Secondary traumatic stress among victim advocates: prevalence and correlates

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ABSTRACT

Purpose: The purpose of this study was to establish the prevalence of Secondary Traumatic Stress (STS) among victim advocates and to determine if risk factors (for the development of STS) that have been cited in the literature (with other populations) are applicable to victim advocates. Methods: Data was collected from 135 victim advocates using an online survey. Results: The prevalence rate of STS among victim advocates is approximately 50% and risk factors include number of hours worked per week, direct service hours, and working with adult survivors of child sexual abuse. Discussion: Our results suggest that cumulative trauma exposure acts as risk factors to the development of STS among victim advocates. Conclusion: Intervention efforts for this population are sorely needed and the information gained from this study can be used to guide these intervention efforts.

Keywords: Victim advocate; secondary traumatic stress; vicarious trauma; risk factors

Between 20% and 62% of individuals in the United States experienced rape, violence, and/or stalking at the hands of a current or ex-intimate partner (Walters, Chen, & Breiding, 2013). Both interpersonal and sexual violence have been associated with a myriad of physical and mental health sequelae (Briere & Jordan, 2004; Walters et al., 2013). Despite the prevalence, impact, and cost of interpersonal violence, rates of reporting are troublingly low. For example, it is estimated that fewer than 33% of sexual assaults (Walters et al., 2013) and less than 58% of domestic violence incidents are reported to the police (Truman & Morgan, 2016). In an effort to increase reporting and decrease feelings of a “second victimization” (Madigan & Gamble, 1991), efforts have been made to provide victims with a safe and helping environment in forensic and hospital settings by utilizing a team-based approach. The team-based approach to victim care has yielded positive outcomes (Greeson, Campbell, Bybee, & Kennedy, 2016) and the victim advocate plays a central role in the team-based approach.

Victim advocates provide emotional support, crisis intervention, and counseling (Moylan, Lindhorst, & Tajima, 2015) and aid in addressing and mitigating barriers to victims’ reporting by facilitating victims’ engagement with the criminal justice system (Patterson & Tringali, 2015). According to the National Center for Victims of Crime (2012), a victim advocate is a professional who is trained to support victims of crime, offer information about the different options available to victims, and support their decision-making. Victim advocate support is a
strong predictor of victim cooperation at deposition and case outcome (Camacho & Alarid, 2008) and survivors who have the assistance of a victim advocate are more likely to have police reports taken and less likely to be negatively treated by police officers (Campbell, 2006). Victim advocates also play an important role in gathering information uniquely available at the scene (McCarroll et al., 2008). Despite their clear importance, training for victim advocates varies widely across states, coalitions, and individual agencies (Stover & Lent, 2014). Regardless of these regional differences, it is clear that being a victim advocate is a challenging role. For instance, victim advocates can experience frustration when working with women who choose to stay in abusive circumstances (Dunn & Powell-Williams, 2007). Given the nature of their work, it is not surprising that victim advocates have been noted to experience negative repercussions related to their work.

The role of the victim advocate is complex as victim advocates must be able to work effectively with other members of the team who might have perspectives and approaches that are incongruent with the nature of their position including police officers/law enforcement (Rich & Seffrin, 2013; Sudderth, 2006) and nurses (Patterson & Pennefather, 2015). Indeed, qualitative research has revealed that victim advocates perceive that the power wielded by the police and medical systems revictimizes victims; victim advocates often find themselves attempting to mitigate this revictimization (Maier, 2008). Victim advocates have been noted to be impacted by vicarious trauma (Benuto, Singer, Cummings, & Ahrendt, 2018) and have intense emotional reactions which can be construed as part of vicarious trauma, but can also serve as a resource for working with the clients who they serve (i.e., the intense emotional reaction may be used as a resource to aid in serving the victim: Wasco & Campbell, 2002a). Despite this, victim advocates see their own position as intrinsic to the healing and helping process (Murphy, Banyard, Maynard, & Dufresne, 2011).

The negative repercussions that social workers (Lloyd, King, & Chenoweth, 2002), nurses (Beck, 2011), and other mental health professionals (Wagaman, Geiger, Shockley, & Segal, 2015) experience from their work with victims have been abundantly cited in the literature. These repercussions can include burnout (Lloyd et al., 2002), compassion fatigue (Kapoulitsas & Corcoran, 2015), vicarious trauma (Michalopulos & Aparcio, 2012), or secondary traumatic stress (Lloyd et al., 2002). However, research on how working with trauma victims impacts victim advocates is much more limited despite their central role in the victim services arena. Of the research that does exist, Babin, Palazzolo, and Rivera (2012) found that advocates who hold staff positions reported higher levels of emotional exhaustion than volunteers, perhaps because they are more likely to have direct contact with victims. They also found that perceived emotional support was negatively related to burnout. Additionally, qualitative research has indicated that advocates experience difficulty coping with occupational stress (Powell-Williams, White, & Powell-Williams, 2013), that advocates do not feel that the emotional work they do with clients is respected (Kolb, 2011), and that organizational barriers exist and staff burnout is a major barrier effecting advocates’ ability to help survivors (Ullman & Townsend, 2007).

**Secondary traumatic stress (STS)**

STS shares similar symptom structure with post-traumatic stress disorder (PTSD: Beck, 2011) and is defined as distress related to helping or wishing to help individuals who have undergone trauma or victimization (Figley, 1995). In a comprehensive meta-analysis, Hensel, Ruiz,
Finney, and Dewa (2015) found that there are several risk factors related to the development of STS among professionals who are indirectly exposed to trauma through their work with trauma victims. These included caseload volume, caseload frequency, and having a personal trauma history. Additionally, lack of experience working with trauma victims (Pearlman & McKinley, 1995) and caseloads high in sexual violence (Schauben & Frazier, 1995) have been cited as predictors of STS (Wasco & Campbell, 2002a).

With regard to prevalence rates, Hensel et al. (2015) noted that the prevalence rates of STS range substantially. For example, the prevalence of STS was noted to be 34% among child protective service workers (Bride, Jones, & Macmaster, 2007) and 15.2% among licensed social workers (Bride, 2007). A research agenda that includes determining the scope of prevalence of STS was recently created by leaders in the field (Molnar et al., 2017). While gaining an understanding of prevalence rates within service providers is important, it is also critical to develop a nuanced understanding of how STS manifests across different occupations.

Currently little is known regarding the experiences of STS among victim advocates. This represents a deficit in the literature; victim advocates are often a victim’s first source of contact with the legal system and aid in ensuring that victims have a more positive experience with the adjudication process (Camacho & Alarid, 2008; Campbell, 2006). Moreover, experts in the field have called for research on the identification of risk factors in the development of STS (Molnar et al., 2017). Thus understanding the factors that contribute to STS among victim advocates is imperative. The purpose of the current study was to determine the prevalence rate of STS among victim advocates and to assess factors that are related to STS. The specific research questions that guided this study were:

1. What is the prevalence of STS among victim advocates?
2. What are risk factors in the development of STS among victim advocates?

**Methodology**

**Procedure**

Approval for this study was granted from the University of Nevada, Reno Institutional Review Board (IRB). A web search was conducted using the term “victim advocate” in order to identify agencies (N = 75) that employed victim advocates around the United States; agencies were then contacted and asked to distribute an email to the victim advocates at their organization that contained an invitation to participate in the study between February 2016 and February 2017. This invitation contained a link to a brief introduction and consent form, a demographic form, and the study instruments. Study instruments were administered using Survey Monkey and the estimated time to complete the study was 20 min. Additionally, researchers requested that participants forward the link to the study to other victim advocates. A total of 142 victim advocates responded to the survey. Ten participants were excluded from the study due to submitting incomplete surveys.
Materials

Demographic Questionnaire
Information about the advocates’ age, ethnicity, gender, education, income, dependents in household, work, years of experience, hours worked per week, and direct hours working with victims per week was gathered. Additionally, information regarding the type of victims and services that participants provide was also collected. Finally, advocates were asked if they had a personal history of trauma.

Secondary Traumatic Stress Scale (STSS)
The STSS is a 17-item, self-report measure that assesses STS (Bride, Robinson, Yegidis, & Figley, 2004); the STSS has strong reliability and validity and was originally validated with a sample of master’s level social workers. The STSS has been used to measure STS in people of different service occupations (Meadors, Lamson, Swanson, White, & Sira, 2009) and has been demonstrated to have adequate psychometric properties with victim advocates (Benuto, Yang, Ahrendt, & Cummings, 2018). Cronbach’s alpha coefficients for this sample indicated high internal consistency, $\alpha = 0.93$, 95% CI = [0.91, 0.94].

Participants
One hundred and forty-five participants were initially recruited; however, 10 were excluded due to missing data exceeding 5%. The remaining participants consisted of 135 victim advocates with an average of 7.66 years of experience (SD = 7.62). Six victim advocates indicated that they were unpaid. Advocates worked an average of 38.07 h per week (SD = 9.29) with an average of 25.31 h (SD = 11.79) per week working directly (i.e., face to face) with victims. Participants were predominantly female (94.1%). Age ranged widely, from 21 to 72 years ($M = 37.96$, $SD = 12.71$). The majority of participants identified as white (77.8%). For a complete breakdown of ethnicity, see Table 1.

Data analysis plan
All analyses were conducted in SPSS version 24 (Armonk, NY, US: IBM Corp.). Aside from the cases excluded, there were relatively little missing data. Of these due to the nature of the data missing (e.g., age, direct service hours) we chose not to attempt to impute based on sample characteristics and used listwise deletion in analyses. The prevalence of STS was determined using three different methods outlined below and potential risk factors for the development of STS were evaluated using a series of multiple linear regressions.

Evaluating STS prevalence
There is relatively little empirical research evaluating prevalence of STS and to our knowledge none examining victim advocates specifically. As this is a relatively unexplored area, three different methods of determining prevalence rates of STS among the sample were used, based on previous work by Bride (2007). The first approach mirrors the diagnostic criteria for PTSD presented in the Diagnostic and Statistical Manual of
Mental Disorders IV Text Revision (DSM IV-TR; American Psychological Association, 2000). Using this strategy prevalence is determined by whether individual subjects endorse at least one item on the intrusion subscale, at least three times on the avoidance subscale, and at least two items on the arousal subscale (Bride, 2007). Participants were considered to have endorsed an item if they scored a three ("occasionally") or higher on the item.

The second approach to determining prevalence of PTSD due to STS classifies individuals based on normative data collected using a social worker sample (Bride, 2007). Based on these data, individuals with scores in the lower 50th percentile (i.e., scores below 28) are classified as having little to no STS, scores that fall from the 51st to 75th percentile (scores between 28 and 37) are considered mild STS, scores in the 76th to 90th percentile (scores between 38 and 43) are considered as moderate STS, scores in the 91st to 95th percentile (scores between 44 and 48) are considered as high STS, and, finally, scores falling above the 95th percentile (scores of 49 or above) are considered to have severe STS (Bride, 2007).

The third approach that Bride (2007) suggests involves determining prevalence by using a cutoff score. This score is based on the score ranges presented in the second method, and the recommended cutoff based on these score ranges is 38.

Table 1. Advocate characteristics.

<table>
<thead>
<tr>
<th>Race*</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>20</td>
<td>14.8</td>
</tr>
<tr>
<td>White</td>
<td>105</td>
<td>77.8</td>
</tr>
<tr>
<td>Mixed</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Hawaiian or other Pacific Islander</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>2</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Rates of STS by percentile

<table>
<thead>
<tr>
<th>STS Level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little to no STS</td>
<td>29</td>
<td>21.5</td>
</tr>
<tr>
<td>Mild STS</td>
<td>35</td>
<td>25.9</td>
</tr>
<tr>
<td>Moderate STS</td>
<td>24</td>
<td>17.8</td>
</tr>
<tr>
<td>High STS</td>
<td>15</td>
<td>11.1</td>
</tr>
<tr>
<td>Severe STS</td>
<td>32</td>
<td>23.7</td>
</tr>
</tbody>
</table>

Advocate services provided

<table>
<thead>
<tr>
<th>Advocate Service</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logistical Services</td>
<td>130</td>
<td>96.3</td>
</tr>
<tr>
<td>Information Services</td>
<td>119</td>
<td>88.1</td>
</tr>
<tr>
<td>Support Services</td>
<td>128</td>
<td>94.8</td>
</tr>
<tr>
<td>Advocacy Services</td>
<td>109</td>
<td>80.7</td>
</tr>
</tbody>
</table>

Victims worked with

<table>
<thead>
<tr>
<th>Victim Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child victims of sexual abuse (CSA)</td>
<td>78</td>
<td>57.8</td>
</tr>
<tr>
<td>Adult victims of sexual assault</td>
<td>114</td>
<td>84.4</td>
</tr>
<tr>
<td>Adult survivors of CSA</td>
<td>93</td>
<td>68.9</td>
</tr>
<tr>
<td>Domestic violence victims</td>
<td>123</td>
<td>91.1</td>
</tr>
</tbody>
</table>

*One participant did not specify ethnicity.

Table 2. STSS descriptive statistics.

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusion</td>
<td>5.00</td>
<td>23.00</td>
<td>11.03</td>
<td>3.70</td>
</tr>
<tr>
<td>Avoidance</td>
<td>7.00</td>
<td>31.00</td>
<td>16.00</td>
<td>5.72</td>
</tr>
<tr>
<td>Arousal</td>
<td>5.00</td>
<td>23.00</td>
<td>12.01</td>
<td>4.17</td>
</tr>
<tr>
<td>STS total</td>
<td>18.00</td>
<td>73.00</td>
<td>39.04</td>
<td>12.56</td>
</tr>
</tbody>
</table>
Evaluating potential risk factors for STS

In order to examine potential risk factors for STS among advocates, a series of multiple linear regression analyses were conducted, with predictors entered in a single step. A single regression, with all predictor variables, was initially considered; however, as this is exploratory, with a high number of variables being evaluated the necessary corrections for alpha were considered to be overly conservative in the context of this study. Instead, predictors were grouped based on class (i.e., advocate characteristics, types of victims worked, with and types of services provided) in order to account for them in the model. These predictor variables were selected as the extant literature indicates that these are predictors of STS in other populations (Baird & Kracen, 2006; Hensel et al., 2015; Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Wasco & Campbell, 2002a). However, as increasing the number of tests can increase the potential for Type I errors, we encourage readers to interpret findings as preliminary and in need of corroboration.

Results

Prevalence rates of STS among advocates

The three methods outlined by Bride (2007) for determining STS prevalence previously described yielded fairly similar results. Using the first strategy wherein prevalence is determined by endorsement of items from the different subscales (i.e., intrusion, avoidance, and arousal see Table 2), 66 participants (48.89%) met the threshold for STS. The second approach, comparing data to a normative sample and classifying individuals into categories ranging from little to no STS (i.e., lower 50th percentile), to severe STS (i.e., 91st percentile and above) suggested that over half (52.6%) of the sample could be classified as having moderate, high, or severe STS. Specific results using this method are presented in Table 1. Finally, the third approach uses a cutoff score of 38 (i.e., >75th percentile). Applying this cutoff to the present sample yields a total of 71 participants above the cutoff, or 52.95% of our sample. This method was somewhat more liberal than the algorithmic method; however, there was 93% agreement between the two methods on identification of individuals with STS.

Contributing factors to STSS

To examine what specific factors contribute to STS symptoms, three linear regressions were conducted. The first regression included a variety of factors including total hours worked, direct service hours, years of experience, and the advocate’s own victim status. The second regression evaluated the contribution of the types of services advocates engaged in and the final regression examined whether the type of victim that victim advocates worked with contributes to secondary trauma.

Regression data screening and assumptions

Preliminary data analysis included visual inspection of the scatterplots of continuous predictor variables and the outcome variable. The scatterplots suggested weak linear relationships between predictor variables and the outcome variable. Continuous variables were also assessed for normality using the standardized skew and kurtosis scores, as well as the Shapiro-Wilk test. Many variables were non-normal; however, no transformations were
made; this was due in part to the nature of the variables (i.e., transformations of age, years of experience, etc., would make the data less interpretable without retransformation), but more importantly transformations can be problematic (see Glass, Peckham & Sanders, 1972) and may be unnecessary provided residuals are normally distributed (Field, Miles, & Field, 2012). Specific normality results are presented in Table 3. Normality and scatterplots of residual scores were assessed for homoscedasticity and independence. Residuals were normally distributed; however, scatterplots of residuals suggested some mild changes in variance across scores for all regressions, which may indicate the presence of a moderating variable. Unidimensionality of the outcome measure was also assessed, Cronbach’s alpha = 0.913. Multicollinearity between predictor variables was assessed using Pearson’s r correlation, tolerance scores, Variance inflation factor (VIF), and Condition Index scores. There were no apparent issues with multicollinearity for regressions 1 and 2. Pearson’s r correlations were all < 0.6, except in regression 3, where childhood physical and sexual abuse had a correlation of 0.8. However, this is not unexpected given the high rate of co-occurrence of these experiences. Multicollinearity can impact the accuracy of specific beta values; it tends to result in R and R² for the model being more conservative. The typical cutoff scores for Pearson’s r are between 0.8 and 0.9 (Field et al., 2012) and as all other assessments of multicollinearity were within the cutoff range the analysis proceeded normally. Finally, multivariate outlier analyses were conducted for each regression using the method outlined by Tabachnik and Fidell (2000).

Regression 1: trauma exposure—direct service hours, total hours, victim status, and years of experience

The first regression examined the impact on STS, of advocate’s total hours worked, total direct service hours, whether they themselves were a victim, and their years of experience. Five multivariate outliers were removed based on critical Cook’s and Leverage values. The omnibus test was significant, R = 0.369, R² = 0.136, Adjusted R² = 0.108, F(4, 123) = 4.84, p = 0.001. Of the predictor variables, total hours worked per week and direct services hours per week were both significant predictors of STS, β = 0.304, t (126) = 2.29, p = 0.02 and β = 0.205, t (126) = 2.00, p = 0.047, respectively. For complete results of the regression, see Table 4.

Table 3. Normality tests.

<table>
<thead>
<tr>
<th></th>
<th>z-Skew</th>
<th>z-Kurtosis</th>
<th>Shapiro-Wilk (df = 137)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of experience</td>
<td>6.58</td>
<td>3.54</td>
<td>0.85*</td>
</tr>
<tr>
<td>Direct service hours per week</td>
<td>0.55</td>
<td>−0.09</td>
<td>0.97*</td>
</tr>
<tr>
<td>Total hours per week</td>
<td>−8.08</td>
<td>9.04</td>
<td>0.71*</td>
</tr>
<tr>
<td>Secondary traumatic stress symptoms</td>
<td>1.69</td>
<td>−1.07</td>
<td>0.98*</td>
</tr>
</tbody>
</table>

*p < 0.05.

Table 4. Trauma exposure as a predictor of STS.

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total hours per week</td>
<td>21.03</td>
<td>4.77</td>
<td>0.22</td>
<td>4.41**</td>
</tr>
<tr>
<td>Total direct service hours</td>
<td>0.30</td>
<td>0.13</td>
<td>0.22</td>
<td>2.29*</td>
</tr>
<tr>
<td>Years of experience</td>
<td>0.21</td>
<td>0.10</td>
<td>0.20</td>
<td>2.00*</td>
</tr>
<tr>
<td>Trauma status</td>
<td>−0.11</td>
<td>0.15</td>
<td>−0.07</td>
<td>−0.79</td>
</tr>
<tr>
<td></td>
<td>2.57</td>
<td>2.13</td>
<td>0.10</td>
<td>1.21</td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.001.
**Regression 2: services provided**

The second regression examined the role of services provided in STS. See Table 1 for the frequency and percent of the sample providing each type of service. Types of services were broken down into four categories: (a) advocacy services, including accompanying victims to court and legal proceedings, as well as intervening on the victim’s behalf with landlords, employers, etc., (b) support services, including individual and group counseling, (c) logistical services, including making referrals, helping victims with paperwork, applications, etc., and (d) providing information to the victim. Seven multivariate outliers were removed based on critical Cook’s and Leverage values. The omnibus test was not significant: $R = 0.221$, $R^2 = 0.049$, Adjusted $R^2 = 0.018$, $F(4, 123) = 1.58$, $p < 0.18$, suggesting that types of services provided by advocates do not impact STS.

**Regression 3: types of victims**

The final regression examined the impact of the type of victim advocates worked with on STS. Types of victim included: child victims of sexual and physical assault, domestic violence victims, adult victims of sexual assault, as well as adult survivors of childhood sexual assault. See Table 1 for the frequency and percent of victim types. Seven multivariate outliers were removed based on critical Cook’s and Leverage values. The omnibus test was significant; $R = 0.346$, $R^2 = 0.119$, Adjusted $R^2 = 0.083$, $F(5, 122) = 3.31$, $p = 0.008$, indicating that type of victim predicted STS. However, of the predictor variables, only working with adult survivors of sexual abuse was a significant predictor of STS (see Table 5 for complete results). In addition, given the potential issues with multicollinearity specific betas for this regression should be interpreted with caution.

**Discussion**

The purpose of this study was to establish the prevalence of STS among victim advocates and to determine if risk factors (for the development of STS) that have been cited in the literature (with other populations including school personnel, child protective or welfare workers, domestic violence workers chaplains [Hensel et al., 2015], and mental health professionals [Baird & Kracen, 2006; Hensel et al., 2015; Pearlman & MacIan, 1995; Schauben & Frazier, 1995]) are applicable to victim advocates. Depending on the criteria used for STS, prevalence rates ranged in this sample from 48.89% to 52.95%. Participants were noted to score the highest on the avoidance subscale.

With regard to risk factors and STS, the extant literature cites caseload volume, caseload frequency, having a personal trauma work history (Hensel et al., 2015), cumulative

<table>
<thead>
<tr>
<th>Type of victim as a predictor of STS.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>$\beta$</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>35.82</td>
</tr>
<tr>
<td>Children who have been sexually abused</td>
</tr>
<tr>
<td>Children who have been physically abused</td>
</tr>
<tr>
<td>Victims of domestic abuse</td>
</tr>
<tr>
<td>Adult victims of sexual assault</td>
</tr>
<tr>
<td>Adult survivors of sexual abuse</td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.001.
exposure, and hours spent working with trauma clients (Baird & Kracen, 2006) as being linked to the development of STS. Additionally, little exposure to or few experiences with trauma victims (Pearlman & MacIan, 1995) and caseloads high in sexual violence (Schauben & Frazier, 1995) have been cited as robust predictors of STS (Wasco & Campbell, 2002a). Our results indicate that the only consistent predictors of STS in this sample were number of hours worked per week, direct service hours, and working with adult survivors of child sexual abuse.

Prevalence of STS

Assessing the prevalence of STS is challenging as there are different ways in which assessment scores can be interpreted. For instance, scores on the STSS can be interpreted in at least three different ways (Bride, 2007). These include (a) assessment based on the endorsement of a specific number of items on each of the three DSM IV-TR PTSD core criteria-based subscales (i.e., at least one item on the intrusion subscale, at least three items on the avoidance subscale, and at least two items on the arousal subscale), (b) using normative percentages (i.e., comparing one’s score to a normative distribution and then determining severity based on the percentage of the population that it is above), and (c) using a cut-score (i.e., at or above a specific score indicates the presence of STS; Bride, 2007).

Using the first method can be beneficial as it is the most reflective of DSM-IV-TR (and is fairly proximal to the criteria listed in the DSM-5 [American Psychiatric Association, 2013]); each participant’s scores across the three areas of symptomatology that is required for diagnosis of PTSD (intrusion, arousal, and avoidance) are assessed. A symptom is considered present if the participant rates the corresponding item at 3 or higher on the 7-point Likert scale (i.e., participant experiences the symptom occasionally, often, or very often). Using this method, 66 participants (48.89%) were found to meet criteria for experiencing clinical levels of STS in our sample. This is much greater than the 15.2% prevalence rate Bride (2007) found among social workers.

The second method involves assessing severity by comparing scores to the sample population and then separating them into categories based on their percentile ranking (see Results and Table 1 for a breakdown of this classification). Unfortunately, Bride (2007) did not report his sample’s scores in this manner and therefore we cannot compare our findings to his. We found that 47% of our sample had no, little, or mild STS and over one third of our sample had high or severe STS. The third method uses a cut-score to classify participants into dichotomous groups (i.e., meeting or not meeting criteria); obtaining a score of 38 or more on the STSS is indicative of having STS (Bride, 2007). Comparing our findings to those of other studies who have used the dichotomous cut score, our rate of STS in victim advocates (52.95%) far exceeds the rates of STS among other occupations. For example, nurses have been noted to have an STS prevalence rate of between 20% and 38% (38%: Quinal et al., 2009; 20.3%: Morden, Geraldine, Yangsong-Serondo, 2017) and child protective workers have been noted to have a prevalence rate of STS of 34% (Bride, Jones, & Macmaster, 2007).

While STS can be interpreted using a variety of methods, it is evident that the prevalence of STS is high among victim advocates regardless of the method that we use to interpret scores on the STSS. Specifically, our population had higher rates of STS
compared to other studies across each of the three methods of interpreting STS prevalence. While Hensel et al. (2015) noted that the prevalence of STS ranged substantially across occupations (the highest rate was noted to be 34% among child protective service workers (Bride, Jones, & Macmaster, 2007), the prevalence rate of STS among our sample was substantially higher than this. Victim advocates may have higher rates of STS than what is observed in other occupations as they are exposed to secondary trauma via the stories they hear from their clients, they may be included as part of the on-site team (i.e., they may work on actual crime scenes), and their job requires them to engage in a diverse range of duties.

**Contributing factors of STS**

**Trauma Exposure**

In this study, we investigated exposure to traumatic material via an examination of how direct service hours, a personal history of trauma (which would be indicative of additional exposure to trauma), and years of experience as a victim advocate were related to scores on the STSS. Our results indicated that the number of hours worked per week and the number of direct hours worked with victims predicted STS. These results suggest that cumulative trauma exposure acts as risk factors to the development of STS among victim advocates. This is consistent with the extant literature as there is a persuasive level of evidence (Baird & Kracen, 2006) that the amount of exposure (including hours with trauma clients, percentage on caseload, and cumulative exposure to traumatic material of clients) increases the likelihood of STS (Brady, Guy, Poelstra, & Brokaw, 1999; Creamer, 2002; Myers & Cornille, 2002; Simonds, 1996; Wee & Myers, 2002).

Structured approaches to decrease susceptibility to burn-out and STS typically involve educational or skills trainings, with a focus on self-care (Awa, Plaumann, & Walter, 2010). While a discussion of what types of interventions might be effective in preventing STS is beyond the scope of this paper (see Benuto, Singer, Gonzalez, Newlands, & Hooft, Under Review for such a discussion), it is worth noting that at a minimum, agencies may wish to monitor the number of hours worked per week (including number of direct hour worked with victims). It is noteworthy that advocates spent (on average) 66% of their time directly with victims. This is substantial and our results suggest that agencies may wish to structure victim advocate’s time in a manner that allows them to engage with victims and also allots them substantial time to do the work that is necessary behind the scenes.

Our findings that a personal history of trauma is not related to the development of STSS fit with the equivocal body of literature on personal history of trauma and STS (Baird & Kracen, 2006). There is a reasonable level of evidence that supports that having a personal trauma history is both linked (Allt, 1999; Dickes, 1998; Nelson-Gardell & Harris, 2003; Price, 2001) and not linked (Creamer, 2002; Follette, Polusny, & Milbeck, 1994; Simonds, 1996) to the development of STS. Given that many victim advocates have a history of personal trauma, perhaps victim advocates use their work with victims as a mechanism of healing from personal trauma (Michalopoulos & Aparcio, 2012; Slattery & Goodman, 2009), which may explain why we found that being a victim is not related to STS in this population. The only study to our knowledge that has investigated STS with victim advocates was conducted by Slattery and
Goodman (2009) who found that individuals who had a trauma history were more likely to develop STS; Slattery and Goodman suggested that the discrepant findings across studies are due to the variant nature in which how trauma is defined. In our study, we simply asked participants if they themselves were a victim of trauma. It is however peculiar that our findings diverged from those of Slattery and Goodman as our sample reported working with child victims, sexual assault victims, and victims of domestic violence whereas Slattery and Goodman’s participants only worked with victims of domestic violence. It has been noted that secondary trauma is more likely to occur with those who work with sexually abused clients (Cunningham, 2003). Arguably working with different victim populations seems as though it would further exacerbate personal trauma as a risk factor in STS although we did not find this to be the case in our study. Additional points for consideration include that some (albeit a small percentage) of our participants were volunteers. Volunteer status may be indicative of an intrinsic motivation to work with victims and perhaps results in greater work satisfaction. This could explain why in our sample we did not observe a relationship between victim status, years of experience, and STS although again, only a small minority of our participants were volunteers.

**Services provided**

STS is defined by the stress resulting from exposure to a traumatic event experienced by another person (Figley, 1999). This in turn fosters the notion that the services more closely related to the trauma itself would result in higher rates of STS. However, our results indicated that the development of STS is independent of the types of services provided. Because the victim advocate position requires most, if not all, of these services, a more specific breakdown of the time spent providing each type of service and which type of victims they are provided to may be necessary to assess the impact on STS more accurately. Alternatively, it may simply be that STS is not related to the types of services a victim advocate provides.

**Victims worked with**

Our findings indicated that working with adult survivors of sexual abuse was a significant predictor of STS. This is somewhat consistent with the extant literature that suggests that caseloads high in sexual violence (Schauben & Frazier, 1995) are robust predictors of STS (Wasco & Campbell, 2002a). However, it is peculiar that in our sample working with victims of other classes of sexual violence was not associated with increased STS; this suggests that working with adult survivors of sexual violence may carry a more substantial impact on victim advocates than working with child victims of child sexual abuse or adult victims of sexual assault. Sexual assault cases move very slowly through the justice system and advocates report that victims are seldom believed, causing anger and frustration for the advocate (Wasco & Campbell, 2002a), as well as an emotional drain on both the victim and their advocate (Murphy et al., 2011). Professionals working with these victims have an increased risk of STS when they closely relate to the victim (Gates & Gillespie, 2008), possibly explaining why adult victims had a greater impact on STS scores (although this does not explain why working with adult victims of sexual assault did not predict STS). One potential explanation of why adult survivors significantly predicted STS, but adult sexual assault did not may be a difference in client distress. It has been noted that survivors of child sexual abuse report higher levels of mental health symptomology
Therefore, victim advocates who work with this population may have higher rates of STS due to the level of distress that adult survivors of childhood sexual abuse may manifest.

**Limitations and future directions**

While 135 victim advocates participated in the study, it is difficult to know whether these individuals' traits are representative of the victim advocate population or if they differ as a result of self-selection bias. Also related to sample bias, because our recruitment efforts involved contacting agencies (and those agencies were asked to forward the study invitation to advocates who worked at their agency), we were unable to track how many advocates were invited to participate; thus, the response rate to the survey is unknown. We also do not have information about the agencies that our participants worked for or the geographic location of our participants. Another limitation of our study is that while we found total hours worked per week and direct service hours spent with a victim were both significant predictors of STS, we do not have a breakdown of either of these types of hours. Since victim advocates engage in a large number of diverse tasks both with and without direct contact with clients, having a detailed record of the time they spent conducting specific tasks would increase our understanding of STS and its potential causes and correlates. Moreover, while it was not the aim of the current paper, it may be that a combination of victim type, as well as the breakdown of specific types of services or hours spent providing these services, is more predictive of STS. Additionally, while our study examined some potential correlates of STS (information regarding the type of victims that the advocate worked with, the services the victim advocates provided, the types of support the advocate had in their life, the type of support their work provided them, the types of self-care and coping mechanisms they use, and their personal history of trauma) there are several other factors that may contribute to, or mitigate STS development or severity. For this reason, we recommend that future research examines other possible moderating variable such as, but not limited to, job satisfaction, mental health prior to becoming an advocate, satisfaction with quality of social support provided, quality of mental health support provided, and relationship quality. Finally, our study is limited by the selection of victim population that we chose to study. Due to the unique traits and professional responsibilities that victim advocates possess, caution should be used when generalizing these results to other work populations. By conducting additional research examining the correlates of STS and gaining a more nuanced understanding of the specific contributing and protective factors to the development of STS, researchers can develop prevention programs to decrease STS development as well as more specific and effective interventions to effectively and efficiently treat STS. An additional future direction consideration is with regard to generalizability to ethnic minority groups. Because of the assessment and treatment implications of secondary traumatic stress and because cultural considerations must be made with regard to psychological assessment (Benuto, 2013a; Benuto 2013b) and possibly with regard to ethnicity (Benuto & O'Donohue, 2015; O'Donohue & Benuto, 2010), future researchers should attempt to study secondary traumatic stress with a more diverse sample. This would allow for intervention efforts to be informed by the cultural and sociodemographic background of the client
which has been noted to be relevant and important (Benuto, 2017; Benuto & Leany, 2017; Benuto & Bennett, 2015).

References


