Secondary Traumatic Stress Among Nationally Credentialed Victim Advocates: Baseline and Risk Factors

by

Bette Marie Stebbins Inch

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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Approved by:

Stephany Pracht, EdD, Committee Chair

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Abstract

Crime victims rely on the expertise of nationally recognized victim advocates to navigate the complex criminal justice process that includes reporting the crime and participating in the criminal legal system while recovering from trauma. People indirectly involved in traumatic events can also experience adverse effects. Providing direct services to traumatized crime victims may increase an advocate's risk of developing secondary traumatic stress and negatively affect client services. This study was designed to examine the occurrence of specific symptoms matching the Secondary Traumatic Stress Scale to establish a baseline of secondary traumatic stress among a sample of nationally credentialed victim advocates working with military or civilian communities. The data identified potential risk factors, including victim advocates' caseload volume and frequency, personal history of trauma, the nature of support from their employing organizations, long-term engagement with trauma victims, and demographic variables of gender, age, and ethnicity. This study was quantitative, descriptive, and exploratory. Results indicated secondary traumatic stress is a genuine phenomenon that affects victim advocates working with traumatic crime victims, that advocates working in military or civilian communities did not differ in terms of the impact of indirect trauma exposure and secondary traumatic stress, and that caseload volume was a minor risk factor. Of the 59 respondents, 43 experienced at least one symptom of secondary traumatic stress in the previous 7 days. Comparing advocates working with the military to those working with the civilian community showed half reported high to severe symptoms based on the Secondary Traumatic Stress Scale.

Keywords: victim advocate, credential, secondary traumatic stress, military, civilian

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Dedication

I humbly dedicate this dissertation and my doctorate in community care and counseling with a concentration in traumatology to the many people who have supported me and prayed for me throughout this journey.

First and foremost, I offer my deepest gratitude to Jesus Christ, my Savior, whose unending love and guidance have sustained me through the challenges of this endeavor. His grace has provided for all my needs, enabling me to persevere and emerge victorious.

I would also like to express my heartfelt appreciation to my beloved husband, Mark Inch, and my family—Rachael and Garrett Oka, Matthew and Heaven Inch, Michael and Toni Inch, Katie and Giancarlo Jacobs, Kari and Evan Grainger, and my dear mother's Joan Inch and June Stebbins. Your unwavering support, encouragement, and sacrifices have been instrumental in my success, and I am forever grateful for your love.

I extend my gratitude to Lynn Klein, Laura Stacio, Jane Jones, Annette DiSarno, Andrea Keller and Rachel Hutchings, my sisters who have prayed for me throughout this dissertation journey. Many thanks—you are the best!

Moreover, I would like to dedicate my research and this dissertation to all victim advocates. Your steadfast commitment to serving and advocating for traumatized victims of crime deserves the utmost appreciation and recognition. "May the LORD bless you and keep you; the LORD make his face to shine upon you and be gracious to you; The LORD lift up his countenance upon you and give you peace" (*English Standard Version* 2001/2008, 6:24-26).

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List of Abbreviations

Compassion Satisfaction (CS)

Compassion Fatigue (CF)

Credentialed Advocate (CA)

Department of Defense Sexual Assault Advocate Credentialing Program (D-SAACP)

Federal Bureau of Investigation (FBI)

Intimate Partner Violence (IPV)

Mann-Whitney U (MWU)

National Advocate Credentialing Program (NACP)

Nationally Credentialed Victim Advocates (NCVA)

National Organization for Victim Assistance (NOVA)

Professional Quality of Life (ProQOL)

Posttraumatic Stress Disorder (PTSD)

Rape, Abuse, and Incest National Network (RAINN)

Secondary Traumatic Stress (STS)

Secondary Traumatic Stress Scale (STSS)

Sexual Assault Prevention and Response Office (SAPRO)

Uniform Code of Military Justice (UCMJ)

U.S. Department of Defense (DoD)

Victim Advocate(s) (VA)

Victim Advocacy Survey (VAS)

Victim-Witness Assistance Program (VWAP)

Chapter One: Introduction

Overview

This chapter establishes the foundation for investigating secondary traumatic stress (STS) among nationally credentialed victim advocates (NCVAs) that results from indirect trauma incurred from working with traumatic crime victims. The focus is on victim advocates (VAs) and undocumented STS experienced by NCVAs who work with military or civilian traumatic crime victims. STS negatively impacts their work and places them at-risk for developing posttraumatic stress disorder (PTSD) (Beck, 2011; Figley, 1995a). The background, problem statement, purpose statement, significance of the study, research questions, definitions, and summary follow.

Background

VAs are among helping professionals known to be at-risk for developing STS (Benuto, Newlands, et al., 2018; Benuto et al., 2019). STS results from indirect exposure to trauma and increases adverse mental health outcomes such as chronic stress and decreased job satisfaction (Cieslak et al., 2014; Cummings et al., 2021). It can also impede the ability of VAs to provide essential support services and puts them at-risk for PTSD (Benuto, Newlands, et al., 2018; Benuto et al., 2019; Figley, 1995b).

Historical Overview

In the 1980s, the National Organization for Victim Assistance (NOVA) pioneered a collective identity for advocates of crime victims (National Advocate Credentialing Program [NACP], 2021b). NOVA's efforts to steer the field of victim service organizations and individual providers in high-quality and ethical response culminated with the board of directors' formal

adoption of national standards and a code of professional ethics in 1995 (NACP, 2021a). Discussions among national victim assistance organizations, including Mothers Against Drunk Driving National, National Association of Crime Victim Compensation Boards, National Association of Victims of Crime Assistance Administrators, National Center for Victims of Crime, Ohio Organization for Victim Assistance, Ohio Advocate Network, and Pennsylvania Coalition on Crime and Delinquency in 2001, laid the foundation for the NACP in 2003 (NACP, 2021b). NACP's goal is to professionalize the role of VAs throughout civilian and military communities (NACP, n.d.-b).

Victim service providers are frontline responders who interact most frequently with crime victims providing them with vital support and care (S. Lee, 2019). NCVAs are a subtype of victim service providers who have demonstrated exceptional professional judgment and exemplify professional standards, ethical behavior, and proven subject-matter expertise with ongoing requirements for continuing education (NOVA, 2022). Credentialing is voluntary, and advocates have no time limit to meet credentialing standards except when one is required for employment (NACP, 2022a). Ultimately, credentialed advocates must meet renewal training standards every 2 years to retain their national credentials (NACP, 2022a).

Civilians

Researchers have examined STS symptoms among VAs in civilian communities but did not indicate whether advocates possessed a national credential and cautioned against generalizing to the broader communities of VAs and other helping professionals (Benut, Newlands, et al., 2018). Furthermore, researchers recognized the need for more research to examine the correlates of STS and "gain a more nuanced understanding of the specific contributing and protective factors to the development of STS" (Benut, Newlands, et al., 2018, p.

505). Research of social workers (Bride, 2007; Choi, 2017), nurses (Beck, 2011; Gates & Gillespie, 2008; Townsend & Campbell, 2009), forensic interviewers (Bonach & Heckert, 2012), and the therapeutic work performed with trauma victims (Hensel et al., 2015) highlights the risk of developing STS among these helping professionals as well. The lack of any study or scientifically based information leaves a gaping hole in the data about nationally credentialed VAs and their relationship with STS (Benuto, Newlands, et al., 2018). The gap leaves leaders in the victim advocacy profession at a loss when developing industry standards to mitigate the risk of VAs developing STS and PTSD from indirect exposure to trauma through their work (NACP, 2022b). Data are needed to inform intervention and prevention policies and the national credential training requirements impacting victim service providers within the military and civilian environments (NACP, 2022b).

Military

Credentialed VAs work within the military environment on installations and bases worldwide and at military universities (U.S. Department of Defense [DoD], 2021a, 2021b). These advocates support violent crime victims through reporting, military justice, and recovery processes (DoD, 2021a, 2021b). Military personnel are uniquely positioned to experience violent crime, which can alter their well-being and break the bonds of trust with colleagues and commanders, eroding unit cohesion and damaging mission readiness (Rosenthal et al., 2021). Recognizing the critical value of VAs, the Independent Review Commission on Sexual Assault in the Military (Rosenthal et al., 2021) cited having part-time VA as a "critical deficiency in the workforce" (p. 5) and recommended the secretary of defense employ a full-time only victim advocacy workforce and establish a DoD level particular VA. There is little research on STS within the military environment among helping professionals (i.e., Benuto, Newlands, et al.,

2018); VAs, credential unspecified (Wood et al., 2020); health providers (Cieslak et al., 2014; Kintzle et al., 2013); behavioral or mental healthcare providers suffering from trauma (Secosan et al., 2020); deployed healthcare staff (Penix et al., 2019); or family members (Diehle et al., 2017).

Theory

STS theory (Bride et al., 2004) served as the theoretical foundation for the study. STS theory holds that individuals who work closely with trauma victims can vicariously experience trauma, leading to adverse physiological responses that can impair functioning (Bride et al., 2004). STS is the expression of avoidance, intrusion, negative cognitions and mood, and arousal symptoms, such as avoiding clients, disturbing dreams, feeling emotionally numb, and irritability (Bride, 2007) (Table 1).

Table 1

STS Theory

STS symptoms	STS expressions
Intrusion symptoms	Repeated and intrusive remembrance of the shocking event; acting or sensing as if the event were repeating expressed as illusions, or reexperiencing the event; and strong emotional suffering or physiological re-activity when subjected to certain cues from the event (American Psychiatric Association [APA], 2013; Bride, 2007, 2004).
Avoidance symptoms	Include the evasion or efforts to evade stimuli associated with the shocking event, including deadening of reactions. They may be expressed as efforts to avoid anything related to the traumatic event, such as, thoughts, feelings, or conversations or to avoid reminders of the event, such as people, places, and activities. May also involve memory loss, separation, and detachment from individuals related to parts of the traumatic event, or limited ability to feel, and a foreboding sense of gloom (APA, 2013; Bride, 2007, 2004).

STS symptoms	STS expressions
Negative cognitions & mood symptoms	Feelings of being emotionally numb; diminished desire and participation in life activities; gaps in memory about sessions with clients; negative emotions; negative expectations and blaming others. (APA, 2013; Bride, 2007, 2004).
Arousal symptoms	Encompasses continual feelings of anxiety or increased stimulation, not felt before the trauma, involving sleeping problems, petulance, trouble focusing, hypervigilance, or overstated startle reaction (APA, 2013; Bride, 2007, 2004).

STS theory was developed to explain the stress that results from assisting or wanting to assist traumatized individuals (Figley, 1995b). Individuals who work closely with trauma victims can experience adverse physiological responses and stress that are nearly identical to those of primary exposure (Bride et al., 2004). Figley (1995b) posited that subjection to a traumatizing event suffered by one person could become a traumatizing event for another person. Researchers have used STS theory to advance scientific study in many ways (Bride et al., 2004; Sprang et al., 2019). For example, Bride et al. (2004) developed the Secondary Traumatic Stress Scale (STSS) to measure the presence of STS in individuals who are indirectly exposed to trauma through a traumatized client, providing the field of helping professionals with an instrument for measuring the presence of STS. The field of scientific study has provided a trauma-focused framework, STS theory, to inform the additional suppositions related to identifying STS presence, risk, and protective factors among helping professionals to decrease the toll of indirect trauma (Sprang et al., 2019).

Problem Statement

The existing research (Benuto, Newlands, et al., 2018; Benuto, Yang, et al., 2018) has included examinations of STS among VAs in the civilian community but makes no reference as to whether advocates possess a national credential and recommends additional research to

examine the correlates of STS and "gain a more nuanced understanding of the specific contributing and protective factors to the development of STS" (Benuto, Newlands, et al., 2018, p. 505). Additional current research examining other helping professionals who work with trauma victims, such as social workers (Bride, 2007; Choi, 2017), nurses (Beck, 2011; Gates & Gillespie, 2008; Townsend & Campbell, 2009), and forensic interviewers (Bonach & Heckert, 2012), as well as the therapeutic work performed with trauma victims (Hensel et al., 2015) highlights the risk of developing STS among these professionals and identify potential risk factors. Additionally, the identification of risk factors in the development of STS from public health, organizational, and personal perspectives informed the selection of potential risk factors as variables (i.e., caseload volume, caseload frequency, history of personal trauma, type of organization, organizational support, long-term engagements, and age, gender, and ethnicity; Beckerman & Wozniak, 2018; Cronje & Vilakazi, 2020; Frey et al., 2017; Greinacher et al., 2019; Levi et al., 2021; Molnar et al., 2017; Ogińska-Bulik et al., 2021; Owens-King, 2019; Penix et al., 2019; Quinn et al., 2019; Sprang et al., 2019; Voth Schrag et al., 2022; Wood et al., 2020).

Benuto, Newlands, et al. (2018) recommendations included the need for a more varied sample, greater demographics reflecting diversity, and larger samples that are generalizable. Benuto et al. (2019) recognized and highlighted the role of VAs in aiding victims during their recovery and the criminal justice process, stressing the utmost need to lessen STS among VAs. Benuto, Newlands, et al. (2018) and Benuto et al. (2019) began exploring the prevalence and risk factors associated with VAs who developed STS but did not focus on those advocates possessing a national credential working with both the military and civilian communities.

The problem is the amount of STS experienced by NCVAs, the frontline responders for military and civilian traumatic crime victims, and any risk factors associated with STS are unknown (Benuto, Newlands, et al., 2018), and only limited research exists examining STS among unspecified VAs working with other communities mainly in the civilian community (Benuto et al., 2019).

Purpose Statement

The purpose of this study was to establish a baseline of STS among a surveyed sample of NCVAs working with traumatic crime victims within military or civilian communities. The baseline of STS was established by assessing the presence of avoidance, arousal, negative cognition and mood, and intrusion, as measured by the STSS. By utilizing the STSS scoring protocol, an assessment of the surveyed sample's intensity was ascertained and linked with other study communities. Additionally, this study was designed to elucidate the relationships between surveyed predictor variables (risk factors). Potential risk factors were caseload volume and frequency, a personal history of trauma, organizational type and support, long-term engagement with trauma victims, and a diversity index based on the cross-tabulation of gender, age, and ethnicity.

Researchers developed an agenda that includes determining the extent of STS among helping professionals and identifying risk factors for developing STS (Molnar et al., 2017). Molnar et al. (2017) reviewed the literature from a public health perspective on professions that regularly expose workers to traumatic events, including those who provide victim assistance, mental health, law enforcement, fire response, and emergency medical services. A review of research from an organizational and individual perspective provided a foundation of the risk factors selected for this study; caseload volume and frequency, history of personal trauma,

organization type, and support, long-term engagement with trauma victims, age, gender, and ethnicity (Cronje & Vilakazi, 2020; Owens-King, 2019). Findings by Benuto, Newlands, et al. (2018) indicated that the number of direct hours of victim services was the only significant predictor of STS, and three were reliable predictors of STS among VAs (credentialing status unknown) that included hours worked per week, direct service hours, and engagement with adult survivors of child sexual abuse.

This study was designed to address the gaps in the literature by providing a greater understanding of the current extent of STS among a previously unstudied community of helping professionals who provide essential services to traumatized victims of crime, namely NCVAs working with military or civilian traumatic crime victims. The goal was to contribute to the collective understanding of STS by expanding the body of knowledge about indirect trauma among helping professionals. Second, results can inform victim advocacy professionals by providing empirically based data to advance the NCAP's credentialing standards, national and military victim advocacy programs, and policies to prevent and mitigate the development of STS symptoms.

Significance of the Study

This study was designed to fill a knowledge gap about NCVAs impacting the profession of VAs, victim assistance organizations, and traumatic crime victims across America (Benuto, Newlands, et al., 2018). This study was also designed to aid helping professionals and VAs by identifying further research that may be needed. Though several studies have identified interventions for STS for helping professionals, such as nurses working in war zones (Chargualaf & Elliott, 2019), military primary and mental healthcare providers (Kintzle et al., 2013), child welfare workers (Salloum et al., 2019), and non-mental health professionals such as gang

intervention workers (Dierkhising & Kerig, 2018), a gap in the literature exists about nationally credentialed VAs (Sprang et al., 2019). Studies have confirmed that organizational culture and environmental aspects play a role in placing helping professionals, such as nurses, at-risk for developing STS and PTSD (Beck, 2011; M. L. Bourke & Craun, 2014; Handran, 2014). Filling this gap in the literature will add necessary information as the profession moves forward, creating psychoeducational protocols to ameliorate their professional functioning related to experiencing STS (Sprang et al., 2019). Filling this vital knowledge gap may strengthen military readiness, lessen a public health crisis, and contribute to a safer society by increasing NCVAs' resistance to STS and ability to aid victims of crime during the reporting, recovery, and criminal justice process (Barr, 2020; Centers for Disease Control and Prevention [CDC], 2021).

Research Questions

RQ1: What is the baseline of STS among surveyed nationally credentialed victim advocates working within military and civilian communities?

RQ2: What are the risk factors associated with STS among surveyed nationally credentialed victim advocates working within military and civilian communities?

Definitions

1. *Burnout* - A term applied to an individual's occupation resulting from chronic work-related stress and characterized by "feelings of energy depletion or exhaustion; increased mental distance from one's job or feeling of negativism or cynicism related to one's job; and reduced professional efficacy" (World Health Organization, 2019, p. 1).
2. *Compassion fatigue* - A term encompassing feelings of helplessness, confusion, isolation, numbness or avoidance, and persistent arousal in those who interact with traumatized individuals (Sprang et al., 2019).

3. *Indirect exposure* - Occurs when an individual, in the course of their work, is subjected to the explicit details of horrific events suffered by another, as with indirect exposure to traumatic events and stressors (Sprang et al., 2019).
4. *Indirect trauma* - A term applied to "experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)" (APA, 2013, p. 271).
5. *Occupational stress* - The day-to-day stress an employee incurs because of the working conditions and responsibilities faced daily (Singh et al., 2020).
6. *Other helping professionals* - Refers to individuals whose professional role subjects them to working in the trauma field, such as mental health, law enforcement, fire response, emergency medical services, "and other professions exposed to traumatic events on a regular basis" (Molnar et al., 2017, p. 129).
7. *Risk factor* - A commonly used term to describe the characteristics, situations, and behaviors of those working with traumatized crime victims (Offord & Kraemer, 2000).
8. *Secondary traumatic stress* (STS) - A term applied to reactions from indirect exposure to traumatic stressors or stress reactions, impairing functioning. It is a parallel reaction to experiencing the psychobiological impact on clients of their traumatic event and subsequent symptoms of PTSD (Sprang et al., 2019, p. 76).
9. *Trauma* - The body's intense psychological response—immediate or delayed, brief or prolonged—to experiencing violence, such as rape, and traumatic events, such as abuse, neglect, disasters, and war, and is considered a costly public health problem (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022).

10. *Traumatic crime victim* - An individual who suffers trauma as a direct result of a crime. The trauma may be physical or psychological (FBI, 2022).
11. *Traumatic event* - A term applied to a shocking, life-threatening experience, such as disasters (e.g., hurricanes, floods), acts of violence (e.g., assault, terrorist attacks), or accidents (e.g., car crashes; National Institute of Mental Health, 2020).
12. *Vicarious trauma* - A term applied when referring "to the exposure to the trauma experiences of others, considered an occupational challenge" (Molnar et al., 2017, p. 130).
13. *Victim advocate* (VA) - An individual trained to provide services to crime victims, such as emotional support, information regarding legal rights, navigating the criminal justice process and court accompaniment, accessing resources and providing referrals, and safety planning (National Organization for Victim Assistance, 2022). For the purposes of this study, the term VA included victim services providers, victim assistance personnel, victim–witness liaisons, victim–witness coordinators, sexual assault prevention and response coordinators, sexual assault prevention and response VA, and domestic abuse VA.

Summary

Indirect exposure to traumatic events through traumatized clients may cause STS symptoms (Hensel et al., 2015) and place NCVAs at high risk for developing STS and PTSD (Ray et al., 2013). It can negatively impact their ability to provide essential support services to traumatic crime victims across military and civilian communities (Bride et al., 2004). An estimated 1.31 million violent crimes were committed in the United States in 2020 (Morgan & Truman, 2020). There are no publicly available data on violent crimes outside the United States involving military members and United States citizens. Nationally credentialed VAs stand ready

to assist traumatic crime victims through reporting, recovery, and justice processes (Department of Justice [DoJ], 2020). However, the extent of STS experienced by NCVAs is unknown; therefore, current requirements to obtain a national credential may not fully address preventive and mediating measures associated with it (NACP, n.d.-b).

Chapter Two: Literature Review

Overview

This chapter includes the theoretical framework that informed this research, a literature review on traumatic crime victimization in the United States, the National Advocacy Credentialing Program, trauma, STS, PTSD, and a summary. A review of the current research informed the selection of risk factors to study for developing STS among NCVAs. An examination of the literature concerning the scope of violent crime in the United States and the trauma resulting in its aftermath provided a foundation for understanding the necessity for NCVAs. The literature review also covers national advocate credentialing, the demanding work of VAs, correlates associated with STS, and the frequency of STS among helping professionals, family, friends, and allied professionals who experience indirect trauma through their work with and support of traumatized individuals within the military and civilian communities.

Theoretical Framework

STS Theory

STS theory served as the theoretical foundation for this study. It holds that individuals who work closely with trauma victims can be impacted by vicariously experiencing trauma and the adverse physiological responses that can impair functioning due to the cumulative effect (Bride et al., 2004; Figley, 1995a). According to STS theory, STS symptoms are similar to symptoms of PTSD, as described in the *Diagnostics and Statistical Manual of Mental Illnesses* (5th edition) (DSM–5) (APA, 2013; Bride et al., 2004).

Bride et al. (2004) built their framework, in part, upon the research of Figley (1995a) and Chrestman (1999). As part of an STS hypothesis, Chrestman (1999) connected PTSD symptoms to traumatic disclosure, avoidant responses, physiological arousal, distressing emotions, and

functional impairment experienced by clinicians working with those who had experienced trauma. Several researchers (e.g., Courtois, 1988; Danieli, 1988; Herman, 1992; McCann & Pearlman, 1990) established intrusive imagery as a reaction by the therapist to client traumatic disclosure. Another basis for Chrestman's (1999) avoidant response hypothesis was provided by Courtois (1988) in her work with adult incest survivors and Haley's (1974) research with Vietnam veterans. Several researchers (e.g., Dutton & Rubinstein, 1995; Figley, 1995b; McCann & Pearlman, 1990) provided the groundwork for physiological arousal as a response of clinicians working with traumatized clients, as did Courtois (1988) and Herman (1992) for distressing emotions. The final PTSD symptom in Chrestman's (1999) STS hypothesis, functional impairment, was informed by several researchers (e.g., Dutton & Rubinstein, 1995; Figley, 1995b; McCann & Pearlman, 1990). Together, these expressions of PTSD were grouped by Figley (1995b) as STS symptoms, including intrusion, avoidance, and arousal. Negative cognition and mood were recently added to this list based on the *DSM–5* revision in 2013 that recognizes STS may occur in those indirectly exposed to trauma (Hensel et al., 2015).

STS theory was developed to explain the stress that results from assisting or wanting to assist traumatized individuals (Figley, 1995b). Working closely with trauma victims can produce adverse physiological responses and stress nearly identical to those of primary exposure (Bride et al., 2004). Figley (1995b) posited that subjection to a traumatizing event suffered by one person could become a traumatizing event for another person. For this study, a traumatized crime victim was defined as an individual suffering a horrific event or violent crime (e.g., rape, abuse, trafficking, terrorism, or homicide), and the "other person" was the NCVA. Advancing STS theory, Figley (1995a) asserted that helping professionals experiencing STS symptoms are at-risk for making poor professional judgments and developing PTSD. Additionally, STS is believed to

be one reason for helping professionals' attrition (Bride et al., 2004; Figley, 1995b; MacEachern et al., 2019).

Toward a Mechanism and Theory of STS

STS is a theory that came from dynamic systems (Figley, 1983). Figley (1983) initially recognized secondary victimization as secondary trauma and later developed the terms STS and compassion fatigue (CF; Figley, 1995a). These ideas played a crucial role in his first CF paradigm (Figley, 1995a). Since 1995, Figley has made periodic improvements to his well-known model, particularly showing how trauma accumulates and spreads among therapists, firefighters, clergy, emergency responders, law enforcement officers, and other professions. These recurring adjustments reflect a growing understanding of trauma within the academic community and highlight the need for additional peer-reviewed articles (Molnar et al., 2017).

Adhering to one perspective on a situation is restrictive and prevents seeing all its components and carefully evaluating the impact on psychological, biological, and organizational factors (Carver & Scheier, 2002), similarly to how combining theories may give a more rounded overview of complicated occurrences in many situations and disclose all their impacts (McLeod, 1997). Factors that are quantitative, well-known, and easily adaptable to the environment are frequently preferred by researchers (Nunnally, 1978; Streiner, 2003; Terwee et al., 2007). There are several scenarios where an STS-based methodology of identified factors may be used, for example, but not restricted to trauma-informed mental health professionals. For example, Figley's STS-based CF method has been widely used by everyone, from physicians to those who care for animals (Hoy-Gerlach et al., 2021; Kase et al., 2022). Empathy has been found to be essential because it affects the social skills individuals need to get along in society, such as within households and institutions (Riggio & Tucker, 2012). People with empathy seem more

well-liked and excellent leaders (Damasio, 1994; Sundheim, 2013). On the contrary, if the absorption of upsetting material is not managed effectively, the empathetic capacity may turn into stress (Finkel et al., 2013).

Researchers have used STS theory to advance the field of scientific study in many ways. For example, Bride et al. (2004) developed STSS to measure the presence of STS at the moment in time in individuals indirectly exposed to trauma through a traumatized client, providing the field of helping professionals with an instrument specific to measuring the presence of STS. Other uses in measuring STS, such as the Professional Quality of Life Scale and the Trauma Attachment Belief Scale, are designed more broadly and focused elsewhere (Sprang et al., 2019). The Professional Quality of Life Scale encompasses STS, burnout, and compassion satisfaction (CS), and the Trauma Attachment Belief Scale measures trauma's impact on personal belief systems about control, safety, trust, esteem, and intimacy (Sprang et al., 2019). Only STSS focuses on symptoms consistent with the diagnostic criteria for PTSD (Sprang et al., 2019). The field of scientific study was provided a trauma-focused framework, STS theory, to structure and test additional suppositions using STSS related to identifying STS presence, risk, and protective factors to decrease the toll indirect trauma has on helping professionals (Sprang et al., 2019).

This study was designed to establish a baseline of STS by detecting the presence of STS symptoms at a point in time among NCVAs working with military or civilian traumatized crime victims to reduce the risk of NCVAs experiencing STS symptoms that could compromise professional judgment and put them at-risk for developing PTSD. Risk factors included caseload volume and frequency, personal history of trauma, the nature of support from employing organizations, long-term engagement with traumatized clients, and age, gender, and ethnicity variables similar to those examined by Benuto, Newlands, et al. (2018), Benuto et al. (2019), and

Singer et al. (2020) and others involving different professional communities (e.g., Boamah, 2020; Brady, 2017; Owens-King, 2019). This study's correlates fall within STS theory's tri-level framework—personal, professional, and organizational levels—where predictors are found (Bride et al., 2004; Figley, 1995b). At the individual level is the VA's personal history of trauma; at the professional level is caseload volume and frequency, long-term engagement with traumatic crime victims, and types of victims served (e.g., child victims of sexual and physical assault, domestic violence victims, adult victims of sexual assault, and adult survivors of childhood sexual assault). At the organizational level is the nature of support from employing organizations, including time, structure, professional training/conferences, counseling, and support groups (Boamah, 2020; Brady, 2017).

The study was consistent with STS theory in that it was quantitative and descriptive (Bride et al., 2004). This study was designed to add to the understanding of STS among an unstudied sample community of VAs working with traumatized crime victims by establishing a baseline of STS at the moment in time and evaluating risk factors. This study was intended to provide the advocacy field with scientifically based valuable intelligence in the prevention and intervention of STS by developing psychoeducational protocols (i.e., national training and program standards).

Related Literature

Traumatic Crime Victimization in the United States

The Honorable Lois Haight Herrington, Chair of the President's Task Force on Victims of Crime in 1982, was the first outspoken political proponent of victims' rights, propelling the field of victim advocacy. Haight (Herrington et al., 1982) highlighted how rampant crime in the

United States touched every citizen, setting the stage for crime victim rights and the profession of victim advocacy:

> Something insidious has happened in America: Crime has made victims of us all. Awareness of its danger affects how we think, where we live, where we go, what we buy, how we raise our children, and the quality of our lives as we age. The specter of violent crime and the knowledge that, without warning, any person can be attacked or crippled, robbed, or killed lurks at the fringes of consciousness. Every citizen of this country is more impoverished, less free, more fearful, and less safe because of the ever-present criminal. (Herrington et al., 1982, p. vii)

The extent of trauma work by VAs begins with the scope of traumatic crime and its negative impacts. According to the Bureau of Justice Statistics, there were 1.2 million victims of violent crime, excluding simple assault, in 2019. However, fewer than half of all violent crimes are reported to the police due to the victims' lack of trust in the police (Morgan & Truman, 2020). The FBI reported a 5.6% increase in violent crime in 2020 compared to 2019 (FBI, 2021a). This was for reported violent crime. Approximately 60% of violent crimes (i.e., sexual assault and rape) go unreported each year (FBI, 2021b).

Additionally, research indicated a 12% increase in violent crime in 2020 compared to 2010, based on FBI data of approximately 3,000 cities with a minimum of 10,000 people in the United States (SafeHome.org Research, 2022). The DoD estimated that sexual crimes that fall within the parameters of violations under the Uniform Code of Military Justice (UCMJ) are also highly underreported, with an estimated past-year prevalence of 20,500 surveyed service members indicating an experience of sexual assault and 6,053 service members reporting sexual assault incidents in 2018 (DoD Sexual Assault Prevention and Response Office [SAPRO],

2020b). Fear of losing privacy, not being believed, and retaliation are some of the reasons victims do not report to law enforcement, making violent crime challenging to measure (Morgan & Truman, 2020). Additionally, crime victims who do report to the police may later withdraw their participation in the criminal justice process due to feeling revictimized by retelling their story repeatedly (Morgan & Thompson, 2021).

There are also ways to disclose assault without notifying police (disclosure versus report) that are not counted by the bureau (Morgan & Truman, 2020). Victims often disclose to someone they trust and believe will not judge them, such as a friend, hotline worker, or sexual assault forensic nurse (Rape, Abuse, and Incest National Network [RAINN], 2021). In the military, such disclosure of sexual assault or rape is known as restricted reporting (DoD SAPRO, 2020a). Restricted reporting allows victims to report the crime and receive help without triggering a criminal investigation (DoD SAPRO, 2020a). Many jurisdictions throughout the civilian community have also adopted the restricted reporting option (Garvin & Beloof, 2015). Victims get the care and time they need while deciding whether to report the crime to the police (DoD SAPRO, 2020a). Previous sexual assault increases a victim's risk of being assaulted again, thus compounding their trauma and making it more challenging to report (Petrak, 2002). Anonymous surveys with behaviorally based questions are used to estimate the prevalence of sexual violence in the military and justice departments (Morgan & Truman, 2020; DoD SAPRO, 2020a).

Though sexual violence is difficult to measure, RAINN (2021) compiles data from several national sources to determine the scope of the problem. Sexual assault occurs every 68 seconds in the United States: "For FY [fiscal year] 2020, there are nationally 618,000 (rounded) victims of child abuse and neglect" (Children's Bureau, 2022, p. 20). Additionally, an estimated

80,600 inmates were sexually assaulted or raped in 2020 (RAINN, 2021). The estimated lifetime cost of rape is $122,461 per victim (Peterson et al., 2017). Peterson et al. (2017) estimated that >25 million U.S. adults had been raped, bringing a "population economic burden of nearly 3.1 trillion (2014 U.S. dollars) over victims' lifetimes" (p. 697). The estimated costs include criminal justice and medical costs, loss of victim and perpetrator productivity, and long-term treatment (e.g., victim's mental health, substance abuse, and physical health; Peterson et al., 2017). These are some tangible costs of the crimes to society, and there are also intangible costs.

Sexual violence in the nation's schools and college campuses is "pervasive" (RAINN, 2021, para. 1), impacting students, teachers, campus staff, and their communities. In 2020, an estimated 13% of all college students experienced rape or sexual assault, and 72% of campus law enforcement agencies employed a survivor response and assistance staff member (RAINN, 2021). College-age women ages 18–24 were found to be at three times greater risk of sexual violence than all women (RAINN, 2021). At military service academies in the academic year 2020–2021, sexual assault reports increased by 32 from the previous academic year, with a total of 161 reports at all three academies (DoD SAPRO, 2022).

In addition to sexual violence, human trafficking is an example of traumatic crime devasting its victims (DoJ, 2020). Human trafficking is a form of modern-day slavery, forcing victims to engage in commercial sex acts or labor (DoJ, 2020). The U.S. Attorney's Office, District of Rhode Island (2016) stated, "human trafficking is the world's fastest-growing criminal enterprise, valued to be an estimated $32 billion-a-year global industry" (para. 3). In 2022, over 50,000 human trafficking cases were reported in the United States (National Human Trafficking Hotline, 2022). However, with the dramatic rise of illegal immigrants crossing from Mexico, many experts speculate the number of human trafficking victims is much higher

(Vaughan, 2022). Non-sexual violence is also a problem (Campus Safety Staff, 2022). From 1970 through 2021, there were 1,924 K–12 school shootings in the United States, killing a total of 637 people (Campus Safety Staff, 2022). At the time of this report, the greatest number of people killed in school shootings occurred in 2021 (249), with the next highest number (119) killed in 2019 (Campus Safety Staff, 2022).

It is common for victims of crime to hesitate when considering participating in the criminal justice system (De La Rue et al., 2023). Thompson and Tapp (2022) estimated that in the year 2021, 54% of violent crime victims did not report their offenses to the police. There are many reasons for this occurrence, such as safety concerns, fear of retaliation, lack of trust in the system, emotional trauma, fear of not being believed, and shame (National Institute of Corrections, 2023; RAINN, 2023). Advocacy has a positive impact on a victim's engagement, and VAs are believed to be key to breaking down these barriers for victims (Patterson & Tringali, 2015).

Advocates' cognitive schemas may shift as a result of experiencing STS due to their work, resulting in a diminished ability to fully assist victims of crime (E. Hopper & Bassuk, 2021). Like direct trauma victims, advocates' worldviews may shift and narrow, now viewing the world through the lens of trauma and affecting their feelings, interpersonal connections, and quality of life (Uhernik, 2017). The five emotional experiences of safety, trust, respect for oneself and others, control, and closeness may be altered or disrupted cognitively, especially in advocates subjected to repeated traumatic experiences with clients who have experienced trauma (E. Hopper & Bassuk, 2021). Intruding images and pictures, painful emotions, physical reactions, and functional disability are other STS indications (Uhernik, 2017). There is a need for an STS study because STS also negatively affects helping individuals while also having an

impact on how they serve others. According to studies, STS sufferers might negatively affect the helpers' capacity to exercise sound judgment while providing services (Grey et al., 2019; Luxton et al., 2017). Research into STS occurrence and contributing factors among advocates is crucial to ensuring advocates can function effectively and offer clients helpful and moral services (E. Hopper & Bassuk, 2021). Over the last 20 years, STS has evolved into a recognized phenomenon in the United States (Yeates, 2017).

In the United States, there has been much research on STS among helping professionals (Brackenhoff & Carlson, 2017; Harpaz-Rotem & Rosenheck, 2015; Kelsall, 2015; Scholten et al., 2015). Various STS-related topics have been the focus of an extensive investigation (Baker & Everly, 2018). Several studies have pinpointed personal risk and mitigating variables concerning the development of STS (Benuto, Newlands, et al., 2018; Walter & Latack, 2018). They discovered that a history of personal trauma might serve as a factor in developing STS (Benuto, Newlands, et al., 2018). On the contrary, providing social and organizational assistance, being an elder, obtaining a higher degree, and maintaining a socioeconomic position can all typically help to reduce the risk of STS (Choi, 2017; Jetten et al., 2014; Maschi et al., 2015). In the organization, macro-level elements that might either exacerbate or alleviate the incidence of STS were looked at. According to some studies, organizational traits, including administrative restrictions, poor supervision, a scarcity of client services, as well as an absence of assistance from peers and colleagues, may contribute to the emergence of STS (Arnetz et al., 2015; Hoeft & Lee, 2017). However, some STS-related literature produced contradictory results.

Secondary Traumatic Stress

STS refers to individuals with symptoms mimicking PTSD after hearing firsthand accounts of trauma experienced by another person (Beck, 2020). The inconsistencies in

terminology (e.g., vicarious trauma, compassion fatigue, moral distress, trauma exposure response) and theoretical connection have produced challenges in the literature with understanding the impact of repeatedly working with trauma victims (Newell et al., 2016). STS symptoms include reactions expressed as intrusion, avoidance, negative cognition and mood, and arousal, similarly found in posttraumatic stress but specifically related to experiencing indirect trauma from providing services to victims of trauma (Beck, 2020). Research indicates that working with traumatized individuals, other helping professionals experience indirect trauma and are at-risk for STS (Bride, 2007; Hensel et al., 2015). The body of literature reveals that having a history of trauma (Cunningham, 2003; Hensel et al., 2015), high trauma caseloads (Hensel et al., 2015), and women (Baum, 2016; Cieslak et al., 2014) generally have higher rates of STS. In addition to determining the presence of STS in helping professionals, risk and protective factors have been studied, establishing a basis to launch this study (Benuto, Newlands et al., 2018). Unfortunately, none of the VA studies identified their credentials or if they worked with traumatic crime victims (Benuto, Newlands, et al., 2018, Benuto et al., 2019). NCVAs have not been explicitly studied; therefore, the presence of STS symptoms establishing a baseline for credentialed VAs and contributing factors are currently unknown (Benuto, Newlands, et al., 2018). Based on STS research among helping professionals, NCVAs may experience STS due to their work with traumatic crime victims in military or civilian communities (Ellis & Knight, 2021).

Posttraumatic Stress Disorder and Secondary Traumatic Stress

The study of STS, as well as posttraumatic stress (PTSD), continues to remain relatively young (Lewis et al., 2019). In earlier versions of the *DSM* (APA, 2013), PTSD has been described as “traumatic neurotic tendencies,” “battered kid condition,” “battle exhaustion,” and

"war psychosis." Long-standing knowledge existed that war veterans who observed traumatic events displayed unfavorable psychological symptoms (Ganesh et al., 2015). Common diagnoses that included these characteristics included drinking, sadness, and even schizophrenia (Ganesh et al., 2015). But after considerable debate and research, it was discovered that the soldiers' reactions may not have been due to their abnormalities; instead, they were showing the expected effects of exposure to the unusual shocks of war (Scott, 1990). This knowledge served as the cornerstone for PTSD's adoption as a distinct diagnosis (Friedman & Charney, 1995).

The requirement that the individual must have gone through an abnormally distressing incident was crucial to the initial creation of PTSD (Andreasen, 2010). Such an occurrence was classified by the *DSM-III* as a major stressor that went beyond the normal range of human awareness (Friedman, 2013). War, cruelty, and assault were all seen as stresses (Friedman, 2013). Vicarious trauma was eliminated from these aberrant stressors, which were clearly distinguished from usual stressors like divorce, unemployment, or major disease (Friedman, 2013). The fundamental assumption was that although most people can cope with routine, stressful situations, their adapting skills are likely overpowered when a catastrophic stressor is present (Friedman, 2013).

One of the earliest scholars to postulate that being exposed to another person's trauma may cause that person to become traumatized in a similar manner was Charles R. Figley. He indicated experts who addressed the accounts of traumatized people as well as their immediate relatives and friends, are susceptible to certain vicarious trauma (Figley, 1995a). This phenomenon was alluded to by Figley (1995a) as that of the "price of caring" (p. 1). According to his definition, it is "the normal follow-up actions and feelings ensuing from learning of a traumatic incident suffered by a substantial other, or perhaps the requirements tend from

assisting or desiring to aid a traumatic or distressed individual" (p. 1). The idea of vicarious trauma exposure has been described using a variety of meanings and terminologies. In the 1980s, Figley first coined the phrase "compassion fatigue," defining it as emotions of powerlessness, perplexity, alienation, evasion, and chronic arousal experienced by people who engage with traumatized people (Figley, 1983). The term secondary traumatic stress (STS) was later created by Figley as well as other scientists, after it was shown that secondary traumatization causes symptoms that are almost comparable to those of PTSD (Bride, 2004; Figley, 1983).

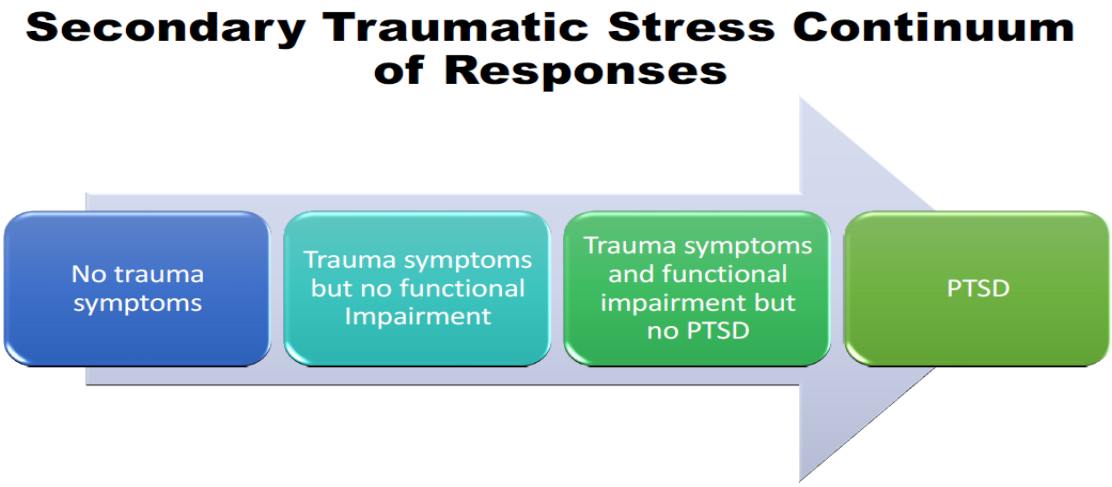
Different approaches have been used by other investigators. Pearlman and Saakvitne (1995) focused on the long-term effects of understanding the specifics of other people's horrific memories on experts. They looked at how this indirect experience of traumatization can change the practitioner's cognitive models and frameworks of meaning using cognitive self-development theories (Pearlman & Saakvitne, 1995). This conceptualization refers to the occurrence as "vicarious traumatization" (Pearlman & Saakvitne, 1995, 2013).

It is critical to consider the PTSD criteria for a diagnosis to comprehend STS. A PTSD assessment, as per the *DSM-5* (APA, 2013), has been defined as a response to any one of multiple perceived stress requirements. A continuum of responses was explained by Sprang and Steckler (2022) as beginning with no trauma symptoms, progressing to trauma symptoms but no functional impairment, then trauma symptoms and functional impairment but no PTSD, and finally, the development of PTSD (Figure 1). These stresses are referred to as exposure criteria, together with immediate exposure to trauma, including a recurrent engagement to upsetting facts of a traumatic incident. Following exposure, the four symptomatic groupings of aversion, intrusive remembrance of the traumatic incident, negative cognitive distortions and moods, and hypervigilance appear (APA, 2013). The requirements for a specified length of illnesses, the

functional importance of the diagnoses, and the elimination of any other potential explanations must also be satisfied (APA, 2013; Sprang & Steckler, 2022).

Figure 1

Secondary Traumatic Stress Continuum of Responses



Prevalence of Secondary Traumatic Stress

The incidence of STS has been investigated in a wide range of professional demographics, and it differs dramatically amongst the studied occupations. For instance, the frequency of STS has been discovered to be between 49% to 53% among victim supporters (Benuto, Newlands, et al., 2018), 37% among staff members of child protective services (A. Patel & Patel, 2020), and 35% among law enforcement officers in Great Britain who look into cases of child survivors of sexual assault (MacEachern et al., 2019). Having an appreciation for the vulnerability inherent to the work of helping professionals resulting in experiencing STS symptoms and understanding the frequency with which STS occurs in other populations is crucial to comprehend the risk for credentialed VAs in military and civilian communities (Benuto, Newlands, et al., 2018).

Consequences of Secondary Traumatic Stress

Compared to the reactions to significant exposure, the effects of secondary exposure following emotional stress have received comparatively less investigation. Few but increasing numbers of researchers think the work mental health professionals do makes them vulnerable to secondary trauma responses. The study that followed looked at the connection between secondary trauma among practitioners of mental health and working with traumatized military members (Chard & Hansen, 2018). The extent underlying secondary trauma across clinicians was anticipated to be influenced by a practitioner's experience working with the traumatized, their own trauma experience, and their capacity for emotional distance (Knudsen et al., 2017).

STS responses and high job expectations are believed to be the main reasons for the rise in mental healthcare professional turnover across military environments (Voss Horrell et al., 2011). STS could also limit treatment efficacy (Sprang et al., 2019). STS has been made up of emotional responses that are very similar to PTSD and are brought on by subliminal and repeated exposure to painful as well as traumatic circumstances (Holland & Laux, 2015). STS is seen by academics from several fields as a potential adverse effect that increases worker turnover (Gentry & Gambrill, 2015).

Scars of Trauma

The DoJ (2020) reported that approximately 70% of adults, or 223.4 million people in America, experience a traumatic event at least once in their lives. Most people in the United States will experience varying levels of trauma in their lifetime and will need assistance from a helping professional (McLean Hospital, 2022). Trauma can result from shocking events, such as experiencing disasters, war, or accidents, or from violent crimes, such as rape, domestic violence, abuse, human/sex trafficking, and terrorist attacks (Kleber, 2019). Trauma is the body's

intense psychological response to such an experience affecting the body and mind and may be immediate or delayed, brief or prolonged, and is considered a costly public health problem (SAMHSA, 2022). The President of the United States of America proclaimed in National Sexual Assault Awareness and Prevention Month 2022 that sexual violence is a public health crisis and a matter of national security and military readiness (Biden, 2022).

Violent crimes are traumatizing events that can leave lasting scars (Vivian & Hormann, 2015). The negative health consequences for victims of intimate partner violence (IPV), for example, are considered a significant public health issue (CDC, 2021). Survivors may experience chronic symptoms related to their heart, digestion, reproduction, muscles, bones, and nervous system, and psychological symptoms such as depression and PTSD (CDC, 2021). Victims of IPV are also prone to engage in risky behaviors (CDC, 2021). Other violent crime victims are also likely to suffer negative physical and psychological problems (CDC, 2022). The lasting scars are often visible and still raw when services and support are provided by the credentialed VA (Bywood & McMillan, 2019). Over time they can have a cumulative effect on the advocate in the form of STS (CDC, 2022). After-effects may be experienced in varying degrees at different moments in time.

Because the brain and body are designed to keep us safe when that safety is threatened, the stress response is activated, causing stress, anxiety, panic, terror, and emotional injury stored in the cells of our body (van der Kolk, 2014). A crime victim's body is often the crime scene, as in rape, causing victims to detach from themselves (Fisher et al., 2017). This lasting emotional imprint on the body and mind is intense (van der Kolk, 2014). For many, the trauma is simply too big to process in their mind, and they are left stuck with fragmented and unprocessed memories (van der Kolk, 2014). These unprocessed memories can trigger the emotions

experienced at the time of the crime for victims and during the helping process for advocates (Leclerc et al., 2017). Victims of crime may relive the experience in the present moment repeatedly through flashbacks and intrusive memories, avoidance, hypervigilance, and cognitive alterations (Uhernik, 2017).

Victims in the military are no exception (Morral et al., 2021). Military crime victims are especially at-risk for developing compound trauma due to additional stressors experienced from day-to-day military culture (J. Bourke, 2022). It can affect well-being and sow fear and mistrust among colleagues and commanders, leading to the erosion of unit cohesion and negatively impacting national security (Rosenthal et al., 2021). Military families may also experience pain, suffering, diminished quality of life, fear, anxiety, and PTSD (Morral et al., 2021). Experiencing sexual assault doubles the odds of attrition within 28 months, with an estimated 16,000 person-years of service lost. According to Morral et al. (2021):

> Sexual assault and sexual harassment are associated with a wide range of harms to individual service members, but this study highlights another negative impact of these crimes—higher rates of attrition and associated harms to force readiness representing a considerable loss to the military in training costs and national security. (para. 3)

Additionally, the estimated cost of violent crime in the United States is between $690 billion and $3.41 trillion annually (U.S. Government Accountability Office [GAO], 2017). Although challenges exist in estimating these costs, violent crime is a public health issue requiring a trauma-informed approach (GAO, 2017).

Trauma-Informed Intervention

A trauma-informed approach is a method of engagement with victims and other multi-disciplinarians beginning with a foundational understanding of the response spectrum of a victim

of a crime that includes acknowledging trauma is widespread, recognizing the presence of trauma, and implementing a systemic response that avoids re-traumatization (Center for Substance Abuse Treatment, 2014; Office for Victims of Crime [OVC], 2020). To better comprehend the spectrum of trauma exposure, researchers led study attempts to define secondary trauma responses (Bride et al., 2004). Scholars assert that there are three levels of encounter with traumatic information and occurrences: primary, secondary, and tertiary (Wilson & Dufresen, 2018). Charles Figley, an associate professor of social studies, described the aspects of secondary trauma in a significant paper from 1995. STS is characterized in terms of the stress brought on by interacting with individuals who are traumatized or in pain (Figley, 1995a).

There are common experiences and responses to trauma, but clinicians working from trauma-informed approaches are careful not to presuppose a reaction as appropriate or normal (Center for Substance Abuse Treatment, 2014). NCVAs are specially trained experts in understanding and applying trauma-informed approaches through reporting, recovery, and justice processes (NACP, 2021b).

The undeniable value of NCVAs to victims and the criminal justice process is documented in law and policy (DoJ, 2020). The first President's Task Force on Victims of Crime was tasked by President Ronald Reagan with evaluating the treatment of crime victims in the criminal justice system and providing solutions to improve treatment (Herrington et al., 1982). In 1982, the *Final Report* was issued and included 68 recommendations for action to improve victim treatment, lessen revictimization by the justice process, and help victims recover (Herrington et al., 1982). In 1982, victims of crime were recognized as critical to the criminal justice system. The Victim and Witness Protection Act became federal law (Heinz, 1983). One goal was to improve the treatment of crime victims, with special attention paid to violent crime

victims during the criminal justice process (Goldstein, 1984). Since then, several more laws have passed recognizing a crime victim's right to participate in the justice process and to have the assistance of a VA (DoJ, 2020). Upon passing the Victim and Witness Protection Act of 1982, Congress directed the federal attorney general to establish *Guidelines for the Treatment of Crime Victims and Witnesses in the Criminal Justice System*, institutionalizing a systemic approach of "assistance and services to crime victims and witnesses of crime" (DoJ, 2012, p. 1). This document has been revised several times as victims' rights were enhanced through The Victims' Rights and Restitution Act in 2006, mandating victim services, and the Crime Victims' Rights Act, comprising court-enforceable rights. All 50 states and the UCMJ have adopted victim services based on these laws, state Constitutional amendments, and attorney general guidelines, thus launching victim service providers (e.g., VA) and birthing the profession of victim advocacy (OVC, 2002, 2021).

National Advocate Credentialing Program for Victim Advocates

The NACP was developed in 2003 to professionalize the role of VAs (NACP, n.d.-b). It was the first voluntary credentialing program available nationwide and remains the sole national credential for victim service providers (NOVA, 2022). This national credential provides "professional identification with a group whose common good is victim services and whose members abide by *Professional Ethics for Victim Assistance Providers*" (NACP, 2021, p. 1). In addition, national credentialing affirms advocate experience and competence (NACP, n.d.-a). National accreditation requires meeting high industry standards regarding training hours and training competencies. VA is required to continue their education and abide by high ethical standards (NACP, n.d.-a).

The value of meeting national standards was acknowledged by the DoD SAPRO with the development of the Department of Defense Sexual Assault Advocate Credentialing Program in 2012. It adopted NACP credentialing requirements for sexual assault prevention and response coordinators and VAs (DoD, 2013). Helping professionals suffering STS have been known to demonstrate poor professional judgment, negatively impacting services to traumatic crime victims as they progress through recovery and criminal justice processes (Figley, 1995b; Patterson & Tringali, 2015). Conversely, credentialed advocates demonstrate advanced professional judgment (NACP, n.d.-b; DoD, 2020).

VAs possessing a national credential differ from those who do not in terms of demonstrated competency and accountability through enhanced credibility, standardized minimum training requirements, continuing education, and observance of the *Professional Code of Ethics for Victim Service Professionals* (NACP, 2021a). NCVAs are professionals, as defined by the advocacy profession, and have been trained in and meet mandatory victim advocacy-specific training topics, such as trauma-informed advocacy and victims' rights (NACP, n.d.-a). A minimum of 40 hours is required for specialty training, and an additional 32 hours of continuing education are required every 2 years (NACP, n.d.-a). Credentialed advocates must meet competency standards for victims' rights, crisis intervention, trauma, crime victim compensation, civil/criminal justice, cultural sensitivity, advocacy, and basic specialty topics such as domestic violence, adult and child sexual assault, child abuse, drunk driving, homicide, campus advocacy, and human trafficking (NACP, n.d.-a). The current minimum of 10 training topics does not expressly require topics related to STS, such as risks of indirect trauma, self-care, prevention and intervention actions to mitigate symptoms, and related PTSD. Finally, all advocates are required to abide by a professional code of ethics (NACP, 2021a). National credentials are issued by

NOVA, the administrator for NACP, D-SAACP (D-SAACP; NOVA, 2022). NCVAs span military and civilian organizations, including military service academies and civilian universities, the Departments of Justice and Defense, and key national policymakers who inform NACP and D-SAACP standards (NOVA, 2022).

Victim Advocates Working With the Military

Across the DoD, there are currently three primary victim assistance-related programs that engage the use of VAs (DoD, 2018): (a) the Sexual Assault Prevention & Response Program (DoD, 2021d), (b) the Family Advocacy Program (DoD, 2021c), and (c) the Victim-Witness Assistance Program (VWAP; DoD, 2021b). Complicating the service provision, each program was established independently of the others with different program goals and advocate roles (DoD, 2018). SAPR program requires sexual assault response coordinators and sexual assault prevention and response VAs to obtain the D-SAACP credential before providing sexual assault services as described in D-SAACP instruction 6495.03 (DoD, 2020).

The second DoD victim assistance-related program, Family Advocacy Program, requires trauma-informed victim advocacy services for victims of domestic abuse (DoD, 2021c) involving a military member, spouse, or intimate partner sexual assault and child abuse.

The third DoD victim assistance-related program, VWAP, requires VWAP liaisons and personnel to participate in special victim teams, also known as special victims' investigation and prosecution (SVIP) capability (DoD, 2021b). Their aim is to support victims of military crime in exercising their legal rights throughout the investigation to case conclusion in accordance with UCMJ, Article 6b, and section 573 of Public Law 112-239. VWAP liaisons and VWAP personnel requirements are detailed in Department of Defense Instruction 1030.02 (DoD,

2021b). Of note, VWAP liaisons and personnel who work with sexual assault victims may also voluntarily pursue D-SAACP and NACP credentialing (NACP, 2021b).

Together, these three victim-assistance-related programs within the DoD are responsible for victims of all military crimes regardless of victim status (i.e., military or civilian, child or adult; DoD, 2018). For this reason, and for the purpose of this study, SARCs, SAPR VAs, domestic abuse VAs, VWAP liaisons/coordinators, VWAP personnel, and other victim assistance personnel will be referred to as VAs.

The need for qualified full-time VA working with the military has increased over the years and is not expected to decrease soon (Rosenthal et al., 2021). There have been over 50 surveys, reports, and Congressional hearings, beginning in 1988, when the issue of sexual violence in the military first surfaced, through 2004, when the Task Force Report on Care for Victims of Sexual Assault issued its recommendations for the DoD to create a single authority for sexual assault policy matters (DoD, 2004), and the establishment of VAs throughout the DoD. Since that time, there have been numerous recommendations from oversight bodies, government panels, and task forces to include the GAO related to preventing and responding to sexual violence in the military, yet the prevalence of sexual assault in the military is on the rise (DoD SAPRO, 2020a).

One of many oversight reviews performed on sexual violence in the military since that time was by the Independent Review Commission on Sexual Assault in the Military (Rosenthal et al., 2021). This oversight body was charged with providing a current independent and impartial assessment of sexual violence in the military by the secretary of defense, as directed by the President of the United States. One of four areas in the report addressed support and care for victims. The Independent Review Commission acknowledged the toll crime takes, particularly

the heavyweight victims carry and the critical need for victims to receive support from a professionally trained advocate due to the complexities of navigating military criminal justice and healthcare processes (Rosenthal et al., 2021). The need for VAs to help commanders provide appropriate responses to victims in their units and ensure victim safety and recovery adds a measure of support not found in the civilian sector (Rosenthal et al., 2021).

Victim Advocates Working With Civilians

This group works with adults outside the military, primarily with civilian traumatic crime victims, although some VAs in this group also work with military victims outside the military environment (DoD, 2021c). Privacy concerns often motivate military crime victims to seek assistance away from the military environment to ensure their personal information remains confidential (DoD SAPRO, 2014). Obtaining the NACP credential is voluntary for VAs working with civilians and is not a requirement to work in the civilian community (NACP, 2021c).

Many types of advocates work with civilian traumatic crime victims, including community-based advocates, such as crisis intervention advocates working at nonprofit community agencies and shelters, campus advocates working at colleges and university campuses, and system advocates working within the federal, state, and county criminal justice systems (DoJ, 2012). There are also many types of advocates who work within the federal, state, and county criminal justice systems, including prisons, criminal investigator offices, and victim-witness coordinators/liaisons working in prosecutor offices (DoJ, 2012). Some characterize the locations as public and nonprofit, cautioning that the placement of VAs can contribute to victim support or create additional tensions within the criminal justice process (Globokar & Erez, 2019). Advocates located within the criminal justice system, for example, will have competing

interests with investigators and prosecutors, complicating victim support (Globokar & Erez, 2019).

A tenet of VA is to honor a victim's decision whether to participate in prosecuting the perpetrator (Wedlock & Tapley, 2016). Advocates may explain the pros and cons, but honoring the decision will empower the victim (Wedlock & Tapley, 2016). Working with military or civilian communities is equally important (DoJ, 2012). For example, the *Attorney General Guidelines for Victims and Witnesses of Crime* state that the criminal justice system would not function effectively without the cooperation of victims and witnesses (DoJ, 2012). For the first time in American history, a single resource was established focusing on assisting crime victims and providing leadership—the Office for Victims of Crime (OVC, 2020). Vasquez and Houston-Kolnik (2017) documented milestones indicating the critical importance of VAs in helping victims mitigate the effects of crime. Additionally, their value has been recognized for working with other professionals in the criminal justice field (DoJ, 2020).

Unfortunately, VAs who experience indirect trauma are at-risk for developing STS symptoms, putting them at high risk for PTSD and hindering their ability to provide essential support services to traumatic crime victims on and off military bases and installations (Ray et al., 2013). Professional VAs are needed everywhere crime occurs (DoJ, 2020). The field of credentialed VAs will benefit from establishing a baseline of STS and identification of risk predictors, generalizable to the advocacy profession (Benuto, Newlands, et al., 2018).

Victim Advocates and STS

Working with victims of traumatic crime is demanding work (DoJ, 2020). The challenge with advocacy is that advocates are exposed to higher levels of others' trauma and suffering than is common (Smith & Freyd, 2017). This higher level of exposure creates the risk for advocates to

limit their worldview through a lens of trauma (Najavitis, 2002). Trauma exposure may manifest in an NCVA's work performance in their behavior toward victims (e.g., they may be harsher toward victims and less empathetic, more irritable with colleagues, suffer from weariness and display increased apathy (Smith & Freyd, 2017). If these symptoms go unattended, it could lead to a lessening of personal and professional satisfaction and more serious problems (Smith & Freyd, 2017). If advocates do not recognize the risks associated with advocacy, they can hurt themselves and create limits on their capacity to serve victims of traumatic crime (Benuto et al., 2019; Smith & Freyd, 2017).

The prevalence rates of STS among VAs ranged between 48.89% and 52.95% (Benuto, Newlands, et al., 2018). Benuto, Newlands, et al. (2018) found reliable predictors of STS included hours worked per week, direct service hours, and work with adult survivors of child sexual abuse. Hensel et al. (2015) found caseload volume and frequency, as well as personal trauma work history, to be predictors of STS in domestic violence workers, school personnel, child protective workers, and chaplains. However, a deeper review of the literature revealed the only significant predictor was the number of direct victim assistance hours (Benuto et al., 2019). Working with traumatic crime victims requires dedication, yet little is known about the scope of STS and the common factors impacting professionals who routinely work with them (Benuto, Newlands, et al., 2018; OVC, 2020).

Focusing on the positive effects of advocacy work and resilience building, Frey et al. (2017) conducted a quantitative study on vicarious resilience, personal trauma experiences, peer relational quality, and perceived organizational support among sexual assault and domestic violence VAs. They analyzed survey data from 222 randomly selected sexual assault and domestic VAs and found that an advocate's trauma history and peer relational health acted as

predictors of CS and vicarious posttraumatic growth; however, organizational support predicted only CS. The findings highlighted the importance at the personal and organizational levels of conceptualizing the personal growth of VAs through the lens of vicarious resilience (Coulter, 2013; Frey et al., 2017).

To investigate the impact of workplace support, victim status, years of experience, and hours of direct contact with victims, Benuto et al. (2019) used a quantitative methodology. Benuto et al. (2019) surveyed 142 VAs, of which 134 were women and 77.5% were Caucasian. Analysis was conducted on the 132 completed surveys. Benuto et al. found STS among helping professionals exposed to repeated secondary trauma and that it put them at-risk for impaired relations with their clients. Highlighting the lack of literature on workplace support regarding VAs and STS, Benuto et al. compared the availability of workplace support with those without available workplace support. Based on scores reflecting STS symptoms (i.e., intrusion, avoidance, and arousal subscales), Benuto et al. did not find a significant difference between the two groups. However, women were found to have high rates of STS, and the number of direct hours of victim services was the only significant predictor of STS. The results were consistent with previous studies regarding victim status and years of experience as being non-predictors of STS, as well as direct hours worked with victims being a predictor of STS. Recommendations were workplace support and strategies for advocates to cope with STS as needed (Benuto et al., 2019).

To better understand VA experiences with STS and vicarious trauma (VT) while working with military suffering from combat-related burnout, Cummings et al. (2021) conducted a quantitative study of 132 VAs using a demographic survey and three instruments (Vicarious Trauma Scale, STSS, and Professional Quality of Life [ProQOL]). Participants were selected

randomly from across the United States. Most participants were Caucasian (78%) and women (94%). Cummings et al. examined psychological responses, VT, STS, and burnout while testing the effect of CS on the relationships between the response and STSS and ProQOL STS subscales. They found a strong relationship between STSS and ProQOL STS subscale. They recommended leveraging ProQOL STS subscale over STSS for research and in clinical settings due to its ability to measure numerous psychological responses versus limiting psychological responses to four subscales as with the STSS. They also found that VT, burnout, and STS were co-occurring and had a strong inverse relationship between burnout and CS. Additionally, CS was found to be an influencer between burnout and VT and burnout and STS. Their findings indicated that increased CS could help reduce burnout associated with STS and VT. Organizations should consider intervention efforts that emphasize increasing CS (Cummings et al., 2021; Dodson & Heng, 2022).

To understand organizational influences on organizational stress and STS, two studies identified risk and protective factors associated with stress and trauma (Voth Schrag et al., 2022; Wood et al., 2020). Highlighting trauma-informed approaches in addressing organizational stress to reduce turnover, the studies were focused on a narrow community of IPV and sexual assault workers. Voth Schrag et al. (2022) examined occupational stress and underscored the importance of organizations incorporating trauma-informed approaches to address service providers suffering from occupational stress. Wood et al. (2020) found higher levels of burnout were associated with a personal trauma history within the previous 12 months among IPV and sexual assault professionals.

Collins (2003) argued that STS is a workplace safety issue, impacting not only the individual experiencing STS with the potential for making poor professional judgments, and by

extension, impacting everyone around them, resulting in "organizational dysfunction and costly employee turnover" (Potocky & Guskovict, 2020, p. 6). Potocky and Guskovict (2020) found the best practices for STS intervention efforts to be applicable "across settings and other populations" (p. 4). Other communities are professionals whose work involves assisting traumatic crime victims; these professionals include law enforcement personnel, medical and mental health service providers, social workers, paramedics, and other first responders to acts of violence and crime (Cronje & Vilakazi, 2020; MacEachern et al., 2019). Helping professionals run a significant chance of developing STS (Ogińska-Bulik et al., 2021). As an illustration, 34% of children's services professionals and 55% of sexual violence counselors, respectively, were determined to have STS signs (Cieslak et al., 2013). Understanding the prevalence of STS and its correlates in other communities increases the overall knowledge base and is greatly useful in informing STS development in other populations (i.e., NCVAs; S. Lee, 2019).

Other Helping Professionals and STS

NCVAs are a distinct group of VAs and helping professionals, as they provide services to traumatized individuals (Bride et al., 2004; Figley, 1999). Researchers have studied STS in communities who work with traumatized individuals other than VAs, which contributes to greater understanding in relation to STS through indirect trauma and potential risk factors and protective factors (Cummings et al., 2021). Medical healthcare providers, social workers, mental health counselors, and law enforcement personnel are examples of other helping professionals who work with traumatic crime victims where STS was found and potential risk factors identified (Cronje & Vilakazi, 2020; Greinacher et al., 2019; MacEachern et al., 2019). Risk and protective factors in STS among helping professionals have been studied in terms of prevention, intervention, and treatment, as discussed in detail by Sprang et al. (2019) in a recent meta-

analysis of STS. According to Sprang et al. (2019), an examination of lessons learned in the research and leading experts revealed more research is needed in the general understanding, prevention, and treatment of STS. The identification of risk factors is consistent with previous studies and contributes to helping professionals' systematic discovery related to STS (Sprang et al., 2019).

Healthcare Professionals

Healthcare workers are similar to VAs in their role as they often encounter victims of crime (Shoji et al., 2014). Much research has been performed among healthcare providers related to CS, CF, VT, and burnout. Each is defined differently than STS (Ogińska-Bulik et al., 2021; Singer et al., 2020). Singer et al. (2020) and Ogińska-Bulik et al. (2021) found healthcare providers and VAs differed in that CS and CF were greater predictors of burnout for VA satisfaction with work and was the main variable that predicted STS symptoms in a recent study of medical staff. Risk factors for STS for those working with trauma victims include caseload volume, case frequency, caseload type, organizational support, and personal trauma history (Benuto, Newlands, et al., 2018).

To better understand VT and STS from a public health approach and to develop a research agenda for addressing VT and STS in the workplace, Molnar et al. (2017) reviewed the literature from a public health perspective on professionals working in various professions that regularly expose them to traumatic events. Molnar et al. used a four-step approach commonly implemented in public health research: (a) define the problem and measure the scope, (b) identify risk and protective factors for negative outcomes, (c) develop interventions and policies, and (d) monitor and evaluate interventions and policies over time. Molnar et al. included findings and limitations specific to each profession at each step and discussed recommendations. Among

the recommendations, they suggested developing a validated instrument to measure the full range of VT/STS/CF symptoms (Levi et al., 2021; Molnar et al., 2017).

I used Bride's (2013) STSS to identify the presence of STS among NCVAs due to its ability to measure STS symptoms related to avoidance, arousal, negative cognitions and mood, and intrusion. Beck (2020) performed a secondary qualitative data analysis that found maternal-newborn nurses with PTSD symptoms due to the nature of their work. Intrusion category, negative cognitions, and mood category were first and second, respectively. The four categories of PTSD—avoidance, arousal, negative cognitions and mood, and intrusion—are also used in measuring STS symptoms (Bride et al., 2004).

Butler et al. (2017) examined the impact of trauma-related information on mental health training curricula. Indirect trauma experienced through training was found to be trauma exposure and considered a risk factor (Butler et al., 2017). Similarly, emergency medicine physicians and advanced practice providers were found to have high rates of STS due to their work with traumatically injured patients. Roden-Foreman et al. (2017) found a personal history of trauma was also a significant risk factor. Furthermore, it is well documented that nurses are at-risk for STS and that it negatively impacts the people they serve and their organizations (Levi et al., 2021). Recommendations for policies that acknowledge and mitigate risk among nurses were included and considered in the current study.

Researchers Penix et al. (2019) and Stearns et al. (2018) examined job burnout among military healthcare providers, with job demands and resources predicting burnout. Data on the prevalence of STS and burnout were collected in these studies. STS was initially reported at 19.2% for healthcare providers working with traumatized veterans, and it was found that burnout is also prevalent and can lead to STS (Stearns et al., 2018).

It is important to understand how factors other than indirect trauma contribute to the presence of STS in helping professionals (Penix et al., 2019). The degree to which deployed healthcare staff reported STS symptoms was studied, adding to the body of knowledge. They found that a few of the surveyed 236 military healthcare staff deployed to Afghanistan reported STS symptoms. In fact, combat exposure, work demands, and burnout are positively associated with STS. Self-care and health-promoting leadership are inversely associated with STS and may be protective factors, as are behavioral health staff that provides trauma narrative techniques positively associated with STS. This highlighted implications for my study regarding risk factors. Though foreign deployment has distinct stressors, stateside assignments, and environments may also be predictors (Penix et al., 2019; Stearns et al., 2018).

A study of emergency nurses in Jordan found nearly half of the surveyed sample with high to severe levels of STS from working in emergency units with trauma victims (Ratrout & Hamdan-Mansour, 2019). The only predictors found were coping and empathy, and the data suggest STS may not be linked to demographic factors (Ratrout & Hamdan-Mansour, 2019). Of note to the study of NCVAs and STS is that STS was not linked to demographic factors for these nurses, consistent with previous findings by Dworkin et al. (2016) and Hensel et al. (2015). Therefore, the demographics I chose to study among NCVAs were limited to gender, age, and ethnicity.

Social Workers and Mental Health Counselors

Social workers and mental health counselors are often exposed to indirect trauma similar to VAs (Beckerman & Wozniak, 2018) but without the added dimension of repeated exposure through service provisions to crime victims during the reporting, recovery, and criminal justice processes, such as with NCVAs (OVC, 2019).

Mental health counselors working in domestic violence shelters are susceptible to developing STS based on two risk factors: a history of trauma and the volume of trauma exposure (Beckerman & Wozniak, 2018). Beckerman and Wozniak (2018) conducted a qualitative study with two focus groups of female domestic violence shelter counselors, of which 73% were women of color. They explored the experiences of 11 domestic violence shelter counselors, broken into three groups counseling psychologically impacted domestic abuse survivors. STS was based on three manifestations of PTSD: (a) re-experiencing shared traumatic events, (b) avoidance/numbing, and (c) persistent arousal and hypervigilance. Criteria included being a domestic violence counselor working in a shelter, having a mental health counseling degree, and having less than 6 years of experience working in a shelter. Participants also all displayed symptoms of VT, a finding confirmed in a consequent literature review (Leung et al., 2022).

Four themes emerged from the focus group data: (a) hypervigilance/fear of harm, (b) impact on personal life, (c) a negative shift in worldview, and (d) methods of coping to avoid negative outcomes (Beckerman & Wozniak, 2018). Beckerman and Wozniak (2018) recommended closure for counselors in relation to clients, such as writing successful conclusions through journaling. They also recommended organizational support to provide counselors closure and reprieve, consistent with other populations of helping professionals (Kulkarni et al., 2013; K. Lee et al., 2017).

Using a predictive model for forecasting STS, Quinn et al. (2019) examined specified risk and protective factors among social workers. The cross-sectional survey-based quantitative study included 500 randomly selected licensed master's-level social workers. A total of 124 responded to the survey request, and 107 (21%) participated. A demographic questionnaire, the

Supervisory Relationship Inventory, and STSS were used to measure STS prevalence and predictor variables. They found that supervisory relationship, salary, caseload size, and personal anxiety were significant risk factors; conversely, high rates of supervision and higher income levels were associated with decreased levels of STS. However, they indicated that work environment, type of trauma, and amount of exposure to client trauma should continue to be studied. Practical implications at the organizational level included higher salaries, reasonable caseloads, and increased access to skilled supervisors. At the individual level, practical implications included self-care to reduce anxiety (Quinn et al., 2019). Taken together, the literature on social workers and mental health counselors provides insight for studying NCVAs and adds to the body of knowledge, specifically with the role of organizational factors (Sutton et al., 2022).

To better understand the prevalence and correlates of STS among social workers, Owens-King (2019) conducted a quantitative study that measured the magnitude of work, self-care, and job satisfaction. Owens-King sent a random survey to 5,000 members of the National Association of Social Workers specializing in mental health. Analyses were conducted on 161 completed online surveys from 126 women and 35 men. They found participants experienced low levels of STS. Two significant predictors were the magnitude of work with trauma-exposed clients and self-care activity. The greater the self-care, the fewer STS symptoms, a finding that has been subsequently confirmed in the literature (Hansen Zhang et al., 2020).

To fill gaps in the literature related to occupational health outcomes for helping professionals, Rauvola et al. (2019) conducted a qualitative study of empathy-based stress, which involves CF, STS, and VT from working with victims of traumatic crimes or events. An 8-month search of numerous academic databases produced 4,091 articles. Rauvola et al. applied exclusion

criteria (empirical, peer-reviewed, and studies measuring at least one of the three empathy-based stressors), yielding 724 papers. They identified common themes, definitions, measures, and knowledge gaps. The framework included "experiential, resiliency, and fatigue etiological" (p. 308) components, as well as an empathy-based stress model to identify empathy-based strains that culminate in occupational health reactions and outcomes. Resiliency studies involved individual and organizational factors that place helping professionals at-risk for experiencing "empathy-based symptoms." However, according to the researchers, the etiological fatigue viewpoint is most compatible with STS, as it helps to understand the flight of stress responses while accounting for the conundrum of expressing empathy, an essential skill for helping clients, which leaves them vulnerable to "empathy-based stress" (p. 309). Additionally, Rauvola et al. (2019) found that the study of contextual variables, personality traits, and organizational attributes and structure was infrequent and varied throughout the literature. They also found a gap regarding how work affects behaviors and how cognitions affect outcomes. Four major knowledge gaps in the literature were identified: lack of conceptual distinctions between empathy-based strain constructs, lack of contextual application in identifying empathy-based strain professions, lack of qualitative contributions regarding empathy-based stress, and a dearth of measures and study designs.

Focusing on the role of organizational factors, Sutton et al. (2022) conducted a meta-analysis that included 36 studies of mental health professionals. They sought to identify beneficial and detrimental elements that impacted STS and VT in mental health professionals. Sutton et al. identified six organizational factors: caseload as it relates to levels of exposure, trauma training, peer support, supervision, organizational support, and organizational culture. Practical recommendations included consistent and relational-orientated supervision, strong peer

support networks, and balanced, diverse caseloads. Similar to previous studies (Lu & Wang, 2020; Teyber & Teyber, 2017), recommendations for future research included identifying strategies and conditions that help lessen and prevent STS and encourage posttraumatic growth.

Mental Healthcare Providers Within the U.S. Military

Mental healthcare providers working within the unique environment of the U.S. military often support service members with complex trauma due to the distinctive environments with which they work (e.g., deployed locations away from family, war zones, and intense training locations), unlike civilians (Foa et al., 2010). Cieslak et al. (2013) and Resick et al. (2008) demonstrate the high prevalence of complex trauma among service members and the need for mental healthcare providers to be equipped to address these unique needs. Bovin et al. (2018) and Zapor et al. (2017) studied STS and predictors of STS among military healthcare providers to improve the understanding of STS and its impact on the U.S. military. To develop effective strategies for preventing and treating this condition, Bovin et al. (2018) and Zapor et al. (2017) examined the prevalence, predictors, and consequences of STS among military healthcare providers, adding to a limited body of knowledge on STS and studying military populations.

Law Enforcement

Detectives also work closely with traumatic crime victims and are at-risk for developing STS (MacEachern et al., 2019). To examine the scope of STS in detectives from the United Kingdom's family protection units (FPU) indirectly exposed to trauma, MacEachern et al. (2019) conducted a mixed-method study. All 100 FPU police officers were invited, with 63 (34 women and 29 men) participating. They used STSS to assess STS prevalence and determine gender differences in STS levels. They included open-ended questions to gain insight into their experiences with STS symptoms at work and how it affected their quality of life, providing

insight into possible risks and the negative impact left uninterrupted. MacEachern et al. (2019) found that over half (51%) of the participants experienced STS symptoms, with 11% indicating high or severe symptoms. This fact highlights that officers working in child protection cases are at-risk for developing STS, much like individuals working in social services and healthcare. Burnout, sleep difficulties, altered emotional responses to work, and changes in empathy toward witnesses were revealed in the findings.

Additionally, they found that the qualitative data eased a knowledge gap regarding FPU detective experiences with STS symptoms and cognitive and behavioral changes similar to VAs. This finding is similar to that of Cronje and Vilakazi (2020) who conducted a quantitative study to elucidate the scope of STS among police detective officers working in the Family Violence, Child Protection, and Sexual Offenses unit of the South African Police Service. A survey was sent to 65 officers, and 14 declined. Of the 51 participants, 29 were men, and 22 were women. STSS and a biographical questionnaire were used to measure levels of STS symptoms. Forty-nine participants had been exposed to trauma.

Cronje and Vilakazi (2020) found that 61% were experiencing moderate, high, or severe STS symptoms. They found that the type of crime was the only statistically significant factor, reinforcing the type of crime as a predictor variable. Officers working in sexual crimes units were at-risk, suggesting that sexual crimes are especially traumatic for this community and that sexual crimes may also be traumatic for other professionals. Cronje and Vilakazi recommended further research on the risk and protective factors for police detective officers. Additional studies found that other law enforcement personnel are also at-risk for developing STS. Brady (2017) found that one in four child exploitation investigators displayed low CS and high levels of STS and burnout due to indirect trauma from their investigative work. Work-related risk factors

include poor organizational support, recurrent ancillary exposure to disturbing materials, and a personal-related risk factor of having a history of trauma. Similarly, burnout and secondary trauma were prevalent for forensic interviewers (Fansher et al., 2020). Forensic interviewers have specialized training in interviewing child abuse victims and were also found to be at-risk for burnout due to work-related factors such as inadequate job support, funding constraints, and demanding workloads (Starcher & Stolzenberg, 2020). These studies further reinforce potential risk factors associated with STS and NCVAs.

Though not considered law enforcement, family law attorneys often serve clients who have suffered traumatic events, such as domestic violence, child abuse, and events occurring from living with spouses experiencing PTSD, leaving them at high risk for developing STS and legal bias (Brobst, 2014). Brobst (2014) explained that legal bias occurs when attorneys experience cognitive dissonance, display hypervigilance, and distance themselves from their clients' traumatic histories, negatively impacting court cases and their profession. Of particular relevance to this study, Brobst recommended a strengths-based approach specific to the culture of victim service professions.

Friends and Family

Friends and family supporting traumatic crime victims may also be at-risk for developing STS symptoms (Figley & Ludick, 2017). Gregory et al. (2017) conducted a qualitative study across community-based domestic violence organizations in the United Kingdom to explore the health and well-being of adults who provide informal support and care to domestic abuse survivors. They interviewed 23 participants, mostly women and found that psychological and emotional well-being, and physical health were impacted. Research is emerging on STS in informal caregivers who support domestic violence survivors; however, this community is

especially at-risk because they often do not have the resources to support them (Gregory et al., 2017).

Summary

Indirect exposure to traumatic events through traumatized clients may cause STS symptoms (Hensel et al., 2015), placing NCVAs at elevated risk for developing STS and PTSD (Ray et al., 2013) and impacting their ability to provide essential support services to traumatic crime victims (Bride et al., 2004). VAs uniquely assist crime victims through the daunting criminal justice and healthcare processes requiring specialized training, ethical behavior, and reoccurring education (NOVA, 2022).

There is a gap in measuring STS among NCVAs who work with traumatized crime victims in civilian or military communities, and the current study was designed to be generalizable across those communities (Benuto, Newlands, et al., 2018). The literature also indicated gaps about risk factors associated with STS among NCVAs; therefore, this study was designed to evaluate the predictors or risk factors, including VA caseload volume and frequency, personal history of trauma, the nature of the support of employing organizations, long-term engagement with traumatized clients, and demographic variables (i.e., age, gender, and ethnicity; Benuto, Newlands, et al., 2018).

Chapter Three: Methods

Overview

This study was built upon Benuto, Newlands, et al.'s (2018) prior research on STS among VAs. This chapter explains the methodology in seven sections: design, research questions, hypotheses, participants and setting, instrumentation, procedures, and data analysis.

Design

The design was quantitative descriptive, and exploratory. The quantitative approach was justified because it was based on numeric evidence that enabled variables to be analyzed empirically for statistical significance (Rahi, 2017; C. Williams, 2007). The descriptive approach was justified because the study was based on self-reported survey data, mostly measured with Likert scales in the absence of interventions or treatments (Khadka, 2015; Rahi, 2017) (Appendix B and Appendix C). These data provided a way to establish baseline measures, associations, and group differences (Warner, 2013) to explore the relationships between STS and potential risk factors at a given time (Bride, 2007). The descriptive design was consistent with previous studies of individuals who may be indirectly exposed to trauma through their work, such as healthcare workers (Ogińska-Bulik et al., 2021). Benuto et al. (2019) used descriptive statistics to describe workplace supports available to VAs and to understand the relationship between workplace supports and STS among VAs. Descriptive statistics can be used to quantify the relationships between STSS and individual subscale items, such as intrusion and avoidance (Kesmodel, 2018). For example, the method was used to measure STS among mental health providers working with the military (Cieslak et al., 2013). Finally, descriptive design plays a key role during the initial stage of systematic discovery when exploring an observed occurrence

(Heppner et al., 2016), as is the case with understanding STS among NCVAs (Benuto, Newlands et al., 2018).

This study was designed to identify which, if any, of the proposed variables were factors in developing STS symptoms and quantifying their impact on the development of STS. Descriptive statistics can measure baseline levels of STS, potential risk factors, and the relationships between risk factors with STS among VAs working with military or civilians—currently unknown information. Additionally, because descriptive statistics can be compared to other study samples for the presence of STS and potential risk factors, they provide information pertinent to victim advocacy program evaluations and direct future studies in generating hypotheses.

Appropriate descriptive statistics for an exploratory study include statistical tests to describe various relationships between variables (Heppner et al., 2016). Based on past studies (e.g., Benuto, Newlands, et al., 2018; M. L. Bourke & Craun, 2014; Brady, 2017; Butler et al., 2017; Hensel et al., 2015; Kanno & Giddings, 2017; Penix et al., 2019), seven risk factors of STS were examined: caseload volume; caseload frequency; personal trauma history; organizational support; type of organization; long-term engagement in trauma victim advocacy; and demographic diversity based on gender, age, and ethnicity. Specific analytical approaches are described in the data analysis section of this chapter.

Research Questions

RQ1: What is the baseline of STS among surveyed nationally credentialed victim advocates working with the military and civilian communities?

RQ2: What are the risk factors associated with STS among surveyed nationally credentialed victim advocates working with military and civilian communities?

Hypotheses

H_a1: Numbers of VAs differ significantly across the five STS categories.

$H_0$1: Numbers of VAs do not differ significantly across the five STS categories.

For RQ2 hypotheses, VAS refers to the Victim Advocacy Survey (see Instrumentation section of this chapter).

H_a2: Caseload volume, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$2: Caseload volume, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a3: Caseload frequency, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$3: Caseload frequency, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a4: A history of personal trauma, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms

$H_0$4: A history of personal trauma, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a5: Type of organization, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$5: Type of organization, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a6: Organizational support, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$6: Organizational support, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a7: Long-term engagement with victim advocacy, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$7: Long-term engagement with trauma victims, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a8: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$8: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

Participants and Setting

NOVA indicated that about 2,500 NCVAs could be reached through their e-blast, newsletter, and social media accounts. NOVA's executive director granted permission to invite group members to participate in this study via the methods listed above (C. Ponder Selib, personal communication, January 11, 2022). Thus, the target communities and accessible sample were the same in this study.

Three inclusion criteria were used to identify potential participants: (a) the participant was an adult who was 18 years of age or older, (b) the participant was a VA who held a national advocate credential, and (c) the participant worked with military or adult civilian victims of traumatic crime. The third inclusion criterion pertained to two types of certified VAs. One group was certified advocates who worked with military traumatic crime victims. The other group was adult VAs working outside the military environment with civilian traumatic crime victims and

possessing NACP credentials. For this study, traumatic crime victims was defined as victims of sexual assault, domestic violence, human or sex trafficking, homicide, stalking, or physical abuse (OVC, 2020).

A cross-sectional sample was collected with a survey. Cross-sectional samples were used because they detect relevant information at a given point in time based on the inclusion and exclusion criteria (Setia, 2016). Small samples compromise the power to detect statistically significant relationships and to generalize findings; therefore, a minimum of 15–20 participants for each independent variable was needed (Hair et al., 2010). Based on the study's seven potential risk factors, a sampling minimum of 140 participants was needed to complete the survey. Because the study had 59 participants, statistical significance was unlikely in many hypothesis tests, generalization is limited.

Instrumentation

The Victim Advocate Survey (VAS) was used. It is composed of 41 items that are a combination of Bride's (2013) Secondary Traumatic Stress Survey (STSS) (Appendix B) and select demographic items (Appendix C). The STSS and demographic items have been collected in past studies of VAs at-risk for developing STS (Benuto, Newlands, et al., 2018; Hensel et al., 2015).

Secondary Traumatic Stress Scale

Because STS data were fundamental to this study, the VAs started with Bride's (2013) 21-item STSS survey items. The STSS items were followed by the 20 items that measured potential risk factors (items 22–42).

The STSS was initially developed by Bride (2004) as a 17-item scale that measured three subscales: intrusion, avoidance, and arousal. Bride (2013) expanded the STSS to a 21-item scale

by adding a fourth subscale: negative cognition, and mood. The expansion aimed to measure changes to PTSD symptoms as per the *DSM–5* to reflect individuals who were subjected to trauma indirectly (APA, 2013). Each item relates to a PTSD criterion found in the *DSM–5* (APA, 2013), except for item 5, which was excluded from the analysis. The STSS is the only instrument concentrated solely on traumatic stress symptoms (Bride et al., 2004; Sprang et al., 2019). STSS items are measured on a 5-point Likert scale of frequency (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *often*, 5 = *very often*). When the numeric values of the items are summed, they range in value from 21–105. Bride et al. (2004) holds the STSS copyright; permission to use STSS was received on January 25, 2022 (Appendix A).

The STSS has been validated as a reliable measure of STS among social workers (Bride, 2007) and VAs (Benuto, Yang, et al., 2018). Benuto, Yang, et al. validated the initial 17-item STSS with a sample of VAs. Bride et al. (2004) demonstrated adequate psychometric properties and high internal consistency with a strong Cronbach's $\alpha = 0.93$ (95% CI = [0.91, 0.94], p. 2578). A recent meta-analysis conducted to define STS and develop targeted assessments and interventions indicated that of similar assessments (e.g., the Professional Quality of Life Scale, the Trauma Attachment Belief Scale, the World Assumption Scale, and the Traumatic Stress Institute Belief Scale), the STSS was the only one specifically designed to measure "reactions to indirect exposure to traumatic stress" (Sprang et al., 2019, p. 73). It includes criteria distinguishing STS from CS, VT, and burnout, although further development of validated measures is still needed to identify targets for STS interventions (Sprang et al., 2019). Master's level social workers have confirmed its strong reliability and validity to measure STS within different service organizations (Meadors et al., 2009).

Victim Advocate Survey Part 2: Demographics

Personal demographic variables were collected via items 22, 23, 24, and 29–32. Organizational support and type variables were collected via items 25–28, 33–38, and 42. Items 39–41 measured demographic diversity (i.e., gender, age, and ethnicity). The survey ended with an open-ended question to encourage participants to provide further insights.

This study's internal validity and external reliability were strengthened by using the well-validated STSS instrument to measure the symptoms of STS, normality screening, and quantitation of reliability with Cronbach's α statistics. Bias was minimized by using standardized survey questions (Heppner et al., 2016). In this case, the general community was composed of NCVAs. Further, validity was strengthened through quality control of methodology by carefully wording questions and response formats to reduce ambiguity. The STSS survey items and demographic questionnaire (Appendices B and C) were peer-reviewed by a statistical consultant to minimize the possibility of social desirability bias (Warner, 2013).

Procedures

Following Institutional Review Board (IRB) approval, invitations to participate were sent with a link to the SurveyMonkey.com survey to the NOVA webmaster. The invitation briefly described the study and purpose, the consent form, the estimated completion time, and my contact information (email address and phone number). The link gave participants direct access to the consent form and survey on the SurveyMonkey.com site. SurveyMonkey is an online survey site allowing clients to create surveys or use templates. A range of services can be purchased, from the basic survey to advanced analytics. Participants were asked to indicate their consent by checking the form, stating that participation was voluntary, confidential, and

uncompensated. Once participants agreed with the informed consent form, they were given access to the survey.

Recruitment was accomplished through a direct and indirect approach. Direct outreach to NCVAs was accomplished by advertising this study in the NOVA e-blast (email to credentialed advocates) and in the newsletter emailed to all NCVAs. Indirect outreach to NCVAs was accomplished by advertising on NOVA's social media sites. The webmaster posted the invitation to participate and linked to the SurveyMonkey.com survey on NOVA's Twitter, Facebook, and LinkedIn sites. Based on expert recommendations that surveys open between 1 and 3 weeks generally receive an 80% response rate within 7 days (Atkinson, n.d.), the invitation and link were posted weekly on the social media sites for 3 weeks to encourage participation. At the end of 3 weeks, the sample size was evaluated, and, as per my dissertation committee, recruitment ended with 60 respondents, of which 59 participated. Study results were reported through NOVA's newsletter per IRB approval.

Participation was voluntary and free of deception. The informed consent letter transparently disclosed the study title, purpose, benefits of participation, risks, costs, and protection of participants' identifying information (Appendix E). It stated that completing the survey indicated that the participants agreed to participate voluntarily.

This study involved a deeply distressing reality—trauma. Any suggestion that VAs are not 100% prepared to work with trauma victims could elicit negative professional consequences, such as revoking their national credential and losing employment (DoD, 2020). Therefore, participant anonymity was a priority. To safeguard the anonymity of government employees, a statement in the Informed Consent (Appendix E) recommended that survey participants use personal computers to take the survey and that they be cognizant of the environment in which the

survey was taken (privacy) was included. Identifiable questions and identifiable custom variables were not used in the survey (Momentive, n.d.-a, para. 2). Additionally, SurveyMonkey's anonymous responses feature was enabled, preventing the software from tracking or storing identifying information from participants (Momentive, n.d.-b, para. 1). SurveyMonkey's privacy notice explains that they "use and analyze usage information about responses (for example looking at page view data, response rates, response types, and survey type)" for several reasons (Momentive, n.d., para. 2). However, responses were anonymous.

Following data collection, participants were identified with a case number that was not traceable to them. Electronic data are securely stored in a designated password-protected locked file on my password-protected PC. It requires a two-step authentication process to access and is secured with encryption. Data will be kept confidential for 3 years and then erased.

Data Analysis

Following data collection, individual participant responses were securely exported from SurveyMonkey.com into a Microsoft Excel spreadsheet by accessing the Export Survey Data feature and choosing the All Responses option. Participants were screened to ensure that only those who met the inclusion criteria (i.e., adult credentialed VAs working with adult military or civilian crime victims) were included in the analysis. The data were transferred to SPSS (version 28) and analyzed. Statistical significance was set at $\alpha = .050$.

Individual variables were screened for missing values, outliers, and assumptions of statistical normality, as well as checks of linearity among bivariate pairs of variables (Warner, 2013). If information was missing from the surveys, one of two primary methods consistent with best practices was leveraged to address it: imputation or removing data (Kang, 2013).

H1 Statistical Procedures

Cronbach's α tests were generated to assess the internal consistency of the items (Leedy & Ormrod, 2019) that were used to measure each STSS subscale (VAS items 1–21) (Appendix B). The four STSS subscales were then calculated by summing conceptually related items. For example, an Intrusion subscale item is, "I thought about my work with clients when I did not intend to." For each participant, the numeric values of responses to items 2, 3, 6, 10, and 13 were summed for an Intrusion subscale score. An example of an Avoidance subscale item is, "I avoided people, places, or things that reminded me of my work with clients." The numeric values of responses to items 12 and 14 were summed for an Avoidance subscale score. An example of an Arousal subscale item is, "I engaged in reckless or self-destructive behavior." The numeric values of responses to items 4, 8, 11, 15, 16, and 19 were summed for an Arousal subscale score. An example of a Negative Cognition and Mood subscale item was, "I had little interest in being around others." The numeric values of responses to items 1, 7, 9, 17, 18, 20, and 21 were summed for a Negative Cognition and Mood subscale score. Item 5 was excluded from scoring because it is not part of the *DSM–5* for PTSD (Bride, 2013). For each participant, subscale scores were added for a Total STSS score. Higher scores indicated more frequent experiences of secondary trauma symptoms and were interpreted as follows: scores of less than 28 indicated little or no STS, scores of 28–37 reflected mild STS, scores of 38–43 reflected moderate STS, scores of 44–48 reflected high STS, and scores of 49+ reflected severe STS (Bride, 2013). Baseline measures were generated with descriptive statistics.

H2–8 Statistical Procedures

Demographic variables (VAS items 29, 30, 31, 33–4) were summarized with descriptive statistics (Appendix C). Responses to the open-ended item 43 were summarized in tabular form. The remaining analyses addressed risk factors.

Warner (2013) recommended taking steps to ensure "all the predictor variables are given equal treatment, and the predictive usefulness of each predictor variable is assessed controlling for all other predictors" (p. 549). To address her recommendation while answering RQ2, the following analytical procedures were conducted based on the measurement scale of STSS and each risk factor. As described in the Instrumentation section, the overall STSS scores and four subscale scores were calculated as data points on a continuous measurement scale (Appendix B). The first statistical procedure measured associations between potential risk factors and correlations. Specifically, STS was correlated with the three potential risk factors of caseload volume, caseload frequency, and long-term engagement in trauma victim advocacy. Correlations were appropriate because, like STSS scores, these three potential risk factors were variables measured continuously. Factors correlated strongly and positively with STSS scores were labeled risk factors.

The second statistical procedure measured group differences with independent *t*-tests. Specifically, STSS scores were evaluated for significant differences for the two potential risk factors of personal trauma history (yes or no) and type of organization (military or civilian). Independent *t* tests were appropriate because *t* tests are based on a dichotomous (Warner, 2013) categorical independent variable (in this case, both personal trauma history and type of organization were measured dichotomously; and a continuous or numeric dependent variable (in this case, STSS scores). Personal trauma history was labeled a risk factor if participants who had

personal histories of trauma reported significantly higher STSS scores than participants who did not report personal histories of trauma. Similarly, if the difference in STSS scores by type of organization (military or civilian) was statistically significant, the organizational type of the VAs who reported the higher STSS score would be labeled a risk factor.

The third statistical procedure was to measure group differences with ANOVA tests. Specifically, STSS scores were evaluated for significant differences in the two potential risk factors of organizational support and demographic diversity based on gender, age, and ethnicity. ANOVA tests were appropriate because they examine continuous or numeric dependent variables (in this case, STSS scores) across levels of a categorical independent variable with more than two levels (Warner, 2013). In this study, organizational support had four levels (i.e., advocacy support, adequate time, structure conducive to victim support, and sufficient time to practice self-care). Demographic diversity was measured by three categorical variables (i.e., gender, age, and ethnicity). If significantly higher STSS scores emerged for one or more types of organizational support, that type would be labeled a risk factor. Similarly, if significant differences in STS emerged for gender, age, or ethnicity, significant demographic characteristics would be labeled a risk factor. The next chapter presents the results addressing the research questions.

Chapter Four: Findings

Overview

Originally but erroneously described as "compassion fatigue" STS is a distinct pattern of psychological symptoms that are broadly similar to the symptoms of PTSD (Figley, 1995a). It emerges among individuals exposed to trauma indirectly through extensive contact with victims of traumatic crimes. Although VAs are frontline health professionals trained to support victims of crime and interpersonal violence, exposure to clients whose traumatic experiences are repeatedly reexamined during the therapeutic process can elicit symptoms of STS in advocates. VAs are at-risk for developing STS but have been neglected in the extant literature (Benuto, Yang, et al., 2018). This chapter presents the study's research questions, the hypothesis, the descriptive statistics, the results, and a summary.

Research Questions

This study addressed two research questions derived from the problem and purpose statements.

RQ1: What is the baseline of STS among surveyed nationally credentialed victim advocates working with the military and civilian communities?

RQ2: What are the risk factors associated with STS among surveyed nationally credentialed victim advocates working with military and civilian traumatic crime victims?

Hypotheses

These results are organized by research questions and accompanying hypotheses. In each section addressing hypotheses, the corresponding statistical test is briefly described. Results include the retain-reject decision about the null and whether the alternate hypothesis was supported, partially supported, or not supported.

H_a1: Numbers of NCVAs differ significantly across the five STS categories.

$H_0$1: Numbers of NCVAs do not differ significantly across the five STS categories.

H_a2: Caseload volume, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$2: Caseload volume, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a3: Caseload frequency, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$3: Caseload frequency, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a4: A history of personal trauma, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms

$H_0$4: A history of personal trauma, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a5: Type of organization, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$5: Type of organization, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a6: Organizational support, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$6: Organizational support, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a7: Long-term engagement with victim advocacy, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$7: Long-term engagement with trauma victims, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

H_a8: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$8: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

Screening, Reliability, Summated Scales, Overall Breakdown of Survey Participants, Statistical Tests, and Assumptions Tests

Screening

Data were initially screened for entry errors and missing data points. Data were collected with an online survey, so there were no entry errors. There were some scattered missing data points; however, they did not show any systematic pattern, although the final number of participants tended to vary across individual tests. Likert-scaled responses for measures of STS were screened for normality, homoscedasticity, outliers, and linearity to determine whether they could be treated as continuous data (Tabachnick & Fidell, 2019). The Likert data did not show any systematic departures from statistical normality.

Reliability

The reliability or internal consistency of the conceptually-related Likert survey items was checked with Cronbach's alpha—values for Cronbach's alpha range from 0 to 1. The closer

Cronbach's alpha is to 1, the greater the reliability of the database. Indices of .70 or higher reflect an adequately reliable database.

Summated Scales

After screening and reliability checks, summated scales were generated for Total STSS scores, the four STSS subscales, and an Organizational Support summated scale by summing the numeric values of the conceptually related measures. A summated scale is a single empirical measure representing multiple aspects of a construct in one variable (Tabachnick & Fidell, 2019). Derived from several related aspects, a summated scale is a single composite measure that decreases measurement error in the original data, increases data reliability, increases validity, and increases parsimony in the overall number of variables (Tabachnick & Fidell, 2019). Because the four STSS subscales were each based on a different number of survey items (i.e., that summed to different ranges of values), they could not be compared directly.

Overall Breakdown of Survey Participants

One aim of this research was to address the research questions for VAs who worked with military victims and VAs who worked with civilian victims. This meant the sample had to be subdivided by type of VA. However, the final sample was small (N = 59 VAs). Eleven participants did not provide information about whether they worked with military or civilian victims.

Of the remaining 48 VAs who provided information on work with military or civilian victims, 17 worked with military victims. Five were classed in the Low Secondary Trauma group; the modal VA was a White female who had possessed her NACP or D-SAACP credential for less than 10 years (M = 8.00, SD = 6.58, *min-max* 1–16, n = 4) and was in her early 40s (age: M = 43.75, SD = 9.28, *min-max* 33–52, n = 4). The other 12 were classed in the High Secondary

Trauma group; the modal VA was a White female who had possessed her NACP or D-SAACP credential for about 5 years (*M* = 5.36, *SD* = 4.58, *min-max* 1–15, *n* = 11) and was in her early 40s (age: *M* = 41.91, *SD* = 13.95, *min-max* 23–63, *n* = 11).

The other 31 VAs worked with civilian victims. Thirteen were classed in the Low Secondary Trauma group; the modal VA was a White female who had possessed her NACP or D-SAACP credential for less than 5 years (*M* = 4.44 years, *SD* = 4.27, *min-max* 1–10, *n* = 9) and was in her late 40s (age: *M* = 46.85 years, *SD* = 11.47, *min-max* 32–69, *n* = 13). Eighteen were classed in the High Secondary Trauma group; the modal VA was a White female who had possessed her NACP or D-SAACP credential for less than 4 years (*M* = 3.93, *SD* = 4.71, *min-max* 1–18, *n* = 15) and was in her early 40s (age: *M* = 44.00, *SD* = 10.54, *min-max* 23–63, *n* = 17). The details of STS derivation are presented in the results for RQ1.

Statistical Tests

Whereas the original intention was to examine the data with parametric inferential statistical tests (i.e., *t* tests, ANOVA tests), subdividing the sample into two types of VAs led to small samples that required the use of non-parametric tests instead. For RQ1, baseline measures were addressed with 1 x 5 chi-square goodness of fit tests.

RQ2 hypotheses 2, 3, 5, and 8 involved comparisons of two groups and were run with Mann-Whitney U (MWU) tests, the non-parametric counterpart to parametric independent samples *t* tests. MWU tests are used when individual samples are less than 20 cases (Tabachnick & Fidell, 2019). They compare medians rather than means because means are strongly affected by extreme values and small samples, whereas medians are not similarly affected (Siegel & Castellan, 1988). The sample size was inadequate for ANOVA tests, so they were not run.

RQ2 hypotheses 4 and 6 were addressed with Fisher's exact probability tests. Fisher's tests were specially designed versions of chi-square tests for small samples measured as two dichotomous categorical variables (2 x 2 tables) (Siegel & Castellan, 1988). Fisher's exact test analyses were used to test hypotheses about personal history with trauma and organizational support because the former was measured dichotomously (yes or no), and the latter was collapsed dichotomously. The Fisher's exact test is useful for analyzing nominal and ordinal data when the two categorical variables are independent, the samples are small (i.e., only 20–30 data points), and it makes conceptual sense to create dichotomous categories (Siegel & Castellan, 1988). Similar to the output for chi-squares but designed for small samples, Fisher's exact test determines whether the two groups differ in the proportions of one variable in the two classifications of the other variable. If proportions differ more than expected by chance, the variables are significantly associated. SPSS output for Fisher's exact test provides a *p* value only.

Because small sample sizes hinder statistical significance (Tabachnick & Fidell, 2019), effect size statistics were also generated and examined for continuous variables because they revealed the effects of working with victims of traumatic crimes on STS regardless of sample size. Effect sizes were measured with Cohen's *d*, which standardizes the difference between means so that .20 = a small effect, .50 = a medium effect, .80 = a large effect, and all *d* statistics larger than .80 = very large effects of the independent variable. Regardless of statistical significance, Cohen's *d* effects sizes were used to assess the magnitude and practical importance of results (Weaver & Goldberg, 2012).

Assumptions Tests

The data were screened for normality. However, non-parametric tests do not require the data to be normally distributed.

Explanation of the Derivation of STSS Scores

STS was measured with Bride's (2013) 21-item STSS, which measures changes to PTSD symptoms that reflect indirect exposure to trauma as per the *DSM–5* (APA, 2013). Each item related to a PTSD criterion found in the *DSM–5* except for Item 5, which was added as a simulated survey item, and is not part of the *DSM–5* for PTSD, was excluded from analyses (Bride, 2013). Items on the STSS were measured on a 5-point Likert scale of frequency (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *often*, 5 = *very often*) to quantify the occurrence of symptoms experienced in the last 7 days. Total STS scores were calculated for each VA by adding the numeric values of their responses to the 20 survey items. Because Item 5 was excluded, the possible range of Total STSS scores was 20–100. The Total STSS score was examined quantitatively and interpreted categorically for each participant. Scores of less than 28 indicated little or no STS. Scores of 28–37 reflected mild STS. Scores of 38–43 reflected moderate STS. Scores of 44–48 reflected high STS. Scores of 49+ reflected severe STS (Bride, 2013). Note that the interval values used to classify the severity of symptoms were uneven (e.g., high secondary trauma ranged from 5 points (44–48), whereas severe secondary trauma ranged from 51 points (49–100). Higher scores indicated more frequent experiences of symptoms of secondary trauma.

However, the STSS also measures four subscales. Cronbach's α tests were generated to assess the internal consistency of the items used to measure each STSS subscale (Leedy & Ormrod, 2019). Then the four STSS subscales were calculated by summing conceptually related items for each participant. For the Negative Cognition and Mood Subscale, the numeric values of responses to items 1, 7, 9, 17, 18, 20, and 21 were summed; reliability was excellent (Cronbach's α = .80). For the Arousal Subscale, the numeric values of responses to items 4, 8, 11, 15, 16, and

19 were summed; reliability was excellent (Cronbach's α = .75). For the Avoidance Subscale, the numeric values of responses to items 12 and 14 were added; reliability was acceptable (Cronbach's α = .64). For the Intrusion Subscale, the numeric values of responses to items 2, 3, 6, 10, and 13 were summed; reliability was excellent (Cronbach's α = .76).

Results for RQ1

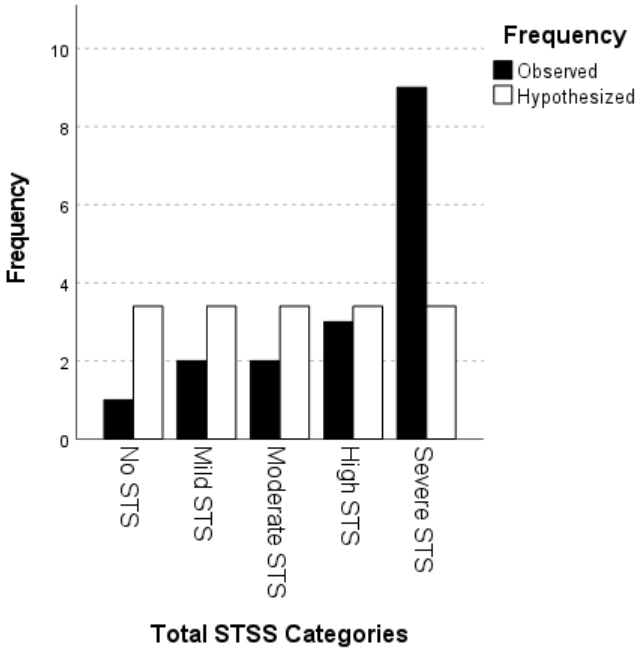
RQ1: What is the baseline of STS among surveyed nationally credentialed victim advocates working with the military and civilian communities? This section presents descriptive statistics that characterize baseline measures of STS symptoms. First, descriptive statistics of baseline measures of secondary trauma are presented for the VAs who worked with military communities. Second, descriptive statistics of baseline measures are presented for the VAs who worked with civilian communities.

Baseline Descriptive Statistics of STS of VAs Working With Military

There were 17 VAs who worked with military communities. The numbers of VAs by STS categories are illustrated in Figure 2. A combined total of 12 VAs working with the military communities fell in the High and Severe STS categories (70%). Over half of the VAs fell in the Severe STS category (53%, *n* = 9). Nearly 20% fell in the High STS category (17%, *n* = 3 VAs). One VA fell in the category of No STS (6%), and equal numbers of VAs fell in the Mild STS and Moderate STS categories (12%, *n* = 2).

Figure 2

Observed and Expected Numbers of VAs Working With Military by Total STSS Category



A chi-square goodness of fit test was run to compare the numbers of VAs across STS categories using the expected frequency of 3.4, derived by dividing 17 VAs by five categories. The hypotheses were:

H_a: Numbers of VAs differ significantly across the five STS categories.

H_0: Numbers of VAs do not differ significantly across the five STS categories.

Results of the goodness of fit test showed the numbers of VAs differed significantly across the five STS categories, $\chi^2(4, 17) = 12.12$, $p = .016$. The null hypothesis was rejected. The alternate hypothesis was supported. Based on the distribution of VAs across the stress category (Figure 2), VAs were recoded into two groups based on the extent of secondary trauma symptoms. There were five VAs in the No to Moderate STSS categories and labeled the Low Secondary Trauma group (29%). There were 12 VAs in the High to Severe STSS and labeled the High Secondary

Trauma group (71%). Among VAs who worked with military victims, the odds of exhibiting high-severe secondary trauma symptoms to low symptoms was 2.4 to 1.

For VAs who worked with military, descriptive statistics of Total STS scores for the entire sample, Low Secondary Trauma group, and High Secondary Trauma group are listed in Table 2. In the overall sample, the median fell in the Severe category, and the mean fell at the cusp between the High STS and Severe STS categories. The maximum indicated that the VA who reported the highest STS (*max* = 80) was close to the maximum possible value.

Statistics from the Low and High Secondary Trauma groups show how distinct their scores were. For the five VAs in the Low Secondary Trauma group, Total STS scores indicated no to moderate symptoms of secondary trauma. For example, their mean fell in the category of mild symptoms. For the 12 VAs in the High Secondary Trauma group, their statistics also reflected their status as exhibiting high to severe symptoms of secondary trauma. For example, their median and mean fell in the severe category.

Table 2

Baseline Secondary Trauma Descriptive Statistics for VAs Working With Military

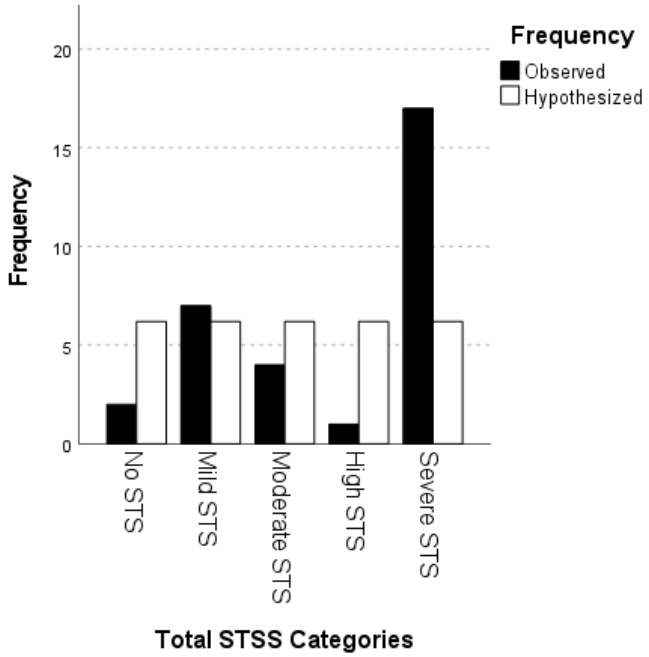
		Total STS	Secondary trauma group	
		Overall Sample	Low	High
Median		49.00	36.00	52.00
Mean		48.88	34.80	54.75
95% Confidence interval for the mean	Lower bound	42.25	27.07	48.40
	Upper bound	55.50	42.52	61.09
5% trimmed mean		48.36	34.83	53.94
Variance		165.98	38.70	99.65
Std. deviation		12.88	6.22	9.98
Minimum		27.00	27.00	44.00
Maximum		80.00	42.00	80.00
Range		53.00	15.00	36.00
Interquartile range		17.50	12.00	13.50
Skewness		0.49	-0.23	1.53
Kurtosis		0.97	-1.96	2.89

Baseline Descriptive Statistics of Secondary Trauma for VAs Working With Civilians

STSS scores were examined to see how the VAs who worked with civilian victims were distributed across secondary trauma categories (Figure 3). Eighteen of the 31 VAs fell in the High or Severe STS category (58%). Of those, a little over half fell in the Severe STSS category (55%, $n = 17$), and one fell in the High STSs category (3%). The second highest number of VAs fell in the Mild STS category (23%, $n = 7$ VAs), followed by the Moderate STS category (13%, $n = 4$ VAs). Two VAs fell in the No STS category (6%).

Figure 3

Observed and Expected Numbers of VAs Working With Civilians by Total STSS Category



A chi-square goodness of fit test was run to compare the numbers of VAs working with civilian traumatic crime victims across STS categories using the expected frequency of 6.2, derived by dividing 31 VAs by five categories. The hypotheses were:

H_a: Numbers of VAs differ significantly across the five STS categories.

H_0: Numbers of VAs did not differ significantly across the five STS categories.

The goodness of fit test results showed that the frequencies differed significantly across the five STS categories, $\chi^2(4, 31) = 26.90$, $p < .001$. The null hypothesis was rejected. The alternate hypothesis was supported. Based on the distribution of VAs across the stress category in Figure 3, they were placed into two groups according to the extent of secondary trauma symptoms. There were 13 VAs in the No to Moderate STSS, hereafter called the Low Secondary Trauma group (42%). There were 18 VAs in the High to Severe STSS, hereafter called the High

Secondary Trauma group (58%). Among VAs who worked with civilians, the odds of exhibiting high-severe secondary trauma symptoms to low symptoms was 1.4 to 1.

Baseline descriptive statistics for STS are listed in Table 3 for VAs who worked with civilians. The mean of Total STSS scores fell at the cusp between the High STS and Severe STS categories. The maximum indicated that the VA who reported the highest STS (*max* = 78) was close to the maximum possible value.

There were 13 VAs in the Low Secondary Trauma group. Total STS scores in Table 3 reflect their status as exhibiting no to moderate symptoms of secondary trauma. For example, their mean fell in the category of mild symptoms. There were 18 VAs in the High Secondary Trauma group. Their statistics also reflect their status as exhibiting high to severe symptoms of secondary trauma. For example, their median and mean fell in the severe category.

Table 3

Baseline Secondary Trauma Descriptive Statistics for VAs Working With Civilians

		Total STS	Secondary Trauma Group	
		Overall Sample	Low	High
Median		49.00	36.00	56.50
Mean		48.38	35.07	58.00
95% Confidence interval for the mean	Lower bound	43.39	31.21	53.98
	Upper bound	53.38	38.93	62.01
5% trimmed mean		48.28	35.36	57.44
Variance		49.00	36.00	56.50
Std. deviation		185.37	40.74	65.05
Minimum		13.61	6.38	8.06
Maximum		22.00	22.00	48.00
Range		78.00	43.00	78.00
Interquartile range		56.00	21.00	30.00
Skewness		22.00	10.50	12.00
Kurtosis		0.04	-0.51	0.88

Answer to RQ1

The baseline of STS among surveyed NCVAs working with military or civilian traumatic crime victims was divided. Half of the VAs reported no to moderate symptoms, and the other half reported high to severe symptoms. Although both types of VAs in the High Secondary Trauma group had median and mean Total STSS scores that clearly reflected high to severe secondary trauma symptoms, severity was higher among VAs who worked with the military than those who worked with civilians. Specifically, 71% of the VAs who worked with the military community fell in the High or Severe STS group compared to 58% of the VAs who worked with civilians. The odds of high-severe secondary trauma to low-moderate symptoms among VAs working with the military was 2.4 to 1. The odds of high-severe secondary trauma to low-

moderate symptoms among VAs working with civilians was 1.4 to 1. VAs were classified as belonging either to a Low Secondary Trauma group or a High Secondary Trauma group for subsequent group comparisons for RQ2.

Results for RQ2

RQ2 was: What are the risk factors associated with STS among surveyed nationally credentialed victim advocates working with military and civilian traumatic crime communities? This question was addressed by testing seven hypotheses about different potential risk factors. Risk factors are presented separately. Each hypothesis was first tested on VAs who worked with the military community and then on VAs who worked with civilians. Results are presented similarly (i.e., military first, civilian second).

Caseload Volume as a Risk Factor for Developing STS Symptoms

Caseload volume was measured as the number of clients seen during the typical week. The hypotheses were:

H_a2: Caseload volume, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

H_02: Caseload volume, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

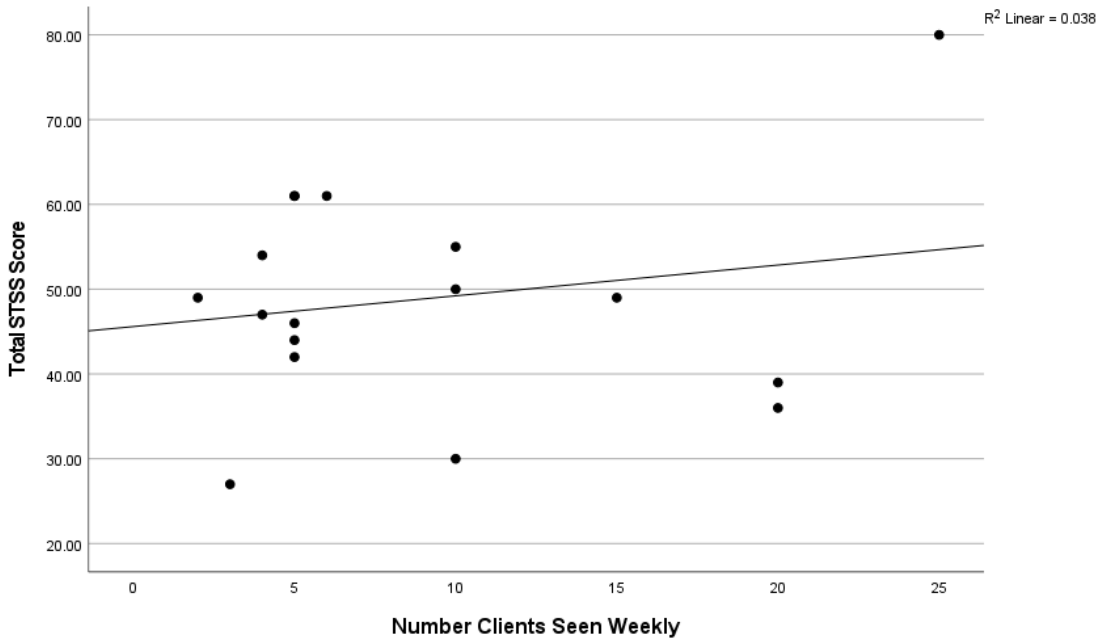
First, scatter plots were examined, and correlations were run to measure the linear relationship between secondary trauma and caseload volume. Second, means were examined. Third, MWU tests were run to determine if median caseloads of VAs with low and high levels of secondary trauma differed significantly. If caseload was a risk factor, caseloads were expected to be significantly higher among VAs in the High Secondary Trauma group than in the Low Secondary Trauma group.

Caseload Volume Among VAs Working With Military

The correlation between Total STS scores and caseload volume was positive and medium in magnitude, $r(15) = .25$, $p = .342$. The coefficient of determination estimated that caseload volume explained 6% of secondary stress ($r^2 = .06$). The correlation is illustrated in Figure 4 as a scatter plot with a superimposed line of best fit. The regression line formula for the line of best fit in Figure 4 predicted the Total STSS score based on the calculation of 45.6 + 0.36 (caseload volume), although due to the small sample, this result needs to be replicated with a larger sample.

Figure 4

Scatter Plot of Correlation Between Secondary Trauma and Caseload Volume of VAs who Worked With Military

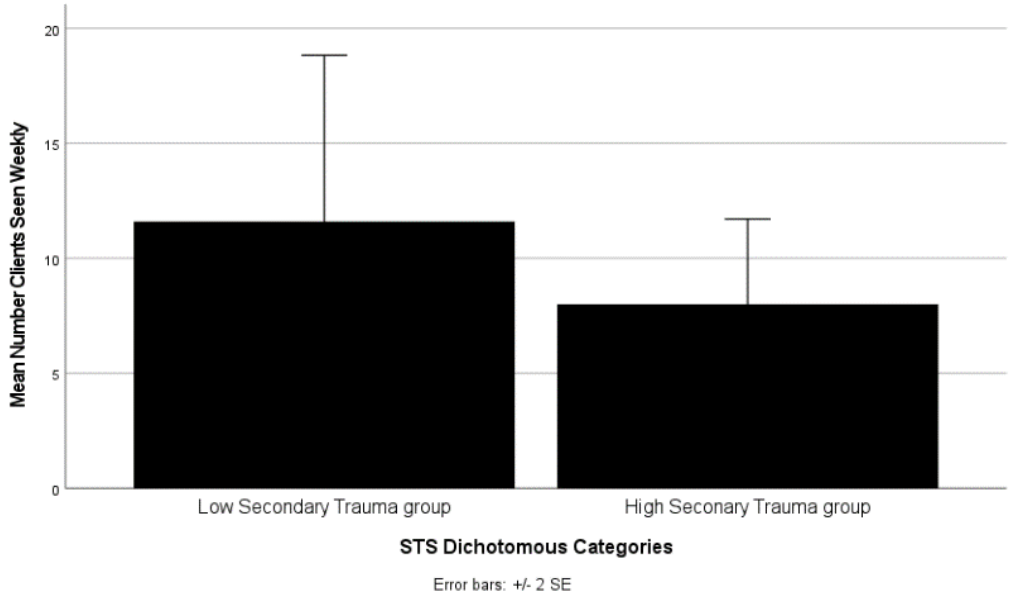


Mean caseload volumes for the low and high groups of secondary trauma among VAs working with the military are illustrated in Figure 5. Caseload volume was slightly higher on average among the Low Secondary Trauma group ($M = 11.60$ clients/week, $SD = 8.08$, $n = 5$

VAs) than the High Secondary Trauma group (M = 8.00 clients/week, SD = 6.42, n = 12 VAs). Caseload volume exerted a medium effect on secondary trauma (d = .52).

Figure 5

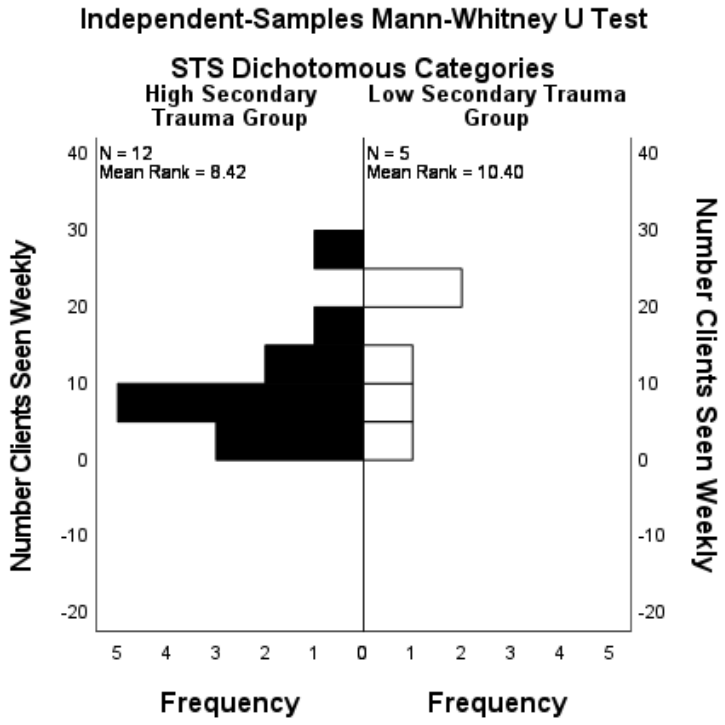
Mean Caseload Volume of VAs Working With Military in Low and High Secondary Trauma Groups



Among VAs who worked with the military community, the caseload volume *median* = 10 clients/week for the Low Secondary Trauma group and caseload volume *median* = 5 clients/week for the High Secondary Trauma group. Results of comparing the medians with an MWU test showed that the difference between the medians was not significant (MWU = 23, p = .453, n = 17). The null hypothesis was retained. The alternative hypothesis was not supported. The median comparison is illustrated in Figure 6.

Figure 6

Comparisons of Medians of Number of Clients Seen Weekly Across Low and High Secondary Trauma Groups of VAs Working With Military

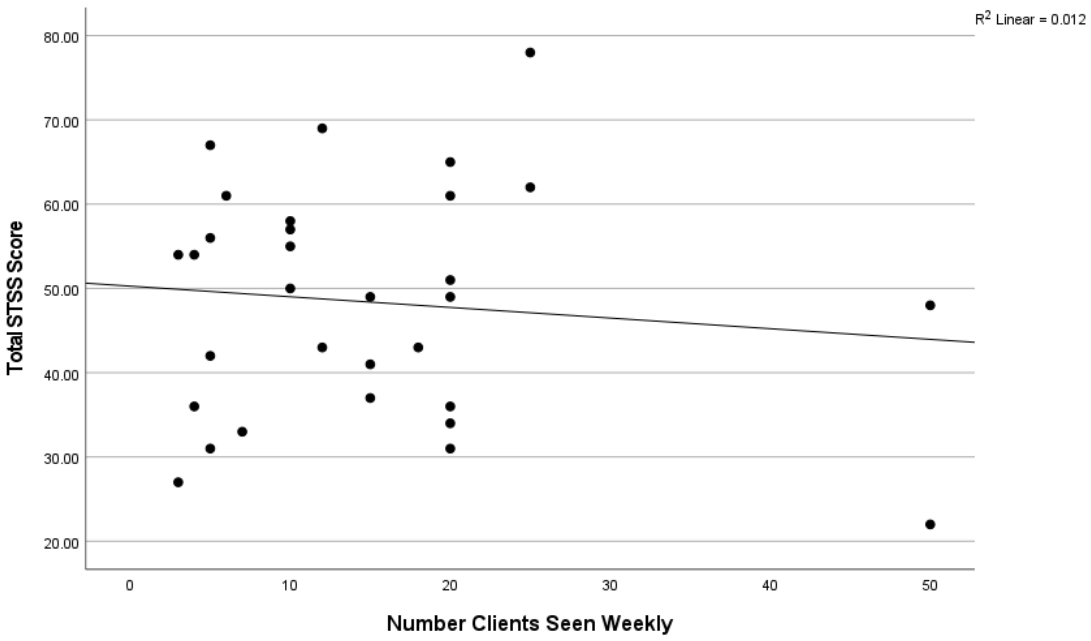


Caseload Volume for VAs Working With Civilians

The correlation between Total STS scores and caseload volume was negative and small in magnitude, $r(29) = -.09$, $p = .633$. The coefficient of determination estimated that caseload volume explained less than 1% of secondary stress ($r^2 = .008$). The correlation is illustrated in Figure 7 as a scatter plot with a superimposed line of best fit. The regression line formula estimated that a VA's Total STSS score could be predicted by subtracting the quantity 0.13(caseload volume) from the baseline measure of 50.3.

Figure 7

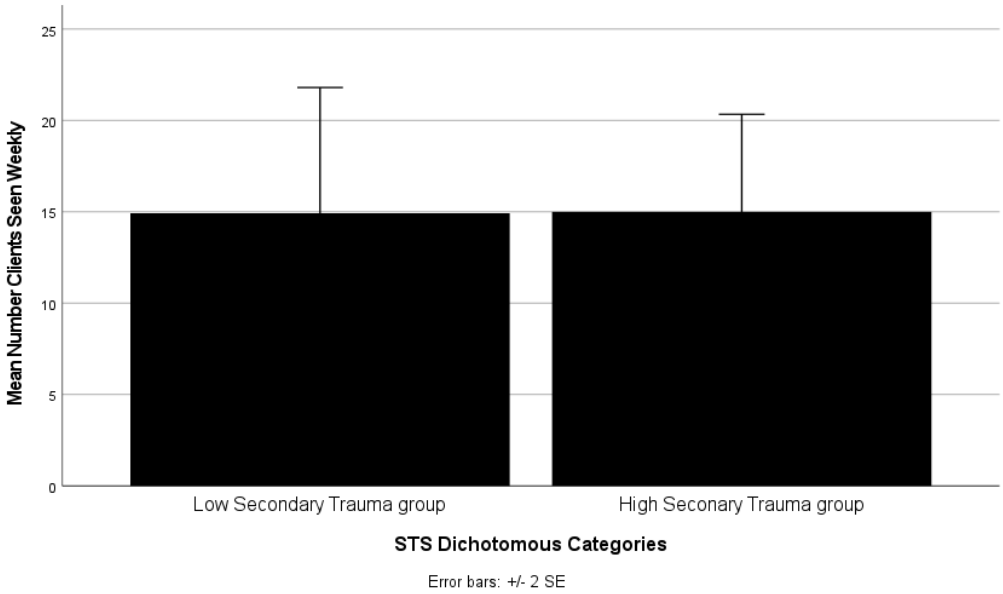
Scatter Plot of Correlation Between Secondary Trauma and Caseload Volume of VAs who Worked With Civilians



The mean caseload volume for the low and high groups of secondary trauma are illustrated in Figure 8. Caseload volume was comparable across the two groups (Low Secondary Trauma group: M = 14.92 clients/week, SD = 12.41, n = 13; High Secondary Trauma group: M = 15.00 clients/week, SD = 11.32, n = 18). Caseload volume exerted no effect on secondary trauma among VAs who worked with civilians (d = .007).

Figure 8

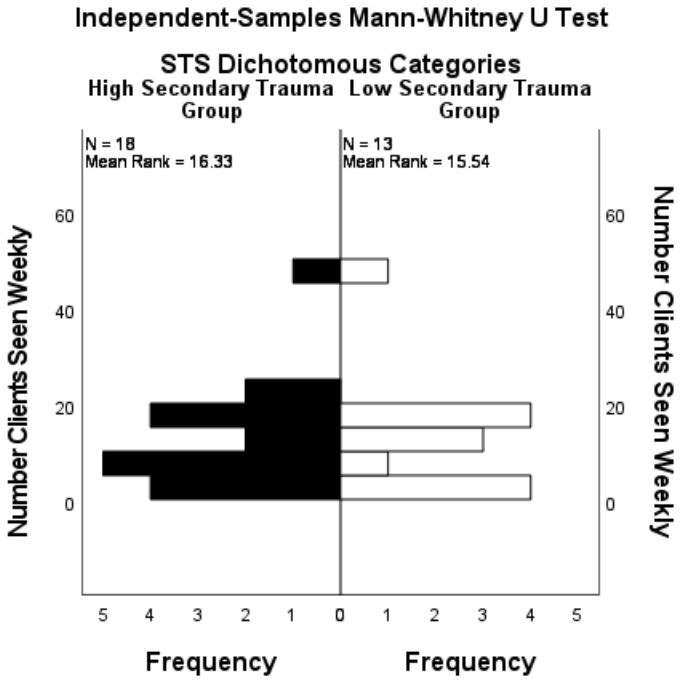
Mean Caseload Volume of VAs in the Low and High Secondary Trauma Groups Working With Civilians



Among VAs who worked with civilians, the *median* = 15 clients/week for the Low Secondary Trauma group caseload volume and *the median* = 11 clients/week for the High Secondary Trauma group. Results of comparing the medians with an MWU test showed that the difference between the medians was not significant (*MWU* = 123, *p* = .809, *n* = 31). The null hypothesis was retained. The alternative hypothesis was not supported. The median comparison is illustrated in Figure 9.

Figure 9

Comparisons of Medians of the Numbers of Clients Seen Weekly Across Low and High Secondary Trauma Groups of VAs Working With Civilians



Caseload volume appeared to be a minor risk factor for developing secondary trauma. Nonetheless, it may be more of a potential risk factor among VAs who worked with the military community, in that caseload volume explained about 6% of secondary trauma. In contrast, compared to VAs who worked with civilians, caseload volume explained less than 1% of secondary trauma.

Caseload Frequency as a Risk Factor for Developing STS Symptoms

Caseload frequency was measured as an estimated annual frequency of seeing traumatic crime victims of nine possible types (adult victims of sexual abuse, adult victims of childhood sexual abuse, physical assault, domestic violence, child sexual abuse, sex trafficking, stalking,

homicide, or other). Frequency was on a 5-point Likert scale (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *often*, 5 = *very often*) in the last year. Frequencies were compared across the two secondary trauma groups with MWU tests. The hypotheses were:

H_a3: Caseload frequency, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

H_03: Caseload frequency, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

Caseload Frequency of VAs Working With Military

Table 4 lists the means, medians, and results of MWU tests comparing the frequencies that VAs worked with the military community subjected to a range of traumatic crimes during the last year. For High > Low, traumas are listed in descending order of mean frequencies in the High Secondary Trauma group. VAs in the High Secondary Trauma group reported higher mean frequencies of working with adult victims of childhood sexual abuse, domestic violence, homicide, physical assault, stalking, and sex trafficking than did VAs in the Low Secondary Trauma group. VAs working with adult victims of sexual abuse reported the same mean frequencies.

For Low > High, traumas are listed in descending order of mean frequencies in the Low Secondary Trauma group. For five traumatic crimes, only one VA provided information on frequency, which meant MWU tests could not be run because multiple cases are needed to generate a median. The MWU tests that could be run were non-significant (Table 4). For these types of crimes, the null hypothesis was retained. The alternative hypothesis was not supported.

Table 4

Descriptive Statistics and MWU Test Results of Frequency of Working With the Multiple Types of Traumatic Crime Victims Among VAs Working With Military

	Secondary Trauma Group										
	Low				High			Low	High		
High > Low	*M*	*SD*	*n*	*x*	*M*	*SD*	*n*	*Mdn*	*Mdn*	*MWU*	*p*
Adult victims of sexual abuse	4.33	1.15	3		4.33	1.32	9	5	5	14	1.00
Adult victims of childhood sexual abuse	3.00	0.00	1		3.75	0.95	4	x	3.5	x	x
Domestic violence	2.00	0.00	1		3.50	1.91	4	x	4	x	x
Homicide	2.33	1.58	3		3.00	2.00	3	2	3	5.5	.700
Physical assault	1.00	0.00	1		3.00	0.00	1	x	x	x	x
Stalking	2.67	0.57	3		3.00	1.31	8	3	3	14	.776
Sex trafficking	2.00	1.41	2		2.33	1.03	6	2	2	7	1
Child sexual abuse	5.00	0.00	1		3.00	1.73	3	x	5	x	x
Other	4.00	0.00	1		1.67	1.15	3	x	4	x	x

Effect size statistics were also examined because they quantified the effects of frequencies of working with various types of trauma on secondary trauma regardless of sample size. Effect sizes were measured with Cohen's *d*, which standardizes the difference between means so that .20 = a small effect, .50 = a medium effect, .80 = a large effect, and all *d* statistics larger than .80 = very large effects.

Table 5 lists point estimates and confidence intervals of the effect sizes of various types of traumatic crimes in descending order among VAs who worked with the military community. The frequency of working with victims of Other traumatic crimes had a very large impact. Unfortunately, the participating VAs did not provide more details on what Other traumas meant. There was also a very large effect on secondary trauma of working with victims of child sexual

abuse. For both types of trauma, the effect was larger in the Low Secondary Trauma group than in the High Secondary Trauma group.

There were large effects on secondary trauma of working with adult victims of childhood sexual abuse and domestic violence. For the remaining traumatic crimes, effect sizes dropped to between small and medium for sex trafficking, homicide, and stalking. For these types of traumatic crimes, there were larger effects on secondary trauma in the High Secondary Trauma group.

Table 5

Cohen's d Effect Sizes for Frequency of Working With the Multiple Types of Traumatic Crime Victims of VAs Working With Military

VAs Working With Military	Cohen's *d* point estimate	95% Confidence Interval	
		Lower	Upper
Other (Low > High)	2.02	-1.00	4.81
Child sexual abuse (Low > High)	1.15	-1.44	3.54
Adult victims of childhood sexual abuse (High > Low)	0.78	-2.99	1.54
Domestic violence (High > Low)	0.78	-2.99	1.54
Homicide (High > Low)	0.37	-1.97	1.26
Sex trafficking (High > Low)	0.30	-1.89	1.32
Stalking (High > Low)	0.28	-1.60	1.06
Adult victims of sexual abuse (High > Low)	0.00	-1.30	1.30

Caseload Frequency of VAs Working With Civilians

Table 6 lists the means, medians, and MWU test results for frequencies of seeing victims of nine possible types among VAs working with the civilian community. Due to small sample sizes, the MWU tests did not register significant differences in the medians of the low and High

Secondary Trauma groups. The null hypothesis was retained for all tests. The alternative hypothesis was not supported.

Table 6

Descriptive Statistics of Frequency of Working With the Following Types of Traumatic Crime Victims Across the Last Year of VAs Working With Civilians

	Secondary Trauma Group									
	Low				High			Low	High	*MWU*	*p*
High > Low	*M*	*SD*	*n*	*x*	*M*	*SD*	*n*	*Mdn*	*Mdn*	*p*	*MD*
Adult victims of sexual abuse	3.50	1.20	6		4.33	0.86	9	3	5	38	.224
Domestic violence	3.75	1.25	4		4.00	1.41	8	4	4.5	19	.683
Homicide	3.75	1.75	8		3.82	1.53	11	4.5	4	43	.968
Child sexual abuse	2.60	0.89	5		3.75	1.25	4	2	4	15.5	.190
Adult victims of childhood sexual abuse	3.40	1.14	5		3.67	0.57	3	3	4	9	.786
Stalking	2.57	0.97	7		2.67	0.88	12	3	3	44.0	.902
Sex trafficking	1.83	0.75	6		2.08	0.64	13	2	2	46.5	.521
Other	4.50	0.70	2		1.80	1.09	5	4.5	1	0.0	.095
Physical assault	3.60	0.54	5		3.00	0.81	4	4	3	5.5	.286

Cohen's *d* effect size statistics were also examined to quantify the effects of various types of traumatic crimes (.20 = a small effect, .50 = a medium effect, .80 = a large effect, and all *d* statistics larger than .80 = very large effects). Table 7 lists point estimates and confidence intervals of Cohen's *d*-effect sizes in descending order. Among VAs who worked with civilians, the frequency of working with victims of Other traumatic crimes again exerted a very large impact. Unfortunately, the VAs did not provide more details about the nature of Other traumas. For working with victims of Other traumatic crimes, the effect was larger in the Low Secondary Trauma group than in the High Secondary Trauma group. The next strongest effects were very

large effects exerted, in descending order, by working with civilian child victims of child sexual abuse, physical assault, and adult victims of sexual abuse. The effects of working with victims of sexual abuse were larger in the High Secondary Trauma group. The effect of working with victims of physical assault was larger in the Low Secondary Trauma group. For the remaining traumatic crimes, effect sizes dropped to between small and medium for sex trafficking, adult victims of childhood sexual abuse, and domestic violence. Stalking and homicide exerted the least secondary trauma on VAs who worked in the civilian community.

Table 7

Cohen's d Effect Sizes for Frequency of Working With the Following Types of Traumatic Crime Victims Across the Last Year of VAs Working With Civilians

	Cohen's *d* point estimates	95% Confidence Interval	
		Lower	Upper
Other (Low > High)	2.62	0.28	4.83
Child sexual abuse (High > Low)	1.08	-2.47	0.38
Physical assault (Low > High)	0.89	-0.53	2.25
Adult victims of sexual abuse (High > Low)	0.82	-1.88	0.27
Sex trafficking (High > Low)	0.36	-1.33	0.61
Adult victims of childhood sexual abuse (High > Low)	0.27	-1.69	1.18
Domestic violence (High > Low)	0.18	-1.38	1.02
Stalking (High > Low)	0.10	-1.03	0.83
Homicide (High > Low)	0.04	-0.95	0.87

Caseload frequency did not differentiate VAs who worked with military victims from VAs who worked with civilian victims. However, regarding whether caseload frequency is a risk factor for developing STS symptoms, the data suggested that specific traumatic crimes should be considered individually. There were three main reasons for this. The first reason was that the

caseload frequency that emerged with the greatest impact was working with Other traumas. However, although this effect characterized VAs who worked with military or civilian victims, the issue did not qualify as a risk factor because frequencies were higher in the Low Secondary Trauma group than in the High Secondary Trauma group for both types of VAs. The second reason was that the caseload frequency that emerged having the second greatest impact, working with victims of child sexual abuse, applied to VAs who worked with military or civilian victims, but had opposite effects in the two groups. That is, among VAs who worked with military victims, those in the Low Secondary Trauma group reported higher frequencies than those in the High Secondary Trauma group.

In contrast, among VAs who worked with civilian victims, those in the High Secondary Trauma group reported higher frequencies than those in the Low Secondary Trauma group. The third reason was that the next two largest effects diverged. Among VAs who worked with civilian victims, higher frequencies of physical assault characterized the Low Secondary Trauma group. Physical assault was not a risk factor. However, working with adult victims of sexual abuse was a risk factor in that higher frequencies characterized the High Secondary Trauma group. Among VAs who worked with military victims, two potential risk factors were adult victims of childhood sexual abuse and domestic violence in that higher frequencies characterized the High Secondary Trauma group.

Personal History as a Risk Factor for Developing STS Symptoms

Personal history of trauma was measured dichotomously as a Yes or No survey item. The hypotheses were:

H_a4: A history of personal trauma, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms

$H_0$4: A history of personal trauma, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

Fisher's Exact Probability Test for 2 x 2 Tables

Hypotheses about small sample sizes based on dichotomous categories are tested with specially designed tests called Fisher's exact probability test (Siegel & Castellan, 1988). Recall that 17 VAs who worked with military victims were further classified as either belonging to the Low Secondary Trauma group (n = 5 VAs) or the High Secondary Trauma group (n = 12 VAs) and that the 31 VAs who worked with civilian victims were also classified as either belonging to the Low Secondary Trauma group (n = 13 VAs) or the High Secondary Trauma group (n = 18 VAs).

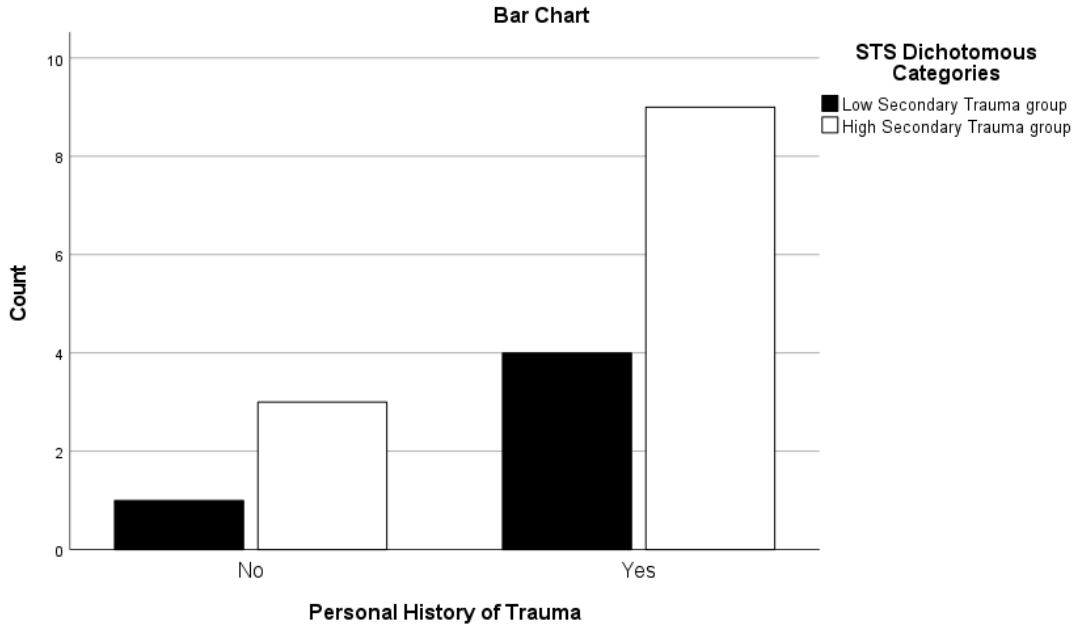
The cross-tabulation of the secondary trauma group and personal history of trauma created 2x2 tests. With small sample sizes like these, the convention is to use a 2 x 2 Fisher's exact probability test instead of a chi-square test (Siegel & Castellan, 1988). Similar to the output for chi-squares but designed for small samples, Fisher's exact test determines whether the two groups differ in the proportions with which each falls in the two classifications. If proportions differ, the variables are significantly associated. Fisher's exact test analyses were used to test the hypothesis about personal history with trauma because it was measured dichotomously (yes or no). SPSS output for Fisher's exact test provides a p value only.

Personal History of Trauma of VAs Working With Military

Figure 10 illustrates the number of VAs who worked with military victims per secondary trauma group and personal trauma history. Four of the five VAs in the Low Secondary Trauma group (black bars) had a personal history of trauma (80%). Nine of the 12 VAs who fell in the High Secondary Trauma group (white bars) had a personal history of trauma (75%).

Figure 10

Cross-Tabulation of Numbers of VAs by Secondary Trauma Group and Personal History of Trauma of VAs Working With Military



The probability resulting from the Fisher exact test, $p = .670$, indicated that the proportions of VAs in the Low and High Secondary Trauma groups who had and did not have personal histories of trauma did not differ. The null hypothesis was retained. The alternate hypothesis was not supported.

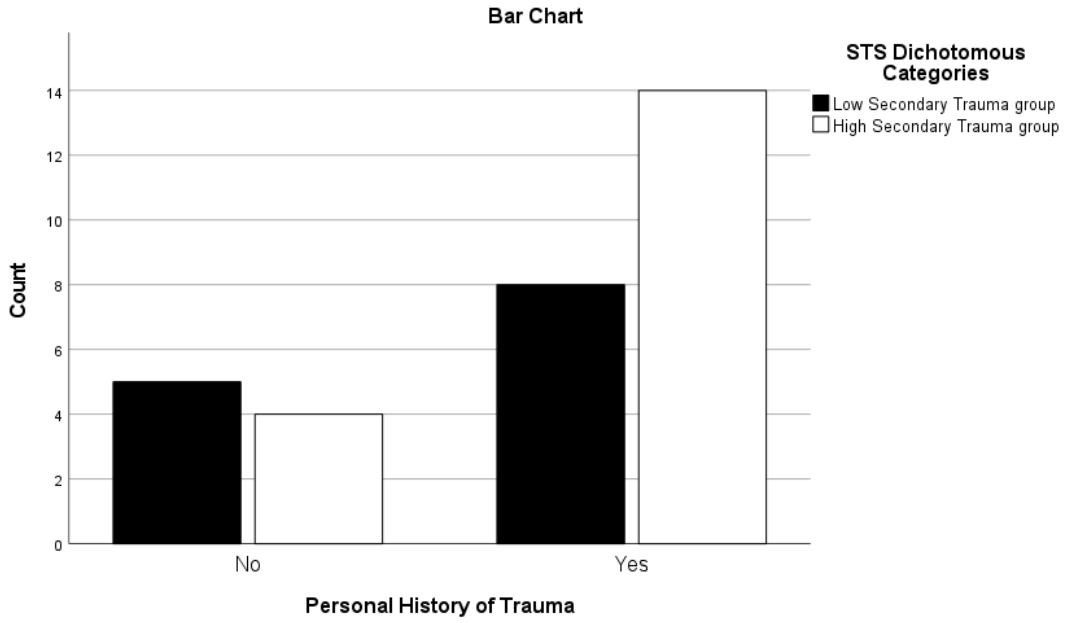
Personal History of Trauma of VAs Working With Civilians

Figure 11 illustrates the number of VAs who worked with civilian victims per secondary trauma group and personal trauma history. Eight of the 13 VAs who fell into the Low Secondary Trauma group (black bars) had a personal history of trauma (62%). Fourteen of the 18 VAs who fell in the High Secondary Trauma group (white bars) had a personal history of trauma (78%). The probability resulting from the Fisher exact test, $p = .433$, indicated that the proportions of

VAs in the Low and High Secondary Trauma groups who had and did not have personal histories of trauma did not differ. The null hypothesis was retained. The alternate hypothesis was not supported.

Figure 11

Cross-Tabulation of Numbers of VAs by Secondary Trauma Group and Personal History of Trauma of VAs Working With Civilians



A personal history of trauma did not differentiate the Low Secondary Trauma group from the High Secondary Trauma group for either type of VA. Therefore, a personal history of trauma did not emerge as a risk factor for developing symptoms of secondary trauma.

Type of Organization as a Risk Factor for Developing STS Symptoms

VAs in this study worked for one of two types of organizations: military or civilian. The hypotheses about the roles of military versus civilian organizations were:

H_a5: Type of organization, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

$H_0$5: Type of organization, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

Results are presented in six sections. The first and second sections present the results of comparisons of Total STSS scores and STSS subscale scores across the two types of VAs in the High Secondary Trauma groups. Comparisons were made with non-parametric MWU tests. The third and fourth sections present results for the military work environment and titles. The fifth and sixth sections present results for the civilian work environment and titles.

MWU Test Results for Total STSS Scores

The section presents the results of comparisons of total secondary trauma levels among VAs who worked with military victims in the High Secondary Trauma group to VAs who worked with civilian victims in the High Secondary Trauma group. Comparisons were made with non-parametric MWU tests. The results are listed in Table 8. For the Total STSS scores, the difference in secondary trauma medians between VAs in the High Secondary Trauma groups working with military or civilian victims was insignificant. The null hypothesis was retained. The alternate hypothesis was not supported.

Table 8

Results of MWU Tests Comparing Secondary Traumatic Stress Across VAs Working With Military or Civilians in the High Secondary Trauma Group

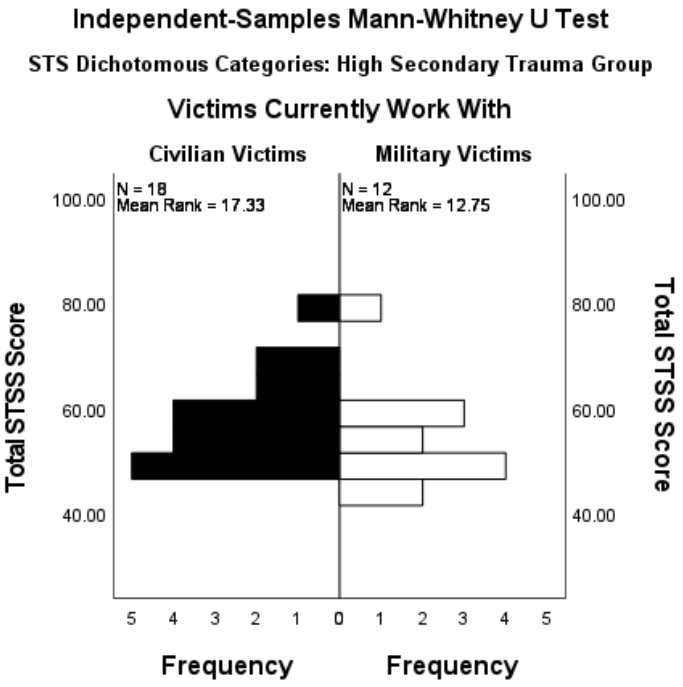
	VAs Working With Military			VAs Working With Civilians					
Secondary trauma	*M*	*SD*	*Mdn*	*M*	*SD*	*Mdn*	*MWU*	*p*	Cohen's *d*
Total STSS	54.75	9.98	52.00	58.00	8.06	56.50	75.0	.172	.13
Negative subscale	19.50	4.14	20.50	20.44	4.25	20.00	98.5	.692	.20
Arousal subscale	16.67	3.33	16.50	17.67	2.35	17.50	88.0	.415	.24

Intrusion subscale	13.50	3.06	13.00	14.50	2.87	14.00	82.0	.285	.15
Avoidance subscale	5.08	1.73	5.00	5.50	1.50	5.00	75.0	.573	.17

Figure 12 illustrates the comparison of data in the two groups. Although the VAs who worked with military victims had lower Total STSS values, overall, the values did not differ more than by chance amounts. Cohen's *d* indicated a small effect of organizational differences (Table 8).

Figure 12

Comparisons of Total STSS Score Medians Across VAs Working With Civilians/Military



MWU Test Results for STSS Subscale Scores

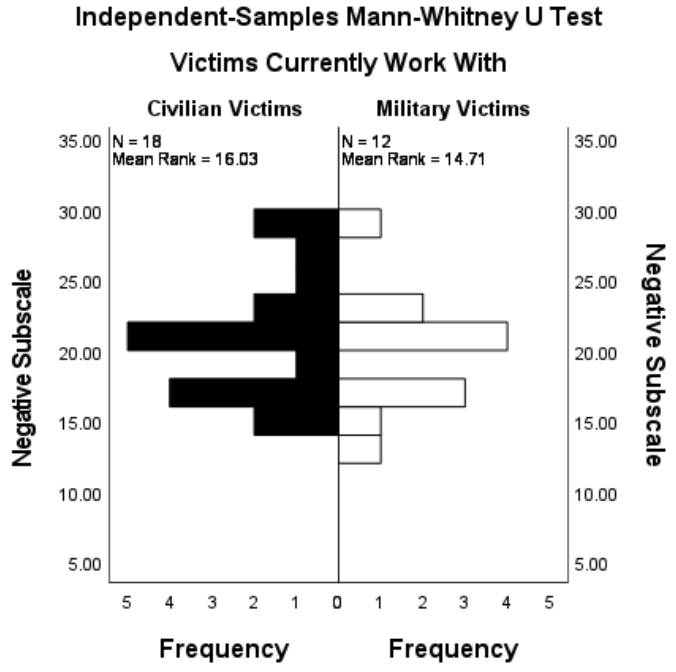
The STSS also measures four specific symptoms as subscales: negative cognition and mood, arousal, intrusion, and avoidance. These subscales were also measured on the 5-point

Likert scale of frequency (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *often*, 5 = *very often*) and reflected how often symptoms related to providing services to traumatized crime victims were experienced in the last 7 days.

Negative Subscale. Results of the MWU test in Table 8 for the Negative subscale scores showed that the difference in secondary trauma medians between VAs in the High Secondary Trauma groups who worked with military or civilian victims was insignificant. The null hypothesis was retained. The alternate hypothesis was not supported. Figure 13 shows the comparison of data in the two groups. Although the VAs who worked with military victims had lower values, the values did not differ overall. Cohen's *d* indicated a small to medium effect of organizational differences (Table 8).

Figure 13

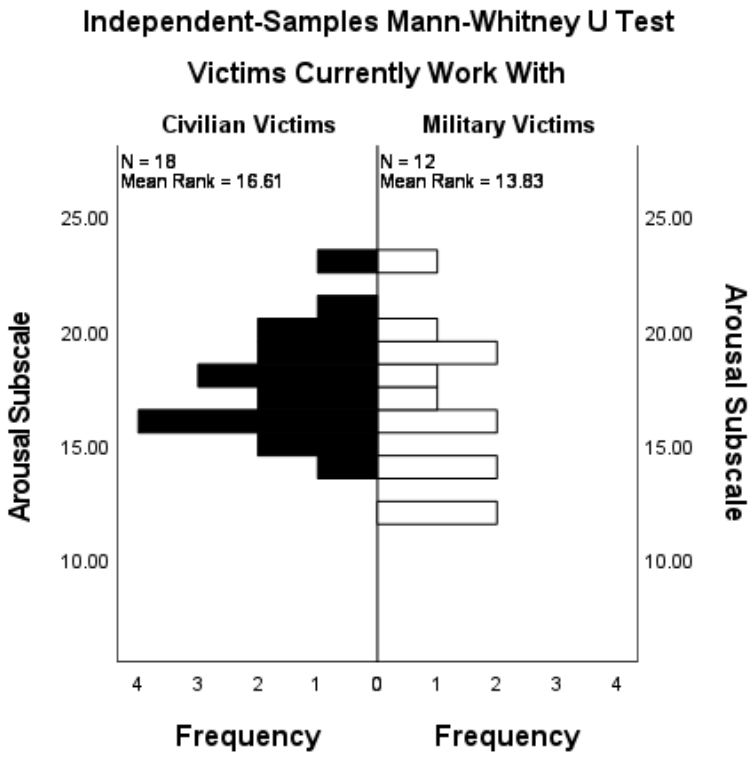
Comparisons of Negative Subscale Score Medians Across VAs Working With Civilians/Military



Arousal Subscale. Results of the MWU test in Table 8 for the Arousal subscale showed that the difference in secondary trauma medians between VAs in the High Secondary Trauma groups who worked with civilian or military victims was insignificant. The null hypothesis was retained. The alternate hypothesis was not supported. Figure 14 shows the comparison of data in the two groups. Although the VAs who worked with military victims had a few lower values, overall, the values did not differ more than would be expected by chance. Cohen's *d* indicated a small to medium effect of organizational differences (Table 8).

Figure 14

Comparisons of Arousal Subscale Score Medians Across VAs Working With Civilians/Military

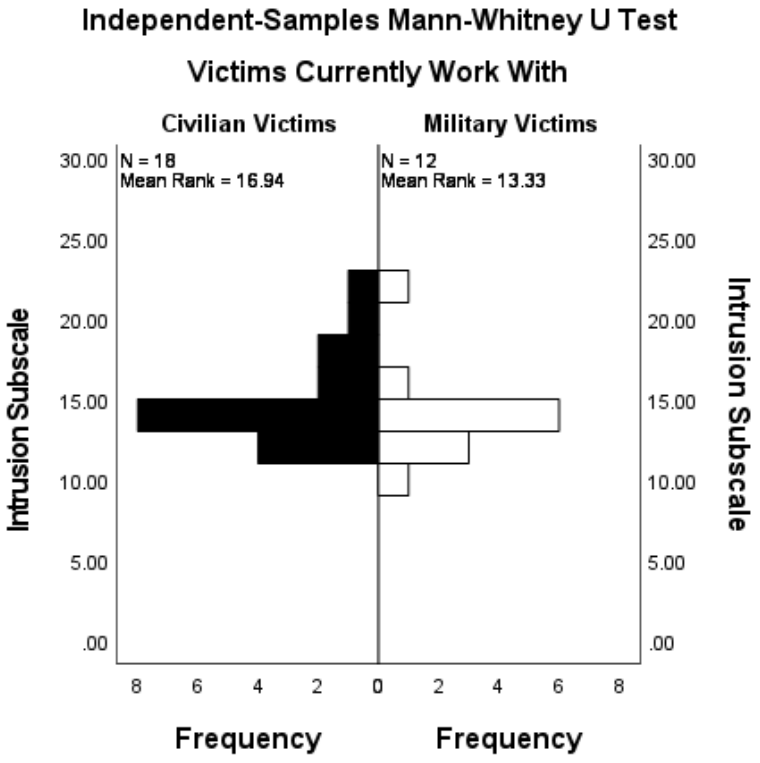


Intrusion Subscale. Results of the MWU test in Table 8 for the Intrusion subscale showed that the difference in secondary trauma medians between VAs in the High Secondary

Trauma groups working with military or civilian victims was insignificant. The null hypothesis was retained. The alternate hypothesis was not supported. Figure 15 shows the comparison of data in the two groups. Although the VAs who worked with military victims had lower values overall, the values did not differ statistically. Cohen's *d* indicated a small effect of organizational differences (Table 8).

Figure 15

Comparisons of Intrusion Subscale Score Medians Across VAs Working With Civilians/Military

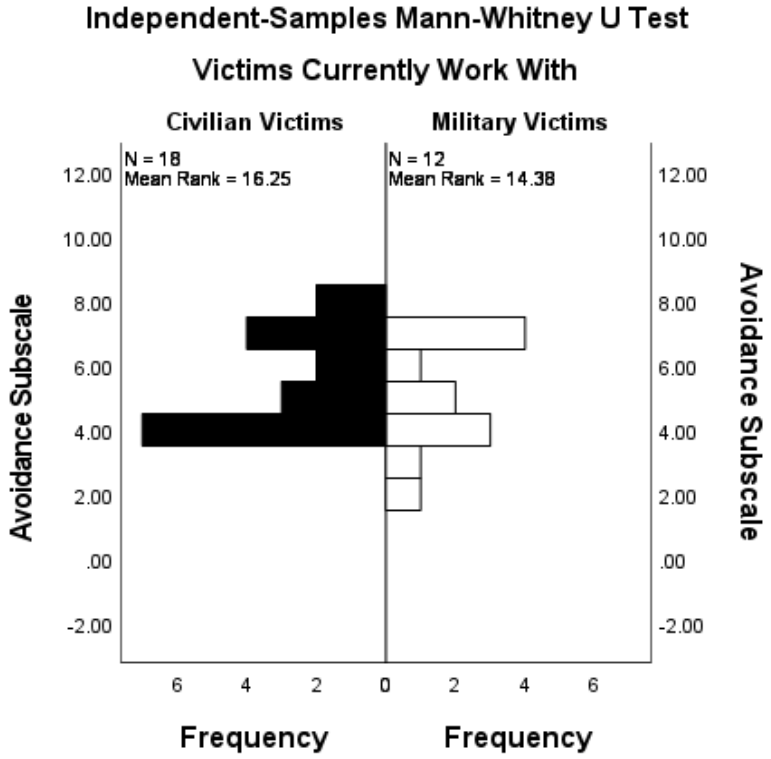


Avoidance Subscale. Results of the MWU test in Table 8 for the Avoidance subscale showed that the difference in secondary trauma medians between VAs in the High Secondary Trauma groups working with civilian and military victims was insignificant. The null hypothesis was retained. The alternate hypothesis was not supported. Figure 16 shows the comparison of

data in the two groups. Although the VAs who worked with military victims had lower values, overall, the values did not differ statistically. Cohen's *d* indicated a small effect of organizational differences (Table 8).

Figure 16

Comparisons of Avoidance Subscale Score Medians Across VAs Working With Civilians/Military

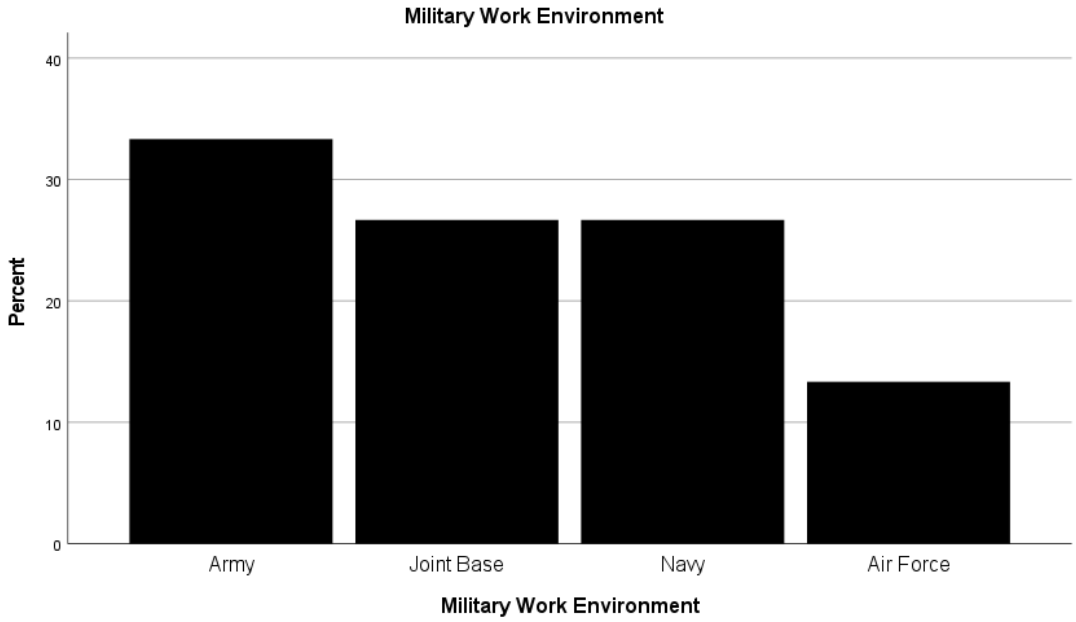


Military Work Environments

Figure 17 shows the distribution of VAs who worked with military victims across the type of work environment. A third worked for the Army. A quarter each worked for the Navy and on Joint Bases. Thirteen percent worked for the Air Force.

Figure 17

Frequency Distribution Across Military Work Environments



Military Titles

Figure 18 illustrates the frequency distribution of military titles. Half of the VAs who worked with military victims chose the survey item Other. Their open-ended comments are listed in Table 9. Over a third worked as sexual assault prevention and response victim advocates. Six percent each worked as family advocacy/domestic abuse victim advocates and victim witness liaisons.

Figure 18

Frequency Distribution Across Military Titles

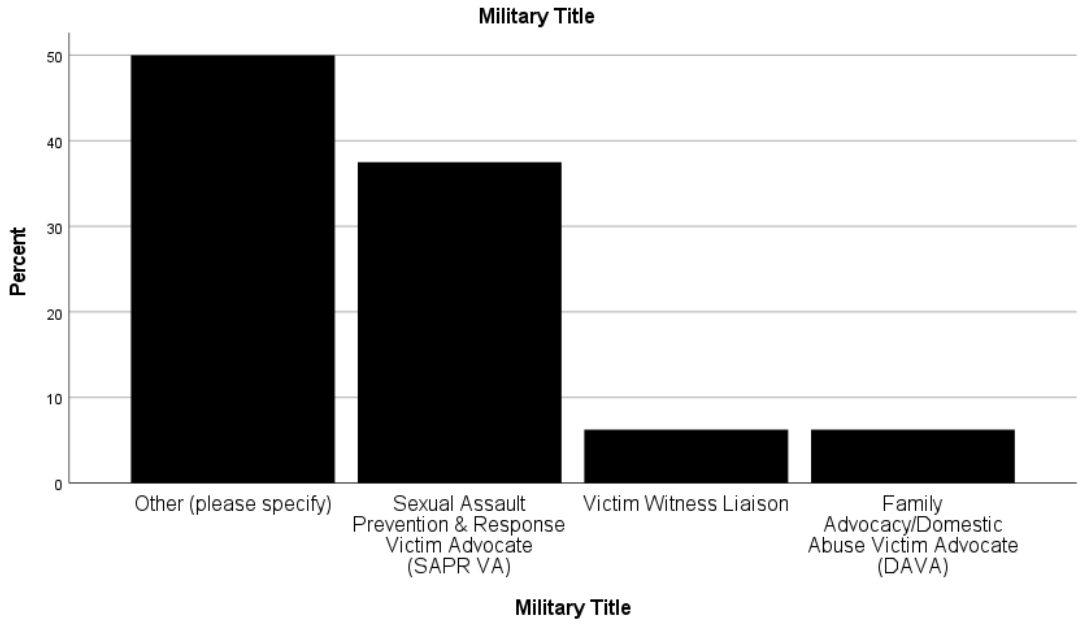


Table 9 lists the open-ended comments about Other working military titles.

Table 9

List of Other Military Working Titles

Case Number	Other That Best Represents Military Working Title
1	Victim Services and Community Outreach Administrative Assistant
5	Post-conviction
6	Victim Services Specialist for the Division of Corrections & Rehabilitation
7	Administrator, Office of Victim Services
10	Corrections-Based Victim Advocate
13	Director of Victim Services
18	SHARP Program Manager
19	Victim Advocate Within Law Enforcement
22	Crisis Intervention Specialist
28	Equal Opportunity Specialist

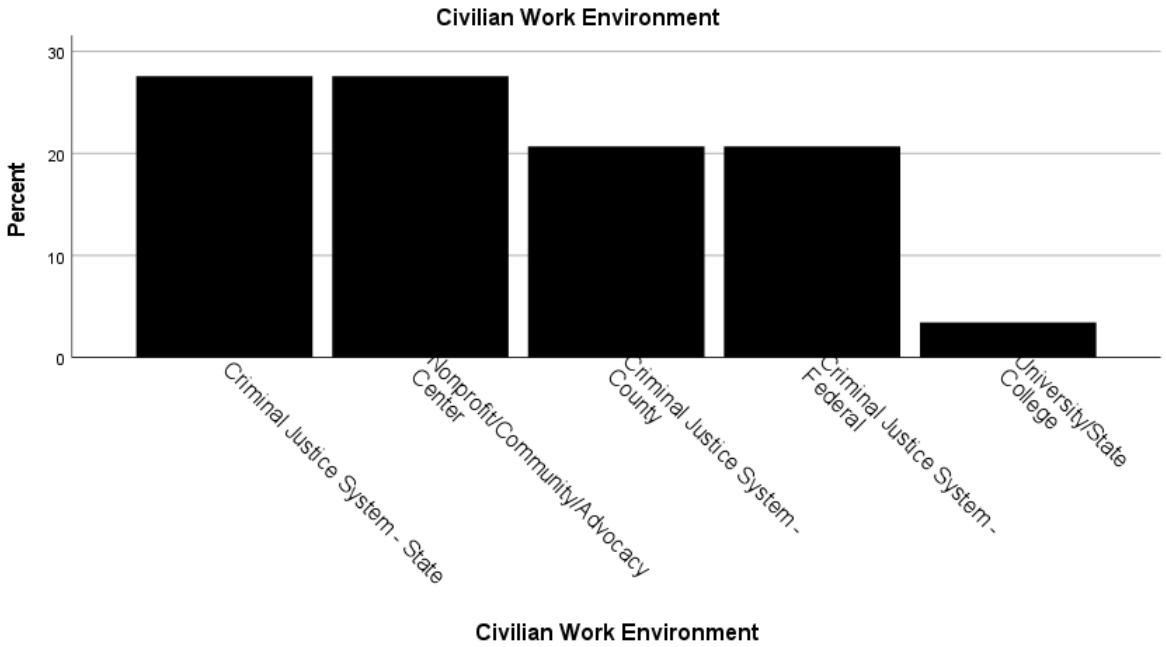
29	CSEC/HT MDT Coordinator
31	VSP
39	SAPR Program Manager
47	SAPR Program Manager
50	Program Manager
54	Trauma Therapist
55	Violent Crime Victim Advocate
58	Felony-Level Victims of Crime and Drug Cases

Civilian Work Environments

Figure 19 illustrates the distribution of civilian work environments. Over a quarter of the VAs working with civilian victims worked at nonprofit, community, or advocacy centers or in the state criminal justice system. Twenty percent worked in the federal or county criminal justice system. One VA worked for a university.

Figure 19

Frequency Distribution Across Civilian Work Environments

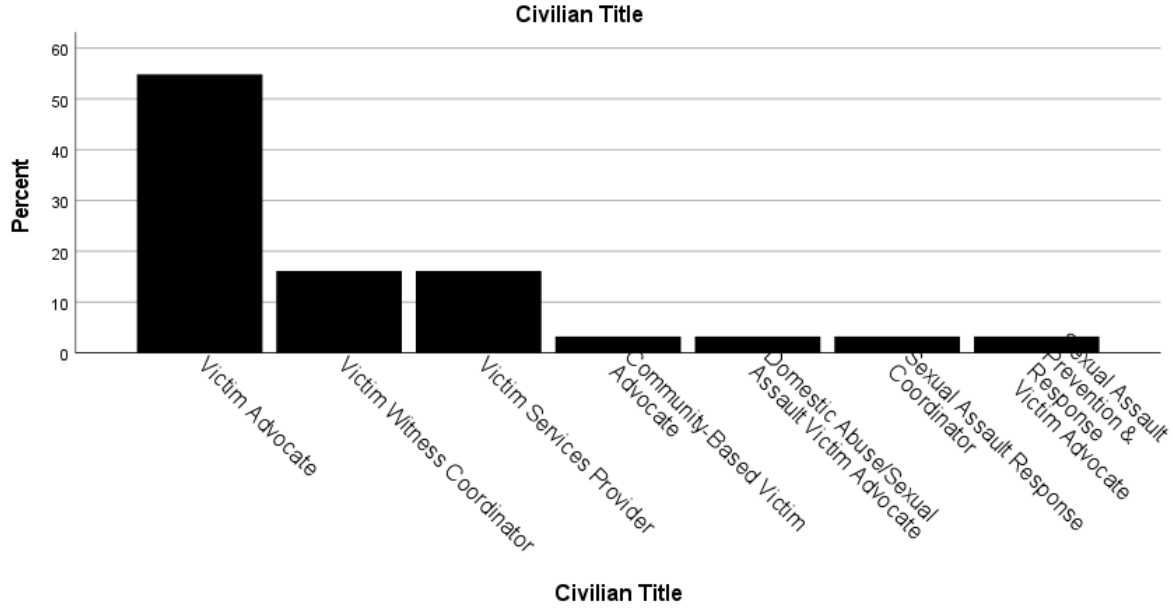


Civilian Titles

The distribution of civilian titles is illustrated in Figure 20. A little over half worked as VAs. Another 16% each worked as victim service providers or victim witness coordinators. About 3% each worked as sexual assault prevention and response VAs, sexual assault response coordinators, domestic abuse/sexual assault VAs, or community-based VAs.

Figure 20

Frequency Distribution Across Civilian Titles



Involvement with either of the two types of organizations in this study, military and civilian, did not appear to pose different risks of developing secondary trauma. The first two sections showed that neither Total STSS symptoms nor subscale symptoms were significantly higher across the two types of VAs in the High Secondary Trauma groups.

Organizational Support as a Risk Factor for Developing STS Symptoms

Organizational support was measured with four statements soliciting dichotomous yes or no responses: Does your organization provide the advocacy support you need to adequately assist victims? Does your organization allow you the time you need to work with victims? Is your organizational structure conducive to you providing the best possible support to victims? Does your organization support your self-care by providing you time to access self-care activities and making support/programs available? The hypotheses were:

H_a6: Organizational support, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

H_06: Organizational support, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

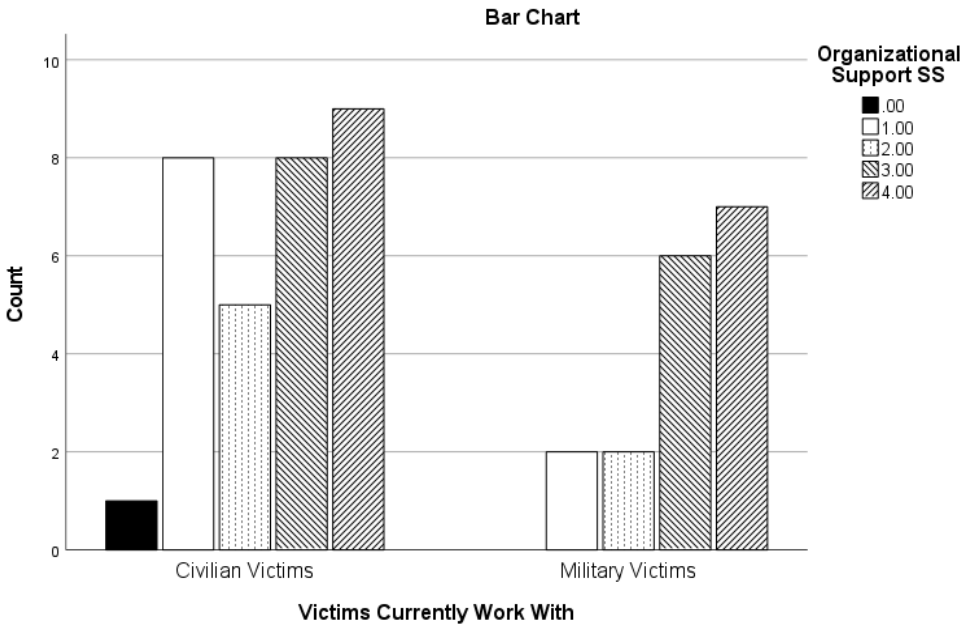
To test the hypotheses, an Organizational Support Summated Scale score was calculated for each VA as the sum of their responses to the four support questions. Each no answer was worth 0 points. Each yes answer was worth 1 point. The Organizational Support Summated Scale score had a range of 0–4 points. Only Case 37, a VA who worked with civilian victims, answered no to all four organizational support questions.

The cross-tabulation of VAs by Organizational Support Summated Scale scores, illustrated in Figure 21, shows the proportions of scores across the two types of VAs. Among VAs who worked with civilian victims, there appeared to be an approximate split, with 45% reporting zero to two supports compared to 55% reporting three to four supports. In apparent contrast, among VAs who worked with military victims, 24% reported one to two supports compared to 76% who reported three to four supports. However, a Fisher probability test was

run, and the results, $p = .214$, indicated that the proportions did not differ more than expected by chance. The null hypothesis was retained. The alternate hypothesis was not supported.

Figure 21

Cross-Tabulation of Organizational Support Summated Scale Scores by Type of VA



Levels of organizational support did not appear to constitute a risk factor for STS in that support levels did not differ across the two types of VAs.

Long-Term Engagement With Trauma Victims as a Risk Factor for Developing STS

Another potential risk factor for developing STS was the length of exposure to victims of traumatic crimes. This study measured exposure as the number of years of working directly with victims of traumatic crimes, represented as long-term engagement.

A second related measure was also collected, total years working as a victim advocate. Correlations between long-term engagement with victims of traumatic crimes and total years working as a victim advocate showed the two measures were synonymous (VAs who worked

with military victims $r(14) = .97$, $p < .001$; VAs who worked with civilian victims $r(28) = .96$, $p < .001$). The hypotheses were:

H_a7: Long-term engagement with victim advocacy, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

H_07: Long-term engagement with trauma victims, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

The hypotheses were tested by correlating Total STSS scores with long-term engagement with victims of traumatic crimes, the results of which follow descriptive statistics.

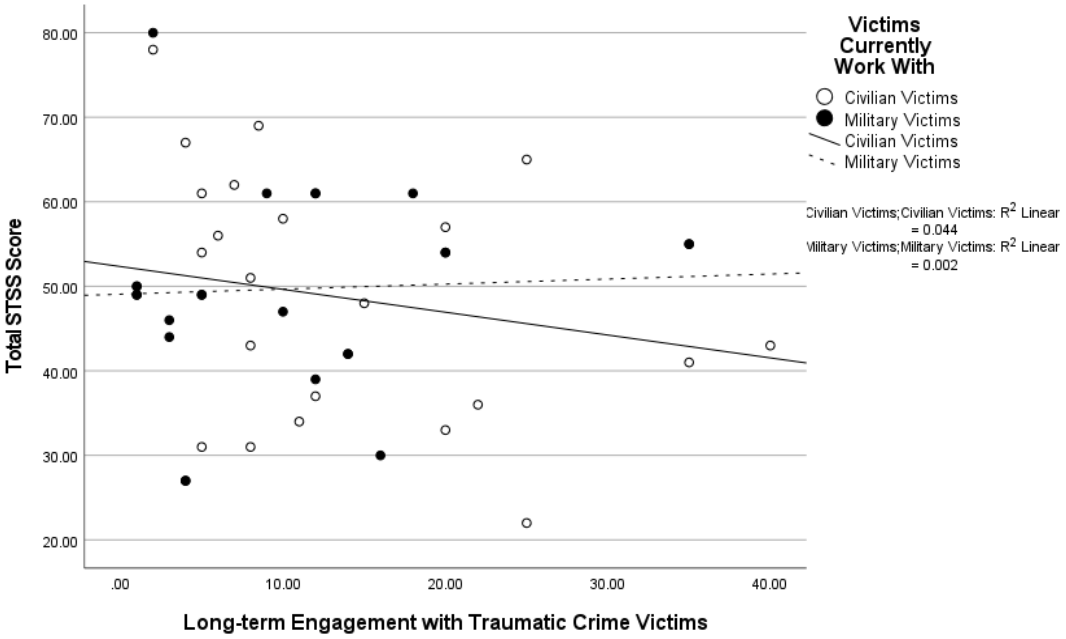
Long-Term Engagement With Victims of Traumatic Crimes of VAs Working With Military

The average years of long-term engagement with traumatic crime victims was a decade ($M = 10.13$, $SD = 9.06$, *min* = 1.00 year, *max* = 35 years). Exposure was divided at about a decade ($Mdn = 9.50$ years) in that half of the VAs had less than 9 years of exposure and the other half had more than 9 years of exposure.

The correlation between long-term engagement and the Total STSS scores among VAs who worked with military victims was negligible, $r(28) = .04$, $p = .877$. Long-term engagement explained none of the secondary trauma ($r^2 < .001$). The null hypothesis was retained. The alternative hypothesis was not supported. In Figure 22, which illustrates the correlation as a scatter plot, the dotted line showing the line of best fit for the VAs who worked with military victims was almost horizontal. For VAs who worked with military victims, the regression line formula estimated that a VA's Total STSS score could be predicted by multiplying the number of years of long-term engagement by .06 and adding that quantity to the baseline measure of 49.07.

Figure 22

Scatter Plot of the Correlation between Long-Term Engagement With Traumatic Crime Victims and Total STSS Scores



Long-Term Engagement With Traumatic Crime Victims of VAs Working With Civilians

Among VAs who worked with civilian victims, the average number of years of long-term engagement with victims of traumatic crimes was just over 12 (M = 13.12, SD = 10.56, *min* = 1.00 year, *max* = 40 years). However, this was divided at about a decade(Mdn = 9.25 years). The correlation with Total STSS scores was negative and between small and medium magnitude, $r(28) = -.21$, $p = .267$. The null hypothesis was retained. The alternative hypothesis was not supported. Long-term engagement explained 4% of secondary trauma ($r^2 = .04$). Figure 22 also illustrates the correlations between long-term engagement and the Total STSS scores among VAs who worked with civilian victims. In Figure 22, the black line showing the line of best fit reflected the negative correlation. For VAs who worked with civilian victims, the regression line

formula estimated that a VA's Total STSS score could be predicted by multiplying the number of years of long-term engagement by .27 and subtracting that quantity to the baseline measure of 52.34. Long-term engagement was not a risk factor for developing symptoms of STS among either type of VA.

Demographic Diversity as a Risk Factor for Developing STS Symptoms

A final potential risk factor was a combination of demographic characteristics across participants that were intended to be combined into a demographic diversity index. This section shows that age and race distributions were comparable across men and women participants. Because scant diversity emerged among the VAs on these two characteristics, men and women were compared.

There were six times fewer men (10%, n = 6 VAs) than women (66%, n = 39). On average, the men were in their late 40s (M = 49.60 years, SD = 14.08, Mdn = 52.00 years, min = 30 years, max = 69 years). Most were Caucasian (67%, n = 4). Small percentages were African American (17%, n = 1), or Hispanic man (17%, n = 1). Women averaged mid-40s (M = 44.49 years, SD = 10.85, Mdn = 45.00 years, min = 23 years, max = 66 years). Most were Caucasian (66%, n = 25). Small percentages were Asian (3%, n = 1), African American(16%, n = 6), or Hispanic (16%, n = 6). Table 10 provides a comparison of STSS scores. A dozen of the 59 participants did not provide gender information (20%). The fewest were the two nonbinary participants (4%). The nonbinary participants were the same age (M = 28.00 years, SD = 0.00), Caucasian, and worked with civilian victims. Total STSS scores were compared across men and women, representing demographic diversity because of the close parallels of age and race. Table 10 lists the descriptive statistics for the two groups by gender. The men had lower mean STSS

scores than the women for VAs who worked with military and VAs who worked with civilian victims, although the difference was more dramatic with military victims.

Table 10

Total STSS Score Descriptive Statistics for the Demographic Diversity Index

	M	*SD*	Mdn	Minimum	Maximum	*n*
VAs Working With Military						
Men	40.33	9.60	42.00	30.00	49.00	3
Women	52.09	14.50	54.00	27.00	80.00	11
VAs Working With Civilians						
Men	45.33	4.93	43.00	42.00	51.00	3
Women	48.71	14.24	49.50	22.00	78.00	28

MWU tests were run to compare median Total STSS scores across men and women for VAs who worked with military or civilian victims. The hypotheses were:

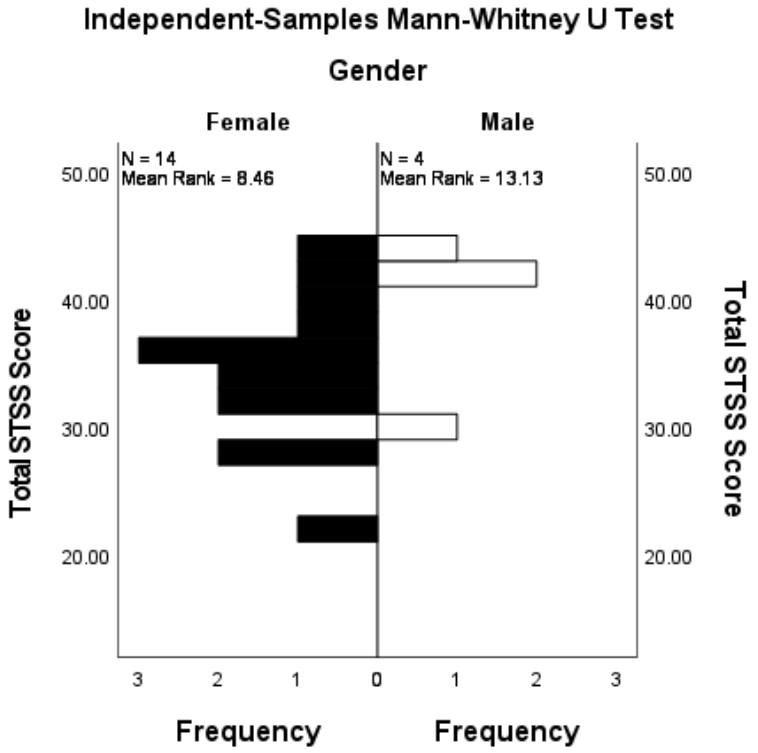
H_a8: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is a risk factor for nationally credentialed victim advocates developing STS symptoms.

H_08: The demographic diversity based on gender, age, and ethnicity, as measured by the VAS, is not a significant risk factor for nationally credentialed victim advocates developing STS symptoms.

An MWU test was run to compare men and women VAs with parallel age and race characteristics. Results showed that for VAs who worked with military victims, the medians did not differ more than expected by chance ($MWU = 25.5$, $p = .170$). The null hypothesis was retained. The alternative hypothesis was not supported. Figure 23 shows the distribution of Total STSS scores across gender for VAs working with military victims.

Figure 23

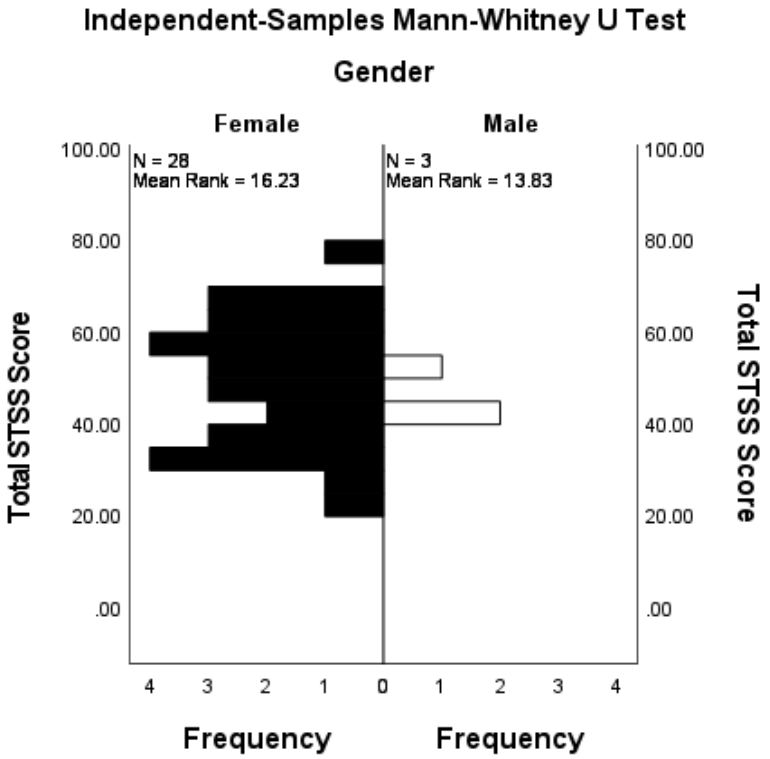
Comparisons of STSS Score Medians Across Men and Women VAs Working With Military



Results of the MWU test comparing men and women VAs who worked with civilian victims also showed that the medians did not differ more than expected by chance (*MWU* = 48.5, *p* = .681). The null hypothesis was retained. The alternative hypothesis was not supported. Figure 24 shows the distribution of Total STSS scores across gender for VAs working with civilian victims.

Figure 24

Comparisons of STSS Score Medians Across Men and Women VAs Working With Civilians



Demographic diversity did not appear to be a risk factor for developing STS symptoms in that Total STSS scores did not differ across groups that differed by gender but not age and race. These results held for VAs who worked with military or civilian victims.

Open-Ended Comments

The survey ended by asking VAs for further comment. Comments are listed by case number in Table 11 and ranged from suggestions that STS had limited their jobs, to the critical need for employer support. Some participants suggested ways to improve the survey. The open-ended comments are verbatim.

Table 11

Open-Ended Comments

Case	Comment
1	Every scenario and experience is unique.
4	Sometimes it is very rewarding, others, it is just so very hard.
6	I work with all victims of crime in my state of 55 counties. I normally work with victims whose offender has already been convicted of the crime. However, I have been brought in early before. I can serve any victim and assist in Parole Hearings is normally where I am needed. I serve Victims of Domestic Violence, Adults of Assault and Rape and Violence. The survey would not let me rank them. I don't see Trafficking. I do see some Stalking Harassment.
10	I was not able to click the appropriate number of "dots" in one question . . . so, the types of victims I work with is not accurate. In corrections, we work with victims of all crimes . . . I would have to say homicide, domestic violence & sexual assault are the highest (I just couldn't choose multiple dots within the same column for that question). Thank you!
19	There isn't enough resources to help them.
24	Question 24 doesn't allow me to choose each category.
27	That we need to do a much better job within prisons to care for those who experience traumas.
29	No cap on clients, lacking support and empathy needed.
36	I didn't mind the work so much. I actually loved what I did. I recently left the rape crisis center that I was working for because management wrote me up for exhibiting signs of secondary PTSD.
37	Due to my position, I continue to provide direct services to survivors of crime. However, the frequency and quantity has severely decreased over the years. Our program as a whole has continued to offer the best advocacy services we can within our staff capacity.
40	Employer support is critical to the success of this position.
58	Wish I could do more but often feel like fatigue and "burn out" are setting in. I never thought it would happen.

Summary

The baseline of STS among surveyed NCVAs working with military or civilian traumatic crime victims was divided. Half of the VAs reported no to moderate symptoms, and the other

half reported high to severe symptoms. Severity appeared somewhat higher among VAs who worked with military victims than those who worked with civilian victims. Specifically, among VAs who worked with military victims, 71% fell in the High or Severe STS category compared to 58% of the VAs who worked with civilian victims. The odds of exhibiting high-severe secondary trauma symptoms to low-moderate symptoms among VAs who worked with military victims was 2.4 to 1. The odds of exhibiting high-severe secondary trauma symptoms to low-moderate symptoms among VAs who worked with civilian victims was 1.4 to 1. VAs were classified as a Low Secondary Trauma group or a High Secondary Trauma group for subsequent group comparisons re: RQ2.

Caseload volume appeared to be a minor risk factor for developing secondary trauma. Nonetheless, it may be more of a potential risk factor among VAs who work with military victims. In that caseload volume explained about 6% of secondary trauma. In contrast, for VAs who worked with civilian victims, caseload volume explained less than 1% of secondary trauma.

Caseload frequency did not differentiate VAs who worked with military victims from those who worked with civilian victims. However, as a risk factor for developing STS symptoms, the data suggested that the caseload frequency of specific traumatic crimes should be considered individually. There were three main reasons. One, working with Other traumas, emerged as the caseload frequency with the greatest impact among both types of VAs, but did not qualify as a risk factor because frequencies were higher in the Low Secondary Trauma groups. Two, working with victims of child sexual abuse was the caseload frequency with the second greatest impact, but exerted opposite effects. That is, VAs who worked with military victims reported higher frequencies in the Low Secondary Trauma group. In contrast, VAs who worked with civilian victims reported higher frequencies in the High Secondary Trauma group.

Three, the two largest effects diverged. Among VAs who worked with civilian victims, higher frequencies of physical assault characterized the Low Secondary Trauma group, whereas higher frequencies of adult victims of sexual abuse characterized the High Secondary Trauma group. Among VAs who worked with military victims, two potential risk factors were adult victims of childhood sexual abuse and domestic violence in that higher frequencies characterized the High Secondary Trauma group.

A personal history of trauma did not differentiate the Low Secondary Trauma group from the High Secondary Trauma group for either type of VA. Therefore, a personal history of trauma did not emerge as a risk factor for developing symptoms of secondary trauma.

Involvement with military or civilian organizations did not appear to pose different risks of developing secondary trauma. In the High Secondary Trauma groups, neither Total SPSS symptoms nor subscale symptoms were significantly higher across the two types of VAs.

Levels of organizational support did not appear to constitute a risk factor for STS in that support levels did not differ across the two types of VAs.

Long-term engagement (i.e., years) was not a risk factor for developing symptoms of STS among VAs who worked with civilian or military victims.

Demographic diversity did not appear to be a risk factor for developing STS symptoms in that Total STSS scores did not differ across groups that differed by gender but not age and race. These results held for VAs who worked with military or civilian victims.

The next chapter puts the results into perspective with the literature, addresses implications for the field, and makes recommendations for future research.

Chapter Five: Conclusions

Overview

The STSS was used to establish a baseline of STS among NCVAs and identify potential risk factors through anonymous data generated via a secure online survey and a demographic questionnaire. This chapter begins with a general discussion, implications, limitations, and recommendations for further research.

Discussion

This purpose of this study was to establish a baseline of STS among a surveyed sample of NCVAs working with traumatic crime victims within military or civilian communities by assessing the presence of avoidance, arousal, negative mood and cognition, and intrusion, as measured by the STSS, and to determine potential risk factors. There were two key findings. First, the data indicated that STS is a genuine phenomenon that affects VAs working with traumatic crime victims. The second key finding was that VAs working with trauma victims in two disparate environments, the military or civilian communities, did not differ regarding the impact of indirect traumatic exposure on the development of STS. The most important implication is that working with traumatized victims of crime may be unrelated to the setting, and VAs who work with traumatized victims may be equally susceptible or equally non-susceptible to STS, regardless of the setting. No other study has compared these two communities to date.

The study involved 59 participants who worked with traumatic crime victims in the reporting, criminal justice, and recovery processes. In addition to a demographic questionnaire, the STSS was used to gather anonymous data through a secured online survey. All respondents indicated working with traumatic crime victims, and 43 experienced at least one symptom of

STS in the previous 7 days. There were no significant differences in the subscales (arousal, avoidance, intrusion, and negative mood cognition) between advocates who worked with military or civilian communities. Of the seven risk factors, caseload volume was the only potential risk factor identified as a minor risk factor for developing STS.

STS theory holds that individuals who work closely with trauma victims can vicariously experience trauma, leading to adverse physiological responses that can impair functioning (Bride et al., 2004). VAs are among the helping professionals known to be at-risk for developing STS (Benuto, Newlands, et al., 2018; Benuto et al., 2019) their work with traumatic crime victims can impede their ability to provide essential support services, putting them at-risk for PTSD (Benuto, Newlands, et al., 2018; Benuto et al., 2019; Figley, 1995b). It is critical to fill this knowledge gap. By increasing NCVAs' resistance to STS and their ability to aid victims of crime during the reporting, recovery, and criminal justice process, military readiness is strengthened, a public health crisis is lessened, and a significant contribution is made toward a safer society (Barr, 2020; CDC, 2021).

Implications

Implications Related to RQ1

RQ1 was designed to identify a baseline of STS among surveyed NCVAs working with traumatic crime victims in military or civilian communities. This study measured advocates' experience of STS symptoms within 7 days of taking the survey using the STS scale. The data showed that STS is a genuine phenomenon that affects VAs working with traumatic crime victims. Of the 59 respondents, 43 experienced at least one symptom of STS in the previous 7 days. Among advocates working with the military and those working with the civilian community, half reported no to moderate symptoms, and the other half reported high to severe

symptoms based on the STSS. Although both types of advocates in this High Secondary Trauma group had median and mean Total STSS scores that clearly reflected high to severe secondary trauma symptoms, severity was higher among advocates who worked with the military than those who worked with civilians. One reason might that advocates in the military work primarily with adult sexual assault victims. Seventeen participants working with military indicated their title was sexual assault prevention and response VA (n = 6), sexual harassment and response prevention /SAPR program manager (n = 18), family advocacy/domestic abuse VA (n = 1), victim witness liaisons (n = 6), and victim witness coordinator (n = 4), and 18 indicated their title was something other than the options provided on the survey. The SAPR advocates assist adult victims of sexual assault involving a military member regardless of when it occurred. For instance, a military member who had been sexually assaulted as a child could request support to cope with additional layers of stress placed on them inherent to the military community (e.g., military culture, training requirements, deployments). Other sexual assault victims included adult military members assaulted since being in the military. For victim-witness coordinators and liaisons, the typology is broad and includes victims of military crimes (n = 10). Family advocacy/domestic abuse VAs assist military victims involving family and intimate partners. Studies have shown the impact of sexual assault is profound impacting victims in many ways and is considered one of the most traumatic crimes a person can experience (Campbell, 2013; CDC, 2021; Haskell & Randall, 2019; Morabito et al., 2021; Ogińska-Bulik et al., 2022). The CDC (2021) maintains that there are negative physical, psychological, emotional, *and* spiritual consequences for victims of sexual assault**.** It is not surprising that advocates working primarily with this type of traumatic crime victim might experience high to severe STS symptoms.

To better understand the severity of STS among advocates, I conducted a hypothesis test to determine if the number of advocates differed significantly across the five STS categories. Results showed that the number of advocates did in fact differ significantly. Therefore, two groups were established based on the extent of STS symptoms. One advocate group was placed in the No to Moderate STSS categories and labeled as the Low Secondary Trauma group (29%). The advocates who fell into the High to Severe STSS categories were labeled the High Secondary Trauma group (71%).

Over 70% of the VAs who worked with military victims, and 58% of the VAs who worked with civilian victims reported high to severe levels of STS. The finding supports data from other studies that found helping professionals suffer from STS symptoms due to their work with traumatized victims (Benuto et al., 2019).

Benuto et al. (2019) found that VAs endorsed experiencing STS symptoms due to their work with traumatized victims. This discovery is not surprising. Like this study, Benuto et al.'s findings were not generalizable because of the possibility of recruitment bias, sample size, and gender imbalance. Also, Benuto et al. did not require participants to possess a national credential—critical information to inform current credentialing standards. Benuto, Newlands, et al.'s (2018) findings lacked diversity, ethnicity was limited, and the response rate was not disclosed. Additionally, it was unknown whether the VAs possessed a national credential or the organizational context where they worked. They found approximately 50% prevalence (Benuto, Newlands, et al., 2018). Like the current study, the findings are not generalizable to the broader communities of VAs due to the small sample size and the limited diversity.

The overall research on the prevalence of STS among other helping professionals affirms similar results. For example, an estimated 15% of social workers experience STS (Bride, 2007);

50% of the sampled police officers conducting investigations in the United Kingdom reported experiencing STS symptoms (MacEachern et al., 2019); almost 50% a sample of emergency nurses in Jordan experienced STS (Ratrout & Hamdan-Mansour 2019), and several studies found that up to 40% of mental health professionals may experience STS (Lu & Wang, 2020; S. Patel & Lloyd-Evans, 2019; Szente & Lundorff, 2019). This study confirms the findings of allied helping professionals.

Implications Related to RQ2

RQ2 was designed to identify risk factors associated with the development of STS among NCVAs working with military or civilian traumatic crime victims. Seven variables were identified as potential risk factors based on previous research: caseload volume, caseload frequency, a history of personal trauma, type of organization, level of organizational support, long-term engagement with victim advocacy, and demographic diversity (Sprang et al., 2019).

This study demonstrated that military and civilian victims and environments do not differ concerning the effects of risk factors on advocates. In fact, the risk factors were found common to various helping professionals (Sprang et al., 2019) and influence VAs working with military or civilian advocates equally. This finding and merits confirmation with a larger sample in future research.

Caseload Volume

Caseload volume, or the number of clients an individual is responsible for, was found to be a minor risk factor for developing STS among NCVAs. Nonetheless, it may be more of a potential risk factor among VAs who work with military victims, in that caseload volume explained six times more secondary trauma among them compared to VAs who worked with civilian victims. Similarly, caseload volume has been identified as a potential risk factor for STS

in various helping professions. For example, higher caseload volume was associated with increased symptoms of STS among child welfare workers (Molnar et al., 2017), social workers (Quinn et al., 2019), and nurses (Levi et al., 2021). Like VAs, these helping professionals experience indirect trauma (Levi et al., 2021; Molnar et al., 2017; Quinn et al., 2019). Benuto, Newlands, et al. (2018) also found that the number of hours worked per week predicted STS among a sample of VAs.

Caseload Frequency

Caseload frequency, or the rate at which new clients are added to an individual's workload, was not found to be a significant risk factor. Differences in caseload frequency did not differentiate VAs who worked with military victims from VAs who worked with civilian victims. This was surprising because some frequency variance was expected due to the different types of crime victims and the roles VAs have working within military or civilian communities.

Most of the other studies I reviewed supported the idea that high frequency of exposure to trauma and traumatic material is positively associated with STS. For example, higher caseload frequency was associated with increased symptoms of STS among child welfare workers (Salloum et al., 2019) and nurses (Kelly, 2020).

This study raised questions whether caseload frequency of traumatic crimes should be considered individually as risk factors for developing STS symptoms. First, working with Other traumas was the caseload frequency with the greatest impact among both types of advocates but did not qualify as a risk factor because frequencies were higher in the Low Secondary Trauma groups. Secondly, working with victims of child sexual abuse was the caseload frequency that had the second greatest impact, but exerted opposite effects. That is, advocates who worked with

military victims reported higher frequencies in the Low Secondary Trauma group. One reason may be that military advocates work mostly with crime victims that are not child abuse victims.

In contrast, advocates who worked with civilian victims reported higher frequencies in the High Secondary Trauma group. Thirdly, the two largest effects diverged. Among VAs who worked civilians, higher frequencies of physical assault characterized the Low Secondary Trauma group, whereas higher frequencies of adult victims of sexual abuse characterized the High Secondary Trauma group. Among VAs who worked with military, two risk factors were adult victims of childhood sexual abuse and domestic violence in that higher frequencies characterized the High Secondary Trauma group, consistent with findings from Benuto et al. (2019), who found working with adult survivors of child sexual abuse to be a risk factor when the STS rate was about 50%. Given the counterintuitive behavior often displayed by sexual assault victims that conflicts with public expectations, such as passivity during the sexual assault (Long, 2016) and feelings of shame, stigma, and institutional betrayal (not being believed) (Peter-Hagene & Ullman, 2018), this finding was not surprising. The literature suggested that special attention should be given to advocates working with sexual assault victims, given their increased risk of developing STS, and this study confirms that.

A History of Personal Trauma

A history of personal trauma, such as experiencing a traumatic event or growing up in a traumatic environment, has been identified as a risk factor for STS among other helping professionals and seems to be the consensus. For example, Leung et al. (2022) found that personal trauma history was a significant predictor of STS in therapists and Sprang et al. (2019) found they were more likely to experience STS when working in traumatic environments. Yazici

and Ozdemir (2022) also found that a history of personal trauma was associated with increased symptoms of STS among healthcare professionals.

I did not find a history of personal trauma to be a significant risk factor. That is, there were no significant differences between the Low and High Secondary Trauma groups for the types of advocates. The results confirm other findings that did not indicate a personal history of trauma was related to the development of STS symptoms (Benuto, Newlands, et al., 2018).

Hensel et al. (2015) indicated there might be an interconnectedness between gender, personal history of sexual assault, and STS. The results from my study do not rule out personal exposure to trauma as a risk factor. Nevertheless, since most research indicates there is a connection raises questions about potential differences in the VAs sampled compared to other helping professionals—these questions merit investigation in future research on larger samples.

Type of Organization

Previous research primarily examined environments with high trauma exposure. For example, Sprang et al. (2019) found that individuals working in a civilian environment with high trauma exposure were more likely to experience STS. Inversely, two other studies found that organizations with higher organizational support had lower levels of STS (Levin et al., 2021; Sprang et al., 2021). I found that involvement with military or civilian organizations did not appear to pose different risks of developing secondary trauma. In the High Secondary Trauma groups, Total STSS symptoms nor subscale symptoms were significantly higher across the two types of advocates.

Military culture can significantly impact the development of STS. For example, Stearns and Benight (2016) reported that the organizational environment is a critical factor with developing STS in military health providers, especially given that service members' cases

include the complexities of added layers of trauma, such as PTSD and traumatic brain injury. Additionally, Sudkamp et al. (2022) did not find deployment was a factor; poor management and toxic work environments exacerbate the risk of developing STS among the intelligence community for military or civilian workers who are daily exposed to violent and traumatizing events.

However, other studies have found that certain aspects of military culture make it difficult for service members to seek help for STS and other mental health issues, such having to admit to STS and the stigma associated with mental healthcare (Sharp et al., 2015). Sudkamp et al. (2022) found a lack of awareness and understanding of the impact of indirect trauma within the intelligence community. Questions about stigma in the military environment and civilian helping environments remain. For example, VAs may feel particularly pressured to appear strong and capable for their clients, because their clients are traumatic crime victims.

Organizational Support

Organizational support did not appear to constitute a risk factor for STS in that support levels did not differ across the two types of advocates. This does not mean it is not a risk factor, due to the small sample size. Limited studies, also with small sample sizes examined workplace support and STS among advocates, and organizational support did not appear to be a risk factor (Benuto et al., 2019). Although, no studies compared the two organizations (i.e., military and civilian) as the current study did. The results of this study are surprising given that much of the literature about STS in other populations found a lack of work support as a significant risk factor for STS (Hensel et al., 2015).

Perceived organizational support has also been identified as a key risk factor for STS among healthcare workers (Y. J. Kim & Johnson, 2020), and a systemic review by Benjamin et

al. (2018) found that a lack of organizational support is a consistent risk factor developing STS among healthcare workers. Further investigation is warranted on credentialed advocates working with traumatic crime victims in military or civilian communities, given the current finding and unique organizational structure of the military.

Long-Term Engagement

Several studies of various helping professionals indicated cumulative exposure to traumatic events was a risk factor (M. L. Bourke & Craun, 2014; Brady, 2017; Owens-King, 2019). Benuto, Newlands, et al. (2018) found that the hours worked per week and number of direct hours worked with victims predicted STS. Benuto et al. (2019) also found that the number of direct hours worked was related to higher STS scores, consistent with existing literature. However, I could not confirm the length of time working with trauma victims was a risk factor for developing symptoms of STS among advocates who worked with civilian victims or military victims. The results do not rule out long-term engagement with traumatic crime victims as a risk factor, but it raises questions about potential differences in the NCVAs sampled in this study compared to other helping professionals. It is possible that the training standards required of credentialed VAs prepare the advocates to mitigate the risks of cumulative exposure. This study also compared military and civilian advocates, raising questions that merit further investigation with larger samples.

Demographic Diversity

Demographic diversity based on gender, age, and ethnicity did not appear to be a risk factor in that Total STSS scores did not differ across groups that differed by gender but not age and race. The results held for advocates who worked with military or civilian victims and mirrored a study by Penix et al. (2019) which did not find a connection between gender and STS

among 236 healthcare staff. However, it disconfirmed a study by Brady (2017), that indicated male workers had lower levels of stress than female workers. However, because there is a general lack of gender diversity among the helping professions most VA participants are women.

I found that NCVAs are at-risk for developing STS, but specific factors may combine uniquely in different types of VAs and requires more investigation. Seveny-three percent of the participants experienced at least one symptom of STS in the previous 7 days with half reporting high to severe symptoms. Advocates are also at additional risk for experiencing burnout and compassion fatigue similar to other helping professionals (Corbett-Hone & Johnson, 2022), and from STS progressing to PTSD, negatively impacting their ability to provide services to victims. Of note, severity was higher among advocates working mostly with sexual assault victims in the military community, indicating that sexual assault advocates may be at greater risk, consistent with earlier studies (Crivatu et al., 2021; Mihelicova et al., 2021). For example, Crivatu et al. (2021) found trauma symptoms significant, among other negative consequences of working with victims of sexual violence, meriting advocates' increased awareness of the risks.

This study confirmed the presence of STS among VAs working with traumatic crime victims through indirect exposure to trauma similar to other helping professionals (Sprang et al., 2019) and represents a first step in examining potential risk factors that influence the development of STS. Though the small sample size hindered the ability to find statistical significance for six risk factors, caseload volume did appear to play a minor role. This is consistent with studies of other helping professionals (Benuto, Newlands, et al., 2018; Butler et al., 2017; S. Lee, 2019; Quinn et al., 2019) and implies the need for further study to better understand STS symptoms in advocates so that psychosocial educational products targeting

intervention, recognition of resilience-building techniques, and treatments posttraumatic growth may be identified and incorporated into clinical treatment, training, policies, and programs.

There are also practical implications that can be gleaned from this study as it identified STS as a real issue for VAs. Bringing attention to this topic will expand the scope and study of the issues and aid in developing strategies to minimize the negative effects of working with victims. STS symptoms can include feelings of guilt, helplessness, hopelessness, and physical and emotional exhaustion (Bride, 2007), as well as spiritual and moral conflict (J. W. Hopper, 2020). This study highlights the importance of recognizing STS as a real phenomenon among VAs and the need to address it in the workplace, in national victim advocate credentialing training requirements, and in mental health intervention and treatment modalities.

Spiritual and Moral Implications

STS can be seen as a form of spiritual injury or moral injury (M. C. Williams et al., 2015). Trauma can shatter one's sense of safety, trust, and connection to the divine and others (M. C. Williams et al., 2015). It is associated with a loss of personal values and a decrease in the ability to find meaning in work and life (Frankl, 2006). This can result in feelings of betrayal, guilt, and a loss of faith in the goodness of humanity or a higher power (Peres & Maltby, 2017).

Moral injury is a concept that has been used to explain the emotional and psychological distress experienced by professionals who work with trauma survivors (Litz & Kerig, 2019). It is characterized by a sense of moral dissonance and ethical conflict that arises from the gap between what a person knows is right and what they can do in their professional role (Farnsworth et al., 2017). From a moral perspective, STS raises ethical questions about the responsibility of those who are exposed to trauma and the impact it has on their own moral identity (Hopper, 2020). For example, exposure to the trauma of others can lead to feelings of guilt and

responsibility for not being able to fix it (Burgess et al., 2009). Additionally, working with trauma survivors can bring up questions of suffering, injustice, and theodicy which can challenge an advocate's own faith and beliefs and lead to feelings of despair, hopelessness, and cynicism (Frankl, 2006).

To address the spiritual and moral implications of STS, advocates need to be aware of the potential impact that working with traumatic crime victims can have on their own spiritual and moral well-being. They need to find opportunities for spiritual and moral reflection and be encouraged to seek out pastoral care, spiritual direction, or counseling. Furthermore, advocates should be encouraged to engage in practices such as meditation, prayer, or other spiritual practices that can help them cultivate compassion, empathy, and resilience (Burgess et al., 2009). These practices can help ground advocates in a sense of purpose, meaning, and hope and can be a source of strength and comfort during difficult times (Cole, 2021).

Limitations

The sample size was small. Therefore, statistically significant results were unlikely, the survey results were not generalizable to the greater communities of NCVAs and lacked demographic diversity.

The survey did not include a spiritual and moral component or seek to identify the best intervention and treatment practices to inform training standards, policies, and practices in recognizing and avoiding STS.

Though this study had limitations, it had major strengths. Other researchers investigated the impact of STS on VAs (Benuto, Newlands, et al., 2018), but none focused on VAs working with traumatic crime victims or those possessing a national credential. No studies included advocates working with the military community. This study contributes new information about

NCVAs being at-risk for developing STS due to their work with traumatic crime victims and sexual assault victims, in particular. It may be that working with traumatized victims is the same regardless of the particular environment in which advocates and clients forge an alliance. Although the sample size for this study was small, 43 of the 59 respondents experienced at least one symptom of STS in the previous 7 days and half to three-quarters reported high to severe symptoms. The severity was higher among advocates working mostly with sexual assault victims in the military community, indicating sexual assault advocates may be at greater risk for developing STS.

Furthermore, the survey instrument consisting of the STSS and demographic information proved efficient in capturing the intended data in that the average time it took participants to complete the test was approximately 10 minutes, excluding the platform glitch mentioned above. Moreover, the additional six proposed risk factors may also be risk factors better understood within a larger sample size.

Recommendations for Future Research

First, more research with a larger sample size and diversity is needed to fully grasp potential risk factors for developing STS.

Second, I recruited NCVAs through an invitation via NOVA's newsletter, emails, and social media; future recruitment should reach out to advocates at NOVA's annual training event with an attendance of 1,000–2,000 participants, for maximum visibility and participation. In addition, advocates should be able to take the survey throughout the conference at appointed times with the researcher present. It would ensure advocates had the time to focus on the survey, and create an opportunity to explore issues and better understand complexities.

Third, future research should not be limited to NCVAs, but include all VAs working with traumatic crime victims in the military or civilian communities. Including all advocates while identifying those possessing a national credential will allow for greater participation, deeper exploration of topics, and extensive comparisons that may provide valuable insights.

Fourth, in addition to disaggregating and ranking types of victims served, identifying sexual assault victims is needed to confirm sexual assault VAs are at greater risk, as previous research suggests.

Fifth, VAs need to be aware of the potential impact that working with trauma survivors can have on their own spiritual and moral well-being. Therefore, future research should include implications for the spiritual and moral dimensions of STS. These data are needed to develop best practices that help ground advocates in a sense of purpose, meaning, and hope can be a source of strength and comfort during difficult times (J. W. Hopper, 2020).

Sixth, previous research suggests trauma techniques such as mindfulness-based interventions, peer support programs, cognitive-behavioral therapy, and virtual reality interventions may be effective (Burke et al., 2020; Ehring et al., 2019; Esterman et al., 2019; Rothbaum et al., 2020). Identifying best practices is warranted to ensure VAs are fully equipped to aid traumatic crime victims as they recover and navigate the criminal justice processes and shield themselves from STS and PTSD. Findings from future research should be incorporated into psychoeducational resources offered by civilian and military employers, the national advocate credentialing standards, and intervention and holistic treatment modalities.

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Appendix A

Copyright Permission

Received January 25, 2022

From: Brian Bride [redacted]

Sent: Thursday, March 30, 2023, 10:04 AM

To: Inch, Bette Marie Stebbins [redacted]

Subject: [External] Re: Request Permission to publish the STSS as part of my Dissertation

Permission is granted for you to reproduce the STSS in its entirety In your dissertation.

Good luck,

Brian

Brian E. Bride, Ph.D., M.S.W., M.P.H.

Distinguished University Professor

School of Social Work

Andrew Young School of Policy Studies

Georgia State University

Atlanta, Georgia 30302

Jan 25, 2022
Brian Bride < [redacted]
Re: Copyright Permission Request
To: Bette Stebbins [redacted]

Hi Bette,

I am sorry for missing your original email. I am happy to grant you permission to use the STSS in your research.

Best,
Brian

Brian E. Bride, Ph.D., M.S.W., M.P.H.
Distinguished University Professor
School of Social Work
Georgia State University
55 Park Place, NE, 5th Floor
Atlanta, Georgia 30302
[redacted]

Good Afternoon, Dr. Bride -

I am reaching out to you again in hope of receiving your permission to use the 2017 STSS instrument in my upcoming survey research for my dissertation, This is the only tool I have found that is narrow enough to measure the aspects of STS specifically related to traumatic stress reflecting reactions from indirect trauma for those professionals working with, in the case of my study, traumatic crime victims.

My initial email request is included below for your reference.

Kindly advise if there is another route I should be taking to obtain this copyright permission.

Best,
Bette Inch
[redacted]

Begin forwarded message:

From: bette marie [redacted]
Date: November 1, 2021 at 3:06:37 PM CDT

Appendix B

The Victim Advocate Survey Part 1

Please read each statement and indicate how frequently the statement was true for you in the past seven (7) days by checking the corresponding number next to the statement. Rate your answer to the questions below: 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Often, 5 = Very Often (Items will be formatted so participants can indicate their response to each question).

NOTE: "Client" refers to persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work, such as consumer, patient, recipient, etc.

1. I felt emotionally numb.
2. My heart started pounding when I thought about my work with clients.
3. It seems as if I was reliving the trauma(s) experienced by my clients (s).
4. I had trouble sleeping.
5. I felt discouraged about the future.
6. Reminders of my work with clients upset me.
7. I had little interest in being around others.
8. I felt jumpy.
9. I was less active than usual.
10. I thought about my work with clients when I didn't intend to.
11. I had trouble concentrating.
12. I avoided people, places, or things that reminded me of my work with clients.
13. I had disturbing dreams about my work with clients.
14. I wanted to avoid working with some clients.

15. I was easily annoyed.
16. I expected something bad to happen.
17. I noticed gaps in my memory about client sessions.
18. I experienced negative emotions.
19. I engaged in reckless or self-destructive behavior.
20. I unrealistically blamed others for the cause or consequences of the trauma(s) experienced by my client(s).
21. I had negative expectations about myself, others, or the world.

Bride, B. E. (2013). *The Secondary Traumatic Stress Scale* (DSM5 Revision). Unpublished

Scoring Instructions for DSM-V

intrusion (items 2, 3, 6, 10, 13), avoidance (items 12, 14), negative cognitions and mood (1, 7, 9, 17, 18, 20, 21), and arousal (items 4, 8, 11, 15, 16, 19), symptomology of posttraumatic stress disorder (APA, 2013).

Permission to use the Secondary Traumatic Stress Scale was granted (Appendix E).

Appendix C

The Victim Advocate Survey Part 2 Demographics

22. How many clients do you see during the typical work week? _____

23. Thinking about the last year, how frequently did you work with the following types of traumatic crime victims? Please rank frequency as 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Often, 5 = Very Often (Items will be formatted so participants can circle their response to each question).

a. Adult victims of sexual abuse (includes rape, sexual assault, and harassment) ___

b. Adult victims of childhood sexual abuse ___

c. Physical assault ___

d. Domestic violence ___

e. Child sexual abuse ___

f. Sex trafficking/human trafficking ___

g. Stalking ___

h. Homicide ___

i. Other – please specify

24. Do you have a personal history of trauma?

a. Yes __

b. No __

25. Does your organization provide the advocacy support you need to adequately assist victims?

a. Yes ___

b. No ___

26. Does your organization allow you the time you need to work with victims?

a. Yes __

b. No __

27. Is your organizational structure conducive to you providing the best possible support to victims?

a. Yes __

b. No __

28. Does your organization support your self-care by providing you time to access self-care activities and making support/programs available?

a. Yes __

b. No __

29. How many years have you possessed NACP or D-SAACP credential? _____

30. Identify the current level of your credential

a. NACP: Provisional ___

b. NACP: Basic ___

c. NACP: Intermediate ___

d. NACP: Advanced ___

e. DSAACP: Level I ___

f. DSAACP: Level II ___

g. DSAACP: Level III ___

h. DSAACP: Level IV ___

31. How many total years have you worked in the field of victim advocacy? _____

32. How many years have you worked *directly* with traumatic crime victims? _____

33. Do you currently work with military victims? (If no, skip questions 34 & 35 and proceed to question 36.)

a. Yes __

b. No __

34. What type of military environment do you currently work in?

a. Army

b. Navy

c. Air Force

d. Marine Corps

e. Joint Base

f. Army National Guard

g. Air National Guard

h. Coast Guard

i. U.S. Military Academy

j. U.S. Air Force Academy

k. U.S. Naval Academy

l. Coast Guard Academy

m. Veterans Administration

35. Which title below best represents your working title?

a. Sexual Assault Prevention & Response Coordinator (SARC)

b. Sexual Assault Prevention & Response Victim Advocate (SAPR VA)

c. Family Advocacy/Domestic Abuse Victim Advocate (DAVA)

d. Sexual Assault Prevention & Response Victim Advocate (SAPR VA)

e. Victim Witness Liaison

f. Victim Witness Coordinator

g. Other – please specify

36. Do you currently work with civilian victims? (If no, skip questions 37 & 38 and proceed to question 39.)

a. Yes

b. No

37. What type of civilian environment do you currently work in?

a. Nonprofit/Community/Advocacy center (includes rape crises centers, domestic violence shelters)

b. Criminal Justice System (includes law enforcement, prosecutor's office, corrections)

i. Federal

ii. State

iii. County

c. Civil Justice System

d. Medical Health care System

e. Mental Health care System

f. University/State College

38. Which title below best represents your working title?

a. Domestic Abuse Victim Advocate

b. Sexual Assault Prevention & Response Victim Advocate

c. Sexual Assault Response Coordination

d. Domestic Abuse /Sexual Assault Victim Advocate

e. Community-Based Victim Advocate

f. Victim Advocate

g. Victim Services Provider

h. Victim Witness Liaison

i. Victim Witness Coordinator

j. Other – please specify

39. What is your gender?

a. Female

b. Male

c. Nonbinary

d. Do not wish to disclose

40. What is your age? _____

41. Which description below best recognizes your ethnicity?

e. American Indian or Alaska Native

f. Asian

g. Black or African American

h. Hispanic, Latinx, or Spanish

i. Native Hawaiian or other Pacific Islander

j. White or Caucasian

k. Other

42. Is there anything further you would like to describe about your working environment with victims of traumatic crimes? _____

Appendix D

Recruitment Invitation

Secondary Traumatic Stress Among Nationally Credentialed Victim Advocates: Baseline and Risk Factors

***Newsletter and e-blast*:** The following information will be included in NOVA's quarterly newsletter distributed to nationally credentialed victim advocates:

From Bette Inch, First U.S. Department of Defense Senior Victim Assistance Advisor (retired 2019).

As a doctoral candidate in the School of Behavioral Science at Liberty University, I am conducting research to better understand Secondary Traumatic Stress (STS) among nationally credentialed victim advocates. I need volunteers to participate in a short survey regarding STS and nationally-credentialed victim advocates – for this study, the term "victim advocate" includes ALL victim service providers working with traumatized crime victims.

If you are interested in participating in the survey or learning more about this study and you are working with crime victims who have experienced trauma, please click on the attached link

I can be reached via email at: [redacted]

Social Media: The following information will be included on the researcher's and NOVA's *LinkedIn* and *Facebook* accounts:

ATTENTION NOVA Members/Victim Service Providers: I/Bette Inch am conducting research as part of the requirements for a Doctor of Education degree in the School of Behavioral Science at Liberty University. The purpose of my study is to establish a baseline of Secondary Traumatic Stress (STS) and understand better the existence of STS as measured by the presence of avoidance, arousal, negative cognition and mood, and intrusion. Additionally, this study will

clarify the relationships between surveyed risk factors i.e., caseload volume and frequency, a personal history of trauma, organizational type and support, long-term engagement with trauma victims, and a demographic diversity based on gender, age, and ethnicity, of secondary traumatic stress among victim service providers (e.g., victim advocates, SARCs, DAVA, victim service providers). To participate, you must be NACP or D-SAACP credentialed and work with adult victims of crime who have experienced trauma, e.g., sexual assault, domestic abuse, human/sex trafficking, stalking, physical abuse, and homicide (family members), adult victims of childhood sexual assault, adult victims of childhood human/sex trafficking, and adult. Victims of childhood domestic abuse and adult victims of physical abuse must be 18 years of age or older. Participants will be asked to complete a survey via *Survey Monkey*, which should take about 15 minutes. If you would like to participate and meet the study criteria, please click here https://www.surveymonkey.com/r/7V2779T or contact me directly at [redacted]

A consent document is provided as the first page of the survey, and once completed, it will link you to the research questions. Participants will not be compensated.

The following will be included in NOVA's ***Twitter*** Account.

Are you working with crime victims who have experienced trauma? Click here for information about a research study on victim advocates and secondary traumatic stress, https://www.surveymonkey.com/r/7V2779T.

Appendix E

Consent to Participate

Title of the Project: Secondary Traumatic Stress Among Nationally Credentialed Victim Advocates: Baseline and Risk Factors

Principal Investigator: Bette Inch, Doctoral Candidate, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18+ years of age, be nationally credentialed (i.e., NACP or D-SAACP) and work with adult victims of crime who have experienced trauma, e.g., sexual assault, domestic abuse, human/sex trafficking, stalking, physical abuse, and homicide (family members), adult victims of childhood sexual assault, adult victims of childhood human/sex trafficking, and adult victims domestic abuse. Victims of childhood domestic abuse and physical abuse must be 18 years of age or older. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this study is to understand how secondary traumatic stress (STS) affects nationally credentialed victim advocates (NCVAs) working with civilian or military traumatic crime victims. NCVAs may include the following victim service providers- victim advocates, sexual assault prevention & response coordinators, victim-witness liaisons/coordinators, sexual assault prevention and response victim advocates, and domestic abuse victim advocates.

For this study traumatic crime victims will be defined as adult victims of crime, such as sexual assault/domestic violence, human/sex trafficking, stalking, physical abuse, homicide (family members) and adult victims of childhood sexual assault, human/sex trafficking, homicide, stalking, physical abuse.

This study is being done to help victim advocates by increasing their resistance to STS. Through filling a knowledge gap in research, needed information is provided to inform the national advocate credentialing program training standards specifically related to self-and organizational care of victim advocatess; inform prevention and intervention efforts related to STS with military and civilian victim advocacy programs and policies; increase the knowledge base of STS, and to further advance the profession of victim advocacy.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete the Victim Advocate Survey, parts I and II.
    a. Part I: Twenty-one questions from the *Secondary Traumatic Stress Scale* (STSS), a valid and reliable instrument used to measure Secondary Traumatic Stress among NCVAs and other helping professionals.
    b. Part II: Twenty questions regarding demographic information about you, your organization, hours worked, type of victims worked with, and if there is any history of personal trauma. No personally identifiable information such as your name will be collected.
2. It is estimated to take 15 minutes to fully complete. Questions may be skipped, and the survey may be terminated at any point.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include the potential to strengthen military readiness, lessen a public health crisis, and contribute to a safer society by increasing NCVAs resistance to STS and ability to aid victims of crime during the reporting, recovery, and criminal justice process.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

This study will involve a deeply distressing reality—trauma. Any suggestion that victim advocates are not 100% prepared to work with trauma victims could elicit negative professional consequences, such as revoking the national credential and loss of employment. To ensure your privacy, it is recommended that you use your personal computer to take the survey and be aware of the environment in which you take the survey (e.g., take the survey when no one else is around, do not leave the survey unattended).

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be anonymous.

- The researcher will securely export from *SurveyMonkey* individual data to a Microsoft Excel spreadsheet and secure your information encrypted offline with two-step authentication on the researcher's desktop. Information collected will be kept for three years, then shredded. Data will be used in the researcher's final approved dissertation and in follow-on presentations for educational purposes, such as at the National Organization for Victim Assistance annual conference. All data will be reported in the aggregate and no individual data will be reported.

Does the researcher have any conflicts of interest?

The researcher serves as an unpaid board member for The National Organization for Victims Assistance (not a sponsor for this study) and is retired from the Department of Defense Sexual Assault Prevention and Response Office (SAPRO) where she served as the Senior Victim Assistance Advisor from April 2007-August 2019. To limit potential or perceived conflicts the study will be anonymous, so the researcher will not know who participated.

This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or The National Organization for Victims Assistance. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Bette Inch. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] or [redacted] You may also contact the researcher's faculty sponsor,

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.