 2012). The findings from this study provide strong practical implications to guide organizations in the development of a trauma-informed system that includes the caregivers providing the trauma services. With the continued interest on the effectiveness of trauma-informed systems of care, research efforts must include the caregivers who provide the services to prevent, reduce, and treat compassion fatigue and increase compassion satisfaction and ultimately improve client care.



## REFERENCES

- Abendroth, M., & Flannery, J. (2006). Predicting the risk of compassion fatigue: A study of hospice nurses. *Journal of Hospice and Palliative Nursing*, 8(6), 346-356.
- Acker, G.M. (2011). Burnout among mental health care providers. *Journal of Social Work*, 12(5), 475-490, doi: 10.1177/1468017310392418.
- The Adverse Childhood (ACE) Study. (n.d.). Bridging the gap between childhood trauma and negative consequence later in life. Retrieved from <http://www.cestudy.org/>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Anda, R.F., & Felitti, V.J. (2003). The adverse childhood experiences (ACE) study: Bridging the gap between childhood trauma and negative consequences later in life. *Ace Reporter*, 1(1), 1-4. Retrieved on December 14, 2011 from <http://www.cestudy.org/>
- Arledge, E., & Wolfson, R. (2001). Care of the clinician: Effective services for trauma survivors rely on addressing the support and care needs of clinicians and administrators. In Harris, M. & Fallot, R.D (Eds.), *Using trauma theory to design service systems* (pp. 91-98). San Francisco, CA: Jossey-Bass.
- Azar, S. T. (2000). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: A cognitive behavioral approach to supervision. *Journal of Clinical Psychology*, 56(5), 643-663. doi: 10.1002/(SICI)10974679(200005)56:5<643::AID-JCLP6>3.0.CO;2-U
- Babbie, E. (2004). *The practice of social research* (10<sup>th</sup> ed.). Belmont, CA: Thompson.
- Bahraini, N. (2008). Development and validation of the professional support inventory for mental health professionals. Retrieved from ProQuest Digital Dissertations. (UMI 3320576)
- Barsade, S.G. (2002). The ripple effect: Emotional contagion and its influence on group behavior. *Administrative Science Quarterly*, 47, 644-657.
- Baumeister, R.F., Bratslavsky, E., Finkenauer, C., & Vohs, K.D. (2001). Bad is stronger than good. *Review of General Psychology*, 5(4), 323-370. doi:10.1037//1089-2680.5.4.33

- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organization prevention of vicarious trauma. *Families in Society. The Journal of Contemporary Human Services*, 84(4), 463-470.
- Bloom, S.L. (1999). Trauma theory abbreviated. *Final Action Plan: A Coordinated Community-Based Response to Family Violence*. Attorney General of Pennsylvania Family Violence Task Force, Retrieved January 17, 2013 from [http://www.sanctuaryweb.com/PDFs\\_new/Bloom%20Trauma%20Theory%20Abbreviated.pdf](http://www.sanctuaryweb.com/PDFs_new/Bloom%20Trauma%20Theory%20Abbreviated.pdf)
- Bloom, S. L. (2006). Organizational stress as a barrier to trauma-sensitive change and system transformation. Adapted from: *Living Sanctuary: Complex Antidotes to Organizational Stress in a Changing World*, Retrieved on May 1, 2010 from [www.sanctuaryweb.com](http://www.sanctuaryweb.com)
- Bloom, S.L., & Farragher, B. (2011). *Destroying sanctuary*, New York, NY: Oxford Press.
- Bloom, S.L., & Yanosy-Sreedhar, S. (2008). The sanctuary model of trauma-informed organizational change. *Reclaiming Children and Youth*, 17(3), 48-53.
- Breslau, N., Kessler, R.C., Chilcoat, H.D., Schultz, L.R., Davis, G.C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit area survey of trauma. *Archives of General Psychiatry*, 55, 626-632.
- Bride, B (2007). Prevalence of secondary traumatic stress among social workers. *National Association of Social Workers*, 25(1), 63-69.
- Bride, B., & Figley, C. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal*, 35(3), 151-153. doi: 10.1007/s10615-007-0093-5
- Cameron, K. (2008). *Positive leadership: Strategies for extraordinary performance*. San Francisco, CA: Barrett-Koehler Publishers, Inc.
- Cameron, K.S., Bright, D., & Caza, A. (2004). Exploring the relationships between organizational virtuousness and performance. *American Behavioral Scientist*, 47, 766-790. doi: 10.1177/0002764203260209
- Campbell, J. P., Dunnette, M. D., Lawler, E. E., & Weick, K. E. (1970). *Managerial behavior, performance, and effectiveness*. New York, NY: McGraw Hill.
- Christensen, R. C., Hodgkins, C.C., Garces, L.K. Estlund, K.L., Miller, D.M., & Touchton, R. (2005). Homeless, mentally ill and addicted: The need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved*, 16(4), 615-621.

- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd edition)*, Hillsdale, NJ: Erlbaum.
- Colorado Department of Human Services: The Omni Institute. (2008). *Homeless point in time study: City and County of Denver*. Retrieved from [http://www.cdhs.state.co.us/shhp/PDFs/Point-and\\_timeFullReport\\_2008.pdf](http://www.cdhs.state.co.us/shhp/PDFs/Point-and_timeFullReport_2008.pdf)
- Compassion Fatigue Awareness Project. (2010). *Recognizing compassion fatigue*. Retrieved June 15, 2010 from [www.compassionfatigue.org](http://www.compassionfatigue.org)
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child, youth, and family workers. *Child Abuse and Neglect*, 30(10), 1071-1080. doi:10.1016/j.chiabu.2006.03.009
- Cooper, J.L, Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. (2007). Strengthening policies to support children, youth, and families who experience trauma. *The National Center for Children in Poverty (NCCP). Unclaimed Children Revisited Working Paper No. 2*. Retrieved on March 5, 2009 from [http://www.nccp.org/publications/pub\\_940.html](http://www.nccp.org/publications/pub_940.html)
- Cozolino, L. (2006). *The neuroscience of human relationships: Attachment and the developing social brain*. New York, NY: WW Norton and Company.
- Craig, C.D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, 23(3), 319-339.
- Dale, M. (2008). Social workers owe it to themselves and clients to value a healthy lifestyle. The profession must prioritize self-care. *NASW News*, 53(10), 4.
- Dillman, D.A. (2007). *Mail and Internet Surveys: The tailored design method (2nd ed.)*. Hoboken, NJ: John Wiley and Sons.
- Dillman, D.A., Smyth, J.D., & Christian, L.M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method (3rd ed.)*. Hoboken, NJ: John Wiley and Sons.
- Douglas, K. (2012). When caring stops, staffing doesn't really matter. *Nursing Economics*, 28(6), 415-419.
- Edwards, P., Roberts, I., Sandercock, P., & Frost, C. (2004). Follow-up by mail in clinical trials: Does questionnaire length matter? *Controlled Clinical Trials*, 25, 31-52.
- Eisenberger, R. (2008). *Perceived organizational support*. Retrieved from <http://eisenberger.psych.udel.edu/POS.html>
- Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied Psychology*, 71(3), 500-507.

- Etherington, K. (2000). Supervising counselors who work with survivors of childhood sexual abuse. *Counseling Psychology Quarterly*, 13(4), 377-389.
- Felitti, V.J. (2002). The relationship of adverse childhood experiences in adult health: Turning gold into lead. *The Permanente Journal*, 6(1), 44-47.
- Ferguson, S. S. (2007). Clergy compassion fatigue. *Family Therapy Magazine*, March-April, 16-19.
- Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In Stamm, B.H. (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (pp. 3-28). Lutherville, MD: Sidran Press.
- Figley, C.R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice*. 58(11), 1433-1441.
- Figley, C. R., & Roop, R. (2006) *Compassion fatigue in the animal care community*. Washington, DC: Humane Society Press.
- Frandsen, B.M. (2010). Burnout or compassion fatigue? *Living for the continuing care professional*, 59(5), 50-52.
- Friedman, R. (2002). The importance of helping the helper. *Trauma and Child Welfare*, Retrieved October 23, 2008 from: [http://www.vachss.com/guest\\_dispatches/friedman.html](http://www.vachss.com/guest_dispatches/friedman.html)
- Ga-Young, C. (2011): Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work*, 35(3), 225-242. doi.org/10.1080/03643107.2011.575333
- Gearon, J.S., & Bellack, A.S. (1999). Women with schizophrenia and co-occurring substance use disorders: An increased risk for violent victimization and HIV. *Community Mental Health Journal*, 35, 401-419.
- Gliner, J.A., Morgan, G.A., & Leech, N.L. (2009). *Research methods in applied settings: An integrated approach to design and analysis* (2<sup>nd</sup> ed.). New York, NY: Routledge.
- Glisson, C. (2007). Assessing and changing organizational culture and climate for effective services. *Research on Social Work Practice*, 17, 736-747. doi: 10.1177/1049731507301659.
- Goleman, D., Boyatzis, R., and McKee, A. (2002). The emotional reality of teams. *Journal of Organizational Excellence*, 21(2), 55-65.

- Gunn, A.M., Richburg, R.W., & Smilkstein, R. (2007). *Igniting student potential: Teaching with the brain's natural learning process*. Thousand Oaks, CA: Corwin Press.
- Harris, M., & Fallot, R.D. (2001). *Using trauma theory to design service systems*. San Francisco, CA: Jossey-Bass.
- Harrison, R.L., & Westwood, M.J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research Practice, Training, 46*(2), 203–219. doi:10.1037/a0016081.
- Hatfield, E., Cacioppo, J.T., & Rapson, R.L. (1992). Primitive emotional contagion. Clark, M.S. (Ed.), *Review of personality and social psychology: Emotions and social behavior, (Vol. 14)*, (151-177) Newbury Park, CA: Sage .
- Hatfield, E., Cacioppo, J.T., & Rapson, R.L. (1993). Emotional contagion. *Current Directions in Psychological Science, 2*(3), 96-99.
- Hatfield, E., Cacioppo, J.T., & Rapson, R.L. (1994). *Emotional contagion: Studies in emotion and social interaction*. New York, NY: Cambridge University Press.
- Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchinson, B., & Hyter, Y. (2011) A grassroots prototype for trauma-informed child welfare system change. *Child Welfare, 90*(6), 169-186.
- Hormann, S., & Vivian, P. (2005). Toward an understanding of traumatized organizations and how to intervene in them. *Traumatology, 11*(3), 159-169.
- Horwitz, M. (1998). Social worker trauma: Building resilience in child protection social workers. *Social Work Trauma, 68*(3), 363-377.
- The Humane Society of the United States (HSUS). 2003-2004. Compassion satisfaction/fatigue self-test: animal care. Adapted with permission from C.R. 1995. *Compassion fatigue: Coping with secondary traumatic stress disorder*. Washington, DC: Humane Society of the United States.
- Illiffe, G., & Steed, L. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence, *Journal of Interpersonal Violence, 15*(4), 393-412. doi: 10.1177/088626000015004004
- Jankoski, J.A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare, 89*(6), 105-120.
- Jansen, G. (2004). Vicarious trauma: An interview with Golie Jansen, Associate Professor, Department of social work, Eastern Washington University. *Research and Advocacy Digest*, Washington Coalition of Sexual Assault Programs.

- Kast, F.E., & Rosenzweig, J.E. (1972). General systems theory: Applications for organization and management. *Academy of Management Journal*, 447-465.
- Kees, N. (2009). Creating safe learning environments, In Timpson, W. M., Canette, S.S., Borrayo, E., & Yang, R (Eds.), *Teaching diversity: Challenges and complexities, identities, and integrity* (pp. 55-64). Madison, WI: Atwood Publishing.
- Keller, D.K. & Casadevall-Keller, M.L. (2010). *The tao of research: A path to validity*, Thousand Oaks, CA: Sage.
- Kim, M.M., Ford, J.D., Howard, D.L., & Bradford, D.W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health and Social Work*, 35(1), 39-50.
- Knight, C. (2004). Working with survivors of childhood trauma: Implications for clinical supervision. *The Clinical Supervisor*, 23(2), 81-101. DOI: 10.1300/J001v23n02\_06
- Laschinger, H.K.S. (2001). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economics*, 19(2), 42-52.
- Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post-traumatic stress symptoms and their relationship to professional quality of life (ProQOL) in nursing staff at a forensic psychiatric security unit: a cross-sectional study. *Health & Quality of Life Outcomes*, 7, 1-6. doi: 10.1186/1477-7525-7-31.
- Levine, P.A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*, Berkley, CA: North Atlantic Books.
- Mandziuk, P, A, (1997), Continuity of spiritual care. *Journal of Religion and Health*, 36(1), 65-70.
- Martin, J. (2002). *Organizational culture: Mapping the terrain*. Thousand Oaks, CA: Sage.
- Mary, N.L. (2005). Transformational leadership in human services organizations. *Administration in Social Work*, 29(2), 105-118.
- Maslach, C. (1982). *Burnout: The cost of caring*. English Cliffs, NJ: Prentice-Hall.
- Maslach, C., & Leiter, M.P. (1997). *The truth about burnout: How organizations cause personal stress and what to do about it*. San Francisco, CA: Jossey-Bass Publishers.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50, 370-396.
- McCalister, K.T., Dolbier, C.L., Webster, J.A., Mallon, M.W., & Steinhardt, M.A. (2006). Hardiness and support at work as predictors of work stress and job satisfaction. *Stress Management*, 20(3), 183-191.

- Medrano, M.A., Hatch, J.P., Zule, W.A., & Desmond, D. P. (2003). Childhood trauma and adult prostitution behavior in a multiethnic heterosexual drug-using population. *American Journal of Drug and Alcohol Abuse*, 29(2), 462-486.
- Milford, J.L. (2008). Lifetime trauma and associated mental health symptoms in homeless women: Impulsivity as a feature of posttraumatic stress disorder and addiction. *Dissertation Abstracts International*, 68(7-B), 4836-4964.
- Morgan, G.A., Leech, N.L., Gloeckner, G.W., & Barrett, K.C. (2007). *SPSS for introductory statistics: Use and Interpretation* (3<sup>rd</sup> ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Morgan, G.A., Leech, N.L., Gloeckner, G.W., & Barrett, K.C. (2010). *SPSS for introductory statistics: Use and Interpretation* 4<sup>th</sup> ed.). New York, NY: Taylor and Francis Group.
- Moore, S. (2007). Developing leaders at every level: Accountability and empowerment actualized through shared governance. *Journal of Nursing Administration*, 37(12), 564-568.
- National Council for Community Behavioral Health Care. (2013). *Trauma-informed care: Behavioral Health Overview*. Retrieved March 9, 2013 from [http://www.thenationalcouncil.org/cs/behavioral\\_health\\_overview](http://www.thenationalcouncil.org/cs/behavioral_health_overview)
- Newell, J.M., & MacNeil, G.A. (2011). A comparative analysis of burnout and professional quality of life in clinical mental health providers and health care administrators. *Journal of Workplace Behavioral Health*, 26(1), 25-43.
- Nolan, D. (2005). Do social workers in child protection agency need a stress de-briefing program? *Kentucky Cabinet for Health and Family Services, Spalding University*, Retrieved on November 23, 2010 from [http://chfs.ky.gov/NR/rdonlyres/2BDCC02B-A833-46D3-8C17-7ADB8789C85D/0/2005FSEMPLOYEESNolan\\_Danyell.pdf](http://chfs.ky.gov/NR/rdonlyres/2BDCC02B-A833-46D3-8C17-7ADB8789C85D/0/2005FSEMPLOYEESNolan_Danyell.pdf)
- Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for health care and social service workers*. United States Department of Labor, Retrieved March 3, 2010 from <http://www.osha.gov/Publications/osh3148.pdf>
- Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations service individuals who have experienced chronic homelessness. *Journal of Behavioral Health Services & Research*, 37(2), 226-240.
- Oyefeso, A., Clancy, C., & Farmer, R. (2008). Prevalence and associated factors in burnout psychological morbidity among substance misuse professionals. *BMC Health Services Research*, 8(39), n.p. doi: 10.1186/1472-6963-8-39.

- Padgett, D.K., Hawkins, R.L., Abrahms, C., & Davis, A. (2006). In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry*, 76(4), 461-467.
- Pearlman, L.A., & McKay, L. (2008). Vicarious trauma: What can managers do? Excerpted by CARE from: *Understanding and addressing vicarious trauma*, Headington Institute, Retrieved on November 3, 2010 from [www.headington-institute.org](http://www.headington-institute.org)
- Perry, B. D. (2002). Helping traumatized children: A brief overview for caregivers. *Child Trauma Academy*, Retrieved September 17, 2010 from [http://childtraumaacademy.org/Documents/Printcare\\_03\\_v2.pdf](http://childtraumaacademy.org/Documents/Printcare_03_v2.pdf)
- Perry, B.D. (2003). The cost of caring: Secondary traumatic stress and the impact of working with high-risk children and families. *The Child Trauma Academy*, Retrieved September 15, 2008 from [www.childtrauma.org](http://www.childtrauma.org)
- Pilon, J.G. (2008). Health behaviors of homeless women: Using a cross-sectional, descriptive, and non-experimental design. *Gender Issues*, 25(30), 210-213.
- Purdy, N., Laschinger, H.K., Finegan, J., Kerr, M., & Olivera, F. (2010). Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management*, 18, 901-913.
- Rakoczy, S. (2011). Compassion fatigue in child welfare. *The New Social Worker*, Retrieved September 21, 2010 from [http://www.socialworker.com/home/Feature\\_Articles/Professional\\_Development\\_&\\_Advancement/Compassion\\_Fatigue\\_in\\_Child\\_Welfare/](http://www.socialworker.com/home/Feature_Articles/Professional_Development_&_Advancement/Compassion_Fatigue_in_Child_Welfare/)
- Räikkönen, O., Perälä, M.L., & Kahanpää (2008). Staffing adequacy, supervisory support and quality of care in long-term care settings: staff perceptions. *Journal of Advanced Nursing*, (60)6, 615-626. doi: 10.1111/j.365-2648.2007.04442.x.
- Rank, M.G., Zapanick, T.L., & Gentry, J.E. (2009). Nonhuman-animal care compassion fatigue: Training as treatment. *Best Practices in Mental Health*, 5(2), 40-63.
- Reeve, C.L., Rogelberg, S.G., Spitzmüller, C., & DiGiacomo, N. (2005). The caring-killing paradox: Euthanasia-related strain among animal-shelter workers. *Journal of Applied Social Psychology*, 35(1), 119-143.
- Reynolds, J.R., & Turner, R.J. (2008). Major life events: Their personal meaning, resolution, and mental health significance. *Journal of Health and Social Behavior*. 49, 223-237. doi: 10.1177/002214650804900208.
- Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. The Center for Research on Violence against Women and Children: The University of Western Ontario, London, Ontario, Canada.



- Riggio, R.E., & Smith Orr, S. (2004). *Transformational leadership in nonprofit organizations*. San Francisco, CA: Wiley and Sons.
- Riggle, R.J., Edmondson, D.R., & Hansen, J.D. (2009). A meta-analysis of the relationship between perceived organizational support and job outcomes: 20 years of research. *Journal of Business Research*, 62(10), 1027-1030. doi:10.1016/j.jbusres.2008.05.003.
- Risley-Curtiss, C., Holley, L.C., & Wolf, S. (2006). The animal-human bond and ethnic diversity. *Social Work*, 51, 257-268.
- Roberts, A.R. (2000). An overview of crisis theory and crisis intervention. In A.R. Roberts (Ed.), *Crisis intervention handbook. Assessment, Treatment, and Research* (pp. 3-30). New York, NY : Oxford University Press.
- Roche, A.M., Todd, C.L., & O'Connor, J. (2007). Clinical supervision in the alcohol and other drugs field: An imperative or an option? *Drug and Alcohol Review*, 26, 241 – 249.
- Rosenbloom, D.J., Pratt, A.C., & Pearlman, L.A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In Stamm, B.H. (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*. (pp. 65-79). Lutherville, MD: Sidran Press.
- Ross, R. R., Altmaier, E.M., & Russel, D.W. (1989). Job stress, social support and burnout among counseling center staff. *Journal of Counseling Psychology*, 35(4), 464-470. doi:0022-0167/89/500.75.
- Royse, D., Thyer, B.A., & Padgett, D.K. (2010). *Program evaluation*. Belmont, CA: Wadsworth.
- Rowold, J., & Rohmann, A. (2009). Relationships between leadership styles and followers' emotional experience and effectiveness in the voluntary sector. *Nonprofit and Voluntary Sector Quarterly*, 38(2), 270-286.
- Rubin, A., & Babbie, E. (2011). *Research methods for social work*. Belmont, CA: Brooks/Cole.
- Saakvitne, K.W., Gamble, S., Pearlman, L.A., & Tabor, L.B. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Lutherville, MD: Sidran Institute.
- Saakvitne, K.W., & Pearlman, L.A. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. The Traumatic Stress Institute, New York, NY: W.W. Norton & Company, Inc.

- Sapolsky, R.M. (1998). *Why zebras don't get ulcers: The acclaimed guide to stress, stress-related diseases, and coping*. (3<sup>rd</sup> ed.). New York, NY: Henry Holt and Company.
- Scheid, T.L. (2003). Managed care and the rationalization of mental health services. *Journal of Health and Social Behavior*, 44(2), 142-61.
- Schein, E. H. (1996). Organizational culture: The missing concept in organization studies. *Administrative Science Quarterly*, 41, 229-240.
- Schein, E.H. (2010). *Organizational culture and leadership*. (4<sup>th</sup> ed.) San Francisco, CA: Jossey-Bass.
- Schwartz, R. (2008). *Working conditions and secondary traumatic stress*. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Thesis (UMI No. 3289935).
- Shanock, L.R., & Eisenberger, R. (2006). When supervisors feel supported: Relationships with subordinates perceived supervisor support, perceived organizational support, and performance. *Journal of Applied Psychology*, 91(3), 689-695. doi: 10.1037/0021-9010.91.3.689.
- Sharp, S. (2013). Trauma-informed care: Behavioral health overview. *National Council for Community Behavioral Health*, Retrieved January 23, 2013 from [http://www.thenationalcouncil.org/cs/behavioral\\_health\\_overview](http://www.thenationalcouncil.org/cs/behavioral_health_overview)
- Sheafor, B.W., & Horejsi, C. R (2008). *Techniques and guidelines for social work practice*. (8<sup>th</sup> ed.). Boston, MA: Pearson Education Inc.
- Spielberger, C. D., Vagg, P. R., & Wasala, C. F. (2003). Occupational stress: Job pressures and lack of support. In J. C. Quick & L. E. Tetrick (Eds.), *Handbook of occupational health psychology* (pp. 185-200). Washington, DC: American Psychological Association.
- Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, 90(6), 149-168.
- Stamm, B.H. (2005). *The ProQOL manual: The Professional Quality of Life Compassion Satisfaction, Burnout, and Compassion fatigue/Secondary Trauma Scales*, Baltimore, MD: Sidran Press.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107–120). New York, NY: Brunner-Routledge.
- Stamm, B.H. (2009). *The Concise ProQOL Manual*, (2<sup>nd</sup> ed.). Pocatello, ID: [www.ProQOL.org](http://www.ProQOL.org)

- Stamm, B. H. (2011). *The ProQOL*. [www.proqol.org](http://www.proqol.org)
- Stump, M.J., & Smith, J.E. (2008). The relationship between posttraumatic growth and substance use in homeless women with histories of traumatic experience. *American Journal on Addictions*, 17(6), 478-487.
- Substance Abuse Mental Health Services Administration. (2003). *Co-occurring disorders: Integrated dual disorders treatment. Implementation Resource Kit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services, U.S. Department of Health and Human Services, Retrieved from [http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTpractinfoAJ1\\_04.pdf](http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTpractinfoAJ1_04.pdf)
- Substance Abuse Mental Health Services Administration (SAMHSA). (n.d.). *National Center for Trauma Informed Care. Welcome to the National Center for Trauma-Informed Care*. Retrieved on November 23, 2010 from <http://www.samhsa.gov/nctic/>
- Tehrani, N., Osborne, D., & Lane, D. (2012). Restoring meaning and wholeness: The role for coaching after trauma. *International Coaching Psychology Review*, 7(2), 239-246.
- Timpson, W. M., Canette, S.S., Borrayo, E., & Yang, R. (Eds.), *Teaching diversity: Challenges and complexities, identities, and integrity* (pp. 263-264). Madison, WI: Atwood Publishing.
- Tyler, T.A. (2012). The limbic model of systemic trauma. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, 26(1), 125-138.
- United States Department of Health and Human Service, Administration on Children, Youth, and Families. (2011). *Child Maltreatment 2010*. Available from [http://www.acompassionfatigue.hhs.gov/programs/cb/stats\\_research/index.htm#can](http://www.acompassionfatigue.hhs.gov/programs/cb/stats_research/index.htm#can)
- Valent, P (2002). Diagnosis and treatment of helper stresses, traumas, and illnesses. In C Figley (Ed.). *Treating Compassion fatigue* (pp. 17-38). New York, NY: Brunner, Routledge.
- Van Der Kolk, B.A., & McFarlane, A.C. (1996). The black hole of trauma. In B.A. Van Der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York, NY: Guilford Press.
- Van Dernoot Lipsky, L., & Burk, C., (2009). *Trauma-stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler, Inc.
- Wen, C.K., Hudok, P.L., & Hwang, S.W. (2007). Populations at risk: Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. *Journal of General Internal Medicine*, 22(7), 1011-1017.

- Wenzel, J., Shaha, M., Klimmek, R., & Krumm, S. (2011). Working through grief and loss: Oncology nurses' perspectives on professional bereavement. *Oncology Nursing Forum*, 38(4), 272-282.
- Whitaker, T., Weismiller, T., & Clark, E. (2006). Assuring the sufficiency of a frontline workforce: Executive summary. Washington, DC: National Association of Social Workers.
- Yang, R. (2009). Analysis: Safety is the Leitmotif, In Timpson, W. M., Canette, S.S., Borrayo, E., & Yang, R. (Eds.), *Teaching diversity: Challenges and complexities, identities, and integrity* (pp. 263-264). Madison, WI: Atwood Publishing.



**Individuals who provide services to people who have experienced trauma are at heightened risk for developing symptoms of compassion fatigue. The following questionnaire consists of two survey instruments that in combination will be used to identify the roles safety, support, and trauma awareness and how they may relate to compassion satisfaction and compassion fatigue in individuals who provide services to trauma survivors.**

**These surveys should take less 10 minutes to complete. Your responses will remain anonymous. Following the study you will be given an email address. If you are interested in entering a drawing with a chance to win one of six \$50.00 gift cash cards please send a contact phone number or email address to this email. Your personal information will never be shared or sold. This contact information will be destroyed after the winners have been notified. Your participation completely voluntary and is greatly appreciated.**

**If you feel any emotional vulnerability following the participation in this survey please contact Tracy Gano, MSW, LCSW at (303) 818-6649. Tracy Gano will provide referrals to appropriate resources for anyone who experiences distress from completing the survey.**

**Should you have any questions or concerns regarding this survey please contact the Principal Investigator, Gene Gloeckner, at (970) 491-7661, the Co-Principal Investigator, Joni Handran, at (720) 261-7042, or the Research Integrity and Compliance Review Office Coordinator, Janell Barker, at 970-491-1655.**

**Trauma Informed Organizational Culture: Please rate the following statements.**

1=Strongly Disagree    2=Disagree    3=Undecided    4=Agree    5=Strongly Agree

- |   |           |
|---|-----------|
| 1. I feel safe at my job.   | 1 2 3 4 5 |
| 2. I witness violence at my job.  | 1 2 3 4 5 |
| 3. My organization has policies and procedures in place to ensure my safety.  | 1 2 3 4 5 |
| 4. I am asked to do things at my job that I do not feel safe doing.   | 1 2 3 4 5 |
| 5. My organization values people who have different types of skills.  | 1 2 3 4 5 |
| 6. My organization values me as a person.   | 1 2 3 4 5 |
| 7. My organization offers adequate health insurance to employees that include confidential mental health services.                        | 1 2 3 4 5 |
| 8. My organization compensates me or provides comp time when I work long hours or overtime.   | 1 2 3 4 5 |
| 9. My organization encourages me to take care of myself.  | 1 2 3 4 5 |
| 10. My work day is filled with different types of activities.   | 1 2 3 4 5 |
| 11. I feel like I do not have enough work time to do get my job done during a normal business day.  | 1 2 3 4 5 |
| 12. I feel like I do not have enough resources to succeed at my job.  | 1 2 3 4 5 |
| 13. I feel like my organization does not support me.  | 1 2 3 4 5 |
| 14. I feel comfortable talking to my supervisor about work related problems.  | 1 2 3 4 5 |
| 15. My supervisor asks me for suggestions or about my opinions.   | 1 2 3 4 5 |
| 16. I receive regularly scheduled supervision for my job.   | 1 2 3 4 5 |
| 17. My supervisor encourages me to take care of myself.   | 1 2 3 4 5 |
| 18. I trust my supervisor.  | 1 2 3 4 5 |
| 19. My supervisor supports my decisions.  | 1 2 3 4 5 |
| 20. I trust my co-workers.  | 1 2 3 4 5 |
| 21. My co-workers know at least a few personal things about me.<br>(for example birthday, partner's name, favorite type of food or hobby) | 1 2 3 4 5 |
| 22. I generally like my co-workers.   | 1 2 3 4 5 |
| 23. I feel comfortable discussing work related problems with my co-workers.   | 1 2 3 4 5 |
| 24. I feel comfortable discussing personal problems with my co-workers.   | 1 2 3 4 5 |
| 25. I have received training through my current job to help me effectively work with individuals who have experienced trauma.             | 1 2 3 4 5 |

- |   |           |
|---|-----------|
| 26. I have received information at my current job on the importance of self-care.             | 1 2 3 4 5 |
| 27. I have received information at my current job on compassion fatigue.                      | 1 2 3 4 5 |
| 28. I work in a stressful environment.  | 1 2 3 4 5 |
| 29. When something upsetting happens at my agency workers are given time to process and heal. | 1 2 3 4 5 |
| 30. I work in an agency that supports my self-care efforts.                                   | 1 2 3 4 5 |

**Is there anything else that you feel you need from your organization that would help you work more effectively with individuals or animals who have experienced trauma?**

**The next survey is the Professional Quality of Life Scale (ProQOL). The ProQOL is used to measure worker compassion fatigue and compassion satisfaction. Please see directions below.**

# Professional Quality of Life Scale (ProQOL)

## *Compassion Satisfaction and Compassion Fatigue*

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I am preoccupied with more than one person I *[help]*.
- \_\_\_\_\_ 3. I get satisfaction from being able to *[help]* people.
- \_\_\_\_\_ 4. I feel connected to others.
- \_\_\_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_\_\_ 6. I feel invigorated after working with those I *[help]*.
- \_\_\_\_\_ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- \_\_\_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
- \_\_\_\_\_ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
- \_\_\_\_\_ 10. I feel trapped by my job as a *[helper]*.
- \_\_\_\_\_ 11. Because of my *[helping]*, I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a *[helper]*.
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
- \_\_\_\_\_ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- \_\_\_\_\_ 15. I have beliefs that sustain me.
- \_\_\_\_\_ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
- \_\_\_\_\_ 17. I am the person I always wanted to be.
- \_\_\_\_\_ 18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. I feel worn out because of my work as a *[helper]*.
- \_\_\_\_\_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my case [work] load seems endless.
- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
- \_\_\_\_\_ 24. I am proud of what I can do to *[help]*.
- \_\_\_\_\_ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a *[helper]*.
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_\_\_ 29. I am a very caring person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.

Stamm, B.H. (2009). *The Concise ProQOL Manual, (2nd ed.)*. Pocatello, ID: [www.ProQOL.org](http://www.ProQOL.org)



**Please complete the following demographic questions.**

Do you work with people or animals that have experienced trauma?  Yes  No

Approximately what percent of your time at work do you provide direct services to people or animals that have experienced trauma?

25% or Less  26-50%  51-75%  76%-100%

Approximately how many people work at your organization? \_\_\_\_\_

Please check one of the following that best describes your trauma work:

- Animal Protection
- Child Protection
- Individuals who work with the homeless

Approximately how many years have you worked with trauma survivors? \_\_\_\_\_

What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received?

- High School / GED
- Associate of Arts Degree
- Bachelor's Degree
- Graduate Degree
- Professional Certification

For Child Protection and Individuals who work with the homeless:

Do you have a Bachelor's Degree in Social Work (BSW)?  Yes  No

Do you have a Master's Degree in Social Work (MSW)?  Yes  No

**Thank you for taking the time to participate in this study. Your feedback is greatly appreciated!**

**If you are interested in participating in a chance to win one of six \$50.00 cash gift cards, please send your name and contact information to [traumainformedcaresurvey@gmail.com](mailto:traumainformedcaresurvey@gmail.com) Your information will not be shared with anyone and cannot be linked to your survey.**

## Appendix B

School of Education

College of Applied Human Sciences



**Individuals who provide services to animals that have experienced trauma are at heightened risk for developing symptoms of compassion fatigue. The following questionnaire consists of two survey instruments that in combination will be used to identify the roles safety, support, and trauma awareness and how they may relate to compassion satisfaction and compassion fatigue in individuals who provide services to trauma survivors.**

**These surveys should take less 10 minutes to complete. Your responses will remain anonymous. Following the study you will be given an email address. If you are interested in entering a drawing with a chance to win one of six \$50.00 gift cash cards please send a contact phone number or email address to this email. Your personal information will never be shared or sold. This contact information will be destroyed after the winners have been notified. Your participation completely voluntary and is greatly appreciated.**

**If you feel any emotional vulnerability following the participation in this survey please contact Tracy Gano, MSW, LCSW at (303) 818-6649. Tracy Gano will provide referrals to appropriate resources for anyone who experiences distress from completing the survey.**

**Should you have any questions or concerns regarding this survey please contact the Principal Investigator, Gene Gloeckner at (970) 491-7661, the Co-Principal Investigator, Joni Handran, at (720) 261-7042 or the Research Integrity and Compliance Review Office Coordinator, Janell Barker, at 970-491-1655.**

**Trauma Informed Organizational Culture: Please rate the following statements.**

1=Strongly Disagree    2=Disagree    3=Undecided    4=Agree    5=Strongly Agree

- |  |           |
|--|-----------|
| 1. I feel safe at my job.  | 1 2 3 4 5 |
| 2. I witness violence at my job.   | 1 2 3 4 5 |
| 3. My organization has policies and procedures in place to ensure my safety.   | 1 2 3 4 5 |
| 4. I am asked to do things at my job that I do not feel safe doing.  | 1 2 3 4 5 |
| 5. My organization values people who have different types of skills.   | 1 2 3 4 5 |
| 6. My organization values me as a person.  | 1 2 3 4 5 |
| 7. My organization offers adequate health insurance to employees that include confidential mental health services.                     | 1 2 3 4 5 |
| 8. My organization compensates me or provides comp time when I work long hours or overtime.  | 1 2 3 4 5 |
| 9. My organization encourages me to take care of myself.   | 1 2 3 4 5 |
| 10. My work day is filled with different types of activities.  | 1 2 3 4 5 |
| 11. I feel like I do not have enough work time to do get my job done during a normal business day.                                     | 1 2 3 4 5 |
| 12. I feel like I do not have enough resources to succeed at my job.   | 1 2 3 4 5 |
| 13. I feel like my organization does not support me.   | 1 2 3 4 5 |
| 14. I feel comfortable talking to my supervisor about work related problems.   | 1 2 3 4 5 |
| 15. My supervisor asks me for suggestions or about my opinions.  | 1 2 3 4 5 |
| 16. I receive regularly scheduled supervision for my job.  | 1 2 3 4 5 |
| 17. My supervisor encourages me to take care of myself.  | 1 2 3 4 5 |
| 18. I trust my supervisor.   | 1 2 3 4 5 |
| 19. My supervisor supports my decisions.   | 1 2 3 4 5 |
| 20. I trust my co-workers.   | 1 2 3 4 5 |
| 21. My co-workers know at least a few personal things about me. (for example birthday, partner's name, favorite type of food or hobby) | 1 2 3 4 5 |

- |   |           |
|---|-----------|
| 22. I generally like my co-workers.   | 1 2 3 4 5 |
| 23. I feel comfortable discussing work related problems with my co-workers.   | 1 2 3 4 5 |
| 24. I feel comfortable discussing personal problems with my co-workers.   | 1 2 3 4 5 |
| 25. I have received training through my current job to help me effectively work with animals who have experienced trauma. | 1 2 3 4 5 |
| 26. I have received information at my current job on the importance of self-care.   | 1 2 3 4 5 |
| 27. I have received information at my current job on compassion fatigue.  | 1 2 3 4 5 |
| 28. I work in a stressful environment.  | 1 2 3 4 5 |
| 29. When something upsetting happens at my agency workers are given time to process and heal.                             | 1 2 3 4 5 |
| 30. I work in an agency that supports my self-care efforts.   | 1 2 3 4 5 |

**Is there anything else that you feel you need from your organization that would help you work more effectively with animals who have experienced trauma?**

Next Survey is the Professional Quality of Life Scale (ProQOL). The ProQOL is used to measure worker compassion fatigue and compassion satisfaction.

## Professional Quality of Life Scale (ProQOL)

When you *help animals* you have direct contact with their lives. As you may have found, your compassion for those animals you [*help*] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [*helper*]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

- \_\_\_\_\_ 1. I am happy.
- \_\_\_\_\_ 2. I am preoccupied with more than one animal I [*help*].
- \_\_\_\_\_ 3. I get satisfaction from being able to [*help*] animals.
- \_\_\_\_\_ 4. I feel connected to others.
- \_\_\_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_\_\_ 6. I feel invigorated after working with the animals I [*help*].
- \_\_\_\_\_ 7. I find it difficult to separate my personal life from my life as a [*helper*].
- \_\_\_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of an animal I [*help*].
- \_\_\_\_\_ 9. I think that I might have been affected by the traumatic stress of animals I [*help*].
- \_\_\_\_\_ 10. I feel trapped by my job as a [*helper*].
- \_\_\_\_\_ 11. Because of my [*helping*], I have felt "on edge" about various things.
- \_\_\_\_\_ 12. I like my work as a [*helper*].
- \_\_\_\_\_ 13. I feel depressed because of the traumatic experiences of the animals I [*help*].
- \_\_\_\_\_ 14. I feel as though I am experiencing the trauma of an animal I have [*helped*].
- \_\_\_\_\_ 15. I have beliefs that sustain me.
- \_\_\_\_\_ 16. I am pleased with how I am able to keep up with [*helping*] techniques and protocols.
- \_\_\_\_\_ 17. I am the person I always wanted to be.
- \_\_\_\_\_ 18. My work makes me feel satisfied.
- \_\_\_\_\_ 19. I feel worn out because of my work as a [*helper*].
- \_\_\_\_\_ 20. I have happy thoughts and feelings about the animals I [*help*] and how I could help them.
- \_\_\_\_\_ 21. I feel overwhelmed because my case [work] load seems endless.
- \_\_\_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the animals I [*help*].
- \_\_\_\_\_ 24. I am proud of what I can do to [*help*].
- \_\_\_\_\_ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
- \_\_\_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_\_\_ 27. I have thoughts that I am a "success" as a [*helper*].
- \_\_\_\_\_ 28. I can't recall important parts of my work with trauma victims. (Animals)
- \_\_\_\_\_ 29. I am a very caring person.
- \_\_\_\_\_ 30. I am happy that I chose to do this work.

Stamm, B.H. (2009). *The Concise ProQOL Manual*, (2nd ed.). Pocatello, ID: [www.ProQOL.org](http://www.ProQOL.org)

**Please complete the following demographic questions.**

Do you work with people or animals that have experienced trauma?  Yes  No

Approximately what percent of your time at work do you provide direct services to people or animals that have experienced trauma?

25% or Less  26-50%  51-75%  76%-100%

Approximately how many people work at your organization? \_\_\_\_\_

Please check one of the following that best describes your trauma work:

- Animal Protection
- Child Protection
- Individuals who work with the homeless

Approximately how many years have you worked with trauma survivors? \_\_\_\_\_

What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.

- High School / GED
- Associate of Arts Degree
- Bachelor's Degree
- Graduate Degree
- Professional Certification
- Other

**Thank you for taking the time to participate in this study. Your feedback is greatly appreciated! If you are interested in participating in a chance to win one of six \$50.00 cash gift cards, please send your name and contact information to [traumainformedcaresurvey@gmail.com](mailto:traumainformedcaresurvey@gmail.com) Your information will not be shared with anyone and cannot be linked to your survey.**

## APPENDIX C

June 2, 2012

Dear Caregiver:

I am a graduate student working under the direction of Gene Gloeckner, Ph.D. in the Department of Education and Social Work at Colorado State University. I am also a caregiver with experience in the field of trauma.

Caregivers who provide services to trauma survivors are at heightened risk of experiencing the same symptoms that those they care for experience, a concept described as compassion fatigue. I am conducting a research study on the effects organizational culture has on individuals who provide services to people and animals that have experienced trauma.

I am asking for you to participate in an online survey to help understand what organizational factors influence worker burnout and compassion fatigue. This survey is online and should take less than 10 minutes to complete. There are no known risks associated with this research; however, the questions on the surveys may probe some emotional/challenging memories. There are no known direct benefits to you associated with this research. Your participation is greatly appreciated and your responses to the survey will remain anonymous. That means that no one, not even members of the research team, will know that the information you give comes from you. If this study is ever published, your name will not be known.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. Individuals who participate in the study can enroll for a chance to win one of six \$50.00 cash gift cards. To be entered into the drawing for a gift card, you must send an email to the email address provided at the end of the survey and provide your name and email address. It will not be possible for the researchers to link your survey responses to you. You may complete the survey without entering into the drawing, and you can skip any survey questions that you would prefer not to answer. Your participation is completely voluntary and is greatly appreciated.

**To take the anonymous online survey, please go to:**

[https://csuedu.qualtrics.com/SE/?SID=SV\\_20n5IjUJ3qfm4M4](https://csuedu.qualtrics.com/SE/?SID=SV_20n5IjUJ3qfm4M4)

If you have any questions concerning the research study, please call the Principal Investigator, Gene Gloeckner, at (970) 491-7661 or the Co-Principal Investigator, Joni Handran, (720) 261-7042. If you have any questions about your rights as a volunteer in this research, contact Janell Barker, Human Research Administrator in the Research Integrity & Compliance Review Office at 970-491-1655.

Sincerely,

Joni Handran, LCSW, CACIII  
Doctoral Candidate  
Colorado State University, School of Education  
2525 16<sup>th</sup> Street, Suite 118G  
Denver, CO 80211  
720.261.7042  
[jonihandran@yahoo.com](mailto:jonihandran@yahoo.com)

Gene Gloeckner, Ph.D.  
Professor  
Colorado State University, School of Education  
920.291.7661  
Gene.Gloeckner@colostate.edu



APPENDIX D



Research Integrity & Compliance Review Office  
Office of the Vice President for Research  
321 General Services Building - Campus Delivery 2011 Fort Collins,  
CO  
TEL: (970) 491-1553  
FAX: (970) 491-2293

**NOTICE OF APPROVAL FOR HUMAN RESEARCH**

**DATE:** June 01, 2012  
**TO:** Gloeckner, Gene, 1588 School of Education  
Buchan, Victoria, Handran, Joni, Oltjenbruns, Kevin  
**FROM:** Barker, Janell, Coordinator, CSU IRB 2  
**PROTOCOL TITLE:** TRAUMA-INFORMED ORGANIZATIONAL CULTURE: THE ROLE OF ORGANIZATIONS IN THE PREVENTION, REDUCTION, AND TREATMENT OF COMPASSION FATIGUE  
**FUNDING SOURCE:** NONE  
**PROTOCOL NUMBER:** 11-3182H  
**APPROVAL PERIOD:** Approval Date: May 31, 2012 Expiration Date: May 03, 2013

The CSU Institutional Review Board (IRB) for the protection of human subjects has reviewed the protocol entitled: TRAUMA-INFORMED ORGANIZATIONAL CULTURE: THE ROLE OF ORGANIZATIONS IN THE PREVENTION, REDUCTION, AND TREATMENT OF COMPASSION FATIGUE. The project has been approved for the procedures and subjects described in the protocol. This protocol must be reviewed for renewal on a yearly basis for as long as the research remains active. Should the protocol not be renewed before expiration, all activities must cease until the protocol has been re-reviewed.

If approval did not accompany a proposal when it was submitted to a sponsor, it is the PI's responsibility to provide the sponsor with the approval notice.

This approval is issued under Colorado State University's Federal Wide Assurance 00000647 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under CSU's Assurance, please do not hesitate to contact us.

Please direct any questions about the IRB's actions on this project to:

Janell Barker, Senior IRB Coordinator - (970) 491-1655 [Janell.Barker@Colostate.edu](mailto:Janell.Barker@Colostate.edu)  
Evelyn Swiss, IRB Coordinator - (970) 491-1381 [Evelyn.Swiss@Colostate.edu](mailto:Evelyn.Swiss@Colostate.edu)

Barker, Janell

Barker, Janell

Approval is to recruit 850 participants with the approved recruitment cover letter. Because of the nature of this research, it will not be necessary to obtain a signed consent form. However, all subjects must be consented with the approved electronic cover letter. The requirement of documentation of a consent form is waived under § \_\_.117(c)(2). NOTE: Please submit letters of cooperation from research sites once obtained. These letters can be submitted to the IRB as an amendment via eProtocol. Recruitment cannot begin at any site until this letter/email has been obtained.

---

**Approval Period:** May 31, 2012 through May 03, 2013  
**Review Type:** EXPEDITED  
**IRB Number:** 00000202

## APPENDIX E

May 9, 2012  
CSU IRB  
Colorado State University  
Fort Collins, Colorado 80523

To Whom It May Concern:

This letter is to verify that I will provide support for Joni Handran during her dissertation research. I will be available should any participant need mental health support as a result of participating in the survey. Joni Handran has provided me with a list of available resources in Denver and the larger Metro area for any person who is in need of mental resources. Should you have any questions regarding this letter please contact me at 303.818.6649.

Sincerely,

A handwritten signature in cursive script that reads "Tracy Gano".

Tracy Gano, LCSW

## APPENDIX F

### Resources for Crisis Mental Health Services

#### **Joni Handran, LCSW, CACIII- Co-Investigator**

2525 16<sup>th</sup> Street, Suite 118G

Denver, CO 8022

720.261.7042

Jonihandran.com

jonihandran@yahoo.com

#### **Community Reach Center**

8931 Huron Street

Thornton, Colorado 80260

303-853-3500

#### **Mental Health Center of Denver**

4141 E Dickenson Place

Denver, CO 80222

303.504.6500

#### **Jefferson Center for Mental Health**

9808 West Cedar Avenue

Lakewood, CO 80033

(303) 425-0300

#### **Denver Metro Crisis Line**

Suicide, Mental Health, Emotional Crisis Intervention

Free, Confidential, Guidance & Support

24 hours / 7 days

1-888-885-1222

<http://suicidehotlines.com/colorado.html>