Vicarious Trauma in the DSS Human Services Workforce

Focus Group Results Report
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VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Authors:

Sandra Lamm, PhD

Sarah Ausmus Smith, PhD

dss.virginia.gov/community/otrp

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EXECUTIVE SUMMARY

The Office of Trauma and Resilience Policy partnered with the Office of Research and Planning to conduct a qualitative study of Local Departments of Social Services (LDSS) and regional human services personnel's experiences with vicarious trauma, personal coping strategies, and agency mitigation strategies.

This report summarizes the findings of 20 focus groups with 65 participants. Many of the clients of the Virginia social services system are survivors of traumatic experiences; these events may be intrinsic to their involvement with their respective LDSS. Frontline and supervisory staff involved in these cases, as well as the Practice Consultants who work with them, are often indirectly affected by these circumstances. Vicarious trauma refers to the negative effects of supporting vulnerable clients through their own traumatic circumstances on helping professionals. Vicarious trauma is associated with negative psychological, personal, and professional effects and may also be related to symptoms of post-traumatic stress disorder. Policymakers and researchers have increasingly prioritized vicarious trauma as a public management issue as it relates to the quality of care through personnel turnover and professional performance (Middleton and Potter 2015; Pryce et al 2007). According to some estimates, upwards of a quarter of child welfare workers experience some level of vicarious trauma (Middleton and Potter 2015; Molnar et al 2020). However, much less is known about the prevalence of vicarious trauma for other human services workers. Some of the key findings of this study include:

- Participants' perceptions and experiences of vicarious trauma are multifaceted and evolving. The antecedents of vicarious trauma for participants included: exposure to others' trauma, workload or staffing issues, stress, and the inherent nature of their occupation. Participants also reflected on the ways their view has changed over time or compared it to other mental health phenomena. The focus groups identified negative psychological (e.g., burnout, overwhelmed, anxiety, disconnection), personal (e.g., relationships and lack of work/life boundaries), professional (e.g., turnover), and physical consequences of vicarious trauma, both in their own lives and observed in others.
- The focus groups related a variety of personal coping strategies, such as exercise, hobbies, enforcing work/life boundaries, family and social relationships, and professional support. With respect to agency strategies, participants highlighted the role of social support from colleagues; events, trainings, or meetings; and workplace benefits and policies (e.g., employee assistance programs, extra paid leave). However, agencies face barriers to mitigating vicarious trauma for their personnel, including a lack of prioritization and high workloads.
- Participants recommended agencies augment workplace benefits and/or policies (e.g., hire more personnel, increase salaries, institutionalize debriefing, hire an in-house therapist). They also suggested management prioritize cultural change to acknowledge and validate the ways vicarious trauma affects personnel.
- There was no one universal experience of the pandemic. Across roles, respondents felt isolated, afraid, stressed, anxious or worried. Transitioning to telework, multitasking between family and professional obligations, and managing intense cases and the unknown were all challenging. However, some respondents identified positive outcomes from the pandemic for their workplace cultures, caseloads, and telework. Some respondents adapted their coping strategies, while others did not. The same can be said of agency strategies.

INTRODUCTION

The Office of Trauma and Resilience Policy (OTRP) has partnered with the Office of Research and Planning (ORP) to better understand the role and scope of vicarious trauma for LDSS and regional human services personnel. This research project consists of two stages — qualitative focus groups followed by a survey of the broader study population. In this first stage, the team has engaged directly with personnel via qualitative focus groups to understand how vicarious trauma impacts them, how they cope, and how their agencies address vicarious trauma in the workplace. The results show that vicarious trauma as a workplace phenomenon crosses region, role, and service type. Participants offered a description of their experiences, both professional and personal, alongside policy and practice recommendations. Before presenting the findings, this report provides a background on what vicarious trauma is and its importance in a public management context and explains how the study was designed and implemented.

BACKGROUND

Many of the life circumstances that bring families into local social services agencies are traumatic (e.g., abuse, neglect, domestic violence, mental illness). Research has identified the importance of trauma to health and social outcomes; for example, adverse childhood events (ACEs) are associated with higher risk for a variety of health conditions in adulthood (Felitti et al 1998; Petruccelli et al 2019). In recent years, the impact of supporting vulnerable populations through traumatic events on workers has also become a policy priority, particularly as it relates to the coronavirus pandemic. As Figley and Ludick (2017) aptly write, “There is a cost to caring.” According to one estimate, between 26 and 35 percent of child welfare workers experience some level of vicarious trauma (Middleton and Potter 2015). Other studies have produced much higher estimates for child welfare workers (Molnar et al 2020). Much less is known about the prevalence of vicarious trauma for other human services personnel, namely those who work with benefits clients. A recent study of all government workers in a mid-sized city and one state agency revealed 21 percent experienced compassion fatigue and 33 percent experienced burnout (Sciepura and Linos 2022). The following sections provide an overview of vicarious trauma and connect vicarious trauma to public management and organizational outcomes.

Terminology

The study of vicarious trauma touches several research disciplines—psychology, medicine, social work, and public management are just a few. Perhaps as a result, there are ongoing debates regarding concepts often used interchangeably with vicarious trauma, such as secondary trauma, compassion fatigue, and burnout. How are these and related terms defined, and are they distinct from each other? Table 1 provides some short working definitions, but these are by no means absolute. For example, vicarious trauma and secondary traumatic stress (STS) are often presented as synonyms but may also be differentiated as the exposure and the response to that exposure, alternatively as cumulative or acute (Molnar et al 2017; Branson 2019). In their seminal work on vicarious traumatization, McCann and Pearlman (1990) argue working with victims of trauma can disrupt the

"mental frameworks include[ing] beliefs, assumptions, and expectations about self and world." They posit helping professionals could become distrustful or pessimistic; experience a sense of vulnerability or lack of autonomy; or feel alienated from others in their lives. This shift in worldview could include an altered sense of self as well (Newell and MacNeil 2010).

Table 1: Guide to Terminology

Term	Sample Definition(s)
Vicarious trauma	"Exposure to the trauma of others" (Molnar et al 2017) The "profound psychological effects" helping professionals may develop as the result of exposure to others' traumatic experiences (McCann and Pearlman 1990) "Vicarious traumatization is a negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work" (Office for Victims of Crime).
Secondary traumatic stress (STS)	"Constellation of symptoms that may run parallel to those of posttraumatic stress disorder (PTSD)" (Molnar et al 2017)
Compassion fatigue	"Fatigue, as we use it in this context, is the mental weariness resulting from exertion that is associated with attending to the emotional and physical pain of others… compassion fatigue is exhaustion is exhaustion resulting from compassion stress, the demands of being empathic and helpful to those who are suffering" (Figley and Ludick 2017).
Post-traumatic stress disorder (PTSD)	The DSM-V, the psychiatric manual that lays out diagnosis criteria, defines PTSD as "exposure to actual or threatened death, serious injury, or sexual violence," which could be either directly or indirectly experienced, is followed by an array of sustained symptoms (American Psychiatric Association). The "core features of PTSD are the persistence of intense, distressing, and fearfully avoided reactions to reminders of the triggering event, alteration of mood and cognition, a pervasive sense of imminent threat, disturbed sleep, and hypervigilance" (Shalev et al 2017).
Burnout	"Work-related syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment" (Sciepura and Linos 2022; Maslach et al 2001).

Compassion fatigue and STS are also often identified as overlapping or synonymous— STS may be a process leading to an outcome of compassion fatigue (Figley 1995; Figley and Ludick 2017; Molnar et al 2017). Others argue STS and vicarious trauma are distinct constructs, with the former emphasizing behaviors and the latter being a "cognitive change process resulting from chronic direct practice with trauma populations" (Newell and MacNeil

2010). Secondary traumatization may be linked to the diagnostic criteria for PTSD. There are greater distinctions between burnout and vicarious trauma. Vicarious trauma results from helping trauma survivors; burnout is broader—professionals that work with any social services client population may experience burnout, inclusive of those who assist trauma survivors (Newell and MacNeil 2010). While there is value in finely delineating concepts, interrelationships, and processes, study staff are not clinicians, and the purpose of this project is not to diagnose individuals; rather, this study explores professional experiences, their impacts, and mitigation strategies in the context of frontline human services. Dealing with inconsistencies in operationalizing these concepts is also an ongoing effort across this body of research and is outside the scope of the present study. Throughout this project, study staff have operationalized the term vicarious trauma using the Office for Victims of Crime (OVC) definition:

> *"Vicarious traumatization is a negative reaction to trauma exposure and includes a range of psychosocial symptoms. Vicarious trauma occurs when a person is exposed to the trauma of another person. As a result, the person's worldview may shift, and they may experience symptoms that can negatively impact their life and their work."*

Role of Vicarious Trauma in Public Management

Vicarious trauma has implications that extend beyond the well-being of individual professionals to the human services agency itself. Vicarious trauma may affect the quality of care through personnel turnover and professional performance (Middleton and Potter 2015; Pryce et al 2007). Turnover is costly for agencies across multiple dimensions (Linos et al 2022). Hiring and training new staff has the potential to strain the capacity of existing employees, create inconsistencies or gaps in care as case work is handed off, and require financial resources to complete (Strolin et al 2006). Excessive frontline worker turnover may decrease performance through a reduction in personnel experience or qualifications, but that is not a forgone conclusion (An and Meier 2022; Sorensen and Ladd 2020; Kini and Podolsky 2016).

While vicarious trauma may be an occupational hazard inherent to social services, workplace conditions can offer both risk and protective factors. There are correlations between STS and supervisor support, peer social support, and caseload size (Molnar et al 2020; Bride et al 2007). However, there is a dearth of methodologically rigorous evaluations of organizational interventions specifically targeting vicarious trauma (e.g., debriefing, peer support groups). This is particularly true for the roles featured in this study. Most of the studies reviewed focused on emergency response, counseling, or social work professions. Given this context, Molnar and their co-authors (2017) point out the primacy of self-care strategies, writing: "Supportive, self-directed, and nontherapeutic approaches are by far the most utilized methods of addressing STS from a prevention perspective, and for those who are already symptomatic," including "yoga, meditation, relaxation, achieving a work-life balance, physical activity, proper nutrition." Little is known about the contours of vicarious trauma for other human service professionals (e.g., benefits eligibility workers), nor the impact organizational strategies have on those groups.

Project Goals

This report describes findings from the first stage of an ongoing OTRP project to understand the impact of vicarious trauma on frontline staff, supervisors, and regional practice consultants for both family services and benefits programs. Research questions include:

- What are human services workers' experiences with vicarious trauma?
  - » How has COVID-19 impacted their experiences with vicarious trauma?
- What coping strategies do workers use to mitigate vicarious trauma?
- What management practices and/or strategies are being used to mitigate vicarious trauma?
- How have those practices and/or strategies changed since the COVID-19 pandemic?

As noted in the previous section, vicarious trauma as a public management issue is an area of emerging evidence. The conclusions drawn from this qualitative study will serve as the foundation for a future quantitative project and inform VDSS policy priorities focusing on vicarious trauma.

METHODOLOGY

The OTRP spearheaded this project, partnering with ORP to develop focus group questions and processes. After conducting the focus groups, OTRP cleaned and de-identified the transcripts before handing them off to ORP researchers to conduct an independent analysis. The following sections describe in greater detail how the focus groups were designed, who participated, and the analytical strategy.

Focus Group Design

OTRP leadership partnered with ORP researchers to design the focus groups, which were conducted virtually using Microsoft Teams. The focus group facilitator followed a script for the 75-minute discussions, which included expectations for participation, verbal consent procedures, and ten primary open-ended questions. Each session was recorded and transcribed using Microsoft Teams functionality. The questions asked respondents to reflect on their understanding of vicarious trauma; how it affected them professionally and/or personally; their personal coping strategies; agency and leadership-led mitigation efforts; and any changes they've seen (in themselves or their agencies) relative to the pandemic.

The research team targeted a sample that would encompass as many perspectives and workplace contexts as possible. The OTRP recruited 220 participants, ten in each of 22 planned focus groups, from across the Commonwealth via e-mail. Ultimately, 65 current workers participated in 20 focus groups; 17 of these focus groups were broken out by region, service, and role. There were two focus groups for practice consultants, due to their regional service coverage, and one combined group for Central and Piedmont-based benefits frontline workers. Each group had between two and four participants, with a mean of 3.25 individuals. The supervisor and frontline worker groups were very similar in size—the former averaging 3.11 people, and the latter averaging 3.22 workers. The Practice Consultants had the largest focus groups, with four participants each. By service area, Family Services had not only more focus groups but also more participants in each—the mean group size was 3.55, compared to 2.89 for Benefits.

Table 2 provides descriptive statistics for the participants. Overall, the participants represent a diversity of experiences with respect to service area, role, region, race/ethnicity, and age. The participants were overwhelmingly female, which is reflective of the DSS human services workforce. Nearly half of the group is quite experienced, with

more than ten years of service in the field. Less than a fifth are new to the field (less than five years of service). This level of experience could influence the results in several ways. Participants have a deep knowledge of institutional history and personal experience to draw upon, which enriches the discussion; at the same time, the findings may not fully reflect the perspectives of early-career workers.

Table 2: Participation Summary

Characteristic	Distribution
By Service	
Family Services	60%
Benefits	40%
By Role	
Regional Practice Consultants	12%
Local Supervisors	43%
Local Frontline	45%
By Region	
Central	14%
Eastern	14%
Piedmont	15%
Northern	22%
Western	18%
All/Multi	17%
By Age#	
22 to 34 Years Old	28%
35 to 44 Years Old	32%
45 to 54 Years Old	22%
55 to 64 Years Old	14%
By Gender*	
Female	91%
By Race and Ethnicity±	
Caucasian	57%
African American	20%
Hispanic/Latino	9%
Other	6%
Years of Service in Human Services^	
0 to 2 Years	6%
3 to 5 Years	12%
6 to 10 Years	28%
>10 Years	49%

Percentages rounded to nearest whole number.

*# Not reported: 5%, * Not reported: 5%, ± Not reported: 8%, ^ Not reported: 5%*

After the completion of the focus groups in the spring of 2023, OTRP staff prepared the automatically generated transcriptions for coding and analysis, including de-identifying participants, prior to transmitting them to ORP researchers.

Analytical Approach

The researchers deployed a descriptive qualitative approach, given the purpose of this project is to uncover new themes and points of difference that would guide the development of a survey (Nowell and Albrecht 2019; Kahlke 2014). To conduct an inductive thematic content analysis, the researchers assigned a primary and secondary coder for each transcript. Both researchers independently coded the first transcript to establish a shared coding schema. A series of meetings using this first script solidified this coding schema for subsequent usage and confirmed intercoder reliability. Subsequently, each researcher independently coded half of the remaining scripts, identifying additional codes and sub-codes, while the other researcher acted as a secondary reviewer. The researchers met periodically to reconcile discrepancies between primary coding and secondary reviews and to confirm coding consistency. For example, if the same participant expressed an idea multiple times in the same session, code(s) were only applied once. Conversely, if an individual agreed with a sentiment voiced by another, it was coded twice.

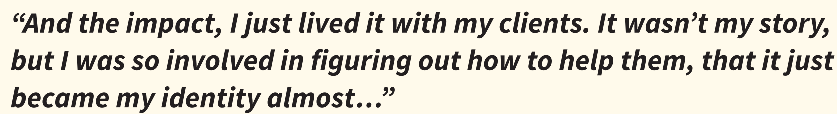
Upon completion of the coding process, the researchers met to discuss overall themes and to determine the reporting process. Given the sensitive nature of the topics discussed, additional steps were taken to safeguard anonymity. While the researchers investigated differences by role and service type, they omitted regionality from their analyses. Since the scripts were de-identified prior to analysis the researchers were also unable to draw conclusions for other subgroups (e.g., tenure, race), unless respondents explicitly self-identified to add context to their remarks (e.g., early-career professionals reflecting on expectations or habits during college and their current state).

RESULTS

The participants offered a rich description of their experiences and perspectives for analysis; nearly 1,800 individual codes were applied across the focus groups. The results are organized by research question.

Experiences with Vicarious Trauma

Antecedents



When discussing their experiences with vicarious trauma, many respondents touched on perceived antecedents—the circumstances and events that they associated with vicarious trauma. After coding the focus group transcripts, antecedents were categorized into exposure, workload/staffing, nature of work, stress, COVID-19, personal experiences, organizational, and miscellaneous, with exposure having the most discussion, specifically exposure to another person's trauma or supporting others through trauma. Indirect exposure to others' trauma is a key component of any definition of vicarious trauma.

Table 3: Antecedents of Vicarious Trauma: Categories and Examples

Category	Examples
Exposure related	Exposure to other's trauma, supporting others through trauma, repetitive trauma, prolonged exposure (cumulative)
Workload/staffing related	Workload, lack of staff
Nature of work	Conflicts with clients, systemic stress, [being] source of clients' trauma
Stress related	Personal stress, exposure to other's stress
COVID-19 related	Risk of exposure to illness
Personal experiences	Identify with client family, personal childhood experiences
Organizational related	Dysfunctional system
Miscellaneous	Unable to disengage from work, insincere caring, not taken seriously

Many participants described the repetitive nature of the exposure, and that the exposure could also be prolonged. This is an important differentiation between vicarious trauma and STS, which can be precipitated from a singular event (Baird and Kracen, 2006). Participants connected workload and staffing issues to vicarious trauma; this was especially true for Family Services frontline workers. Several frontline workers noted the impact of staffing on their immediate supervisors and their reluctance to add to their supervisor's burdens by seeking personal relief:

> *"She does what she can, but she's also now carrying cases… And so it has been a very trying year. … there's only so much she can take, and I don't want her to just up and walk out because I'm trying to have some relief of some sort."*

The very nature of human services work can itself be an antecedent of vicarious trauma, as interacting with government agencies can be traumatizing for families. One Family Services respondent captures this sentiment:

> *"…it can cause me a lot of emotional distress because I have to do things that I don't necessarily want to do, even though it's kind of a necessary evil at times. And when the families that we're working with are experiencing these traumas, whether it just be the hardship that they're having or right up to removal, there's times where I know that I'm a part of the system that's creating this, but I'm traumatized right along with them."*

Other focus group participants associated stress, either personal stress or being exposed to others' stress, with vicarious trauma. Several touch on organizational factors as antecedents, including dysfunctional systems:

> *"And new people that come in kind of walk in like this is not normal. And yet, we're so numb to it that have been here for a while that we're just it's second nature to us and just kind of how we just perform."*

Definitions of Vicarious Trauma

As noted earlier, many respondents gave antecedents of vicarious trauma in their definitions. Others included some of the effects of vicarious trauma, which will be discussed later. Many participants made comparisons to PTSD and secondary trauma/traumatic stress. Nearly everyone had something to say about vicarious trauma; very few respondents were unfamiliar with the concept.

Table 4: Definitions of Vicarious Trauma: Categories and Examples

Category	Examples
Tenuousness of definition	Evolving understanding, unknown
External source/internal differentiation	Trauma from working with others' pain/problems, personal differences, internalizing trauma of people being served, secondhand
Similar concepts	Secondary trauma
Inevitability	Unavoidable given nature of work
Validity of vicarious trauma	Real, buzzword
Emotional response	Emotional fear from seeing people scared, emotions/feelings from trauma and how it affects work
Persistence	Short-term effects, permanent harmful reaction

A key theme related to defining vicarious trauma is the tenuousness of the definition of vicarious trauma. Respondents reflected that their understanding of vicarious trauma has evolved, whether as a function of career tenure or in response to a role change within their career. One supervisor noted:

> *"Probably because before I started this job, I had never even heard of vicarious trauma. So, and if you would have told me, you know, ten years ago, I would have been like, oh, that's not a thing."*

While another supervisor said:

> *"I think my point of view is changed just from having experienced it firsthand as a worker and now also experiencing it through my workers as their supervisor."*

Not everyone had a clear conceptualization of vicarious trauma. Others admitted they were unsure of the definition, or how to differentiate from stress or other traumas. An almost equal number of responses were categorized as defining vicarious trauma as having an external source (i.e., exposure to other people's pain/problems) but an internal differentiation, defined as not everyone is affected in the same manner or intensity. As noted by a frontline worker:

> *"My understanding is that it's specific to every person, their life and their experiences and situations. It could be delayed; it can be immediate and anything can set you off. It's usually related or anything can set it off. So, it's specific to each person."*

Some respondents thought vicarious trauma was an inevitable response to human services work. This category was specific to supervisors, with one supervisor saying:

> *"I think that anytime you are working with the vulnerable populations that we're working with, there's absolutely no way that we don't have trauma because it's not natural for these circumstances to occur."*

Effects of Vicarious Trauma

Although vicarious trauma is defined as a disruption in the cognitive schema of those who work with the victims of trauma (McCann & Pearlman, 1990), respondents catalogued a wide variety of effects in response to the focus group prompts, which are listed in Appendix A. Most of the responses focused on the psychological effects, followed by personal life effects, professional and organizational effects, physical effects, and then miscellaneous effects. Only two focus group participants responded that they did not observe any effects of vicarious trauma.

Psychological Effects

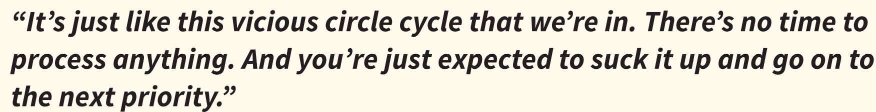
The focus group respondents attributed a wide variety of psychological effects to vicarious trauma, both in themselves and observed in their colleagues. Although Family Services respondents provided a more robust account of the negative psychological effects, participants working in Benefits also connect anxiety, frustration, and feeling overwhelmed with their experience of vicarious trauma.

Table 5: Effects of Vicarious Trauma, Psychological Effects: Categories and Examples

Category	Examples
Effects on coworkers (attributed)	Burnout, overwhelmed, angry, disconnected
Cognitive	Overwhelmed, sense of futility, fear, negative worldview/pessimism
Anxiety/persistent arousal	Anxiety, triggers past experiences, irritable, hypervigilance
Impairment	Burnout, decision fatigue, empathy fatigue
Withdrawal/numbness	Disconnected, numbness, desensitized, isolated
Emotional states	Frustration, angry, weepy

Perhaps not surprisingly, given the fact that focus groups consisted of human services workers, respondents had many conversations about the attributed psychological effects of vicarious trauma on their coworkers. Supervisors attributed burnout, feelings of being overwhelmed, empathy fatigue, and coworker irritability; while frontline workers attributed feeling helpless and being stressed to their coworkers.

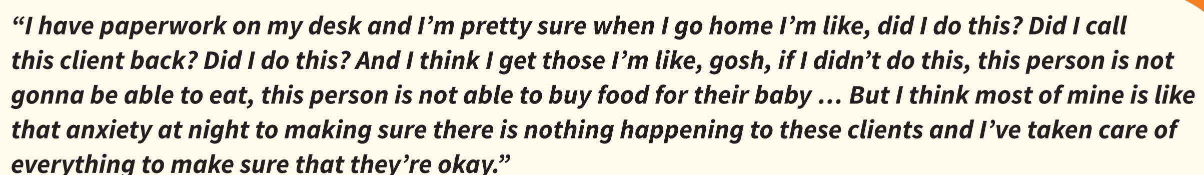
When discussing personal psychological effects, frontline workers dominated the responses discussing the effect of feeling overwhelmed, although practice consultants and supervisors also contributed responses. One practice consultant noted:



Benefits workers were more likely to note having a sense of futility and fear. Some recall events that happened not to their clients, but to them personally—these events may fit the definition of primary trauma over vicarious. Since the participants described these experiences in the context of vicarious trauma, we report them in this discussion. One particularly disturbing quote from a Benefits frontline worker as they describe client interactions:

> *"Because of their [clients'] expectations and then not getting what they thought they was gonna receive. And we don't have security or nothing. It's just one-on-one confrontations with the client…. As I thought about it when I went home, I thought about it a lot and yeah, it brings fear."*

Benefits and Family Services workers were almost equally represented in reporting anxiety; with the sources of anxiety including concerns for clients, effects of vicarious trauma, and general anxiety. A Benefits supervisor describes their anxiety as:



Burnout, decision fatigue, and empathy fatigue were the most discussed psychological effects of vicarious trauma in the impairment category. Contrary to the attributed effects on coworkers, almost all the roles and services discussed burnout, while discussions on decision fatigue and empathy fatigue were entirely exclusive to supervisors, and all but one were from Family Services. Supervisors are often consulted when frontline staff have particularly challenging issues to solve—it is perhaps not surprising that decision and empathy fatigue were exclusively reported by supervisors.

Family Services personnel also dominated the discussions in the withdrawal/numbness category, especially the effects of feeling disconnected and numb. Two Family Services frontline workers noted:

> *"I think at some point when you have repeated difficult situations that you continually are exposed to, I guess a part of that I think for myself, when I I've gotten to that point, I think it's almost like you try to detach yourself in a way because you know you don't want to. But you're trying to protect yourself."*

"Another thing is I also have gone through periods of just feeling numb. I'm not gonna say not anything, but it's just kind of like, well, another day of problems and everybody has them type of thing. That feeling also doesn't feel good."

Most of the discussions around the emotional states category dealt with a sense of frustration. Some respondents focused on frustrations related to a lack of resources, such as being unable to help clients or clients having an inflated sense of how much the worker can accomplish:

"I think that sometimes the frustration shows because a lot of the clients…, I think that they think that we have more authority than what we actually have. And so it frustrates the workers when they let the clients know or let someone else know that we don't have the authority to do that. And people just expect so much more out of DSS because we serve the public and the community. I think they expect so much more out of us and it takes a lot out of the workers when they already giving their best."

Other respondents focused on external sources of frustrations, such as a lack of recognition for the importance of human services work or the recognition that some roles are different in their complexities and conditions. A Family Services supervisor summed this desire for recognition:

"Our agency here's like, well, everyone has different roles, but everyone has to be treated the same way. And it's like no, CPS is different. We are out in the middle of the night...it would just be nice to have some recognition because we're not all doing the same job."

Personal Life Effects

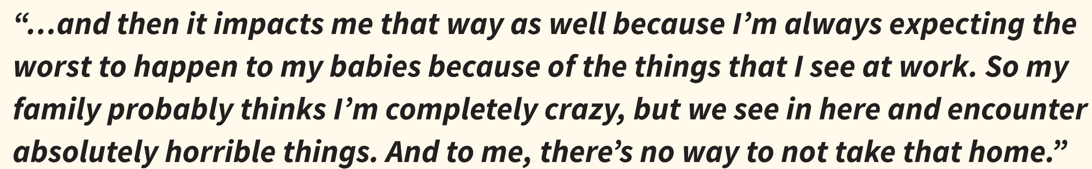
Respondents also attributed several personal life effects to vicarious trauma. These effects were categorized into relationships, work/life boundaries, withdrawal, and emotional state at home. Some of these categories echo the psychological effects categories, such as withdrawal, but also impact workers' home lives and personal relationships.

Table 6: Effects of Vicarious Trauma, Personal Life Effects: Categories and Examples

Category	Examples
Relationships	Effect on children and parenting, disconnected from family/friends, overprotective of family, feeling guilty, impact on personal relationships
Work/life boundaries	Lack of boundaries between work and home
Withdrawal	Desire to be alone
Emotional state	Emotional spillover, outlook, desensitized

Relationship discussions were dominated by family services workers, especially supervisors. Benefits frontline workers did not link vicarious trauma to their personal relationships, although Benefits supervisors did. Effects on children or parenting were divided into the actual effects on the children, and projecting or fearing what could happen to a worker's family, based on cases the worker has seen. These quotes highlight these sentiments:

"And I think my children also, they could sense the stress too, and they could tell that I was, you know, very stressed out a lot of times. And so, they, they would act out as well sometimes or, you know, be a little bit emotionally distraught too."



"…and then it impacts me that way as well because I'm always expecting the worst to happen to my babies because of the things that I see at work. So my family probably thinks I'm completely crazy, but we see in here and encounter absolutely horrible things. And to me, there's no way to not take that home."

Other workers discuss disconnecting from family and friends as a result of events at work. One supervisor noted:

"I think you kind of go through that process so long that that kind of carries over into your personal life and sometimes you detach yourself from close loved ones. I know I do. You know, just you have to live in this kind of bubble so everything doesn't affect you. I just feel like sometimes you don't respond like a normal human being would…"

One supervisor specifically noted disconnecting to protect their family:

"And so I think when you know trauma has happened, particularly to kids, you come home and you think about what if my child had that, that makes it difficult. And then sometimes I think it's easy to put relationships at arm's length to avoid trying to vicariously give them trauma through what you've experienced yourself."

On a similar theme, both Benefits and Family Services supervisors noted feeling overprotective of their families:

"I tended to be more protective and a little more hovering from those stories and people that trusted other folks and looking at some of the foster care and things I do. …read some of the affidavits and it makes you more protective."

While others felt guilty not giving their families their full attention, either because they were not mentally present, had to perform work at home, or were taking time to engage in self-care to cope with vicarious trauma:

"But I then struggle with that feeling of guilt like they might have really needed me in this time, and I couldn't be there because I had to get myself together. And I know I do have to practice self-care, but it's just kind of how I work. I feel like I have to be there for everybody. And when I can't, I feel guilty about it."

The overall picture shows the effects of vicarious trauma affecting workers' relationships throughout their personal lives:

"So figuring out how that impacted my personal life then, how that impacted how I parent my children, my relationship with my husband, my relationship with anybody outside of this job. Just all around. Yeah, just really impacted every aspect of my life."

The work/life boundaries category also skewed heavily towards Family Services. The lack of boundaries between work and home overwhelmingly consisted of not being able to "turn off" work experiences, although having to perform work at home due to caseload or working from home was also included:

> *"So even though you know you get off work that your mind is still, I gotta do this. I didn't do this. And it could basically affect you for the rest of the evening, because you're not restful thinking about what you have to do. And I guess that could be with any job. But when you're talking about people's lives, or did you do something that might—you didn't finish something that might have impact on whether somebody ate last night, that could be nerve wracking."*

Many workers noted a desire to be alone, withdrawing from friends and family as they were too mentally or emotionally drained, or needed the opportunity to regroup:

> *"So I look a lot of times for my family to kind of leave home so I have to deal with them so I can kind of have that peace of mind and just not have to deal with anybody."*

While others noted that emotions generated at work can spill over at home:

> *"I get emotional even when I'm around my child when it has nothing to do with my kid."*

Professional Effects

Participants also identified ways vicarious trauma impacts their workplaces. Professional and organizational effects were categorized into productivity, client/worker relationships, and career effects.

Table 7: Effects of Vicarious Trauma, Physical Effects: Categories and Examples

Category	Examples
Productivity	Turnover, effects on coworkers
Client/coworker relationships	Impact on professional relationships
Career effects	Question career choices

Not surprisingly, the majority of the respondents discussing the effect of vicarious trauma on turnover were supervisors. However, some of the most poignant comments on turnover was made by frontline workers:

"We don't want to leave. But I feel like the burnout rate in the turnover rate is so high because we know if we continue on this path and keep doing what we're doing we're gonna stress ourselves out, make yourself sick. It's gonna affect our family, it's gonna affect things. So we are almost forced to leave because we can't do it. There's no other options. We've tried everything. There's no other options except to leave."

> *"I had to leave because I could see the mental, physical toll it was taking and the toll on my family...as much as I love the job, I can't do this forever, I really can't."*

Other focus group participants were concerned about the effects of vicarious trauma on professional relationships. For example, one participant worried that vicarious trauma would negatively impact interactions with both colleagues and clients. Ultimately, some participants also questioned their choice of career as a result of their exposure to vicarious trauma.

Physical Effects

When asked about how vicarious trauma impacts them, some focus groups identified physical problems. Respondents reported having more specific physical effects, such as insomnia and exhaustion, than non-specific symptoms such as getting tense or not feeling well; overall, Family Services personnel were more specific in this area. For example, Family Services supervisors report being unable to sleep due to worrying about decision they made about cases or re-running work scenarios in their mind. Exhausted participants felt that clients had drained their energy.

Table 8: Effects of Vicarious Trauma, Physical Effects: Categories and Examples

Category	Examples
Specific Symptoms	Insomnia, exhausted
Non-specific symptoms	Get tense, not feeling well

Personal Coping Strategies

Respondents discussed a wide variety of personal coping strategies. These were categorized into inward-facing, escape-avoidance, social support, professional support, religious or spiritual activities, and miscellaneous coping strategies.

Table 9: Personal Coping Strategies: Categories and Examples

Category	Examples
Inward facing	Exercise, hobbies, decompress time/destress, pets, connect with nature
Escape-avoidance	Maintain work-life boundaries, books/TV/podcasts/music, getting away (paid leave, travel), compartmentalize
Seeking social support	Family activities & relationships, talk with family/friends, talk with colleagues, venting/verbalizing, socializing with friends
Professional support	Counseling/therapy, medication
Religious or spiritual activities	Attending religious services, faith-based communities, spiritual practices
Miscellaneous	Lack of strategies, personal differences, barriers to coping

Respondents who used inward facing coping strategies were roughly evenly distributed amongst the various roles and services. Exercise was the coping strategy with the most discussion, with respondents walking, with or without dogs, doing yoga, or playing organized sports, to name a few examples. Hobbies and decompression/de-stress time were also mentioned as personal coping mechanisms. Many respondents noted they used their commute as a decompression time.

Perhaps because work-life balance was discussed more by Family Services personnel in the personal life effects, discussion on coping with vicarious trauma by maintaining work-life boundaries was also dominated by Family Services workers, roughly split evenly between frontline workers and supervisors:

> *"I have to have a disconnect when I leave in the evenings. If I'm not on call, I'm not responding to my work cell phone. I'm not checking my emails.... So I think just completely disconnecting from work is how I am able to manage those boundaries so that it doesn't continuously impact my personal life."*

Books, TV, podcasts, and music were all used as a means of escape to cope with vicarious trauma. As a Benefits supervisor said:

> *"I'll just watch a comedy or something that makes you laugh or listen to something on my phone just to get out of that negative headspace for a little while."*

Respondents also reached out for both social and professional support as part of their coping strategies. Family, friends, colleagues, and mental health professionals were all utilized.

"I have a really close colleague. We work very well together… But we have also a good relationship outside of the office and I feel we kind of cling to each other. When things get hard we're able to vent to each other, and she kind of grounds me. And sometimes when she's in a tailspin I kind of ground her. So really for work stuff for me it is having that go-to person that when things are hard or when I feel I'm losing control, she's able to kind of help me get back to myself."

Respondents also mentioned faith-based support, either through religious communities or individual faith-based activities. As noted earlier, participants catalogued a number of personal coping strategies, underscoring how each respondent may have found strategies that work for their individual situation. In the context of a discussion on how a certain strategy may be helpful, a Benefits supervisor summarized this concept:

> *"Some of them are I'm just here to work. I just come sit at my desk and do what I need to do, and I want to go home. And then you have others who have social relationships and work is the only time they get to talk to anyone else besides who's living in their home. So you have just very different opinions about what work is to all of your staff and then to be able to generalize how to teach them to cope with things. I don't think it's feasible."*

Management Mitigation Strategies

Participants had much to say about how vicarious trauma is currently addressed in their agencies, barriers, and recommendations for future interventions. In general, the supervisor and practice consultant focus groups articulated more on these topics. Staff identified a wide variety of approaches related to ameliorating vicarious trauma—some were informal or intangible, while others were concrete programs. Not all participants could identify efforts in their agencies to manage vicarious trauma stemming from their work, while others described outside organizations' initiatives instead. After coding, the researchers developed broad categories to describe how vicarious trauma is managed in the workplace.

Table 9: Management Strategy Categories

Category	Examples
Interpersonal relationships or informal social support	Support from a manager, peer-to-peer relationships
Events, meetings, trainings	Debriefings after traumatic events, retreats, guest speakers, mental health trainings, vicarious trauma groups
Workplace benefits, policies, practices	Employee assistance programs (EAP), access to therapist on-site, extra paid time off (PTO), workload reductions, telework
Self-service spaces or resources	Decompression room, meditation space, massage therapist

Workplace culture	United, supportive, collaborative
Community support	Local organizations, recognition (e.g., lunch)
None	-

With respect to current professional strategies, speakers emphasized most the role of social supports from colleagues; this theme was particularly strong for Family Services personnel. Regardless of role, participants report frontline workers looking to supervisors and agency leadership for both tangible and intangible support; supervisors may cover cases for overextended staff or encourage them to prioritize their own well-being (e.g., utilizing PTO). Supervisors were cognizant of how important their relationships were with their units. One supervisor describes how they have engaged staff processing their experiences:

> *"So the way they [staff] show it [impact of clients' trauma] is that a lot of times they come to me for support… I would have workers come into my office and we'd have sessions where basically I felt like I was a therapist. I'm talking to them and I'm trying to let them know it's okay to feel the way you feel. It's okay to process this information the way you are, just trying to work through it and just let them know that they're valued workers, that they're valued and I understand where they're coming from. I've experienced it myself and just work through it, but it does slow down the work because we do have to stop sometimes and take care of our staff and support them in the way they need."*

Respondents also talked about their colleagues being a source of support. As a protective factor, peer relationships may develop organically or through purposeful team building activities. Workers characterize these relationships as a "support system," providing a community in which they can talk through their experiences.

To a lesser extent, participants describe events, trainings, and meetings as providing them tools to manage vicarious trauma. Few of the trainings described directly and explicitly targeted vicarious trauma—both Benefits and Family Services personnel recall training opportunities related to mental health, trauma-informed care, or burnout. Guest speakers may be incorporated into existing meetings to educate staff about trauma, vicarious trauma, and related topics. Perhaps unsurprisingly, given the centrality of relationships, multiple connected events (e.g. shared meals off-site, light hearted celebrations) were cited as important sources of stress relief and support. The focus groups offered up several striking examples of on-site vicarious trauma groups, which could function as de facto debriefings or address mental health issues more generally:

> *"[She] does our vicarious trauma meetings. She treats it like a debriefing. You know, you go through and, okay, what has been triggering you? What's been on your mind and then how do you feel about that? And then how did you react to that? So she tries to keep it on certain categories. So that way you're actually hitting the root of the problem. And we've had people cry, you know, breakdown and cry and not realize that things are affecting them."*

> *"[The counselor or social worker] would come in and she would do different activities. A lot of it was like mindfulness and breathing, which all the workers felt much better when they left the group.*

She would start off the groups with like the mindfulness and the breathing and being present in the moment. And then sometimes it was just talking. Sometimes she would have an activity to do."

Local agencies' policies and practices have also played a role. Benefits workers in particular identified telework flexibility, extra time off, and access to benefits such as a wellness center or EAP as being instrumental. Some of these offerings fall under the authority of city officials and be open to all local government employees. For example, one worker talked about changes made to their locality's EAP counseling coverage. Workers expressed accessing therapy in a number of ways—some agencies have brought licensed counselors on-site, while staff may also leverage personnel benefits as a jumping off point.

As a matter of procedure, only one respondent described a debriefing protocol for personnel involved in a traumatic situation to meet with a licensed psychologist. They recall the first instance they had participated in such a debriefing as formative:

"And I think that that the first one that I participated in has really stuck with me and I think has been probably the most official thing that I've ever participated in my career. And it wasn't even lengthy and it wasn't like a whole lot of talking. But this psychologist, his one statement of what else could you have possibly done...So there was nothing I could do and I think just that realization and recognition that I'm not responsible for everybody and people make their own choices and do what they're going to do. Sometimes we can be helpful and other times things are just going to happen the way that they're going to happen, regardless of what you do or don't do."

They go on to describe how this process informs their interactions with other staff and guides their practice. Self-service resources (such as quiet spaces set aside for reflection or decompression), community support, and agency culture were all present topics, but less discussed. One participant captures how their leadership and office relationships intersect to create a culture that prioritizes staff well-being:

"And we're all very close and we're all very attentive to each other's needs and how we're feeling. And so I feel like my team looks out for each other and will absolutely say, hey, you're having a bad day, why don't you go? I'm gonna cover for you the rest of the day. It's like so our team really, really cares about each other. And I think that comes from the people that they are. But it also comes from our leadership. [They are] excellent and [they] absolutely want to make sure that everybody's okay every day."

Barriers to Mitigation

Roadblocks to addressing vicarious trauma featured in the discussion of workplace strategies, particularly for supervisors. Respondents recognized issues related to management, personnel, stigma, and resource constraints as impediments; organizational or management limitations featured most prominently. For example, respondents felt that a lack of prioritization and dysfunctional workplace culture are barriers; some participants describe their office as punitive. Agencies may also struggle with stigma—staff may not feel comfortable engaging in emotionally

vulnerable activities. High workloads and lack of time also prevent workers and managers from utilizing vicarious trauma mitigation tools. One supervisor notes the tension between addressing traumatic experiences and productivity pressures:

> ***"My locality has had a number of… traumatic child fatalities. My workers are going in with law enforcement and seeing bodies on the ground. And then the next day they're getting two new cases, so there's not time to process because it's just a constant flow. There's no time to breathe."***

Recommendations

The focus groups proposed a variety of reforms to better address vicarious trauma, both ex ante and ex post. Out of the variety of suggestions emerged six categories. Workplace benefits, policies, and practices dominated conversation overall, particularly for Family Services, followed by workplace culture. An additional key theme that emerged is the importance of implementation—participants often talked about not just specific programs or strategies, but prioritizing frontline workers, accessibility, and preemptive support. Other topics that came up but were less robustly considered include self-service spaces, and events or trainings.

Table 10: Recommendations from Participants

Category	Examples
Workplace benefits, policies, practices	More personnel (e.g., supervisors, practice consultants , staff), personal support groups or specialist, decreased workload, debriefing, increase salaries/benefits, therapist
Workplace culture	Culture change, counter stereotypes, acknowledgement, recognize differences
General implementation approach	Proactive support, accessibility, focus on frontline workers
Interpersonal relationships or informal support	More empathy, encouragement
Self-service spaces or resources	Decompression room, "space to talk"
Events, meetings, trainings	Training (e.g., vicarious trauma, trauma-informed supervision)
None/Unknown	-

Recommendations that focused on benefits, policies, and practices came up in 18 of the 20 focus groups. Some of the suggestions solved for workforce shortages (e.g., more staff, decreasing staff workloads, or adding a "floating" position to cover staff leave). More prominently featured were ideas to expand employee benefits—increasing salaries, offering bonuses or hazard pay, and increasing paid time off. One participant talked about how being underpaid magnified the stress of their job, saying:

"I appreciate the benefits and I love the place, the people I work with. But we definitely do not get compensated enough. And it is really hard to endure this kind of stress. And you know that you're going home, and you're stressing about your bills and things like that because we are underpaid."

The focus groups identified several strategies that would provide staff ways to psychologically process their experiences. Some respondents also felt that their agencies should institutionalize therapy for staff by providing it "in-house," potentially through a local employee. One respondent discussed the inadequacy of the current state of coverage (i.e., through health insurance or a limited number of sessions through EAP), stating that both therapy as service and time spent in therapy should be compensated. Speakers also viewed routine access to debriefing, citing protocols followed by law enforcement or the military, as having useful applications in human services. Alternatively, participants across service types and positions felt that personal support groups would be beneficial. One person from a Benefits-related focus group states their rationale for why this would be helpful, even in the face of staffing shortages:

"So if they had, you know, peer support specialists or groups… and not necessarily worry about a supervisor or a leader being in there, that might commandeer the conversation or make them feel as though they can[n't] express themselves. Because like [redacted] says, sometimes they just need to vent. Sometimes they need to work through and process those feelings, and sometimes they may not even know that they're projecting things that have rubbed off on them from other clients to other people. So it's just that conscious awareness and being able to have a safe space to speak."

One striking view held by multiple frontline Family Services staff is that they should be treated as "first responders" by their local governments. Shifting the way human services workers are seen as more akin to police officers or fire fighters is threaded throughout a couple of the focus groups. For these individuals, this change would serve as a (re-)organizing principle for how their careers are treated—through hazard pay, shorter required years of service to draw expanded retirement benefits, more resources dedicated to therapeutic support, and more robust debriefing protocols. Below are quotes from two different focus groups that make this case; in both focus groups, participants returned to this theme, stressing the danger they face in their work.

"I went to a training [years ago] .... And I will never forget [what the trainer] said—it was a social worker safety training, and he said you guys go in with literally a pad of paper and a pen and maybe a cell phone that works depending on where you're located and maybe not. And there's no GPS, there's no radios that you guys have, and the only weapon you have is your mouth. You have to be able to talk yourself out of any situation. And yet here we are. I don't want to be a police officer. I don't want to carry a gun. That's not what I want. We go into these situations and the expectation is we are taking people's children from them. Their most prized possession, and we are taking them, and we are expected to just deal and cope with it."

"I think that there needs to be a public movement to see us as first responders. And I think that seeing the people who do this work, benefit services, foster care, CPS, seeing us as first responders would change a lot of the systemic stuff that's broken for us. We would have more ability to have resources if we were seen as first responders like the fire department or police do. There would be expectations

that if you have this traumatic response or this traumatic case that you're working on that you will be taken care of because that can bleed into your personal life and that can bleed into other cases."

Beyond the way their professions are characterized, participants advocated for cultural changes. For example, their organizations could foster cultures of listening, where management is less punitive and more "compassionate," both acknowledging and validating the ways trauma affects them. The next subsection considers how the pandemic affected participants' vicarious trauma experiences and coping strategies.

Role of the COVID-19 Pandemic

There is no single dominant narrative to describe the interaction of vicarious trauma with the pandemic for participants. Frontline staff, practice consultants, and supervisors describe feeling socially isolated, afraid, stressed, anxious or worried. According to one Benefits participant, the pandemic made people "hypersensitive" to vicarious trauma; others talked about the impact of losing loved ones and colleagues to COVID-19. Participants talked about how life became more complicated. For some, work became more challenging. Transitioning to telework was discussed in the majority of the focus groups. On the one hand, workers struggled to multitask or maintain work-life boundaries while both teleworking and managing their own children's virtual education. Some workers recounted cases becoming more intense—with fewer mandated reporters physically interacting with children (e.g., teachers), cases were "more horrific" by the time Family Services became involved. Some workers worried about how the lack of human interaction would harm their clients. Conducting home visits was accompanied by an additional layer of the unknown:

"So having to meet with these families, but then not knowing—because everybody has different thoughts and feelings about that disease. So you would go to one house and you'd have to be fully masked, outside of their house one, wouldn't lets you in, but then you're having to check all these things in their house. And you can't. I feel like they use it as an out. I feel they don't do as much of their work as they could be because of COVID. So and then I have other people who were kind of the opposite, I guess, of the spectrum. So it was hard to navigate."

While many staff characterized the consequences in negative terms, others identified positive effects. For example, some of the focus group members felt their office cultures and relationships had improved as a result of the pandemic; caseloads were smaller; some found value in the virtual tools. Some detailed improvements in management. One Benefits participant stated, "I don't think we had a lot of issues, honestly. Like I think people were teleworking fine."

Did personal coping or organizational mitigation strategies change during the pandemic? For some, the answer to both is "no." Focus group participants from both service areas and across roles did not notice a change in how they coped. For those that did, adaptions to personal coping were highly variable and thus challenging to draw broad themes (e.g., changes in personal mindset, more exercise, starting therapy, lack of access to support networks or coping strategies). Adjustments in organizational approaches to vicarious trauma were similarly out of focus—changes in modality (e.g., virtual), more social support from supervisors, reduction in offerings (e.g., guest speakers) were all identified.

DISCUSSION

The focus groups provide many insights into how participants perceive vicarious trauma and inspire new questions. In general, respondents paint a picture of a human services workforce experiencing the effects of vicarious trauma in a myriad of ways, ranging from psychological to physical, and in both their personal and professional lives. Some of the listed effects may not be typically ascribed to vicarious trauma, but focus group participants attributed them to vicarious trauma in their discussions.

The most frequently discussed personal coping strategies are in the inward facing and escape-avoidance categories. This may have implications for organizational strategies, and future research and discussion may center on how best the agency can support these types of personal coping styles. Conversely, personal coping strategies that are outward facing, such as seeking social and professional support, may require different agency support and may overlap with management mitigation strategies.

The depth and breadth of discussion around agency strategies suggests there may be a diversity of approaches across localities. Many of the strategies identified were not exclusive to managing vicarious trauma. For example, it is clear that interpersonal relationships, both supervisory and peer-to-peer, are an important source of relief to participants. However, resource constraints (e.g., time, staff) have made it difficult for some supervisors to fully engage with staff in the ways they would like; this sentiment dovetails with many of the suggested strategies to relieve workload pressures. Peer-to-peer support through building positive relationships or via more structured settings also feature prominently. Interestingly, many of the recommended reforms focus on benefits-related policies—increased salaries, covered health services, and support. A couple of participants conceptually packaged these ideas together by advocating for "a public movement to see us as first responders."

The pandemic was a time of great uncertainty and challenge for many of the participants. Some talked about the difficulties of losing friends, family members, and professional colleagues; new complexities in their client-facing work; and challenges in balancing their home and work lives. However, each participant's reaction to these potential stressors was different—some were able to exercise their personal coping skills, while others had to shift tactics. Local agencies also had highly variable responses to the pandemic in the supports that they offered personnel.

Next Steps

Additional questions arise from these findings. For example, which strategies are most effective and/or efficient in managing the negative effects of exposure to clients' trauma? And given the differences in client populations and nature of the services provided, are distinct mitigation strategies needed for Benefits and Family Services workers? For supervisors versus frontline staff? In the next stage of this project, these findings are the foundation for a survey of DSS staff about their experiences with vicarious trauma, coping mechanisms, and organizational and personal coping strategies. These research approaches are complementary; the qualitative study provides a rich depiction of a small group of staff, while the survey will tell OTRP much more about the prevalence of experiences for an entire population of human services professionals in Virginia.

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APPENDIX A: FOCUS GROUP PROMPTS

1. **What is your understanding of vicarious trauma?**
    a. Would you say your understanding of vicarious trauma has changed over your time working in human services?
    b. If so, in what ways?

2. **How does vicarious trauma affect you professionally?**
    a. What situations trigger this type of trauma for you?
    b. Have you seen vicarious trauma affect your colleagues?
    c. If so, in what ways?
    d. Is anyone able to share any examples that stand out to them?

3. **How does vicarious trauma affect you personally?**

4. **If you experience the effects of vicarious trauma, how do you cope?**
    a. How helpful have you found coping strategy X to be?
    b. Where did you find out about this coping strategy?
    c. Have you seen others use this coping strategy?
    d. If so, how have you seen it help others?

5. **How did the COVID-19 pandemic affect your experience of vicarious trauma, either personally or professionally?**

6. **If you experience the effects of vicarious trauma, how have your coping strategies changed since the COVID-19 pandemic began?**

7. **What kind of agency or leadership-driven efforts have you experienced prior to, during, and in the current phase of the COVID-19 pandemic that try to address vicarious trauma in the workplace?**
    a. Have these efforts been helping you or your co-workers?
    b. If yes, in what ways did they help?
    c. What do you think led to the success (or lack of success) of these efforts?

8. **Have these agency or leadership-driven efforts to address vicarious trauma changed since the COVID-19 pandemic?**

9. **What could the agency do differently to address vicarious trauma among workers?**

10. **Is there anything else you'd like to share related to your experiences with vicarious trauma?**

APPENDIX B: THEMATIC MAPS

Figure 1: Antecedents of Vicarious Trauma

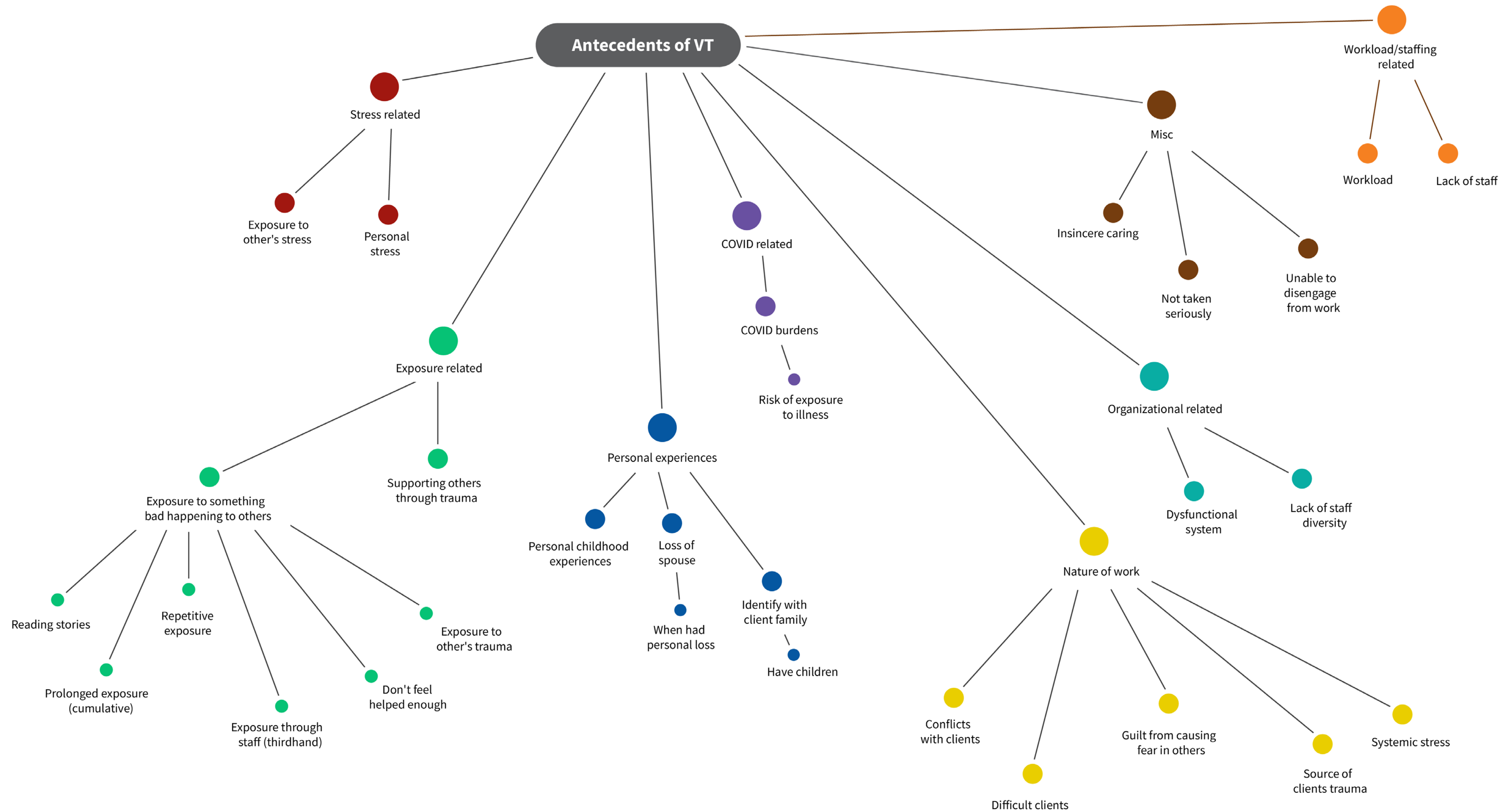


Figure 2: Definition Vicarious Trauma

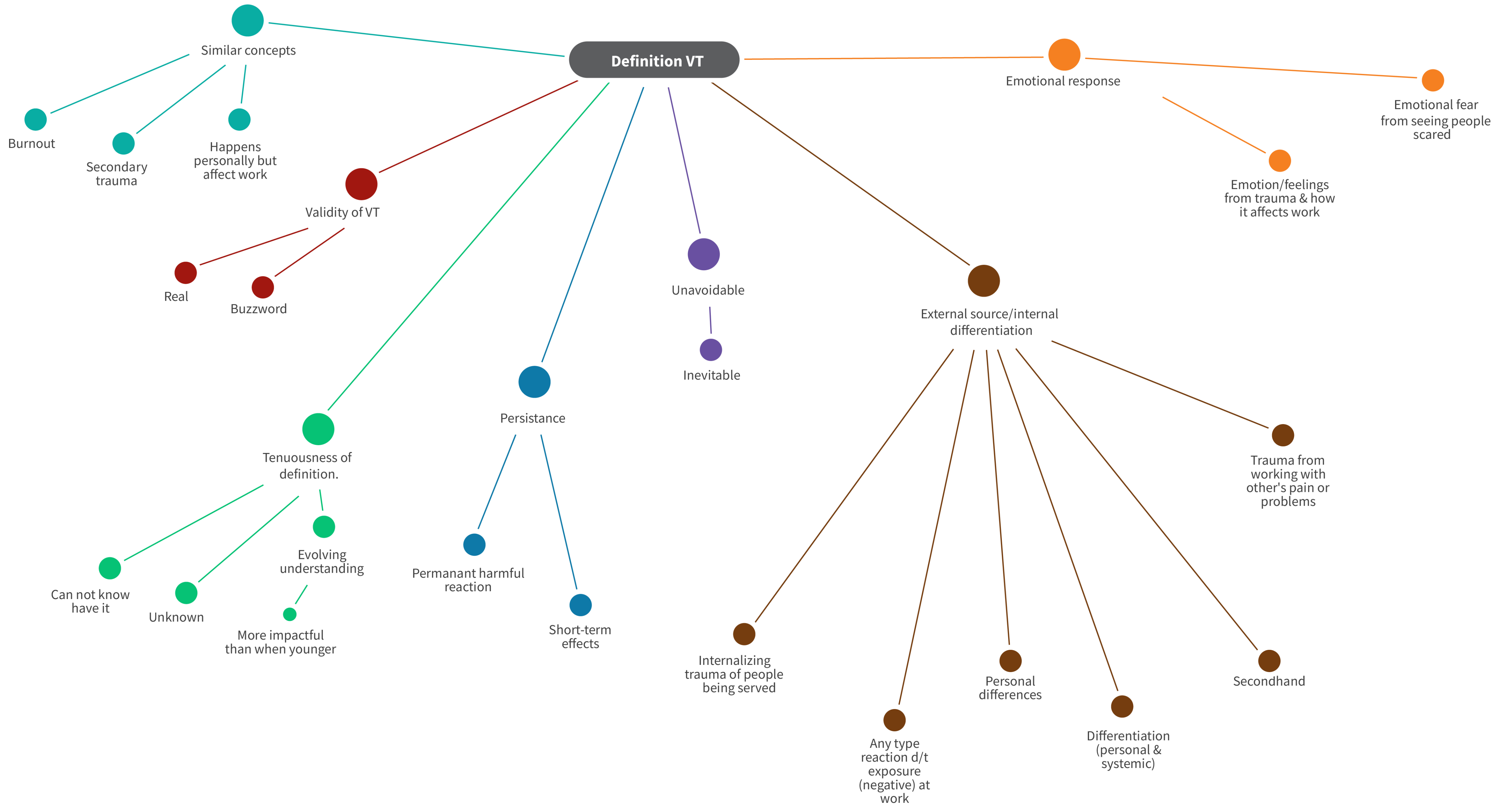


Figure 3: Effects of Vicarious Trauma: Professional, Organizational Effects

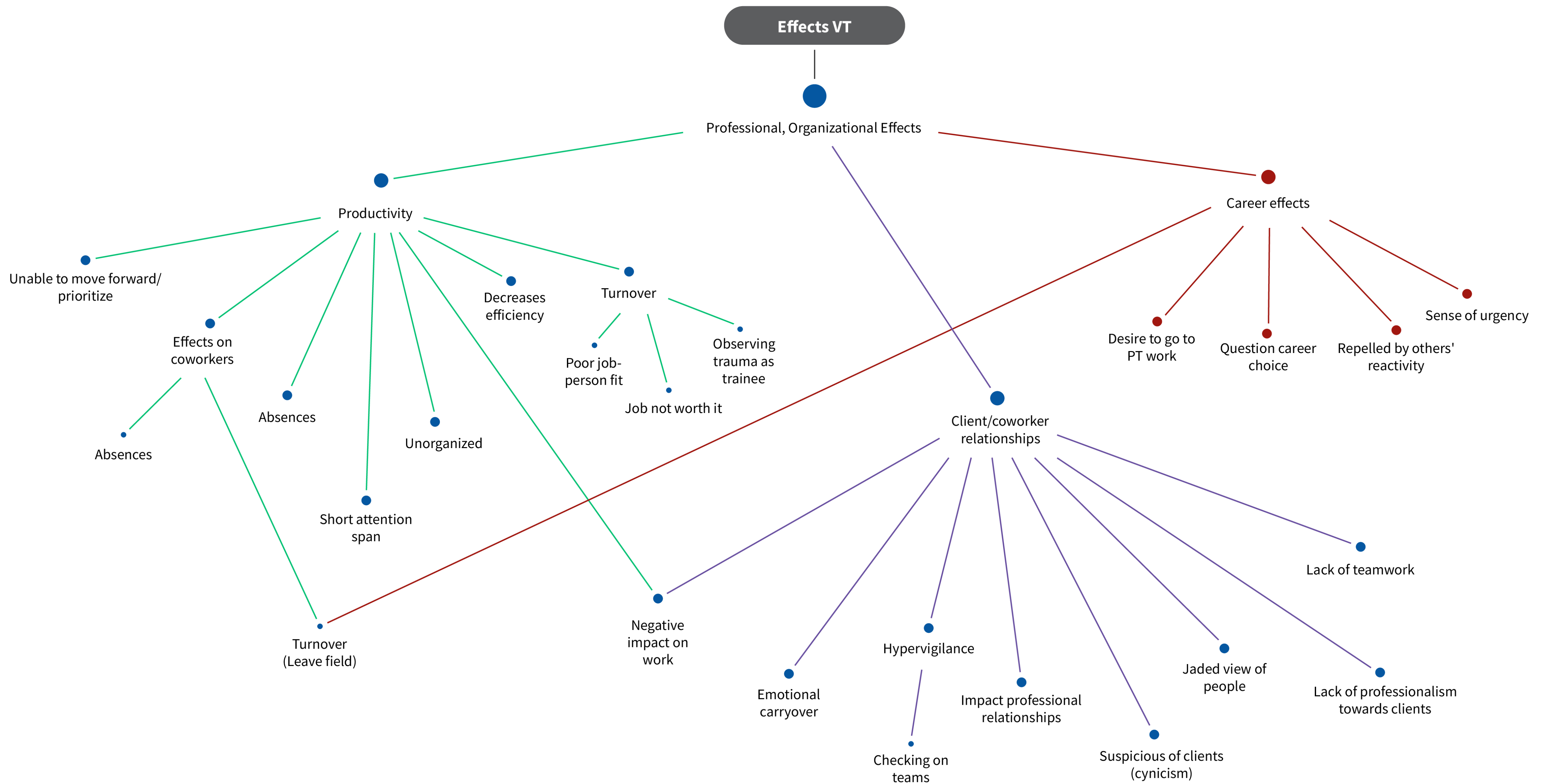


Figure 4: Effects of Vicarious Trauma: Personal Life Effects

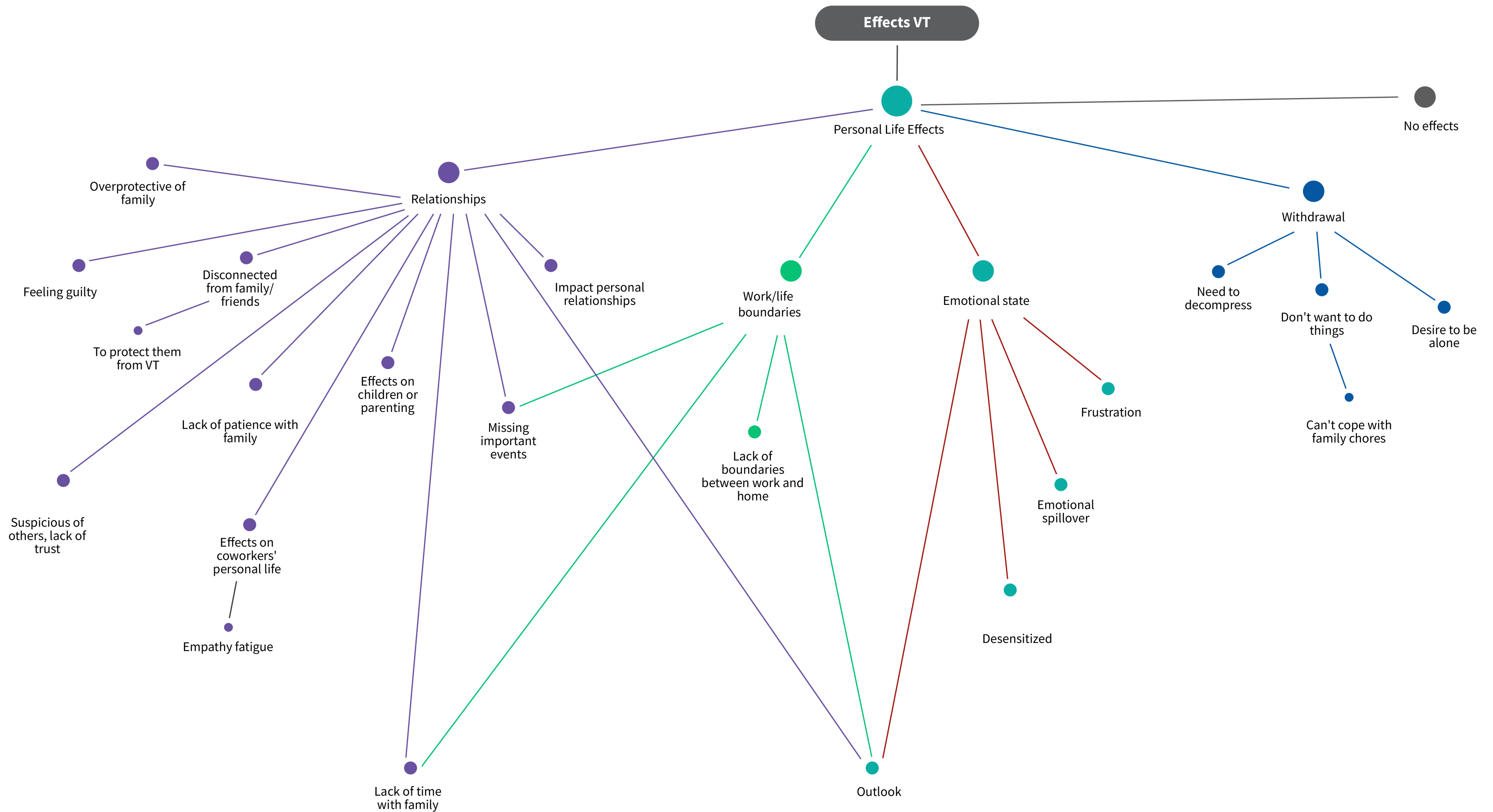


Figure 5: Effects of Vicarious Trauma: Physical Effects

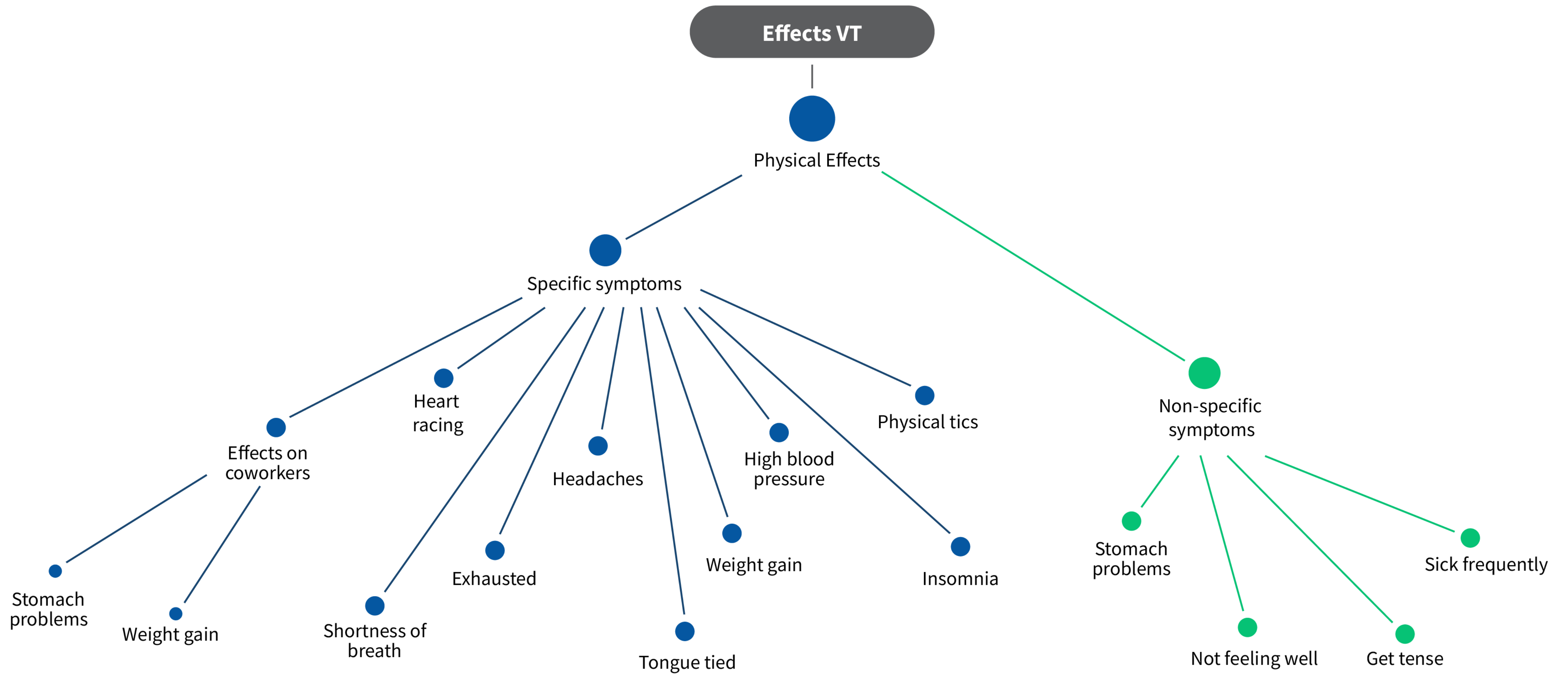


Figure 6: Effects of Vicarious Trauma: Personal Coping Strategies

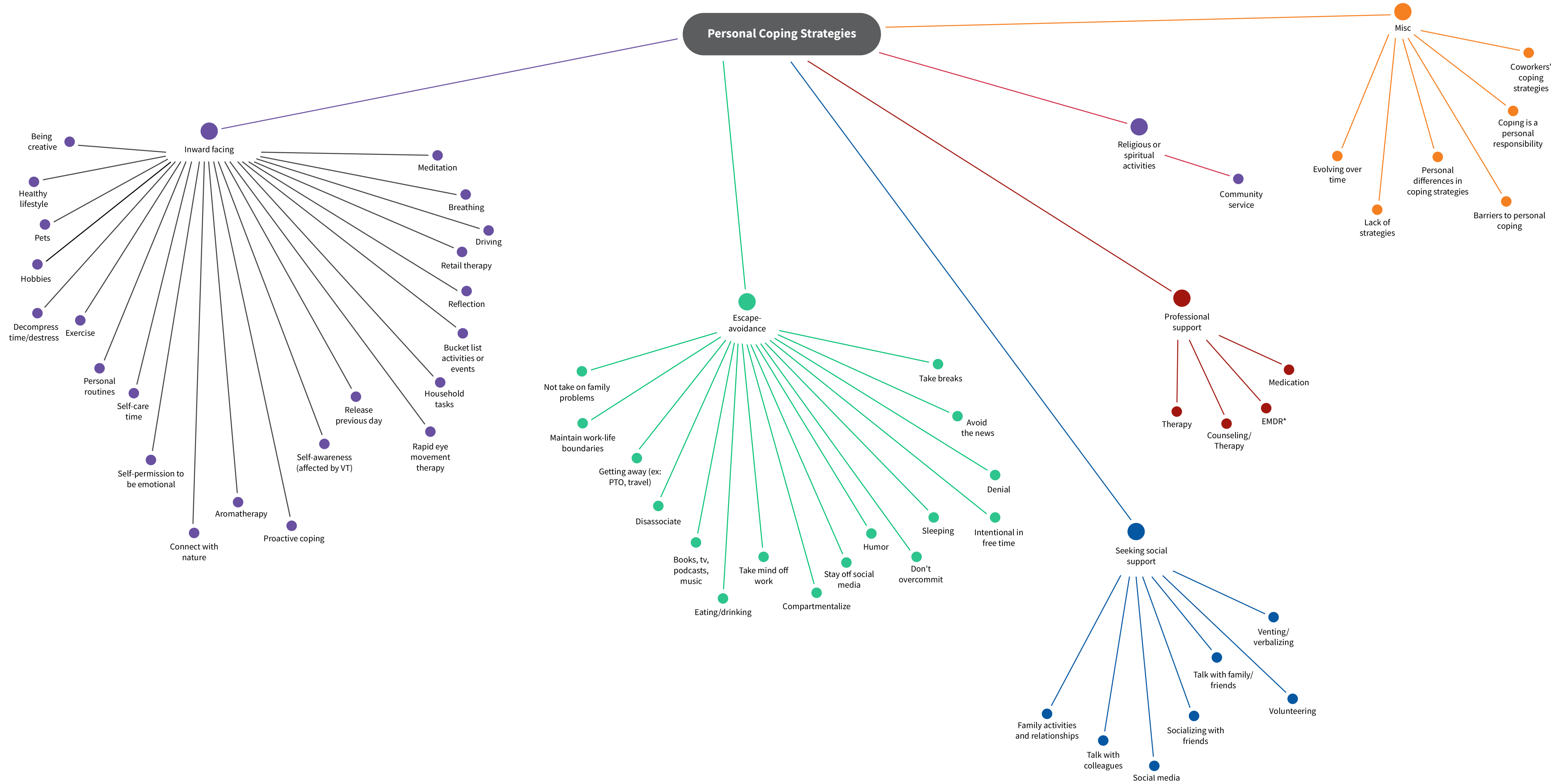


Figure 7: Agency Mitigation Strategies

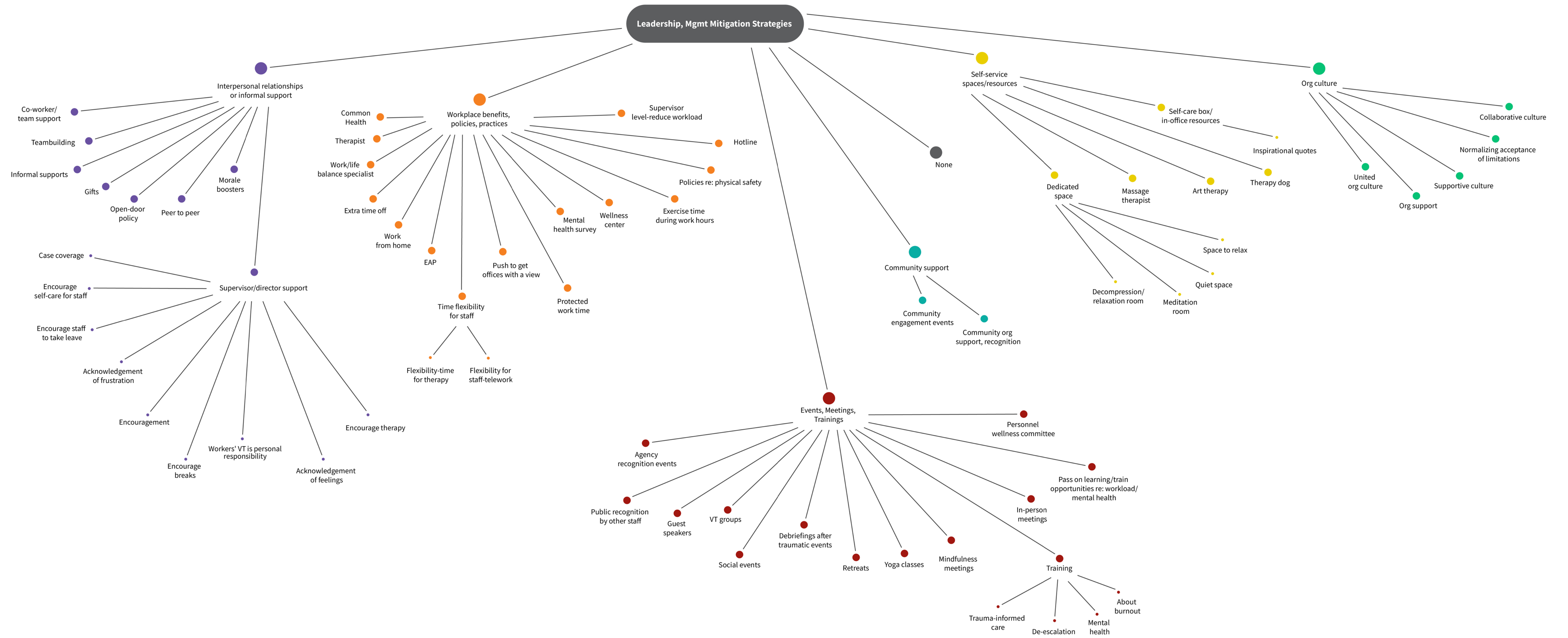


Figure 8: Barriers to Mitigation

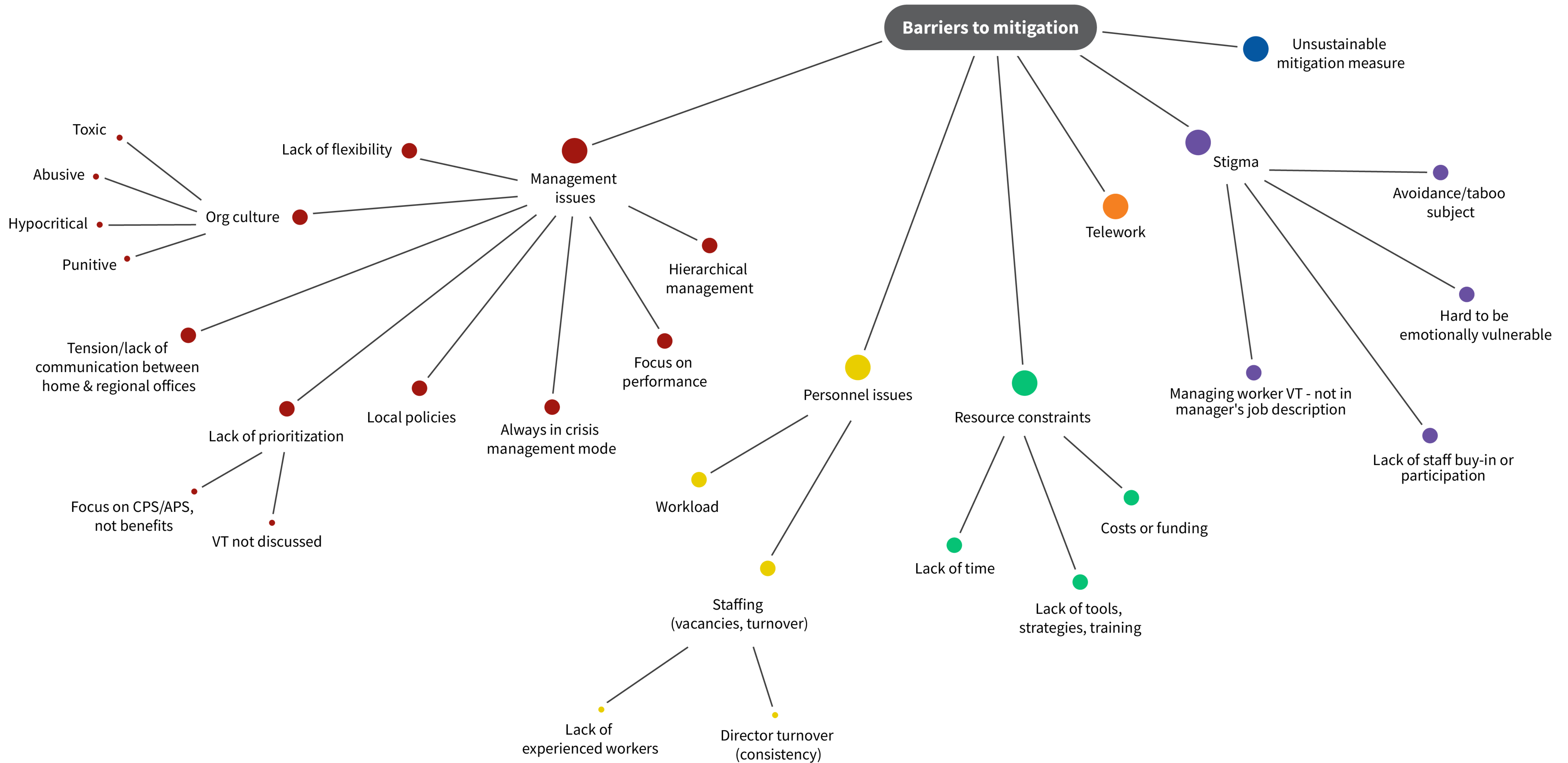


Figure 9: Management Strategy Recommendations

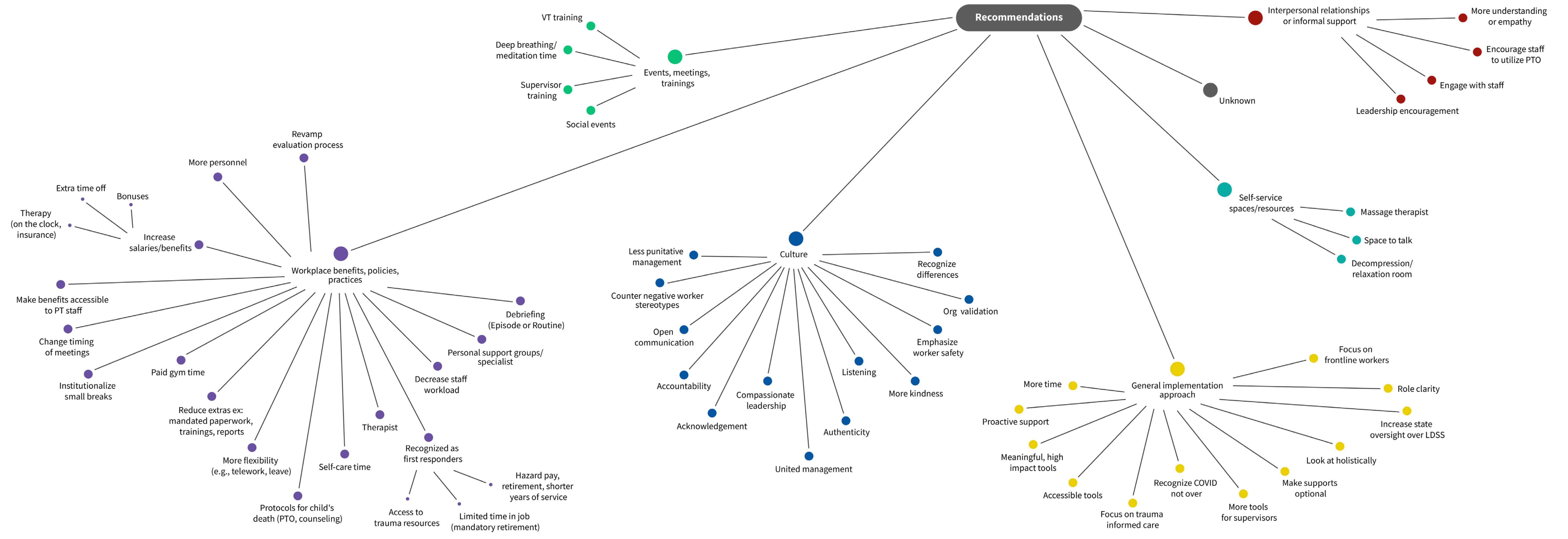


Figure 10: Pandemic Effects (Negative)

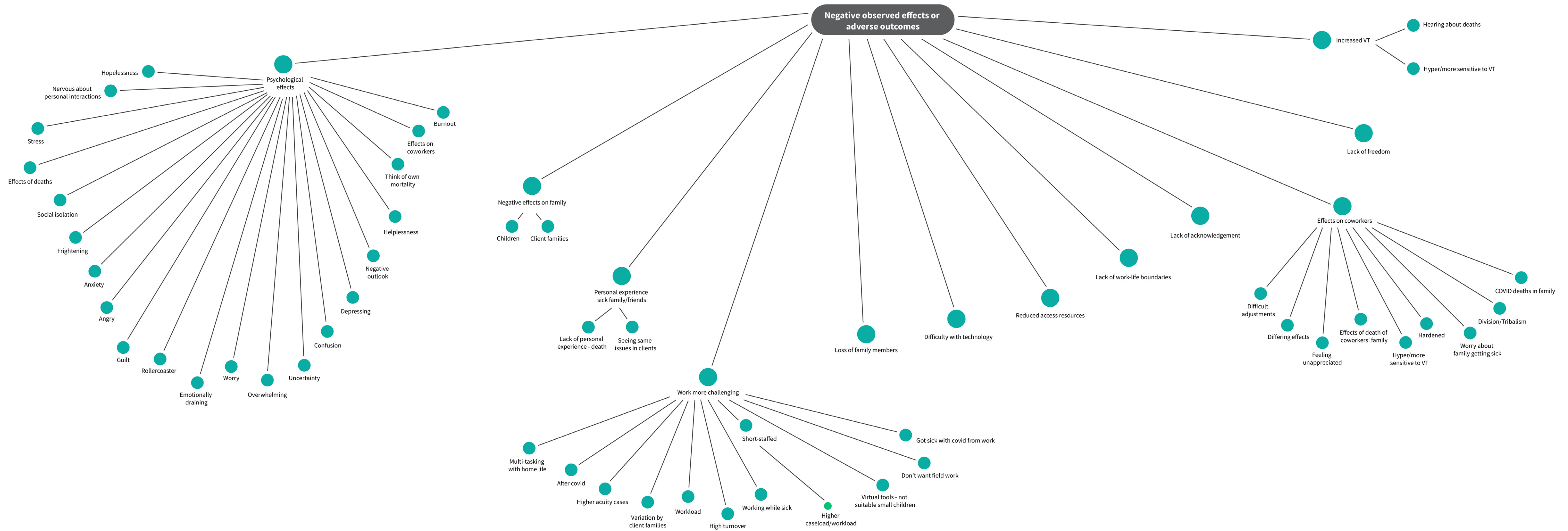
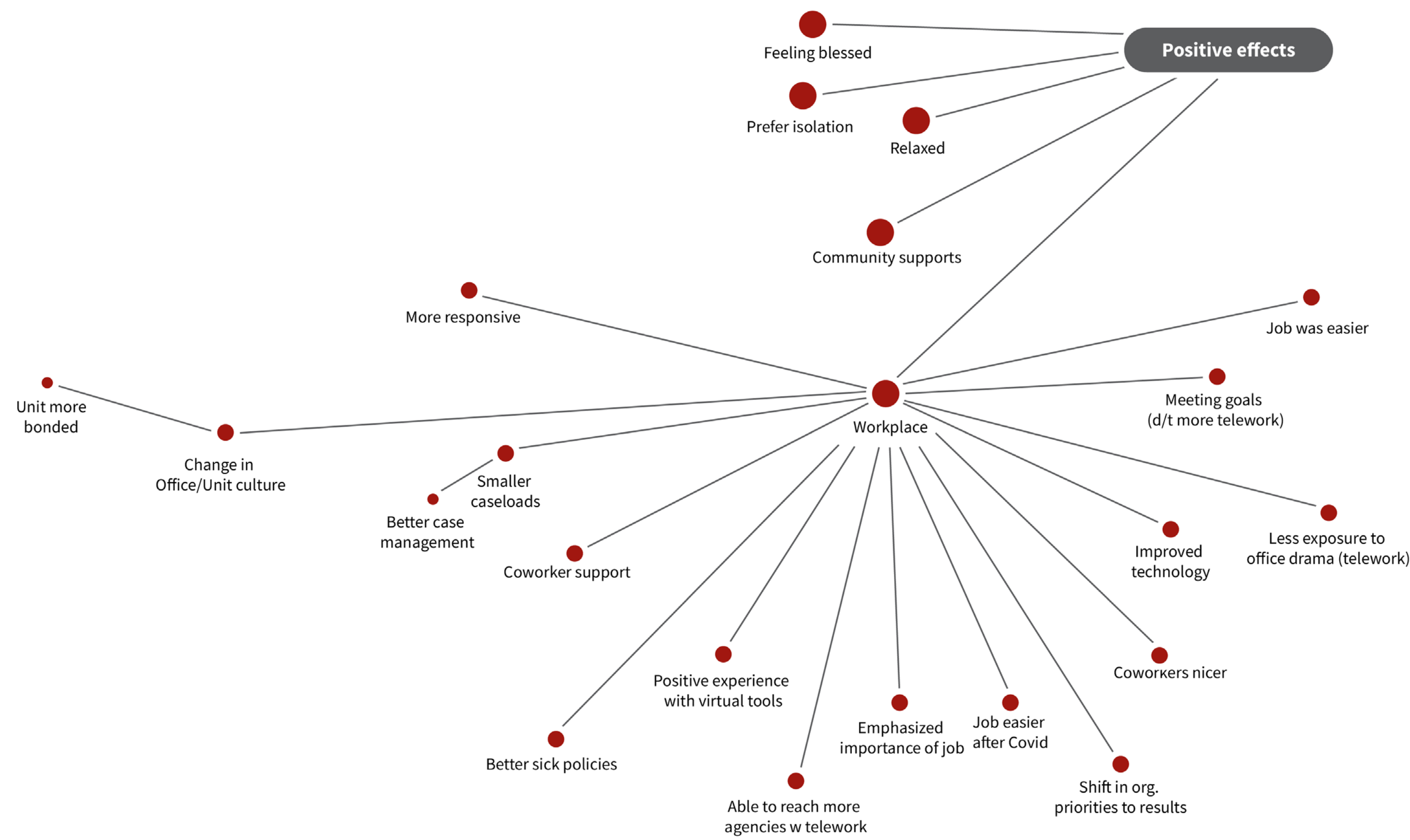


Figure 11: Pandemic Effects (Positive, Ongoing)



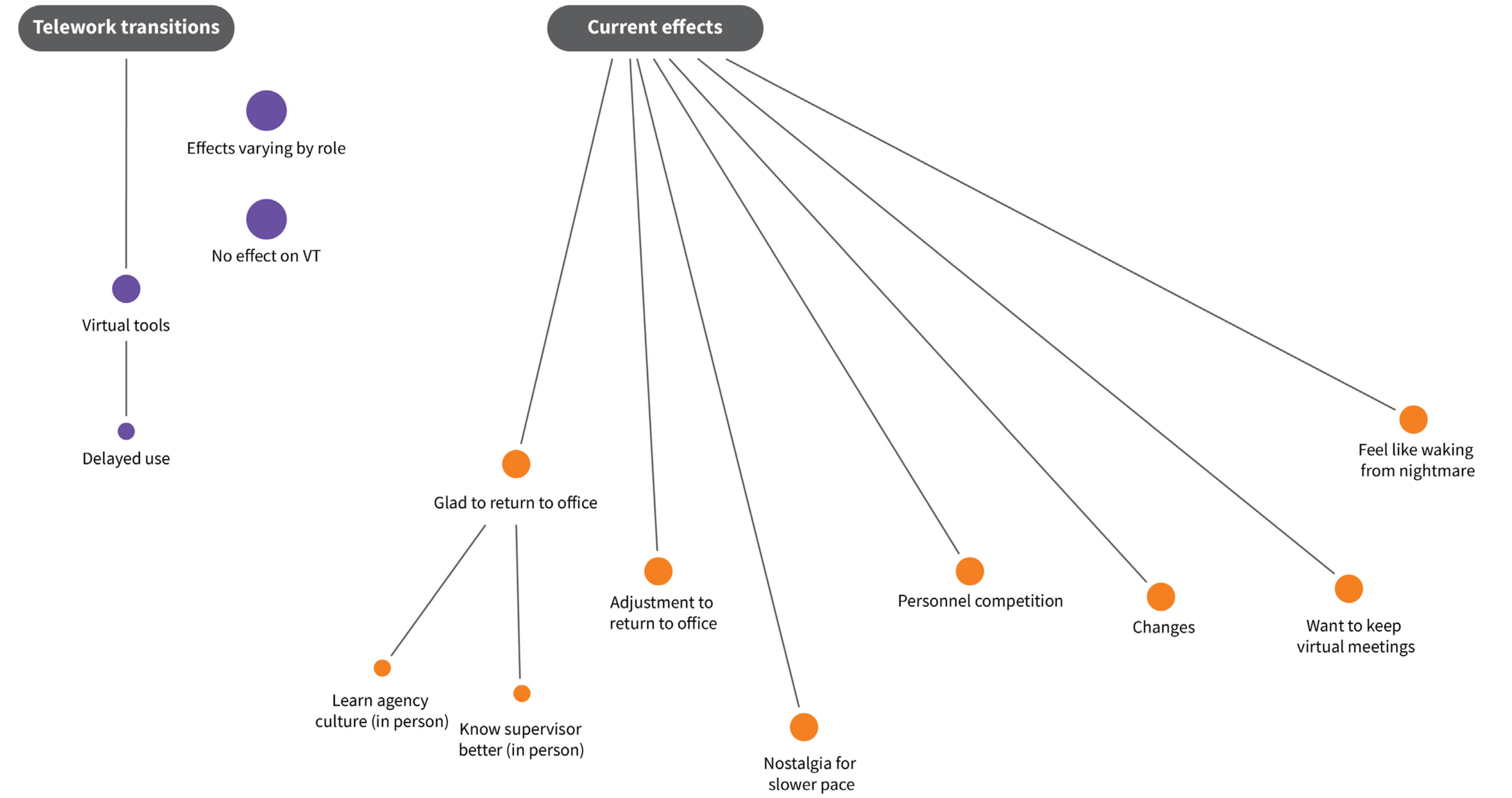
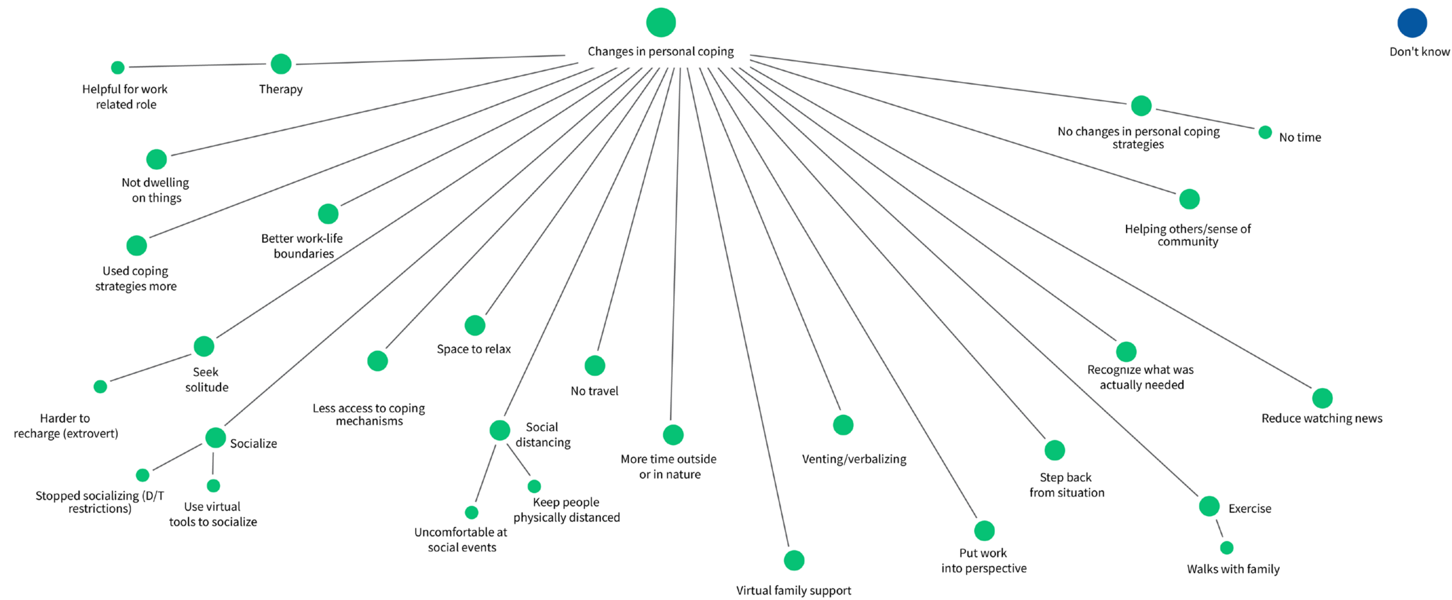
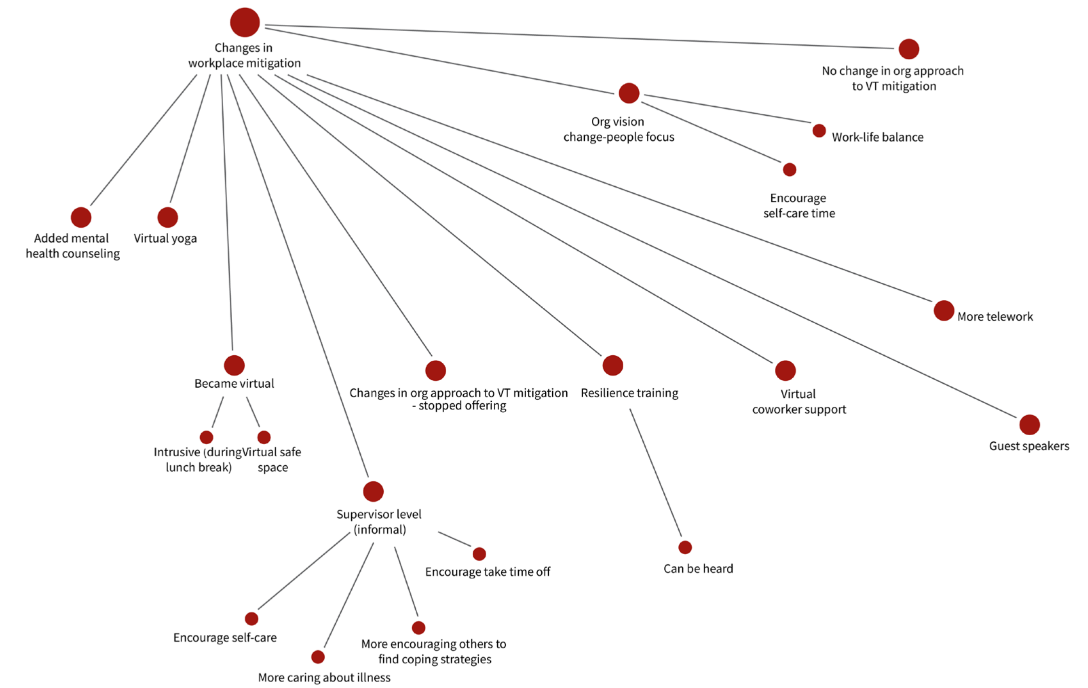


Figure 12: Pandemic-Driven Changes in Coping Strategies





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