VICARIOUS RESILIENCE AMONG EMPLOYEES AND VOLUNTEERS AT A RAPE CRISIS CENTER

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DEDICATION

This dissertation is dedicated to several important people who I value and love.

To my beloved God and Savior Jesus Christ, speak LORD, for your servant hears. This dissertation is a testimony to display Your glory. Thank you for entrusting me with much.

To my beloved husband, Esteban, thank you. You are the man of my dreams and my love for you runs deep. I love the life we lead in the Lord and look forward to continued kingdom work.

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ABSTRACT

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Vicarious resilience is a newer concept to combating burnout and improving the health and wellness of sexual assault trauma workers at rape crisis centers (RCCs). The primary goal of the study was to explore the predictive nature of intrapersonal and interpersonal and organizational factors for vicarious resilience among trauma workers at a RCC. A targeted, cross-sectional research approach was used to predict the relationship between: 1) intrapersonal factors and vicarious resilience; and 2) interpersonal and organizational factors and vicarious resilience. A quantitative questionnaire was administered to trauma workers at a RCC in North Central Texas (n = 46) using the Copenhagen Burnout Inventory, subscales from the Copenhagen Psychosocial Questionnaire III (COPSOQ III), the Vicarious Resilience Scale, and questions based on recommendations from experts in the field.

A descriptive analysis was used to establish the context of trauma worker demographics and work environment. Multiple linear regressions were used to determine whether trauma workers' intrapersonal, interpersonal, or organizational factors were predictive of high vicarious resilience. The results of the multiple regression analyses indicated statistical significance for intrapersonal factors (total time of service in IPV

field, age, and chronic health conditions) and interpersonal and organizational factors (coping strategies) predictive of high vicarious resilience. Findings from this study may be used for RCC management to improve trauma worker wellness and expand trauma-informed training curricula beyond self-care strategies for sexual assault trauma workers. Vicarious resilience is a promising multidimensional approach to adapting to trauma work and transforms trauma workers' perspectives on a valued field.

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CHAPTER I

INTRODUCTION

Rape crisis center (RCC) management faces significant challenges with maintaining productivity and quality of services considering the well-established impacts of burnout among their trauma workers. While RCCs implement self-care and wellness trainings or programs to mitigate the impact of burnout, there is minimal documentation on the role of vicarious resilience. Burnout is a natural response that may occur after chronic exposure to emotional and interpersonal work stressors and is especially prevalent among trauma workers (Kulkarni et al., 2013). Chronic exposure to sexual assault trauma is wearisome for RCC employees and may lead to a shift in hope or worldview. In addition to emotional or psychological effects, burnout impacts nearly all areas of life including the physical, cognitive, sexual, behavioral, and spiritual (McLindon & Harms, 2011; Newell & MacNeil, 2010; Sabin-Farrell & Turpin, 2003). RCCs with employees experiencing burnout will likely face challenges with poor productivity, absenteeism, job satisfaction, organizational commitment, eventual interruption or reduction in time of service, and turnover intention (Alarcon, 2011; Bemiller & Williams, 2011). The individual and organizational implications of burnout are well supported in the literature; thus, researchers are shifting focus to a newer concept of vicarious resilience. Recent studies highlight the value of vicarious resilience as an antidote to burnout. Vicarious resilience is referred to as the positive or healthy response to trauma work by focusing on personal growth (Hernandez-Wolfe et al., 2015).

Employees may gain motivation from client persistence considering hardship or the mere satisfaction of helping victims of violence. Vicarious resilience may also grow from a greater appreciation for life because of a new frame of reference (Frey et al., 2017). This positive response to trauma work allows trauma workers to strengthen their skills and develop a new purpose to sustain their practice in the field.

The presence of vicarious resilience does not imply the absence of burnout; rather, symptoms of burnout and vicarious resilience occur simultaneously but the promotion of vicarious resilience mitigates the negative impact of burnout. Burnout and the negative impact of trauma workers' chronic exposure to trauma have been discussed in the literature for over 40 years (Canfield, 2005). Burnout is a construct of compassion fatigue and often used interchangeably in the literature with secondary traumatic stress and vicarious trauma (Kulkarni et al., 2013). While all these concepts are negative responses to trauma work, the negative trauma response highlighted in this study is *burnout*. As the impacts of burnout were discovered, professional training curricula and resources were developed to promote self-care and other wellness strategies to mitigate burnout. However, in spite of the conceptualization of vicarious resilience over the last 10 years (Hernández et al., 2007), few trainings or resources provide an understanding of this concept and the processes involved.

Hernández et al. (2007) first coined the concept of vicarious resilience after exploratory interviews with psychotherapists who work with victims of political violence and kidnapping. Researchers analyzed and developed vicarious resilience through the concepts of vicarious impact and resilience. Vicarious impact draws from vicarious

traumatization, which focuses on an inner transformation and change of cognitive schemas. Resilience is rooted in positive psychology and adaptive behavior to describe the positive adaptation to challenges (Hernández et al., 2007).

McCann and Pearlman (1990) developed the construct of vicarious traumatization in the context of the constructivist self-development theory (CSDT). In this theory, the development of cognitive schemas or set of beliefs, assumptions, and expectations of self and world, allow individuals to make sense of their experiences (Cohen & Collens, 2013; McCann & Pearlman, 1990). Thus, trauma workers experience a disruption in cognitive schemas when exposed to victims' trauma. Resilience, however, stems from human adaptive abilities.

Despite varying definitions of resilience, two common core conditions are: 1) exposure to adversity, and 2) achievement of positive adaptation (Munoz et al., 2017). Locus of control (LOC) is a cognitive state associated with resilience and is explained as perceptions of who or what is in control of one's life outcomes. LOC consists of multiple dimensions where individuals perceive life outcomes as within their control or outside of their control. Researchers suggest ILOC is strongly related to empowerment, in which empowered individuals hold a specific cognitive set in which they perceive behavior choice leads to desired outcomes. Individuals with ILOC are more likely to approach adversity with determination and positive outlook because of the perceived ability to control the outcome (Munoz et al., 2017). Thus, trauma workers with ILOC are more likely to be resilient despite adverse work environments and trauma exposure, due to their individual empowerment and self-determination.

Exploring and advocating for trauma worker resiliency is even more critical during the present COVID-19 pandemic when trauma workers seek to cope with service delivery changes in addition to personal crises. The National Sexual Assault Hotline supported by the Rape, Abuse, and Incest National Network (RAINN), reported a 22% increase in monthly calls from children at the end of March 2020 (Kamenetz, 2020). For the first time in the network's history, half of incoming calls came from minors. RAINN concluded the closing of schools across the nation contributed to an increase in severity and frequency of child sexual abuse, as 79% of minors calling reported they were currently living with their abuser (Kamenetz, 2020). Beyond changes in victimization reporting, new challenges also arise with racial/ethnic minority survivors who are disproportionately affected by COVID-19 (Vera Institute of Justice, 2020). Historically marginalized communities experience even greater social inequalities, such as availability of resources and access to quality healthcare services. Thus, trauma workers experience the added complexities of COVID-19 on historically marginalized communities when seeking to provide services. Other expressed concerns from trauma workers include the increased workload with limited or no social support from a team due to remote service delivery, loss of volunteers, and inability to provide in-person advocacy (Vera Institute of Justice, 2020). The escalating impacts of trauma during the COVID-19 pandemic have changed the dynamics of RCC trauma work. RCC management has worked rapidly to adjust protocols to meet the needs of clients during the COVID-19 pandemic and trauma worker health and wellness must also take priority.

While the narratives and existence of burnout are strongly supported in the literature, the area of vicarious resilience is still underdeveloped in the field of sexual assault. There is a gap in the literature to specifically understand the predictive factors for vicarious resilience among sexual assault trauma workers. Further exploration of vicarious resilience among sexual assault trauma workers would provide organizations with the understanding of factors influencing their employee and volunteer health and wellness. RCC management should aim for maintaining a trauma-informed organizational culture where victims of sexual assault and the trauma workers who help them are equally supported. Understanding factors associated with higher levels of vicarious resilience allows RCC management to create health promotion programs, improve professional training curricula, improve employee wellness, and potentially provide hiring managers with key characteristics to observe when interviewing potential employees and volunteers.

Theoretical Foundation

The theoretical underpinning to understanding potential predictors of vicarious resilience among trauma workers at a RCC involves multiple constructs from theories or concepts including CSDT, LOC, transactional model of stress and coping, social cognitive theory (SCT), and social ecological model. As explained above, CSDT and LOC are foundational theories explaining vicarious traumatization and resilience. The transactional model of stress and coping is a well-suited theoretical framework for this study, as it is a classic approach to evaluate the process of coping with stressors (Wethington et al., 2015). In the transactional model of stress and coping, stressful

experiences are understood as person-environment transactions where the individual holds the ability to mediate the impact of the stressor through personal appraisal of the matter via psychosocial or material resources. The transactional Model begins when an individual encounters an environmental stressor. The individual assesses the significance of the stressor, referred to as primary appraisal. The individual then undergoes a secondary appraisal or second evaluation to assess individual capacity to mediate the stressor through coping efforts. The outcome of the coping strategies represents individual adaptation to a stressor (Wethington et al., 2015). Examples of coping outcomes include emotional wellbeing and health behaviors. The transactional model of stress and coping introduces adaptive coping strategies and informs the stress and coping literature on resilience models. Thus, the transactional model of stress and coping informs the process of developing vicarious resilience (an adaptive coping strategy) among trauma workers at a RCC.

Another theory guiding the potential predictors of vicarious resilience among trauma workers is Albert Bandura's SCT. This theory applies to both individual and organizational influences predictive of vicarious resilience. Self-efficacy is a distinct construct of the SCT in which an individual's level of confidence in their ability to control their behavior is formed by multiple factors including vicarious experience. Vicarious experience is an observational learning process where the observation of another individual's success (e.g., sexual assault survivor healing from victimization) grows personal confidence to carry out a task (Kelder et al., 2015). Thus, a trauma worker may develop self-efficacy by deciding to cope with chronic trauma exposure and

believing in their ability to grow from the experience. This motivational aspect of self-efficacy is an internal response that may guide the understanding of vicarious resilience among trauma workers.

Beyond the individual level factors of coping with trauma stressors, are the organizational level influences promoting vicarious resilience. Workplace support and social support are critical factors in mitigating burnout among trauma workers (Kulkarni et al., 2013). Such support stems from social networks within an organization, which foster supportive interpersonal relationships (Kelder et al., 2015). Another major construct of the SCT is the environmental influences on behavior. Similar to ecological models, the SCT includes environmental influences as a level of influence on behavior. Interpersonal relationships promote health and wellness by reducing stress or providing tangible support. Social support is described in four categories: emotional support, esteem support, informational support, and instrumental support (Kelder et al., 2015). RCCs with trauma-informed organizational cultures fosters the various forms of social support to promote the health and wellness of their trauma workers.

Lastly, the layered structure of levels of influence on health as demonstrated by the social ecological model guide the selection of predictors for the present study (Stokols, 1996). The theory holds environmental influences (e.g., social support, work environment stressors) as a negative or positive influence on individual behaviors (e.g., coping strategies, doctor's visits, calling in sick; Stokols, 1996). Thus, the present study included predictors for vicarious resilience from multiple potential levels of influence including intrapersonal (individual), interpersonal, and organizational.

The CSDT, LOC, transactional model of stress and coping, SCT, and social ecological model are frameworks providing sufficient support in the individual and organizational level predictions of vicarious resilience. Each model guides the understanding of behavior responses to trauma stressors and the coping strategies involved in mitigating or modifying the behavior response. A logic model of the theoretical models used to design the present study, the associated constructs, and the relationship to the predictive factors as listed in the hypotheses is in Appendix A.

Purpose of the Study

The purpose of this study was to explore the relationship between intrapersonal factors (length of service at the women's center; total time of service in field of intimate partner violence; age; gender; race/ethnicity; Hispanic ethnicity; education; income; marital status; religion; religious affiliation; frequency of calling in sick; frequency of doctor's visits; changes in health since working/volunteering; general health, chronic conditions), interpersonal and organizational factors (employment or volunteer role; if volunteer, number of shifts; part-time or full-time; average hours of work per week; hours of direct client care; type of contact; utilization of the employee assistance program [EAP]; coping strategies; workplace support from colleagues; workplace support from supervisor; burnout), and vicarious resilience among trauma workers at a RCC in a county in North Central Texas.

Research Questions

Surveys were administered to collect data to answer the following research questions:

1. What intrapersonal factors are predictive of high levels of vicarious resilience among trauma workers at a rape crisis center?
2. What interpersonal and organizational factors are predictive of high levels of vicarious resilience among trauma workers at a rape crisis center?

Hypotheses

The null hypotheses for this study were as follows:

Ho_1. Intrapersonal factors (length of service at the women's center; total time of service in field of intimate partner violence; age; gender; race/ethnicity; Hispanic ethnicity; education; income; marital status; religion; religious affiliation; frequency of calling in sick; frequency of doctor's visits; changes in health since working/volunteering; general health, chronic conditions) will not be predictive of high vicarious resilience among trauma workers at a rape crisis center.

Ho_2. Interpersonal and organizational factors (employment or volunteer role; if volunteer, number of shifts; part-time or full-time; average hours of work per week; hours of direct client care; type of contact; utilization of the employee assistance program [EAP]; coping strategies; workplace support from colleagues; workplace support from supervisor; burnout) will not be predictive of high vicarious resilience among trauma workers at a rape crisis center.

Delimitations

The delimitations for this study were as follows:

1. The sample population was limited to employees and volunteers who provide services to clients at a RCC in North Central Texas.

2. Employees and volunteers must be 18 years of age and over to participate.

Limitations

The limitations for this study were as follows:

1. Nonprobability sampling was used for this exploratory study; thus, the results are not generalizable to all trauma workers at RCCs;
2. Participants were asked to self-report, which may introduce recall bias, response bias, and social desirability.
3. Data collection took place during the COVID-19 pandemic; thus, study outcomes may be impacted due to additional workplace stressors.

Assumptions

The assumptions for this study were as follows:

1. Participants were able to read and understand English at an eighth grade literacy level or higher;
2. Participants answered all the questions on the survey honestly.

Definition of the Terms

Burnout – A psychological syndrome as a result of chronic workplace stressors (e.g., work overload, lack of autonomy, low social support; Bemiller & Williams, 2011).

Rape crisis center (RCC) – Each RCC varies in the type and number of services offered; however, most funding sources require RCCs to have three core services: 1) 24-hour crisis hotline; 2) counseling; and 3) legal and medical advocacy (Shaw & Campbell, 2011).

Sexual assault – Multiple forms of contact sexual violence including sexualized touching, attempted penetration (oral, anal, vaginal, or other) or completed penetration (Mellins et al., 2017).

Trauma worker – A mixed group of mental health workers (e.g., social workers, counselors) and rape crisis or sexual assault advocates (Frey et al., 2017).

Vicarious resilience – The positive influence on and personal growth of therapists resulting from exposure to clients' resilience (Hernández et al., 2007).

Importance of the Study

This study is significant because it elaborates on the trauma-informed organizational culture of RCCs to improve employee and volunteer health and wellness. RCC employees and volunteers benefit from understanding protective factors against burnout to improve their productivity and contribution to this valued field. This study is innovative by including employees and volunteers from multiple teams (rape crisis and victim services, general counseling, and employment solutions), rather than limiting to only advocates or only counselors. A wide array of employees and volunteers provide services to victims of sexual assault and are exposed to the victims' trauma through varying mechanisms. This innovative approach of including all employees and volunteers across multiple teams at the RCC may present new individual or organizational factors not previously explored by researchers.

Further, the results of this study advocate for the role of health educators in organizations committed to improving the health and wellness of their employees and volunteers. This is especially important for trauma workers as organizations often provide

trainings on mitigating burnout yet provide little to no support on promoting vicarious resilience. Health educators carry a significant role in understanding a population and tailoring interventions or programs to suit population needs. Trauma workers have an extensive caseload and may not be able to carry out another volunteer position on a wellness team. Thus, health educators at the RCC may offer needed workplace support to promote workplace wellness.

CHAPTER II

LITERATURE REVIEW

Creating a trauma-informed organizational culture where trauma workers thrive is vital to the sustainability of RCCs. Establishing RCC services as trauma work is important to first understanding the context in which trauma workers operate. Conceptualizing workplace stressors across multiple positions at RCCs generates a comprehensive view of the workplace environment and exposure to trauma. Workplace exposure to trauma is well established in the literature as leading to both negative and positive responses from trauma workers (Dworkin et al., 2016; Quitangon, 2019). Second, understanding the identified demographic influences, which contribute to trauma worker response, is helpful to begin understanding predictive factors for high levels of vicarious resilience. Intrapersonal factors related to identity and workplace setting are repeatedly associated with trauma worker outcomes (Dworkin et al., 2016; Slattery & Goodman, 2009). Furthermore, exploring the impact of workplace support on trauma worker health and wellness is critical to expanding the understanding of interpersonal and organizational factors predictive of vicarious resilience. A historical perspective of RCC organizational structure sheds light on trends in organizational services and operation and emphasizes the current value of workplace support (Figley & Figley, 2017; Martin, 2013; National Sexual Assault Coalition Resource Sharing Project, 2010). A glance of past and present RCC services and operations highlights the potential varying perspectives of workplace support by experienced trauma workers compared to novice trauma workers.

Exploration of intrapersonal, interpersonal, and organizational factors provide a strong framework for understanding negative and positive responses to trauma work.

The negative impacts of trauma work are well established in the literature (Canfield, 2005; Kulkarni et al., 2013), with fewer studies highlighting the latest concept of vicarious resilience related to positive outcomes of trauma work (Frey et al., 2017; Hernandez-Wolfe et al., 2015). A detailed view at the research on burnout and related negative responses to trauma work support the argument of burnout being a historical topic in trauma work literature. On the other hand, the limited number of studies on vicarious resilience among sexual assault trauma workers highlights the need for further study. Nonetheless, the literature on sexual assault trauma work and impact of trauma is well established with exploratory opportunities.

Understanding intrapersonal, interpersonal, and organizational factors predictive of high levels of vicarious resilience are valuable to developing employee wellness programs and advocating for health educator positions at RCCs. The following review provides a comprehensive view of existing literature related to the research questions: (1) What intrapersonal factors are predictive of high vicarious resilience among trauma workers at a rape crisis center? (2) What interpersonal and organizational factors are predictive of high vicarious resilience among trauma workers at a rape crisis center?

Literature Sources and Search Strategy

A comprehensive literature review was conducted by searching through multiple databases including: Academic Search Complete, CINAHL Complete, PsycInfo, PubMed, and SocINDEX. Key terms used in the comprehensive search include: sexual

violence, rape crisis center, sexual assault, sexual abuse, social work, advocate, trauma worker, trauma informed culture, organizational culture, feminism, history, burnout, secondary traumatic stress, compassion fatigue, vicarious trauma, compassion satisfaction, posttraumatic growth, vicarious posttraumatic growth, resilience, and vicarious resilience. PubMed MeSH and PsycInfo Thesaurus were used to locate synonyms and controlled vocabulary used in the literature. Boolean logic terms "AND" and "OR" were used to combine multiple terms either used interchangeably or combined to increase specificity of terms in the search. Citation references from articles located in databases were also used in search engines (e.g., Google Scholar) to locate newer articles or primary resources. Additional literature sources include printed textbooks and related nonprofit organization websites.

Online database searches were limited with use of filters including full text electronic article or book availability, date of publication from 2010–2020, and English language. However, some exceptions were made regarding publication year for seminal pieces in the field or articles with relevant historical documentation. A comprehensive literature search was conducted for each general topic area discussed in the following review.

RCC Services as Trauma Work

Work stressors at RCCs, such as regularly listening to victims' personal accounts of sexual assault or providing crisis interventions, qualify RCC services as trauma work. Several trained professionals carry out RCC comprehensive services across multiple programs. Such services may include program areas such as, rape crisis and victim

services, violence prevention and education, employment solutions, and general counseling (The Women's Center of Tarrant County, n.d.-a). These program areas coincide with three core services common for RCCs: 24-hour crisis hotline, counseling, and legal and medical advocacy (Gornick et al., 1985; National Sexual Assault Coalition Resource Sharing Project, 2010). In addition to the three common core services, some RCCs also offer community education and employment services. Each of these program areas employs RCC trauma workers (e.g., assistant director, case manager, community education specialist, crisis interventionist, intake specialist, paralegal, program assistant, and therapist) who provide direct services to clients. The nature of the services provided to victims varies, with rape crisis and victim services and general counseling team members having more direct contact with victims' personal accounts of sexual assault.

Rape crisis and victim services offer services including crisis hotline, in-person crisis intervention and advocacy, rape exam support, individual and group counseling, case management, and criminal justice accompaniment (The Women's Center of Tarrant County, n.d.-b). Victim advocates who answer hotline calls or are present at the hospital during evidence collection experience high-stress and crisis conditions, which present a high risk for occupational stress or secondary trauma (Dworkin et al., 2016). Advocates are uniquely exposed to repeated and detailed accounts of assault, observations of immediate posttraumatic stress and physical injuries, serve as first responders, and are positioned as short-term crisis interventionists with limited knowledge of survivor outcomes (Frey et al., 2017). Thus, the work of advocates is characterized by chronic exposure to trauma.

Therapists also experience psychological occupational hazards after listening to countless stories of human suffering and experiencing chronic exposure to victims' traumatic memories and responses (Quitangon, 2019). Therapists are exposed to unique aspects of psychological trauma from victim accounts, possibly both past and current. The degree of trauma exposure may heighten during group counseling sessions with more victims sharing their experiences of sexual assault.

Other victim services members, such as paralegals or legal advocates, are also exposed to a degree of trauma. Paralegals and legal advocates support victims during preparation for court proceedings and accompany victims during law enforcement procedures and trials, interviews, and criminal justice processes (The Women's Center of Tarrant County, n.d.-b). RCC victim services members are further exposed to chronic trauma when listening to the details disclosed during legal proceedings and interviews.

While RCC members involved with other teams such as violence prevention and education, employment solutions, and general counseling may experience less direct contact with accounts of sexual assault, they are still exposed to some degree of trauma. Clients are not restricted to whom they disclose information to. Thus, while an RCC member from employment services may assist a client with a job application, the client may disclose personal information related to their experience of sexual assault. All members of an RCC are exposed to chronic trauma with some trauma workers experiencing more immediate or crisis situations.

Nonetheless, all RCC services are considered trauma work with varying levels of severity or impact. RCCs where comprehensive services are offered may create a heavier

workload for trauma workers in addition to the inherent weight of trauma work (Baird & Jenkins, 2003; Kulkarni et al., 2013). RCCs should remain committed to improving a trauma-informed organizational culture to increase the positive impact of trauma work.

Demographic Influences on Response to Trauma Work

Researchers examined the individual- and organizational-level factors influencing the RCC staff response to trauma work among sexual assault and domestic violence staff, sexual assault counselors, and sexual assault nurse examiners (SANE) nurses (Baird & Jenkins, 2003; Choi, 2011; Dworkin et al., 2016; Ghahramanlou & Brodbeck, 2000; Pearlman & MacIan, 1995; Townsend & Campbell, 2009). While the results for each study vary, most studies demonstrate age and employment or volunteer setting as significant correlates with trauma worker health and wellness. Further, trauma workers are encouraged to identify aspects of their identity (e.g., gender, education, religion, and ethnicity), which potentially introduce bias or privilege (Hernández et al., 2010). Such biases or power imbalances have the potential to influence trauma worker response to client interaction. Identifying such demographic characteristics is important to predict which trauma workers are more susceptible to vicarious resilience or burnout and to develop wellness promotion efforts focused on demographic influences on vicarious resilience.

Identity

Age and experience are two factors examined in previous studies where researchers explore the relationship between trauma worker age and burnout. Baird and Jenkins (2003) analyzed age and experience independently with burnout among sexual

assault and domestic violence agency staff (*n* = 101). In this study, researchers measured burnout according to the Maslach Burnout Inventory, which includes a total score and three subscale scores–emotional exhaustion, depersonalization, and personal achievement. Younger trauma workers scored higher in total burnout and the emotional exhaustion subscale. More experienced trauma workers also scored high in the emotional exhaustion subscale; however, differed in a high score of personal achievement (Baird & Jenkins, 2003). Since both younger age and more experience were positively correlated with a similar subscale, assumptions cannot be made equating younger age with less experience. The two factors remain independent of each other, with younger age being highly associated with burnout.

Other studies examined the impact of age on adverse reactions to trauma exposure and researchers consistently reported a significant association between younger age and burnout, psychological distress, or secondary trauma (Dworkin et al., 2016; Ghahramanlou & Brodbeck, 2000; Townsend & Campbell, 2009). In a study with sexual assault trauma counselors (*n* = 89), Ghahramanlou and Brodbeck (2000) propose younger trauma workers over-identify with client experiences or have greater difficulty of disassociating with client trauma. One researcher shared observations of younger trauma workers sharing more details at monthly meetings and being more likely to inquire about client outcomes. Researchers recommend increased supervision time with younger volunteers to develop coping strategies (Ghahramanlou & Brodbeck, 2000). Further, Townsend and Campbell (2009) conducted a study with SANE nurses (*n* = 144) and propose younger SANE nurses have a heightened emotional risk. While there are varying

hypotheses as to why younger age is associated with a negative response to trauma work, younger age is nonetheless supported as an influence on adverse reactions to trauma exposure.

Other dimensions of identity influencing trauma workers' response to client interaction include gender, education, religion, and ethnicity. Hernández et al. (2010) encouraged trauma workers to examine such aspects of their identity as to reflect on privilege and oppression affecting the trauma workers' ability to understand how they can learn from their clients. This form of reciprocity is fundamental to determining negative and positive responses to trauma work. Hernández et al. (2010) described a young male Latino clinician's response to reflecting on his work with a client at a woman's correctional facility during a group workshop. The one-session, 5-hour workshop was held with four to eight therapists and intended to assist clinical supervisors and therapists in understanding both the negative and positive impacts of their trauma work. When asked to consider how the clinician's ethnicity, class, sexual orientation, religion, and gender play a role in shaping their work experience, the clinician shared the contrast of his identity as an upper middle class educated individual compared to his description of the client as low income, uneducated, and African American. The clinician noted his reflection on privilege and great sense of responsibility to assist others and contribute to society to the best of his ability (Hernández et al., 2010). While the clinician's perspective is subjective, this exercise highlights the impact of aspects of identity, which influence changes in self-perception during trauma work. Identifying the multiple

dimensions of identity is critical to fully exploring variables predictive of vicarious resilience.

Workplace Setting

The type of work setting for trauma workers also influences their response to trauma exposure, thus affecting their health and wellness. Slattery and Goodman (2009) evaluated workplace setting in relation to secondary traumatic stress among domestic violence advocates (n = 148). Trauma workers varied in the type of workplace (e.g., shelter, domestic violence service, court/legal service, crisis center, community health center, social service agency, or hospital), and the marked characteristic impacting trauma worker secondary trauma was the organizational structure (hierarchical model vs. shared power). Workplaces with shared power promoted a supportive environment where trauma workers were less likely to experience secondary trauma (Slattery & Goodman, 2009). Nonetheless, workplace settings vary in the intensity of trauma and contribute to stressors, which impact trauma workers' health and wellness.

Other workplace factors affecting trauma workers' response to trauma include type of client care (e.g., direct vs. indirect, crisis, ongoing care). In a study examining vicarious resilience among sexual assault and domestic violence advocates (n = 222), researchers collected work-related characteristics including years of direct experience working with survivors and type of advocacy or primary responsibilities. Frey et al. (2017) discovered a significant correlation between years of direct advocacy experience and compassion satisfaction. Understanding the individual and organizational-level

factors influencing trauma worker response to trauma work helps further identify individuals more likely to respond to their work by growing resilience.

Impact of Workplace Support on Trauma Worker Health and Wellness

A critical review of the history of RCCs including the organizational structure and services provides a rich context for understanding workplace environment for trauma workers. A comparison of the historical organizational structure and current organizational services provide a comprehensive view of organizational culture and workplace support. Workplace support is an important variable in exploring trauma worker health and wellness and supported in the literature as an organizational-level predictor of burnout. Thus, a look into the history of RCC origins, the transition into its current organizational structure, and the impact on workplace environment provides RCC management with a comprehensive view in promoting a trauma-informed organizational culture.

History of Organizational Structure

Early Feminist Influences

RCCs emerged in the United States during the 1970s' anti-rape movement and radical feminism. While first-wave feminism focused on women's legal and labor rights (particularly voting), second-wave feminism further fought for gender equality, with an emphasis on sexuality and ending violence against women (McHugh, 2007). During this second-wave feminist movement, passionate feminists focused on deconstructing a patriarchal society degrading women (Martin, 2013). Feminists viewed rape as a systemic issue caused by institutions devaluing women. Early RCC leaders focused on

deconstructing male power over women and actively participated in protests and public speaking engagements to shift a political agenda. Volunteers who gave their time and resources in grassroots efforts to support victims of sexual assault and advocate for social reform ran early RCCs. The leaders rallied support from fellow feminists and were self-sufficient in running the RCCs exclusive of bureaucratic or hierarchical structure. The anti-rape movement quickly grew the number of RCCs in the US from 400 to 1,000 in a span of 3 years (Gornick et al., 1985). With the expansion of RCCs came transitional changes challenging original organizational grassroots efforts of shared power structure with shared decision-making.

Shift in Organizational Structure

RCC leaders struggled to sustain efforts as volunteers experienced burnout and early RCC leaders aged and were unable to maintain the fast pace of activism (Maier, 2011). As a result, a shift occurred in the 1980s where RCC leaders turned to government and agency funding and collaborated with mainstream organizations (Martin, 2013). With this shift in organizational structure, RCCs made the necessary accommodations to implement hierarchical organizational structures demanded by government funding sources. The organizational structure transformed from shared decision-making structure to a hierarchy, which mostly included a board of directors, executive director, and program coordinators. This shift in personnel and organizational structure transformed RCCs from grassroots organizations to social service agencies (Maier, 2011; Martin, 2013). RCC leaders wrestled with the idea of now trusting bureaucratic funding sources they fought so arduously to separate from. Along with changes in hierarchical structure,

RCCs adapted to changes in political activism, professionalism, reliance on volunteers, collaboration with other systems or agencies, and types of services offered.

Changes in Political Activism

Despite the emphasis on social services, funding agencies restricted the high degree of activism and social change once characterizing RCCs (Maier, 2011). Early RCC leaders were active protestors and prioritized an agenda to create social change. RCC members would protest, boycott, and go through extensive measures to publicly deconstruct mainstream organizations associated with retraumatizing victims (Martin, 2013). However, when RCCs turned to mainstream organizations as funding sources, political activism was restricted. RCCs faced limitations and were required to engage in unobtrusive mobilization as a less controversial or disruptive form of activism (Maier, 2011). While RCCs still engage in social reform, political activism is now manifested in the form of public speaking, education, or community awareness (Maier, 2011). In addition to the transition of political activism, RCCs also experienced changes in professionalism.

Changes in Professionalism

Along with changes in organizational structure and the shift to hierarchy, involved the hiring of professional staff. RCCs were no longer able to fully rely on volunteers and now had the capacity to hire trained personnel with newly available funding. Funding agencies required trained personnel to deliver services and the overall level of expertise or professionalism increased (Macy et al., 2010; Maier, 2011). This shift in hiring contributed to further tension between grassroots and professional services.

Changes in Volunteer Reliance

Corresponding to the changes in hiring professional staff were changes in volunteer reliance. RCCs were no longer able to sustain a new service model on volunteer teams alone (Maier, 2011). The quantity and quality of comprehensive services now provided by RCCs demanded the increase in professionalism and diminished reliance on volunteers. While the dependence on volunteers to sustain services changed, volunteers still carry a critical role in delivering RCC services. The decreased reliance on volunteers does not imply the elimination of volunteers; merely a change in dependability as RCCs were once ran by solely volunteers.

Changes in Collaborative Efforts

RCCs also experienced shifts from independent to embedded centers. Independent centers focus solely on sexual assault, which allows the center to directly allocate all resources to victim services (O'Sullivan & Carlton, 2001). Autonomy and feminism are two key principles in independent centers. Autonomy offers the freedom to design and implement its own agenda, while feminism serves as a guiding force informing this agenda. Funding sources encourage agencies to expand services and incorporate domestic violence victim services or other community education efforts (O'Sullivan & Carlton, 2001). Such diversity in services, as demonstrated in embedded centers, removes focus from direct sexual assault victim services and limits resources for addressing sexual assault victim needs. Other examples of embedded centers involve integrating RCCs into existing social service or mental health agencies or clinical settings.

Changes in Services

With the transition to comprehensive services, whether as independent or embedded centers, RCCs expanded the types of services provided to victims of sexual assault. Early RCCs provided victims with a 24-hour hotline and peer counseling, with volunteer advocacy support at the hospital and court (O'Sullivan & Carlton, 2001). Also coinciding with changes in funding sources and increased professionalism, the type and quality of services were enhanced. RCCs now provide long-term counseling with a licensed professional and other services (e.g., hospital or court victim advocacy, legal assistance) with a trained social worker or professional.

Organizational Services and Operation

RCCs undoubtedly experienced multiple changes in merely five decades since inception. Largely due to funding requirements, most RCCs have three core services: 1) 24-hour crisis hotline; 2) counseling; and 3) legal and medical advocacy (Gornick et al., 1985; National Sexual Assault Coalition Resource Sharing Project, 2010). While these three core services have withstood the adaptation of time and funding streams, the quality and professionalism of services have improved. A 24-hour telephone hotline is considered a core service with detailed hotline requirements (National Sexual Assault Coalition Resource Sharing Project, 2010). Hotline services are managed with detailed regulations including crisis intervention and follow-up care. Counseling or therapy is a core service in many regions; however, some RCCs may consider such services as supplemental with no staff counselors on site (National Sexual Assault Coalition Resource Sharing Project, 2010). Nonetheless, RCCs still refer clients out to counseling

resources and thus value the therapeutic aspect of counseling. Medical and legal advocacy are also important core services provided by RCCs to support victims of sexual assault. Medical advocacy is a critical service to victims who are seen in hospitals immediately following a rape incident or attending a clinical visit for follow-up care. Legal advocacy provides support to survivors as they present to law enforcement or appear in court proceedings. RCCs provide immense support to victims of sexual assault through each of the three core services.

In addition to the three core services, RCCs may also provide general advocacy or case management, community education, and support groups. Each RCC varies in the selection and delivery of services. RCCs operate with a hierarchical form of accountability with a board of directors and agency personnel. They are also client-centered and responsible for providing quality services to survivors of sexual assault (National Sexual Assault Coalition Resource Sharing Project, 2010). Comprehensive or complex services allow survivors to access wrap-around services addressing multiple needs related to sexual assault. The history of organizational structure of RCCs and the transitions from grassroots to professionalized services provide a rich context for understanding the importance of work environment. One of the most critical work environment factors for RCCs is workplace support.

Workplace Support

RCC workplace support is characterized by the social support a trauma worker gains from their supervisor or colleagues. Social support, clinical supervision, and shared decision-making have been described as three of the most important contributors to

trauma worker health and wellness (Slattery & Goodman, 2009). However, as observed in the history of RCC organizational structure, the dynamics of social support have changed over time. Social support may have looked differently for RCCs in earlier years. Nonetheless, researchers explored the impacts of workplace social support related to the negative impacts of trauma work.

Babin et al. (2012) explored the impact of communication skills, perceived social support, and feelings of burnout among advocates (n = 69) at a domestic violence agency. The researchers deconstructed social support into informational support and emotional support. Informational support was described as knowledge base (e.g., information needed to manage a crisis hotline call) and emotional support was described as feelings of concern from others (e.g., a supervisor or colleague offering sympathy). Researchers assumed emotional support would mitigate burnout due to the burnout construct of emotional exhaustion; however, a unique finding of this study is the significance of informational support. Due to the focus of informational support on task-related aspects, researchers conclude informational support may provide advocates with solutions, which in turn mitigate emotional exhaustion leading to burnout. Researchers recommend formalized mentoring programs for less experienced trauma workers to create a place where questions are welcome and trauma workers feel supported (Babin et al., 2012).

In another study, Michalopoulos and Aparicio (2012) explored the role of personal trauma history, social support, and years of social work experience as predictors of vicarious trauma among licensed social workers (n = 160). Consistent with the literature, researchers concluded social support as a predictor of vicarious trauma. High

levels of social support were predictive of less vicarious trauma for social workers who did not report a trauma history. Researchers suggested social workers with perceived social support may have a personal connection to others which protects against vicarious trauma (Michalopoulos & Aparicio, 2012).

Researchers have established the importance and impact of workplace support on organizational culture (Choi, 2011; Figley & Figley, 2017; Handran, 2015). Perceived supervisor or peer support contributes greatly to trauma worker health and wellness by mitigating the negative impacts of trauma work. Trauma workers who contributed to the field since early RCC days may vary in attitudes about the transitional changes of RCCs compared to new trauma workers who may be removed from feminist ideologies or perhaps engaged in newer waves of feminism. Differing opinions about organizational structure from early RCC leaders and trauma workers new to the field may lead to workplace tension. Further, while the more professional hierarchical structure may improve organization and accountability, this structure also creates power imbalances among staff. Thus, RCC management has a unique role in balancing workplace climate with the overall goal of producing a trauma-informed organizational culture.

The demographic influences on trauma worker health and wellness are well supported in the literature, despite some conflicting findings. Age is a non-modifiable individual-level predictor of adverse reactions to trauma exposure. Workplace setting, hours and type of client contact, and workplace support are modifiable organizational-level predictors of distress among trauma workers. Further exploring these demographic characteristics allows RCC management to develop and tailor wellness promotion efforts.

The impact on trauma worker health and wellness is explained in the literature as either positive or negative. While some of the terms may be used interchangeably, researchers explored the marked differences between each positive and negative response to trauma work.

Negative Responses to Trauma Work

Trauma workers experience chronic or repeated exposure to trauma, which has the potential to lead to multiple negative responses, including vicarious trauma, compassion fatigue, secondary traumatic stress, or burnout (Slattery & Goodman, 2009). While these terms are used interchangeably in the literature, some researchers argue the marked characteristics differentiating each negative response to trauma work (Baird & Jenkins, 2003; Craig & Sprang, 2010; Jirek, 2015; Quitangon, 2019). Understanding the differences between vicarious trauma, compassion fatigue, secondary traumatic stress, and burnout are critical to establishing the unique characteristics of burnout among RCC trauma workers. Further, examining the individual- and organizational-level predictors of burnout provides a rich context to understanding the challenges of trauma work.

Vicarious Trauma

McCann and Pearlman (1990) first coined "vicarious traumatization" and expanded the literature on therapists' unique responses to victim trauma. The researchers shifted focus from client psychological aftermath of victimization to therapists' psychological consequences of trauma exposure from victim clients. McCann and Pearlman (1990) acknowledged the discussion of countertransference within victimization literature, as demonstrated in research with Vietnam veterans, incest

survivors, and Holocaust survivors. Countertransference emphasizes personal preexisting characteristics, likely unresolved conflict, as a predictor for therapists' response to trauma work. Additional victimization literature highlights characteristics of the stressor as a predictor for therapists' response to trauma work. However, McCann and Pearlman (1990) took a different approach and explained trauma response in light of the CSDT. This view of trauma acknowledges therapists' trauma response by recognizing both the characteristics of the stressor and therapists' unique cognitive schemas and psychological needs (Cohen & Collens, 2013; McCann & Pearlman, 1990). Thus, vicarious trauma is a complex interaction between stressors and therapists' needs and concepts of self and world. Trauma work often disrupts or alters therapists' cognitive schemas and psychological needs, leading to intrusive thoughts or images, sleep disturbance, anxiety, or distrust with others (Jirek, 2015).

Since the development of vicarious traumatization, researchers focused on examining predictors and associated constructs with vicarious trauma. Halevi and Idisis (2018) examined predictors of vicarious traumatization between individual and group therapists (n = 134) working in public and private clinics. Therapists with a lower degree of differentiation of self were more likely to experience a higher degree of vicarious traumatization. Such therapists had difficulty establishing boundaries to separate the clients' emotional world from their own. This limited ability to separate from clients' emotions increased the risk for possible damage to basic cognitive schemas, thus leading to vicarious traumatization. In addition to having a lower degree of differentiation,

therapists with higher levels of vicarious traumatization were also found to have a higher likelihood of being in therapy (Halevi & Idisis, 2018).

Researchers largely support McCann and Pearlman's (1990) original findings regarding vicarious trauma. Studies on vicarious trauma among different types of trauma workers continues to reveal a disruption in trauma workers' cognitive schemas or worldview with symptoms mirroring posttraumatic stress disorder (PTSD; Houston-Kolnik et al., 2021; Jirek, 2015; Michalopoulos & Aparicio, 2012; Quitangon, 2019). Quitangon (2019) reported a change in *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which now includes repeated exposure to details of a traumatic event as a qualifying stressor for PTSD. Thus, vicarious trauma is an occupational risk and if left untreated, may lead to PTSD. These psychological stressors qualify as occupational hazards, which demand the attention of RCC management. Ongoing exposure to stress, as explained in the weathering hypothesis (Geronimus, 1992), increases the allostatic load and can lead to poor organ function. Vicarious trauma is a critical health risk for trauma workers, which manifests as an internal response to trauma work and if left unaddressed, may result in psychological adverse effects (e.g., feelings of hopelessness, emotional numbness, anger, grief). A shift in cognitive schemas and PTSD related symptoms are two differing characteristics of vicarious trauma from other negative responses to trauma.

Compassion Fatigue or Secondary Traumatic Stress

Compassion fatigue was first coined by Charles Figley in 1995 following his research on secondary victimization (Figley, 2013). This phenomenon was originally

known as secondary traumatic stress, secondary traumatic stress syndrome, or secondary traumatic stress disorder; however, Figley changed the term to compassion fatigue after feedback to use a friendlier or less stigmatizing term. Thus, Figley expanded research on understanding compassion fatigue and noting the differences with McCann and Pearlman's research on vicarious trauma. Figley (2013) noted compassion fatigue as an extension beyond countertransference (as used in vicarious trauma), which requires empathic engagement.

Figley (2002) developed the compassion stress and fatigue model to demonstrate a pathway explaining how compassion fatigue can develop and how to address it. The model demonstrates that once a trauma worker is exposed to a client's experiences, the trauma worker must first experience both empathic ability and empathic concern to then have an empathic response to clients' trauma (Figley, 2002). Thus, the model suggests without empathy, trauma workers will not experience compassion fatigue. The emotional energy from this empathic response transfers to compassion stress, which is a persistent desire to relieve clients' suffering. If compassion stress is left unaddressed, it could progress to life disruptions (e.g., health concerns, social interactions, change in daily activities), which differ from cognitive disruptions (e.g., change in worldview, change in perceptions of self or world; Figley, 2002). Compassion fatigue is similar to vicarious trauma in the potential to progress to PTSD-like symptoms; however, it differs in disruption of cognitive schemas. Compassion fatigue does not involve cognitive disruptions (Quitangon, 2019). The marked characterisitic distinguishing compassion fatigue from vicaroius trauma is the emphasis on empathy as the pivotal variable in

desiring to help others and being sensitive to the cost of caring. While some of the negative responses to trauma have notable differences by definition, compassion fatigue and secondary traumatic stress are established as interchangeable terms. Thus, literature using either of the two terms will be discussed.

Secondary traumatic stress and empowerment were examined in a study with social workers (n = 154) who worked with family violence or sexual assault survivors (Choi, 2017). Secondary traumatic stress, psychological empowerment, and sociodemographic variables were analyzed to explore the influence of psychological empowerment on secondary traumamatic stress. In the findings, social workers who reported higher levels of psychological empowerment measured lower in secondary traumatic stress. Also, social workers who reported a past history of trauma demonstrated significantly higher levels of secondary traumatic stress (Choi, 2017). These findings suggest RCC management have an opportunity to address secondary traumatic stress by improving a work environment conducive to promoting psychological empowerment.

Other system-level influences on secondary trauamtic stress among RCC trauma workers include frequency of supervision and client load. Dworkin et al. (2016) examined individual and setting-level correlates with secondary traumatic stress among RCC staff (n = 164). Increased secondary traumatic stress was associated with system-level factors of less frequent supervision and high client load, and individual-level factors of younger age and increased severity of sexual assault history (Dworkin et al., 2016). Another system-level influence on secondary traumatic stress supported in the literature is shared decision-making (Slattery & Goodman, 2009). RCCs with hierarchical

structures are less likely to promote shared decision-making, while RCCs with traditional grassroots models, include trauma workers in decision-making. This shared power mitigates workplace stressors contributing to secondary traumatic stress. Secondary traumatic stress or compassion fatigue are adverse responses to trauma exposure with unique emphasis on empathy. Researchers have identified multiple avenues for RCC management to potentially intervene and improve organizational trauma-informed culture for trauma workers. The last major negative response to trauma work discussed in the literature is burnout.

Burnout

Burnout is not specific to the trauma worker role; however, trauma work presents unique qualifying occupational hazards, which support why burnout was first characterized in human services. Freudenberg first used the term burnout in 1974 to describe the progressive emotional depletion and loss of motivation he observed among volunteers as a consulting psychiatrist in New York (Schaufeli et al., 2009). In 1976, a social psychological researcher in California, Maslach, interviewed human services workers who described their emotional exhaustion as “burnout”. Maslach noted three common characteristics in the interviews: emotional exhaustion, negative perceptions towards clients, and crises in professional efficacy. Maslach continued to explore burnout and formalized a psychometric tool–Maslach Burnout Inventory (MBI)–to assess burnout as a construct with three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment (Schaufeli et al., 2009). In the late 1980s, the study of burnout expanded to other sectors outside of human services; however, burnout is still

widely explored among trauma workers in sexual assault as they undoubtedly experience a work environment with high demands and low resources (Bemiller & Williams, 2011; Schaufeli et al., 2009). The Conservation of Resources (COR) theoretical framework explains the burnout engendered by this complex interaction of demands and resources in an organizational context.

COR is the leading theory for researchers to explain organizational stress such as burnout (Alarcon, 2011; Ben-Porat & Itzhaky, 2015; Hobfoll et al., 2018; Shoji et al., 2015). This motivational theory created by Hobfoll in 1989 primarily explains human behavior based on the need to acquire resources to survive (Ben-Porat & Itzhaky, 2015; Hobfoll et al., 2018). The fundamental concept of COR is the strive for individuals or groups to "obtain, retain, foster, and protect those things they centrally value" (Hobfoll et al., 2018, p. 106). Thus, a resource gain is necessary to protect against resource loss. According to the COR theory, there are four categories of resources: objects (e.g., office supplies), conditions (e.g., employment, years of work experience), personality characteristics (e.g., self-efficacy, optimism), and energies (e.g., time, knowledge; Ben-Porat & Itzhaky, 2015; Hobfoll et al., 2018). Individuals react to loss of resources (referred to in the theory as demands) with stress, and in the case of extreme or prolonged depletion of resources, individuals develop burnout (Alarcon, 2011). According to the COR theory, trauma workers who chronically experience high demands (e.g., large caseloads, long or nontraditional work hours) and low resources (e.g., low pay, limited organizational resources, and limited direct supervision) are at risk for burnout. For this reason, the COR theory is a commonly used theory to evaluate organizational or

workplace structure. RCC management benefits from identifying the predictive nature of burnout along with other individual and environmental workplace factors, some of which have been identified in the literature.

Individual-level Predictors

Ben-Porat and Itzhaky (2015) conducted a study to explore the contribution of personal and environmental resources to burnout among social workers (n = 214) working with trauma victims. The social workers were provided a questionnaire assessing personal background information, burnout, mastery (feelings of control over environment), self-esteem, sense of role competence, perceived social support, and colleague support. Researchers discovered the factors contributing to burnout among social workers included: age, self-esteem, mastery, and influence (role competence). Thus, personal resources contributed more significantly compared to environmental resources (perceived social support and colleague support). Of the personal resources, Ben-Porat and Itzhaky (2015) deemed influence as the most noteworthy finding. Social workers who had a higher self-efficacy and believed in their ability to influence their work environment reported lower levels of burnout. While this ties into organizational factors of shared decision making, the emphasis is on the individual-level predictor of influence on burnout.

Another study examining burnout among domestic violence and sexual assault advocates (n = 194) was conducted by Bemiller and Williams (2011). Researchers sought to understand how advocates only reported moderate levels of burnout despite high demands and low resources. The concept of "good soldiering" was the most significant

finding in the research. Advocates described this phenomenon as a way of life beyond what other studies may refer to as "the calling". This concept extends further and embodies an adaptive coping mechanism where advocates adapt to the demands of the job and push forward for the sake of the cause (Bemiller & Williams, 2011). Thus, this individual-level predictor of good soldiering is another predictor of burnout and useful for RCC management to be aware of when hiring trauma workers. A holistic approach to examining trauma workers and their workplace environment is to observe individual- and organizational-level predictors. Researchers have also looked at organizational-level factors contributing to trauma worker burnout.

Organizational-level Predictors

Kulkarni et al. (2013) described burnout as a progressive development of chronic stress overload. Researchers conducted a study to explore the neglected role of organizational factors contributing to burnout among domestic violence service providers (n = 236). Researchers used a person-environment fit model to explore the compatibility between service providers and their organizational work environment. A 160-item survey including standardized and additional items developed by the research team, were administered to trauma workers. Perceived unreasonable workload was the strongest risk factor for burnout. Researchers recommend an organizational culture promoting stress management and other self-care strategies to intentionally increase restorative activities over those considered avoidant (e.g., watching television, taking time off work; Kulkarni et al., 2013). This system- or organizational-level recommendation is important for RCC management seeking to promote workplace wellness and mitigate the risk for burnout.

Organizational-level influences are further supported in the literature by Handran (2015) who explored the role of organizational culture in the development of burnout among trauma workers (n = 282). Handran (2015) discussed a trauma-informed system of care, which consists of organizational support, supervisor support, peer support, and trauma-informed caregiver development. In this study, the researcher developed a Trauma-Informed Organizational Culture (TIOC) survey, which was administered with the Professional Quality of Life (ProQOL) instrument. Organizational support and trauma-informed caregiver development were the most significant predictors of burnout (Handran, 2015). Thus, trauma workers with perceptions of low support from their supervisors and peers and those who have not received trauma-specific training have an increased risk for developing burnout. The researcher recommends a systems theory approach where management promotes a trauma-informed organizational culture to maintain trauma-informed client care. Trauma-informed organizations enhance positive wellbeing for everyone involved – survivors of trauma, trauma workers, and the organizational leaders.

The negative responses to trauma work, including vicarious traumatization, compassion fatigue, secondary traumatic stress, and burnout, have been exceptionally saturated and studied in the literature for over four decades. The shift from client trauma to provider trauma was a significant milestone for promoting trauma worker health and wellness. However, the positive responses to trauma work have only been evaluated for nearly two decades. The literature on positive responses to trauma among sexual assault trauma workers is not yet as extensive as the negative responses. Nonetheless, health

promotion among trauma workers is an important public health and management challenge and RCCs must focus on mitigating the negative responses while also promoting the positive responses to trauma work.

Positive Responses to Trauma Work

When trauma workers are equipped to implement healthy coping strategies and surrounded by a supportive work environment, the vast amount of trauma exposure can instead transform into vicarious resilience–a healthy response that focuses on growth and strengths from trauma exposure (Hernandez-Wolfe et al., 2015). Vicarious resilience is associated with other positive responses to trauma including compassion satisfaction and posttraumatic growth or vicarious posttraumatic growth (Ben-Porat, 2015; Choi, 2017; Frey et al., 2017). Similar to the negative responses to trauma, some positive responses to trauma are used interchangeably in the literature; however, there are notable differences between each response.

Compassion Satisfaction

Beth Stamm (2002), a colleague of Charles Figley who coined compassion fatigue, used the term *compassion satisfaction* to describe a new subscale in the expanded Professional Quality of Life (ProQOL) assessment. This new construct was defined as the pleasure resulting from helping or a sense of accomplishment from work (Figley & Figley, 2017; Stamm, 2002). At the turn of a new millennium, researchers shifted from a negative to positive approach in exploring trauma work and a wave of interest grew in the emerging field of positive psychology (Schaufeli et al., 2009). Compassion satisfaction is conceptually rooted in positive psychology as the emphasis is placed on self-efficacy or

the ability to contribute to a satisfying redemptive change (Stamm, 2002; Wachter et al., 2020). Figley's Compassion Fatigue Test included a question asking if individuals felt estranged from others (Stamm, 2002). While there was an option to answer "no", researchers were uncertain how to interpret this response. Researchers concluded the existence of a protective aspect to trauma work and satisfaction despite the cost of caring; however, such positive aspects of trauma work had not yet been studied in detail. Thus emerged the construct and new subscale of compassion satisfaction (Stamm, 2002). Since the addition of the compassion satisfaction subscale, the ProQOL has been used in multiple studies exploring factors contributing to a positive response in trauma work (Craig & Sprang, 2010; Handran, 2015; Kulkarni et al., 2013). While these studies include assessment of the additional two subscales in the ProQOL–burnout and compassion fatigue/secondary trauma–other studies have uniquely examined compassion satisfaction and its variance with other positive responses to trauma.

Frey et al. (2017) explored the positive impact of work experience among sexual assault and domestic violence advocates (n = 222). Researchers examined vicarious resilience, personal trauma experience, peer relational quality, and perceived organizational support. Perceived organizational support was the only individual predictor of compassion satisfaction after controlling for shared variance. Further, when analyzing the variance between the three different positive responses—compassion satisfaction, vicarious posttraumatic growth, and resilience—compassion satisfaction and vicarious posttraumatic growth were determined as unidimensional variables, while vicarious resilience was concluded as a multidimensional all-encompassing variable

(Frey et al., 2017). Thus, compassion satisfaction may be viewed as a construct for vicarious resilience. These findings are supported in the development of the Vicarious Resilience Scale, in which researchers reported posttraumatic growth and compassion satisfaction accounting for 42.8% of vicarious resilience (Killian et al., 2017).

Another study uniquely analyzed factors associated with compassion satisfaction among intimate partner violence (IPV) and sexual assault trauma workers (n = 623) and the mediating role of coping behaviors (Wachter et al., 2020). A cross-sectional survey was administered to measure demographics, compassion satisfaction, coping behaviors, workplace resources, and workforce assets. Wachter et al. (2020) analyzed the findings and reported increased frequency of coping behaviors and high reports of organizational-level coping strategies (e.g., team supervision, team care planning) resulted in higher levels of compassion satisfaction. Thus, individual and organizational coping factors contribute to the development of compassion satisfaction among trauma workers.

Compassion satisfaction coexists with negative responses to trauma (e.g., burnout and compassion fatigue/secondary trauma) and RCC management could implement organizational coping strategies as part of an organizational culture promoting trauma worker health and wellness. While not many studies isolated the compassion satisfaction variable to observe its unique characteristics, the emphasis on job satisfaction and the mere pleasure of helping others distinguishes this variable from other positive responses to trauma. Compassion satisfaction shares characteristics similar to posttraumatic growth, a phenomenon with more constructs compared to compassion satisfaction.

Posttraumatic Growth and Vicarious Posttraumatic Growth

In the emergence of positive psychology, Calhoun and Tedeschi (2006) joined the wave of scholars in psychology, social work, counseling, and other fields who focused on growth after an encounter with trauma. Calhoun and Tedeschi (2006) are quick to note coping with loss or grief or posttraumatic positive responses are not new discoveries, as these concepts are reflected in ancient literature and philosophy. However, the concept of *posttraumatic growth* and its related constructs are the new contributions to social and behavioral science. In 1995, Tedeschi and Calhoun were the first to write a book on posttraumatic growth, explaining the positive changes that occur after an encounter with trauma from a social and behavioral science perspective. A year later Calhoun and Tedeschi (2006) produced the Posttraumatic Growth Inventory (PTGI), which divided growth into three general categories; however, after factor analysis, the PTGI was expanded to a five-factor approach.

The five domains included in the assessment tool are: personal strength, new possibilities, relating to others, appreciation of life, and spiritual change (Calhoun & Tedeschi, 2006). A phrase commonly used by the researchers to describe personal strength is "vulnerable yet stronger" (Calhoun & Tedeschi, 2006, p. 5). Trauma experiences create a new perception of the world and of self, leading individuals to a new view of their personal resiliency. Experiences of trauma also lead to the start of new possibilities or paths in life, which individuals did not consider prior to the trauma. Thus, the first 2 factors measuring posttraumatic growth explain positive changes to cognitive schemas. The third factor of relating to others is characterized by a change of increased

compassion, sense of intimacy, or vulnerability because of the trauma. The fourth factor—an appreciation of life—is also a positively disrupted cognitive schema, where individuals sense a greater appreciation of minor details or items not previously valued. Lastly, some individuals experience a spiritual or religious change as an area of greatest growth. Individuals may find a greater sense of purpose or meaning of life after experiencing trauma (Calhoun & Tedeschi, 2006). Thus, unlike compassion satisfaction, posttraumatic growth involves more change in cognitive schemas where trauma leads to changed perceptions of self and philosophies of life. Such positive responses to trauma require a developmental process where individuals are transformed in their worldview and consequently their behavior.

Some researchers argue posttraumatic growth as the experience of victims of sexual assault, whereas trauma workers experience it vicariously. Vicarious posttraumatic growth is a psychological growth after vicarious exposure to trauma (Arnold et al., 2005; Ben-Porat, 2015; Frey et al., 2017). Arnold et al. (2005) are credited for coining the term *vicarious posttraumatic growth* after an exploratory study where naturalistic interviews were conducted with 21 psychotherapists. Arnold et al. focused on vicarious traumatization (McCann & Pearlman, 1990) and perceived psychological growth (Calhoun & Tedeschi, 2006). All 21 psychotherapists reported both negative and positive outcomes associated with their work with trauma survivors, and an overwhelming 76% spontaneously mentioned the positive consequence in response to the neutral open-ended questions. Arnold et al. (2005) reported all 21 psychotherapists to have shared experiences fitting the three general areas measured in the PTGI.

While Arnold et al. (2005) observed posttraumatic growth following vicarious exposure to trauma, a theoretical model or working definition of vicarious posttraumatic growth was still lacking. Therefore, Cohen and Collens (2013) developed a metasynthesis to examine the process of vicarious posttraumatic growth in the context of vicarious traumatization. Researchers perceived the process of posttraumatic growth within the context of the CSDT, similar to vicarious traumatization. Researchers discovered similarities between posttraumatic growth and vicarious posttraumatic growth; however, the two were distinguished in the marked characteristics of vicarious posttraumatic growth relating more to trauma work and thus, included aspects related to professional development. Further, Cohen and Collens (2013) noted exposure to client posttraumatic growth is first necessary for trauma workers to then experience vicarious posttraumatic growth. The differentiation between posttraumatic growth and vicarious posttraumatic growth is further supported in studies using an adapted version of the PTGI known as the Vicarious Posttraumatic Growth Inventory (VPTGI; Brockhouse et al., 2011; Frey et al., 2017).

Thus, posttraumatic growth and vicarious posttraumatic growth are two similar positive responses to trauma work, with the differing characteristic of vicarious posttraumatic growth relating to the experience of trauma workers after exposure to client growth. Nonetheless, these two variables expand the understanding of positive responses to trauma work. The last commonly used variable in positive responses to trauma work is the newest variable—vicarious resilience.

Vicarious Resilience

Vicarious resilience was coined by Hernández et al. (2007) as a result of qualitative exploration to understand how trauma workers are impacted by client stories. Hernández et al. (2007) described vicarious resilience as a unique and positive response to client trauma and resiliency. It is not the sum of all the positive experiences gathered by trauma workers or is it a broad term to describe everything that inspires a trauma worker. Rather, this variable or phenomenon is multidimensional, producing a shift in cognitive schemas, and placing a unique value on the therapy process. Further, vicarious resilience may occur simultaneously with the trauma victims' experience of growth or resilience (Hernández et al., 2007). Since its conception, researchers further explored this new phenomenon and its relation to other positive responses to trauma work, including compassion satisfaction and posttraumatic growth (Edelkott et al., 2016; Engstrom et al., 2008; Frey et al., 2017; Killian et al., 2017; Silveira & Boyer, 2015).

Engstrom et al. (2008) took a grounded theory approach to further explore the concept of vicarious resilience and establish a theoretical context. Engstrom et al. conducted semi-structured interviews with mental health providers (n = 10) working with survivors of torture. Mental health providers were asked to share their thoughts on how clients coping with adversity affect providers and to share any examples from their work. The main themes emerged from the interviews include: positive responses to client resilience, change in provider's worldview, and valuing the therapy process (Engstrom et al., 2008). This work affirmed the original concept of vicarious resilience and called for further research to expand the meaning of vicarious resilience.

While some concepts endure multiple iterations of research prior to being used in training materials, researchers behind the vicarious resilience concept were proactive in executing a training and supervision exercise to concurrently further explore the concepts related to vicarious resilience (Hernández et al., 2010). This training served as a pivotal application of vicarious resilience in which researchers acknowledged the need to expand exploration of this concept to other types of trauma work outside of therapists working with political violence victims.

Silveira and Boyer (2015) were the first to introduce Hernández et al. (2007) concept of vicarious resilience in the field of interpersonal violence. In this study, Silveira and Boyer (2015) explored the impact of vicarious resilience on the personal and professional lives of counselors (n = 4) working with child and youth victims of interpersonal violence. A qualitative multiple case study design was used to interview counselors on five general questions related to the impact of client trauma and shared thoughts on the concept of vicarious resilience. The emerging themes from the interviews include an increased optimistic worldview and adoption of a strengths-based approach to counseling (Silveira & Boyer, 2015).

Hernandez-Wolfe et al. (2015) continued to explore the constructs within vicarious resilience and conducted another qualitative exploratory study with mental health providers (n = 13) working with torture survivors. Hernandez-Wolfe et al. (2015) conducted semi-structured interviews to explore the coexistence of vicarious resilience and vicarious trauma. Researchers discovered vicarious resilience indeed coexists with vicarious trauma. The vicarious resilience themes emerging from this study include:

change in goals, increased hopefulness, change on spiritual beliefs, increased self-care, increased personal resilience, and increased awareness of relative privilege and oppression. Researchers further advocated for the need to focus explicitly on vicarious resilience during trauma work trainings and supervision as a means to mitigate the impact of burnout (Hernandez-Wolfe et al., 2015).

The multiple qualitative studies on vicarious resilience were culminated in the development of the Vicarious Resilience Scale (VRS). Killian et al. (2017) created the VRS to create a valid measure of vicarious trauma as defined by seven dimensions including:

> 1) changes in life goal and perspectives, 2) client-inspired hope, 3) increased self-awareness and self-care practices, 4) increased capacity for resourcefulness, 5) increased recognition of clients' spirituality as a therapeutic response, 6) consciousness about power and privilege relative to clients' social location, and 7) increased capacity for remaining present while listening to trauma narratives. (p. 24)

In this study, Killian et al. (2017) measured vicarious resilience in correlation with posttraumatic growth, compassion satisfaction, and compassion fatigue. The questionnaire was administered to helping professionals (n = 190) working with survivors of severe trauma. An exploratory factor analysis was performed, and the 48-item scale was subsequently reduced to 27 items corresponding with the initial seven dimensions. Researchers concluded the VRS as having good validity and internal consistency, with all seven subscales also having very good reliability. Further, the VRS had a moderate

correlation with the PTGI and compassion satisfaction. This finding supports previous research describing vicarious resilience as an all-encompassing variable (Frey et al., 2017).

Thus, vicarious resilience is an ideal measure of the positive responses to trauma work due to its correlation with other positive responses to trauma work and multidimensional structure. Though the measurement of vicarious resilience has not yet been widely applied to interpersonal violence, much less sexual assault trauma work, this variable is a good fit for the field. Vicarious resilience captures the multiple aspects of positive growth from witnessing client resiliency while also valuing the process of recovery work.

The existing literature on RCCs and trauma work provide strong support in understanding the demographic influences, impact of workplace support, and type of response (negative or positive) to trauma work; however, such evidence is presented in fractions. There is a gap in the literature to provide a comprehensive understanding of the individual- and organizational-level predictive factors for vicarious resilience among sexual assault trauma workers. Identifying such factors provides RCC management with knowledge on characteristics to observe for when hiring and to develop trauma-informed and evidence-based wellness promotion efforts for employees and volunteers. Trauma worker health and wellness is essential to a productive RCC functioning at maximum capacity to best serve survivors of sexual assault.

CHAPTER III

METHODOLOGY

The study was conducted at a RCC in North Central Texas to explore predictive factors for vicarious resilience among trauma workers. A targeted cross-sectional research approach was used to predict the relationship between: 1) intrapersonal factors and vicarious resilience; and 2) interpersonal and organizational factors and vicarious resilience.

Participants and Sampling

The final sample consisted of 46 employees and volunteers at a women's RCC in North Central Texas. Eligibility criteria included a minimum of 18 years of age and employment or volunteer status and involvement in providing services to clients at the time of study participation. Participants were not excluded based on race or gender. Nonprobability sampling was used in the study. The target sample size was $n = 100$, as there were 58 full-time and part-time employees and 50 eligible volunteers during the initial planning phase. However, due to the COVID-19 pandemic, the number of volunteers at the RCC significantly declined. Further, due to remote service delivery, recruitment strategies were limited to email only. A total of 58 participants chose to participate and 46 completed the survey. Texas Woman's University's (TWU) Institutional Review Board (IRB) granted approval for this study. Participation in the study was voluntary and online informed consent was obtained for all participants who agreed to continue with the online survey.

Instrumentation

A quantitative questionnaire was administered to assess the following variable domains: intrapersonal factors, interpersonal and organizational factors, and vicarious resilience. A copy of the questionnaire used for this study is in Appendix A.

Intrapersonal Factors

Demographics

The demographic section included 16 items that examined the following variables: length of service at the women's center (self-report, in years); total time of service in field of intimate partner violence (self-report, in years); age (self-report, in years); gender (self-report, multiple choice); race/ethnicity (self-report, multiple choice); Hispanic ethnicity (self-report, multiple choice); education (self-report, multiple choice); income (self-report, multiple choice); marital status (self-report, multiple choice); religion (self-report, multiple choice); if practice religion, religious affiliation (self-report, multiple choice); frequency of calling in sick (self-report, multiple choice); frequency of doctor's visits (self-report, multiple choice); changes in health since working/volunteering (self-report, multiple choice); general health (self-report, multiple choice), and trauma worker chronic conditions (self-report, multiple choice).

Interpersonal and Organizational Factors

Work Environment

The section on work environment included nine questions surrounding employee wellness used as descriptive questions to assess the work environment. Questions were based on recommendations from experts in the field and included the following variables:

employment or volunteer role (self-report, multiple choice); if volunteer, number of shifts (self-report, multiple choice); part-time or full-time (self-report, multiple choice); average hours of work per week (self-report, multiple choice); indirect or direct care (self-report, multiple choice); hours of direct client care (self-report, multiple choice); type of contact (self-report, multiple choice); utilization of the EAP (self-report, multiple choice); and coping strategies (self-report, multiple choice).

Workplace Support

Workplace support was assessed using the Copenhagen Psychosocial Questionnaire III (COPSOQ III; Kristensen, Hannerz, et al., 2005). This section consisted of six items, which assessed colleague support, colleague willingness to listen to problems, colleague affirmation, supervisor support, supervisor willingness to listen to problems, and supervisor affirmation. The six items are two subscales of the COPSOQ III and were coded as follows: 100 = *Always*, 75 = *Often*, 50 = *Sometimes*, 25 = *Seldom*, 0 = *Never/hardly ever*, and 9 = *I do not have colleagues/a supervisor*. According to the original instrument, scores should be added together, and the average score used to determine workplace support from colleagues and workplace support from supervisors. The COPSOQ III has good reliability for the social support from supervisor subscale (α = .81) and social support from colleagues subscale (α = .87) and is well validated in the field of psychosocial work environment (Burr et al., 2019; Kristensen, Hannerz, et al., 2005).

Burnout

Burnout was assessed using the Copenhagen Burnout Inventory (Kristensen, Borritz, et al., 2005). This instrument consists of three subscales including personal burnout, work-related burnout, and client-related burnout. Personal burnout examined six items on individual feelings of tiredness, physical exhaustion, emotional exhaustion, thoughts of "I can't take it anymore", feeling worn out, and feeling weak and susceptible to illness. All questions in the personal burnout subscale were measured on a 5-point Likert scale coded as follows: 100 = *Always*, 75 = *Often*, 50 = *Sometimes*, 25 = *Seldom*, 0 = *Never/almost never*. Work-related burnout consisted of seven items regarding feeling worn out at the end of the work-day, exhaustion at the thought of another work-day, working hours feeling tiring, energy for leisure time, emotional exhaustion at work, frustration with work, and feelings of burnout because of work. The first 4 questions related to feeling worn out, exhaustion, work hours and energy were measured on a 5-point Likert scale coded as follows: 100 = *Always*, 75 = *Often*, 50 = *Sometimes*, 25 = *Seldom*, 0 = *Never/almost never*. The next three questions in this subscale regarding emotional exhaustion, frustration, and feeling burnt out were measured on a 5-point Likert scales coded as follows: 100 = *To a very high degree*, 75 = *To a high degree*, 50 = *Somewhat*, 25 = *To a low degree*, 0 = *To a very low degree*. Lastly, the subscale on client-related burnout included six items on difficulty of working with clients, drained energy with clients, frustration with clients, giving more than receiving from clients, tiredness of working with clients, and wonders of how to continue working with clients. The first 4 questions related to working with clients, energy drain, frustration, and giving

were measured on a 5-point Likert scale coded as follows: 100 = *To a very high degree*, 75 = *To a high degree*, 50 = *Somewhat*, 25 = *To a low degree*, 0 = *To a very low degree*. The last two questions in this subscale regarding tiredness and future work were measured on a 5-point Likert scales coded as follows: 100 = *Always*, 75 = *Often*, 50 = *Sometimes*, 25 = *Seldom*, 0 = *Never/almost never*. Subscales were scored independently and a total score on each subscale was measured by the average of the scores on the items within the respective subscale. If less than three questions were answered, the respondent was classified as non-responder. Researchers who developed the instrument used the following cut-off scores: <50 indicate no/low burnout, 50–74 suggests moderate burnout, 75–99 indicates high burnout; and 100 indicate severe burnout (Creedy et al., 2017). The Copenhagen Burnout Inventory is used in multiple studies across the world and translated into 8 languages, with good Cronbach's alphas for internal reliability ranging from .85–.87 and strong predictive validity for a number of variables (e.g., sick days, sleep problems, and intention to quit the workplace; Kristensen, Borritz, et al., 2005).

Vicarious Resilience

The last section on vicarious resilience was assessed using the 27-item Vicarious Resilience Scale (Killian et al., 2017). The statements examined how trauma worker attitudes, experiences, and view on life may have changed since beginning this work. Statements for reflection included but are not limited to: hope for peoples' capacity to heal from trauma, ideas on what is important in life, inspiration from peoples' capacity to persevere, increased connection with people, increased compassion, greater hope and focus on client strengths, more time and energy into relationships, increased mindfulness

and reflection, increased recognition of spirituality as important path to recovery, less reactive experiences when distressed, better presence when hearing trauma narratives, and increased time for meditation, mindfulness, or spiritual practices (Killian et al., 2017). All statements were measured using a 5-point Likert scale coded as follows: 0 = *Did not experience this*, 1 = *Experienced this to a very small degree*, 2 = *Experienced this to a small degree*, 3 = *Experienced this to a moderate degree*, 4 = *Experienced this to a great degree*, and 5 = *Experienced this to a very great degree*. All 27 responses are totaled, with total possible scores ranging from 0 to 135. Higher scores indicate high levels of vicarious resilience, and lower scores indicate lower levels of vicarious resilience. The Vicarious Resilience Scale is used in studies across the nation with a high internal reliability ($\alpha = .92$) and good validity (Killian et al., 2017).

Procedures

A purposive sample was used for this cross-sectional study to evaluate for significant relationships between intrapersonal factors, interpersonal and organizational factors, and vicarious resilience. Assessing such relationships further details the factors that may increase vicarious resilience.

TWU approved an IRB research protocol, and a memorandum of understanding (MOU) was signed by the women's crisis center in North Central Texas. After the study was approved, informed consent was required for any eligible individuals who chose to participate in the study. Participants were invited to take part in the study through recruitment flyers and employee e-mail. All employees and volunteers at the center were emailed a recruitment flyer and questionnaire link, which directed participants to an

informed consent statement. If a participant chose to participate in the study, they indicated their consent by clicking “agree” to continue to the questionnaire. Participants were informed they could stop participation at any time. If a participant chose to decline participation in the study, they indicated by clicking “disagree” to continue to the questionnaire or closed the browser. Participants who agreed to participate and provided consent were asked questions on intrapersonal, interpersonal and organizational factors, and vicarious resilience. Individual responses were not examined for analysis; rather, findings were combined to create aggregate data. All participants who completed the online questionnaire were entered in a drawing for a chance to win one of two $50 gift cards as an incentive for their participation in the study. Data was downloaded into Excel and stored in a secure password-protected drive only the research team had access to.

Treatment of the Data

The research design for this study is a targeted cross-sectional design, which included creating and piloting a survey that was administered to employees and volunteers at a RCC. There were multiple independent variables including intrapersonal (e.g., length of service and religion), and interpersonal and organizational factors (e.g., work environment, workplace support, and burnout) with the dependent variable of vicarious resilience.

Data Management

Data was collected via PsychData, an online survey software tool. Data was exported into an Excel spreadsheet and imported into SPSS software to clean, code, and analyze. Workplace support scores were dummy coded to 2 = *high/medium workplace*

support, and 1 = *low/no workplace support*. Burnout scores were dummy coded to 2 = *high/medium burnout*, and 1 = *low/no burnout*. Vicarious resilience was scored according to the original instrument scoring methods. Vicarious resilience scores from each item were added to create a total score treated as a continuous variable. Higher scores indicated higher levels of vicarious resilience and lower scores indicated lower levels of vicarious resilience.

Data Analysis

The data was analyzed only on secure and password-protected computers using SPSS v25. Data was summarized using frequency tables and graphs. Descriptive statistics (means, medians, modes, standard deviation, range, tables, and graphs) were used to describe the intrapersonal factors including demographics and interpersonal and organizational factors including work environment (as detailed on pp. 48–49).

Multiple linear regressions were used to test Hypothesis 1 as follows: Ho_1. Intrapersonal factors (length of service at the women's center; total time of service in field of intimate partner violence; age; gender; race/ethnicity; Hispanic ethnicity; education; income; marital status; religion; religious affiliation; frequency of calling in sick; frequency of doctor's visits; changes in health since working/volunteering; general health; and chronic conditions) will not be predictive of high vicarious resilience among trauma workers at a RCC. Analysis answers Research Question 1: What intrapersonal factors are predictive of high vicarious resilience among trauma workers at a rape crisis center?

Multiple linear regressions were also run to evaluate the association between the variables listed in Hypothesis 2 as follows: $Ho_{2,}$ o_4. Interpersonal and organizational factors (employment or volunteer role; if volunteer, number of shifts; part-time or full-time; average hours of work per week; hours of direct client care; type of contact; utilization of the EAP; coping strategies; workplace support from colleagues; workplace support from supervisor; burnout) will not be predictive of high vicarious resilience among trauma workers at a RCC. Analysis answers Research Question 2: What interpersonal and organizational factors are predictive of high vicarious resilience among trauma workers at a rape crisis center.

CHAPTER IV

RESULTS

The purpose of this quantitative study was to explore the relationship between 1) intrapersonal factors and vicarious resilience; and 2) interpersonal and organizational factors and vicarious resilience among trauma workers at a RCC in a county in North Central Texas. A targeted cross-sectional research approach was used, a quantitative questionnaire was administered using the Copenhagen Burnout Inventory, subscales from the COPSOQ III, the Vicarious Resilience Scale, and questions based on recommendations from experts in the field. The data was examined using multiple linear regressions to determine whether trauma workers' intrapersonal, interpersonal, or organizational factors were predictive of high vicarious resilience. The results of the data analysis are discussed in this chapter.

Power Analysis Information

An a priori power analysis was conducted using G*Power 3.1.9 to determine the minimum sample size required to find statistical significance using Pearson's correlation analysis. With a desired level of power set at .80, an alpha (α) level at .05, and a moderate effect size of .30 (ρ), it was determined that a minimum of 84 participants would be required to ensure adequate power. However, with a moderate to large effect size (ρ = .40), a sample of 46 participants would be required (Cohen, 1988)

Preliminary Analysis Procedures

Pre-analysis procedures were carried out prior to statistical analysis to ensure all assumptions were met. The raw data set included 58 survey responses. However, after checking for duplicate cases, identifying invalid cases based on survey duration, checking scales for zero variance, checking variables for invalid data, and checking Box and Whisker plots for extreme outliers, 12 cases were removed. The final sample size for data analysis was $n = 46$. Data was further assessed for scale reliability, distribution of categorical variables, and normality of continuous variables. Prior to running multiple linear regressions, all assumptions of normality, independence, linearity, homoscedasticity, and model specification were checked. All independent variables were dummy coded to binary variables.

Descriptive Data

Descriptive statistics (means, medians, modes, standard deviation, range, tables, and graphs) were used to describe the intrapersonal factors (demographics) and interpersonal and organizational factors (work environment). The results of the descriptive statistical analysis for demographic characteristics are displayed below in Table 1 and work environment characteristics are displayed in Table 2. Table 3 includes other interpersonal and organizational descriptive statistics.

Table 1

Intrapersonal Factors: Demographic Characteristics

	Total	
	N	%
Total time at RCC		
3 years or less	27	58.7
More than 3 years	19	41.3
Total time of service in Intimate Partner Violence		
3 years or less	20	44.4
More than 3 years	25	55.6
Age		
Less than 45 years	26	56.5
45 years or older	20	43.5
Gender		
Not Female	0	0.0
Female	46	100.0
Race		
Not White	9	20.5
White	35	79.5
Hispanic		
Not Hispanic	35	76.1
Hispanic	11	23.9
Education		
Bachelor's degree or below	26	56.5
Master's degree or higher	20	43.5
Income		
$50,000 or less	20	43.5
Over $50,000	26	56.5
Marital status		

	Total	
	N	%
Not married	21	45.7
Married	25	54.3
Practice spirituality or religion		
No	14	31.8
Yes	30	68.2
Religion		
Not Christian	21	45.7
Christian	25	54.3
Monthly sick call-ins		
No	40	87.0
Yes	6	13.0
Monthly doctor's visits		
No	37	80.4
Yes	9	19.6
Change in health		
Very low/Low degree	30	65.2
Somewhat/High degree	16	34.8
General health		
Very poor/Poor	12	26.1
Good/Very good	34	73.9
Chronic health conditions		
Not Present	5	10.9
Present	41	89.1

Table 2

Interpersonal and Organizational Factors: Work Environment Characteristics

	Total	
	N	%
Role		
Volunteer	11	23.9
Employee	35	76.1
Monthly volunteer shifts		
3 or less	6	54.5
More than 3	5	45.5
Scheduled		
Part-time	20	43.5
Full-time	26	56.5
Actual hours		
30 hours or less	23	50.0
More than 30 hours	23	50.0
Type of client care		
Indirect	20	43.5
Direct	26	56.5
Direct care hours		
10 hours or less	25	54.3
More than 10 hours	21	45.7
Type of client contact		
Ongoing care	8	24.2
Crisis	25	75.8
EAP use		
No	33	82.5
Yes	7	17.5
Coping strategies present		

	Total	
	N	%
No	1	2.2
Yes	45	97.8

Table 3

Interpersonal and Organizational Factors: Workplace Support and Burnout Descriptive Statistics

			Range	
	Mean	Std. Deviation	Min	Max
Workplace Support				
Colleague support	71.71	19.08	8	100
Supervisor support	74.26	18.70	33	100
Total workplace support	72.87	15.07	42	100
Burnout				
Personal burnout	44.62	19.92	4	83
Work-related burnout	43.43	12.55	11	71
Client-related burnout	18.93	16.96	0	67
Total burnout	36.07	13.70	8	67

Intrapersonal Factors

Demographics

Gender, Age, Time at RCC, and Time in Intimate Partner Violence (IPV)

Field. The final sample consisted of 46 female trauma workers at a RCC in North Central Texas. All 46 participants (100%) identified as female, 56.5% (n = 26) reported to be less than 45 years old, and 43.5% (n = 20) reported to be 45 years or older. More than half of participants (58.7%, n = 27) reported to have three or less years of service at the RCC,

whereas 41.3% (*n* = 19) of participants reported more than three years of service at this location. In contrast, over half of participants (55.6%, *n* = 25) reported more than three years of total time of service in the IPV field and fewer participants (44.4%, *n* = 20) reported to have three years or less total time of service working or volunteering in the IPV field.

Race/Ethnicity, Education, Income, and Marital Status. Nearly four in every five participants (79.5%, *n* = 35) identified as White and 20.5% (*n* = 9) did not identify as White. Further, 23.9% (*n* = 11) of participants identified as Hispanic and 76.1% (*n* = 35) as not Hispanic. Slightly more than half of participants (56.5%, *n* = 26) reported to have a Bachelor's degree or less education, whereas 43.5% (*n* = 20) of participants reported a Master's degree or higher. Fewer participants (43.5%, *n* = 20) reported an individual annual income of $50,000 or less, compared to over half of participants (56.5%, *n* = 26) who reported an individual annual income of over $50,000. Fewer participants (45.7%, *n* = 21) reported to not be married compared to participants who reported to be married (54.3%, *n* = 25).

Practice Spirituality or Religion and Religious Affiliation. Slightly more than two-thirds of participants (68.2%, *n* = 30) reported to practice spirituality or affiliate with a religion or faith, with the remaining near third (31.8%, *n* = 14) not practicing spirituality or affiliating with a religion or faith. Of those who are affiliated with a religion or faith, 54.3% (*n* = 25) identified as Christian, and 45.7% (*n* = 21) identified with another religion or faith.

Call in Sick, Doctor's Visits, Change in Health, General Health, and Chronic Conditions. Very few participants (13.0%, *n* = 6) reported calling in sick at least once in a given month; most participants (87.0%, *n* = 40) reported not calling in sick. Similarly, less than a quarter of participants (19.6%, *n* = 9) reported to visit a doctor's office or clinic for their health in a given month, whereas 80.4% (*n* = 37) reported to not visit a doctor's office or clinic for their health in a given month. Slightly more than one third of participants (34.8%, *n* = 16) noticed somewhat of a change in their health since working or volunteering at the RCC. However, most participants (65.2%, *n* = 30) noticed little change in their health. Nearly nine in every ten participants (89.1%, *n* = 41) reported at least one chronic health condition (e.g., asthma, anxiety, back pain, cancer, chronic obstructive pulmonary disease [COPD], chronic pain, depression, diabetes, headaches, heart disease, high blood cholesterol, high blood pressure, joint disease, neurological or musculoskeletal disease, sleep disturbances, or stomach disturbances). Anxiety (45.7%, *n* = 21), headaches or migraines (45.7%, *n* = 21), and depression (37.0%, *n* = 17) were the most reported chronic conditions. Even so, nearly three-fourths of participants (73.9%, *n* = 34) rated their health as good or very good, with 26.1% (*n* = 12) of participants rating their health as very poor, poor, or fair.

Interpersonal and Organizational Factors

Work Environment

Role, Volunteer Shifts, Schedule, Actual Hours, Type of Client Care, Direct Care Hours, and Type of Client Contact. Slightly more than three-fourths of the final sample size (76.1%, *n* = 35) were employees, and the remaining quarter (23.9%, *n* = 11)

were volunteers. Of participants who reported to be volunteers, 54.5% (n = 6) reported to volunteer three shifts or less and 45.5% (n = 5) reported to volunteer more than three shifts per month. About half of participants (43.5%, n = 20) reported working part-time (20 hours or less per week) and the other half of participants (56.5%, n = 26) reported working full-time (more than 20 hours per week). However, when asked how many actual hours were worked per week, exactly 50% (n = 23) of participants reported to work 30 hours or less and the other half (50%, n = 23) reported to work more than 30 hours per week. Slightly less than half of participants (43.5%, n = 20) reported to mostly engage in indirect care with clients on a regular basis, whereas 56.5% (n = 26) of participants reported to mostly have direct care with clients. Similarly, 54.3% (n = 25) of participants reported to have up to 10 hours of direct care for clients in a given week and 45.7% (n = 21) of participants reported to have more than 10 hours of direct care for clients in a given week. Three in every four participants (75.8%, n = 25) reported to mostly work with clients in a crisis capacity (e.g., hotline, hospital, walk-in) compared to the quarter of participants (24.2%, n = 8) who reported to mostly engage with clients in ongoing care (e.g., follow-up care, repeated contact).

EAP Use and Coping Strategies. Few participants (17.5%, n = 7) reported using the EAP, whereas 82.5% (n = 33) of participants reported not using it. Lastly, an overwhelming majority of participants (97.8%, n = 45) reported to engage in coping strategies to reduce work- or client-related stress. Talking with others (82.6%, n = 38), low to moderate exercise (e.g., walking, social dancing, gardening; 71.7%; n = 33), and reading (69.6%, n = 32) were the most commonly reported coping strategies.

Workplace Support

Workplace support was scored by averaging two subscales–colleague support and supervisor support. Participants averaged a colleague support score ranging from 8 to 100 (M = 71.71, SD = 19.08), with higher scores indicating higher levels of colleague support. Supervisor support scores were higher, with a range of scores from 33 to 100 (M = 74.26, SD = 18.70). Participants averaged a total workplace support score ranging from 42 to 100 (M = 72.87, SD = 15.07), with higher scores indicating higher levels of overall workplace support. Workplace support scores were dummy coded, nearly nine in every 10 participants (91.1%) scored high/medium workplace support and 8.9% reported low/no workplace support.

Burnout

Burnout was scored using three subscales–personal burnout, work-related burnout, and client-related burnout–with higher scores indicating high levels of burnout. Mean scores for the burnout subscales were as follows: Personal burnout (M = 44.62, SD = 19.92), Work-related burnout (M = 43.43, SD = 12.55), and Client-related burnout (M = 18.93, SD = 16.96). Total burnout scores were an average of the three subscales and participants averaged a total burnout score of M = 36.07 (SD = 13.70). Total burnout score was dummy coded and 84.8% of participants scored low/no burnout and 15.2% scored high/medium burnout.

Vicarious Resilience

Vicarious resilience was measured with seven subscales and the sum of all subscales were calculated to develop the total vicarious resilience score. Higher scores

indicated higher levels of vicarious resilience. Mean scores for the Vicarious Resilience Scale subscales are as follows: Increased Capacity for Resourcefulness (*M* = 20.87, *SD* = 7.57), Changes in Life Goals and Perspectives (*M* = 16.52, *SD* = 3.40), Increased Self-Awareness and Self-Care Practices (*M* = 12.41, *SD* = 5.95), Client-inspired Hope (*M* = 9.04, *SD* = 1.32), Increased Recognition of Spirituality as a Client Resource (*M* = 7.80, *SD* = 4.77), Increased Capacity to Remain Present During Trauma Narratives (*M* = 10.46, *SD* = 3.59), and Increased Consciousness around Social Location and Power (*M* = 6.04, *SD* = 3.55). The three subscales with the highest average scores included: Increased Capacity for Resourcefulness, Changes in Life Goals and Perspectives, and Increased Self-Awareness and Self-Care Practices. The seven subscales were totaled to create a total vicarious resilience score (*M* = 83.02, *SD* = 23.64). Table 4 displays the descriptive statistics for the independent variable–vicarious resilience–and its seven subscales.

Table 4

Vicarious Resilience Scale Descriptive Statistics

			Range	
Subscale	Mean	Std. Deviation	Min	Max
Increased Capacity for Resourcefulness	20.87	7.57	0	30
Changes in Life Goals and Perspectives	16.52	3.4	7	21
Increased Self-Awareness and Self-Care Practices	12.41	5.95	0	20
Client-inspired Hope	9.04	1.32	6	12
Increased Recognition of Spirituality as a Client Resource	7.80	4.77	0	15
Increased Capacity to Remain Present During Trauma Narratives	10.46	3.59	0	15

Increased Consciousness around Social Location and Power	6.04	3.55	0	10
Total Vicarious Resilience	83.02	23.64	18	120

Multiple Linear Regressions

Multiple linear regressions were used to determine how intrapersonal factors (demographics) and interpersonal and organizational factors (work environment, workplace support, and burnout) predict high levels of vicarious resilience among trauma workers at a RCC. Two regression analyses were conducted, one for each research question. Normal P-P plots and scatterplots determined the assumptions of linearity, normality, and homoscedasticity. Multicollinearity was tested with variance inflation factors (VIF) and tolerance values. Results of normal P-P plots and scatterplots from the two regression models indicate the assumptions of linearity, normality, and homoscedasticity were met. All assumptions of multicollinearity were also met based on VIF values less than 5 and tolerance values greater than .10. The normal P-P plots and scatterplots for the regression models are displayed in Figures 1 to 4.

Research Question 1: Intrapersonal Factors

Figure 1

RQ1: Assumption Testing Results – Normality (DV: Vicarious resilience)

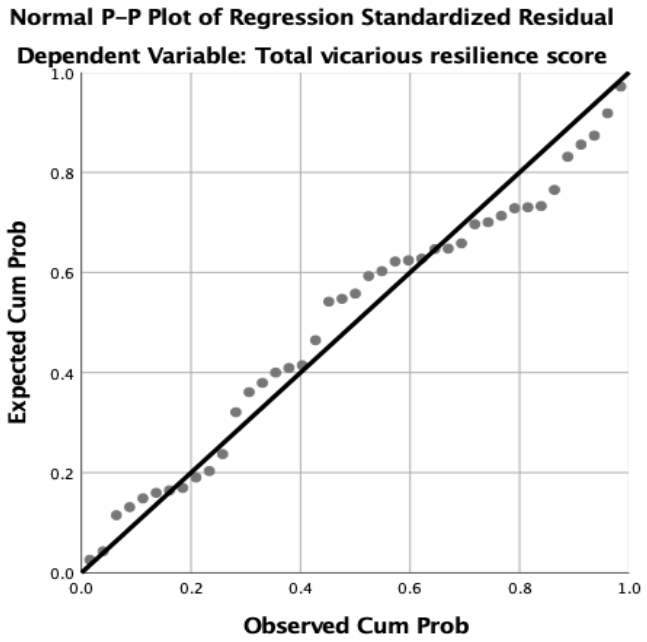
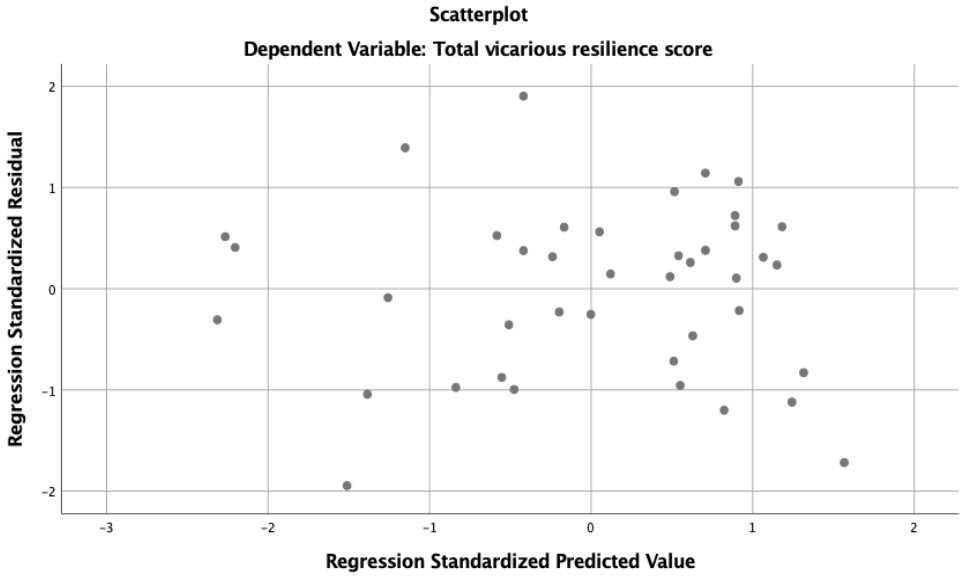


Figure 2

RQ1: Assumption Testing Results – Homoscedasticity (DV: Vicarious resilience)



Results indicated that the overall model for intrapersonal factors as predictors was significant, $F(15, 26) = 2.22$, $p = .04$, and accounted for 31% of the variance in vicarious resilience. Of the predictors, total time of service in the IPV field, age, and chronic conditions were statistically significant (see Table 5). Based on the positive regression coefficients, longer time working or volunteering in IPV (ß = .55, $p = .05$) and the presence of chronic health conditions (ß = .37, $p = .02$) were associated with higher levels of vicarious resilience. Based on the negative regression coefficient, younger age (ß = -.49, $p = .01$) was associated with higher levels of vicarious resilience. A summary of the standard multiple regression analysis results to answer Research Question 1 are listed below in Table 5.

Table 5

Summary of Multiple Regression Analysis for Intrapersonal Factors Predicting Vicarious Resilience Scores

	Unstandardized		Standardized		
Predictor	b	*SE*	ß	*t*	*p*
Total time at RCC	-6.78	12.25	-0.14	-0.55	0.58
Total time in Intimate Partner Violence	25.80	12.25	0.55	2.11	0.05*
Age	-23.20	8.72	-0.49	-2.66	0.01*
Race/Ethnicity	-0.63	8.61	-0.01	-0.07	0.94
Hispanic/Latino	-1.65	9.11	-0.03	-0.18	0.86
Education	9.84	7.10	0.21	1.39	0.18
Income	8.35	7.57	0.18	1.10	0.28
Marital status	-11.58	7.82	-0.25	-1.48	0.15

Practice spirituality or religion	12.17	13.06	0.24	0.93	0.36
Religious affiliation	1.97	11.39	0.04	0.17	0.86
Call in sick	11.51	13.94	0.17	0.83	0.42
Doctor's visits	16.22	8.77	0.28	1.85	0.08
Change in health	-9.58	8.02	-0.20	-1.19	0.24
General health	11.04	9.36	0.21	1.18	0.25
Chronic health conditions	21.90	8.82	0.37	2.48	0.02*

Note. $F(15, 26) = 2.22$, $p = .04$, R^2, = .56, adjusted $R^2 = .31$; *$p < .05$.

Research Question 2: Interpersonal and Organizational Factors

Figure 3

RQ2: Assumption Testing Results – Normality (DV: Vicarious resilience)

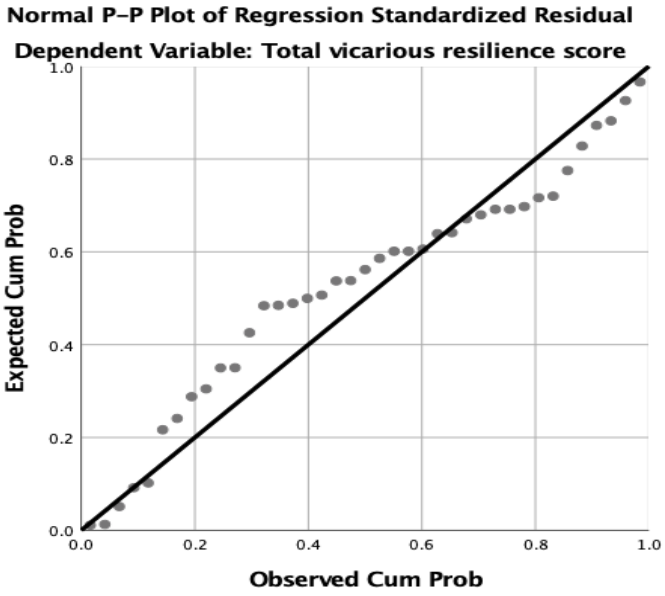
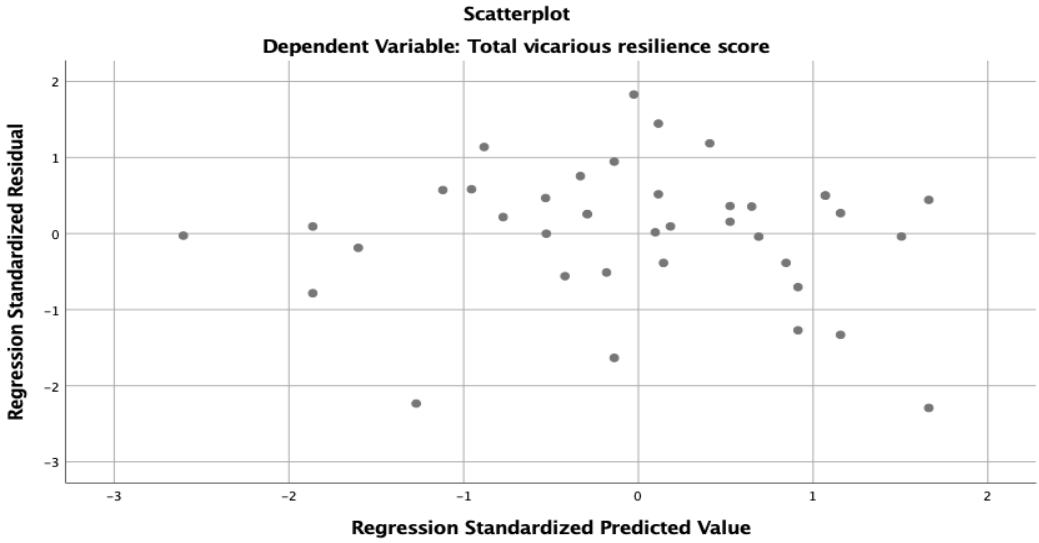


Figure 4

RQ 2: Assumption Testing Results – Homoscedasticity (DV: Vicarious resilience)



A hierarchical regression was conducted to examine how interpersonal and organizational factors (work environment, workplace support, and burnout) predict the likelihood of high levels of vicarious resilience. Step 1 of the hierarchical regression included total time of service in IPV, age, and chronic health conditions as predictors, which were found to be significant in the standard regression analysis for Research Question 1. Consistent with the standard regression analysis, results of the hierarchical regression indicated that Step 1 of the model was significant, $F(3, 35) = 5.71$, $p < .01$, and explained 27.1% of the variance in the likelihood of high levels of vicarious resilience. This indicates 72.9% of the variation of vicarious resilience cannot be explained by demographics alone. In Step 1, total time of service in the IPV field ($\beta = .40$, $p < .01$) and chronic health conditions ($\beta = .36$, $p = .01$) contributed significantly to the model. In Step 2, interpersonal variables (work environment characteristics) were entered as predictors.

Results indicated Step 2 of the model was statistically significant $F(9, 29) = 3.11$, $p = .01$. Total time of service in the IPV field ($\beta = .39$, $p = .04$), chronic health conditions ($\beta = .48$, $p < .01$), and coping strategies ($\beta = .34$, $p = .03$) were significant predictors in the model. Finally, interpersonal and organizational factors (workplace support and burnout) were entered as predictors in Step 3 and results indicated Step 3 of the model was statistically significant, $F(11, 27) = 2.68$, $p = .02$. Chronic health conditions was the only significant predictor in Step 3 the model ($\beta = .49$, $p < .01$). The overall model accounts for 33% of the total variation of vicarious resilience. A summary of the hierarchical multiple regression analysis results answering Research Question 2 are listed below in Table 6.

Table 6

Summary of Multiple Regression Analysis for Interpersonal and Organizational Factors Predicting Vicarious Resilience Scores

	Step 1			Step 2			Step 3		
Variable	*b*	*SE*	β	*b*	*SE*	β	*b*	*SE*	β
Total time in Intimate Partner Violence	18.81	6.57	0.40**	18.14	8.38	0.39*	16.75	8.58	0.36
Age	-12.16	6.59	-0.26	-7.40	7.11	-0.16	-10.11	7.43	-0.21
Chronic health conditions	21.02	8.16	0.36*	28.18	8.97	0.48**	28.84	9.03	0.49**
Role				6.71	11.51	0.12	5.16	12.12	0.09
Average actual hours				2.65	8.70	0.06	4.53	8.89	0.10
Direct or indirect client care				-8.71	9.68	-0.18	-10.96	10.04	-0.23
Hours of direct care				3.90	10.04	0.08	8.29	10.80	0.18
EAP use				-8.04	9.48	-0.13	-8.63	9.53	-0.14
Coping strategies				54.63	24.03	0.34*	32.87	31.20	0.21
Workplace support							7.32	14.28	0.09
Burnout							-13.96	10.69	-0.21
R^2		.27*			.33			.33	
F for change in R^2					1.54			0.89	

Note. *$p < .05$, ** $p < .01$.

Summary

The purpose of this quantitative study was to explore the relationship between 1) intrapersonal factors and vicarious resilience and 2) interpersonal and organizational factors and vicarious resilience among trauma workers at a RCC in a county in North Central Texas. Two multiple linear regressions were conducted, a standard multiple regression to answer Research Question 1 and a hierarchical multiple regression to answer Research Question 2. The results of the multiple regression analyses indicated statistical significance for intrapersonal factors (total time of service in IPV field, age, and chronic health conditions) and interpersonal and organizational factors (coping strategies) associated with high vicarious resilience. The following chapter provides a thorough discussion on these findings considering current literature, implications of findings, limitations to this study, and recommendations for future research and practice.

CHAPTER V

IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

This study explored the predictive factors for vicarious resilience among trauma workers at a RCC in North Central Texas. Understanding such predictive factors supports RCC management in improving a trauma-informed workplace promoting trauma worker wellness. Such findings contribute to a newer focus of workplace wellness on vicarious resilience and the positive impact of trauma work. Rather than focusing on burnout and the negative impacts of trauma work, a shift on adaptive coping and vicarious resilience empowers trauma workers to grow personally and professionally. Understanding factors associated with higher levels of vicarious resilience provide RCC management with resources to improve a trauma-informed workplace and potentially provide hiring managers with key characteristics to observe when interviewing employee or volunteer applicants.

A quantitative cross-sectional survey was administered using the Copenhagen Burnout Inventory, subscales from the COPSOQ III, the Vicarious Resilience Scale, and questions based on recommendations from experts in the field. The primary goal of the study was to explore the predictive nature of intrapersonal, interpersonal, and organizational factors for vicarious resilience among trauma workers at a RCC. The key variables of interest in this study were: 1) intrapersonal factors and vicarious resilience; and 2) interpersonal and organizational factors and vicarious resilience. A total of 58 surveys were collected; however, only 46 were completed and used for analysis.

Intrapersonal factors, including demographic variables, and interpersonal and organizational factors, including work environment variables, workplace support, and burnout, were examined as predictors for vicarious resilience. Multiple linear regressions were run to answer the following research questions: 1) What intrapersonal factors are predictive of high vicarious resilience among trauma workers at a rape crisis center? and 2) What interpersonal and organizational factors are predictive of high vicarious resilience among trauma workers at a rape crisis center? Some of the intrapersonal, interpersonal, and organizational factors were identified as statistically significant predictors of high levels of vicarious resilience among trauma workers and are discussed in the summary of findings. This chapter includes a thorough discussion of findings in the context of current literature, present study implications, limitations, and recommendations for future research and practice.

Summary of Findings

The overall model for intrapersonal factors was significant, thus rejecting the Research Question 1 null hypothesis: Intrapersonal factors will not be predictive of high vicarious resilience among trauma workers at a RCC. Total time of service in the IPV field, age, and chronic health conditions were found to be statistically significant predictors of high levels of vicarious resilience, which is in part consistent with existing literature discussed in Chapter 2. However, several intrapersonal variables were not found to be statistically significant predictors on total vicarious resilience scores. The following intrapersonal factors were nonsignificant: length of service at the women's center; gender; race/ethnicity; Hispanic ethnicity; education; income; marital status;

religion; religious affiliation; frequency of calling in sick; frequency of doctor's visits; changes in health since working/volunteering; and general health. The overall model for interpersonal and organizational factors was significant, thus rejecting the Research Question 2 null hypothesis: Interpersonal and organizational factors will not be predictive of high vicarious resilience among trauma workers at a RCC. Coping strategies was found to be statistically significant predictors of high levels of vicarious resilience. The nonsignificant interpersonal and organizational factors are as follows: employment or volunteer role; if volunteer, number of shifts; part-time or full-time; average hours of work per week; hours of direct client care; type of contact; utilization of the EAP; workplace support from colleagues; workplace support from supervisor; and burnout. The study findings and relevance to existing literature are discussed in this section.

Research Question 1: Intrapersonal Factors

Demographics

Three of the 16 demographic predictors were found to be statistically significant and predictive of vicarious resilience. Total time of service in the IPV field, age, and chronic conditions were found to be significant predictors of high levels of vicarious resilience. Significant and nonsignificant intrapersonal factors in this study are consistent with existing literature.

Total Time of Service in IPV. Total time of service in the IPV field is consistent with studies exploring the influence of years of experience with constructs related to vicarious resilience (Brockhouse et al., 2011; Frey et al., 2017). While the relationship between years of experience and the newer concept of vicarious resilience have not been

directly measured in the literature, there are studies where years of experience and concepts related to or with shared variance in vicarious resilience were explored (Brockhouse et al., 2011; Frey et al., 2017). Frey et al. (2017) discussed the significant positive correlation between years of direct advocacy experience in IPV and compassion satisfaction. Compassion satisfaction accounts for some of the variance in vicarious resilience (Killian et al., 2017); therefore, the Frey et al. (2017) study could imply years of direct advocacy experience as a possible association with vicarious resilience. In another study, Brockhouse et al. (2011) found a positive correlation between higher cumulative levels of vicarious exposure to trauma and vicarious posttraumatic growth. Similar to the positive correlation between compassion satisfaction and vicarious resilience, posttraumatic growth and vicarious resilience are also positively correlated and share similarities in constructs (Killian et al., 2017). Therefore, higher cumulative levels of vicarious exposure to trauma may also have a potential correlation with vicarious resilience. An important finding in the Brockhouse et al. (2011) study supportive of the present study is the finding of recent measures of trauma exposure not predicting vicarious resilience; rather, cumulative exposure predicted such growth. This literature is also consistent with McCann & Pearlman's (1990) emphasis on the cumulative nature of vicarious traumatization as supported by the CSDT. Thus, trauma workers who worked with trauma clients over time had chronic exposure to vicarious trauma and were more likely to have higher levels of vicarious resilience (McCann & Pearlman, 1990). The present study is consistent with these findings as there was a positive prediction of vicarious resilience by total time of service in the IPV field.

Individuals who reported a longer career duration were more likely to have higher levels of vicarious resilience. However, length of service at the women's center, which is potentially a shorter length of time in comparison to the cumulative time of service in IPV, was not found to be a significant predictor of vicarious resilience. The latter is consistent with Brockhouse et al. (2011) who discussed the nonsignificant prediction of acute or recent measures of vicarious exposure to trauma for related dimensions of vicarious resilience.

Further, total time of service in the IPV field is also consistent with literature focusing on the time involved in change of cognitive schemas associated with vicarious resilience (Calhoun & Tedeschi, 2006; Hernández et al., 2007; Munoz et al., 2017). A positive disruption in cognitive schema requires a developmental process in which an individual reframes their worldview and consequently their behavior (Calhoun & Tedeschi, 2006; Munoz et al., 2017). This change in cognitive schema occurs when developing vicarious resilience and requires time (Hernández et al., 2007). Therefore, as time accumulates for an individual who continues to work in the IPV field, they could also undergo the process of changing their worldview or cognitive schema. Thus, the cumulative or long-term aspect found in the total time of service in the IPV field factor in the present study is supported by existing literature on cognitive schemas associated with vicarious resilience. Trauma workers with longer career duration have a higher likelihood of developing a positive shift or disruption in cognitive schema, leading to vicarious resilience.

Age. Deviating from existing literature, age was found to have a negative correlation in the present study; younger age was significantly predictive of high levels of vicarious resilience. Age as a predictive factor is independent of the previously discussed predictive factor regarding years of experience. Baird and Jenkins (2003) established years of experience and age as independent measures when their findings demonstrated younger age and more experience were both positively correlated with a subscale of burnout. Therefore, researchers concluded younger age cannot assume less experience. Baird and Jenkins' (2003) finding of younger age highly associated with burnout and the present study finding of younger age predictive of vicarious resilience, further support the coexistence of burnout and vicarious resilience (Hernández et al., 2007; Killian et al., 2017). The presence of burnout and vicarious resilience among younger trauma workers indicates both the negative and positive impacts of trauma occur simultaneously; the presence of one response to trauma does not indicate the absence of another. Rather, trauma workers experience both negative and positive responses to trauma and there are mediators to help mitigate the impact of burnout to promote vicarious resilience (Engstrom et al., 2008; Hernández et al., 2007; Killian et al., 2017).

Brockhouse et al. (2011) conducted intercorrelations with demographics and variables related to vicarious resilience, in which older age was associated with similar constructs to vicarious resilience. Other researchers propose ideas suggesting younger aged trauma workers overly identify with client experiences, have greater difficulty disassociating with client trauma, or have a heightened emotional risk (Ghahramanlou & Brodbeck, 2000; Townsend & Campbell, 2009). Thus, the present study offers a varying

perspective on younger aged trauma workers and the prediction of higher levels of vicarious resilience. Younger trauma workers may experience symptoms related to burnout as established in the literature; however, the present study suggests they also have intrapersonal factors contributing to higher levels of vicarious resilience.

Chronic Health Conditions. The presence of chronic health conditions was also found to be predictive of high levels of vicarious resilience. This is a novel variable not explicitly used in previous studies on vicarious resilience; however, existing literature on the association of personal trauma and vicarious resilience may relate to this finding in the present study. Examining the relevance of having and managing a chronic health condition with personal trauma could be a worthwhile exploration, adding to the present study finding of chronic health conditions as a predictive factor for vicarious resilience.

The existing literature has inconsistent findings on the influence of personal trauma history on vicarious resilience. Some researchers suggest personal trauma as a predictor of vicarious resilience (Linley & Joseph, 2007); whereas others conclude nonsignificant correlations or predictions of trauma history with vicarious resilience (Frey et al., 2017; Killian et al., 2017). Further, the type of personal trauma remains inconsistently defined. In relation to sexual assault trauma workers, personal trauma history may assume personal sexual assault trauma history. However, previous studies (Killian et al., 2017; Linley & Joseph, 2007) explored other types of trauma workers (e.g., therapists working with torture survivors, general counseling therapists) where the type of personal trauma history was unspecified. Thus, the type of trauma could have derived from any personal adverse experience, not limited to experiencing a chronic

health condition. The present study listed examples of a chronic health condition including: asthma, anxiety, back pain, cancer, COPD, chronic pain, depression, diabetes, headaches, heart disease, high blood cholesterol, high blood pressure, joint disease, neurological or musculoskeletal disease, sleep disturbances, or stomach disturbances. While the existing literature may not explicitly support the finding of a positive prediction of chronic health conditions with vicarious resilience, there is not sufficient evidence to exclude the presence of a chronic health condition as a qualifier of personal trauma.

Nonsignificant Predictors. Lastly, some of the nonsignificant predictors are also consistent with findings in the literature. Frey et al. (2017) reported all continuous demographic variables to be nonsignificant during bivariate correlation analyses. Such demographic variables included income and education. These two demographic variables were also found to be nonsignificant in the present study; thus, corresponding with the nonsignificant predictors explored by Frey et al. (2017).

Research Question 2: Interpersonal and Organizational Factors

Work Environment

Only one of the 11 interpersonal and organizational factors — coping strategies — was found to be significantly predictive of high levels of vicarious resilience in the present study. The core concept of vicarious resilience is understanding how trauma workers are positively impacted by clients' coping with adversity (Hernández et al., 2007; Hernández et al. 2010). Thus, coping strategies are a key characteristic to vicarious resilience. Researchers who established and expanded the understanding of vicarious

resilience essentially explored how trauma workers cope with trauma work. Coping strategies are the epitome of the Vicarious Resilience Scale dimensions. The seven dimensions summarize the mechanisms by which trauma workers respond to trauma work–changes in life goals and perspectives, client-inspired hope, increased self-awareness and self-care practices, increased capacity for resourcefulness, increased recognition of clients' spirituality as a therapeutic resource, consciousness about power and privilege relative to clients' social location, and increased capacity for remaining present while listening to trauma narratives (Killian et al., 2017). Many of these dimensions parallel or directly represent coping strategies. While the present study is novel in the quantitative identification of coping strategies implemented by trauma workers to predict vicarious resilience, the researchers who coined vicarious resilience explored an array of coping strategies summarized in the Vicarious Resilience Scale dimensions (Killian et al., 2017). Thus, the conceptual framework of vicarious resilience and the seven dimensions in the Vicarious Resilience Scale supports the present study finding of coping strategies as predictive of high levels of vicarious resilience.

The transactional model of stress and coping supports the prediction of coping strategies for high levels of vicarious resilience (Wethington et al., 2015). This theoretical model presents coping strategies as mediators for reducing environmental stressors. When an individual experiences an environmental stressor, they use a coping strategy to adapt and mitigate the stress, leading to a positive behavioral outcome (Bemiller & Williams, 2011; McCann & Pearlman, 1990); Wethington et al., 2015). The same adaptive behavior is found in vicarious resilience which is considered an adaptive coping

outcome stemming from mitigating the impact of trauma work stressors (Hernández et al., 2007). Thus, the transactional model of stress and coping supports the finding of the present study for coping strategies as a predictive factor leading to the positive behavioral outcome of vicarious resilience.

Nonsignificant Predictors

Most of the work environment characteristics (role, volunteer shifts, schedule, actual hours, type of client care, direct care hours, type of client contact, and EAP use) and workplace support and burnout were not found to be statistically significant predictors of vicarious resilience in the present study. While the existing literature supports the association of these variables with vicarious resilience (Frey et al., 2017), there are a limited number of studies exploring the predictive influence of interpersonal and organizational impacts on the newly developed measure of vicarious resilience. The nonsignificant findings of the present study may also be explained by study limitations discussed later in this chapter.

Summary

Exploring the predictive factors of vicarious resilience among trauma workers at a RCC is critical to highlighting the newer focus on the positive impact of trauma work and trauma worker personal and professional growth. The findings from this study answer the two research questions on the relationship between 1) intrapersonal factors and vicarious resilience, and 2) interpersonal and organizational factors and vicarious resilience. Findings in the present study demonstrate total time serving in the IPV field, age, chronic conditions, and coping strategies as statistically significant predictive factors of high

levels of vicarious resilience. These intrapersonal, interpersonal, and organizational factors are useful for RCC management to improve trauma worker wellness and an overall trauma-informed organizational culture. Findings from this study may be used to expand trauma-informed training curricula beyond self-care strategies. Vicarious resilience is a multidimensional approach to adapting to trauma work and transforms trauma workers' perspectives on a valued field.

Implications

Theoretical Implications

The theoretical implications discussed in this section emphasize the value of this study and the contributions to research and practice. The findings in the present study demonstrate the association of intrapersonal, interpersonal, organizational factors on high levels of vicarious resilience. Such findings advance researchers and practitioners' understandings of the theories and models used to develop this research study, including, LOC, SCT, CSDT, and transactional model of stress and coping.

As previously discussed in the theoretical foundation section (see p. 5), LOC is a fundamental concept related to resilience. Resilience theory presents ILOC as the perceived ability to choose behaviors to control outcomes (Munoz et al., 2017). The present study expands knowledge on trauma worker ILOC as related to the development of vicarious resilience. The finding of chronic health conditions as predictive of vicarious resilience in the present study potentially implies an adaptive coping mechanism involved in chronic health disease management. Trauma workers who experience chronic health conditions may choose to adapt to a lifestyle of chronic health disease management and

have a perceived ability to control outcomes of a healthier lifestyle. Thus, trauma workers with ILOC may adapt to their chronic health condition and approach their chronic health disease management or other areas of their life (e.g., trauma work) with empowerment and self-determination. Thus, the present study presents a unique perspective on ILOC among trauma workers and contributes to the existing knowledge and application of resilience theories and ILOC.

The finding of chronic health conditions predicting high levels of vicarious could also contribute to further understanding the role of self-efficacy in Bandura's SCT. Self-efficacy is the perceived ability to control behavior and is developed through many different avenues, including vicarious experience (Kelder et al., 2015). Observing client self-efficacy may affect trauma worker self-efficacy both personally and professionally. A trauma worker could witness a client overcome personal adversity, which in turn may motivate the trauma worker to take control of their behavior. Such behaviors may range from personal chronic health disease management to professional workstation organization. Thus, the present study finding of chronic health conditions as predictive of vicarious resilience could further expand the knowledge on vicarious experience and the development of self-efficacy. This also leaves room for further exploration of the relationship between self-efficacy and vicarious resilience and how trauma worker self-efficacy may be applied to trauma worker response to trauma work.

The present study findings also expand knowledge of the CSDT in relation to chronic exposure to trauma and resilience developed with a longer career duration. McCann and Pearlman (1990) created the CSDT as an explanation of the development of

cognitive schemas or set of beliefs to make sense of the world. They further expanded this concept to explain vicarious traumatization as a cumulative process developing over time (McCann & Pearlman, 1990). Trauma workers who work for a longer period in the IPV field experience chronic exposure to trauma, leading to vicarious traumatization. Thus, the present study finding of longer time serving in the IPV field predicting higher levels of vicarious resilience could expand the understanding of CSDT to explain the cumulative process in developing vicarious resilience.

Lastly, the present study finding of coping strategies predictive of vicarious resilience advances the understanding of the transactional model of stress and coping. In the transactional model of stress and coping, coping efforts are used to mediate the impact of environmental stressors and lead to adaptation, such as reduced stress or practicing self-care (Wethington et al., 2015). The finding of coping strategies predicting vicarious resilience could further explain the mediating process of coping efforts leading to adaptive outcomes such as vicarious resilience. Future research could deconstruct coping strategies used by sexual assault trauma workers to further understand the impact on vicarious resilience as an adaptive coping outcome.

Implications for Future Research and Practice

The findings from this study also present new considerations for future research and practice. The finding of age as predictive of high levels of vicarious resilience demands the need for exploring and understanding this relationship. Younger trauma workers may have a higher likelihood of experiencing vicarious resilience and implementing coping strategies or adaptive behaviors due to more recent trends and

awareness of mental health and self-care (Mental Health America, 2021). While vicarious resilience extends beyond self-care strategies and focuses on personal and professional development and growth from the therapy process, it is nonetheless rooted in positive psychology and adaptive behaviors, which are more openly discussed in recent years (Mental Health America, 2021). Thus, younger trauma workers potentially grew up in an age of positive psychology conversations and as a result, have a higher likelihood of implementing such strategies. Such awareness of mental health coping has great impact on future trauma-informed practices for RCCs. If mental health coping and resilience strategies become normalized, the IPV field will have a workforce better prepared to implement healthy coping strategies and adapt to their trauma exposure by identifying their clients' resilience and growing from it. Future research may consider the base knowledge or previous trainings trauma workers have on resiliency or other adaptive coping strategies (Hernández et al., 2010). Such studies would capture a trend in the awareness of vicarious resilience and if repeated among the same group of trauma workers, could provide a record for observing the gradual change in developing vicarious resilience.

Further, the significant finding of career longevity and commitment to service in the IPV field demonstrates the need to promote trauma worker wellness. RCC management has a valuable opportunity to learn the reasons why trauma workers stay in the field for long periods of time despite the chronic exposure to trauma. Based on the present study finding of longer career duration as predictive of vicarious resilience, RCC

management should value their trauma workers and see the benefit or long-term investment of promoting longevity.

The need to value trauma workers is further supported by the descriptive findings on workplace support and burnout in the present study. Frequency counts and percentages of workplace support subscales show higher supervisor support compared to colleague support. Further, more trauma workers reported higher levels of personal burnout, followed by work-related burnout. The average scores on client-related burnout were significantly lower compared to personal and work-related burnout. This suggests trauma workers may experience more personal challenges and need improved colleague support. While the findings are merely descriptive data, they nonetheless present an opportunity for evaluating the focus of trauma-informed training curricula and workplace wellness programs. The descriptive data on burnout and workplace support potentially imply the need to focus on building up trauma workers as resilient individuals both personally and professionally (Gallegos & Gonzalez-Pons, 2020).

Vicarious resilience is a newer concept to trauma-informed organizational culture and professional training curricula for sexual assault trauma workers. Hernández et al. (2010) emphasize the need for increased trainings to improve the understanding of vicarious resilience and the processes involved. Findings from the present study imply the presence of resilient trauma workers at the women's center in North Central Texas. Professional trainings may also be a time for RCC management to highlight the resilient workforce in their organization. The resilience built by personal trauma histories, including chronic disease management, may shed light on the adaptive coping strategies

trauma workers are already implementing and are perhaps unaware how to duplicate in their work or volunteer environment. The mere discussion of vicarious resilience may support trauma workers in identifying behaviors or practices leading to their development of vicarious resilience.

Lastly, only 33% of the total variation of vicarious resilience was explained by four variables in the present study; thus 67% of the total variation of vicarious resilience among sexual assault trauma workers remains unexplained. These findings suggest the need to further explore the intrapersonal, interpersonal, and organizational factors predictive of high levels of vicarious resilience among sexual assault trauma workers. Vicarious resilience is a newer concept to the field of sexual assault research and practice and the present study implies there is much more to be assessed to fully understand how to promote vicarious resilience among sexual assault trauma workers (Gallegos & Gonzalez-Pons, 2020). Even so, some of the unexplained variation of vicarious resilience in the present study may be accounted for in the study limitations.

Study Limitations

This study has several limitations. First, nonprobability sampling was used for this exploratory study and the survey was collected from trauma workers at a RCC; thus, the results are not generalizable to all trauma workers at RCCs. This study focused on one RCC in a county in North Central Texas that has the potential to introduce limitations to the generalizability of results to RCCs in other geographic areas. Sample size is also a potential limitation to the generalizability of findings. This study met the requirements for a moderate to large effect size ($\rho = .40$) with a desired level of power set at .80, an

alpha (α) level at .05; however, increasing the sample size would improve the generalizability of results. Further, participants were asked to self-report, which may have introduced recall bias, response bias, and social desirability.

The innovative approach of including all employees and volunteers across multiple teams at the RCC also presents a limitation in the application of findings. In the case that RCC management wanted to focus on applying results to a specific team (e.g., only counselors/therapists, only advocates, only case managers); the results are not conclusive to apply to one specific team at a RCC.

Another limitation to this study is the way variables were coded for analysis. The use of binary variables was helpful for interpreting multiple regression results for an exploratory study; however, this method reduces the variability of responses.

Further, data collection took place during the COVID-19 pandemic, which led to several limitations. Beginning with the target sample size, the number of employees and volunteers at the RCC changed. Volunteer opportunities were significantly reduced; therefore, the number of volunteers was drastically reduced during data collection efforts. The RCC was closed for in-person services and employees worked from home. Remote service delivery limited recruitment to email only, whereas previous recruitment efforts were intended for email and in-person flyers. This limited the opportunity for employees to see flyers as a reminder of the research study opportunity. Remote service delivery also brought additional stress to employees and volunteers with limited time availability to take the study survey. RCC management shared the complexities of navigating remote service delivery and the time constraints to accomplish work. Lastly, the stressors of

remote service delivery on top of personal crises during the COVID-19 pandemic potentially introduced bias into participant responses.

Recommendations for Research

This study establishes significant groundwork for future research focused on vicarious resilience among sexual assault trauma workers. Future research should expand the geographic regions where surveys are administered. Expanding the target sample size would provide a larger sample size and comparison groups to observe similarities and differences in RCCs across different statewide or national regions.

Future research should consider improving the variability of predictive factors, rather than using binary variables. Binary variables were suitable for this exploratory study; however, future research should expand on this groundwork by improving the variability of each independent variable. Participants in this study represented an all-Female and predominantly White sample of trauma workers. Future research should consider a more racially/ethnically diverse population.

Identity is an important area of study to consider when understanding vicarious resilience (Dworkin et al., 2016; Hernandez-Wolfe, 2018; Slattery & Goodman, 2009). Future research should consider factors associated with bilingualism/biculturalism. Bilingual/bicultural trauma workers may have unique experiences that could hinder or contribute to vicarious resilience development. These experiences include but are not limited to an even greater workload depending on geographic demand for dual language, cultural biases, limited supervision support acknowledging impacts of bilingual role, or perspectives from working with clients experiencing sociocultural inequalities.

Future research should include the impact of a variety of personal trauma histories on vicarious resilience. Past studies vary in the definition and measure of personal trauma history (Frey et al., 2017; Killian et al., 2017; Linley & Joseph, 2007); however, none of the studies explicitly looked at chronic health conditions as a personal history. Considering chronic health conditions was a consistent statistically significant predictor for vicarious resilience across multiple regression models, future research should consider the role of chronic health conditions as a personal trauma or at least as an independent variable with significant implications. The exploration of chronic health conditions would also open new opportunities to better understand the health impacts of trauma work on sexual assault trauma workers. This is a unique area of study lacking much attention in the literature.

Recommendations for Practice

This study also provides valuable information to inform recommendations for IPV trauma worker practice and RCC management of workplace wellness. The first and perhaps most pressing recommendation considering the current COVID-19 pandemic is providing quality trauma-informed care for clients and trauma workers (Gallegos & Gonzalez-Pons, 2020). Developing and maintaining a trauma-informed work culture is a challenge for RCC management as best practices for workplace wellness in the context of traumatic global adversities are limited. RCC management should develop and implement innovative strategies for trauma worker resilience-building without increasing burnout. Trauma-informed care professional trainings should inform trauma workers on the factors influencing their health and wellness. Vicarious resilience should be presented

as more than self-care strategies or the sum of positive experiences (Hernandez-Wolfe, 2018). Vicarious resilience training is an opportunity to reflect on trauma work, consider client growth, and engage in effective self-care. Trauma workers are encouraged to consider the activities, habits, and practices likely contributing to high levels of vicarious resilience (Killian et al., 2016). A healthy trauma-informed organizational culture involves trauma workers expressing their needs for professional growth and RCC management acknowledging and responding to these needs. While every need may not be addressed, RCC management should do their best to invest in trauma worker wellness as to reduce turnover rates, improve productivity, and ultimately longevity. As demonstrated in the present study, long-term service in the IPV field is associated with higher levels of vicarious resilience.

RCC management should consider predictive factors for vicarious resilience when interviewing employee and volunteer applicants. Based on the present study, the recommended key characteristics are longer time working in the IPV field and practice of coping strategies. While younger age and presence of a chronic health condition are also predictive of high vicarious resilience, hiring managers must abide by non-discriminatory practices. The workplace benefits of hiring trauma workers with the likelihood of developing higher levels of vicarious resilience involve combating poor productivity, absenteeism, and turnover intention often associated with burnout (Alarcon, 2011; Bemiller & Williams, 2011). Since vicarious resilience is a counterbalance to burnout, there is a potential reduction in observing negative workplace practices among trauma workers demonstrating predictors of high levels of vicarious resilience.

The results of this study advocate for the role of health educators at RCCs. To promote a trauma-informed organizational culture, RCC management may ask employees or volunteers to form a self-care or wellness team. Without dispute, trauma workers often experience high number caseloads or other factors that contribute to working beyond their scheduled hours (Gallegos & Gonzalez-Pons, 2020). Adding one more job task may be the tipping point to work-related burnout. Instead, RCC management should focus on hiring a trained health educator to offer workplace support and promote workplace wellness. Health educators carry a unique skill set to understand a population and tailor interventions or programs to suit population needs (National Commission for Health Education Credentialing, 2020). Health education professionals are advocated for in clinical settings due to the opportunity to save clinician time and influence health outcomes related to social determinants of health (Sturges et al., 2018). RCCs may also benefit from hiring a health educator to protect trauma worker time and take into consideration the sociodemographic factors affecting trauma worker wellness. This is further supported by the present study with the finding of high levels of personal burnout compared to lower levels of work- or client-related burnout. Vicarious resilience requires a socioecological approach due to the intrapersonal, interpersonal, and organizational factors contributing to its development. Further, trauma workers are encouraged to reflect on the influence of external privileges or biases on the trauma workers' ability to learn from their clients (Hernández et al., 2010). Thus, health educators who develop curriculum and trainings from a socioecological perspective are a remarkable solution to promoting trauma worker health and wellness.

Other recommendations for RCC management include consideration of innovative ways to promote vicarious resilience through telehealth-platforms or remote service delivery (Gallegos & Gonzalez-Pons, 2020). Due to the COVID-19 impacts on service delivery, such innovation could also be used for trauma worker trainings and supervision sessions. The innovative strategies to engage with clients during socially distant restrictions should also be applied to trauma worker support to ensure all barriers to trauma worker wellness are addressed.

In addition to RCC management providing a trauma-informed environment, trauma workers are also responsible for their health management and workplace wellness. Effective trauma-informed care trainings highlighting vicarious resilience should support trauma workers in understanding protective factors against burnout to improve their productivity and contribution to this valued field. Part of the responsibility is on trauma workers to implement teachings from trauma-informed trainings. RCC management may provide the most opportune trauma-informed environment; however, trauma workers should make the most of these opportunities and implement the strategies they learn in trainings.

Lastly, outside of RCCs, higher education institutions and other entities educating students who plan to enter trauma-focused fields (e.g., IPV, first responder, counseling), should consider integrating vicarious resilience awareness into their curricula (Gallegos & Gonzalez-Pons, 2020). As the concept of vicarious resilience continues to gain traction in practice, educators should better equip their students with effective professional training including vicarious resilience concepts before students enter the field. Educating

incoming helping professionals prior to their entry in the field would provide a first level of protection against burnout and instead promote healthier adaptive coping strategies as found in vicarious resilience.

Vicarious resilience is a promising multidimensional approach to adapting to trauma work. The current literature on sexual assault trauma work provides vast knowledge on the negative impacts of burnout. However, recent trends towards vicarious resilience as a positive adaptation to trauma work empowers trauma workers to grow from their chronic exposure to trauma. RCC management has a great opportunity to capitalize on building a resilient workforce to better serve clients in a trauma-informed organization. The findings from this study are consistent with existing literature and fill a gap in the literature for understanding the predictors of vicarious resilience among sexual assault trauma workers. The present study also establishes the foundation for future research to further expand the understanding of how to better equip RCCs to promote vicarious resilience among their trauma workers.

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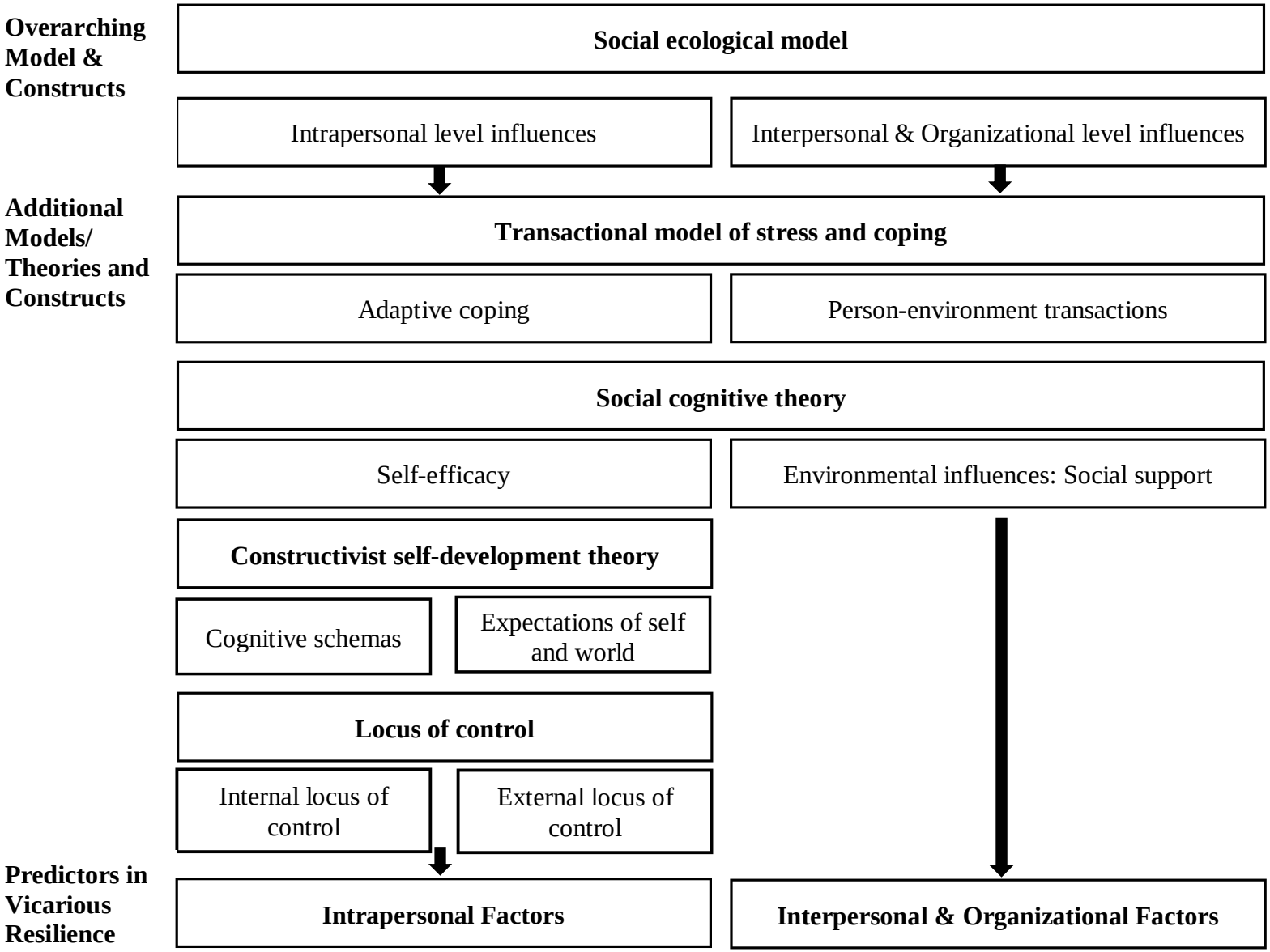
APPENDIX A

Theoretical Framework for Vicarious Resilience Study


Overarching Model & Constructs
Social ecological model
Intrapersonal level influences
Interpersonal & Organizational level influences
Additional Models/ Theories and Constructs
Transactional model of stress and coping
Adaptive coping
Person-environment transactions
Social cognitive theory
Self-efficacy
Environmental influences: Social support
Constructivist self-development theory
Cognitive schemas
Expectations of self and world
Locus of control
Internal locus of control
External locus of control
Predictors in Vicarious Resilience Study
Intrapersonal Factors
Interpersonal & Organizational Factors

APPENDIX B

Vicarious Resilience Study Survey

Vicarious Resilience Survey

Thank you for your willingness to participate in this survey. We recognize there are hard aspects of your job that lead to increased stress and burnout. We also believe in your ability to learn from client experiences and grow in resiliency. We created this survey to better understand the overall resiliency among employees and volunteers at your organization. Management will be provided with general results and conclusions that arise from the data collected. This information will be used to provide recommendations to management regarding health and wellness strategies to promote a trauma-informed culture for your organization.

Please read the Informed Consent provided below. You will be able to download a copy of this consent form to keep at the following link: Vicarious Resilience Study Informed Consent copy.

TEXAS WOMAN'S UNIVERSITY (TWU)

CONSENT TO PARTICIPATE IN RESEARCH

Title: VICARIOUS RESILIENCE AMONG EMPLOYEES AND VOLUNTEERS AT A RAPE CRISIS CENTER

Principal Investigator: Irene Gallegos..... igallegos1@twu.edu 214/991-8979

Faculty Advisor: Ann Amuta, PhD..... AAmuta@twu.edu 940/898-2856

Summary and Key Information about the Study

You are being asked to participate in a research study conducted by Irene Gallegos, a student at Texas Woman's University, as a part of her dissertation. The purpose of this study is to better understand the overall resiliency among employees and volunteers at your organization. The information from this survey will be used to provide recommendations to management regarding health and wellness strategies to promote a trauma-informed culture for your organization. You have been invited to participate in this study because you are an employee or volunteer at a rape crisis center in North central Texas and are at least 18 years of age. As a participant you will be asked to take part in an online survey regarding your experiences as a trauma worker. The total time commitment for this study will be about 10 minutes. The survey will be taken on a device of your choice at a location of your choice. Following the completion of the study you will have the opportunity to enter into a drawing for a $50 gift card for your participation. The greatest risks of this study include potential loss of confidentiality and stress when recounting environmental work stressors. We will discuss these risks and the rest of the study procedures in greater detail below.

Your participation in this study is completely voluntary. If you are interested in learning more about this study, please review this consent form carefully and take your time deciding whether or not you want to participate. Please feel free to ask the researcher any questions you have about the study at any time.

Description of Procedures

As a participant in this study you will be asked to spend approximately 10 minutes of your time to complete an online survey. The researcher will provide a survey link via e-mail. If you choose to participate in the study, you will click on the "agree" button to continue on to the questionnaire. You may stop participation at any time. If you choose to decline participation in the study, you will click "disagree" or close the browser. If you agree to participate and provide consent, you will be asked questions on individual, relational and organizational factors, and vicarious resilience. Individual questions include demographic questions such as total time of service in the field of intimate partner violence, age, gender, and race/ethnicity. Relational questions include questions about employee work environment, workplace support, and burnout. Vicarious resilience questions include statements examining how your attitude, experiences, and view on life may have changed since beginning this work. If you complete the online questionnaire, you will be asked through a separate link if you would like to enter in a drawing for a chance to win one of two $50 gift cards for your participation in the study.

Potential Risks

In the survey, you will be asked about your experiences regarding environmental work stressors. A possible risk in this study is stress with the questions you are asked. If you become tired or upset you may take breaks as needed. You may also stop answering questions at any time and end the survey. If you feel you need to talk to a professional about any potential stress, the researcher has provided you with a list of resources.

Additional potential risks in this study include loss of confidentiality in all email, downloading, and Internet transactions, and potential identification due to demographic questions. Confidentiality will be protected to the extent that is allowed by law. Your email address will be destroyed past the study end date and you will not be contacted for additional purposes. To protect your privacy, the survey will be taken on a device of your choice at a location of your choice.

The survey responses will be collected in TWU's secure PsychData online tool, downloaded over a password secure Internet network, and stored in a password-protected drive accessible only by the research team. The results of the study may be reported in scientific magazines or journals but your name or any other identifying information will not be collected and therefore not included. Individual responses will not be examined for analysis, rather, findings will be combined to create aggregate data. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and Internet transactions.

There is a potential risk of coercion as management will assist in recruitment by providing email addresses. Your involvement in this study is completely voluntary and you may withdraw from the study at any time. You may stop participation at any time without penalty. Your choice to participate or decline participation in the research study will have no impact on your employment or volunteerism with the rape crisis center.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will try to help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. Following the completion of the study you will have the opportunity to enter into a drawing for a $50 gift card for your participation. The researcher will provide general results, conclusions, and recommendations to the center's leadership for evidence-based improvements for employees and volunteers.

Questions Regarding the Study

You will be able to download a copy of this consent form to keep. If you have any questions about the research study you should ask the researchers; their contact information is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the TWU Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

If you choose to participate in the study, you will click on the "agree" button to continue on to the questionnaire. You may stop participation at any time. If you choose to decline participation in the study, you will click "disagree" or close the browser. Your choice to participate or decline participation in the research study will have no impact on your employment or volunteerism with the rape crisis center.

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1) By clicking "agree" you indicate that you have read the Informed Consent provided below, acknowledge and understand the requirements for eligibility, and give your consent to take this survey.

If you do not wish to participate, please decline participation by clicking "disagree" or by closing the browser.

Thank you for your time.

◯ Agree [Value=1] ◯ Disagree [Value=2]

Question Logic
If **[Agree]** is selected, then skip to question **[after #1, Text]** (See "Edit Logic" for details)
If **[Disagree]** is selected, then skip to question **[after #1, Text]** (See "Edit Logic" for details)

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Thank you for your time. Please close browser.

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Let's get started! This first section asks standard demographic questions.

2) How long have you worked and/or volunteered at this organization?

◯ Less than 6 months [Value=1]
◯ 6-11 months [Value=2]
◯ 1-3 years [Value=3]
◯ 4-6 years [Value=4]
◯ 7-10 years [Value=5]
◯ More than 10 years [Value=6]

3) How long have you worked and/or volunteered in the field of intimate partner violence including at this organization and prior organizations?

◯ Less than 6 months [Value=1]
◯ 6-11 months [Value=2]
◯ 1-3 years [Value=3]
◯ 4-6 years [Value=4]
◯ 7-10 years [Value=5]
◯ More than 10 years [Value=6]

4) How old are you?
- ◯ 18-24 years [Value=1]
- ◯ 25-44 years [Value=2]
- ◯ 45-64 years [Value=3]
- ◯ 65 years and over [Value=4]

5) What gender do you associate with?
- ◯ Female [Value=1]
- ◯ Male [Value=2]
- ◯ Transgender [Value=3]
- ◯ Prefer not to answer [Value=4]

6) What race/ethnicity do you identify with?
- ◯ White [Value=1]
- ◯ Black/African American [Value=2]
- ◯ Asian [Value=3]
- ◯ American Indian/Alaska Native [Value=4]
- ◯ Native Hawaiian or other Pacific Islander [Value=5]
- ◯ Multiracial [Value=6]
- ◯ Prefer not to answer [Value=7]

7) Are you Hispanic/Latino?
- ◯ No [Value=1]
- ◯ Yes [Value=2]

8) What is your highest level of education completed?
- ◯ Less than high school [Value=1]
- ◯ High school [Value=2]
- ◯ Some college [Value=3]
- ◯ Associate's/Trade school [Value=4]
- ◯ Bachelor's degree [Value=5]
- ◯ Master's degree [Value=6]
- ◯ Doctoral degree [Value=7]

9) Which category best reflects your annual income (not combined household income)?
- ◯ $25,000 or less [Value=1]
- ◯ $25,001 - $50,000 [Value=2]
- ◯ $50,001 - $75,000 [Value=3]
- ◯ $75,001 - $100,000 [Value=4]
- ◯ $100,000 + [Value=5]

10) What is your marital status?
- ◯ Single [Value=1]
- ◯ Cohabitating [Value=2]
- ◯ Married [Value=3]
- ◯ Separated [Value=4]
- ◯ Divorced [Value=5]
- ◯ Widowed [Value=6]

11) Do you practice spirituality or affiliate with a religion or faith?

- ◯ No [Value=1]
- ◯ Yes [Value=2]
- ◯ Prefer not to answer [Value=3]

Question Logic
If **[No]** is selected, then skip to question **[#13]**
If **[Yes]** is selected, then skip to question **[#12]**
If **[Prefer not to answer]** is selected, then skip to question **[#13]**

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12) What religion or faith do you affiliate with?

- ◯ Buddhist [Value=1]
- ◯ Catholic [Value=2]
- ◯ Christian [Value=3]
- ◯ Hindu [Value=4]
- ◯ Jewish [Value=5]
- ◯ Muslim [Value=6]
- ◯ Other (please specify) [Value=7]

13) On average, how many times do you call in sick in a given month?

- ◯ 0 times [Value=1]
- ◯ 1-3 times [Value=2]
- ◯ 4-6 times [Value=3]
- ◯ 7+ times [Value=4]

14) On average, how many times do you visit a doctor's office or clinic for your health in a given month?

- ◯ 0 times [Value=1]
- ◯ 1-3 times [Value=2]
- ◯ 4-6 times [Value=3]
- ◯ 7+ times [Value=4]

15) Have you noticed a change in your health since working/volunteering at this organization?

- ◯ To a very high degree [Value=1]
- ◯ To a high degree [Value=2]
- ◯ Somewhat [Value=3]
- ◯ To a low degree [Value=4]
- ◯ To a very low degree [Value=5]

16) In general, how would you rate your overall health?

- ◯ Very Good [Value=1]
- ◯ Good [Value=2]
- ◯ Fair [Value=3]
- ◯ Poor [Value=4]
- ◯ Very Poor [Value=5]
- ◯ Prefer not to answer [Value=6]

17) Do you experience any of the following chronic conditions? (check all that apply)

- ☐ Anxiety [Checked=1]
- ☐ Asthma [Checked=1]
- ☐ Back pain [Checked=1]

- [ ] Cancer [Checked=1]
- [ ] Chronic obstructive pulmonary disease (COPD) [Checked=1]
- [ ] Chronic pain [Checked=1]
- [ ] Depression [Checked=1]
- [ ] Diabetes [Checked=1]
- [ ] Headaches or migraines [Checked=1]
- [ ] Heart disease (e.g. heart attack, stroke, coronary heart disease, angina) [Checked=1]
- [ ] High blood cholesterol [Checked=1]
- [ ] High blood pressure [Checked=1]
- [ ] Joint disease (e.g. athritis, rheumatoid arthritis, gout, lupus, fibromyalgia) [Checked=1]
- [ ] Neurological and musculoskeletal diseases [Checked=1]
- [ ] Sleep disturbances (e.g. nightmares, problems sleeping) [Checked=1]
- [ ] Stomach disturbances and ulcers [Checked=1]
- [ ] Other (please specify) [Checked=1]
- [ ] I do not have any known chronic health conditions [Checked=1]

18) Are you an employee or volunteer at this organization?

- ◯ Employee [Value=1]
- ◯ Volunteer [Value=2]

Question Logic
If **[Employee]** is selected, then skip to question **[#20]**
If **[Volunteer]** is selected, then skip to question **[#19]**

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19) How many shifts per month do you take?

- ◯ 1 [Value=1]
- ◯ 2-3 [Value=2]
- ◯ More than 3 [Value=3]

20) Are you scheduled to work/volunteer part-time or full-time?

- ◯ Part-time (<20 hours per week) [Value=1]
- ◯ Full-time (20+ hours per week) [Value=2]

21) On average, how many hours per week do you work/volunteer (including after hours work in the office or at home)?

- ◯ 0-10 hours [Value=1]
- ◯ 11-20 hours [Value=2]
- ◯ 21-30 hours [Value=3]
- ◯ 31-40 hours [Value=4]
- ◯ 41-50 hours [Value=5]
- ◯ 51-60 hours [Value=6]
- ◯ 61-70 hours [Value=7]
- ◯ 71-80 hours [Value=8]
- ◯ 81+ hours [Value=9]

22) On average, do you mostly provide indirect or direct client care during more than half of your work/volunteer time?

- ◯ Indirect [Value=1]
- ◯ Direct [Value=2]

23) In an average week, how many hours of direct client care do you provide?

- ○ 0-10 hours [Value=1]
- ○ 11-20 hours [Value=2]
- ○ 21-30 hours [Value=3]
- ○ 31-40 hours [Value=4]
- ○ 41-50 hours [Value=5]
- ○ 51-60 hours [Value=6]
- ○ 61-70 hours [Value=7]
- ○ 71-80 hours [Value=8]
- ○ 81+ hours [Value=9]

24) On average, what type of client contact do you mostly engage in?

- ○ Crisis (e.g. hotline, hospital, walk-in) [Value=1]
- ○ Ongoing care (e.g. follow-up care, repeated contact) [Value=2]

25) Have you utilized the employee assistance program (EAP)?

- ○ No [Value=1]
- ○ Yes [Value=2]
- ○ N/A; I am ineligible for EAP benefits [Value=3]

26) What coping strategies do you use to reduce work- or client-related stress? (check all that apply)

- ☐ Low to Moderate Exercising (walking, social dancing, gardening) [Checked=1]
- ☐ Vigorous Exercising (hiking uphill, running, aerobic dancing) [Checked=1]
- ☐ Meditating [Checked=1]
- ☐ Praying [Checked=1]
- ☐ Journaling [Checked=1]
- ☐ Breathing exercises [Checked=1]
- ☐ Talking with others [Checked=1]
- ☐ Reading [Checked=1]
- ☐ I do not practice any coping strategies [Checked=1]
- ☐ Other (please specify) [Checked=1]

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The following questions refer to your relationships with your **colleagues**.

		Always	Often	Sometimes	Seldom	Never/hardly ever	I do not have colleagues
27)	How often do you get help and support from your colleagues, if needed?	○ [Value=1]	○ [Value=2]	○ [Value=3]	○ [Value=4]	○ [Value=5]	○ [Value=6]
28)	How often are your colleagues willing to listen to your problems at work, if needed?	○ [Value=1]	○ [Value=2]	○ [Value=3]	○ [Value=4]	○ [Value=5]	○ [Value=6]
29)	How often do your colleagues talk with you about how well you carry out your work?	○ [Value=1]	○ [Value=2]	○ [Value=3]	○ [Value=4]	○ [Value=5]	○ [Value=6]

The following questions refer to your relationships with your **supervisor**.

		Always	Often	Sometimes	Seldom	Never/harly ever	I do not have a supervisor
30)	How often is your immediate supervisor willing to listen to your problems at work, if needed?	○ [Value=1]	○ [Value=2]	○ [Value=3]	○ [Value=4]	○ [Value=5]	○ [Value=6]
31)	How often do you get help and support from your immediate supervisor, if needed?	○ [Value=1]	○ [Value=2]	○ [Value=3]	○ [Value=4]	○ [Value=5]	○ [Value=6]

32)	How often does your immediate supervisor talk with you about how well you carry out your work?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]

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The following questions ask about your **personal experiences** with prolonged physical and psychological exhaustion. For each question, select the response that most accurately describes your personal experiences.

		Always	Often	Sometimes	Seldom	Never/almost never
33)	How often do you feel tired?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
34)	How often are you physically exhausted?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
35)	How often are you emotionally exhausted?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
36)	How often do you think: "I can't take it anymore"?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
37)	How often do you feel worn out?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
38)	How often do you feel weak and susceptible to illness?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

The following questions ask about your **work-related experiences** with prolonged physical and psychological exhaustion. For each question, select the response that most accurately describes your work-related experiences.

		Always	Often	Sometimes	Seldom	Never/almost never
39)	Do you feel worn out at the end of the working day?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
40)	Are you exhausted in the morning at the thought of another day at work?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
41)	Do you feel that every working hour is tiring for you?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
42)	Do you have enough energy for family and friends during leisure time?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
43)	Is your work emotionally exhausting?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
44)	Does your work frustrate you?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
45)	Do you feel burnt out because of your work?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

The following questions ask about your **client-related experiences** with prolonged physical and psychological exhaustion. For each question, select the response that most accurately describes your client-related experiences.

		To a very high degree	To a high degree	Somewhat	To a low degree	To a very low degree
46)	Do you find it hard to work with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
47)	Does it drain your energy to work with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
48)	Do you find it frustrating to work with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
49)	Do you feel that you give more than you get back when you work with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]
50)	Are you tired of working with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

51)	Do you sometimes wonder how long you will be able to continue working with clients?	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]

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Please reflect on your experience working with persons who have survived severe traumas (e.g., physical and sexual assault, domestic violence, and other forms of interpersonal violence). Since you began this work, you may have undergone changes in how you view your clients, your approach to this work, and/or your own experience or worldview. Please read each of the following statements about how your attitudes, experiences, and your view of life may have changed since you began this work, and indicate the degree to which you experienced each item by selecting the appropriate response to the right.

		Experienced this to a very great degree	**Experienced this to a great degree**	**Experienced this to a moderate degree**	**Experienced this to a small degree**	**Experienced this to a very small degree**	**Did not experience this**
52)	I am more hopeful about peoples' capacity to heal and recover from traumas.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
53)	My ideas about what is important in life have changed.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
54)	I am inspired by peoples' capacity to persevere through awful circumstances.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
55)	My life goals and priorities have evolved.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
56)	I am better able to keep my perspective when things go wrong.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
57)	I am more connected to people in my life.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
58)	I feel more compassion for people.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
59)	I am more hopeful and engaged when I focus on clients' strengths alongside their suffering.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]
60)	I invest more time and energy into all my relationships.	[Value=6]	[Value=5]	[Value=4]	[Value=3]	[Value=2]	[Value=1]

		Experienced this to a very great degree	**Experienced this to a great degree**	**Experienced this to a moderate degree**	**Experienced this to a small degree**	**Experienced this to a very small degree**	**Did not experience this**
61)	I am more mindful and reflective.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
62)	I increasingly recognize spirituality as an important component in clients' survival and path to recovery.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
63)	When I experience distressing thoughts or images from work, I am able to just notice them without reacting.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
64)	I am better able to remain present when hearing trauma narratives.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
65)	I make more time for meditative, mindful or spiritual practices in my life.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
66)	When appropriate, I highlight clients' spiritual/religious beliefs to promote their resilience.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
67)	I am more in tune with my body (i.e., presence of tension, relaxation, etc.).	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
68)	I am better at self-care (e.g., practices such as meditation, yoga, walks, exercise, massage).	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
69)	Some clients' spiritual practices are a source of inspiration and feed my own resilience.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]

		Experienced	**Experienced**	**Experienced**	**Experienced**	**Experienced**	**Did not**

		this to a very great degree	this to a great degree	this to a moderate degree	this to a small degree	this to a very small degree	experience this
70)	I have become more resourceful as a result of this work.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
71)	I am better able to cope with the uncertainties that come with my work.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
72)	I see my life as more manageable than before I started this work.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
73)	I am better able to reassess the dimensions of my own problems.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
74)	I have learned how to deal with difficult situations associated with this work.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
75)	I am better able to assess my level of stress or fatigue.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
76)	I am able to notice distressing memories of clients' trauma narratives without getting lost in them.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
77)	Therapists' and clients' ethnicity, gender, class, sexual orientation, and religion inform their relative power and privilege in the therapy room and beyond.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]
78)	Clients' race, class, gender, sexual orientation, and accompanying privilege and marginalization organize their access to resources for overcoming adversity.	[Value=1]	[Value=2]	[Value=3]	[Value=4]	[Value=5]	[Value=6]

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Vicarious Resilience Survey

Thank you!

Thank you for your time in completing this survey. Your responses are important to the recommendations that will be made to improve your organization's trauma-informed culture for employees and volunteers.

If you would like to enter the drawing for a $50 gift card, please click on the following link: Vicarious Resilience Survey Drawing (https://www.psychdata.com/s.asp?SID=190458)

Winners will be announced at the end of the survey availability window and notified via email.

We acknowledge the potential risk of stress when asked about your experiences regarding environmental work stressors. If you feel the need to talk to a professional about any potential stress, please see the following list of resources.

LOCAL RESOURCES

- The Women's Center of Tarrant County - Employee Assistance Program
  - Contact Human Resources
- Tarrant Cares
  - https://tarrant.tx.networkofcare.org/mh/

ONLINE RESOURCES

- CDC - Mental Health in the Workplace
  - https://www.cdc.gov/workplacehealthpromotion/tools-resources/workplace-health/mental-health/index.html
- American Psychiatric Association Foundation – Center for Workplace Mental Health
  - http://workplacementalhealth.org/Mental-Health-Topics/Workplace-Stress

- Mental Health America – Live Your Life Well
  - https://www.mhanational.org/live-your-life-well

For maximum confidentiality, please close this window.

APPENDIX C

IRB Approval Letter Copy

Texas Woman's University
Institutional Review Board (IRB)
irb@twu.edu
https://www.twu.edu/institutional-review-board-irb/

October 7, 2020

Irene Gallegos
Health Promotion & Kinesiology

Re: Exempt - IRB-FY2020-196 Vicarious Resilience among Employees and Volunteers at a Rape Crisis Center

Dear Irene Gallegos,

The above referenced study has been reviewed by the TWU IRB - Denton operating under FWA00000178 and was determined to be exempt on October 6, 2020.

Note that any modifications to this study must be submitted for IRB review prior to their implementation, including the submission of any agency approval letters, changes in research personnel, and any changes in study procedures or instruments. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All modification requests, incident reports, and requests to close the file must be submitted through Cayuse.

On October 5, 2021, this approval will expire and the study must be renewed or closed. A reminder will be sent 45 days prior to this date.

If you have any questions or need additional information, please contact the IRB analyst indicated on your application in Cayuse or refer to the IRB website at http://www.twu.edu/institutional-review-board-irb/.

Sincerely,

TWU IRB - Denton