Social Work in Mental Health

ISSN: 1533-2985 (Print) 1533-2993 (Online) Journal homepage: http://www.tandfonline.com/loi/wsmh20

Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support

N. L. Beckerman & Danielle F. Wozniak

To cite this article: N. L. Beckerman & Danielle F. Wozniak (2018) Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support, Social Work in Mental Health, 16:4, 470-490, DOI: 10.1080/15332985.2018.1425795

To link to this article: https://doi.org/10.1080/15332985.2018.1425795

Accepted author version posted online: 11 Jan 2018.
Published online: 05 Feb 2018.

SOCIAL WORK IN MENTAL HEALTH
2018, VOL. 16, NO. 4, 470–490
https://doi.org/10.1080/15332985.2018.1425795

Routledge
Taylor & Francis Group

Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support

N. L. Beckerman, LCSW, DSW[a] and Danielle F. Wozniak, MSW, PhD[a]

[a]Wurzweiler School of Social Work, Yeshiva University, New York City, NY, USA

ABSTRACT

Mental health counselors who provide trauma counseling to domestic violence survivors are exposed to catastrophic stories of danger, physical and emotional vulnerability. As counselors try to assess and treatment plan for and with survivors, they are often deeply affected. For some practitioners, bearing witness to these frightening narratives results in a sympathetic form of trauma known as secondary traumatic stress. This article reports on the findings from a convenience sampling of domestic violence shelter counselors (N = 11). Patterns of emotional reactions emerge as a result of two focus groups. Four themes emerged: 1) hypervigilance, 2) impact on personal life, 3) a shift in worldview and 4) methods of coping.

KEYWORDS

Domestic violence; secondary traumatic stress; shelter counseling

Introduction

This article reports on the findings of a qualitative study of a convenience-based sampling (N = 11) of three focus groups comprising domestic violence (DV) shelter counselors. 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.

Mental health counselors who provide trauma counseling to domestic violence survivors are exposed to catastrophic stories of danger and physical and emotional vulnerability. As counselors try to assess and treatment plan for and with survivors, they are often deeply affected (Baird & Kracen, 2006; Iliffe & Steed, 2000). For some practitioners, bearing witness to these frightening narratives results in a sympathetic form of trauma known as secondary traumatic stress (STS) (Astin, 1997). Figley (1995) defined 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 post-traumatic stress disorder (PTSD): 1) re-experiencing the traumatic event shared, 2) avoidance and/or numbing in response to reminders of this event, and 3) persistent

CONTACT N. L. Beckerman beckerma@yu.edu Wurzweiler School of Social Work, Yeshiva University, 2495 Amsterdam Avenue, New York City, NY, USA.

arousal and hypervigilance (Figley & McCubbin, 1995). More recently, Baird and Kracen (2006) defined STS as a set of psychological symptoms that mimic PTSD but which are acquired through exposure to persons suffering the effects of trauma (Baird & Kracen, 2006; Sabin-Farrell & Turpin, 2003).

Literature review

Secondary traumatic stress among social work providers

In STS, the counselor begins to experience physical and psychological trauma after exposure to direct contact with clients who have shared their traumatic emotional experiences (Figley & McCubbin, 1983). This worldview and emotional state often affect the direct work with clients as well as the intrapsychic world of the direct practitioner (Brien, 1998; Clemans, 2004; Jenkins & Baird, 2002; Nelson, Gardell, & Harris, 2003). 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 (Brady, Guy, Poelstraw, & Brokaw, 1999; Jenkins & Baird, 2002; McCann & Pearlman, 1990).

Research has identified several potential premorbid and comorbid psychological factors that place a mental health counselor at a higher risk for developing and suffering from the various symptoms of STS (Canfield, 2005; Clemans, 2004; Figley, 1995). The more history a counselor has with personal trauma, the more likely that exposure to traumatized clients will develop into STS (Cunningham, 2003; Lee, 1996; Lobel, 1997; Pearlman & McCann, 1998). Another intervening variable that has been identified as a possible correlation to secondary traumatization is the amount of experience the worker has; the less experience, the more likely the counselor is to develop STS (Dworkin, Sorell, and Allen 2016; Good, 1996; Jenkins & Baird, 2002; Neuman & Gamble, 1995). Baird and Jenkins (2003) studied findings indicating that there were two prevalent primary factors. Nelson-Gardell and Harris (2003) studied child welfare workers (N = 166). Using STS scales, they found that there was a correlation between personal history of primary trauma, childhood abuse, or childhood neglect and a heightened risk for secondary traumatic stress in child welfare workers (Nelson-Gardell & Harris, 2003). However, 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 (Rzeszutek, Partyka, & Golab, 2015). In this study, there were no significant findings that correlated work-related variables to the existence or intensity of STS.

Secondary traumatic stress among domestic violence social workers

What are the unique emotional (STS) experiences of DV workers in a shelter? What do DV shelter counselors struggle with? How do they make meaning of their experiences so that they are able to continue their work? Researchers studied mental health counselors (N = 101) who worked in domestic violence shelters. Two primary corollaries for developing STS were: 1) personal trauma history and 2) the amount of exposure to trauma material. Other noteworthy and intervening variables included supervision (the more supervision, the less likely to develop STS and VT) and education counselors had (the more education the counselor had, the less likely they were to present signs of STS or VT) (Baird & Jenkins, 2003). Cunningham (2003), Pearlman and McCann (1998) and Schauben and Frazier (1995) determined that the higher the DV workload, the more likely the counselor was to experience STS. Therapists and counselors who have a personal history of sexual assault show more symptoms related to psychological trauma than do nonassaulted persons (Cunningham, 2003; Follette, Polusny, & Milbeck, 1994). Some counselors who have survived domestic violence and sexual assault can enter into this work to support and assist other women through this crisis (Cunningham, 2003; McCann & Pearlman, 1990; Schauben & Frazier, 1995).

Jenkins, Mitchell, Baird, Whitfield, and Meyer (2012) studied sexual assault and domestic violence counselors' (N = 101) recalled motivations for their entry into domestic violence and trauma work as well as their reported subjective personal changes, their secondary and vicarious trauma symptoms, and their experiences of burnout. Interestingly, these counselors motivated by their own respective histories of interpersonal trauma reported both more burnout symptoms and positive changes (including dealing with their own trauma). However, the researchers also found that those with interpersonal trauma history who were "seeking personal meaning report becoming more hypervigilant and self-isolating" as opposed to those counselors who learned about trauma from clients who rated their trauma burnout symptoms lower (Jenkins et al., 2012, p. 2993).

Way, VanDeusen, MartIn, Brooks, and Jandle (2004) 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 (Way et al., 2004). Dworkin, Sorell, and Allen (2016) 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. The higher the caseload and the more frequent the supervision, the less likely STS was experienced. This speaks to the role of setting and supervision as

preventative and interventive, as distinct from the individual counselors' experiences with prior trauma exposure or personal traits. Interestingly, another study in Israel (N = 142) examined the possible positive professional growth that vicarious post-traumatic growth (VPTG) caused in the trauma counselor (Ben-Porat, 2015). For trauma counselors who are part of larger social service departments, there is more professional growth and adaptive coping than for those who are in a trauma center, emergency room, or other host setting (Ben-Porat, 2015). Not all research is consistent on the existence of STS and VT (Schauben & Frazier, 1995). Sabin-Farrell and Turpin (2003) studied research and 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 makeup and personal exposure to trauma that individual trauma counselors possess.

When working in a DV shelter, trauma 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. This can take the form of fear of stalking and the fear of retaliation for leaving the relationship, and this may seep into the worker's psyche as well (Breidling et al., 2014; Johnson & Hunter, 1997; Pyles & Postmus, 2004; Warshaw, Sullivan, & Rivera, 2013).

A significant conceptual addition to this area of work and research is that of STS and its assault on the assumptive world. Once there is a traumatic event, ones worldview can be shattered and realigned through the lens of trauma, loss, and fear for one's safety (Kauffman, 2002). How has the DV shelter worker's assumptive world been altered after being exposed to the physical, spiritual, and emotional sequelae of domestic violence?

Current study

The existing research on DV workers and STS is important because it demonstrates that DV workers are indeed at risk for STS. Hence they are they are at risk for burnout in an understaffed area of social work, vulnerable to negative effects on their own mental health and well-being, and, in turn, provide less-than-professionally-objective assessment and care of our most vulnerable clients. Though STS has been researched among DV workers, there has not been a qualitative study to examine the nuances and subtleties of their lived experiences and the impact of this work in a more textured way than testing the existence of STS in this cohort. This qualitative study is a first step in trying to identify the range of experiences of STS and other related psychosocial sequelae.

Methodology

The authors selected a qualitative design, employing nonnumeric textual data and 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 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" (Padgett, 1998, p. 8). 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 lived them. This design was selected to learn about and convey "complex worlds by in-vivo interviewing" as well as the generation of themes (Padgett, 1998, p. 8; see Appendix).

With a focus group modality, several objectives were met, including the 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 that brings together individuals who share the same occupational context. The focus groups used an interview guide so that the same questions were asked in three groups, and participants responded 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 (3–4 members) group format with peers (Padgett, 1998).

The eligibility criteria included 1) a mental health counselor providing services in a domestic violence shelter (with a MSW or mental health counseling degree), 2) currently or recently (over the past two years) having worked as a counselor in a domestic violence shelter, 3) cognizance of the purpose of the study, and 4) 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 United States. Of 16 who were invited to participate, 13 voluntarily agreed to participate. Two provided services to children and not adults; therefore, they were not selected for the discussion group. The convenience sampling resulted in 11 counselors who were assured of complete anonymity with no identifying factors of the shelter or location. This is an important point because the name and location of a particular a shelter are absolutely never to be shared as this information 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 affected their

worldview and their own psychological functioning. The interview guide was developed by the authors and consisted of ten questions specifically aimed at generalizing knowledge about the sample's emotional experiences of working in a domestic violence shelter (Baird & Kracen, 2006; Jenkins & Baird, 2002; Padgett, 1998). The development of the guide was informed by the work and key findings of Breiding et al. (2014), Johnson and Hunter (1997), Jenkins et al. (2012), Pyles and Postmus (2004) and Warshaw et al. (2013). These studies highlighted the ways in which DV workers might experience STS in their personal and professional lives. Kauffman's work (2002) on the assumptive world and trauma informed the development of the interview guide question about how the workers' assumptive world has been altered after their exposure to DV shelter work.

The guide was piloted first with a subset of DV counselors (N = 6) who were not later used in the study. The feedback helped to refine and shorten the interview guide. In particular, 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.

The primary limitations of this study and report are twofold. First, the small sample size cannot be widely generalized to this area of social work practice, but is instead a snapshot of a small number and the potential impact on this area of direct practice. Second, this is a convenience sample that represents those counselors who were interested in attending a focus group and therefore may have been eager to have an opportunity to vent or gain support. A secondary limitation was that we did not ask for further details 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 assumptive 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 audio-taped 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 deidentified and all information was used anonymously.

All comments were used to generate a richer understanding of how mental health counselors are affected by their work with domestic violence survivors.

The audiotapes were reviewed, the focus group notes were analyzed, and the narratives and exchanges were coded during the analysis phase to secure the integrity of the theme generation. 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) (Padgett, 1998). Words such as "depressed," "anxiety," or "PTSD" were voiced by the participants and are considered self-reported. No scales were administered on mood disorders or PTSD symptomotalogy. Participants repeatedly used several key words to denote the psychological impact of working with trauma survivors. These words included "afraid," "scared," "terrified," and "nervous" in the theme of the induced fear of doing this work, while "alert," "careful," and "on guard" speak to the sense of hypervigilance these workers experience. Regarding how it affected their personal lives, counselors reported "not trusting," "poisoned," and "depressed," and several said their sense of their personal lives felt "battered and beaten up." When asked about shifts in worldview, "cynical," "pessimistic about men," "disillusioned about love," and "mistrusting of the world" were used. When asked how they coped, "withdrew," and "bonded with other workers," "more self-protective," were used.

The authors used both a preset code based on existing themes identified in research and and those that emerged from reading and analyzing (Hypervigilance, Impact on Personal Life, Shift in Worldview, and Methods of Coping), called *emergent codes*. This informed the interview guide and, subsequently, the statements were analyzed and categorized into numerous themes. The interview transcripts were read initially without coding; on a second reading, participant responses were created from both preset codes as well as those that emerged from interviews—emergent codes. Those statements that had high content-agreement were organized into four repeating themes, which validated what researchers expected to find: 1) Hypervigilance/Fear of Harm, 2) Emotional Impact on Personal Life, 3) Shifts in Worldview, and 4) Methods of Coping. This coding process of participant remarks and responses allowed researchers to evaluate a wide range of experiences (including signs of STS) for this cohort of DV shelter workers.

Results

Sample characteristics

All of the respondents were women (N = 11, 100%), and eight (73%) of the workers identified as women of color. Within that cohort, five identified as African American and three identified as biracial. There were no further racial or ethnic identifiers for this group. The remaining three workers (27%) identified as white. The respondents' education was predominantly MSW

Table 1. Sample characteristics (N = 11).

Characteristic	N	Percent
Gender		
Female	11	100
Years in Field		
Under five	10	90
Over five	1	10
Race		
Non-White	8	73
White	3	27
Education		
MSW	9	82
Mental Health Counselor	2	18
Pre-Existing Mental Health Issues		
Premorbid Anxiety	2	
Premorbid Depression	2	
Premorbid PTSD	1	

entry level (N = 9; 82%) and two (18%) held an MA in mental health counseling. Respondents were also asked if they had experienced anxiety (1%) or depression (2%) prior to working in domestic violence shelters. Across age, race, and academic background, four themes emerged with great repetition and at least 10 respondents reported the first three themes and 8 respondents reported the fourth theme (Table 1).

Theme 1: Hypervigilance/fear of harm

When counselors talked about their work, they expressed fear of harm. To them, the risks of shelter work were immediate and imminent. Repeatedly hearing the stories of women's violation suggested that the counselors too were targets of abusers' violence. Counselors felt threatened by their clients' abusers. Some of these statements reflected the problem of proximity. They were in "harm's way" by being close to the target of violence—battered women. These women's comments are strikingly similar to statements one would expect to hear from a victim of violence herself. Counselors were afraid to be identified, they were afraid when leaving the shelter, and they were afraid an abuser would track them down and harm them. The sub-themes, however, were revelations. Some of the subthemes of this fear are understood as manifestations of a dynamic in which counselors experienced themselves as potential targets as their clients continued to be potential targets. There was a high degree of consensus among respondents, suggesting that this was an experience they all had and shared. Statements that reflected fear of harm sounded like these:

> "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?"

"After all the horrific stories I've heard about my clients being pursued and attacked, I feel nervous that their attackers have found this shelter, and I'm directly in harm's way."

"I feel afraid to tell my supervisor that someone is breaking the shelter rules. They (clients) are so hypervigilant, 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."

Theme 2: Impact on personal life

The respondents spoke about the impact of violence on their personal lives. These statements suggest that the feelings counselors had during their shifts carried into their personal lives. The impact of their experiences at work was pervasive. Counselors' experiences with their clients' violation intruded into their personal lives to cause them to either question events in their lives or to be uncomfortable with them. Many of the comments are those that a battered woman would say and are signs of secondary traumatic stress, including nightmares, lack of ability to enjoy oneself, fear of being followed, and emotional numbing.

"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 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."

"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't 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."

Theme 3: Shift in worldview

As participants discussed the impact of working in such close proximity to violence, they also shared the ways in which their work changed how they saw the world around them. Consistently, these comments suggested that

social workers struggled to remain positive about the world and instead adopted a stance of wary mindfulness about the pervasiveness of violation.

> "I never realized the world is so horrible. I had never seen or heard of the type of abuse these poor women have had to live with."

> "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."

> "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."

Theme 4: Methods of coping

The primary challenge for many domestic violence social workers is how to empathize and provide support without being subsumed emotionally. Many spoke of "getting more distance" as opposed to staying engaged in the clinical process. Without clinical training, ongoing supervision, and other creative outlets, this struggle takes some very unfortunate turns, such as burning out very fast (and so shelters have a revolving employment door); workers possibly becoming authoritarian and responding to their own vulnerability by overcontrolling the women and thereby reproducing, on some level, the power and control of the abuser; and withdrawing from emotional pain and trauma and becoming distant from clients. Shelter workers found ways to cope with the complexities of vulnerability, stress, and trauma of working with violence victims in numerous ways. Many attempts involved self-care that suggested the need for balancing the draining work of the shelter with comforting experiences or experiences that intentionally reduce stress such as exercise or meditation. Other means of stress-reduction involved informally garnering support from coworkers by "blowing off steam" after work. As well, there was an indication that culture, community, religion, and family could be a source of sensitivity and support and, simultaneously, a stressor. Other themes problematized proximity to violence and expressed the need for distance or the need to bound violence or clearly mark it as someone else's experience rather than accept it as their own. Still others talked about the need to counter the feelings of vulnerability and victimization through action.

"I have to meditate in the morning before I go to work; otherwise, I'm just too overwrought with one crisis after another."

"The best way of coping is our team meeting where we get trainings and advice about how to work with the survivors and how to set good boundaries so we are not pulled into their lives too far."

"If I didn't have weekly supervision, the chance to review some of these horrible stories and then try to look at them more professionally, and more purposefully, I'd be a puddle by the end of each day."

"We have a monthly training that helps us get some distance and think about our work in a more professional and objective way."

"We all go out after work and drink and share a bit of gallows humor. There's just no way to hear all these stories and not let off a little steam."

"After hearing how vulnerable these women were, I started working out. We have a group of workers that have all taken up boxing and self-defense so we feel a little less vulnerable."

Discussion: How to help helpers?

What emerges from our empathic glimpse of shelter workers is a picture of human struggle and pain. The systemic, sociocultural, and personal variables of this phenomenon are enormously complex. Clearly, the women who participated in this study show signs of vicarious trauma as documented in the literature (Dane, 2000; McCann & Pearlman, 1990; Pearlman & McCann, 1998; Rothschild & Rand, 2006). Counselors' statements about their work were conveyed in emotions that paralleled the experiences of the clients they served. They spoke of being constantly afraid; of fearing being stalked, followed, or watched; and of being joyless and numb. They felt the helplessness of the victims with whom they worked and carried the victim's sense of imminent harm. Their dreams were affected, as were their personal relationships. The semiotics of their words conveyed the conflict of fight or flight. They were both terrified and nervous, emotions that often freeze one in place, and they were watchful, alert, or on guard, emotions that signify action. Several reported enrolling in a self-defense class.

Their language also conveyed their struggle with proximity to violence. They felt the need to bound violence, to "not get pulled too far into women's lives," to "get some distance" or to try to "remain objective." This points to a helpers' struggle—of needing to be empathic to do their work while not being so close to another's pain as to be immobilized. It also suggests that unrelenting proximity to violence narratives/stories can be emotionally overwhelming. This too is consistent with the literature. As Cunningham (2004) suggests, not only is vicarious traumatization impacted by the level

of exposure to traumatized clients but also by the type of trauma one is exposed to. She examined the differences between working with clients exposed to human-made trauma (sexual abuse victims) versus working with those exposed to natural trauma (cancer patients) and found that those who worked with human-made trauma experienced greater degrees of traumatization. Extrapolating from her findings suggests that shelter workers who consistently deal with human-made trauma would be very vulnerable to its effects.

While social work literature understands this phenomenon in terms of secondary trauma as well as issues of burnout and countertransference, decades of neurobiological literature helps us understand what is happening to these workers physically through mirror neurons. As Bandenoch and Cox (2010) tell us, "human beings are hard-wired to connect with one another throughout life" (p. 463). We are necessarily and fundamentally empathic beings, but this level of empathy extends beyond compassion to physical and psychological imitation. Through complex neural networks, we "connect individuals to each other by registering perceived behaviors, emotions and intentions of others" as if "we were enacting or experiencing them" ourselves (Schermer, 2010, p. 488). At a very basic level, mirror neurons "help us understand the emotions of other people by some form of inner imitation," sending signals to the limbic system to "make us feel what other people feel" (Iacoboni, 2009, p. 124). This process is not just effortless and deliberate but also inescapable (p. 119). Thus, while we often consider pain to be limited to the individual level, Iacoboni suggests, based on the work of Hutchison, Davis, and Lozano (1999) and Avenanti, Bueti, Galati, and Aglioti (2005), that our brains actually treat the pain of others as an experience we share (Iacoboni, 2009, p. 124). Hence when shelter workers talk about their need for distance, they may well be describing their need for their empathic or imitative pain to stop. While victims of violence bring one story of (often repeated) violence to the shelter, shelter workers will empathically encode numerous stories in one day, and potentially hundreds in a year. They will feel what their victims feel—over and over again.

Given that our hard-wiring for connection and empathy extends to internal imitation, and given that the level of exposure to human-made trauma increases the likelihood and intensity of secondary trauma, the question then becomes, how do we help people who do this work? The literature is rife with palliative measures, including supervision, education about the risks of secondary trauma, education about the neurobiology of secondary trauma, and self-care. We would like to review these measures and we would like to extend another possibility for consideration.

Clinical supervision in which social workers can process their feelings about the traumas they have heard is critical to minimizing the damaging effects of trauma work. McCann and Pearlman (1990) describe the

importance of "feelings time" (p. 145) when workers can normalize, in group sessions, what they are experiencing and thus process their feelings. "Just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims" (McCann & Pearlman, 1990, p. 145). Group supervision where social workers can share coping strategies with each other is also a part of this support. This allows space for social workers to consider the effect of premorbid conditions that could potentially impact their level of stress—such as depression, anxiety, or previous experiences with abuse—and offers the potential for working through these issues as well as aiding emotional regulation. As Badenoch and Cox (2010) suggest, "the brain's capacity to change (neuroplasticity) is heightened in environments that provide moderate emotional arousal. (Cozolino, 2006) attuned interpersonal relationships support for coming into contact with experiential memories (Badenoch & Cox, 2010), and experiences that disconfirm earlier implicit learnings" (464).

Our data suggested that the shelter workers we interviewed tried organically to form opportunities for support. They collectively processed their work experiences and regularly "blew off steam" by going for drinks or dinner after work, and they joined boxing and fitness classes together. But their informal efforts at comradery really needed to extend from the purely social to the psychoeducational, psychoanalytic, and supportive. As the Ben-Porat (2015) study suggests, social workers appeared to cope better with more infrastructure from a social service department (2015; Ben-Porat & Itzhaky, 2009). The more training and formal supervision domestic violence workers receive, the better they can cope, and even show signs of personal and professional growth (Ben-Porat, 2015). On a neurobiological level, clinical supervision in a group context may harness the power of mirror neurons to bring about a sense of cohesion and togetherness that reduces isolation and further ameliorates vicarious trauma. As Schermer (2010) suggests, "When a group is going well, the members sometimes feel as though they can read each other's minds, as if they can anticipate what someone is going to do or say next. Instead of being considered magical thinking, such intuitions could be understood as a mirror systems effect taken to a level where the members create their own selves in transient mirror neuron 'models' of what is co-occurring amongst them. This type of cohesion is therapeutic in that it helps members feel less alone with their problems and more 'in tune' with each other" (p. 503).

Self-care is another important aspect of normalizing secondary trauma. Our study participants suggested that, again, they organically enacted self-care as a counterweight to their work, through meditation or collective exercise. But institutionalized self-care would better ensure that care is routinized and conveyed as an agency expectation. This would also ensure that as social workers increased the length of time working with trauma

victims and thus increased their risk of vicarious trauma, measures for worker protection in place would be in place. A secondary benefit of institutional policies and practices on self-care is the potential for reduction in staff turnover. Based on what we heard from social workers, another aspect of self-care that might be routinized is a schedule that permits an ebb and flow in the stress one is exposed to. Social workers, who have no opportunity to move away from the pain or to take a break, would be at a higher risk for trauma. Structuring workers' job so they can have several days of direct client work moderated by several days doing behind-the-scenes work would be beneficial.

Education about the risks of trauma practice and the needs of trauma workers is another critical aspect of prevention. Based on the likelihood that social workers will indeed do trauma work, Cunningham (2004) advocates for information about vicarious trauma to be included in social work practice classes. Therefore, it may be helpful to educate students about trauma theory so that they can understand their traumatized clients' dynamics as well as their own reactions (Cunningham, 2004, p. 308). By teaching about trauma-informed practice in the classroom, Cunningham notes that we can simultaneously teach about the importance of self-care and launch students' explorations of ways they can reduce their stress prior to entering the field. Dane (2000), in her work with child welfare workers, also recommends educating workers about the impact secondary trauma can have on them and about the necessity of self-care. Teaching social workers about the neurobiology of secondary traumatic stress may shift the focus from the individual's capacity to deal with trauma and his or her perceived shortcomings to the neurobiological processes involved in trauma work. As Badenoch et al. (2010), suggest, "this decreases shame and blame, while heightening self-compassion, in and of itself a powerful agent of neuroplasticity" (p. 465).

Policies premised on an ethic of care that acknowledges the risks each individual social worker will experience when engaged in trauma work is also an important part of reducing harm. Practices that institutionalize self-care and create a daily rhythm that allows one to step away from trauma work while still contributing to the life of the agency is important. Too often stressed agencies lack the capacity to protect their workers and settle for high worker turnover. Yet we need to be vigilant in our recognition that not having measures in place for worker protection is tantamount to creating trauma in our work force. Thus, even stressed agencies will need a plan for best practices.

Future research: Mirror neurons and game play

Van Rensburg (2004) made the salient point that workers facing trauma require more than supervision, education, and training. The author highlights the importance and effectiveness of creative exercises and art sessions

that in combination with debriefing and supervision sessions were determined to be more effective than supervision and education alone (Van Rensburg, 2011).

We would like to introduce another way to potentially reduce the impact of secondary traumatic stress that has yet been untried—write an ending and find "success." One contributing factor to professional burnout and secondary traumatic stress in social work is high caseloads that often do not end in well-defined success (Daly, 1979). Daly (1979) found that contributing to child welfare workers' sense of emotional exhaustion, frustration, and job dissatisfaction was the fact that they did not get to see their cases resolve and seldom saw "success." Building on Daly's work, Dane (2000) found that success was a moderator for burnout and recorded child welfare workers' elation when a family bonded with them, followed through on a treatment plan, and could experience positive outcomes along with the family.

This is complicated because so much of social work is processual and workers in high-stress jobs in which their clients are making major life changes are often part of a long process toward change. This means that individual social workers often do not get to experience success, resolution, or even positive outcomes. This is certainly true for domestic violence shelter workers. Women stay in shelters for short periods of time with the emphasis on stabilizing the current crisis and developing short-term interventions. Leaving a batterer is a process that may be repeated several times before a woman finally leaves for good. Hence, shelter workers are not just vulnerable to repeated trauma—they are perpetually left in a liminal state of constant trauma. The story has no ending and each new client is an overlay of previous clients who also arrived in dire trauma. On a neurobiological level, neurons are reacting when the counselor sees the client leave while still in trauma and then mimics similar signs of trauma exposure (Keysers, 2010). Thus, the neuron "mirrors" the behavior of the other, as though the observer were itself acting. Due to the mirror neural or imitative level, they are left with open trauma wounds that they cannot close. We suggest that DV shelter workers struggle not so much with distance or objectivity but with the need for healing and positive resolution. We therefore raise the question, what impact could success and positive endings have on reducing vicarious trauma?

Concomitant to supervision, education about vicarious trauma and limbic brain function, as well as an institutional commitment to self-care, we advocate for an opportunity for closure and healing. Social workers must be able to "grow the stories up," to borrow a phrase from structural family therapy, and positively resolve them through some form of narrative that provides simulation. If a client is not ready to have positive resolution—or if the nature of shelter services is such that they only provide very short-term or crisis care—then each shelter worker must be able to take the story or stories she has heard to a logical and positive conclusion. This can be affected

through easy-to-use and easy-to-develop online video games that draw on the power of narrative therapy and game theory. "Over the past five years, a small body of research (Granic, Lobel, & Engels, 2013) has postulated that video games have the potential to foster real-world psychosocial benefits by providing safe contexts for individuals to air negative emotions, gain a sense of control over an external world, learn how to navigate unforeseen crises, and, ultimately, achieve a sense of satisfaction and pride after reaching goals that previously seemed unattainable" (Morrill, Wozniak, & deWinter, 2016). As deWinter notes, "Morris and Forrest (2013) indicated that video games can allow for self-expression through 'experiencing' a different life, where people can learn from perspective-taking and taking on different identities in a way that does not directly impact their physical well-being, unrestricted by environmental limitations," (Morrill et al., 2016). Online games are currently used for a variety of psychological and social purposes as well as to provide frameworks for prosocial behavior and empathy (Anderson et al., 2010; Bachen, Ramos-Hernandex, & Raphael, 2012; Gentile et al., 2009; Greitemeyer, Osswald, & Brauer, 2010; Hromek & Roffey, 2009), reduce depression (Russoniello, Fish, & O'Brien, 2013), and improve coping skills and knowledge of mental health services (Morrill et al., 2016; Procci, Bowers, Wong, & Andrews, 2013). "Data suggest that video games can enhance cognitive control by increasing attention, judgment, and memory" (Anguera et al., 2013; Morrill et al., 2016). We recommend an avatar-based game because avatar creation (sometimes referred to as Doppelganger or Proteus Effect) is closely linked with personal identification and changes in behavior and self-image and definition (Behm-Morawitz, 2013; McCreery, Schrader, Krach, & Boone, 2012; Vasalou & Joinson, 2009). Further, these avatars model behavior and social interactions that players transfer to their daily lives (Fox, Bailenson, & Tricase, 2013; Kim & Sundar, 2012; Lin & Wang, 2014; Morrill et al., 2016). We propose asking social workers to draw on their experiences with women and trauma and to weave those experiences into a cogent narrative, complete with practice-informed life choices. The conclusion of the story resolves the trauma and ends with the avatar's ultimate positive transformation and healing. This experience would not just allow a woman to see a positive conclusion but to potentially *experience* these changes on a mirror neural level.

Conclusion

This article reported on the findings of a qualitative study of a convenience-based sampling (N = 11) from three focus groups of domestic violence shelter counselors. Respondents were able to share their respective experiences of this frontline work as well as the challenges and impact it had on their personal lives, worldviews, and the ways in which they tried to cope.

There are trends that indicate certain symptoms on the continuum of STS (hypervigilance, withdrawal, and numbing). Gaining a preliminary sense of some of these challenges and reactions from this group informs future research on several fronts: 1) the myriad ways in which domestic violence counselors experience their trauma work, 2) how it has impacted them, and, therefore, 3) what their needs for clinical supervision, education, organizational support, and other creative outlets might include. The authors add to the traditional supervision, education, and support the innovative use of avatar play to provide an outlet where counselors' can complete the narratives of the clients they have worked with, providing some relief and closure. Future research will test if online game playing of this form, can indeed interrupt the cycle of potential burnout and STS of frontline domestic violence shelter workers.

References

Anderson, C. A., Shibuya, A., Ihori, N., Swing, E. L., Bushman, B. J., Sakamoto, A., … Saleem, M. (2010). Violent video game effects on aggression, empathy, and prosocial behavior in eastern and western countries: A meta-analytic review. *Psychological Bulletin*, *136*(2), 151–173. doi:10.1037/a0018251

Anguera, J. A., Boccanfuso, J., Rintoul, J. L., Al-Hashimi, O., Faraji, F., Janowich, J., & Gazzaley, A. (2013). Video game training enhances cognitive control in older adults. *Nature*, *501*(7465), 97–101. doi:10.1038/nature12486

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. *Women and Therapy*, *1*(20), 101–109. doi:10.1300/J015v20n01_17

Avenanti, A., Bueti, D., Galati, G., & Aglioti, S. (2005). Transcranial magnetic stimulation highlights the sensorimotor side of empathy for pain. *Nature Neuroscience*, *8*(7), 955–960. doi:10.1038/nn1481

Bachen, C., Ramos-Hernandex, P. F., & Raphael, C. (2012). Simulating REAL LIVES: Promoting global empathy and interest in learning through simulation games. *Simulation and Gaming*, *43*(4), 437–460. doi:10.1177/1046878111432108

Baird, K., & Kracen, A. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counseling Psychology Quarterly*, *19*(2), 181–188. doi:10.1080/09515070600811899

Baird, S., & Jenkins, S. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*(1), 71–86. doi:10.1891/vivi.2003.18.1.71

Bandenoch, B., & Cox, P. (2010). Integrating interpersonal neurobiology with group psychotherapy. *International Journal of Group Psychotherapy*, *60*(4), 462–481. doi:10.1521/ijgp.2010.60.4.462

Behm-Morawitz, E. (2013). Self-presence and the effects of the avatar on health and appearance. *Games for Health: Research, Development, and Clinical Applications.*, *2*(1), 50–52. doi:10.1089/g4h.2013.0005

Ben-Porat, A. (2015). Vicarious post-traumatic growth: Domestic violence therapists versus social service department therapists in Israel. *Journal of Family Violence*, *30*(7), 923–933. doi:10.1007/s10896-015-9714-x

Ben-Porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence*, *24*(7), 507–515. doi:10.1007/s10896-009-9249-0

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 386–393. doi:10.1037/0735-7028.30.4.386

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Jieru, C., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—National intimate partner and sexual violence survey, United States. *MMWR Surveillance Summaries*, *63*(8), 1–18. doi:10.1177/1046878111432109

Brien, K. M. (1998). Understanding stress and burnout in shelter workers. *Professional Psychology: Research and Practice*, *29*(4), 383–385. doi:10.1037/0735-7028.29.4.383

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work*, *75*(2), 81–101. doi:10.1300/J497v75n02_06

Clemans, S. E. (2004). Recognizing vicarious traumatization: A single session group model for trauma workers. *Social Work with Groups*, *27*(2/3), 55–74. doi:10.1300/J009v27n02_05

Cozolino, L. (2006). *The neuroscience of human relationships: Attachment and the developing social brain*.New York City, NY: Norton.

Cunningham, M. (2003). The impact of trauma work on social work clinicians: Empirical findings. *Social Work*, *48*(4), 451–459. doi:10.1093/sw/48.4.451

Daly, R. (1979). Burnout: A smoldering problem in protection services. *Social Work*, *24*(5), 375–379. doi: 10.1093/sw/24.5.375

Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary trauma. *Journal of Social Work Education*, *36*(1), 27–38.

Dworkin, E., Sorell, N., & Allen, N. (2016). Individual- and setting-level correlates of secondary traumatic stress in rape crisis center staff. *Journal of Interpersonal Violence*, *31* (4), 743–759. doi:10.1177/0886260514556111

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York City, NY: Brunner/Mazel.

Figley, C. R., & McCubbin, H. I. (1983). *Stress and the family II: Coping with catastrophe* (pp. 3–20). New York, NY: Brunner/Mazel.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sex abuse survivors. *Journal of Clinical and Consulting Psychology*, *25*(3), 275–282. doi:10.1037/0735-7028.25.3.275

Fox, J., Bailenson, J., & Tricase, L. (2013). The embodiment of sexualized virtual selves: The proteus effect and experiences of self-objectification via avatars. *Computers in Human Behavior*, *29*(3), 930–938. doi:10.1016/j.chb.2012.12.027

Gentile, D., Anderson, C., Yukawa, S., Nobuko, I., Saleem, M., Ming, L. K., … Sakamoto, A. (2009). The effects of prosocial video games on prosocial behaviors: International evidence from correlational, longitudinal, and experimental studies. *Simulation and Gaming*, *39*(4), 528–539. doi: 10.1177/0146167209333045

Good, D. A. (1996). *Secondary traumatic stress in art therapists and related mental health professionals* (Unpublished doctoral dissertation). University of New Mexico, Albuquerque, NM.

Granic, I., Lobel, A., & Engels, R. C. (2013). The benefits of playing video games. *American Psychologist*, *69*(1), 66–78. doi:10.1037/a0034857

Greitemeyer, T., Osswald, S., & Brauer, M. (2010). Playing prosocial video games increases empathy and decreases schadenfreude. *Emotion*, *10*(6), 796–802. doi:10.1037/a0020194

Hromek, R., & Roffey, S. (2009). Promoting social and emotional learning with games: "It's fun and we learn things." *Simulation and Gaming*, *50*(5), 626–644. doi:10.1177/1046878109333793

Hutchison, W. D., Davis, K. D., & Lozano, A. M. (1999). Pain-related neurons in the human cingulate cortex. *Nature Neuroscience*, *2*(5), 403–405. doi:10.1038/8065

Iacoboni, M. (2009). *Mirroring people: The new science of how we connect with others*. New York City, NY: Farrar, Straus & Giroux.

Iliffe, 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

Jenkins, S., Mitchell, J., Baird, S., Whitfield, S., & Meyer, H. (2012). The counselor's trauma as counseling motivation: Vulnerability or stress inoculation? *Journal of Interpersonal Violence*, *26*(12), 2392–2412. doi:10.1177/0886260510383020

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, *15*(5), 423–432. doi:10.1023/A:1020193526843

Johnson, C. N. E., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the new South Wales sexual assault service: An exploratory study. *Work and Stress*, *11*(4), 319–328. doi:10.1080/02678379708252995

Kauffman, J. (2002). Safety and the assumptive world. In J. Kauffman (Ed.), *Loss of the assumptive world: A theory of traumatic loss* (pp. 205–212). New York City, NY: Routledge.

Keysers, C. (2010). Mirror Neurons. *Current Biology*, *19*(21), 971–973. doi:10.1016/j.cub.2009.08.026

Kim, Y., & Sundar, S. (2012). Visualizing ideal self vs. actual self through avatars: Impact on preventive health outcomes. *Computers in Human Behavior*, *28*(4), 1356–1364. doi:10.1016/j.chb.2012.02.021

Lee, C. S. (1996). Secondary traumatic stress in therapists who are exposed to client traumatic material (Unpublished doctoral dissertation). Florida State University, Tallahassee, FL.

Lin, H., & Wang, H. (2014). Avatar creation in virtual worlds: Behaviors and motivations. *Computers in Human Behavior*, *34*(4), 213–218. doi:10.1016/j.chb.2013.10.005

Lobel, J. A. (1997). The vicarious effects of treating female rape survivors: The therapist's perspective (Unpublished doctoral dissertation). University of Pennsylvania, Philadelphia, PA.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. doi:10.1007/BF00975140

McCreery, M., Schrader, P. G., Krach, S. K., & Boone, R. (2012). A sense of self: The role of presence in virtual environments. *Computers in Human Behavior*, *29*(4), 1635–1640. doi:10.1016/j.chb.2013.02.002

Morrill, A., Wozniak, D., & deWinter, J. (2016). Healing from violence through a cyber simulation game for post traumatic growth. Originally presented as an STTR grant proposal in [2016] with Allison Morrill and Jennifer de Winter.

Morris, G., & Forrest, R. (2013). Wham, sock, kapow! Can Batman defeat his biggest foe yet and combat mental health discrimination? An exploration of the video games industry and its potential for health promotion. *Journal of Psychiatric and Mental Health Nursing*, *20*(8), 752–760. doi:10.1111/jpm.2013.20.issue-8

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare: Journal of Policy, Practice, and Program*, *82*(1), 5–26.

Neuman, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy*, *32*(2), 341. doi:10.1037/0033-3204.32.2.341

Padgett, D. K. (1998). *Qualitative methods in social work research*. New York City, NY: SAGE.

Pearlman, L. A., & McCann, P. S. (1998). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional psychology: Research and Practice*, *26*(6), 558–565. doi:10.1037/0735-7028.26.6.558

Procci, K., Bowers, C., Wong, C., & Andrews, A. (2013). Minigames for mental health: Improving warfighters' coping skills and awareness of mental health resources. *Games for Health Journal*, *2*(4), 240–246. doi:10.1089/g4h.2013.0014

Pyles, L., & Postmus, J. L. (2004). Addressing the problem of domestic violence: How far have we come? *Affilia*, *19*(4), 376–388. doi:10.1177/0886109904268865

Rothschild, B., & Rand, M. (2006). *Help for the helper: Self-care strategies for managing burnout and stress*. New York City, NY: W. W. Norton.

Russoniello, C. V., Fish, M., & O'Brien, K. (2003). The efficacy of casual videogame play in reducing clinical depression: A randomized controlled study. *Games for Health Journal*, *2* (6), 341–346. doi:10.1089/g4h.2013.0010

Rzeszutek, M., Partyka, M., & Golab, A. (2015). Temperament traits, social support, and secondary traumatic stress disorder symptoms in a sample of trauma therapists. *Professional Psychology: Research and Practice*, *4*(46), 213–224. doi:10.1037/pro0000024

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, *3*(23), 449–480. doi:10.1016/S0272-7358(03)00030-8

Schauben, L. J., & Frazier, P. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*(1), 49–64. doi:10.1111/j.1471-6402.1995.tb00278.x

Schermer, V. L. (2010). Mirror neurons: Their implications for group psychotherapy. *International Journal of Group Psychotherapy*, *60*(4), 487–513. doi:10.1521/ijgp.2010.60.4.486

Stalking Resource Center. (1998). *The National Center for victims of crime, stalking fact sheet*. Retrieved from http://www.ncvc.org/src/Main.aspx

Van Rensburg, M. S. J. (2004). *From victim to victory: The experiences of abused women and the salience of the support they encounter*. Pretoria: University of South Africa. Retreived from http://hdl.handle.net/10500/2048

Vasalou, A., & Joinson, A. (2009). Me, myself and I: The role of interactional context on self-presentation through avatars. *Computers in Human Behavior*, *25*(2), 510–520. doi:10.1016/j.chb.2008.11.007

Warshaw, C., Sullivan, C., & Rivera, E. A. (2013). *A systematic review of trauma-focused interventions for domestic violence survivors*. Washington, DC: National Center on Domestic Violence, Trauma, and Mental Health.

Way, I., VanDeusen, K., MartIn, G., Brooks, A., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, *1*(19), 49–71. doi:10.1177/0886260503259050

Appendix

Focus Group Interview Guide:

1. What are your biggest challenges of working in a shelter?
   Potential Probe Questions:
   a) Psychologically
   b) Cognitively
   c) Physically
   d) Spiritually
2. Has working in such close proximity to battered women affected your worldview? (If so, how?)
3. Has it affected your family/social life?
4. Has it affected your mood?
5. Does supervision provide support? (If so, how?)
6. How do you cope with the stress of this job?
7. What would help you to deal better with this work?