

Domestic Violence Shelter Counselors: Implications for Clinical Supervision

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Abstract

This article reports on the findings of a qualitative study of a convenience-based sampling ($n=23$) from four focus-groups of domestic violence shelter counselors in the Northeastern, U.S in the fall of 2017. These focus group members were asked to discuss how their counseling work with assault survivors, residing in a shelter for battered women, affected them psychologically. The goals of this study were to make organizations and supervisors aware of the psychological strains of this field of practice and to help supervisees to manage the stress often associated with their work. These respondents overwhelmingly reported feelings of helplessness, hyper vigilance and the stressful impact of this work on their personal lives and relationships. Respondents also report that their anxiety, depression and secondary traumatic stress symptoms are somewhat higher than prior to their emotional state prior to their domestic violence shelter work. In response to how clinical supervision could be most helpful, the overwhelming answers were: 1) more education about trauma-informed work ($n=19$) and more of a chance to discuss clinical skills and interventions with their contemporaries ($n=17$). Counselors on the frontlines of this type of work often face unique and chronic forms of stress that require informed, responsive and supportive clinical supervision.

Keywords: Domestic violence; Stress; Anxiety; Depression

1. Introduction

This article reports on the findings of a qualitative study of a convenience-based sampling ($n=23$) from four focus-groups of domestic violence shelter counselors in the Northeastern, U.S. These focus group members were asked to discuss how their counseling work with assault survivors, residing in a shelter for battered women, affected them psychologically. The goals of this study were to make organizations and supervisors aware of the psychological strains of this field of practice and to help supervisees to manage the stress often associated with their work. Counselors on the frontlines of this type of work often face unique and chronic forms of stress that require informed, responsive and supportive clinical supervision. The study asks about the unique stressors inherent in this field of practice, and how clinical supervision could best prepare and support them in this work. Respondents also report that their anxiety, depression and secondary traumatic stress symptoms are somewhat higher than prior to their emotional state prior to their domestic violence shelter work.

2. Literature Review

2.1 Role and function of domestic violence counselors

Counselors in domestic violence (DV) shelters have long reported extraordinary stressors, fear for their clients' safety, and fear for their own safety [1-4]. Domestic violence shelter counselors provide safety planning immediately after the last traumatic violent event, psychoeducation, information and advocacy about domestic violence, and through this all, they are primary sources of emotional support and strength as the survivor moves through the trauma of shelter living and a safer return to the community [5]. The largest study of domestic violence shelters residents (n=565) over eight states, reported that domestic violence survivors entered residential shelters with numerous needs, but foremost is usually safety [6,5].

Mental health counselors who provide trauma counseling to domestic violence survivors are exposed to ongoing and pervasive stories of terror, danger, physical and emotional violence. The nature of this work includes both acute stages of trauma, complex trauma and post-traumatic stress disorder with little or no access to the outcome once residents leave the shelter. Ben-porat [7,5] looked at two groups of domestic violence shelter workers (n=143) in Israel; one with specific training on certain relevant phenomenon such as role competence, burnout, and STS and the other group without specific training on these subjects. The study showed two positive correlations: those with specific training experienced a higher sense of role competence and within that- task knowledge/problem solving. Author [2] interviewed DV counselors (n=11) and found that there were three distinctive patterns of emotions that emerged in the majority of workers: 1) Hypervigilance/Fear of harm, 2) Emotional Impact on Personal Life, 3) Shifts in Worldview and how these workers coped with these stressors.

2.2 Secondary traumatic stress among DV counselors

Research about this area of work has documented that counselors are understandably deeply affected [1,6]. Bearing witness to these frightening narratives can result in a sympathetic form of trauma known as secondary traumatic stress (STS) for DV counselors [8,9]. Bell [10] and Figley [11] defined secondary traumatic stress (STS) as the experiencing of emotional duress in persons who have had close contact with a trauma survivor, which may include family members as well as therapists. STS symptoms include the three broad planes of PTSD: 1) re-experiencing the traumatic event shared, 2) avoidance, and/or numbing in response to reminders of this event, 3) and persistent arousal and hyper-vigilance [12,11]. More recently, Baird, et al. [8] defined STS as a set of psychological symptoms that mimic post-traumatic stress disorder, but is acquired through exposure to persons suffering the effects of trauma [8,13,14].

Baird and Jenkins [1] investigated among other dimensions of trauma work- secondary traumatic stress (STS) evident in trauma counselors (n=101), After multivariate analyses, the researchers found that a) client exposure, b) workload and c) being paid as a staff member (vs. volunteer) were related to burnout, but not as they expected to the other occupational hazards such as vicarious trauma, secondary traumatic stress. Baird and Jenkins [1] did find that the more educated counselor and those seeing more clients reported less vicarious trauma and that younger counselors and those with more trauma counseling experience reported more emotional exhaustion. Their findings include the call for more trauma-informed supervision and education as well as agency support to ameliorate this level of emotional exhaustion. This level of emotional exhaustion shifts the worldview and intrapsychic world of the direct practitioner who continues to be exposed to the trauma

of DV survivors [15,9,16]. Vicarious traumatization (VT, sometimes used interchangeably with STS), refers to harmful changes that occur in professionals' views of themselves, others, and the world, because of exposure to the graphic and/or traumatic material of their clients [17,9,18].

Research has identified several of the potential pre-morbid and co-morbid psychological factors, that place a mental health counselor at a higher risk for developing and suffering from the various symptoms of a secondary traumatic stress (STS) [19,15,11,1,20]. The more history a counselor has with personal trauma, the more likely that exposure to traumatized clients will develop into STS [12,6,21,22]. Another intervening variable that has a possible correlation to secondary traumatization is the amount of experience the worker has; the less experience, the more likely the STS [23,24,9,25]. A study from trauma therapists in Poland (n=80), explored the personality traits that might predispose a trauma counselor to STS, and found that emotional reactivity was positively associated with level of STS symptoms [26]. Schauben & Frazier, [27] determined that the higher the domestic violence (DV) workload, the more likely the counselor will experience STS. Therapists and counselors having a personal history of sexual assault show more symptoms related to psychological trauma than do non-assaulted personnel [28,12,29-31]. Way, VanDeusen, MartIn, Brooks, & Jandle [4], compared vicarious trauma in a random sample of clinicians who treat domestic violence survivors (n=95) and those who treat offenders (n=252). Findings demonstrated that both groups of trauma counselors experienced high levels of avoidance and intrusive thoughts [4]. Dworkin, Sorell, & Allen, [23] studied sexual assault workers (n=164) and found that younger age and greater severity of sexual assault history were statistically significant individual-level predictors of increased STS. Interestingly, another study in Israel (n=142) examined the possible positive professional growth that vicarious post-traumatic growth (VPTG) emerges for the trauma counselor [3]. For trauma counselors that are part of larger social service department, there is more professional growth and adaptive coping than for those that are more isolated [3]. Sabin-Farrell, & Turpin [14] studied research and the measurements used for STS and VT scales and cautioned that it is difficult to discern the unique and complex differences between workers experiencing STS without taking into consideration the occupational stressors of the workplace as well as the unique psychological make-up and personal exposure to trauma that individual trauma counselors possess.

When working in a DV shelter, counselors must be alert to the fact that while the actual physical abuse may no longer be occurring, the assault survivor is still psychologically reverberating, in the form of fear from stalking and the fear of retaliation for leaving the relationship, and this may seep into the worker's psyche as well [32,20, 29,33].

2.3 Clinical supervision with DV counselors in shelters

For frontline DV counselors, there is often the reality of the immediate crisis, the large caseload and the developing of a safety and discharge plan and clinical supervision can seem like a luxury to both the counselor and the supervisor [3]. The wish to go deeper and continue to hone clinical skills in the face of so many residents, who are in a multipronged crisis, has been a difficult wish to fulfill in most shelters [10,5]. Yet, there is evidence that proper training and support can in fact reduce secondary traumatization and burnout [34-36].

Many shelters are plainly, too-crisis ridden with urgent decisions to be made to keep women and their children safe and off the street and supervision in this area does not always include comprehensive theoretical frameworks and practice principles

[2,7] or the potential perils of working solely with domestic violence survivors at the height of their crisis. Hensley [35] underscores the unique importance of psychoeducation, training and supportive supervision that is critical to substantive and responsive clinical social work supervision.

Clinical supervision that is both informative and supportive shores up higher levels of clinical work with DV clients and protects somewhat from developing acute and chronic levels of psychic distress from the traumatic nature of this counseling work [36]. Trauma workers have often lamented that they feel helpless in the face of ongoing acute trauma; that they wish they could do more [37]. Others have cited feeling angry because even though they had the time to devote to their clients, what they could do for them was just not enough. Physical and mental exhaustion were reported as the days stretched to months [37].

Clinical supervision for this cohort of counselors has to be particularly attuned to countertransference, induced countertransference, parallel process dynamics (the client who feels traumatized and helpless, the worker, the supervisors and director all experiencing the same feelings of helplessness and traumatic stress. These issues can all be part of the psychoeducation and skills training to prepare domestic violence counselors working in DV shelters [38,39,30,31].

2.4 Current study

With DV counselors at risk for STS, they are more vulnerable to negative impact on their own mental health and well-being, and in turn, at a risk for providing less than professionally objective assessment and care of our most vulnerable clients. This qualitative study attempts to further identify the typical patterns and emotional experiences of STS, and clarify how clinical supervision can be most helpful. The more we understand the impact this work may have on DV counselors, the more we can tailor a more responsive model of clinical supervision.

3. Methodology

3.1 Design

The author selected a qualitative design, employing non-numeric textual data, seeking to discover more about the range of complex psychosocial concerns for those providing counseling in a domestic violence shelter. The rationale for using the qualitative approach was that this is a very intense and confidential area of practice and inquiry and it the researcher deemed a focus group as a safer and more ethical way to inquire about the experiences of counselors in domestic violence shelters. The researcher also wanted to “capture the lived experience from the perspectives of those who have lived it and created meaning from it” [40]. In other words, rather than documenting the existence of secondary trauma, we wanted to empathically see the ways in which DV shelter workers experience their work and understand their struggles as they experienced them [41]. This design was selected in order to learn about and convey “complex worlds by in-vivo interviewing” as well as the generation of themes [40].

With a focus group modality several objectives were met: open exploration of how working in a domestic violence shelter has affected the lives of the workers, while facilitating a safe atmosphere in a small group which brought together individuals who share the same occupational context. The focus groups, facilitated through the fall of 2017, used an interview guide so

that the same questions were asked in three groups and participants respond to guided questions about both their shared and unique experiences. This modality of data collection afforded a rich qualitative exchange wherein individuals were stimulated by the small group format with peers [40].

3.2 Eligibility

The eligibility criteria included: A) A mental health counselor providing services in a domestic violence shelter (MSW or Mental Health Counseling degree) B) currently or recently (over past two years) having worked as a counselor in a domestic violence shelter, C) cognizant of the purpose of the study and D) voluntary willingness to participate in the discussion group. Counselors (all with five years or less experience) from three different shelters were recruited. Participants were recruited by flyers in three different domestic violence shelters in the Northeastern, U.S. of 28 who were invited to participate, 23 voluntarily agreed to participate. Five provided services solely to children and not adults, and therefore they were not selected into the focus groups. The convenience sampling resulted in 23 counselors over a period of a year, who were assured of complete anonymity, with no identifying factors of the shelter or location other than Northeastern, U.S. This is a particularly important point, because confidentiality of where a shelter may be located and the name of a particular shelter are absolutely never to be shared as it may put the residents in direct danger. Participants were informed of the purpose of the study, how the findings would be used, and that participation was on a voluntary basis. All comments were used to generalize a further understanding of how this work has impacted their worldview and their own psychological functioning.

The interview guide was developed by the author and consisted of the original ten questions from prior focus group interviews [2] specifically aimed at generalizing knowledge about the sample's emotional experiences of working in a domestic violence shelter [8,1,40], and the additional open-ended questions about their needs for clinical supervision. The development of the guide was informed by the work and key findings [2,35,20,30,33,41]. These studies highlighted the ways in which DV workers might experience STS in their personal and professional lives. The guide was piloted first with a subset of dv counselors (n=8) who were not later used in the study. The feedback helped to further refine and shorten the interview guide. Particularly, the final interview guide more clearly broke down the impact of their DV shelter work by including the specific probe questions regarding: psychological, cognitive, physical and spiritual well-being. Participants were interviewed during one 90 minute semi-structured focus group.

3.3 Limitations

The primary limitations of this study and report are twofold: A) the small sample size. This cannot be widely generalized to this area of social work practice, but a snapshot of a small number and the potential impact of this area of direct practice. B) This is a convenience sample that represents those counselors that were interested in attending a focus group and therefore they may have been eager to have an opportunity to vent or gain support. A secondary limitation was that we did not ask for further detail of racial and ethnic breakdowns, as those cultural contexts could have shed further light on issues of countertransference with DV survivors and help further developed the discussion on their respective worldviews.

In each group, participants were asked to respond to a series of general open-ended questions designed to identify their shared experiences. The same interview guide was used for all three groups. The data were analyzed from detailed notes, as

well as audiotape transcriptions. All responses were confidential; no names or identifying information were collected or tied to individual responses. Participants were informed of the purpose of the study, how the findings would be used, that participation was on a voluntary basis, and that their services would not be negatively impacted if they declined to participate. There were no incentives offered to participants for this study. The proposal for this pilot study was reviewed by an agent of the Institutional Review Board of the Albert Einstein College of Medicine at Yeshiva University, and was deemed exempt from further review as the sample was de-identified and all information was used anonymously.

Further, participants were not asked specifically if they had experienced symptoms of Depression, Anxiety or PTSD or Secondary Traumatic Stress Syndrome prior to their DV work, but rather asked in an open-ended fashion what emotional issues if any, they experienced prior to their DV shelter work. In their self-reports, participants described their prior therapeutic issues as a client and/or expressed symptoms that typically conform to Depression, Anxiety, PTSD or Secondary Traumatic Stress Syndrome.

3.4 Data analysis

All comments were used to generate a richer understanding of how mental health counselors are impacted by their work with domestic violence survivors. The audiotapes were reviewed; the focus group notes analyzed, narratives and exchanges were coded during the analysis phase to secure the integrity of the theme generation. The analysis did not rely on a statistical package, but the researcher who reviewed audiotapes multiple times to tease out recurring themes. Words and phrases were coded in the initial coding phase and repeated feeling-based words were identified within the context of their emotional experiences (referred to as meaning units) [40]. When words such as depressed, Anxiety or PTSD were voiced by the participants, this was their self-report. No scales were administered on mood disorders or PTSD symptomatology. Participants used several key words repeatedly denoting the psychological impact of working with trauma survivors “afraid”, “scared”, “terrified”, “nervous” in the theme of the induced fear of doing this work, while “alert”, “careful”, “on guard”, speaks to the sense of hyper vigilance these workers experience. Regarding how it affected their personal life, counselors reported, not trusting” “poisoned” “depressed” and several said their sense of their personal life felt “battered and beaten up” When asked about shifts in worldview; ”cynical” pessimistic about men” “disillusioned about love” “mistrusting of the world.” How they coped, “withdrew” “bonded with other workers” “more self-protective”.

The author used both a pre-set code, based on existing themes identified in research and emergent codes (Hypervigilance, Impact on Personal Life, Shift in Worldview, and Methods of Coping and those that emerged from reading and analyzing. This informed the interview guide and subsequently, the statements were analyzed and categorized into numerous themes. The interview transcripts were read initially, without coding, and then on second reading, participant responses were created from both pre-set codes, as well as those that emerged from interviews; emergent codes.

Those statements that had high content agreement were organized into four repeating themes. These occurring themes validated what researchers expected to find: 1) Hyper vigilance/Fear of harm, 2) Emotional Impact on Personal Life, 3) Shifts in Worldview. This coding process of participant remarks and responses allowed researchers to evaluate a wide range of range of experiences (including signs of STS) for this cohort of DV shelter workers.

4. Results

4.1 Sample characteristics

All of the respondents were women (n=23/ 100%). Eighty-nine percent (n=20) of the workers identified as women of color. Within that cohort, 15 identified as African-American, 6 as Latino, and 3 identified as biracial. There were no further racial or ethnic identifiers for this group. Their education was split between BSW, MSW and one held an MA in Mental Health Counseling. Respondents were also asked if they suffered from any mental health issues prior to this counseling work and they self-reported that they had experienced anxiety (9%) or depression (11%). Across age, race and academic background, four themes emerged with great repetition and at least 19 respondents reported the first three themes and 14 fourth theme. These themes were clearly pervasive.

These respondents overwhelmingly reported feelings of helplessness (n=19), and secondly, hypervigilance (n=17), and the third most common theme (n=15) was the impact of this work on their personal lives and relationships (TABLE 1). In response to how clinical supervision could be most helpful, the overwhelming answers were: more education about trauma-informed work (n=19) and more of a chance to discuss clinical skills and interventions with their contemporaries (n=17).

TABLE 1. Sample Characteristics (N=23).

	<u>N</u>	<u>%</u>
Gender		
Female	23	100%
Years in field		
Under 5	19	83%
Over 5	4	17%
Race		
African-American	15	65%
White	3	13%
Hispanic	3	13%
Biracial	3	13%
Education		
BSW	4	17%
MSW	15	65%
Mental Health Counselor	4	17%
Pre-Existing Mental Health Issues (Self-Reported)		
Premorbid Anxiety	5	21%
Premorbid Depression	5	21%
Premorbid Anxiety & Depression	4	17%
PTSD	4	17%

When counselors were asked to talk about their experiences several interrelated themes repeatedly emerged, the two most often discussed were a sense of helplessness, and feelings of hypervigilance.

4.2 Theme 1: Feelings of helplessness

In all five groups, the majority of counselors revealed their shared feelings of helplessness about this work, the children and mothers, the lack of follow up from the community, the unreliability of resident's family, and the overriding sense that they wish they could be more helpful to their clients.

"I just feel like I can't help them enough. What I do is just a band aid."

"I wish I could do more for this family, and all the other families. It's just a terrible feeling that I can't do more."

"The school doesn't care. I can't get the psychiatrist to see his mother and for all the calls I'm making, I can't get him the services he needs."

"No matter how many hours I put in, how kind I am to these folks, I know I'm just a drop in the bucket and they probably will be right back in another dangerous situation."

"I really like this little boy. He is so bright and I wish there was a better post-shelter option, but there's nothing else I can do. He's going to have to start all over with extended family in another town, and he's been through so much already and all I can do is try to prepare him. Just wish he had a better option."

4.3 Theme 2: Hyper vigilance/Fear of harm

Counselors also expressed fear of harm in great numbers. To them, the risks of shelter work were immediate and imminent. Repeatedly hearing that these young families were abused in myriad violent ways, counselors felt the residents were possibly in harm's way at the shelter, and therefore, they too were in "harm's way". The counselors explained that all of their clients had been a victim of violence, battered, knifed, thrown from a moving car, and even shot. The residents were afraid to let anyone know where they were for fear that the abuser would track them and kill them. Many women in the shelter were afraid to let their children go to school, and afraid to take a walk in case someone who knew the abuser could identify them. This pervasive fear became a familiar one that the majority of counselors said they experienced as well. Counselors explained that they experienced themselves as potential target as their clients continued to be potential targets.

"I'm afraid to be identified. I feel like it's dangerous for me to leave the shelter for lunch. What if one of my clients' attacker's is watching the place I don't ever talk about work till I'm home. I'm afraid even far away from the shelter, someone will tell the abuser."

"Even when I'm home... sometimes I see that I lock the door when I didn't use to."

"I've heard so many cases of the residents being stalked, I always feel afraid that their attackers have found this shelter, and I'm directly in harm's way. I'm always looking behind me and around and making sure I'm on the alert."

“I feel afraid to tell my supervisor that someone is breaking the shelter rules. They (clients) are so hyper vigilant, I feel like my supervisor will turn on me, or my client will turn on me, if she finds out I snitched. I’m caught in between.”

“The clients and I can get into serious trouble from the agency or abusers. We’re not allowed to mention the shelter in the street. That’s called breaching”

“If these abusers have followed some of these women across the country, they can certainly find me while I’m going to an appointment with a client.”

“I find I’m a lot jumpier than I was before this work. I don’t like to get into an elevator with someone I don’t know. Even in my own neighborhood and with certain neighbors. I feel suspicious.”

4.4 Theme 3 impact on personal life

Counselors talked about how their personal lives have been impacted by the level of violence they have borne witness to. Their statements often revealed that they have been affected personally. Interestingly, they know that their re-experiencing the traumatic event shared, avoidance, and/or numbing, and persistent arousal and hyper-vigilance and feelings of hopelessness mirror the emotional experiences of their clients; in fact, they are signs of secondary traumatic stress disorder.

“After this work, I am starting to question my own relationships. I feel very sensitive to my boyfriend’s negative comments. I can’t tell anymore whether he’s in the wrong, or I’m just being oversensitive from my work.”

“Even on the weekend, when I’m off duty, sometimes I think an abuser has followed me and knows where I live.”

“I go out of my way to avoid reading or seeing a tv show or a movie where any woman is hurt or abused. It’s just too raw for me.”

“I can’t really enjoy myself out with friends when I think about my clients. One was set on fire, one was run over, and another has changed the names of her children because she feels certain her abuser is out there planning an attack.”

“Sometimes I’m so drained from the level of crisis, I just feel numb. I need more and more time to just zone out and not do anything or take care of anyone. I’m at my best when I can just be left alone more and more of the time.”

“Nightmares and poor sleeping come with this job. There are days I really can’t wind down after work. I just stay upset and even scared in my own apartment.”

“After seeing and hearing so many horrible stories, I’ve become a bit numb. I can do every new intake and hear about women who have been beaten, shot, raped by numerous people in their lives and stay as empathetic as I was when I first started. It’s just not possible.”

“Since my work here, I do look at the world very, very differently. I see I am always watching for signs of abuse, someone being battered by a boyfriend or afraid to leave a relationship with their boyfriend. I can drive my friends a little crazy when I start asking do they feel they’re being treated with respect by a new boyfriend- or girlfriend- or father....”

“Sometimes I see an interaction on the bus or train and I’m dying to protect the woman or somehow let her know she shouldn’t allow herself to be treated that way. I seem to see more abuse around me since I’ve started working with these survivors.”

“You can’t hear these terrible stories of moms being abused and on the run with their little kids and not be fundamentally changed. I could never imagine such evil existed in this world, and now I know it exists and it’s everywhere.”

4.5 Clinical supervision needs

When asked how clinical supervision can be most responsive to these stressors, there were two major answers: 1) More education about trauma- informed practice (n=13), and 2) more time to discuss clinical skills with others doing the same work (n=10). These two responses were provided in approximately half of the respondents, and quite directly as the number one and number two improvements they wish for from their supervision.

Those who have completed a minimum of a year (n=17) were asked about their self-reported emotional health, and how it has changed *solely in response* to their dv shelter work. As the reader can see in TABLE 2, anxiety, depression, and STS (all self-reported) increased in their estimation as a response to their first year’s experiences in the dv shelters. As this is self-reported, these responses are limited to their perceptions of how their mood has shifted as a result of their year working in a dv shelter. In their perception, anxiety, depression, anxiety and depression and signs of STS (as distinct from pre-morbid PTSD), increased by approximately 15%-20%.

TABLE 2. Emotional health in response to DV shelter work after one year (N=19).

Emotional health in response to DV shelter work (Self-Reported)			
Anxiety	8	42%	
Depression	8	42%	
Anxiety & Depression	6	31%	
STS	6	31%	

4.6 Implications for trauma-informed clinical supervision

Supervision in social work has been a central and critical component that supports and enhances the counselor’s professional competencies [38,43,44]. In the domestic violence field of practice, supervision plays an essential role in educating, training

and emotionally supporting the counselor who is faced with chronic acute stress [1,3]. Analyzing the comments of these counselors, it is clear that there is a pronounced parallel process. As the residents feel in harm's way, hypervigilant, and helpless, so too do the counselors. This process can be understood as induced countertransference that many a counselor experiences at some point [45]. However, this is not a solely dyadic transferential transaction, but a systemic one, wherein the same emotions are experienced at all levels in this dysregulated unit: from the client, to the counselor, to the supervisor. Supervision in social work has long been perceived as a safe holding space for new and senior workers alike, to process, learn and be supported in their complex and challenging roles [46]. As Azar [39], has underscored, a key function of good supervision is to help the counselor to process the different components and challenges of issues related to managing the cases under their care [39].

In trauma-informed supervision, the supervisor and the organization should include and honor the complex and profound nature and impact of trauma, resilience and trauma recovery. Often trauma is seen less as an integrated part of supervision and more as an overlay to other presenting diagnoses and complications [47]. Trauma informed clinical supervision will include the impact of trauma in each case review and help the practitioner to understand the client's experience of trauma and the need for safety and consistency in direct practice with this client population. Additionally, the trauma-informed supervisor understands, explains and helps the trauma practitioner to cope with potential fears and anxieties that may be induced in the direct practitioner. As in direct trauma-informed care, the trauma-informed supervisor must emanate and provide: "safety, trustworthiness, choice, collaboration, and empowerment" [47].

4.7 Education about trauma-informed therapy

Reviewing the respondents requests, it appears critical to educate students and counselors about trauma informed theory so that they can understand their traumatized clients' dynamics, key concepts, interventions and their array of personal reactions [12]. Teaching about trauma informed practice in the classroom, in orientation and in ongoing training in-services provides the DV counselor with a theoretical framework, key concepts, practice principles, and interventions that will enable them to keep more professional objectivity and rely on their competencies [12,1,48]. With the evidence based research that demonstrates trauma training can reduce risk of secondary traumatization and burnout it is essential that this particular dimension of supervision include the evolving concepts and interventions of trauma informed therapy and other trauma approaches such as cognitive trauma therapy, EMDR and compassionate mindfulness [49,34,36,50].

4.8 A heads up to new counselors

It has been noted by several supervision articles that we can simultaneously teach about the importance of self-care and launch students' exploration of ways they can reduce their stress prior to entering the field [12]. The more counselors in DV shelters are aware of the potential for becoming overwhelmed, drained, hypervigilant and other feelings that residents experience, the less likely they may alone with these feelings and the quicker they may be able to identify the onset of burnout or STS [34]. Not only should the shelter worker be equipped with the appropriate knowledge and skill of DV and trauma work, some would say that it is essential and only ethical to educate students and counselors about the impact this work may have on them [35,51].

4.9 Group support

Seminal researchers on the topic of STS, McCann and Pearlman point out that workers who bear witness to trauma, "...can normalize, in group sessions, what they are experiencing and process their feelings and just as PTSD is viewed as a normal reaction to an abnormal event, view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims". Group supervision where social workers can share coping strategies with each other is also a part of this support. As Bandenoch & Cox [52] underscored, the mutual aid and emotionally supportive exchanges in a group can shift neurobiological patterns and even moods for the better of group members. The safety and mirroring of mutual support in group supervision also gives space for social workers and their supervisors to consider the impact of pre-morbid conditions that could potentially impact their level of stress like depression, anxiety or previous experiences with abuse. Pulido [37] reported that trauma workers found peer and group support particularly helpful to "discuss case situations and to help them recognize and deal with the STS symptoms they experienced" (281). Counselors will then be more aware and maybe motivated to pursue personal support to address these trigger points as well as practicing coping and emotional regulation in their own personal therapy. When issues of secondary traumatic stress and other implications of direct practice with trauma are built into and acknowledged by the organization, each counselor may feel more supported and empowered [10].

5. Conclusion

Domestic violence counselors in DV shelters bear witness to chronic and acute trauma as each and all of their residents share their experiences of violence and abuse. Research shows that these counselors, who often do not see the possible successful outcomes, have manifested vulnerability for STS [8]. This study shares their thoughts and feelings about how these stressors have affected them. Themes that emerged included: feelings of helplessness, hypervigilance, impact on personal life, and the wish for more information about trauma as well as group support. According to self-report, feelings of anxiety, depression, both and possible STS increased after their first year of work with this population. Moving forward, DV shelters should enhance their efforts to prepare new counselors, provide more trauma informed clinical supervision and opportunities for group support. Such an infrastructure is necessary to support and provide responsive supervision to prevent STS, and other feelings that can ultimately interfere with objective provision of support to vulnerable clients.

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