Walden University

College of Social and Behavioral Sciences

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Tiffany Ann Hardman

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Social Work Faculty

Dr. Janella Melius, Committee Member,
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Walden University
2018

Abstract

Trauma Social Workers' Perspectives on the Response of Rural Social Work Agencies to Vicarious Trauma

by

Tiffany Ann Hardman

MSW, Arizona State University, 2007

BS, Northern Arizona University, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

Walden University

February 2019

Abstract

Social workers are susceptible to the potential negative impacts of vicarious trauma. Perspectives of trauma social workers on the responsiveness of rural social work agencies to vicarious trauma have not been explored even though the trauma-informed care model has been available since 2006 and outlines best practice in all settings of trauma social work. Considering the risk factors and negative effects vicarious trauma has on social workers, an increased understanding of the perspectives of social workers on how rural social work agencies are responding to vicarious trauma was needed. The purpose of this study was to explore this response through consideration of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment. The guiding research question was, what are the perspectives of social workers on the response of rural social work agencies on vicarious trauma and self-care. For this narrative study, storytelling was used as a way to understand and answer the research question. Data were collected using purposeful sampling from 10 trauma social workers through face-to-face interviews and analyzed using a coding and theming process. Organizational culture was identified as a suppressive force that has the potential to be a source of support to therapists. The findings support the need for change in organizational practice standards and furthers knowledge about the potential effects of vicarious trauma on clients, agencies, and therapists and how to mitigate those effects. The awareness this study provided to organizational leaders and policy makers has the potential to be the catalyst for positive practice and policy change.

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

Dedication

I dedicate this study to all the helping professionals who tirelessly serve others even when resources are slim. In addition, I dedicate all the work I put forth to the many mentors who have influenced how I practice and instilled in me the strong social work ethics and values it took to push through the pain of this project. I also dedicate this study to the next generation of professional social workers. Do not be afraid to ask for help in taking care of yourself; you deserve it.

Acknowledgment

First, I thank God for giving me the strength to continue to move forward in this process and the knowledge that always came at the right time. Dr. Dawn Higgins, thank you for starting me off on the right path, and Dr. Alice Yick for keeping me on the path and pushing me to improve. Lastly, to my wife, Dr. Diane Moss, thank you for your encouragement and support through a process that at times had me questioning myself. I love you and appreciate you more than I can express.

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Chapter 1: Introduction to the Study

Introduction

Social workers are susceptible to the potential negative impacts of vicarious trauma (Bercier & Maynard, 2015; Hyatt-Burkhart, 2014; Newell, Nelson-Gardell, & MacNeil; 2016; Robinson-Keilig; 2014) with 67% experiencing professional burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Moreover, in a study by Middleton and Potter (2015), in the United States 33% of social workers reported various vicarious trauma symptomology; half of those reporting symptomologies stated that they were considering leaving their job. Vicarious trauma is defined as secondary exposure to traumatic details of a client's experiences that results in symptomology as if the social worker had experienced the trauma firsthand (Izzo & Miller, 2010). The empathetic engagement of the social worker when working with trauma-exposed clients and hearing graphic and traumatic stories may result in vicarious trauma with symptomology of posttraumatic stress disorder, burnout, and compassion fatigue (Bride, 2004).

For those social workers working in a rural setting, the characteristics that make up what is referred to as "rural culture" (National Association of Social Workers, 2003, p. 300) have the potential to influence the symptomology that results from being a social worker who is secondarily exposed to a client's trauma. Rural values encompass local autonomy, self-reliance, neighbors helping neighbors, religious and organization involvement, tradition, and resistance to change (Waltman, 1986). Rural social service agencies differ from urban social service agencies in their practices due to the availability of resources, funding, formal and informal support systems, and value systems (Hastings & Cohn, 2013). As Mackie (2012) and Pugh (2003) noted, social work in rural areas

comes with the reality of depleted resources, professional isolation, minimal access to supervision, fewer opportunities for professional development, and professional isolation. The National Association of Social Workers (2003) termed these values and realities as "rural culture" (p. 300). The aim of this study was to generate more understanding of how rural social service agencies address vicarious trauma symptomology as perceived by trauma social workers.

Iqbal (2015) strongly recommends that organizational practices align with the values and mission of the social work profession. This alignment includes the holistic approach of advocacy on a macro level for social change in organizational professional standards when policies and laws influence organizations, especially when those organizational practice have potential to cause harm (vicarious trauma) to clients or therapists (Iqbal, 2015). Organizational practices are frequently influenced by macro level policies, according to Iqbal (2015). Based on the mission of social work to address barriers and negative forces that impact the well-being of at-risk populations (therapists who are exposed to secondary trauma) (National Association of Social Work, 2008), organizational leaders have an obligation to address such practices. In alignment with Iqbal's (2015) recommendations for advocacy on the local, state, and federal level, this study provided understanding, awareness, and clarity of potential negative effects to clients, agencies, and therapists if measures are not taken to minimize or mitigate potential negative effects.

In this chapter, I will provide background information on vicarious trauma constructs. In addition, I will state the problem and purpose of this study, present the research question, and describe the study's conceptual framework, the trauma-informed

care model (Fallot & Harris, 2009). I will also describe the nature of the study; provide key definitions; and discuss the assumptions, scope and delimitations, limitations, and significance for social change of this study.

Background

According to researchers, many social workers experience vicarious trauma, which can affect their personal and professional lives. In a national study of 515 mental health therapists, 53.3% of the sample reported feeling that secondary trauma was negatively impacting their professional and personal life (Ting, Jacobson, Sanders, Bride, & Harrington, 2005). Similarly, in a study by Bride (2007), 23.3% of a sample of 294 social workers reported feeling detached from others. If vicarious trauma symptomology is left unaddressed personally and professionally, the result may be over or underinvolvement with the client, burnout, decreased empathy, and poor decision-making skills (Adams & Riggs, 2008). As a result of poor decision-making skills, social workers are likely to display behaviors of impaired competence, to overly distance themselves from clients, and to exhibit changes in behavioral, physical, emotional, and cognitive behavior (Morrissette, 2004). Although there is a significant amount of research available on vicarious trauma risk factors and potential outcomes (see Adam & Riggs, 2008; Bride, 2007; Iqbal, 2015; Morrissette, 2004; Ting et al., 2005), to date, there are no mandates that organizations address vicarious trauma risk factors. Ultimately, it is left to the organization or the individual to seek out and implement best practice standards.

Based on my review of the literature, there are limited studies examining the effects of trauma on rural social workers related to organizational responsiveness to vicarious trauma and the susceptibility of trauma-exposed social workers to the potential

negative impact of secondary trauma. Hence, this study provides more understanding of vicarious trauma among social workers employed in rural settings and identifies best practices for managing responsiveness to vicarious trauma among social workers in these settings. Additionally, the study provides insight about the perspectives of social workers on the responsiveness of rural social work agencies to vicarious trauma and self-care, which has not been explored based on my review of the literature. Social workers have the potential to be negatively impacted either personally and/or professionally from the experience of such trauma. Given the potential for organizations to mitigate such negative influences through trauma-informed practices (see Fallot & Harris, 2009) it is important for personal, professional, organizational, and client outcomes that there is greater understanding of the perspectives of rural trauma social workers on organizational practices related to vicarious trauma.

Problem Statement

Secondary trauma exposure leaves social workers susceptible to potential negative personal and professional impacts (Bercier & Maynard, 2015; Hyatt-Burkhart, 2014; Newell et al., 2016; Robinson-Keilig, 2014). To date, perspectives of social workers on the responsiveness of rural social work agencies to vicarious trauma have not been explored even though the trauma-informed care model, which outlines best practice in all settings of trauma social work, has been available since 2006 (Fallot & Harris, 2009). The slow implementation of protective organizational and individual factors, due to the unrushed process of change and the lack of formal resources in rural organizational culture, may result in trauma social workers in rural settings being overly exposed to secondary trauma (Beecher, Reedy, Loke, Walker, & Raske, 2016; Brownlee, Graham,

Doucette, Hotson, & Halverson, 2009; Hastings & Cohn, 2013; Mackie, 2012; Riebschleger, 2007). Overexposure to secondary trauma may result in personal and professional impairment (Adam & Riggs, 2008).

There has been a significant amount of research on the potential negative outcomes associated with being an empathetically engaged therapist to traumatized clients, as well as the individual and organizational factors that influence those outcomes (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan, Itzhaky, & Ben-Porat, 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; Knight, 2013). However, these researchers did not directly examine whether the practitioners were working in urban or rural areas and where the urban or rural setting influenced the organizations responsiveness to vicarious trauma. Furthermore, these researchers used a quantitative approach to measure specific outcomes. In contrast, in this study I used a more exploratory approach in seeking a deeper understanding of secondary trauma and the rural organizational response to vicarious trauma.

After conducting a comprehensive literature search, I concluded that there does not appear to be current literature that addresses or explores the perspectives of social workers on the responsiveness of rural social service agencies to vicarious trauma. This study has individual and organizational implications for positive change in practice standards and self-care. Consequently, I sought to add to the knowledge base of the social work profession by undertaking this investigation.

Purpose of the Study

The aim of this study was to explore the responses of rural social service agencies to the potential negative impact of vicarious trauma on trauma social workers through the

lens of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). Considering the risk factors and negative influences of vicarious trauma on social workers and agencies (see Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan, Itzhaky, & Ben-Porat, 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; Knight, 2013), there is a need for an increased understanding of the perspectives of trauma social workers on how rural social work agencies are responding to vicarious trauma care. The purpose of this qualitative narrative study was to develop a better understanding of the perceptions of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma.

I based this qualitative inquiry on the epistemological assumptions of a constructivist worldview and self-development. The assumptions of constructivism are that the individuals have the ability to construct their own reality as they move within their environment, creating their own unique model of how they see the world (Rudestam & Newton, 2015). In traumatic experiences, the constructionist view is that the individual's growth and development is dependent upon the evolution of three psychological systems: self, psychological needs, and cognitive schemas (McCann & Pearlman, 1990). The evolution of the three psychological systems will configure the makeup of the traumatic experience, it will determine what is remembered, and shape how it is experienced and interpreted (McCann & Pearlman, 1990).

Research Question

I sought to answer the following research question: What are the perspectives of trauma social workers on the response of rural social work agencies on vicarious trauma and self-care?

Conceptual Framework

I based the conceptual framework used in this study on trauma theory. Alford, Mahone, and Fielstein's (1988) work with combat veterans concerning the emotional sequelae that resulted from primary trauma exposure and Krystal's (1978) study on prolonged exposure to stress and combat situations and the consequences of such engagement laid the ground work for examining trauma response (Bloom, 2006). Trauma theory has evolved over the past 30 years from a culmination of research on human behavior and how an experience influences current behavior (Bloom, 1999). Current behavior includes biological responses of fight-or-flight, emotional responses of learned helplessness; dissociation, numbing, or instability of the internal system of arousal; and psychological deficits with memory issues and processing (Bloom, 2006).

The trauma-informed care model focuses on the service delivery from a systems perspective, acknowledging the pervasiveness of individual trauma in both the service provider and the client (Bloom, 2006; Butler, Critelli, & Rinfrette, 2011; Keesler, 2014). The intent of trauma-informed care is to establish an organizational culture that fosters and emphasizes values of safety, trustworthiness, collaboration, choice, and empowerment (Fallot & Harris, 2009). The five guiding principles of the trauma-informed care model are used by organizations to demonstrate their commitment to preventing future trauma and healing past trauma; each principle addresses an influencing

factor in mitigating future trauma or healing past trauma (Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). A more detailed examination of the propositions of trauma theory and the trauma-informed care model will be provided in Chapter 2.

Historically, trauma theory researchers have avoided the individual nature of victimization and instead focused on the commonalities between victims (see Van der Kolk, 2005). The shift is to now embrace the differences in individual traumatic experience and to understand how traumatic events are experienced and interpreted because of the potential long-term effects (Van der Kolk, 2005). In response to the recognition of the pervasiveness of trauma, many social service organizations are moving towards becoming trauma-informed service systems (Fallot & Harris, 2009). A service system that is trauma-informed recognizes the psychological, neurological, biological, and social effects of violence on an individual's development (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). In Chapter 2, I will provide a more detailed analysis of the logical connections to the elements of the framework.

The current state of knowledge on vicarious trauma is limited by the types of research that have been conducted (Dombo & Blome, 2016). With the recent paradigm shift to include preventative models of care, such as the trauma-informed care model (Fallot & Harris, 2009), exploratory research examining the human service professional's perspective of care is the next logical step in research. I used the five tenets of the trauma-informed care model as the framework to develop the data collection instrument to explore my research question. Additionally, in analyzing data, I explored themes that emerge from concepts related to the trauma-informed care model of practice. This study's focus, thus, was on the perspectives of trauma social workers on the

responsiveness of rural social work agencies to vicarious trauma using the five guiding principles of the trauma-informed care model.

Nature of the Study

I examined the perceptions of rural trauma social workers on the responsiveness of their agency to vicarious trauma using a qualitative narrative approach and framed using the principles of Trauma-Informed Care: Safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). The narrative approach was the most effective tool to examine the perceptions of trauma social workers and rural organizational responsiveness to vicarious trauma. This approach uses storytelling as a way to understand the events and actions of the lived experiences (Toolis & Hammack, 2015). The focus was on each individual social worker's experience and did not seek to understand the experience beyond that one individual. An in-depth examination of the individual's story was used to capture the perspective of their experiences.

A recent shift in the way secondary trauma is perceived is to now include preventative models of care, such as the trauma-informed care model (Fallot & Harris, 2009). With the slower process of change in rural practice, examining the social service professional's perspective of care is the next logical step in the knowledge base (Gjesfjeld, Weaver, & Schommer, 2015). I collected data using face-to-face interviews with follow-up phone calls or e-mails as necessary for clarification. Participation in this study was limited to participants who are working in an agency that provides trauma interventions to clients in the rural regions of Northern Arizona and hold a minimum degree of Master of Social Work. Following the collection of data from 10 participants, the data was then analyzed for common themes among participants.

Definitions

Throughout this study, several terms are used to describe and define similar concepts. To differentiate between terms and concepts, I have provided the following definitions.

Burnout: The emotional exhaustion experienced by social workers from engaging with people which leads to difficulty in being engaged with their clients (Green, Miller, & Aarons, 2013).

Compassion fatigue: The emotional and physical exhaustion that builds up as a result of being empathetically engaged with clients (Figley, 1995).

Rural social work: Social services activities performed by social workers and which take place in geographically isolated areas with populations of no more than 50,000 people (Census Bureau, 2013b).

Secondary trauma: Bearing witness to first-hand verbal recounts and emotional reenactments of a client's traumatic story (Figley, 1995; Weinberg, 2013).

Therapist/clinician/social worker: These terms are used interchangeably to identify a professional social worker who provides therapeutic interventions to clients with traumatic experiences.

Trauma-informed: The recognition of psychological, neurological, biological, and social effects of violence on an individual's development (Elliot et al., 2005).

Vicarious trauma: A representation of a gradual, progressive, and internal transformation that may result in the therapist over-empathizing with and indirectly experiencing clients' emotionally charged reaction to a traumatic event (Dombo & Gray, 2013; Pearlman & MacIan, 1995; Wilson, 2016).

Assumptions

I assumed that participants of this qualitative study were forthcoming and were able to verbalize their perspectives based on their own first-hand knowledge and experience. I also assumed that the social workers who participated in the study have at least some level of awareness of the individual and organizational impact (both positive and negative) of vicarious trauma, secondary trauma exposure, burnout, and compassion fatigue. Lastly, I assumed the participants in this study were interested in participating in this study because they have been significantly affected by occupational trauma and not for any other reason.

The conceptualization of this study is based on trauma theory, which assumes that an individual who experiences a trauma first or second-hand may experience behavioral, cognitive, or physical changes (Emerson & Ramaswamy, 2015). The trauma-informed care model framing this study was developed using the foundation and assumptions of trauma theory. Other studies such as Finklestein, Stein, Greene, Bronstein, and Solomon (2015), also use the assumptions of trauma theory to understand how mental health providers would be affected psychologically, cognitively, and behaviorally by primary and secondary exposure to traumatic events.

Scope and Delimitations

Over the past several decades a significant amount of knowledge has been gained about the constructs and the effects of secondary trauma exposure (Figley, 1995; Weinberg, 2013), compassion fatigue (Figley, 1995), burnout (Green et al., 2013), and vicarious trauma (Pearlman & MacIan, 1995), on helping professionals. However, I was able to locate minimal empirical literature on rural social work and vicarious trauma, but

none of it discussed or explored rural social workers' experiences with agency responsiveness to potential vicarious trauma resulting from therapeutic engagement with traumatized clients. In addition, a significant amount of the research around secondary trauma and vicarious trauma has been quantitative (Bride, 2007; Choi, 2011; Figley, 1999; Finklestein et al., 2015; Ivicic and Motta, 2016; Kilpatrick, Resnick, Milanak, Miller, Keyes, & Friedman, 2013; Middleton and Potter, 2015; Pearlman, 1996; Ting, Jacobson, Sanders, Bride, & Harrision, 2005; Whitfield & Kanter, 2014). Therefore, the qualitative approach of the study captured the depth of the participants' experience with vicarious trauma and the responsiveness of rural social service agencies in addressing its potential effects.

This study was limited to include participants who are currently employed for a minimum of one year at an agency/organization that is identified as rural, has an education with a minimum of a Master of Social Work (MSW) and provides direct therapeutic intervention to clients with trauma histories or those who are in an acute crisis related to trauma. All others were excluded from participation in this study therefore, creating a limitation to generalizability of the study findings. An additional limitation to this study results from having 2 similar theoretical frameworks that could be used to examine the perceptions of social workers.

One potential theoretical framework that could have been used was system theory. The concept of systems theory is a holistic approach to understanding the functioning of an organization or an individual (Von Bertalanffy, 1972). The systems perspective is that each part that makes up the whole is influenced by the other parts and thus, when one part changes, the other parts follow suit (Von Bertalanffy, 1972). In theory, if a positive

change is made in one part it will positively influence change in other parts, positively influencing the entire system (Von Bertalanffy, 1972). The main tenet of system theory is that individual parts cannot be studied in isolation and that the function and meaning of the parts is lost when separated from the whole (Von Bertalanffy, 1972). Thus, based on systems theory, the experiences of a trauma social worker cannot be examined or understood without exploring the experiences of the trauma social worker *prior* to employment with the current agency or organization (Von Bertalanffy, 1972).

Furthermore, the focus of this study was to examine the *current* perspectives and experiences of trauma social workers and organizational responsiveness to vicarious trauma using a trauma-informed conceptual model. Although systems theory applies to organizational participation in trauma-informed practices, including political influences on policies, systems theory does not consider the influence of evidence-based practice on practice standards and how practice standards may decrease vicarious trauma symptomology. Therefore, the Trauma-informed care model was used to explore the experiences of trauma social workers related to the responsiveness of rural social work agencies to vicarious trauma.

The transferability of the study's findings may be possible, although limited, due to the number of participants for the study. The sample size of 10 was selected to gather sufficient data for analysis of themes in a timely manner, and to prevent elongation of the study (Rudestam & Newton, 2015). I used rich and descriptive protocol questions and probes to elicit the depth and breadth of participant responses in attempt to incite a sense of vicariousness therefore, increasing transferability.

Limitations

This study limited participation to subjects who are working in an agency that provides trauma interventions to clients in the Northern Arizona region, and hold a minimum degree of Master of Social Work. My role as a Social Service Director in an agency that provides trauma interventions to clients may have drawn interest from personnel working within my agency. To prevent a conflict of interest, all personnel working within my agency were excluded from being a potential participant in this study and only participants from outside my agency were considered for participation.

Qualitative inquiry uses an inductive approach to explore meaning and often makes inferences based on the identified meaning through the use of in-depth interviews (Rudestam & Newton, 2015). The strength of this qualitative study was to focus on seeking understanding of the experience through rich description, meaning, and the process, over measuring intensity, frequency, and quantity (Rudestam & Newton, 2015). However, this strength was also a limitation. Generalizability to a larger population is not possible with the small sample size of this qualitative approach (Rudestam & Newton, 2015). The smaller sample size and the intent to use face-to-face interviews for data collection limited the geographical location from which potential participants reside/work. In addition, the geographical limitations may hinder transferability of findings to agency/organizations that are located beyond the geographical location of the study's participants due to differences in rural/urban culture. Rural culture is a term used to encompass all the characteristics that describe the make-up of all things rural i.e. attitudes, lifestyles (National Association of Social Workers, 2003) and thus, may be viewed as a distinct cultural group or minority (Daley, 2015). The values and perceptions

of distinct groups may not be transferable to groups beyond that of the participants in the Northern Arizona region

It is impossible to eliminate researcher bias altogether (Maxwell, 2005). Being reflexive is a technique used to minimize researcher bias and is accomplished by the researcher creating transparency about their own 'position' (Rudestam & Newton, 2015). Transparency in the researcher is a conscious effort to make his/her unconscious and conscious experiences, values, and biases known within the context of the study in an attempt to keep from influencing the research findings and conclusions (Rudestam & Newton, 2015). As the researcher, I am biased. I am occupationally a part of the group of participants I researched. To help minimize my biases, I was transparent about my own membership to the study group (not to participants, but in the reflexive nature of this study), used member checking, triangulation (when possible), and prolonged engagement.

The dependability of this study was established through digital audio recordings of the participant interviews during the data collection process. Additionally, a detailed account of the data collection process and analysis is provided for transparency and future replication of similar studies.

Significance

This study filled the gap in research in the understanding of the perspectives of trauma social workers working within the culture of rural social work while offering insight into how rural social service agencies respond to vicarious trauma. Trauma is pervasive, and it's estimated that 89.7% of individuals will experience some sort of trauma in their lifetime with many seeking therapeutic services (Kilpatrick, Resnick,

Milanak, Miller, Keyes, & Friedman, 2013). With the prevalence of clients' trauma histories, 69.6% of mental health workers reported significant amounts of exposure to clients traumatic material (Kadambi & Truscott, 2004), and over 50% of mental health workers reported feeling that secondary trauma was negatively impacting their professional and personal life (Ting et al., 2005).

The culture of rural social work often creates challenges for the implementation of trauma-informed care. This study provoked conscious awareness of the need for organizational action and change in agency practice to support trauma-exposed social workers. This study also created an awareness of the potential negative effects to clients and social workers that call for action in mandating organization practices through a professional code, or federal and state mandates. At minimum, this study educated helping professionals in the potential negative physical, psychological, and professional effects of being exposed to clients' traumatic histories, which may help normalize their reactions and lead them to increase their self-care techniques.

This study has implications for positive social change. In the current state of organizational practices, organizations participation in therapists' support such as supervision, individual therapy, promotion of self-care, variation in trauma caseload, peer support groups, variation in work duties, training, excessive work commitments, and debriefing, is voluntary. This study provided understanding, awareness, or clarity of potential negative effects to clients, agencies, and therapists if measures are not taken to minimize or mitigate potential negative effects. The awareness and understanding this study provided to individuals, organizational leaders, and policy makers, has the potential to be the catalyst for positive practice and policy change.

Summary

Existing research is limited on the perspectives of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma. There is little doubt that social workers are susceptible to the negative impacts of vicarious trauma (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan et al., 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; Knight, 2013). This inquiry of this study explored the perceptions of social workers who therapeutically engage with traumatized clients and how their rural agency addresses vicarious trauma. Chapter 2 offers an in-depth examination of vicarious trauma from initial examination to-date, an in-depth synthesis of potential negative personal, professional, and organizational impacts, along with a discussion on individual and organizational tools to minimize negative impacts.

Chapter 2: Literature Review

Introduction

Social workers are more susceptible to the potential negative impacts of vicarious trauma when an agency is not trauma-informed (Fallot & Harris, 2009). There has been a significant amount of research on the potential negative outcomes associated with being an empathetically engaged therapist to traumatized clients, as well as on the individual and organizational factors that influence those outcomes (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan et al., 2015; Diaconescu, 2015; Dombo & Blome, 2016; Dombo & Gray, 2013; Gil & Weinberg, 2015; Knight, 2013). Within the past 10 years, researchers have given more attention to the specific constructs of vicarious trauma and the difference in presenting factors of compassion fatigue, burnout, and secondary trauma stress (Dombo & Blome, 2016; Dombo & Gray, 2013; Wilson, 2016). This research has helped in the identification of possible influential factors of trauma on the individual therapist, the organization, and client outcomes. Prior to the advent of trauma-informed organizations, it was the sole responsibility of therapists to address vicarious trauma and competent practice (see Iqbal, 2015).

The dynamic of individual therapists having to address issues related to vicarious trauma is evident in rural social work due to the nature of rural social work practice. The practice of rural social work differs from urban social work due to the lack of available resources, funding, and formal and informal support systems, and differing value systems (Ginsburg, 2014; Sethi, 2015; Waltman, 1986). Depleted resources, minimal access to supervision, fewer opportunities for professional development, and professional isolation are all realities of rural social work practice (Blue, Kutzler, & Marcon-Fuller, 2014). The

purpose of this qualitative narrative study was to develop a better understanding of the perceptions of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma.

To begin the chapter, I will review the research strategies I used for locating articles for the literature review. I will then present the theoretical framework and the underlying theory. Next, I will provide a review of seminal research and the current state of knowledge related to vicarious trauma, rural social work, the potential positive and negative influences of trauma, and individual and organizational factors related to outcomes. Last, I will present the ethics of competent social work practice.

Literature Search Strategy

I conducted the literature search using the Walden University and Northern Arizona University online libraries as well as Google Scholar to locate primary sources and also to trace primary sources when used in a secondary source. I began the search by accessing multiple databases, with limiters set for peer-reviewed, full-text sources. Initially, I limited articles to those published in 2012 or later in an effort to obtain current literature; I then expanded my searches to encompass seminal works. PsychInfo was preliminarily searched using the terms *vicarious trauma* or *secondary trauma* and *organizational environment*, with no result. The search terms were expanded by eliminating *organizational environment* in the query; 201 results were located and were then screened for further review. Multiple variations to include *vicarious trauma with organization* search produced few relevant articles as well as many overlapping articles. The most effective search focused on *vicarious trauma or secondary trauma*

independently of *organizational environment*, producing a breadth of articles that focused on organizational culture.

Other databases used to search literature included PsychArticles and SocIndex. The search terms (*organizational environment*, *vicarious trauma or secondary trauma and organizational environment*, *vicarious trauma or secondary trauma and organizational factors*, *vicarious trauma or secondary trauma and agency*, and *occupational stress and environment*) produced little or no variation from PsychInfo, aside from *vicarious trauma or secondary trauma*. During the search, I identified other common search terms as being used to describe similar search terms. For example, I identified *agency* in lieu of the search term *organization*, and used *vicarious traumatization* in lieu of *vicarious trauma*. Additionally, I used *rural social work* and *trauma-informed care* using the same process within the databases. I then used each term within each of the three databases until saturation was established by overlapping results. I further identified seminal research on vicarious trauma through an examination of recent literature in the primary search. Lastly, I used Google Scholar to trace the secondary source back to its primary publication. Because there was no research found examining the intersection between the individual and the organization, the content of this literature review is limited to the examination of individual and organizational factors independently that influence client and therapists' outcomes.

Conceptual Framework

Trauma Theory

Trauma theory developed from the culmination of decades worth of research on traumatic events and how they affect an individual or group. The seminal narratives from

Alford et al's. (1988) work with combat veterans and the emotional sequelae that resulted from primary trauma exposure, along with Krystal's (1978) study on prolonged exposure to stress and combat situations and the consequences of such engagement, laid the ground work for examining trauma response (Bloom, 2006). Soon to follow was Van der Kolk's (1988) research on trauma response and the interaction between biological and social response following trauma exposure, which was followed by his research on developmental negative behavior patterns that are self-destructive to the victim (Van der Kolk, 1989), as well as his research with Greenberg (1987) that delineated the psychobiology of the trauma response with hyperarousal, addiction to trauma, and constriction. Van der Kolk (1998) further delineated the psychobiological response in how trauma negatively affects the memory of those traumatized. The progression of this interest led Van der Kolk in 2005 to include trauma and development of mental health issues in his research, which lends to our current state of knowledge that experiencing a trauma can have negative psychological effects (Finklestein et al., 2015).

Trauma theory is grounded in the notion that traumatization occurs when an individual's internal and external coping resources are overwhelmed or inadequate to cope with the threat (Van der Kolk, 1988). How an individual responds to a traumatic event is complex and unique based on a combination of how the event was interpreted using personal meaning making, worldview, and coping mechanisms (Van der Kolk, 1988). Common responses identified in seminal research may include fight-or flight, learned helplessness (Seligman, 1992); loss of volume control (Van der Kolk, 1998); decreased thinking ability and recall (Alford et al., 1988; Van der Kolk, 1998); dissociation (Pennebaker, 1997); increased endorphins (Van der Kolk & Greenberg,

1987); unhealthy bonding to others (Herman, 1992); repeating of traumatic experiences; physiological disorders; becoming a victimizer; and inability to make meaning of life with spiritual dissonance (Van der Kolk, 1989).

Historically, trauma theory researchers have minimized the individual nature of victimization resulting in a focus on the commonalities between victims (see Van der Kolk, 2005). Currently, the focus is on embracing the differences in individual traumatic experiences as a way to understand how traumatic events are experienced and interpreted given the potential long-term effects (Van der Kolk, 2005). In response to the recognition of the pervasiveness of trauma, social service organizations are moving towards becoming a trauma-informed service system (Fallot & Harris, 2009). As previously stated, a service system that is trauma-informed recognizes the psychological, neurological, biological, and social effects of violence on an individual's development (Elliot et al., 2005).

The Trauma-Informed Care Model

Trauma-informed care is a contemporary model of service delivery for organizations and individuals that is grounded in the tenets of trauma theory with a focus on healing and prevention for all those in the trauma service system (Fallot & Harris, 2009). The Trauma-Informed Care model may be used to "break the cycle" and create a culture of a trauma-informed service delivery system within social service agencies that provide services to traumatized clients (Fallot & Harris, 2009).

Fallot and Harris (2009) extrapolated themes found in the vast amounts of research that contributed to the development of trauma theory and created principles used to develop the following tenets of the trauma-informed care model

- trauma is pervasive,
- the impact of trauma is very broad and touches many life domains,
- the impact of trauma is often deep and life-shaping,
- violent trauma is often self-perpetuating,
- trauma is insidious and preys particularly on the more vulnerable among us,
- trauma affects the way people approach potentially helpful relationships,
- trauma has often occurred in the service context itself, and
- trauma affects staff members as well as consumers in human services programs.

The five principles of the trauma-informed care model were developed to establish a service delivery culture of being trauma-informed are: Safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). The five tenets were developed in response to the study conducted by the Substance Abuse and Mental Health Service Administration (SAMHSA)-funded study, Women, Co-Occurring Disorders, and Violence between 1998-2003. This study examined the mental health needs of women who live with substance abuse, mental health disorders, and co-existing trauma histories with physical and sexual violence (SAMHSA, 2004). The results of the SAMSHA study provided evidence that trauma-informed approaches can in fact increase the effectiveness of mental health services (SAMHSA, 2004).

Safety. Safety can be physical or emotional, promoting environmental safety and respect between interpersonal dynamics is a key tenet for being trauma-informed (Fallot & Harris, 2009). Agency staff and clients need to feel welcomed and safe in the physical environment during program activities (Fallot & Harris, 2009). Environmental safety

should be consistent and modified to be more effective if inconsistencies arise (Fallot & Harris, 2009). Examples of environmental safety include the location and lighting of the service building, hours of operation, clear and visual signs with directions, accessibility of exits (doors locked or unlocked), and security presence (if appropriate) (Fallot & Harris, 2009).

Providing emotional safety is exemplified by an agency's proactive approach to ensuring that staff are well-trained in providing the specific therapeutic services based on a client need and not just encouraging staff to seek out training or reading when times permits (Fallot & Harris, 2009). Additionally, staff may be cognizant and attentive to signs that the client may be uneasy about staff contacting clients and the potential unsafe situations that it may put the client in (i.e. domestic violence) (Fallot & Harris, 2009). A critical component to a person's sense of safety is trust (Fallot & Harris, 2009).

Trustworthiness. Being trustworthy means being consistent, having good interpersonal boundaries, and providing clarity (Fallot & Harris, 2009). The trust for clients is built differently than trust for agency staff. Building trust in clients is established through consistent, sensitive, reliable interactions, with clearly identified expectations, boundaries, and responsibilities (Fallot & Harris, 2009). Similarly, agency staff can benefit from and build trust through management and peer interactions (Fallot & Harris, 2009). Organizations and management foster trust through transparent policies and procedures, consistency in implementation of practice procedures, open dialog between management and staff, team-building exercises, and providing support for decision making (Fallot & Harris, 2009).

Choice. A therapist advocating for his or her own preferences provides a (perceived) level of control over the outcome (Fallot & Harris, 2009). Giving an individual choice includes providing awareness of options that are available to the client, awareness of the options comes from staff's education and training as supported by the agency (Fallot & Harris, 2009). Through education and training, staff develop competencies regarding how to better offer support to client's individual needs, ultimately leading the client to become better able to make informed choices (Fallot & Harris, 2009).

Organizations are also able to foster staff choice though allowing an increase of input into work schedules, types of task assigned, development of policies and procedures, and types and quantity of client caseload (Keesler, 2014). Lastly, staff benefits and opportunities for personal growth and organization change are critical to fostering choice (Fallot & Harris, 2009).

Collaboration. The collapse of the organizational hierarchy is necessary for collaboration to be most effective (Keesler, 2014). Decision making, planning, and service delivery should be a sharing of power between management, service delivery staff, and the client (Fallot & Harris, 2009). Treatment planning and goal setting are most effective when the client and the direct care staff collaborate using the preferences of the client (Keesler, 2014). Whenever practical, agency policies and practice procedures should integrate the perspectives of management and staff (Fallot & Harris, 2009). Ultimately, collaboration is fostered when staff have real or perceived support from one another, and management has relinquished power in favor of taking a supportive role with guidance (Keesler, 2014).

Empowerment. Empowerment is a key component to a client's, staff, or agency's future success (Fallot & Harris, 2009). Empowerment uses the strengths-based perspective through acknowledgment of the skills and abilities that are already possessed by the client or staff, with support services focused on abilities rather than disabilities (Fallot & Harris, 2009). Additionally, identifying and recognizing strengths and skills of an individual can lead to an increase of confidence to overcome obstacles using the resources they already possess (Fallot & Harris, 2009). Organizations may provide support to staff to increase skills by providing opportunity for additional training, or providing encouragement using a positive, affirming attitude towards task completion (Keesler, 2014). Lastly, organizations may empower staff though appropriate attention to accountability and shared responsibility for outcomes (Fallot & Harris, 2009). For example, does the person with the least amount of power become the scape goat?

From the seminal works of vicarious trauma (Pearlman & Saakvitne, 1995), secondary trauma (Van der Kolk, 1988), compassion fatigue (Figley, 1999), and burnout (Bride, 2007), to the current literature exploring the effects (Dombo & Gray, 2013; Wilson, 2016) causes (Gil & Weinberg, 2015; Knight, 2013; McCormack & Adams, 2016), and mitigating factors (Berger & Quiros, 2016; Michalopoulos & Aparicio, 2012; Whitfield & Kanter, 2014), the qualitative and quantitative studies examined in this chapter all explored constructs surrounding the sequelae of being a helping professional.

There is little doubt to the value of the studies to-date on how human service professionals are impacted by helping others. The current state of knowledge is limited by the types of research that have been conducted. With the recent paradigm shift to include preventative models of care, such as the trauma-informed care model, exploratory

research examining the human service professional's perspective of care was the next logical step in research.

Literature Review Related to Key Variables and/or Constructs

Secondary Trauma and Burnout

There is a significant amount of knowledge about the individual and organizational risks associated with being an empathetically engaged therapist with clients who have emotionally charged trauma histories (Dombo & Blome, 2016; Dombo & Gray, 2013; Figley, 1995; Knight, 2013; Weinberg, 2013; Wilson, 2016). Empathy involves the therapist having the capacity to be aware of and feel the distress of their client, as well as, to understand the experience and perspective of the client (Dombo & Gray, 2013). The current state of knowledge was derived from a progression of delineating trauma constructs, with the future direction being driven from how we understand individual and organizational factors to intersect and work together. For the sake of this discussion, secondary trauma and vicarious trauma will be used interchangeably.

Several decades of research studies and literature examinations on the potential effects of vicarious have exposed the vulnerabilities of being a therapist. With such studies as Dombo and Blome (2016) and their exploratory qualitative examination on the effects of trauma on child welfare workers and the organizational response to the trauma-exposed worker, and Knight's (2013) literature examination of the ways in which clinicians are affected by indirect trauma and the implications for self-care strategies, supervision, and organizations. As well as, Wilson's (2016) meta-analysis of vicarious burnout and job burnout with emphasis on identifying, preventing and addressing

vicarious trauma, has left little doubt of the potential dangers of being a therapist to clients with emotionally charged trauma histories. It is estimated that 89.7% of individuals will experience some sort of trauma in their lifetime with many seeking therapeutic services, with 69.6% of mental health workers reporting significant amounts of exposure to client's traumatic material (Kilpatrick et al., 2013). The potential distress of bearing witness to the emotional reenactments of listening to client's traumatic story may result in secondary trauma. Secondary trauma is defined as the therapist's response to a client's first-hand verbal recounts of traumatic events (Figley, 1995; Weinberg, 2013).

It has been estimated that as many as 50% of trauma social workers are at risk of developing conditions that mirror the posttraumatic stress symptoms of their traumatized clients (Whitfield & Kanter, 2014). In an early secondary trauma study consisting of 515 mental health therapists who work in the field of trauma, 53.3% reported feeling that secondary trauma was negatively impacting their professional and personal life (Ting, Jacobson, Sanders, Bride, & Harrision, 2005). In a similar study, of 294 trauma social workers, 23.3% reported feeling detached from others (Bride, 2007). An exploratory study of experience and management of vicarious trauma in 16 oncology social workers by Joubert, Hocking, and Hampson (2013) reported findings as high as 69% for reports of hyper-arousal of emotion and trouble sleeping. Bride's (2007) study of secondary trauma stress in 282 trauma-exposed social workers, Figley's (1999) exploratory examination on compassion fatigue, and Rasmussen and Bliss' (2014) case study on neurological alternations of the brain following secondary trauma exposure, reported that some of the

symptoms of secondary trauma may include hyper-arousal, avoidance behaviors, intrusive thoughts, and flashbacks with detailed imagery.

The examination of secondary trauma resulted from early studies on burnout. Burnout was a general concept used to describe the cumulative symptoms of all employed individuals who are under professional stress and was characterized by a disturbance in the multidimensional constructs of emotional exhaustion, depersonalization, and a decrease in the sense of personal accomplishment (Figley, 1999). Secondary trauma stress was then extrapolated out of the general symptoms of burnout to specifically address the unique stresses of helping professions in the human services field, while identifying the contributing factors related to the individual, organization, and the population served (Bride, 2007). It is estimated that 5-15% of therapists develop secondary trauma stress symptomology in the clinical range of severity (Bride, 2007; Choi, 2011), while a recent study investigating the variables associated with secondary traumatization of 88 trauma clinicians by Ivicic and Motta (2016), reported a higher percentage of 22.7%.

In a meta-analysis with 41 empirical studies on the association of job burnout and secondary trauma stress of clinicians directly working with trauma clients by Cieslak, et al. (2014), type of occupation was correlated to secondary trauma and burnout, the higher the rate of secondary exposure the higher the likelihood of professional burnout. Additionally, in a study examining the relationship between vicarious traumatization and job turnover in 1192 child welfare professionals by Middleton and Potter (2015), child welfare professionals experiencing burnout symptoms may feel a decreased ability to empathize with their client which directly led to the high turnover rates in child welfare

workers. Specifically, approximately 33% of child welfare professionals reported experiencing vicarious trauma symptomology which they reported having a negative impact on the interpersonal functioning, with 50% of the sample reported thoughts of leaving their job because of indirect exposure (Middleton & Potter, 2015). In a review of the literature on burnout of mental health worker by Morse et al. (2012), it is estimated that 21-67% of therapists providing mental health services experience high levels of burnout symptomology. The emotional demands and consequences associated with being a mental health therapist to traumatized clients extends beyond individual consequences of possible, depression, anxiety, and posttraumatic stress disorder symptomology.

Vicarious Trauma

Vicarious trauma is a representation of a gradual, progressive, and internal transformation that may result in the therapist from over-empathizing and indirectly experiencing clients' emotionally charged reaction to a traumatic event (Dombo & Gray, 2013; Pearlman & MacIan, 1995; and Wilson, 2016). After an examination of the literature, Corradini and Antonietti (2013) reported that brain activity that is usually associated with first-hand emotion is activated when a therapist is faced with second-hand emotion that mimics the therapist's own experience with that emotion.

Pearlman and Saakvitne (1995) suggested that untreated vicarious traumatization may have consequences to the individual therapist and the client through a depletion of the therapist's psychological resources influencing the ability for self-care and being present for the client. The early studies of individual burnout and organizational influences and consequences influenced Pearlman (1995) to develop the concept of vicarious trauma. Vicarious trauma included a broad spectrum of possible symptoms or

reactions a therapist may indirectly experience by being chronically emphatically engaged with a traumatized client (McCann & Pearlman, 1990). Over the next ten years, the term vicarious trauma was delineated in causes, symptoms, and results from similar constructs that had been used commonly and interchangeable with vicarious trauma. It was during those decades of research that the individual, professional, and organizational "cost" of providing services to traumatized clients helped lead to the development of trauma-informed services (Fallot & Harris, 2009; Kusmaul, Wilson, & Nochajski, 2015; Wolf et al., 2014).

Individual consequences. The potential effects of vicarious trauma span a broad range of emotional and behavioral consequences, such as cognitive changes in the therapists internal and external frame of reference with their sense of self, world view of personal safety, trust and intimacy difficulties (Pearlman, 1996), spirituality (Dombo & Gray, 2013; McCann & Pearlman, 1990), sense of helplessness, loss of feeling personal control and freedom, a decrease in alertness to emergency situations (Tullberg, Avinadav & Chemtob, 2012), anger, sadness, anxiety, nightmares, and disturbing imagery (McCann & Pearlman, 1990), sleep disturbance (Bride, 2007), relationship satisfaction, and social intimacy (Robinson-Keilig, 2014).

Consequences of vicarious trauma extend beyond the individual therapist to include professional and organizational difficulties (Dombo & Gray, 2013). Study findings from Bride, Radey, and Figley (2007) and Pearlman and Saakvine (1995), reported that helping professionals who are affected by vicarious traumatization are at a higher risk of decreased professional judgment than those professionals not affected by vicarious trauma. Unaddressed secondary trauma exposure has consequences that impact

the effectiveness of caring for the client while being fully present for that client (Dombo & Gray, 2013), which overall impacts the client's quality of life (Cheung & Chow, 2011). Other significant changes that may occur that influence the therapist professionally is a decline in work production, lack of connection with colleagues, and poor morale (Dombo & Gray, 2013).

Organizational consequences. Organizational functioning may be destabilized by a disruption of team cohesion if members of the team are experiencing unaddressed vicarious traumatization (Pack, 2012; 2013). The functional state of the organization decreases with reduced work engagement, increased absenteeism, staff turnover, and decreased morale and job satisfaction, all of which impact the clients in service quality (Green et al., 2013). In a quantitative study with 388 participants, Green, Miller, and Aarons (2013) examined the relationship between risk factors for burnout and emotional exhaustion. The findings indicated a positive correlation between high caseloads and organizational demands that lead to high turnover rates in child–welfare organizations; it is estimated to range from 23% and 60%, with a national average length of employment being less than two years.

Predictors of Vicarious Trauma

The organizational culture plays a role in how a therapist and the organization are influenced by therapists' secondary trauma exposure. A phenomenological study by McCormack and Adams (2016) reported subjective interpretations of working in an inpatient setting with four senior trauma therapists. Their study found that organizations that utilizes oppressive management systems such as a medical model, causes the therapist to feel stressed through intimidation, which coincided with the study's

examination of therapists exposed to complex trauma in an inpatient mental health hospital that utilizes the medical model. Therapists reported feeling self-doubt, frustration, guilt, and questioning of their integrity when feeling 'pressured' to discharge a patient prior to the patient 'feeling' ready or having observed their readiness. A 2016 quantitative study (N=365) by Manning-Jones, de Terte, and Stephens investigated the relationship between the coping strategies of health professionals and secondary trauma stress. The results of the study identified social workers over doctors, nurses, psychologist, and counsellors as being the most likely to experience vicarious trauma, while reporting the use of a moderate amount of coping strategies compared to the other professionals (Manning-Jones, de Terte, & Stephens, 2016).

A lack of supervision or irregular supervision was also correlated to higher levels of secondary trauma symptoms compared to those who reported regular supervision (Gil & Weinberg, 2015; Kanno & Giddings, 2017). Supervision is the supporting of a therapist through the use of linking professional social work practice to theories and frameworks and guidance provided on managing the emotional impact of hearing emotionally charged stories from clients, caseloads, and organizational challenges (Bledsoe, 2012; Joubert, Hocking, & Hampson, 2013). Also, several research studies reported a positive correlation in the amount of time that a therapist spends with traumatized clients and the greater the caseload, the greater the risk of developing vicarious trauma (Dagan et al., 2015; Gil & Weinberg, 2015; Knight, 2013; Pack, 2012; Pearlman & Mac Ian, 1995; Robinson-Keilig, 2014). A recent quantitative study (N = 99) investigated posttraumatic stress disorder and vicarious trauma symptoms among mental health providers; further adding to the knowledge base that years of education,

subjective exposure, professional supports, and perceived professional competence were predictors of vicarious trauma symptoms (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015). An individual's level of effort of self-care was also identified in two recent studies as a predictor vicarious trauma symptomology.

An individual's level of wellness was found to be a significant factor in how much vicarious trauma symptomology was exhibited in a 2018 quantitative (N=68) study by Foreman. Wellness was defined as the extent to which individuals participated in self-care activities, the more individuals participate in self-care practices the lower the reported vicarious trauma symptomology (Foreman, 2018). Lastly, a quantitative study (N=195) by Butler, Carello, and Maguin (2017) where a lower self-care effort was associated with higher burnout and secondary trauma symptomology and a decrease in individual health status.

Protective Factors in Vicarious Trauma

The treatment of secondary trauma exposure is the responsibility of both the individual and the organization with the focus on management and reduction of symptoms (Whitfield & Kanter, 2014). On the individual level, therapists working with traumatized clients should maintain self-care. Self-care includes exercise, spirituality, social connections and supports from family and friends, co-worker support, and personal therapy while self-monitoring their own cognitive state (Berger & Quiros, 2016; Kanno & Giddings, 2017).

Supervision has important clinical implications for the individual and the client. It was recommended by Finklestein et al. (2015), that supervision be used to increase therapist resiliency by decreasing the disturbances in self-efficacy, resulting in an

improvement in the psychological state of the therapist making them more present for their clients. Professional preparation and job experience were reported by Michalopoulos and Aparicio (2012) to decrease vulnerability to secondary trauma exposure while adding specialized training, debriefing, professional supervision, and peer supports to buffer against secondary trauma exposure. In 2018, Veach and Shilling examined the use of trauma-informed supervision and its implementation as a tool to mitigate the effects of secondary trauma exposure in a hospital trauma setting. Trauma-informed supervision has the potential to be applied to other social work setting where prolonged engagement with traumatized clients occurs (Veach & Shilling, 2018). Trauma-informed supervision includes:

> Creating regular opportunities for supervision; seeking continuing education on trauma, injury, illness, and related mental health issues such as post-traumatic stress disorder, and depression; emphasizing self-care with their supervisees and taking additional care to model self-care for supervisees; focusing on the development of the supervisor-supervisee relationship with an emphasis on safety and empowerment; maintaining flexibility in how and when supervision is provided; and attending to secondary trauma experiences with supervisees through intentional, regular check-ins. (Veach & Shilling, 2018, pp. 97-98)

Organizational Climate

The organizational climate has been identified in several studies as a factor in the positive or negative manifestations resulting from indirect trauma exposure of therapists (James & Sells, 1981; Morse et al., 2012; Pack, 2013). James and Sells (1981) defined organizational climate as the collective perception and attitude of the work environment

and is comprised of dimensions that include role conflict, role overload, role clarity, cooperation, and advancement/growth.

A negatively impactful organizational climate is characterized by agency staff having high amounts of role overload with general feelings of being overwhelmed by the amount of work to be completed (Pack, 2013). Furthermore, role ambiguity and conflict also contribute to stressful organizational climates where the therapist feels they have multiple role demands that exceed their ability to complete the necessary tasks (Pack, 2013). In contrast, high functioning climates validate and normalize the therapist's experiences related to indirect trauma (Knight, 2013; Osofsky, 2012). The emphasis is on being supportive, proactive, and early identification.

A therapist's perception of opportunity for professional and personal advancement, as well as, high role clarity where the employee understands their role and how they fit into the organization, and high standards of cooperation and help between coworkers and administrators influences how the therapist recovers from indirect trauma (Knight, 2013). Berger and Quiros (2016) reported that effective organizations are those that provide the following: Regularly scheduled group sessions with therapists, scheduled sessions prior to an adverse event occurring, mentorship between new therapists and experienced ones, individualized supervision, ongoing education that provides skills in management of symptoms (stress reduction), and evenly distribute difficult cases when assigning workloads among staff. Effective organizational process to promote therapists' recovery from indirect trauma is also influenced by the characteristics that make up rural social work.

Rural Social Work

Rural social work differs from urban social work in the availability of resources, funding, differences in formal and informal support systems, differing value systems (Ginsburg, 2014; Hastings & Cohen, 2013; Sethi, 2015; Waltman, 1986), access to professional supervision, availability and access to opportunities for professional development, and varying levels of autonomy (Blue et al., 2014). Up until a few years ago, the U. S. Census Bureau defined a rural county as total population of less than 50,000 people, whereas the 2010 census further delineated rural and urban populations by terming groups 2,500 to 50,000 people as urban clusters; leaving rural to include less than 2,500 people (Kirst-Ashman & Hall, 2012; U.S. Census Bureau, 2013b). For the sake of this discussion, the population recently termed urban clusters will be included as "rural".

According to the U.S. Census Bureau (2013b), more than 60 million people reside in rural America, composing more than 25% of the population but occupy around 83% of the U.S. territory. For those living rurally, the geographical distance to urbanized areas and additional resources provide a unique set of barriers in receiving or providing services to those in need (Hasting & Cohn, 2013; Beecher et al., 2016).

Rural Culture

Rural culture is a term used to encompass all the characteristics that describe the make-up of all things rural i.e. attitudes, lifestyles (National Association of Social Work, 2003) and thus, may be viewed as a distinct cultural group or minority (Daley, 2015). Ginsburg (2014) offered a more personal distinction between rural and urban areas by adding that rural areas have greater personal interaction with less emphasis on formal systems of support. Prior to the term "rural culture," the seminal work of Waltman (1986)

described social work practice in rural areas as being unique in terms of service delivery because of the values that rural people tend to assert: Self-reliance, local autonomy, informal supports in neighbors helping neighbors, tradition, and institutional supports with schools, churches, and service clubs. Moreover, a focus group in a study by Gjesfjeld, Weaver, and Schommer (2015), identified a slower pace of life and a slower pace of change as a way of life that was both positive and negative in rural living; the slower pace of life meant that life was consistent, but community change would be a slow process.

Consistent with a slower pace of life, attitudes and lifestyle, in rural culture, a "rural reality" was identified in a study by Gjesfjeld, Weaver, and Schommer (2015) to describe an attitude from rural people that was made up of apathy in how they responded to the barriers that resulted from living rurally; participants tended to minimize the negative personal impact of living rurally (p. 119). One plausible explanation offered was that rural residents are acutely aware of the barriers and lack of resources by living rurally, and therefore adjust their expectations (Gjesfjeld et al., 2015).

Implications for Practice

Individual behavioral health services are increasingly being accepted as an integral part to an individual's overall well-being. It is estimated that 20% of adults and children meet the criteria for at least one behavioral health disorder, with estimates of 50% of the population developing a behavioral health disorder in their lifetime (Substance Abuse and Mental Health Services Administration, 2013). Access to behavioral health services in rural areas is more limited than urban areas due to the scarcity of qualified behavioral health providers (Rishel, Morris, Colyer, & Gurely-

Calvez, 2014). Mackie (2015) reported that 80-90% of behavioral health specialist are in urban areas, yet the U.S. Census Bureau (2013a) estimated that 25% of the population reside in rural areas, resulting in a shortage of qualified behavioral health specialists to provide services.

Retention and recruitment of social workers in rural areas is a real barrier to sustaining services in remote areas (Mackie, 2012). Moreover, studies from Brocious, Eisenberg, York, Shepard, Clayton, and Van Sickle (2013), Brownlee, Halverson, and Neckoway (2014), Burgard (2013), Humble, Lewis, Scott, and Herzog (2013), Mackie (2012), Sethi (2015), Toner (2015), and Hasting and Cohn (2013), identified the unique characteristics of rural cultures and how those characteristics impact the delivery of social services. For example, rural poverty, dearth of formal resources, lack of anonymity, dual relationships, and heavy workloads all present challenges to providing service (Sethi, 2015). The median income in rural areas is $42,881 compared to urban areas with a $54,042 median income (U.S. Census Bureau, 2013a). Boundary issues with dual relationships (Brocious, Eisenberg, York, Shepard, Clayton, & Van Sickle, 2013; Brownlee, Halverson, & Neckoway, 2014; Burgard, 2013; Humble, Lewis, Scott, & Herzog, 2013), lack of supervision, fewer professional training opportunities (Mackie, 2012; Toner, 2015), geographical distance, inadequate resources, lack of funding, travel time, and paperwork were also all identified as challenges in rural settings (Hasting & Cohn, 2013). Geographical distance coupled with small or tightening agency budgets makes transportation difficult and creates accessing the client all that more difficult in the most rural of areas (Mackie, 2012; Toner, 2015).

Overstreet, Kempson, and Hermansen-Kobulnicky (2015) identified a lack of professional preparedness as the most significant finding in their quantitative non-random pilot study (N = 19) of rural social work with supporting specialized clients (clients with cancer). A similar qualitative study by Averett, Carawan, and Burrows (2012) sought to identify the traits and characteristics of those social work students who successfully completed field placements in rural community organization. The authors reported that students who participated in a rural macro field placement reported feeling better prepared for generalist practice than rural social workers with practice experience. A recent needs assessment that included 60 rural social worker participants resulted in findings that identified challenges to practice with accessing resources, lack of connection, geographic distances, wide range of service population, funding sources, and lack of access to training (Beecher et al., 2016). Video conferencing and Telehealth were identified as ways to minimize the negative impact of rural distance, access to training, and lack of connection (Reed, Messler, Coombs, and Quevillion, 2014).

Organizational Support

Organizational supports to therapists appear to lessen the potential negative impact on secondarily exposed trauma therapists (Bride, Jones, & MacMaster, 2007; Kanno & Giddings, 2017; Neswald-Potter & Simmons, 2016). Supervision has been identified by multiple research studies to be a significant predictor of how secondary trauma exposure may negatively impact a therapist (Berger & Quiros, 2016; Newell, Nelson-Gardell, & MacNeil, 2016; Whitfield & Kanter, 2014). A qualitative study by Berger and Quiros (2016) examined the perspectives of 12 supervisors who provide supervision on trauma informed practice in trauma impacted environment. A common

theme of effective supervision was identified as an empowering relationship between the supervisor and supervisee, while establishing a safe emotional and physical environment for processing feelings and knowledge and ultimately advocating self-care strategies that may be used to manage negative manifestations resulting from indirect trauma (Berger & Quiros, 2016).

Effective supervision is an ongoing relational process that extends through the entire span of employment at the organization. The collaborative relationship in the supervisory role involves a mutual and constant checking in with each other for emotional and physical needs (Berger et al., 2018; Berger & Quiros, 2016; Blue et al., 2014). It also provides the supervisor with the frequent opportunities to normalize and validate the feelings of the supervisee (Knight, 2013). In the narratives of 12 supervisors by Berger and Quiros (2016), the supervisors posited that creating a safe and 'feels' safe environment is one of the most important factors in effective supervision with secondarily exposed trauma therapists. Furthermore, the role of supervision must be clearly identified to the supervisee as an opportunity to discuss feelings without the session transforming into a therapeutic session (Knight, 2013).

Barriers to Organizational Change

Limited resources within an organization create a barrier to implementing organizational change in addressing the needs of a therapist. Limited resources for providing training and the hiring of additional staff, compromises the ability to better manage caseloads and allow for adequate time for a higher level of supervision (Berger & Quiros, 2016). Funding sources may create barriers for agencies. In recent years, the pressure from managed care may have influenced the organizational climate to focus

more on activities that generate revenue and minimize time spent on activities that may be considered secondary to revenue such as supervision (Berger & Quinos, 2014). Dombo and Blome (2016) reported findings on the connections between workplace culture and vicarious trauma in an exploratory qualitative study with five participants with an average of 23.6 of years of experience in child welfare work. A theme emerged from the study was that the organizational climate created an effect of pushing and pulling between bureaucratic and staffing responsibilities. As reported, bureaucratic demands were a priority, leaving the staff to feel "like there is a limited ability to affect change" (Dombo & Blome, 2016, p. 515). Driving the point further, systems within agencies are often moving too quickly resulting in a delayed examination of the potential negative outcomes of trauma in the work or pause to implement trauma-informed practices to more effectively intervene (Collins-Camargo & Antle, 2018).

Employee turnover resulting from burnout has been examined extensively in the literature. Turnover is financially costly to the organization and barriers to client outcomes. Middleton and Potter (2015) reported a causal relationship between vicarious traumatization and employee turnover in a study of 1192 child welfare professionals, and that the high turnover rates in child welfare agencies have implications for client outcomes due to higher caseloads resulting from fewer staff. Middleton and Potter (2015) examined the factors that contribute to employee retention, the organizational climate with factors related to quality of supervision, coworker support, salary, and found that benefits were statistically significant to predict retention. There is little doubt remaining that significant barriers exist with funding shortages, minimal resources, shortage of staff, and organizational climates to creating positive organizational changes.

Ethics and Competency in Social Work Practice

Social workers have an ethical responsibility to be culturally competent (NASW, 2007). Definitions of cultural competence vary but often address ethical commitments and social justice by social workers being culturally empathetic, culturally sensitive, and having cultural awareness (Ginsburg, 2014). In support of the need for cultural competence, practice statements and policy standards of the profession profess a strong commitment to working competently with vulnerable populations (Council on Social Work Education, (CSWE) 2008; NASW, 2008). As previously described by Daley (2015), Ginsburg (2014), and Waltman (1986), rural populations are considered vulnerable because of the characteristics that make up and define rural culture.

In a study by Dombo and Blome (2016) examining the responsiveness of organizational the vicarious trauma in child welfare workers, 80% of participants reported not receiving adequate specialized training to prepare them for working with their clients' traumatic experiences or their own indirect trauma response. Moreover, a study conducted by Rishel and Hartnett (2015) provided specific training elements to participants for working with traumatized clients, customized coursework, mentorship, specialized field placements, and professional networking opportunities that resulted in the participants expressing preparedness for trauma work. One participant reported the new found "ability to appreciate prevention strategies, understand integrated community services, and relate in a more empathetic way to clients who suffer…contribute to me being a more competent clinician" (p. S40).

In 2009, a rural policy statement was issued by NASW to call action to inequities and barriers to practice and receiving social services in rural areas (2009). The U.S.

Department of Health and Human Services, Health Resources, and Services Administration (HRSA) addressed the significant need for competent behavioral health services in high needs populations, including rural, military personnel, veterans and their families, and vulnerable or underserved populations (DHHS, 2014). In 2013 (and subsequent years), HRSA awarded grants to 24 University graduate programs to strengthen the clinical competencies of students in the masters of social work and doctoral psychology programs who area of focus was on one of the high need populations (DHHS, 2014). In their studies, Blue et al. (2014), Lee, Carlson, and Senften (2014), Riebschleger, Norris, Pierce, Pond, and Cummings (2015), and Gjesfield, Weaver, and Schommer (2015) reported a continued need for competent practice in rural settings.

Ethical practice in rural settings was identified by Riebschleger et al. (2015) as being a competent practitioner. A competent rural practitioner was identified in this study as a practitioner who has received formal education in areas of rurality: poverty, resources, trauma, cultural competence, generalist practice, autonomy/need of support, dual relationships, leadership, and community collaboration (Riebschleger, Norris, Pierce, Pond, & Cummings, 2015). Blue et al. (2014) examined ethical supervisory practice in rural social work settings. The themes identified in the findings of the study included ethical challenges unique to rural practice settings due to multiple supervisory roles, dual roles within the agency setting, dual relationships with workers and community members, managing worker and clients' confidentiality, and setting appropriate boundaries with supervisees. One participant reported feeling "isolated from other supervisors, and it's hard to find other supervisors to consult with who understand what you are dealing with" (Blue et al., 2014, p. 8). The need for competency in rural

practice was further confirmed when participants of a study examining family perception of provider cultural competence in the treatment process was positively correlated with provider cultural competence, as practitioner competency increased, family perceptions of provider competence increased (Lee, Carlson, & Senften, 2014).

Lastly, Gjesfield et al's. (2015) study that examined the experiences of women who sought healthcare and mental health care postpartum in rural settings. The findings included themes of difficulties receiving competent services due to provider shortages, and lack of resources and service options (Gjesfield et al., 2015). All of the mentioned studies on ethics in rural settings align with the SAMHSA (2004) report for improved systems and services in rural settings by integrating trauma-specific work that requires higher clinical skills and trauma-informed staff support through trauma-specific supervision.

Summary and Conclusion

Prolonged empathetic engagement with traumatized clients leaves social workers at risk of developing vicarious trauma. The potential organizational, professional and individual harm caused by prolonged exposure to our client's detailed trauma histories calls to action organizational changes that reinforce supporting factors for therapists' and macro change and/or reinforcement of practice and policy standards for social workers.

Organizational culture and policy and practice standards have further practice implications for rural social workers over urban social workers. Rural social workers practice with nearly a quarter of the U.S. population, but spread over the majority of the U.S. territory. Coupled with geographical distance, rural social workers face a unique set of barriers to providing social services, this uniqueness also makes recruiting and

retaining qualified rural social workers difficult. The increasing mental health needs of clients with trauma histories has increased the demand for competent rural social workers. Competencies in social work practice standards with vulnerable populations have been a part of the Social Work *Code of Ethics*, however, it was until the recent decades that rural populations were included as a vulnerable population.

The Trauma-Informed Care conceptual model was developed to acknowledge and address the pervasiveness of trauma on organizational systems (client, therapist, and agency), and grounded in Trauma Theory. The main principle of Trauma Theory is in "how" an individual responds to a traumatic event; the response is complex and unique based on a combination of how the event was interpreted using personal meaning making, worldview, and coping mechanisms. The Trauma-Informed Care model consists of specific tenets related to safety, trustworthiness, choice, collaboration, and empowerment and when used, it can help to minimize the potential negative effects of secondary trauma exposure through implementation of organizational practices.

The current state of knowledge in trauma prevention and recovery for clinicians who experience secondary trauma exposure is based on models such as the Trauma-Informed Care model. Up to this point, there has been very little examination of how the Trauma-Informed Care model has been implemented and its perceived effectiveness in rural social service settings. The purpose of this qualitative narrative study is to develop a better understanding of the perceptions of trauma social workers on the responsiveness of rural social service agencies on vicarious trauma. The narrative approach is the best approach to examine experiences of trauma clinicians through lived and told stories. The narrative approach focuses on a small number of individual's stories through an

examination of chronologically presented written or verbal accounts of experiences (Rudestam & Newton, 2015). This narrative study will use storytelling as a way to understand the events and actions of the lived experiences (Toolis & Hammack, 2015). This study's narrative approach will focus on the experiences of each individual participant and although understanding of their experience will not be generalized beyond that individual, comparative themes may emerge between participant's experiences.

Because little is currently known about the use of the Trauma-Informed Care model and its use in rural social work, this study furthered the knowledge base of rural social work practice with clients' trauma history and the experience of the Trauma-Informed Care conceptual model as a method of addressing prevention and recovery given the cultural uniqueness of rural practice.

Chapter 3: Research Method

Introduction

The purpose of this qualitative narrative study was to develop a better understanding of the perceptions of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma. I explored the perceptions of social workers from rural social service agencies on the responsiveness of their agency to vicarious trauma through the lens of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). Considering the risk factors and negative influences of vicarious trauma on social workers and agencies (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan, Itzhaky, & Ben-Porat, 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; Knight, 2013) , an increased understanding of the perspectives of trauma social workers on how rural social work agencies are responding to vicarious trauma care was needed.

In this chapter, I outline the qualitative method and procedures that I used to understand the experiences of participants. Specifically, this chapter covers the research design and rationale for the study. I examine the role of the researcher, describe in depth the methodology that was used, and discuss issues of trustworthiness and ethical procedures related to the investigation. The chapter concludes with a summary of key points.

Research Design and Rationale

Research Question

The following research question guided the study: What are the perspectives of trauma social workers on the response of rural social work agencies on vicarious trauma and self-care?

Central Concept

The primary concept of interest was vicarious trauma, commonly defined as a representation of a gradual, progressive, and internal transformation that may result in the therapist from overempathizing with and indirectly experiencing clients' emotionally charged reaction to a traumatic event (Dombo & Gray, 2013; Pearlman & MacIan, 1995; and Wilson, 2016).

Research Tradition and Rationale

I examined the perceptions of rural trauma social workers on the responsiveness of their agency to vicarious trauma using a narrative approach developed from the epistemological underpinnings of constructionism and framed using the principles of the trauma-informed care model, which has key concepts safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009).

Constructionism and qualitative inquiry are closely aligned by emphasizing social dimensions of human life. Constructionism posits that the individuals have the ability to construct his/her own reality as they move within their environment, creating their own unique model of how they see the world (McCann & Pearlman, 1990). Moreover, human phenomena are not an objective reality, but are socially constructed (Padgett, 2017). The qualitative inquiry approach of this study was used an inductive approach to explore

meaning and make inferences based on the socially constructed perceptions gleaned from the responses given by the participants during the in-depth interviews. Personal growth and development are dependent upon the evolution of three areas of the psychological system: self, psychological needs, and cognitive schemas (McCann & Pearlman, 1990). The evolution of the three psychological systems will configure the make-up of the traumatic experience; it will determine what is remembered and shape how it is experienced and interpreted (McCann & Pearlman, 1990).

The strength of this qualitative inquiry was my focus on seeking understanding in the experience through rich description, meaning, and process rather than measuring intensity, frequency, and quantity (see Rudestam & Newton, 2015). A narrative approach was the best one to use to examine perceptions of trauma clinicians through their lived and told stories based on their socially constructed vantage point. I utilized storytelling as a way to understand the events, actions, and perceptions of the experiences of rural trauma social workers.

Role of the Researcher

Narrative approach requires extensive researcher involvement in collecting exhaustive information about the participant. As the participant-observer, direct and personal contact gave me the opportunity to capture the context of what was being said by participants and provided the chance to learn details that participants may not have shared had they only been observed. The observations made during the interviews provided firsthand experience and knowledge of visual representations of feelings, impressions, reflections, and introspection that became a part of the data set used in understanding the observational setting (see Patton, 2015).

At the time of this study, I had no personal relationships with any prospective participants. Professionally, I am a director with authoritative power over a social work department with social workers. I deemed all the social workers employed at my agency as ineligible from participation in this study. Because I am a rural social work professional, some study participants knew me on a personal and professional level. However, I did not have any authoritative power or connections to those who have power over prospective participants, such as his/her supervisor.

I may have been at a disadvantage from personal biases. My personal bias of believing that all social service agencies should be mandated to provide protective measures against secondary trauma exposure affects the lens through which the study was approached and can affect what I saw and did not see in an observation (Watts, 2011). Personal biases can also influence how the observations were documented and how the data was coded (Watts, 2011). To ensure a good qualitative study, my bias had to be managed through the preparation process and reflexive measure during the research process. An additional strategy to manage my bias in observation was to document throughout the observation process regarding what I was seeing and what may have been impacting what I was seeing (Watts, 2011). When documenting observations, a 'notes' section was used for reflexive documentation where I wrote down my own thoughts, feelings, or actions based on what I was observing right when it happened. Being a reflexive observer and developing good note taking skills decreased the likelihood of biases and increased the strength of the research study (Badets, Bouquet, Ric, & Pesenti, 2012). Professionally, I myself am a part of the participant group. I am a Masters prepared social worker with well over one year of experience providing direct therapeutic

interventions to clients with significant trauma histories. Moreover, the agency where I provide these services to trauma clients is rural and does not employ a formal process for addressing vicarious trauma symptomology. My experiences of working in an agency that has not yet created a culture of trauma-informed care may have created a personal bias in favoring the need for the trauma-informed care model.

As researchers, we often study what we have a passion for, and may find ourselves having commonalities with our research participants (Janesick, 2011). At times, those commonalities may make it difficult to keep from 'comparing' experiences with the participants. As recommended by Marshall (1996), I kept a journal for note taking and reflected on my experience, feelings and thoughts that arose during the interviewing process that minimized the desire for personal disclosure during the interview.

An additional ethical dilemma that may have arisen is the potential for professional risk. There was potential that the organization the participant is employed at may view the participation in the study as being to 'exposing' to the organization. To minimize any unintended consequences of participation, participants were encouraged during consenting process to notify supervisor of participation, but ultimately, it was at the discretion of the participant to choose to notify the stakeholders (e.g. supervisors, owners, board members, etc.).

Methodology

Participant Selection

The population for this study consisted of social workers from the Northern Arizona region. I used a purposeful sampling strategy to obtain a sample size as close to

15 as possible with 10 being the minimum. A criterion-purposeful sampling strategy was employed because the research questions specifically focus on participant's experiences related to the responsiveness of organizations to vicarious trauma. Criterion-purposive sampling focuses on the unique context and strategically selects participants based upon the degree of the participant's experience with the construct (Maxwell, 2005).

This study was limited to include participants who express an interest in participating in this study and meet the following criteria: Currently employed for a minimum of one year at an agency/organization that is identified as rural, has an education minimum of Master of Social Work (MSW), provides a minimum of one (1) hour of direct therapeutic intervention to clients with trauma histories or in those who are in an acute crisis related to trauma. To determine participant eligibility for this study, upon first contact by phone or e-mail, participants were required to confirm verbally or in written e-mail that they do in fact meet the stated criteria for participation (Appendix C).

The sample size of 10 was selected to gather sufficient data for analysis of themes in a timely manner, and to prevent elongation of the study (Rudestam & Newton, 2015). As recommended by Maxwell (2005), and Miles, Huberman, and Saldana (2014), the sample size may have had to be increased as needed to reach saturation, or decreased if participants drop out, or it was found that the inclusion criteria were not met as initially reported.

As the researcher of this study, I recruited participants using my academic e-mail account and send requests for volunteer study participants to area (within a three-hour drive from my geographical location) social service agencies/organizations who provide crisis and therapeutic interventions to clients. An Internet search using "northern Arizona

social service(s), rural Arizona social service(s), northern Arizona hospital(s), northern Arizona mental health, northern Arizona therapist(s), and rural Arizona therapist(s)" search terms sought to identify social service agencies or organizations that have a social service department within the agency. A list of the agency's therapists (noted as LCSW or MSW) and their employee contact information was then compiled. An e-mail invitation was then sent to those individuals using their agency contact information requesting research participation. The e-mail included an explanation of the study, study purpose, participant criterion, and an opportunity to reach out by e-mail or phone to get additional information (Appendix B). Once the potential participant made e-mail or telephonic contact, I collected their name and preferred contact information. Interviews were scheduled based on the first 15 participants who meet the participant criterion and scheduled a face-to-face interview at their earliest convenience. If more than 15 potential subjects had requested participation in the study, after the first 15, all others would have been put on a first come first serve waiting list. If less than 10-15 subjects volunteered or did not meet the participant criterion, then I would have sought approval from the IRB to expand recruitment beyond the Northern Arizona region.

Instrumentation

Each participant was given the opportunity through a face-to-face interview to share their perspective related to the research question. During the interview process, I took hand written notes from a protocol sheet that I developed (Appendix A). I also noted any observations (Field notes) in participant behavior on the same protocol sheet (Appendix A). The purpose of the protocol sheet was to hand record responses from

participants related to their perceptions of how their organizations responds to vicarious trauma (Appendix A).

During the course of the interview, a digital hand-held audio recorder was used to capture participant responses verbatim. The use of an audio recording ensured accuracy in recording participants' responses during data collection (Rudestam & Newton, 2015). Padgett (2017) also recommends using a digital audio recorder. With the superior technology and affordability of audio recorders, recorders are used as a standard instrument of data collection in interviews (Padgett, 2017). Permission was sought from each study participant to allow for audio recordings of the interview session.

An interview can provide rich and substantive data based on the interviewee's worldview and perspective (Padgett, 2017). The most widely used interview technique is face-to-face, and with the research question having sought understanding of a rural trauma social workers perspective, it is logical to have selected the face-to-face interview for collection of data (Janesick, 2016).

Researcher Developed Instrumentation

To date, there are no previously developed instruments that would sufficiently capture the perceptions of rural trauma social workers related to the responsiveness of their agency to vicarious trauma. Fallot and Harris' trauma-informed care model was developed in 2006 and has been gaining traction over the past decade as an organizational preventative model for secondary trauma and vicarious trauma (Kusmaul et al., 2015). In 2009, Fallot and Harris developed a self-assessment protocol for individuals and organizations to self-measure their current level of being 'trauma-informed'. I created the instrument used as the interview protocol worksheet (Appendix A) by adapting the

Fallot and Harris self-assessment and planning protocol. The Fallot and Harris (2009) protocol for creating a trauma-informed care organization consisted of organizational questions related to each of the five domains of being trauma-informed: safety, trustworthiness, choice, collaboration, and empowerment. Several sample questions were taken from each of the five domains and were adapted to better meet the practices of qualitative inquiry with open ended questions and depth seeking. For example, the Fallot and Harris protocol question under the domain on empowerment asks, "are staff members offered development, training, or other support opportunities to assist with work-related challenges and difficulties?" The question was reworded to better answer this study's research question about perceptions; "tell me about the training you have received related to workplace stressors, including trauma and its potential impact on you?"

Recruitment, Data Collection, and Participation Procedures

Participants for this study were recruited using an e-mail platform. An Internet search will seek to identify social service agencies or organizations that have a social service department within the agency. A list of the agency's therapists (noted as LCSW or MSW) and their employee contact information was compiled. An e-mail invitation was then sent to those individuals using their agency contact information requesting research participation (Appendix B). After receiving verbal or written verification that prospective participant meets this study's criteria for participation, an immediate verbal or written request was made by me to schedule an interview (Appendix C).

Collection of data took place at a private and neutral location therefore, it was suggested to meet in a conference room at the local public library as recommended by Padgett (2017). I conducted all interviews and follow-up interviews as quickly as

feasibly possible given the time frame selected by the participant. It was anticipated that an initial interview will take approximately 1½ half hours to complete, with a follow-up interview for clarification and member checking lasting approximately 30 minutes telephonically. All interviews were digitally audio recorded and the use of field notes was utilized to record responses and observations.

In the event that initial recruitment did not reach saturation within the anticipated 10-15 study participants, the geographical region of this study's participant pool may have been expanded to include a further reach (up to a three-hour drive) until saturation was met. Potential participants of a further geographical reach would have received the same e-mail invitation to participate in the study as the initial region participants received (Appendix B). Ultimately, it was not necessary to expand the participant pool as saturation was met with the 10 study participants.

As recommended by Padgett (2017), all field notes were transcribed as quickly as possible following the interview (same day if possible) to ensure context and meaning are preserved. www.Rev.com transcribed the interviews verbatim using human transcriptionists with a 99% accuracy rate (as stated on their web page). Although transcribing field notes occurred soon following the interview, as suggested, follow-up interviews did not occur for a minimum of three days following the initial interview to allow study participant to reflect on what was shared (Padgett, 2017). During the initial meeting, participants were reminded that a follow-up interview may be necessary for clarification and member checking and will last approximately 30 minutes.

I contacted participant within two weeks of initial interview by phone or e-mail to arrange for a time most convenient to the participant for the follow-up interview if the

follow-up interview was not prearranged at the end of the initial interview. A date and time most convenient to the participant was identified, and the participant provided a phone number for the follow-up interview. Prior to beginning of the follow-up interview, the participant was reminded of the right to withdraw and end participation in the study at any point, privacy of information, risks and rewards, and by making a verbal or written request they can receive a summary of the result of this study and a copy of the Fallot and Harris (2009) planning protocol for developing a trauma-informed organization; *Creating cultures of trauma-informed care: A self-assessment and planning protocol*. At the end of each interview the participant was asked if they have anything else they would like to add? Each participant was verbally thanked by myself for their participation and candor.

Data Analysis Plan

I used a constant comparison method to analyze the data and ensure the codes being applied are consistent throughout the entire coding process. The constant comparative method is a cyclical process that requires continual reflection back to previously coded data to ensure consistency of coding on the current passage (Gibbs & Taylor, 2005). The value in a constant comparison analysis comes from the ability to make sense of myriad comparisons and deducing what is meaningful (Padgett, 2017). The interview protocols and field notes were analyzed using the same technique of theming and coding. The most common form of data analysis in qualitative research is categorizing (Maxwell, 2005). Categories were made up of one to five themes, with themes made up of codes (Rudestam & Newton, 2015). Categorizing began by 'fracturing' segments of meaningful data into sentences or statements, labeling them, and then placed the labels into a broader category of an identified theme (Maxwell, 2005, p.

107). Narrowing of themes is a process of finding themes within the larger theme and is often referred to as a code. Coding involved aggregating the data into smaller bits of information, usually a word or two, and assigning it a label (Rudestam & Newton, 2015).

There was a list of labels that were created from the most prominent data within a passage. The label was then used to search for commonalities between multiple data sets (participants) (Rabinovich & Kacen, 2013). Having a reasonable number of labels kept the data from getting lost in the massive amounts of information as anticipated by this study (Rabinovich & Kacen, 2013); keeping in mind that labels can always be expanded or reduced based on the review of the data.

All data was analyzed by hand using categorization, coding and theming to organize the data. In the case of contradictory or discrepant data provided by participants, clarification was requested during the initial interview and the member checking process. Although each participant expressed similarities and differences in their perceptions, member checking took place in the follow-up interview as a form of validating the research findings (Rudestam & Newton, 2015).

Issues of Trustworthiness

Credibility

A researcher's interview technique will determine if the data collected in the interview enhances the credibility of the research (Janesick, 2011). A skilled and prepared interviewer will elicit the depth of information required to create credibility in a research Study (Janesick, 2011). To ensure the depth of information was elicited, prolonged engagement occurred during the interview process. Additionally, I sought clarity and rephrased interview questions if the topic moved away from the interview

question or the participants' response was too ambiguous. Interview probes were used to seek additional clarity and depth in the participants' response (Appendix A). Moreover, a follow-up interview took place at a later date to verify the accuracy and/or clarify the participants' perspective on a topic (Member checking) (Rudestam & Newton, 2015).

The follow-up interview used for member checking took place over an approximately 30-minute phone interview where participants were engaged in reflecting, reacting, and expanding on their initial interview responses. Prior to the follow-up phone interview, I analyzed the notes taken and the transcripts for any responses that may have been unclear, had multiple meanings, or needed more detail. The identified responses requiring clarification physically noted for the second interview. In addition to seeking clarification on some questions, the participants were asked to validate their initial responses to ensure the correct meaning was attributed to those questions. Once all identified questions requiring clarification were responded to by the participant, the participant was asked if they would like to add any additional information.

Loh (2013) identified the member checking process as form of triangulation of the data, where the participants are able to validate accurate response, clarify vague responses, and add new information. Additional triangulation methods were not possible, policy and procedure manuals were not available for examination and there were no formal policies for organizational or individual practice regarding vicarious trauma or secondary trauma.

Transferability

Several strategies exist to address issues of transferability of the study findings. Rudestam and Newton (2015) recommend using a rich, thick description of the data

provided by the participants. Furthermore, transferability can be established through the relatability of the study's readers (Padgett, 2017). Transferability occurs "when the reader can personally relate to the study's findings and see parallels to their own experiences" (Padgett, 2017, pp. 212-213). I used descriptive details about the participants and the setting of the study to create an illustration for the audience that is transferable to other settings (Houghton, Casey, Shaw, & Murphy, 2013). Moreover, the rich descriptive context description that is ecological validity, lends to the transferability of the study's findings as the reader is able to have a sense of having been there vicariously (Padgett, 2017). I used rich and descriptive protocol questions and probes to elicit the depth and breadth of participant responses in attempt to incite a sense of vicariousness therefore, increasing transferability.

Dependability

Dependability is the consistency of a researcher's approach in being stable across multiple researchers and multiple projects (Janesick, 2011). To ensure consistency and the data being dependable, consistent procedures must be utilized (Janesick, 2011). In this narrative study, the interviews and observations produced mounds of data in transcripts; searching for and correcting obvious errors increased the dependability of the data (Rudestam & Newton, 2015). I created a transparent trail of how decisions were made during the data collection and data analysis process to create accountability for the accuracy of the data and allow for replicability (Maxwell, 2005; Padgett, 2017). Additionally, the use of triangulation between multiple interviews with each participant was used as a way to verify the meaning of the participants' responses (Loh, 2013). Each participant received two interviews, the initial being 1 ½ hours and the follow-up being

30 minutes. Additional triangulation of data occurred when possible with the policy and procedure manual of the organization.

Confirmability

Rudestam and Newton (2015) recommend using a reflexive approach to strengthen the validity of the study. I used reflexivity to create transparency about my own 'position' in attempt to minimize bias. My transparency is a conscious effort to make my unconscious and conscious experiences, values, and biases known within the context of the study in an attempt to keep from influencing the research findings and conclusions (Rudestam & Newton, 2015).

Researcher journaling is a reflexive process where I choose a topic related to the research study and wrote freely on the subject while also noting self-reflections (Janesick, 2011). The purpose of the reflexive process is to create a deeper sense of self-awareness and develop a greater understanding of what the study participants may have felt, thought, or how they behaved, while paying attention to my own feelings when journaling on a topic (Janesick, 2011). The journal become part of the data set that captures an account of the problems and barriers that arose during the research process and be used as a tool to reflect on my thinking patterns (Janesick, 2011).

Coding Reliability

To validate the quality of the data that was determined to be "significant", coding data may be completed by one or more individuals (Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014). I coded the data independently. Moreover, I maintained the reliability of the coding by ensuring through frequent reflection that the

structure and definition of each code or theme did not expand during the coding process (Janesick, 2011).

Ethical Procedures

Prior to recruiting research participants, an application was submitted to the Walden University Institutional Review Board (IRB) requesting permission to seek criterion-based study participants, approval number 04-02-18-0589259. The study participants that were invited to participate in this study were geographically located within the Northern Arizona region. The selection of participants was based on meeting the criteria for participation in this study and excluded any other criteria not explicitly identified in the request for participation (Appendix B), e.g. race, ethnicity, gender, sex, religion.

After receiving IRB approval to conduct research, I collected data from 10 volunteer research participants. Participants were recruited from agencies aside from the agency where I am employed. Furthermore, in an effort to reduce conflict of interests, no participants who were under my supervision or potentially under my future supervision were recruited as participants. Moreover, I had no authority or power to personally or professionally negatively influence a study participant. At no point during the research process was a power differential discovered between the researcher and the participant.

The informed consent process occurred after meeting the participants in person and just prior to the start of the face-to-face interview. The consent form was thoroughly reviewed by myself and the participant together; paying special attention to addressing procedural expectations, rights to withdraw, privacy, and risks and benefits. Procedurally, participants were made aware of the expectations of their participation,

which included: Signing an informed consent, identifying a location, date, and time that best suits their schedule for the interview, meeting twice with the researcher, once face-to-face for approximately 1 ½ hours, and the second by phone for approximately 30 minutes with both sessions being digitally audio recorded for transcription and analysis.

Participants were advised during the informed consent process of their right to withdraw from the study at any point for any reason without punishment. Participants were notified of their privacy and that reports coming out of this study would not share the identities of individual participants. Details that might identify participants, such as the location of the study, also would not be shared. The researcher would not use their personal information for any purpose outside of this research project. Data was kept secure by using codes in place of participant names, electronically stored information on USB flash drives that were kept in a safe along with any paper data inside the researcher residence. Data will be kept for a period of at least five years, as required by the university.

Lastly, participants were made aware of the risks and benefits of their participation. This study involved some risk of the minor discomforts that can be encountered in daily life, such as stress or fatigue. If a break was needed, either the participant or the interviewer may have verbalized the request at any point. Being in this study did not pose risk to the participant's safety or wellbeing. Additionally, there was potential that the organization the participant is employed at may view the participant's participation in the study as being to 'exposing' to the organization and therefore, may punish the participant for their participation in the study. To minimize the unintended consequence or risk of professional punishment, I strongly encouraged the participant to

gain the support and approval from their agency stakeholders (e.g. supervisors, owners, board members, etc.). Ultimately, it was at the discretion of the participant if they chose to gain their agency's support. There were no other known risks associated with participating in this study. The potential benefit of participating in this study may have come in the form of providing awareness of current level of support services in rural social service agencies, and the potential for a 'call to action' for trauma-informed services in rural social services settings.

Although an adverse event did not arise, I was prepared to use my clinical judgment of whether to immediately terminate the interview, refer the participant to their agency's employee assistance program (EAP), or to consult with the participant on whether they wish to proceed. Beyond the obvious adverse event are subtler ethical issues that may have needed addressed.

An unanticipated ethical issue that arose during the research process revolved around an incident of personal disclosure. Since I was studying a topic which I was passionate about, and therefore, in many cases, I had shared commonalities which make it difficult to keep from 'comparing' experiences with the participants. As recommended by Marshall (1996), I minimized the desire for personal disclosure during the interview by journaling and note taking to reflect on the experience, feelings and thoughts that arose during the process.

I assured all participants that all identifying information will remain confidential. At no time was demographics beyond name and contact information necessary, with contact information being kept on a secured list. Any written material that included identifying information was redacted for confidentiality. Each participant's employment

agency remained confidential throughout the entire research process, and at no point was it used beyond the initial contact for study participation. Each digital recording was submitted to www.Rev.com for verbatim transcription (strict confidentiality forms on file with www.Rev.com) with any spoken identifying information redacted prior to submission for transcription. All data collected and used (journals) during the research process were stored on USB drives and kept in a locked safe within my place of residence that only myself had access too. Following the completion of this research study, all records were stored in a safe within my personal residence for five years and then will be destroyed through shredding.

I followed the procedures listed below to recruit and inform study participants about this study, data collection, analysis, storage, confidentially, and rights to study findings.

1. Sent invitation to participate in research study with request to contact me by e-mail or my personal cell phone for participation in this study (Appendix B).
2. Documented contact information from potential participant who e-mailed or phoned to express interest in participating in this study.
3. Returned calls and e-mails of potential participants to confirm that participant does in fact meet the criterion sample requirements (Appendix C).
4. Scheduled date, time, and location of interview with study respondent.
5. Met with participant at the local public library at date and time of their choosing; provided the informed consent; once it was signed, begin the interview using the interview protocol and digital audio recording (Appendix A).

6. At the end of each interview, scheduled date, time, for phone of the follow-up interview for member checking.
7. Each digital recording was submitted to www.Rev.com for verbatim transcription (strict confidentiality forms on file with www.Rev.com). Completed transcriptions were sent to my Walden University e-mail address.
8. Met with each participant by phone within the two weeks the participant identified at the end of the initial interview for a follow-up interview to clarify responses and engage in member-checking.
9. During the follow-up interview, provided participants my contact information should they choose to receive the study results or have additional questions or concerns.
10. All participants were thanked for their participation and candor.

Summary

This aim of this study was to develop a better understanding of trauma social workers and their perceptions of rural social service agency's responsiveness to vicarious trauma. Study participants included 10 master's level social workers from various rural social service agencies in Northern Arizona and engage daily in a therapeutic relationship with traumatized clients.

Data collection occurred through a face-to-face interview and a telephonic follow-up interview. Data analysis occurred using a coding method to identify themes in the responses of participants. The trustworthiness of this study was strengthened through the process of developing credibility, transferability, dependability, and confirmability. Moreover, depth sought with descriptive details and clarity in participant responses

enhanced the transferability of this study's findings to non-participating rural trauma social workers and their organizations.

Prior to data collection, approval from the university's IRS was sought to access study participants. Ethical practices were maintained through the duration of this study with maintaining confidentiality (Appendix D) and ethical practices for handling and storing written and verbal data. All participants were treated with the highest professional standards and respect, including if a participant voluntarily withdrew from this study. Although no financial incentive was offered, participants were thanked for their time and candor, and offered the opportunity to receive the study's findings. In the next chapter, there will be a discussion of how the data was collected, the setting and the demographics of the study participants, and a detailed analysis of the data collected with the results of this study.

Chapter 4: Results

Introduction

The purpose of this study was to explore the perceptions of social workers from rural social service agencies on the responsiveness of their agency to vicarious trauma through the lens of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). Considering the risk factors and negative influences of vicarious trauma on social workers and agencies (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan, Itzhaky, & Ben-Porat, 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; Knight, 2013), an increased understanding of the perspectives of trauma social workers on how rural social work agencies are responding to vicarious trauma care was necessary. I used the following research question to guide this study: What are the perspectives of trauma social workers on the response of rural social work agencies on vicarious trauma and self-care? In this chapter, I will present this study's research findings. The chapter includes an overview of the data collection setting, the demographics of the participants, an in-depth examination of the data analysis process, and a discussion of the study's trustworthiness.

Setting

I recruited participants for this study using an e-mail platform. Furthermore, I used an Internet search to identify social service agencies or organizations that have a social service department within the agency. A list of the agencies' therapists (noted as LCSW or MSW) and their employee contact information was then compiled. I then sent out an e-mail invitation was then generated and sent to those individuals using their

agency contact information requesting research participation (see Appendix B). After I received either an oral or written verification from the prospective participant confirming they met this study's criteria for participation, I made an immediate oral or written request to schedule an interview (see Appendix C).

On three occasions, social workers contacted me about participating in the study despite the fact they had not received a study invitation. All three potential participants had been referred by a participant in the study and contacted me via e-mail indicating their desire to participate in the study. All three of the requestees met the study's inclusion criteria and subsequently participated in this study after consenting to it.

I identified a sampling pool of 655 potential participants using the noted search terms. I recruited participants using my academic e-mail account. Via e-mail, I sent requests for volunteer study participants to area (within a three-hour drive from my geographical location) social service agencies/organizations that provide crisis and therapeutic interventions to clients. An Internet search using *northern Arizona social service(s)*, *rural Arizona social service(s)*, *northern Arizona hospital(s)*, *northern Arizona mental health*, *northern Arizona therapist(s)*, and *rural Arizona therapist(s)* were used to identify social service agencies or organizations that have a social service department within the agency. I identified all 10 of this study's participants and orally verified they are located within the geographical boundaries identified in this study.

The Northern Arizona region spans several hundred miles wide and encompasses four counties: Navajo, Coconino, Apache, and Yavapai. Much of the territory is protected national forests or reservation land, resulting in vast amounts of space between inhabited areas (DHHS, 2014). The geographical distance between occupied areas in the

Northern Arizona region has limited the availability and access to social service resources (DHHS, 2014).

Demographics

All 10 of the participants for this study consisted of social workers from the Northern Arizona region who met the study's inclusion criteria that consisted of (a) currently employed for a minimum of 1 year at an agency or organization that is identified as rural, (b) have an educational minimum of a Master of Social Work (MSW) degree, and (c) a minimum of 1 hour of experience providing direct therapeutic intervention to clients with trauma histories or to those who are in an acute crisis related to trauma. I confirmed eligibility to participate in this study using a screening tool (see Appendix C). The participant profiles are, as follows:

- P1 is a woman who provides direct therapeutic interventions and empathetic engagement for approximately six hours daily in a for-profit end-of-life care organization. She has been employed in this role for 7 years and currently holds a MSW.
- P2 is a man who provides direct, formal therapy interventions for approximately three hours daily in a for-profit mental health organization. He has been employed in this role for 3.5 years and currently holds an LMSW.
- P3 is a man who provides direct, formal therapy interventions for approximately 6 hours daily in a for-profit mental health organization. He has been employed in this role for 3 years although he has been a practicing trauma social worker for over 35 years and currently holds an LCSW.

- P4 is a woman who provides direct therapeutic interventions and empathetic engagements for approximately four hours daily in a government organization that responds to alleged child abuse. She has been employed in this role for five years and currently hold a LMSW.
- P5 is a woman who provides direct therapeutic interventions and empathetic engagement for approximately three hours daily in a for-profit end-of-life care organization. She has been employed in this role for 3 years and currently holds a MSW.
- P6 is a man who provides direct, formal therapy interventions for approximately three hours daily in a for-profit mental health organization. He has been employed in this role for five years and currently holds an LMSW.
- P7 is a woman who provides direct, formal therapy interventions for approximately four hours daily in a for-profit mental health organization. She has been employed in this role for 6 years and currently holds an LMSW.
- P8 is a woman who provides direct, formal therapy interventions, exclusively to trauma clients for approximately six hours daily in a for-profit mental health organization. She has been in employed in this role for 4 years and currently holds a MSW.
- P9 is a woman who provides direct, formal therapy interventions for approximately seven hours daily in a nonprofit government organization with mandated clients. She has been employed in this role for 4 years and currently holds a MSW. She has a total of 15 years of trauma-related therapy experience.

- P10 is a woman who provides direct, formal therapy interventions for approximately six hours daily in a for-profit medical hospital. She has been employed in this role for 2 years and currently holds an LCSW.

Table 1 also provides an overview of the participants.

Table 1

Demographics of Participants

Participant	Gender	Education	Years in current position	Daily hours spent with trauma clients	Agency (for-profit/nonprofit)
P1	Female	MSW	7	6	For-profit
P2	Male	LMSW	3.5	3	For-profit
P3	Male	LCSW	3	6	For-profit
P4	Female	LMSW	5	4	Nonprofit
P5	Female	MSW	3	3	For-profit
P6	Male	LMSW	5	3	For-profit
P7	Female	LMSW	6	4	For-profit
P8	Female	MSW	4	6	For-profit
P9	Female	MSW	4	7	Nonprofit
P10	Female	LCSW	2	6	For-profit

Data Collection

I used a purposeful sampling strategy to obtain a sample size between 10 and 15. This sample size was selected as a starting point to gather sufficient data for analysis of themes in a timely manner, and to prevent elongation of the study (Rudestam & Newton, 2015). Ultimately, saturation of the data was met with the sample size of 10 interviewees. An e-mail invitation (Appendix B) was sent to potential participants, and interested participants responded with either an e-mail or phone call (9 e-mails, 1 phone call). Contact information from potential participants was then recorded and used to

confirm that the participant does in fact meet the criterion sample requirements (Appendix C) and for a follow-up phone call for member checking.

Participants were offered the opportunity to determine the location (town) the interview would take place. The distance between my location and that of many of the research participants varied from 3 to 120 miles. Once the participant identified a convenient geographical area for the interview, I suggested a private neutral location such as, a conference room at the local public library or college. A total of 8 interviews were held at the local college and 2 interviews were at the local public library. Prior to beginning the face-to-face interview, several minutes was spent with each participant in the consenting processes with particular attention to the 'Risks and Benefits' section of the consent form. Each participant then signed the consent form and received a copy for their own record. Following the informed consent process, the interview began by using the interview protocol (Appendix A) with open ended, semi-structured interview questions. At the end of the interview, each participant was thanked for their participation, time, and candor, and I requested to schedule a date and time, for phone of the follow-up interview for clarifying responses and member checking.

Each participant received a follow-up phone interview for member checking between 3 and 14 days from the initial interview. During the member checking process, I provided participants my contact information should they choose to receive the study results or have additional questions or concerns, then participants were thanked for their participation and time in this study.

The face-to-face interview and the follow-up phone interview were both digitally audio recorded for transcription and analysis. There were no variations in the data

collection process from the prescribed protocol as outlined in the planned methodology. During the face-to-face interview, there was an 'unusual occurrence' that took place during the interview with participant three. Although the location of the interview was taking place in a private room at the college library, a stranger opened the door and interrupted the interview with a personal question. This occurrence did not seem to disrupt the flow of the interview as the participant seemed unphased by the disruption and continued speaking where he had left off prior to the disruption.

Data Analysis

Each face-to-face interview was immediately sent electronically to www.Rev.com for transcription. The transcription process was at most a 12 hour turn around to receive the written transcription to my Walden e-mail account. After receiving the transcription, I reviewed the written transcription for obvious errors and then listened to the audio recording while reviewing the written version to identify any errors. Overall, the transcription had very few errors, and were corrected as needed.

Each question on the Interview Protocol Worksheet (Appendix A) was aligned with one of the five principles of the trauma-informed care model: Safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). The participant's responses to the questions within each principle was analyzed in isolation from the other principles. After each of the five principles (categories) were reduced to labels and codes, they were then induced to categorical themes (5 principles) for that participant. Following the completion of individual categorical themes, each participant themes were then complied into the five categorical themes of the trauma-informed care model for the participants as a whole (10 participants).

Coding

Each participant was asked a series of predetermined questions rooted in the conceptual framework of trauma theory and guided by the working model of service of Trauma-Informed Care as it pertains to either the principle of safety, trustworthiness, choice, collaboration, or empowerment (Appendix A). I highlighted when I came across a quote that identified a participant's feeling or experience related to the principle. Each broad participant response within the category was then sorted into piles that had similar meaning, resulting in a code.

Safety. There were two codes that developed within the principle of safety; physical and emotional safety. The organizational setting and environment should promote the physical safety of the staff (Fallot & Harris, 2009). Participants P1, P2, P3, P6, P7, P8, and P9 reported having "no security, or training to handle volatile clients", with P9 reporting that she has to disregard her physical safety and "do things I do not want to do, even if I do not feel safe" and "if a client goes off, I have to pee my pants and run". Feeling "emotionally safe" was reported by participants P2, P7, and P10 as "more important than feeling physical safe". Feeling emotionally supported was a mixed result of feeling emotionally supported by their direct supervisor but less by administration as reported by participants P1, P3, P4, P5, P6 and P9. Participant P6 shared her "willingness to take emotional risk in offering solutions for positive organizational change, and it's just thrown out the window" by her supervisor. While participant P6 shared that he "always feels supported by his supervisor, even if nothing changes".

Feeling emotional support from administration appears less variable based on the responses from the participants. Some of the responses included participant P7's

expressed dissatisfaction of "never seeing administration in the building", or participant P3's perception that "administration is traditional, you get in trouble when you do something wrong, but there is very little support when you do something right", and participant P2's experience that "higher ups do not welcome expression of ourselves, to the point that promotion will be withheld."

Trustworthiness. Three codes developed within the principle of trustworthiness: Emotional impact, supervision, self-care. Staff development of trust for the organization occurs through task clarity, consistency, and interpersonal boundaries (Fallot & Harris, 2009). Consistent supervision provides opportunity for supervisee to seek role clarity and emotional support. Participant P6 reported that "it is difficult to trust my supervisor or the organization when they know the negative impact (trauma work) it has on me, but they do not try to change it". A similar report from participant P2 in that the "culture of caring is missing from administration" that results in a "lack of trust of the organizational process". While participant P1reported that she does "not feel understood as a whole with how involved I am", likely "because of my autonomy".

Supervision was identified by several participants P1, P2, P3, P6, P7, P8, and P10, as a minimally supportive role in feeling supported by their supervisor or agency and is "inconsistent, or non-existent" in some cases. Participant P7 reported that supervision is "inconsistent and used as a punitive tactic". While participant P9 reported that she "feels her supervision is ok, but that is only because my supervisor likes me" and that she has "watched him ignore pleading demands from a colleague".

Support from supervisors and the organization through policies that promote individual self-care strategies were generally perceived by participants as an

organizational culture of care that was inconsistent and lacking support. The "lip service" of support around self-care was reported by several participants P2, P3, P4, P5, P6, P7, P8, and P10, as being a point of "frustration". Participants P2, P7, and P10 went further to say that "self-care is an informal and self-driven, and the clients care definitely comes before my own", participant P10 added that "one of our goals as a department was how we can help take care of other departments, but we never looked inward to see how we could take care of ourselves". Participant P6 reported that "self-care is mentioned but it does not go beyond that" or, "you need to be doing that, but not going to really help you or support you". While participant P7 reported that the use of paid time off (PTO) was "used negatively against me".

Choice. From the principle of choice developed a code; input. The extent to which choice and control are experienced or perceived in the *way* staff's work goals are met influences the severity of impact from secondary trauma exposure (Fallot & Harris, 2009). The level of input each participant has at their agency varied from input in some area and no input in others. The area of input that was consistently identified by all ten participants as the most flexible was in the work schedule, "if I work here, I take time there". Participants P1, P2, P3, P4, P5, P6, P7, P8, P9, and P10 reported that the organization is "mostly interested in whether or not the job got done, not necessarily how I did it", with P5 adding that "I have 40 hours a week to make productivity, how I do it is up to me". However, other areas of potential input such as types of trainings (related to secondary trauma, work place stressors, vicarious trauma, self-care), vacation time, size of case load, or assigned tasks were less supported by supervisors and administration. Participant P2 reported feeling like he has to "scramble" to adjust when additional

demands are made of him (e.g. increased case load), or "scrounge" to find his own professional development trainings, most often at his own expense and on a day off. Participant P2 referred to the extra demands as making him feel like he is "playing catch-up" causing feelings of "resentfulness because I cannot be present with people when work is on a conveyor belt". While participant P10 reports "feeling like I am kind of swimming by myself most of the time". With participant P7 reporting that "I am losing hope in changing the traditional ideas of the organizational culture, and it is making me resentful".

Collaboration. One code was developed from the principle of collaboration; encouragement and support. Collaboration fosters a level of support and shared power between colleagues (Fallot & Harris, 2009). Multiple participants P2, P3, P6, and P7 reported that their supervisor and administration "do not support collaboration" to the extent that P2 expressed "feeling professionally vulnerable" if he provides suggestions or feedback. Participant P7 reported that she does "not feel invested because I have never seen anything carried out". While participant P6 reported that there is "no culture of change, it's a culture of resistance to change at all levels". As reported by participants P2, P3, P6, P7, P9, and P10, a result of having "no support for collaboration between staff" from the agency, the collective "team are cohesive and help each other out". Participant P7 went so far as to say, "we understand what each other are up against (referring to the organization), so we take care of each other". The chasm between staff and administration has resulted in an "us versus them" environment for this participant.

Empowerment. Three codes were developed from the principle of empowerment; feedback, training/education, and responsibility. Empowering staff is a

priority, empowerment is reflected in the development of professional skill building and is enhanced by a supportive supervisor and organization (Fallot & Harris, 2009). Receiving constructive feedback is a tool that may be used to enhance individual empowerment and was commonly reported by participants P3, P7, P8, and P10 as being "less than helpful" with participant P4 adding, it is "more retaliatory and punitive than helpful". Participant P3reported that her supervisors approach to clinical care is "so different from my own that feedback has limited value". While participants P2 and P6 indicated having "no feedback at all", with participant P3 adding, that they "just plow through it".

Ongoing training/education enhances skill building that result in being able to provide the best quality of care to the client (Fallot & Harris, 2009). Receiving training/education regarding the potential negative impact to the individual as a result of prolonged empathetic engagement, secondary trauma exposure, work place stressors, vicarious trauma, or compassion fatigue, may help mitigate the potential negative impact (Fallot & Harris, 2009). All ten participants reported that trainings/education related to trauma, secondary-trauma-exposure, vicarious trauma, self-care, and professional skill building are "self-driven and voluntary", with mandated trainings "focusing or organization structure and how to perform your job duty". Participants P2, P3, P4, P6, P7, P8, and P10, reported that "if they want to receive a specific training on self-care or trauma, they must do so on their own time and money", there is "no support form administration on "self-empowerment". Participant P2 reported that she "felt it was about the bottom line, money was the focus for administration above client outcomes or scope of practice of the therapist".

Responsibility can be shared or individual, each influence an individual's empowerment (Fallot & Harris, 2009). Responsibility with the participants appeared to be more collective than individual, with all the participants except P3 reporting "cohesiveness among colleagues and staff despite what is happening administratively". Participant P1 reported a high rate of shared responsibility because "everyone knows how it will affect others if they do not do their part". Not all of the participants shared the personal experience of cohesiveness. Participant P3 reported difficulty in sharing responsibility because he is "just plowing through things to get them done", and administration does not acknowledge the "value of the sum of all parts" over the individual.

Discrepant Cases

Two discrepant cases were noted; participants P5 and P9, however there was no significant influence on the results. The discrepant case with P5 concerned the level of strengths-based responses to the interview questions. Although P5's responses were similar in theme to many of the other participants (e.g. "I do not get as much supervision as I would like"), P5 also made statements that reflected "having it good here" and "I did not realize how good I have it". P9's discrepancy was similar in that P9 "takes personal responsibility" for "getting what I need from my supervisor" although she reported not having "as much support as I would like from my supervisor and administration". Ultimately, both P5 and P9's strengths-based positive attitude reflects vicarious resiliency/post-traumatic growth. Post traumatic growth/ vicarious resiliency, is the positive transformation of the therapists' levels of optimism, increased coping skills, new

appreciation for spiritual paths, and elevated awareness of one's own positive fortune (Besser & Zeigler-Hill, 2012; Iqbal, 2015).

Evidence of Trustworthiness

Credibility

As a prepared interviewer, I was able to elicit the depth of information required to create credibility in this research study (Rudestam & Newton, 2015). I reserved an hour at minimum to ensure I had time to probe and elicit in-depth information. As an additional tool to elicit depth of information, I sought clarity, used probes, and rephrased interview questions as the topic moved away from the interview question or the participants' response is too ambiguous. Moreover, a follow-up phone interview took place between 3-14 days following the initial interview date to verify the accuracy and/or clarify the participants' perspective on a topic (Member checking) (Rudestam & Newton, 2015).

Loh (2013) identified the member checking process as form of triangulation of the data, where the participant is able to validate accurate response, clarify vague responses, and add new information. The follow-up interview used for member checking took place over an approximately 30-minute phone interview where participants were engaged in reflecting, reacting, and expanding on their initial interview responses. Prior to the follow-up phone interview, I analyze the notes taken and the transcripts for any response that may be unclear, have multiple meanings, or have vague responses. The identified responses requiring clarification were physically noted for the second interview. In addition to seeking clarification on some questions, the participants were also asked to validate their initial responses to ensure the correct meaning was attributed to those

questions. For example, each participant was read a series of statements (themes), some paraphrased and others direct quotes, and asked if this statement represented their perspective. After participants responded and clarified their perspective they were asked if they would like to add any additional information.

Additional procedures had been intended to be used for triangulation between participant responses and policy and procedure manuals. As originally stated in the methodology of this study, there is a real possibility that formal policy and procedure manuals regarding organizational practices in promoting self-care or practices to mitigate secondary trauma exposure (e.g. supervision, varied case load, professional flexibility, etc.) may not exist. This was the case with all 10 of the research participants. Each participant reported that their organization does *not* have a formal policy regarding supervision, vicarious trauma, secondary trauma, or self-care and therefore, triangulation was not possible. Each participant reported that all self-care practices are self-driven and voluntary.

Transferability

Several strategies were used to increase the transferability of the study findings. A rich, thick description of the participants' story increases the transferability as the reader is able to extract relatable information to their own story (Rudestam & Newton, 2015). Transferability occurs "when the reader can personally relate to the study's findings and see parallels to their own experiences" (Padgett, 2017, pp. 212-213). I used as descriptive details as possible to tell the story of the participants and used the setting of the study to create an illustration for the audience that is transferable to other settings (Houghton, Casey, Shaw, & Murphy, 2013). Moreover, the rich descriptive context

description that is ecological validity, lends to the transferability of the study's findings as the reader is able to have a sense of having been there vicariously (Padgett, 2017). Additionally, I used rich and descriptive protocol questions and probes to elicit the depth and breadth of participant responses in attempt to incite a sense of vicariousness therefore, increasing transferability.

Dependability

To ensure consistency and the data being dependable, consistent procedures were utilized (Rudestam & Newton, 2015). In this narrative study, interviews and observations produce mounds of data in transcripts; searching for and correcting obvious errors occurred with each transcript, increasing the dependability of the data (Rudestam & Newton, 2015). The procedures for analyzing the data occurred in exactly the same manner and order as the previous participant. I created a transparent trail of how decisions were made during the data collection and data analysis process to create accountability for the accuracy of the data and allow for replicability (Maxwell, 2005; Padgett, 2017). Additionally, I used triangulation between multiple interviews with each participant as a way to verify the meaning of the participants' responses (Loh, 2013). Each participant participated in two interviews, the initial being 1 ½ hours and the follow-up being 30 minutes.

Conformability

A reflexive approach was used to strengthen the validity of the study. I used reflexivity to create transparency about my own 'position' in attempt to minimize bias. I attempted to be as transparent as possible so to keep from influencing the research findings and conclusions (Rudestam & Newton, 2015). A reflexive process was used

when analyzing each set of data. Each participant's data was analyzed independent of the participant before them by using a reflexive approach where I paused frequently to ask myself how my own biases were influencing how I was interpreting the data. Once I was confident that the interpretation of the data was as untainted by my biases as possible, I recorded the information as the theme of the category.

I used journaling as part of my reflexive process is to create a deeper sense of self-awareness and develop a greater understanding of what the study participants may feel, think, or how they behave, while paying attention to my own feelings when journaling on a topic (Janesick, 2011). The journal was used as part of the data set that captures an account of the problems or barriers that arose during the research process, namely the frustrations of seeking research participants.

Results

The aim of this study was to seek understanding of how rural social service agencies address vicarious trauma symptomology as perceived by trauma social workers by answering the research question: What is the perspective of trauma social workers on the response of rural social work agencies on vicarious trauma and self-care? The 10 participants of this study shared and discussed their experience and perceptions about the responsiveness of their rural organizations to vicarious trauma and self-care. The collected data produced five themes and three subthemes, which include

- impaired safety,
- general lack of trust for organizational authority (subthemes: inconsistent supervision and unsupported self-care),
- minimal input allowed,

- deflated collaboration, and
- incapacitated empowerment (subtheme: missing tools).

See Table 2 for definitions of each theme.

Table 2

Themes and Definitions

Theme (T)/Subtheme (ST)	Definition
Impaired safety (T)	The lack of promotion of physical and/or emotional safety in the work place.
General lack of trust for organizational authority (T)	A pervasive distrust of the organizational and individual intentions of supervisors and administrators.
Inconsistent supervision (ST)	The use of supervision with a supervisee that is informal, infrequent, inflexible, lacks focus or depth in discussion of self-care, ethics, or debriefing, and does not foster a professional relationship between supervisor and supervisee.
Unsupported self-care (ST)	The lack of identified support systems through policy or organizational practices that encourage or require self-care activities be participated in.
Minimal input allowed (T)	The amount of opportunity to provide input into things that individually or professionally affect the social workers (e.g. work schedules, self-care activities, types of education received, offer suggestions for agency improvement, types of clients seen, flex-time, and approached to clinical care).
Deflated collaboration (T)	The lack of sharing of power between staff and organizational management.
Incapacitated empowerment (T)	The lack of accountability or shared responsibility that fosters opportunities for individual or professionally empowerment in agency staff.

Missing tools (ST)	Identified as the lack of opportunity, lack of education/training, and lack of organizational supports that may mitigate the potential effects of secondary trauma exposure.

Theme 1: Impaired Safety

The participant responses related to personal and professional safety generally fell into one of two areas: Physical safety and emotional safety. Impaired safety is defined as the lack of promotion of physical and/or emotional safety in the work place. The participants had a general perception that their organization does not promote their physical and/or emotional safety as much as it should in the workplace. Physical safety encompasses the real or perceived safety in the immediate and surrounding physical environment of the agency including offices, lobby, parking lots, and client homes where evaluations took place; while emotional safety included the participants perception of feeling comfortable expressing themselves and their needs to their supervisors and administration.

Participants generally used terms such as “security”, “lighting”, “drills”, “policies”, “procedures”, “cameras”, and “personal judgement” when referring to their perceptions of being physically safe. The general perception by the participants is that there are some measures taken by the organization to keep them physically safe; however, there are significant areas where improvements can be made. Participant P2 expressed concern over the lack of security or proper lighting in the parking lot where he is most vulnerable. While participant P4 suggested that having security guards may not be enough because of the high turnover rates which leave the building “vulnerable at any given time”. Participant P6 and P3 added that the designated “panic buttons do not work most of the time” and if they do, “whose knows where it will send the alarm too”.

Some policy measures and personal practices of supervisors actually creates a level of risk for physical harm. Participant P3 shared this incident:

> I think we live in a dangerous area treating certain clients that could be dangerous. Receptionists don't have ... They have glass, it's not bulletproof, it's glass, and in fact, we got a mandate about three months ago, four months ago, maybe two, that they needed to leave their glass window open because they saw it as ... Administration saw it as not customer friendly, so the doors to the reception are keyed, but we do get, you know, time-to-time hostile clients, so ...We've had to ask clients to take their guns back out to the car, you know, that's happened several times while I've been there, so ...

Participant P8 shared a similar story of supervisor's behavior creating a level of risk for harm:

> A crisis worker was addressing a client who threatened her physically, and it ended up okay, someone else intervened. So, she didn't get harmed or anything, but she was discouraged to make a police report…. So, I kind of look at it as using our resources, but our director is of the mind, for a good reason, you know, we wanna reduce police contact, we don't wanna have police here if we don't absolutely have to because that's off putting to people who are vulnerable because, again, they do have their own contact. While that's I think really appropriate in some situations, I don't think you can say that is appropriate across the board. There are times when we need to involve other resources.

A common thread among several participants is that they need to take responsibility to ensure their own personal safety. Participant P10 expressed that the

organizations' security measures "do not make me feel safe, what makes me feel safe is the understanding my colleagues and I have in helping to protect each other". A similar sentiment from Participant P8 is that her colleagues and her have an "understanding" when she asks for security help. She reports that "you have to take your own security measures to protect yourself". She even goes so far as to have an "unauthorized" piece of security equipment to use in emergencies to escape a situation, even reporting that she has provided each of her colleagues with the same devise. Participant P9 shared her experience of not feeling physically safe:

> Sometimes I feel like I have to do things that I don't want to do. And I don't want to do it because I don't ... Mostly I don't feel safe. If I don't wanna do a case it's because I don't feel safe. I'm not trained to take anyone down safely in a crisis. If a person goes off, I just have to pee my pants and run.

Participants generally used terms such as "lack of support", "does not listen", "disengaged", "not invested", "minimal emotional risk", "not comfortable", "vulnerable", "worries a lot", "lack of expression", "no trust," and "unwelcoming" when referring to their perceptions of being emotionally safe. Participants generally reported feeling more emotional support from their direct supervisor than administration. Participant P3 reported having received positive affirmations from their supervisor but "would not expect any change to happen" because of the limitations imposed by administration. Participant P6 shares a similar outlook when reporting being willing to take an emotional risk by doing his "due diligence" in going to administration about "some" issues, but "would not expect anything to be done about it". Participant P7 shares her experience with feelings of being supported by supervisors and less by administration:

> I think that at the supervisory level, my direct supervisor, over the course of the last six years, for the most part I have felt supported. At the administrative level, I have not. I feel like there's been a lack of leadership and or investment in employees in their wellbeing, physical, mental, emotional, professional wellbeing. I don't think that the administration cares about people growing. I think that's important for us to all have ambitions and admirations in wanting to expand our professional abilities and those types of things. I don't think that administratively they are willing to invest in me or anybody else.

Participant P1 and P9 expressed similar experiences but differ in how they perceived those experiences. For example, participant P1 reports feeling "comfortable" verbalizing her emotional needs because she "understands" that the support she receives will be limited by the lack of knowledge or capability of her supervisor; while participant P9 verbalized taking "personal responsibility in getting my needs met" and not "just relying on the agency to meet my needs". She reported that she will "make them listen" by being "overly verbal" about her needs, she reported that it "often is a great teaching opportunity, bragging opportunity, or opportunity for a debriefing".

Theme 2: General Lack of Trust for Organizational Authority

Participants reported a pervasive distrust of the organizational and individual intentions of supervisors and administrators. Trust was expressed by participant P6 as "feeling like they have my best interest or the client's best interest in mind". The participants reported in general that they feel they are heard by their supervisor, but do not feel understood or valued personally or professionally. Participants expanded further in reporting that they feel less heard and valued as the as the chain of authority goes up

from the supervisor to administration. Participant P2 shared his perception about the chain of authority:

> I think there's a breakdown at the top and they're so mad about getting heat from up there that then it all comes down. Stuff comes down the pipe and there's nothing, no room for anything to go up the pipe. These types of things where the tail is wagging the dog, it goes on and on and on, because we're always in trouble with the funds source. I don't think it has to be like that.

Participant P3 shared a similar perception of feeling less understood as the organizational authority rises when he expressed his belief that his supervisor "understands" the impact of his secondary trauma exposure, but "I am not sure if the company understands". He expressed his point further with a metaphor to illustrate how he felt he was being treated:

> People that work in the clinics, they're the ones that keep the company alive, we're the ones that make the money for the company, if you're just looking at pure financial and ... So why not take care of ... If you have the money to say invest in a race horse or a whatever, a good truck to run, don't you take care of it or do you feed it weeds?

Participant P5 added that she feels like her supervisor has a better understanding of the impact her work has on her, however, administration comes from a differing "perspective, so they are less understanding of the emotional costs". The overall perspective of participants feeling less heard and even less understood may have emerged as a result of the two subthemes; inconsistent supervision and unsupported self-care.

Subtheme: Inconsistent supervision. Inconsistent supervision refers to the use of supervision with a supervisee that is informal, infrequent, inflexible, lacks focus or depth in discussion of self-care, ethics, or debriefing, and does not foster a professional relationship between supervisor and supervisee. On the other hand, formal supervision was expressed by participants as an expectation of the organization although there are no formal polices to promote this practice. The actuality of how and when supervision is taking place is based on an informal approach between the supervisor and supervisee. Participant P8 identified her supervision as an informal process for "checking in" that actually creates "frustration" with her because it is frequently cancelled or so informal that expectations "are not clear". Participant P10 shares a similar perspective where supervision felt more "checklist" oriented and less supportive, it "never felt touchy". Participant P7's expressed receiving "inconsistent and not constructive feedback" to the extent that she is "dismissive of any feedback she receives". She furthered this point by adding that communication from "higherups" lacks "all the information, feels insulting, punitive, and causes me fear and shame".

Although supervision is more of an informal, inconsistent, self-driven process, as identified by participants P1, P2, P5, and P9, all four reported they utilize other means of support in lieu of formal supervision. Participant P1indicated her direct supervisor is "more of a task manager", so "I use the interdisciplinary team meetings as my opportunity for more formal supervision and sharing". Participant P2 is receiving independent formal supervision from a Licensed Clinical Social Worker (LCSW) to meet licensure requirements. Reporting that "my supervisor does not show any positivity or appreciation for good things that happen, so I use my weekly supervision for my LCSW

as my supervision". Participant 5 and 9 reported utilizing colleagues as an informal supervisory process of support. Participant 9 reported that her and the other clinicians utilize one hour per week to provide "support and supervision" to each other "instead of waiting for a monthly formal meeting with our supervisor". Participant P5 was the only participant to report receiving regularly scheduled formal monthly supervision. Participant P5 also indicated that the formal supervision is "only about 20 minutes long" and that she "takes advantage of daily informal supervision as I need it".

Subtheme: Unsupported self-care. Unsupported self-care is defined by the lack of identified support systems through policy or organizational practices that encourage or require self-care activities be participated in. The extent to which self-care is support varies from participant to participant. Each of the 10 participants reported that no formal policy exists for the promotion of self-care, and participation in self-care is a self-driven and informal process. Each of the participant's organizations varied in how they are perceived in being responsive to the effects of secondary trauma exposure on the participants. The most consistent response from participants is that self-care is often discussed with supervisors. However, the discussion does not appear to be followed through with action. Participant P8 referred to it as "lip service with less actual support", where participant P6 expressed verbal frustration with "the agency tells you to engage in self-care but does not support the process or provide the tools". Participant P3 stated that there is a "huge disconnect" from administration and that self-care if "minimally encouraged with no tools provided". Participant P3 provided an example of how his agency has an Employee Assistance Program (EAP) for psychological and emotional wellness, yet it is "not promoted". Participant P4 and P7 also expressed "frustration"

about EAP opportunities "not being widely known". To participants P2 and P7, available self-care tools are "counted against you". For example, P2 expressed:

> The use of Paid Time Off (PTO) for a vacation meant that you would have twice the amount of work to complete in the following 40-hour work week when you returned from vacation. If the work was not completed the return week of vacation, I would not make my productivity for that week, which could impact my pay or I would receive a nasty e-mail.

Participant P7 shared her perception that agency practices around the use of PTO is "counter to supporting wellness or self-care", to the extent that she "would go to work sick to preserve her vacation time" to be used for actual vacation. Participant 10's perspective about self-care is that "the clients care definitely came before self-care". To drive this point further, participant P10 shared an experience that "sent the wrong message about self-care";

> Within our department, we have set goals. So, one of our goals was how we can help take care of other departments. But we never looked inward to see how we could take care of ourselves, that was never brought up.

Although Participant P1, P5, and P9 shared similar organizational experiences with self-care being self-driven and voluntary, they also did not express that they received any more than the other seven participants in terms of "tools" however; how their perceived self-care opportunities differed from the other seven participants. Participant P1 excitedly shared that she has access to a wellness program that provides "discounts on gym memberships, and discounted health care coverage". Participant P9 shared that her agency is "great about self-care even though there is no formal process, I

just have to ask". She even expressed that "an indicator that the agency cares is by the unquestioned sick leave they give you", however she did note that "you have to take the responsibility to be clear about your needs if you want your needs met". Participant P5 shared a similar sentiment that "if she asks", her agency "will provide all the self-care tools she needs or wants".

Theme 3: Minimal Input Allowed

Minimal input allowed is defined as the amount of opportunity made available to provide input into things that individually or professionally affect the social workers (e.g. work schedules, self-care activities, types of education received, offer suggestions for agency improvement, types of clients seen, flex-time, and approached to clinical care). The participants feel like they have minimal input into creating positive change. Generally, participants expressed having "some" input and choice into things that directly affect them, but no input into things that might actually create change. The most flexibility and ability for input was found to be in "how" the participants completed their jobs. All participants with the exception of P8 reported having complete autonomy in the types of interventions they chose to provide to their clients. Aside from how they provide clinical care, each participant reported having little choice or input into other components of their job, work schedule, training offered, policy and procedure, vacation time, PTO, work hours, continuing education, or self-care activities.

Participant P6 stated that organizational polices are prescribed by administration with "very little room for feedback". Having little choice or room for feedback was identified by participant P7 as causing her to feel "devalued and untrustworthy" by administration, resulting in an "us versus them" feel that "minimizes the cohesive unit

and team work environment". Participant P3 feels like he is "losing hope" at changing the "traditional ideas" of administration. He goes on to express "frustration" at the lack of a "culture of caring" by administration. Participant P6 shared a similar experience expressing that administration has a "suck-it-up" attitude towards "piling up" work tasks and client caseloads, so you "do not see yourself as having the ability to say you need help or time-off". Participant P2's perception of his ability to have choice and input is stated as such:

> I am feeling frustrated by the current process of care for myself and my clients. We cannot seem to keep enough good staff, so I am constantly having new clients added to my case load that keeps me scrambling to find time. I cannot be present for my clients if I am constantly playing catch-up. I am feeling frustrated.

Theme 4: Deflated Collaboration

Collaboration can be defined as the perceived or real sharing of power between staff and organizational management. Deflated collaboration refers to the lack of sharing of power between staff and organizational management. Having power means that individuals at all layers in the organizational hierarchy have input in the decision making or planning process. During the relinquishment of power by management, management will take on a more guiding, supportive and encouraging role to the staff. One opportunity for administration to support staff is through the encouragement of staff to provide suggestions and feedback for organizational improvement. It is not enough to encourage suggestions for improvement, it is necessary that organizational improvements are made based on appropriate suggestions. The shared experience of participants P1, P2, P4, P6, P7, P8, and P10 is that suggestions and feedback are taken by administration but

ultimately, no changes come from the provided information. Participant P4 reported that administration encourages feedback in "some areas but will tell you what to do in others". Where participant P2 expressed a different experience of "feeling pretty vulnerable" with administration because they "focus on petty issues", "lack professional vision", and "they are complimentary and then will cut you with the same breath".

Participant P7 discussed not feeling "validated" when sharing her opinion to the extent that she does not feel "invested" in the organization because of the "lack of positive change". She furthered her point by saying that there are "a lot of meetings but you don't have a lot of outcomes". Participant P10 shares a similar experience:

> I feel heard, but it does not change anything. I am "dissuaded" from making suggestions for organizational change because my supervisor response is always, "nope, we are not going to do any of these". I get the distinct impression that the organization does not want to change.

The slow process of change was also identified by participant P1 as a source of discouragement for providing feedback or suggestions. Participant P1 cited the "large size of the organization" as the reason for bringing about "little change" whereas, participant P6 identified the "culture of resistance to change" as his source of frustration. Regardless of the identified sources of frustration, it is evident by the participant responses that the decision-making and planning process is lacking collaboration and shared responsibility of agency staff.

Theme 5: Incapacitated Empowerment

Individual and professional accountability along with shared responsibility provide opportunities for empowering agency staff. Incapacitated empowerment can be

described as the lack of accountability or shared responsibility that fosters opportunities for individual or professionally empowerment in agency staff. Participants expressed mixed perceptions about accountability and shared responsibility with participant P3 identifying a lack of acknowledgment from administration in the value of the "sum of all parts". Participants P2 reported he receives "little or no feedback" with no accountability, while P1, P6, P7, P8, P9, and P10 reported receiving minimal feedback from administration but the members of the care team hold each other accountable. Participant 1 elaborated on her experience of accountability between colleagues;

> Typically, we all share responsibility, and if somebody doesn't do their part, then it obviously affects our patients, and then the person who ... the next person down the line ... there's not much of that, that goes on. Like, pretty much everybody knows ... it's a well-oiled machine, that team. It really is.

Being held accountable for organizational and client outcomes requires that proper tools be available to help staff be/feel empowered. Two tools from the trauma-informed care model were identified to promote employee empowerment: Training/education, and feedback. All three of these tools were identified by participants as either missing altogether or lacking in some way.

Subtheme: Missing tools. Missing tools is identified as the lack of opportunity, lack of education/training, and lack of organizational supports that may mitigate the potential effects of secondary-trauma-exposure. Educational opportunities allow therapists the opportunity to develop competencies and confidence to better support their trauma clients and promote protective measures against the potential development of vicarious trauma (Fallot & Harris, 2009). It was noted by all ten participants that

education around organizational purposes, such as safety, policy and procedures, patient privacy, dress code, and code of conduct are mandatory on a yearly basis. However, education to address work place stressors, secondary trauma exposure, vicarious trauma, or work place challenges was identified by all ten participants to be on a voluntary basis and self-driven. Participant P2 shared his perspective:

> The agency supports their own financial bottom line above client and therapist outcomes. There is no training or education provided regarding work place stressors. All of the training I have received I had to find on my own and pay for myself. We don't even get a debriefing following an intense secondary trauma exposure, but we do get a training on hygiene and how to wash our hands.

Participant P10 shared her experience with getting the training she wanted:

> So, I went to a three day like trauma certification training on my own dime. Like, I took three days off work and went to that. And that, that helped significantly. So, I worked a 40-hour work week, spent three days on your own time, and then went back and did another 40-hour work week. I had no choice if I wanted the training.

Receiving constructive feedback is the second tool to be used to promote staff empowerment through skill building. Generally, participants either reported minimal feedback or none at all. Participant P10 received "very little feedback" from her supervisor and indicated it was "rarely helpful"; while participant P3 identified the feedback he received as "not useful because of the differences in the clinical approaches between myself and my supervisor". Participant P6's experiences differed from the other participant because feedback was not provided on an individual basis, it was provided to

the “group as a whole”. The experiences of group feedback were not identified as a positive or negative experience, “just different”. Two participants P2 and P4 shared an entirely different perspective and experience regarding supervisor and administrative feedback. Participant P2 said:

> I guess because I do a good job I hardly ever get any feedback but the way the software program is designed, it feels like it is designed to document your shortcomings. There is not one nice word that comes out of their feedback program.

Participant P4 added:

> I find her feedback really constructive. She is really good at finding little things that I miss, so I don't really take her feedback as critical, I just take it as an opportunity to learn. That's when it's coming from her. When it's coming from other people that are higher up, I can take it pretty hardly, it feels more retaliatory and punitive than constructive.

Summary

This research study aimed to seek understanding of how rural social service agencies address vicarious trauma symptomology as perceived by trauma social workers. To address this research study’s aim, I collected data from 10 social workers who are empathetically engaged with trauma clients. I interviewed participants face-to-face with a follow-up phone interview, both digitally audio recorded for professional transcription and analysis.

During the data analysis process, each of the five principles (categories) were reduced to labels and codes, they were then induced to categorical themes (5 principles)

for that participant. Following the completion of individual categorical themes, each participant themes were then complied into the five categorical themes of the trauma-informed care model for the participants as a whole (10 participants). The data produced five themes and three subthemes, which include: Impaired safety, general lack of trust for organizational authority (Subtheme: Inconsistent supervision, unsupported self-care), minimal input allowed, deflated collaboration, and incapacitated empowerment (subtheme: Missing tools). In the next chapter there will be a discussion of the interpretation of the findings, an examination of the study's limitations, recommendations for further research, and an exploration of the study's implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, I explored the perceptions of social workers from rural social service agencies on the responsiveness of their agency to vicarious trauma through the lens of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). Considering the risk factors and negative influences of vicarious trauma on social workers and the agencies (see Adam & Riggs, 2008; Bride, 2007; Iqbal, 2015; Morrissette, 2004; Ting et al., 2005), an increased understanding of the perspectives of trauma social workers on how rural social work agencies are responding to vicarious trauma care was needed. The purpose of this qualitative narrative study was to develop a better understanding of the perceptions of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma.

The results revealed that rural social workers continue to receive a significant amount of secondary trauma exposure through unchanging organizational cultures. The five themes that emerged from this study provide organizational context to the current functioning of rural social service agencies related to the trauma service system and are consistent with the principles from the Fallot and Harris (2009) trauma-informed care model. A trauma-informed service system uses five principles to establish a trauma sensitive organizational culture: safety, trustworthiness, choice, collaboration, and empowerment (Fallot & Harris, 2009). Each of the following five themes and subthemes emerged from one of the five trauma-informed care principles and include impaired safety, general lack of trust for organizational authority with subthemes of inconsistent

supervision and unsupported self-care, minimal input allowed, deflated collaboration, and incapacitated empowerment with a subtheme of missing tools. The results from this research extended the existing literature on rural trauma social work and organizational response to mitigating secondary trauma exposure to therapists not previously mentioned in the literature. In the following section, I will discuss the findings as they relate to the previous literature on this topic presented in Chapter 2.

Interpretation of the Findings

The data presented in Chapter 4 reflected the perspectives of participants as trauma social workers practicing in rural social service agencies and addressed the research question I sought to answer. The research question that I used to guide the study was, what are the perspectives of trauma social workers on the response of rural social work agencies on vicarious trauma and self-care? There has been a significant amount of research on the potential negative outcomes associated with being an empathetically engaged therapist to traumatized clients, as well as the individual and organizational factors that influence those outcomes (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan et al., 2015; Diaconescu, 2015; Dombo & Blome, 2016; Dombo & Gray, 2013; Gil & Weinberg, 2015; Knight, 2013). Moreover, the practice of rural social work differs from urban social work. Participants in this study validated the differences between rural and urban social work (e.g., the lack of available resources, funding, formal and informal support systems, and differing value systems as reported in previous studies [Ginsburg, 2014; Sethi, 2015; Waltman, 1986]). Furthermore, participants' responses of depleted resources, minimal access to supervision, fewer opportunities for professional development, and professional isolation as realities of rural social work practice are

consistent with other researchers' findings (Blue et al., 2014). Overall, the pressures of having minimal resources while feeling like the needs of their clients were increasing further added stress and had a negatively impact on the social worker participants in this study.

Five themes and three subthemes emerged in this study that provide organizational context to the current functioning of rural social service agencies related to the delivery of trauma-informed services to social workers. The first theme to emerge was an *impaired sense of safety*. According to participants, there is a negative result in therapists' trust in the agency due to the perception that organizations do not promote therapists' physical and/or emotional safety as much as they should in the workplace. Furthermore, participants reported that trust in the agency is affected by policy measures and personal practices of supervisors, which creates a level of risk for physical harm to the therapist. These practices have influenced the participants sense of personal and emotional protection from the agency and decreased the level of comfort in expressing needs to their supervisor or administration.

The promotion of a therapist's physical and emotional safety in the workplace as a factor in a therapist's personal or professional wellbeing has not been explored in previous research outside of the trauma-informed service delivery models, based on my review of the literature. Within trauma-informed empirical studies, Veach and Shilling (2018) reported the organizational promotion of therapists' safety; however, this inclusion was only encouraged in relation to the development of the supervisor-supervisee relationship during supervision. Finding from this study indicate that rural social workers have a sense of impaired physical and emotional safety negatively

influencing their overall wellbeing and trust in the organization, which has not been previously mentioned in empirical studies, according to my literature review.

The second theme to emerge from this study resulted from a further examination of trust in organizational authority. The second theme that emerged was a *pervasive distrust* of the organizational and individual intentions of supervisors and administrators. Similar to the findings of Pearlman (1996), therapists reported a decreased sense of trust in supervisors and administration. Unlike Pearlman's study, the participants identified distrust as a direct result of feelings that resulted from not being heard and feelings of being less heard and valued as the as the chain of authority goes up. The overall perspective of participants feeling less heard and even less understood may have emerged as a result of the reported inconsistencies in supervision and lack of organizational support for self-care.

Two subthemes emerged from Theme 2: *inconsistent supervision* and *unsupported self-care*. In previous research, organizational supports to therapists was identified as a mechanism to lessen the potential negative impact of secondary trauma exposure on therapists (e.g., Bride, Jones, & MacMaster, 2007; Kanno & Giddings, 2017; Neswald-Potter & Simmons, 2016). Although previous researchers identified organizational support as a factor in mitigating the development of vicarious trauma, they did not directly examine the relationship between the supervisor and supervisee or administration and supervisee; furthermore, they only examined the supervisor/supervisee relationship through the process of formal supervision (Bride et al., 2007; Kanno & Giddings, 2017; Neswald-Potter & Simmons, 2016). The lack of or inconsistent supervision may be important in understanding the pervasive distrust that the

therapists in this study have for administration and supervisors. Furthermore, the therapist participants reported being distrustful of the intentions of supervisors when the little supervision they do receive is not helpful or supportive to their personal or professional growth. These inconsistencies in supervision do not allow for the opportunity to develop the supervisee/supervisor relationship identified by empirical studies (Berger et al., 2018; Berger & Quinos, 2014, 2016; Bledsoe, 2012; Blue et al., 2014; Dombo &Blome, 2016; Finklestein et al., 2015; Gil & Weinberg, 2015; Joubert et al., 2013; Kanno & Giddings, 2017; Knight, 2013; Mackie, 2012; Middleton & Potter, 2015; Newell et al., 2016; SAMHSA, 2004; Toner, 2015; Veach & Shilling, 2018; Whitfield & Kanter, 2014) as a necessary tool to buffer against the negative effects of secondary trauma exposure.

The subtheme of *unsupported self-care* is not a new concept in empirical studies. Multiple researchers (Berger & Quiros, 2016; Butler et al., 2017; Foreman, 2018; Kanno & Giddings, 2017; Pearlman & Saakvitne, 1995; Whitfield & Kanter, 2014; Veach & Shilling, 2018) have identified self-care as a necessary tool to mitigate the effects of secondary trauma exposure to empathetically engaged social workers. Unlike these studies, the focus of this study was on the extent to which the agency was involved in the promotion of self-care for social workers who are secondarily exposed to trauma through empathetic engagement. Promotion of self-care was identified in participant responses as an organizational weakness, and in some cases, feelings of being punished for trying to promote their own self-care (e.g. personal time off, breaks throughout the day, adjustment to work schedule) were reported. Moreover, reflected in participant responses organizational practices do not promote or support the individual self-care strategies

needed to mitigate the potential negative effects of secondary trauma exposure and formal polices do not exist. Although recent studies (Dombo & Gray, 2013; Fallot & Harris, 2009; Keesler, 2014; Wang, Strosky, & Fletes, 2014) promote implementing policies and practice standards that promote becoming a trauma-informed organization, these studies do not specifically address the implementation of policies around the promotion of self-care.

Somewhat unexpectedly, one of the findings indicated that self-care may be voluntary and self-driven, but the social worker is ultimately responsible for self-care. Berger and Quiros (2016) and Kanno and Giddings (2017) support the responsibility of self-care as being therapist driven, where the therapist is responsible to monitor their own needs and seek out self-care opportunities as needed. Where the finding differed in this study from previous studies is in the exploration of perceived experiences with opportunities for self-care. The difference was noted in the lack of organizational opportunities for self-care and needing to take personal responsibility to ask for the help or the opportunity to participate in a program (e.g. wellness program).

A possible explanation for the differences is perceived opportunities for self-care may be the result of vicarious resiliency or post-traumatic growth. Consistent with Morse et al.'s. (2012) study, 30% of therapists reported having a positive overall outlook about their professional experience even though their professional experiences do not differ from the other therapists (e.g. each therapist reported that self-care is voluntary and self-driven yet 30% report positive experiences about self-care while 70% report less favorable experiences). The discovery of therapists' vicarious resiliency and post-trauma growth in this current study was unexpected however, is prevalent enough in this study

and previous research (Besser & Zeigler-Hill, 2012; Cohen & Collens, 2012; Cox & Steiner, 2013; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Iqbal, 2015; Manning-Jones et al., 2016; Neswald-Potter & Simmons, 2016; Tassie, 2015) to warrant a brief discussion of the concept and its relevance to secondary trauma-exposed therapists following this section. Post traumatic growth, or more recently called vicarious resiliency, is the positive transformation of the therapists' levels of optimism, increased coping skills, new appreciation for spiritual paths, and elevated awareness of one's own positive fortune (Besser & Zeigler-Hill, 2012; Iqbal, 2015).

The role of organizational culture was identified as a contributing factor in the remaining 3 themes. The third theme to emerge stems from therapists being allowed *minimal input* into agency practices and tasks that directly impact the them. Multiple studies (Berger & Quiros, 2016; James & Sells, 1981; Knight, 2013; Pack, 2013) support the protection of therapists through organizations providing a mechanism of buffering against secondary trauma exposure through choice, role clarity, cooperation, flexibility, manageable workloads, and opportunities for professional advancement. The findings in this study did not reflect supervisors supportive role and encouragement through choice and flexibility as found in Berger & Quiros (2016), James and Sells (1981), Knight (2013), and Pack (2013). The findings from this study indicates therapists do not have input into organizational practices affecting them individually or professionally, so much so, that they do not contribute to creating "positive change". Although therapists do not feel as if they have input into many of the organizational practices that impact them, professional autonomy was identified as a positive factor in the flexibility in 'how' they practice. This outcome is not surprising given the implications of rural culture from the

seminal research of Waltman (1986) and recent study by Blue et al. (2014) where autonomy of therapists is organizationally supported. Consequently, having autonomy also created a sense of professional isolation, which was also not surprising in light of previous research (Mackie, 2012; Pugh, 2003).

Although therapists valued the flexibility and autonomy in their work, the sense of professional isolation may be influential in whether therapists seek out collaboration when it may be beneficial. Collaboration occurs at all levels of the organization through a sharing of real or perceived power. One opportunity for administration to support staff is through the encouragement of staff to provide suggestions and feedback for organizational improvement e.g. onsite security for increased personal safety of clients and staff, or a flexible work schedule to allow for therapists' self-care. It is not enough to encourage suggestions for improvement; it is necessary that organizational improvements are made based on appropriate suggestions. Although collaboration is not specifically identified beyond definition in previous studies outside of trauma-informed practices models (Fallot & Harris, 2009), collaboration can be tied back to the influence of organizational culture.

The fourth emerging theme from this study is a sense of *deflated collaboration*. Therapists' sense of collaboration has the propensity to be deflated when suggestions and/or feedback are taken by administration but ultimately, no changes come from the provided information. The personal and professional effects of deflated collaboration on a therapist have not been studied empirically (Blue et al., 2014; Courtois, 2018; Keesler, 2014; Riebschleger et al., 2015). However, similar concepts that influence the collaborative process have been studied empirically. Beecher et al. (2016), Brownlee et

al. (2009), Hastings and Cohn (2013), Mackie (2012), and Riebschleger (2007) identified practice implications for the slow implementation of organizational change that occurs in rural practice, but no examination was done to how this may impact the therapists' emotional or professional satisfaction. The slow process of change, which often occurs in rural setting was a commonly identified as a source of discouragement for therapists to provide feedback or suggestions. Moreover, this type of organizational culture in the rural setting was identified in this study as a factor in reducing the personal and professional satisfaction of therapists.

The final theme is closely tied to collaboration through practices in the organizational culture. *Incapacitated empowerment* is the fifth theme; it is described as the lack of accountability or shared responsibility that fosters opportunities for individual or professionally empowerment in agency staff. Empowerment is not an all or nothing concept; there is a mixed perception about accountability and shared responsibility among therapists with the notion that some staff are held accountable as a collective group (e.g. outcomes as an agency), while others are held to little or no individual accountability or shared responsibility (e.g. outcomes as an individual therapist or as an agency). This finding has not been mentioned in previous studies (Cohen & Collens, 2012; Cox & Steiner, 2013; Dagan et al., 2015; Diaconescu, 2015; Dombo & Gray, 2013; Dombo & Blome, 2016; Gil & Weinberg, 2015; James & Sells, 1981; Knight, 2013; Pack, 2013; Veach & Shilling, 2018); however, Berger and Quiros (2016) in their qualitative study examined the use of supervision as a tool to empower relationships between supervisor and supervisee. The main principle of the study is that the supervisee will feel empowered by the safe emotional and physical environment created in

supervision to advocate for self-care strategies. Although the finding in this study differs in the outcome of empowerment through supervision, it may also explain why therapists feel less empowered. As previously mentioned in the first subtheme, inconsistent supervision or lack of supervision was pervasive in the findings. With the lack of formal supervision having been identified in this study, it was not identified as a positive tool that influenced empowerment of therapists as it was is Berger and Quiros' (2016) study.

The subtheme of *missing tools* emerged from the notion that empowerment is supported through the use of identified strategies of supervision, training/education, and feedback. Being held accountable for organizational and client outcomes requires that proper tools be available to help staff be/feel empowered. Along with supervision, two other tools from the trauma-informed care model were identified to promote employee empowerment: Training/education and feedback. All three of these tools were identified by participants as either missing altogether or lacking in some way in their agency. Although supervision and feedback have already been discussed, it is vital to consider these tools in relation to a tool kit where multiple tools are available for mitigating the effects of secondary trauma exposure. The importance of the third tool, *training/education*, has been explored in previous studies (Berger & Quiros, 2016; Veach & Shilling, 2018) and validates the significant need for ongoing training/education for agencies that provide trauma services through therapists. Furthermore, findings from this study also validated the need for formal training/education related to secondary trauma exposure as it was found that training/education was mandatory around organizational policies, but training/education around vicarious trauma or work place stressors were voluntary and self-driven. Additionally, findings from Dombo and Blome (2016)

validated the need for formal training/education as found that a significant short coming exists in competency and specialized training to prepare social workers to work with their clients' traumatic experiences or their own indirect trauma response.

Participants in this study shared and discussed their experience and perceptions about the responsiveness of their rural organizations to vicarious trauma and self-care using the tenet of each of the five trauma-informed care model principles. Based on the findings, the overarching theme is that organizations have not acted to become trauma informed. Even more significant, participants perspective is that their organizations have not taken the smallest of steps to promote or support their overall well-being.

Contrary to the potential negative effects of secondary trauma exposure, there are several studies that reported positive effects on therapists after exposure to a client's traumatic story and the therapist's contribution to the client's recovery (Cohen & Collens, 2012; Cox & Steiner, 2013; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Neswald-Potter & Simmons, 2016; Tassie, 2015). In Hyatt-Burkhart, Cohen, and Collens' (2013) all the participants reported post-traumatic growth on some level, but only mentioned the growth when directly asked about its benefit. Is it possible that more therapists would have post-traumatic growth and that positive growth may be a protective factor that could be drawn from in areas of higher risk for vicarious trauma? In a recent quantitative study with 365 participants, Manning-Jones et al. (2016) investigated the relationship between the coping strategies of health professionals in relation to post-traumatic growth. They found that social workers over doctors, nurses, psychologist, and counsellors as being the most likely to actually benefit from secondary trauma exposure as long as they engage in a moderate amount of self-care strategies (Manning-Jones et al.,

2016). Their finding further drives the point that post-traumatic growth is possible and should be promoted using self-care individual and organizational supports.

Additionally, a quantitative study with 217 participants by Besser and Zeigler-Hill (2012), organizational support, empathy, and social support were identified as predictive measures for vicarious resiliency. Supervision can be an organizational tool used to harness the protective strength of any level of positive growth, with collaboration between the supervisor and supervisee on how to best use the strength to minimize potential negative effects (Courtois, 2018). A logical progression from the use of supervision as a tool for assuaging secondary trauma is to use a model of care to promote mitigation *and* vicarious resiliency. Neswald-Potter and Simmons (2016) explored how the Regenerative Model may be used as a tool to mitigate the effects of secondary trauma and increasing the potential for post-traumatic growth. The Regenerative Model uses of an authentic relationship between supervisor and supervisee to regenerate expressive development of a working alliance through an "intentional and reflective process that is beneficial to the professional, the profession, and those who seek professional counseling" (Neswald-Potter & Simmons, 2016, p. 88).

Limitations of the Study

Participation in this study was limited to social workers employed in an agency that provides trauma interventions to clients in the Northern Arizona region, and hold a minimum degree of Master of Social Work. Generalizability to a larger population is not possible with the small sample size of this qualitative approach (Rudestam & Newton, 2015). The smaller sample size and the use of face-to-face interviews for data collection limited the geographical location from which potential participants reside/work.

Geographical limitations may hinder transferability of findings to agency/organizations that are located beyond the geography of the study's participants due to rural culture. Rural culture is a term used to encompass all the characteristics that describe the make-up of all things rural i.e. attitudes, lifestyles (National Association of Social Work (NASW), 2003) and thus, may be viewed as a distinct cultural group or minority (Daley, 2015). The values and perceptions of the distinct participant group may not be transferable to groups beyond that of the participants in the rural Northern Arizona region.

Attempts at triangulating data were limited; the inability for the triangulation of data between participant responses to agency practices and actual policies from the policy and procedure manual was not possible. Each of the 10 participants reported that their organization does *not* have a formal policy regarding supervision, vicarious trauma, secondary trauma, or self-care and therefore, triangulation using this method was not possible. Methods of triangulation were reduced to member-checking procedures only.

According to Padgett (2017), transferability occurs "when the reader can personally relate to the study's findings and see parallels to their own experiences" (pp. 212-213). Given the limitations identified, I attempted to increase the transferability by providing a rich, thick description of the data as provided by the participants (Rudestam & Newton, 2015). Furthermore, I used rich and descriptive protocol questions and probes to elicit the depth and breadth of participant responses in attempt to incite a sense of vicariousness. Additionally, I attempted to establish reader relatability through the use of storytelling to describe the experiences of the participants and used descriptive details as much as possible to create an illustration for the audience that is transferable to other settings (Houghton, Casey, Shaw, & Murphy, 2013).

Recommendations

The current state of knowledge of vicarious trauma from an organizational and individual level indicates that participation in remediating factors is at best voluntary. A study by Dombo and Blome (2016) identified concerns by social service organizational leaders for providing the supportive interventions that the social workers need to perform their demanding jobs, while the weight of decreased budgets, constant change, and oversight created challenges in providing those supports. Most, if not all the recommendations for moving organizationally toward being a trauma-informed service provider are based on decades of research on predicting, preventing, removing barriers, and improving outcomes for the entire trauma service system (Brown & Quick, 2013; Cox & Steiner, 2013; Dombo & Blome, 2016; Middleton & Potter, 2015; Pack, 2013).

Although recommendations for ameliorating the effects of vicarious trauma are based on individual and organizational levels, both levels must work in conjunction to be effective (Pack, 2012; Rapp & Anyikwa, 2016). Individuals advocating for themselves and engaging in self-care only provides a fraction of what has been identified in research studies as needed to mitigate the potential harm of indirect trauma (Brown & Quick, 2013; Cox & Steiner, 2013; Dombo & Blome, 2016; Middleton & Potter, 2015; Pack, 2013). This also holds for organizational supports: An organization cannot expect to mitigate all the effects of indirect trauma if the individual therapist does not engage in the individualized supports that minimize their risk of developing symptomology. For example, if a therapist is not willing to make themselves available for individual or group counseling, engage in spiritual needs, or encourages a high caseload of traumatized clients, the therapist may have a higher level of risk for vicarious trauma. Further to the

point, in a study examining the individual and organizational factors and their importance, it was determined that commitment of 'time' to address stress management was the coping strategy with the most potential as a protective factor, driving the point for the need for a supportive organizational culture (Kulkarni, Bell, Hartman, & Herman-Smith, 2013). The findings of this study support the need for an exploratory evaluation of what will be needed/required for rural social service agencies to transition to a trauma-informed organization; possibly funding or mandates?

Implications for Positive Social Change

The culture of rural social work often creates challenges for the implementation of trauma-informed care. This study provoked conscious awareness among participants of the need for organizational action and change in agency practice to support trauma-exposed social workers. This study also created an awareness of the potential negative effects to clients and social workers that call for action in mandating organization practices through a professional code, or federal and state mandates. At minimum, this study educated helping professionals about the potential negative physical, psychological, and professional effects of being exposed to clients' traumatic histories, which may help normalize their reactions and lead them to increase their self-care techniques.

This study has implications for positive social change. In the current state of organizational practices, organizations participation in therapists' support such as supervision, individual therapy, promotion of self-care, variation in trauma caseload, peer support groups, variation in work duties, training, excessive work commitments, and debriefing, is voluntary. This study provided understanding, awareness, or clarity of potential negative effects to clients, agencies, and therapists if measures are not taken to

minimize or mitigate potential negative effects. The awareness and understanding this study provided to individuals, organizational leaders, and policy makers, has the potential to be the catalyst for positive practice and policy change.

Conceptual Framework

A theoretical shift has occurred in trauma theory research. There has been a change from avoiding the individual nature of victimization and instead focusing on the commonalities between victims. The stance is to now embrace the differences in individual traumatic experience and to understand how traumatic events are experienced and interpreted because of the potential long-term effects (Van der Kolk, 2005). In response to the recognition of the pervasiveness of trauma, organizations are moving towards becoming a trauma-informed service system (Fallot & Harris, 2009). The Trauma-Informed Care model of service delivery model grounded in the tenets of trauma theory with a focus on healing and prevention for all those in the trauma service system (Fallot & Harris, 2009).

Supervision was identified as a significant factor in minimizing the effects of secondary trauma exposure on empathetically engaged therapist. Furthermore, it should be used to increase therapist resiliency by decreasing the disturbances in self-efficacy which results in an improvement in the psychological state of the therapist and makes them more present for their clients (Finklestein et al., 2015). In 2018, a study by Veach and Shilling implemented what is known from previous studies about the positive effects of supervision on trauma-exposed therapists. Their study examined the use of trauma-informed supervision as a tool to mitigate the effects of secondary trauma exposure in a hospital setting; with a key focus being on developing trauma-informed practices with

therapists. It was inferred from the findings that trauma-informed supervision may not look the same in every setting but has significant positive potential and should be integrated into all care settings. Given the general suggestions for application in multiple settings, there is potential to be applied to other care settings or helping professions where prolonged engagement with traumatized clients occurs.

Practice Recommendations

Moving forward organizationally. Creating an organizational culture that appropriately responds to manifestations of indirect trauma in a normalizing and supportive manner is necessary for the well-being of the trauma-exposed therapist and the clients they serve (Wilson, 2016; Furlonger & Taylor, 2013). A proactive approach has been identified as an effective way to manage stress in the organizational setting (Quick, Wright, Adkins, Nelson, & Quick, 2013). Gil and Weinberg (2015) recommend that organizations provide education and training as a proactive approach to enhance awareness of maladaptive coping strategies and encourage the development of individualized coping strategies. Policies and practices should reflect a supportive and proactive approach with changes in environmental factors such as mandatory breaks and creating sacred spaces for therapists to meditate, pray, relax, and self-reflect (Dombo & Gray, 2013).

Implications from Green, Albanese, Shapiro, and Aarons' (2014) study examining the influences of the organizational climate, identified having a leader who provides individual attention through supervision could relate to greater perceived administration cooperation, self-efficacy, provided opportunity for role clarity, while leading to greater levels of competence in their work. Salston and Figley (2013) add that therapists should

have available opportunity to seek formal counseling for their mental health and well-being. While Dagan et al. (2015) recommended supervisors consider a balance of trauma clients on the therapists' caseload as a means of finding an appropriate balance. A focus on the organizational practices including supervision, education, culture of support, and encouraging individual self-care strategies are essential components to workforce morale, retention, and wellbeing (Pack, 2012).

Moving forward individually. All helping professionals need to be strong self-advocates. Self-care behaviors that include physical and psychological strategies such as exercise, balanced nutrition, taking lunch breaks, spirituality, developing coping skills, being open to counseling, professional networking for supports, or any other personalized strategy for stress reduction is recommended for maintaining overall well-being (Bercier & Maynard, 2015). Although initiation from the supervisor is recommended for formal supervision, therapists must be willing to actively seek out supervision without waiting for the supervisor to initiate the discussion (Berger & Quiros, 2016).

Having a strong sense of self-advocacy is an obligation a social worker has to the profession of social work. Social workers make up the largest individual group of mental health providers and comprise at least 40% of the volunteer base trained by the American Red Cross for disaster mental health (Bercier & Maynard, 2015). Although the National Association of Social Workers (2008) does not directly address therapists' responsibilities of self-care, the social work Code of Ethics mandates:

> (a) Social workers should not allow their own personal problems, psychological distress, legal problems, substance abuse, or mental health difficulties to interfere

> with their professional judgment and performance or to jeopardize the best interest of people for whom they have a professional responsibility.
>
> (b) Social workers whose personal problems, psychological address, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect client and others. (section 4.05)

Moving forward on a macro level. The ethical responsibility to address and apply protective factors that mitigate vicarious trauma is a shared responsibility between the individual clinician, educators, employers and the professional body (Middleton & Potter, 2015). Professional bodies such as, the National Association of Social Workers, may provide support through education and training opportunities, demands for organizational policies that promote balance between personal and professional roles (e.g. challenge the managed care model), and require organizational practices that promote healing (e.g. supervision and case load diversity) (Wang, Strosky, & Fletes, 2014). Because of the potential negative impact on the well-being of the therapist, the organization, and the client; professional bodies have an ethical responsibility to intervene (Middleton & Potter, 2015).

In staying in line with the tradition of social work, vicarious trauma interventions should address individual, organizational, and macro level practices. The social work profession values the holistic approach to interventions and acknowledges the influence of environment on an individual's functioning. The holistic therapeutic approach uses

multiple systems (micro, mezzo, macro) to identify the influences on the individual as well as to advocate for social change.

As part of the holistic system approach in treating an individual's vicarious trauma, it is necessary to address the potential organizational influences that may be impacting the development of vicarious trauma or affect the recovery process. The practices of the agency (mezzo) may influence whether a therapist develops vicarious trauma or prevents it from becoming more serious. For example, if an agency does not value prevention of vicarious trauma and intervention practices are reactive (after development of vicarious trauma), the value of early intervention in preventing more severe reactions is negated (Middleton & Potter, 2015).

Organizational practices must align with the mission and values of the social work profession, including advocacy for social change on the macro level when policies and laws influence organizations on a macro level that may result in causing harm (vicarious trauma) to therapists or individuals. For example, the demands of managed care have forced agencies to do more with fewer resources. Expectations are that therapists will increase caseloads in order to meet the expectations of the organization (related to reimbursement). As a result of increasing client caseloads and the effects that occur as a result of increased exposure to secondary traumatic events, the therapist is at greater risk of developing symptomology of vicarious trauma including disturbances of their sense of self, spirituality, and worldview (Wang et al., 2014).

Organizational practices are influenced by macro level policies, agencies have a professional obligation based on the mission of social work to address the barriers and negative forces that impact the well-being of at-risk populations (therapists who are

exposed to secondary trauma). Organizations should seek to promote sensitivity and knowledge about the individual and organizational impacts of macro level policies through advocacy at the local, state, and federal level.

Conclusion

Social workers are susceptible to the potential negative impacts of vicarious trauma (Bercier & Maynard, 2015; Hyatt-Burkhart, 2014; Newell, Nelson-Gardell, & MacNeil, 2016; and Robinson-Keilig, 2014) with as high as 67% experiencing professional burnout (Morse et al., 2012). Moreover, 33% of social workers report various vicarious trauma symptomology to the extent that 50% of those reporting symptomologies are considering leaving their job (Middleton & Potter, 2015). With the development of practice models such as, the Trauma-Informed Care model, being empathically engaged with clients does not have to leave the therapist exposed to the potential negative effects of secondary trauma. The Trauma-Informed Care model is a practice model for service delivery at the individual and organizational level focused on healing and prevention for all those in the trauma service system (Fallot & Harris, 2009). The implementation of a trauma-informed model of care is meant to "break the cycle" and create a culture of caring that minimizes the negative effects of trauma to clients and secondary trauma to those working with the client.

A change is needed in practice standards for organizations that provide therapeutic services to traumatized clients. This needed change is evident by the findings of this study in rural social service settings. It is my opinion that it will take a state or federal mandate to create a change in agency practice due to the "slow process of change" that occurs within in social service agencies specifically, rural agencies. The

implementation of trauma-informed and trauma specific practices, has the potential to improve client outcomes, sustain the well-being of therapists, and maintain agency vitality.

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Appendix A: Interview Protocol Worksheet

Interview Protocol Worksheet

Date of Interview:
Time of Interview:
Location of Interview:
Interviewer:
Interviewee:

Start time:

Safety

1. Tell me about how your agency promotes your physical and environmental safety?

Observation Notes:

2. What safety considerations are important to you?

Observation Notes:

3. In your relationships with supervisors and administrators, tell me about your feeling of being supported?

Observation Notes:

4. How comfortable are you with bringing your clinical concerns, vulnerabilities, or emotional responses to a client, to administrators or supervisors?

Observation Notes:

Trustworthiness

1. To what extent does your supervisor understand the work you do with and the direct care you provide?

Observation Notes:

2. Explain what you believe is your supervisors understanding of the emotional impact to you caused by the direct care you provide (burnout, compassion fatigue, vicarious trauma)?

Observation Notes:

3. Explain to what level self-care is encouraged by your supervisor or agency? Are their policies that promote self-care?

Observation Notes:

4. What agency practices are used to promote self-care? (supervision)

Observation Notes:

5. Tell me about how your supervisor makes their expectations known and clear, and are expectations fair and consistent across staff?

Observation Notes:

6. Tell me about how trusted supervisors can be with listening respectfully to your concerns, even if they may not agree with the possible implications?

Observation Notes:

Choice

1. Tell me about how much input you have into creating your own work schedule?

2. How much input do you have into the types of tasks you are assigned at the agency (e.g. policies, in-services, groups)?

Observation Notes:

3. Tell me about your level of input into factors that affect each of these areas:

a) Size of your caseload:
b) Work hours:
c) Flex-time:
d) Vacation or other leave:
e) Kinds of training that are offered:
f) Approaches to clinical care (types of clients i.e. trauma, crisis, groups, mental health):

Observation Notes:

4. Tell me about the balance between your autonomy and clear guidelines in performing your job duties? Are you given flexibility in how you perform your job duties?

Observation Notes:

Collaboration

1. How encouraged are you to provide suggestions, feedback, and ideas of change at all levels of the agency? Is this a formal or informal system?

Observation Notes:

2. To what extent does your agency encourage collaboration among staff at all levels to plan and implement change?

Observation Notes:

3. Tell me about how your supervisor communicates that your opinion is valued even if it is not always implemented?

Observation Notes:

Empowerment

1. What professional development trainings are made available to you to assist with work-related challenges or difficulties? What about to build your professional skills and abilities?

Observation Notes:

2. Tell me about the training you have received related to workplace stressors, including trauma and its potential impact on you?

Observation Notes:

3. To what extent does your supervisor adopt a positive, affirming attitude in encouraging you to fulfill your work tasks?

Observation Notes:

4. Tell me about staff accountability, to what extent is there shared responsibility?

Observation Notes:

5. How constructive is the feedback you receive from your supervisor, even when it is critical?

Observation Notes:

End time:

Thank you for your participation and candor in this interview. You can receive a summary of the study's result by verbal or written request. Please note that I will be arranging for a brief follow-up interview in the near future.

Appendix B: Letter of Invitation Sent to Potential Participants

Dear Potential Participant,

My name is Tiffany Hardman and I am a doctoral candidate at Walden University, Barbara Solomon School of Social Work and Human Services. I am conducting dissertation research on the perceptions of trauma social workers on the responsiveness of rural social service agencies to vicarious trauma. I am looking for voluntary participants to interview who meet the following requirements:

- Social workers with a minimum degree of Master of Social Work (MSW).
- 1 year of employment at their current agency.
- Agency must be classified as "rural" (population of less than 50,000).
- Provide at least 1 hour per day of therapeutic intervention to client(s) with traumatic material (acute or chronic).

The purpose of this study is to explore the response of rural social service agencies to the potential negative impact on trauma social workers through the understanding of the trauma-informed care principles of safety, trustworthiness, choice, collaboration, and empowerment. Considering the risk factors and negative influences of vicarious trauma on the social worker and the agency, an increased understanding of the perspectives of trauma social workers on how rural social work agencies are responding to vicarious trauma care is needed.

I truly believe that your time is important to you and I appreciate your consideration to participate in this study. In order to fully understand your experience, we will need to meet on one occasion for approximately 1 1/2 hour during the first meeting and 30 minutes by telephone for the second meeting. Meetings can be held at a location and time of your choosing and will not require you to do anything you don't feel comfortable doing. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet or if you have any additional questions regarding participating in this study. My telephone number is [redacted]. You can also e-mail me at [redacted]. I look forward to hearing from you.

If you do not meet the participant requirement or you are not interested in participating but know someone who might be, please feel free to pass this invitation on to them.

Sincerely,
Tiffany Hardman, MSW, Doctoral Candidate Walden University

Appendix C: Screening Tool

Participant Screening Tool

Participant Name:
Date:

1. Are you employed in a social service agency that is located in a rural area (defined as less than 50,000 residents)?

2. What is the highest education level you have completed?

3. How long have you been employed at your current agency?

4. How much time to you estimate you are engaged daily with clients who present for services related to trauma history?

Appendix D: Nondisclosure Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer:

During the course of my activity in collecting data for this research: "Perspectives of Trauma Social Workers on the Response of Rural Social Work Agencies on Vicarious Trauma: A Narrative Analysis" I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**