

Organizational Impacts on the Secondary Traumatic Stress of Social Workers Assisting Family Violence or Sexual Assault Survivors

GA-YOUNG CHOI

Department of Social Work, University of Northern Iowa, Cedar Falls, Iowa, USA

This research examines the influence of organizational characteristics on secondary traumatic stress of social workers who provide direct services to survivors of family violence or sexual assault. The sample ($n = 154$) was recruited through the National Association of Social Workers' member list. The study found that social workers who received more support from their coworkers, supervisors, and work teams demonstrated lower levels of secondary traumatic stress. Social workers who also had more access to their organizations' strategic information exhibited lower levels of secondary traumatic stress. Several implications for social work administrators are suggested based on the findings.

KEYWORDS *secondary traumatic stress, compassion fatigue, vicarious traumatization, family violence, sexual assault, organizational characteristics, social workers*

Social workers are likely to encounter survivors of family violence, including sexual assault, regardless of their practice settings, because survivors often need various services to treat multiple issues resulting from the traumatic incidents. Working with family violence or sexual assault survivors can be emotionally challenging for social workers (Baird & Jenkins, 2003). For helping professionals who assist family violence or sexual assault survivors, these intense emotions may go beyond ordinary work-related stress.

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Address correspondence to Ga-Young Choi, Department of Social Work, University of Northern Iowa, Cedar Falls, IA 50614-0405, USA. E-mail: gayoung.choi@uni.edu

Researchers have demonstrated that practitioners can also be indirectly traumatized as they empathically engage with trauma survivors (Figley, 2002; Pearlman & Saakvitne, 1995). In other words, they may experience symptoms of posttraumatic stress disorder (PTSD) (Figley, 1995), including intrusion, avoidance, and arousal (Bride, 2007). This indirect trauma has been defined with the terms *secondary traumatic stress* (STS), *compassion fatigue*, and *vicarious traumatization*, which all refer to helping professionals' psychological, cognitive, and physiological reactions similar to clients' trauma symptoms (Baird & Jenkins, 2003). In this article, STS, a widely used term, refers to indirect trauma (Sabin-Farrell & Turpin, 2003).

As a possible work outcome, STS can adversely impact social workers' personal well-being (Adams, Figley, & Boscarino, 2008; Ben-Porat & Itzhaky, 2009; Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008), the helping process (Munroe, 1999), and the workplace climate (Herman, 1997). In fact, more than half of the social workers (53%) in Ting, Jacobson, Sanders, Bride, and Harrington's (2005) study recognized that their STS impacted their personal and professional lives. Accordingly, social service organizations taking steps to prevent and treat STS of social workers becomes crucial (Bell, Kulkarni, & Dalton, 2003; Illiffe & Steed, 2000; Pearlman & Saakvitne, 1995; Yassen, 1995). For organizations to effectively intervene to prevent STS among social workers, examining which organizational or work characteristics affect social workers' STS experiences is important. However, existing findings on whether organizational and work-related characteristics, such as workload, time spent with traumatized clients, quality of supervision, or coworker support, predict the emergence of STS or reduce STS have been inconsistent. In addition, little research has examined the broader set of organizational features, such as organizational culture and strategic information, in relation to STS. Thus, this research begins to fill these research gaps by examining the relationships between organizational characteristics and STS among social workers providing direct services to survivors of family violence or sexual assault.

LITERATURE REVIEW

Factors Influencing Secondary Traumatic Stress

ORGANIZATIONAL SUPPORT

Organizational support can be described as the general work environment and organizational structural aspects that can support social workers' job performance. In particular, Spreitzer's (1995, 1996) four social structural characteristics, which were used as independent variables in the current research, can measure organizational support. They include sociopolitical support (e.g., support gained through organizational membership and networks), access to information (e.g., work flow, productivity, external environment,

future direction, and mission and goals), access to resources (e.g., time, space, materials, and funds), and organizational culture (e.g., culture that values human capital and participation). A summary of research that has examined these various aspects of organization support in relation to STS follows.

Sociopolitical support in STS research has been defined as the level of peer or coworker support and general organizational support. Townsend (2005) found that greater levels of peer support reduce STS. However, Kim (1999) found no relationship between the level of coworker support and avoidance and intrusion symptoms of therapists' vicarious trauma exposure.

Few previous STS studies have examined the relationship between helping professionals' access to their organizations' strategic information and STS. Nevertheless, having open communications about the organization's mission among staff members is among several guiding principles that O'Brien (2006) suggested to increase and maintain a supportive work environment. This can be one example of having access to strategic information. Furthermore, clearly understanding an organization's goals is one aspect of having access to organizational strategic information. In a study of sexual assault nurse examiners who conducted forensic evaluations and provided treatment to rape victims, Townsend (2005) found that when organizations had diffused goals, nurses were more likely to report STS. Townsend speculated, "A multiplicity of goals, some of which may be in conflict with one another or beyond the nurse's control, may increase nurses' stress and interfere with identifying and actively coping with the trauma-related stressors" (p. 77).

Several STS studies imply that having adequate resources, such as time, materials, space, funds, knowledge, and skills, when working with traumatized clients can prevent STS. For example, providing a secure and comfortable physical work environment, such as a space with comfortable furniture in which to rest (Bell et al., 2003), private office space (Neumann & Gamble, 1995; Yassen, 1995), access to resources to help clients, and training opportunities for therapists (Pearlman & Saakvitne, 1995) might reduce family violence workers' vicarious trauma stress.

In order to develop preventive strategies for STS at the organizational level, examining aspects of organizations' culture is also necessary. However, little research has been conducted in this area. In a review of the literature, Hemmelgarn, Glisson, and James (2006) refer to organizational culture as "the shared norms, beliefs, and behavioral expectations that drive behavior and communicate what is valued in organizations" (p. 75). Researchers have implied that organizational culture can impact the STS experiences of social workers. For example, Bell (2003) claimed that an organizational culture that emphasizes clients' progress versus problems innate in the work could prevent STS. The culture can strengthen the family violence organization and allows practitioners to examine their work across time, enabling them to celebrate small successes and the rewarding aspects of their work (Bell

2003). Moreover, the unhealthy dynamics of trauma victims, such as denial, blaming, and dominance and submission, could be transferred into the organizational culture and coworker relationships (Herman, 1997). Creating a cooperative and healthy organizational culture is also crucial given that strong coworker relationships may reduce STS (Slattery, 2003; Townsend, 2005).

WORK CONDITIONS

More specific organizational characteristics, including supervision and amount of exposure to trauma clients, have been related to STS. First, in terms of how the availability and quality of supervision can influence STS, Dalton (2001) found that the quantity (the number and hours) of non-evaluative supervision was related to lower levels of STS. Although Kassam-Adams (1999) found no relationship between the availability of supervision and the level of PTSD symptoms among trauma therapists, Pearlman and Mac Ian (1995) reported that when compared with therapists with no personal trauma history, those who had experienced trauma had greater disruptions in their cognitive schemas (e.g., safety, self-trust, esteem, and intimacy) if they were not receiving supervision.

Slattery and Goodman (2009) found that the quality of the supervisory relationship as perceived by the practitioners was significantly correlated with the level of STS. Slattery (2003) suggested that within a good quality supervisory relationship, workers might feel safe and comfortable to openly discuss their reactions and emotions about STS and thus prevent it. Trauma researchers have emphasized the importance of supervisors being willing to listen to and address the influences of trauma work on the practitioners' personal and professional lives as well as being willing to validate STS (Etherington, 2000; Knight, 2004; Parlakian, 2001, 2002; Sommer, 2003).

Second, in regards to the weekly hours spent with clients who have trauma issues related to family violence or sexual assault (Adams, Matto, & Harrington, 2001) and the size of the trauma caseload measured by the number or percentage of cases with trauma issues (Lee, 1995; Steed & Bicknell, 2001), these researchers found no significant relationships with STS. Other researchers have found that therapists with more trauma cases actually displayed lower levels of STS (Baird & Jenkins, 2003; Chrestman, 1999). Furthermore, other researchers found significant associations between the number of hours therapists spent listening to the clients' trauma stories and their STS levels (Bober & Regehr, 2006; Lee, 1995). Similar to the inconsistent findings observed for other organizational or work condition features, different samples and measurements may have attributed to these various results in the relationship between the amount of exposure to trauma cases and STS.

DEMOGRAPHIC AND INDIVIDUAL CHARACTERISTICS

Characteristics like educational level (Baird & Jenkins, 2003; Nelson-Gardell & Harris, 2003; Townsend, 2005) and gender (Nelson-Gardell & Harris; Kassam-Adams, 1999) have been examined in relationship to STS, and contradictory findings were observed. Little research has examined the relationship between race/ethnicity and STS because of the few racial/ethnic minority participants present in the study samples (e.g., Garrett, 1999; Schubert & Fraizer, 1995).

Many researchers agree that younger practitioners are more vulnerable to STS (Adams et al., 2001; Nelson-Gardell & Harris, 2003). Nelson-Gardell and Harris (2003) have explained the relationship between young age and increased vulnerability to STS in various ways. For example, older individuals may cope better with STS as they have greater life experiences or better utilization of coping mechanisms gained from years of experiences. It is also possible that those who suffered from STS left the field when they were younger (Nelson-Gardell & Harris, 2003). In addition, younger counselors tend to be more likely to provide direct services to clients, and older therapists are more likely to be supervisors with less intense daily exposure to clients' trauma (Nelson-Gardell & Harris, 2003). However, Dill (2007) argues that supervisors, in particular those in child welfare, might have a greater risk of developing STS and other work-related stress issues due to administrative responsibilities and pressures, in addition to being exposed to clients' traumatic stories by providing supervision. Moreover, several STS studies include supervisors who identify themselves as trauma therapists (e.g., Bober & Regehr, 2006; Bride, 2007; Bride, Jones, & MacMaster, 2007). Thus, whether the therapists in supervisory roles are less affected by clients' trauma than frontline practitioners needs further exploration.

As would be expected, some studies have found a relation between increased years of trauma work experience and higher levels of STS (Bober & Regehr, 2006; Meyers & Cornille, 2002). However, other studies demonstrate that more years working in a trauma field is related to lower levels of cognitive disturbance and PTSD symptoms (Kadambi & Trustcott, 2004; Pearlman & Mac Ian, 1995).

The relationship between a therapist's own past trauma history and STS has been frequently explored, with some researchers finding no significant relationships (Adams et al., 2001; Bober & Regehr, 2006; Kadambi & Trustcott, 2004; Schauben & Frazier, 1995). Other studies have found that therapists with a personal trauma history reported higher levels of STS (Kassam-Adams, 1999; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995; Slattery & Goodman, 2009).

Income or salary has been less frequently examined in STS research compared to other demographic variables. Only two studies that examined the correlation between income or salary and STS could be located.

Higher annual income (Chrestman, 1999) and higher annual salary (Adams et al., 2001) were related to lower levels of STS. Perhaps increased financial resources afford traumatized clinicians increased opportunities to access divergent activities and assistance when they are experiencing STS.

CURRENT STUDY

Research Hypothesis

As supported by some of the previously reviewed studies, organizational characteristics could influence the STS levels of social workers who provide direct services to family violence or sexual assault survivors. Specifically, this research hypothesized that social workers who perceive higher levels of organizational support and higher levels of quality supervision will have lower levels of STS. On the other hand, social workers who spend more hours providing services to trauma cases will have higher levels of STS, controlling for the demographic and individual variables.

Participants

Participants were 154 social workers who provide direct services to family violence or sexual assault survivors on a regular basis in an agency-based setting. The majority of the respondents were female (78.6%) and Caucasian (87.7%). The sample varied little in terms of educational level. Most participants had a master's level education (96.7%), and the majority of them had MSW degrees (93.5%). Only 1.3% of the respondents held BSW degrees, and 1.9% held PhD degrees. The respondents' mean of years working in their current agencies was 8.3. Overall, the respondents reported having 48.1% of their caseloads related to family violence issues. Child abuse (74.7%), intimate partner abuse (70.1%), and sexual assault or rape (65.6%) were the most frequently reported family violence types to which the social workers were exposed. A small proportion of the social workers also helped clients with elder abuse issues (20.8%). Over 80% of the social workers reported experiencing at least one type of personal traumatic events.

Procedures

Study participants were recruited from the National Association of Social Workers (NASW) mailing list upon university institutional review board (IRB) approval. A total of 1,001 NASW members' names were randomly selected from the four work focuses highly likely to serve family violence or sexual assault survivors on a regular basis. The work focuses were alcohol/drug abuse, family issues, health, and violence/victims services. A survey packet including a self-addressed, stamped return envelope, invitation letter, informed consent form, and questionnaires was sent to these

NASW members. In the research invitation letter, social workers were asked to complete the questionnaire only if they met all of the following three criteria: (1) They spend an average of an hour or more per week providing direct services, such as counseling/therapy, referrals, and/or advocacy, to clients who have experienced or are experiencing family violence or sexual assault; (2) they have been exposed to clients reporting family violence and/or sexual assault issues during the past month; and (3) they are currently working in an organizational setting.

The data collection proceeded from April 2008 to September 2008. The total response rate was 29%. Among the returned responses, 182 questionnaires were at least partially completed, and 107 were not completed. The vast majority of the social workers who returned incomplete surveys ($n = 103$; 96.26%) reported being ineligible to participate because they did not fit the study inclusion criteria. Two social workers indicated that they did not want to participate, and the other two were mail delivery failures. After screening the completed 182 surveys, 154 responses were usable. The reasons for eliminating the completed surveys were due to not meeting the study criteria such as practiced only as a private practitioner ($n = 12$), provided less than an hour of services to trauma survivors ($n = 7$), did not return the signed informed consents ($n = 7$), and skipped one entire instrument ($n = 2$). Pearlman and Mac Ian (1995) reported a response rate of 32%, and Adams et al. (2001; 2008) reported a 39% return rate of completed surveys. Perhaps the low response rate of the current study was due to recruiting only social workers providing services to family violence or sexual assault victims instead of victims of any type of trauma, and eliminating social workers in private practice.

Variables and Measures

SECONDARY TRAUMATIC STRESS (DEPENDENT VARIABLE)

STS was measured with the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). In this study, the STSS was labeled as "Responses to Working with Clients" to reduce any bias in responses. This 17-item scale is designed for measuring helping professionals' STS symptoms of intrusion (5 items), avoidance (7 items), and arousal (5 items). The scale measures the frequency of each symptom that participants experienced in the previous week on a 5-point Likert-type scale (1 = *never* to 5 = *very often*). A total sum score was used. The alpha for the total STSS was .86, and alphas for each subscale were .74 (intrusion), .87 (avoidance), and .79 (arousal).

ORGANIZATIONAL SUPPORT (INDEPENDENT VARIABLES)

Organizational support was measured with the Social Structural Scale (Spreitzer, 1995, 1996), which measures four dimensions of a work context: sociopolitical support (3 items), access to strategic information (3 items),

access to resources (3 items), and organizational culture (5 items). All items were measured on a 7-point disagree-agree Likert scale (1 = *very strongly disagree*, 7 = *very strongly agree* for sociopolitical support, strategic information, and resource subscales; 1 = *minimally valued*, 7 = *extensively valued* for organizational culture subscale). One item that measures subordinates' support in the sociopolitical support subscale was dropped, as it does not particularly apply to social workers. The alphas for sociopolitical support, access to information, access to resources subscale, and organizational culture subscales were .71, .89, .93, and .93, respectively.

WORK CONDITIONS (INDEPENDENT VARIABLES)

The hours spent providing services to trauma cases included direct contacts with clients and any efforts made on behalf of clients to resolve issues presented by clients, such as working with hospitals, shelters, police, crime victim services, and court systems. The reason for including non-clinical or non-therapy hours was because social workers can be constantly aware of and reminded of their clients' trauma stories while they engage in these other professional roles.

Information on hours spent providing services to family violence or sexual assault cases, hours of supervision, and quality of supervision was obtained from the Demographic and Individual Survey designed for this study.

To measure the quality of social workers' clinical supervision, four items were created based on the reflective supervision literature (Parlakin, 2001), as no adequate standardized instruments could be located. The items included the regularity of the clinical supervision, the supervisor's attentiveness, the supervisor's encouragement to explore thoughts and feelings related to trauma work, and the degree to which the supervisor focuses on the social worker's personal and professional development. The four items were measured on a 5-point Likert scale (1 = *never*, 5 = *very often*). The higher scores for all of the items indicate that the social workers perceive that they receive higher quality clinical supervision.

The principal components analysis (PCA) indicated that the five supervisory items were inter-correlated and measured one component. All factor loadings were high (ranged from .70 to .90), with Cronbach's alpha of .90. Based on the PCA, the clinical supervision items were summed and labeled "quality of supervision."

DEMOGRAPHIC AND INDIVIDUAL INFORMATION (CONTROL VARIABLES)

Because the sample used in the current study varied little in terms of educational level, this variable was not included in the analysis. Instead, demographic and individual characteristics including the social worker's age, years of experience with trauma cases, past trauma history, salary, gender,

and race/ethnicity were examined. These variables are likely to be related to other variables and also predict STS, thus they were controlled in the multivariate analysis. Age, years of experience in a trauma field, past trauma history, and salary were treated as continuous variables. Past trauma history was measured by the number (up to seven) of different types of trauma that the individual experienced. Thus, the values ranged from 0 (none) to 7. Salary was measured with 13 categories, ranging from 1 = \$80,000 or above to 13 = below \$25,000. The gender and race/ethnicity variables were measured as dummy variables. For gender, female was coded 1, with male being the reference variable. For race/ethnicity, non-White/Caucasian was coded 1, with White/Caucasian being the reference variable.

Data Analysis

All analyses were conducted using SPSS 17. To test the hypothesis, STS was regressed on the organizational support, work conditions, and demographic/control variables using a multivariate OLS linear regression model.

RESULTS

The means, standard deviations, and ranges of all variables in the model analysis are reported in Table 1.

The results of the multivariate model are presented in Table 2. Among the organizational support variables, only having sociopolitical support ($b = -2.216, p < .05$) and access to strategic information ($b = -2.001, p < .05$) are significantly related to STS. That is, the social workers who had more support from their superiors, peers, and work teams experienced lower levels of STS. Moreover, social workers were more likely to experience lower levels of STS if they had more access to the organization's strategic information. None of the work condition variables are significantly related to STS. Past trauma history is the only control variable that predicts STS ($b = 1.367, p < .05$). The coefficient indicates that social workers who had experienced more types of personal traumatic events had more severe levels of STS. Moreover, gender is marginally related to STS ($b = 3.696, p < .10$), suggesting that there might be differences between females and males in their STS levels. The coefficient of gender indicates that female social workers in this study have higher STS levels compared to male social workers. The adjusted R^2 for the model is .149.

DISCUSSION

The purpose of this study was to examine the relationships between organizational characteristics and STS of social workers who provide direct services

TABLE 1 Mean and Standard Deviation (SD) of Dependent, Independent, and Control Variables ($N = 154$)

Variables (Range)	Mean (SD)
Dependent Variable	
Secondary Traumatic Stress (17–62)	32.07 (10.39)
Independent Variables	
<i>Organizational Support</i>	
Sociopolitical Support (2–7)	5.23 (1.10)
Access to Strategic Information (1–7)	5.12 (1.25)
Access to Organizational Resources (1–7)	4.90 (1.37)
Unit (Organizational) Culture (1.2–7)	4.95 (1.38)
<i>Work Conditions</i>	
Hours Providing Services to Trauma (Family Violence) Cases (1–60)	12.21 (12.09)
Quality of Supervision (4–25)	13.02 (5.75)
<i>Demographic/Control Variables</i>	
Age (24–74)	46.71 (12.70)
Years of Experience in Trauma Field (1.08–40)	14.52 (9.45)
Past Personal Trauma Experience (Number of Trauma Types Experienced) (0–7)	1.85 (1.39)
Salary (1–13: Between \$80,000 or Above and Below \$25,000)	6.84 (3.06)
Gender (1 = Female, 0 = Male)	.79 (.41)
Race/Ethnicity (1 = Non-Whites/Caucasians, 0 = Whites/Caucasians)	.12 (.33)

TABLE 2 Summary of OLS Regression Coefficients for Hypothesis Testing ($N = 154$)

Variables	B	SE	B
Organizational Support			
Sociopolitical Support	–2.216*	.994	–.235
Access to Strategic Information	–2.001*	.900	–.241
Access to Resources	1.122	.876	.148
Organizational Culture	–.518	.913	–.069
Work Conditions			
Hours Providing Services to Trauma Cases	.082	.066	.095
Quality of Supervision	.060	.155	.033
Demographic/Control Variables			
Age	–.076	.085	–.093
Years of Experience with Trauma Cases	–.006	.126	–.006
Past Trauma History	1.367*	.574	.183
Salary	.044	.290	.013
Gender	3.696 ⁺	1.991	.146
Race/Ethnicity	–1.616	2.487	–.051
R ²		.215	
Adjusted R ²		.149	

* $p < .05$; ⁺ $p < .10$.

to family violence or sexual assault survivors. The specific organizational characteristics measured in this study included organizational support and work conditions. Among the organizational support variables, having higher levels of sociopolitical support to do one's job well is significantly related to lower levels of STS. This finding supports the existing literature (Bride et al., 2007; Townsend, 2005). In supportive environments social workers can more easily talk about their STS symptoms with their colleagues and obtain emotional support (Townsend, 2005). If support systems within the organization are well established, social workers could also access more resources from their social networks with which to prevent or cope with the STS symptoms. Social workers can also obtain the necessary help from their colleagues or administrators to assist their clients. When social workers are able to help their clients to resolve issues or difficulties related to family violence or sexual assault, they also witness clients' traumatic experiences being transferred into positive and rewarding experiences. This positive helping experience as a result of sociopolitical support could be a buffering factor that reduces or prevents STS.

To create supportive work environments, all personnel in the organization need to acknowledge that STS is the natural consequence of doing trauma work (Figely, 1995; Pearlman & Saakvitne, 1995). Organizations could express their acknowledgment by offering opportunities for social workers to openly discuss their vulnerability and work-related stress with their supervisors (Sommer, 2003), coworkers, or team members (Pooler, 2008). This form of support is especially important considering that the very nature of the work, which requires confidentiality regarding the clients' issues, could contribute to isolated feelings for the therapists and further contribute to the development of STS (West, 1997).

The current finding suggests that administrators who provide more access to organizational strategic information can prevent STS among their social workers. Applying Spreitzer's (1995, 1996) definition, having an organization's strategic information means having a clear understanding about work flow, productivity, and external environmental factors that interact with the organization and impact the organization and its future direction. Understanding the top management's vision and the organization's goals and strategies to achieve the vision are also important aspects of an organization's strategic information.

Organizations could take several strategies to provide their social workers with more access to strategic information. First, administrators could invite frontline social workers to directly participate in the agencies' decision-making process when establishing annual goals and strategic information (O'Brien, 2006). Directly participating in the agencies' decision-making meetings could expedite the process of transmitting any changes or new information from top management to frontline social workers. It could also reduce any confusion or misunderstanding regarding the necessity of

certain goals, visions, or strategies that the organization will pursue. More importantly, social workers could contribute in setting organizational goals and strategies that are more feasible to achieve. When social workers are able to participate in establishing their agencies' monthly or annual goals and the strategies to accomplish the goals, they could raise and advocate for issues more pertinent to their direct service work with survivors of family violence or sexual assault. If the organization's strategic information is closely tied to the helping process of trauma clients, the social workers may feel that their work is supported more by the organization. In turn, practitioners could assist family violence or sexual assault survivors more efficiently and effectively, which could eventually help the clients to escape from their traumatic experiences.

Social workers being directly involved in establishing an organization's strategic information may not be possible in large organizations or if social work is a subdivision in a large organization such as a hospital. Therefore, implementing efficient and effective communication channels is important to ensure that social workers have access to strategic information. Strategies might include providing updated staff manuals or any changes in strategic information using online sources such as e-mail or staff boards on an agency's website.

Having access to strategic information can be more difficult for practitioners new to the agency. As a way of supporting practitioners who may be susceptible to STS, senior workers could help junior workers to successfully adapt to the new work environment by mentoring and guiding them through work tasks (Pryce, Shackelford, & Pryce, 2007). This strategy could also be applied to socializing new employees to the agency's mission, goals, and strategies.

In the current study, having access to resources and being in an organizational culture that values human capital and a cooperative working environment did not predict STS in the regression model. The lack of a relationship between organizational resources and STS might be the result of the organizational resources measure used in this study, which is not specific to preventing or coping with STS. It is also unclear why organizational culture did not predict STS. One possible interpretation might be that an organizational culture that values open discussion or employees' concerns and ideas may not necessarily indicate that the organization values social workers' concerns specifically related to STS.

This study did not identify significant relationships between hours spent providing services to trauma cases and STS. The findings suggest that STS is not affected by the actual amount of exposure to the client's trauma, but might be affected by the therapist's perceptions of the exposure (Lee, 1995). In addition, the workers' ability to emotionally separate themselves from the clients' trauma experiences can affect their STS experiences, regardless of the amount of exposure to trauma cases (Badger, 2005).

The quality of supervision also did not predict the STS of the social workers in this study. Although the scale measured to what degree supervisors encourage social workers to explore their thoughts and feelings related to work involving family violence or sexual assault cases, the measurement did not directly ask about how social workers' STS experiences were addressed in clinical supervision sessions.

As this study indicates, a social worker's experience of more types of traumatic events in his or her own life is an important individual characteristic placing social workers at risk of STS. Over 80% of the social workers in this study experienced at least one traumatic event, and over 70% of them experienced traumatic events related to family violence or sexual assault. Social work administrators and individual social workers should recognize that people with personal trauma histories tend to be more vulnerable towards STS. It is crucial that individual social workers take precautions, such as using healthy coping methods. Some examples of healthy coping methods include balancing or setting boundaries between professional and personal life (Harrison & Westwood, 2009; Pearlman & Saakvitne, 1995), and utilizing cognitive restructuring methods when disrupted by STS symptoms (Azar, 2000). However, since STS can result from performing social work activities, agencies should take a leading role in assisting social workers in preventing or minimizing STS. Providing opportunities for practitioners to enhance their clinical skills, gain education on STS, and learn and use coping strategies are examples of such efforts.

This study found a marginally significant relationship between gender and STS levels indicating that female social workers are more likely to have higher levels of STS than male social workers. This is a similar finding to Kassam-Adams (1999) and Van Hook and Rothenberg (2009). Considering that women are more frequently subjected to rape and intimate partner abuse than men (Tjaden & Thoennes, 2000), it's possible that female practitioners can become more sensitive to their clients' traumatic experiences involving family violence and sexual assault issues. However, it is preliminary to conclude that female social workers have a greater risk of experiencing STS than male social workers (Kassam-Adams, 1999), especially due to limited number of male social workers in the current sample and a marginal significant effect of gender on STS levels.

LIMITATIONS

The study cannot be generalized to all social workers providing services to traumatized clients due to family violence issues. Since the majority of participants had MSW degrees (93.5%), some limitations could exist in understanding the STS effects of social workers at the BSW level. Although race/ethnicity of the social workers was controlled in the statistical analysis,

because relatively few participants were nonwhites, all nonwhite social workers were placed into one category. This classification might have masked important differences in STS among various racial/ethnic groups.

The low response rate also limits generalizing the study finding, and may have introduced some unmeasured self-selection bias. For example, therapists who feel affected by their work might be more likely to respond to the questionnaire, as they perceive the research is relevant and useful. On the contrary, those who are suffering most from STS may feel that participating in research is a burden and thus decline participation (Sabin-Farrell & Turpin, 2003). Moreover, if social workers were demoralized by their organizations' lack of support in assisting traumatized clients, it is possible that participating in this study could increase their level of demoralization toward their organizations, and hence they choose not to participate.

Finally, the study is cross-sectional and correlational; therefore, establishing causation between the independent and dependent variables cannot be done. Finally, the test-retest reliability and validity of the quality supervision scale used in this analysis has not yet been established.

CONTRIBUTIONS AND FUTURE RESEARCH

Considering that existing research is sparse and has produced inconsistent results on which factors affect STS, another piece of research in this area is important. Moreover, the findings add to current knowledge by providing new information, such as whether a broader set of organizational and work factors are related to STS of social workers providing services to traumatized clients.

The current study also suggests future research directions. First, related to the measurement issue, as organizational resources did not predict STS levels, future studies might more concretely define organizational resources. For example, resources can be specifically defined with education and training to enhance social workers' knowledge and skills in assisting trauma clients as well as preventing STS. Organizational resources could also include funds and materials that social workers could utilize in assisting trauma victims. Second, unlike this study's findings, other STS researchers suggest that clinical supervision is an important factor in understanding STS of employees working with traumatized clients (Sommer, 2003; Pearlman & Mac Ian, 1995). Therefore, future research can focus on developing valid and reliable supervision instruments and testing them in models examining social worker's STS. Third, this study did not find a significant relationship between social workers' race/ethnicity and STS levels. However, considering the limited number of social workers from various racial/ethnic backgrounds in this study, future research should further examine how social workers' race/ethnicity might influence their STS experiences. This area of research

is important since sociocultural factors influence the ways in which individuals express their emotional reactions after being exposed to traumatic experiences (Dutton & Rubinstein, 1995). Moreover, cultural differences might also affect organizational culture. For example, openly communicating the workers' vulnerability towards STS may not be accepted in certain cultures. Obtaining sufficient samples of social workers from different racial and ethnic backgrounds appears to be difficult when using national data. Therefore, approaching specific ethnic community-based agencies could be helpful in obtaining the necessary social and cultural information to investigate whether these factors impact social workers' STS. Since almost no research exists in this area, conducting qualitative research could be another option to explore STS experiences in ethnic minority social workers.

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