

## Trauma-Informed Systems of Care: The Role of Organizational Culture in the Development of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction

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### Abstract

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Caregivers who provide services to trauma survivors are at high risk of developing secondary traumatic stress and burnout. Researchers and practitioners in the field of traumatology emphasize the role organizational culture has on individuals who provide services to trauma survivor's well-being. Although there is a considerable amount of theoretical literature on organizational culture and its effects on trauma-workers' well-being, there is a lack of empirical research. The purpose of this exploratory study was to identify what organizational characteristics influence trauma caregivers' compassion fatigue and compassion satisfaction. This study used data from a sample of 282 individuals who provide services to survivors of trauma including 67 animal control officers, 102 child, youth, and family service workers, and 113 individuals who work with the homeless. This research supports the literature and found several significant relationships between the independent and dependent variables. Organizational support and trauma-informed caregiver development were found to be strong predictor variables for burnout and secondary traumatic stress. Practical implications are provided addressing the roles that organizational support, supervisory support, peer support, and trauma-informed caregiver development have in the implementation of a trauma-informed system of care.

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**Keywords:** Trauma-informed care, trauma-informed organizational culture, burnout, secondary traumatic stress, child welfare, animal control officers

### Background

The number of individuals in the general population with exposure to trauma is high, but is even higher in populations who seek the services of social workers and other trauma caregivers (Anda&Felitti, 2003; Bride, 2007; Fairbank, 2008; Felitti, 2002; Knight, 2004).

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It is essential for caregivers to provide unbiased assessments, incorporate best practices, and show compassion and empathy toward clients (Figley, 2002), but to continuously provide a model of excellent service can be very taxing on workers. Valent (2002) claims "attunement and effort needed to help others in trouble may provide great rewards for caregivers when they are met with success, but when they are strained, or worse, when they fail, helpers may be the next dominoes who follow primary victims in suffering themselves" (p. 17).

Although working with trauma survivors may place heavy stress on workers, it is often the workplace environment and working conditions that generate most pressure for trauma caregivers (Choi, 2011). An online anonymous survey, conducted by the National Association of Social Workers (NASW) in 2007, reported it was the work environment, not clients, that caused most of the stress with social workers (N=3,653). Many of those who completed the survey felt they had too high of a workload and did not have enough time to finish their work each day. Several social workers experienced psychological distress and almost three quarters of the respondents felt they suffered from fatigue on the job (Dale, 2008).

### **Emotional Contagion and Trauma-Organized Systems of Care**

Mental abilities decrease when caregivers are under distress (Goleman, Boyatzis, & McKee, 2002). These feelings can be contagious among caregivers in the environment (Cozolino, 2006) affecting an entire organizational culture (Hatfield, Cacioppo, & Rapson, 1994; Hormann & Vivian, 2005). Tyler (2012) explains how organizations are in danger of becoming collectively traumatized in her article "The Limbic Model of Systemic Trauma". Tyler argues that psychological and physiological changes can be transferred from the clients who experienced trauma to professional trauma caregivers. Eventually, individual's stressful emotions can take a toll on organizational climate, become part of the embedded system, and contagious among workers (Hormann & Vivian, 2005). Traumatized systems breed high rates of caregiver burnout and secondary traumatic stress (Bloom & Farragher, 2011) and can damage organizations in numerous ways. According to the Compassion Fatigue Awareness Project (2010), some of the struggles organizations with high levels of compassion fatigue face include personnel issues such as constant changes in co-workers relationships, inability for teams to work well together, and a desire among staff members to break organizational rules.

Other struggles include outbreaks of aggressive behaviors among staff, inability of staff to complete assignments and tasks, failure to respect other staff and clients, and failure to meet deadlines. Ultimately, compassion fatigue leads to lack of flexibility among staff members, negativism toward management, strong reluctance toward change, inability of staff to believe improvement is possible, and lack of a vision for the future. In addition, trauma-organized agencies experience high absenteeism, high employee turnover, and professional misconduct, such as violating boundaries (Bloom, 2006). When organizations experience trauma and make decisions under stress, their perceptions are extremely impaired and they often resort to immediate action instead of thinking about the situation and considering alternative courses of action (Bloom, 1999). Trauma-organized agencies ultimately provide ineffective services (Hansung & Stoner, 2008; Tyler, 2012) and may re-traumatize the person accessing services (Bloom, 2006).

### **Trauma-Informed System of Care**

The relationship between trauma and behavioral health issues has seen an increased awareness over the past 20 years (Clay, 2012) but little emphasis has been placed on organizational culture and its effects on trauma caregiver well-being. The purpose of a trauma-informed organizational system is to enhance organizational resilience to trauma and improve overall organizational health and functioning (Harris & Falot, 2001; Hormann & Vivian, 2005; SAMHSA, N.D.).

Trauma-informed organizations are systems that promote positive well-being for the survivors of trauma receiving services, trauma caregivers, and the organizational leaders. "In a trauma-informed system the human dimension should always be at the forefront, with consideration given to the whole person, regardless of whether the person is a consumer, a clinician, or a program administrator" (Arlidge & Wolfson, 2001, p. 91). For an organization there are specific components crucial to promote the well-being of workers who provide services to trauma survivors. Individuals must feel safe, secure, supported, and work in an environment that is conducive to well-being in order to provide effective services to trauma survivors.

## Research Purpose

The purpose of this cross-sectional quantitative research design was to lessen the gap between the theoretical literature and the empirical research on the impact organizational culture has on trauma caregivers. Subsequently the goal of this research was to gain an understanding of what practices might increase employees' well-being and ultimately lead to a trauma-informed culture for trauma caregivers and individuals receiving care. This research may help advance the knowledge in the growing field of traumatology and the promotion of trauma-informed care practices.

## Methodology

### Research Questions

Based on the literature review the following research questions examine the relationships and predictor variables between trauma-informed organizational culture and burnout, secondary traumatic stress, and compassion satisfaction.

**Research Question # 1:** What is the relationship between trauma-informed organizational culture and number of years working in the trauma field and trauma caregiver levels of burnout, secondary traumatic stress, and compassion satisfaction?

**Research Question #2:** How well can burnout, secondary traumatic stress, and compassion satisfaction be predicted from a combination of the four variables--supervisory support, peer support, organizational support, and trauma-informed caregiver development?

**Research Question # 3.** Is there a correlation between percentage of time spent at work providing direct trauma services and individuals level of burnout, secondary traumatic stress, and compassion satisfaction?

## Measurement

The online survey consisted of three sections including the Trauma-Informed Organizational Culture (TIOC), the Professional Quality of Life (ProQOL, 2011) and a short demographic section.

The TIOC was used to measure a caregivers' perception of the level of safety, support, and trauma-informed caregiver development available at his or her agency. The ProQOL measured burnout and secondary traumatic stress, collectively known as compassion fatigue, and compassion satisfaction.

**Trauma-Informed Organizational Culture (TIOC) survey.** As there was no instrument available that captures workers' perspectives of their agency's level of trauma-informed culture, the Trauma-Informed Organizational Culture Survey (TIOC) is a researcher-created survey. It was developed to measure caregivers' perception of the organizational culture where they work and whether or not they perceive it to be trauma informed. From an extensive literature review, five concepts were consistently found across the trauma literature that prevent or lessen the effects of burnout and secondary traumatic stress on trauma workers. These five concepts included caregivers' perceptions of safety (physical and emotional), organizational support, supervisory support, peer support, and trauma-informed caregiver development (trauma training and trauma responsiveness) at the workplace. The TIOC is a 30 item self-administered questionnaire that uses a five level response likert scale ranging from "strongly disagree" to "strongly agree". For more information on the validation of the TIOC please see xxxx dissertation (xxx, 2013).

**Professional Quality of Life instrument.** The Professional Quality of Life (ProQOL) (Stamm, 2011) was used to measure worker burnout and secondary traumatic stress, together defined as compassion fatigue, and compassion satisfaction. The ProQOL instrument (2009), now in its fifth version, is a 30-item self-administered survey originally created by Figley and then transferred to Stamm (2009). The ProQOL has been extensively used in research for various populations who work in the field of trauma including, child, youth, and family workers (Azar, 2000); social workers (Bride & Figley, 2007); and animal workers (Rank, Zapanick, & Gentry, 2009). In the most recent version, researchers found the following alphas with caregiver populations: secondary traumatic stress alpha .88, burnout .75, and compassion satisfaction .81 (Stamm, 2009).

## Validity and Reliability of Instruments

**Trauma-Informed Organizational Culture Survey.** Five factors were originally requested, which were named employee's perception of safety, organizational support, supervisory support, peer support, and trauma awareness. Exploratory factor analysis helps test for the validity of the instrument and to see if the survey items actually fit the predicted constructs. Factor analysis only identified four constructs in the TIOC. The constructs were labeled supervisory support, peer support, organizational support, and trauma-informed caregiver development. Eight items were dropped from subsequent analysis. To assess whether the data from the four factors formed reliable scales, Cronbach's alphas were computed. The alphas for supervisory support (six items) was .88, peer support (5 items) was .82, organizational support was .90 (5 items), and .82 for the trauma-informed caregiver development (3 items), all of which indicated good internal consistency. The overall internal consistency for the entire TIOC (30 items) was .91 and the overall consistency for the 19 items used in the data analysis was .87.

**ProQol.** The Professional Quality of Life (ProQOL) was found to be reliable. Each of the three subscales had 10 items with the burnout subscale ( $\alpha = .80$ ), the secondary traumatic stress subscale ( $\alpha = .82$ ), and the compassion satisfaction ( $\alpha = .83$ ). These alphas were consistent with previous studies of caregiver populations (Stamm, 2009).

## Procedures and Sampling

The population for this study consisted of three different professional groups who provided services to people or animals who have experienced trauma including child, youth, and family workers, individuals who work with the homeless, and animal control officers. The agencies included a county child protection department, a non-profit organization that provides services to homeless individuals and families, and a non-profit organization that provides support to animal control officers. All individuals who work at the agencies were allowed to participate in the study, including front-line workers, middle management, and administration.

## Data Collection

Because organizations did not feel comfortable giving out employee or member's email addresses, a link to the survey was emailed out to potential participants by the gatekeepers of the three agencies. This email described the intent of the study, incentives provided, information on how to complete the survey, and an explanation of why participation was needed. The introductory email ensured participant anonymity and individual organizational results remained confidential. The link provided in the email guided participants to an anonymous online survey provided by Qualtrics. As an incentive, participants were given the opportunity to enroll into a drawing for \$50.00 gift cards. Six \$50.00 gift cards were awarded to those who completed the survey and were willing to separately give their name and email or other contact information. One week following the introductory email, the gatekeepers were asked to send a follow-up email as a reminder with the link to the survey to for the purpose to increase response rates.

## Results

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) Version 20. Descriptive statistics were performed to describe the demographics of the participants and to depict their type of trauma work, percentage of direct services to survivors of trauma, and years working in the field of trauma.

A total of 282 participants' data were analyzed including 67 animal control officers (23.7%); 102 child, youth, and family services workers (36.2%); and 113 individuals who work with the homeless (40.1%). Altogether 79 participants (28%) reported having a Bachelors of Social Work (BSW) degree or Masters of Social Work (MSW) degree with 35 participants (12.4%) reporting a BSW degree and 44 participants (15.5%) reported having a MSW degree. In the sample, 282 (96%) reported they provided direct services to people or animals who had experienced trauma. Thirty percent spent 51-75% of their time and over thirty percent spent 76-100% of their time in direct trauma services.

By using the *Concise ProQOL Manual* (Stamm, 2009), the levels of burnout, secondary traumatic stress, and compassion satisfaction were determined. Levels of burnout and secondary traumatic stress were low to average for the participants.

Levels of compassion satisfaction were average to high with three people reporting low levels of compassion satisfaction. To see if there was a difference among the three groups of animal control officers, child, youth, and family service workers, and individuals who work with the homeless, an analysis of variance was conducted. There were no significant differences among the three groups on levels of burnout  $F(2, 268) = 1.91, p = .151$ ; secondary traumatic stress  $F(2, 269) = 2.01, p = .136$ ; and compassion satisfaction  $F(2, 272) = 2.34, p = .099$ .

### Correlations

To investigate if there were statistically significant associations between the independent variables--supervisory support, peer support, organizational support, trauma-informed caregiver development, and years working in the field of trauma and the dependent variables burnout, secondary traumatic stress, and compassion fatigue, 15 Pearson Product Moment Correlations were computed. Several statistically significant relationships were found among the variables and Table 1 provides the means, standard deviations, and correlations of these variables. A negative correlation indicates that as the independent variable increased, the level of the dependent variable decreased and positive correlation indicates that as the independent variable increased so did the level of the dependent variable.

**Table 1: Means, Standard Deviations, and Correlations of Dependent Variables Burnout, Secondary Traumatic Stress and Compassion Satisfaction and Independent Variables Supervisory Support, Peer Support, Organizational Support, Trauma-Informed Caregiver Development, and Years Working in Trauma Field**

Independent Variables	Dependent Variables				
	M	SD	Burnout	STS	CS
Supervisory Support	23.16	5.12	-.33**	-.19*	.34**
Peer Support	19.24	3.60	-.21**	-.07	.25**
Organizational Support	18.35	4.32	-.49**	-.26**	.36**
Trauma-Informed Caregiver Development	10.01	2.90	-.33**	-.28**	.45**
Years Working in Trauma	11.06	7.87	-.09	-.11	.16*

\* $p < .01$  \*\* $p < .001$

Table 2 provides the results of the Pearson Product Moment Correlations that found statistically significant relationships between the dependent variables burnout, secondary traumatic stress, and compassion satisfaction and the independent variables supervisory support, peer support, organizational support, trauma-informed caregiver development and years working in the field of trauma. Effect sizes are provided in Table 2 using Cohen’s (1988) guidelines.

**Table 2: Correlations of Independent Variables Supervisory Support, Peer Support, Organizational Support, and Trauma-Informed Caregiver Development and Dependent Variables Burnout, Secondary Traumatic Stress, and Compassion Satisfaction**

Variables	N	R	P	Effect Size	% of Variance
Burnout					
Supervisory Support	268	-.33	< .001	Typical	11
Peer Support				Smaller than Typical	
Organizational Support	265	-.21	.001		4
Trauma-Informed Caregiver Development	271	-.49	< .001	Larger than Typical	24
Secondary Traumatic Stress					
Supervisory Support	270	-.33	< .001	Typical	11
Organizational Support	270	-.19	.002	Typical	4
Trauma-Informed Caregiver Development	271	-.26	< .001	Larger than Typical	6
Compassion Satisfaction					
Supervisory Support	270	-.28	< .001	Typical	8
Peer Support	271	.34	< .001	Typical	12
Organizational Support	265	.25	< .001	Small to Medium	6
Trauma-Informed Caregiver Development	273	.36	< .001	Medium	13
Years Working in Trauma Field	272	.45	< .001	Medium to Large	20
	262	.16	.008	Smaller than Typical	3

### Predictor Variables of Burnout, Secondary Traumatic Stress, and Compassion Satisfaction

Simultaneous multiple regressions were conducted to investigate the extent to which levels of burnout, secondary traumatic stress, and compassion satisfaction can be predicted from the combination of the four variables--supervisory support, peer support, organizational support, and trauma-informed caregiver development.

The means, standard deviations, and intercorrelations for the predictor variables of burnout are found in Table 3. The combination of variables to predict burnout from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development (caregiver development) was statistically significant,  $F(4, 251) = 22.98, p < .001$ .

**Table 3: Predictor Variables for Burnout, Means, Standard Deviations, and Intercorrelations (N=256)**

Variable	M	SD	Supervisor Support	Peer Support	Organizational Support	Trauma-Informed Caregiver Development
Burnout	23.85	5.42	-.34**	-.20*	-.48**	-.40**
Peer Support	19.18	3.58	--	--	.499**	.42**
Supervisory Support	23.18	5.15	--	.41**	.64**	.42**
Organizational Support	18.27	4.32	--	--	--	.52**
Trauma-Informed Caregiver Development	9.93	2.86	--	--	--	--

\*p = .001 \*\*p < .001

The means, standard deviations, and intercorrelations for the predictor variables for secondary traumatic stress are found in Table 4. The combination of variables to predict secondary traumatic stress from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development was statistically significant,  $F(4, 253) = 7.57, p < .001$ .

**Table 4: Predictor Variables for Secondary Traumatic Stress, Means, Standard Deviations, and Intercorrelations (N=258)**

Variable	M	SD	Supervisor Support	Peer Support	Organizational Support	Trauma-Informed Caregiver Development
Secondary Traumatic Stress	23.60	5.83	-.19**	-.07	-.28**	-.25**
Supervisory Support	23.07	5.16	--	.40**	.42**	.64**
Peer Support	19.20	3.60	--	--	.50**	.37**
Organizational Support	18.27	4.33	--	--	--	.53**
Trauma-Informed Caregiver Development	9.96	3.00	--	--	--	--

\*p=.01\*\*p<.001

The means, standard deviations, and intercorrelations for the predictor variables for compassion satisfaction are found in Table 5. The combination of variables to predict compassion satisfaction from perceived levels of supervisory support, peer support, organizational support, and trauma-informed caregiver development (caregiver development) was statistically significant,  $F(4, 253) = 17.08$ ,  $p < .001$ .

**Table 5: Predictor Variables for Compassion Satisfaction, Means, Standard Deviations, and Intercorrelations (N=258)**

Variable	M	SD	Supervisor Support	Peer Support	Organizational Support	Trauma- Informed Caregiver Development
Compassion Satisfaction	38.81	5.91	.34**	.24**	.44**	.34**
Supervisory Support	23.21	5.02	--	.37**	.62**	.41**
Peer Support	19.30	3.51	--	--	.44**	.34**
Organizational Support	18.36	4.25	--	--	--	.53**
Trauma-Informed Caregiver Development	9.97	2.86	--	--	--	--

\*\*p<.001

The beta coefficients are presented in Tables 6, 7 and 8. Organizational support and trauma-informed caregiver development significantly predict burnout, secondary traumatic stress, and compassion satisfaction when all four variables are included. For the prediction of burnout the adjusted  $R^2$  value was .26 indicating that 26% of the variance in burnout was explained by the model. The effect size was .52 according to Cohen this is a large to larger than typical effect size (1998).

**Table 6: Simultaneous Multiple Regression Analysis Summary for Burnout, Supervisory Support, Peer Support, Organizational Support, and Trauma-Informed Caregiver Development (N=256)**

Variable	B	SEB	B
Supervisory Support	-.03	-.08	-.02
Peer Support	.13	.10	.09
Organizational Support	-.51	.10	-.41**
Trauma-Informed Caregiver Development	-.39	.12	-.20*
Constant	35.07	1.78	

Note.  $R^2 = .52$ ;  $F(4, 251) = 22.98$ ,  $p < .001$

\* $p < .01$  \*\* $p < .001$

For the prediction of secondary traumatic stress, the adjusted  $R^2$  value was .09 indicating that 9% of the variance in secondary traumatic stress was explained by the model. The R effect size was .33 and is a medium or typical effect size (Cohen, 1988).

**Table 7: Simultaneous Multiple Regression Analysis Summary for Secondary Traumatic Stress, Supervisory Support, Peer Support, Organizational Support, and Trauma-Informed Caregiver Development (N=258)**

Variable	B	SEB	B
Supervisory Support	-.02	.088	-.01
Peer Support	.20	.11	.13
Organizational Support	-.34	.12	-.25**
Trauma-Informed Caregiver	-.33	.14	-.16*
Constant	29.46	2.10	--

Note.  $R^2 = .12$ ;  $F(4, 253) = 7.57$ ,  $p < .001$

\* $p < .05$  \*\* $p < .01$

For the prediction of compassion satisfaction, organizational support and trauma-informed caregiver development significantly predict compassion satisfaction when all four variables are included. The adjusted  $R^2$  value was .20 indicating that 20% of the variance in secondary traumatic stress can be explained by the model. The R effect size was .46 and is a medium to large effect size (Cohen, 1988).

Table 8: *Simultaneous Multiple Regression Analysis Summary for Compassion Satisfaction, Supervisory Support, Peer Support, Organizational support, and Trauma Education (N=256)*

Variable	B	SEB	B
Supervisory Support	.10	.09	.09
Peer Support	.02	.11	.01
Organizational Support	.42	.113	.30**
Trauma-Informed Caregiver Development	.30	.14	.14*
Constant	25.45	2.01	--

Note.  $R^2 = .21$ ;  $F(4, 253) = 17.08$ ,  $p < .001$ .

\* $p < .05$ ; \*\* $p < .001$

### **Correlation between percentages of time spent at work providing direct trauma services and dependent variables**

To assess the significant correlations between the percentage of time spent providing direct services to trauma survivors and burnout, secondary traumatic stress, and compassion satisfaction Spearman's Rho were conducted for each. Spearman's Rho, a non-parametric statistic, was used because the independent variable, percentage of time spent providing direct trauma services was ordinal level data. The categories of time spent providing direct services to trauma survivors included 1) 25% or less; 2) 26-50%; 3) 51-75%; and 4) 76-100%. There was not a statistically significant association between percentage of time providing direct trauma services and burnout,  $r(280) = .05$ , or between percentage of time spent providing direct trauma services and compassion satisfaction,  $r(280) = .07$ . There was a positive correlation between the two variables of percentage of time providing direct trauma services and secondary traumatic stress,  $r(271) = .19$ ,  $p = .002$ . As the level of direct trauma services provided increased so did the level of secondary traumatic stress. Using Cohen's (1988) guidelines, the effect size was smaller than typical.

## Discussion

This study produced several statistically significant findings that support the researcher's premise of what might constitute a trauma-informed organizational culture. Participants of the study who felt more supported by their organizations, supervisors, and peers tended to be at lower risk for developing burnout and secondary traumatic stress. Also, lack of organizational support and trauma-informed caregiver development were significant predictors of burnout and secondary traumatic stress. Lastly, individuals who spend more time providing direct trauma-services are at higher risk for secondary traumatic stress.

Secondary traumatic stress was negatively correlated with perceived level of organizational support and trauma-informed caregiver development with effect sizes of medium to large. Secondary Traumatic Stress was negatively correlated with supervisory support ( $p=.002$ ), but after effect size was calculated the strength of association was not as strong as organizational support and trauma-informed caregiver development. This does not negate the importance of supervisory support as this study found supervisory support to be significantly associated with higher levels of compassion satisfaction ( $p < .001$ ) and the strength of this relationship was medium when effect sizes were calculated. Countless other researchers have found lack of supervisory support to be a strong predictor of burnout and secondary traumatic stress (Harrison & Westwood, 2009; Jankoski, 2010; Tehrani, Osborne, & Lane, 2012) and correlated with trauma caregiver perceptions of client care (Räikkönen, Perälä, & Kahanpää, 2008).

When the four variables of supervisory support, peer support, organizational support, and trauma-informed caregiver development were each analyzed in relation to burnout, secondary traumatic stress, and compassion satisfaction, multiple regressions revealed that perceived levels of organizational support and trauma-informed caregiver development significantly predicted burnout, secondary traumatic stress, and compassion satisfaction.

Although there was not a correlation between percentage of time spent providing direct trauma-related services and levels of burnout or compassion satisfaction, there was a correlation between percentage of time providing direct services to survivors of trauma and secondary traumatic stress. As the percentage of direct trauma services increased so did the level of secondary traumatic stress.

This finding has strong practical implications and is supported by the trauma literature. Many trauma experts believe that trauma caregivers are at higher risk for secondary traumatic stress if their entire caseload consists of individuals or animals who have experienced trauma (Bell, Kulkarni, & Dalton, 2003; Harrison & Westwood, 2009; Pearlman & McKay, 2008; Saakvitne & Pearlman, 1996). This finding supports the idea that trauma caregivers continuously providing services to survivors of trauma are at higher risk of developing secondary traumatic stress. Organizations should give trauma caregivers opportunities to maintain balanced work duties instead of meeting with client after client. Other opportunities for staff may include training, supervision, research, policy, and/or program development (Saakvitne & Pearlman, 1996).

### **Obstacles to adopting a trauma-informed system of care**

Organizational culture has a profound influence on employee well-being because it is often the workplace environment, not the clients, which increases worker stress and makes caregivers more susceptible to developing compassion fatigue (Bloom, 2006; Dale, 2008). When professional caregivers are experiencing a stress response it is virtually impossible for them to provide effective trauma-informed services (Bloom & Farragher, 2011; Tyler, 2012; Van Derhoot Lipsky & Burk, 2009).

Henry et al. (2011) discovered that lack of sustained consultation to workers and significant child welfare worker turnover, many of whom had not received adequate training, were the main obstacles that prevented child welfare agencies from adopting a trauma-informed approach. Often workers did not stay in child welfare positions long enough to receive adequate training. In addition, staff reported they felt as if they were in "survival mode and had little energy to implement trauma-informed casework practices" (p. 183). Henry et al. (2011) recommend "trauma-informed consultation" be optimized to help reduce burnout and secondary traumatic stress, a common theme with the child welfare staff. These authors highly recommend that welfare staff have lower workloads and more work time devoted to caregiver development including specialized trauma training starting with awareness of compassion fatigue.

It has become increasingly more difficult to provide effective care to survivors of trauma because of cost control, increased demand for services, limited available resources (Scheid, 2003). Changes in funding structures in many organizations, particularly community mental health, have resulted on less emphasis to professional caregiver development and more on achieving the monthly billable hours to ensure organizational funding. The decrease in opportunities and lack of priority for caregiver development and organizational support has become a challenge that trauma caregivers must face as a result of limited funding and financial deficits of mental health care organizations (Acker, 2011; Scheid, 2003; Whitaker, Weismiller, & Clark, 2006).

Well-being of staff and survivors of trauma is top priority in a trauma-informed system and when organizations experience financial stress often the resources that promote staff well-being are diminished. This study is supported by previous findings on the responsibilities organizations have to provide supportive resources to their staff to reduce the risks of compassion fatigue and apply the benefits of employee compassion satisfaction (Douglas, 2012; Ga-Young, 2011; Scheid, 2003). The findings of this study may have implications as mental health and other systems of care attempt to provide efficient quality care at lower cost, but it is usually at the detriment of the workers and ultimately the clients receiving care (Richardson, 2001).

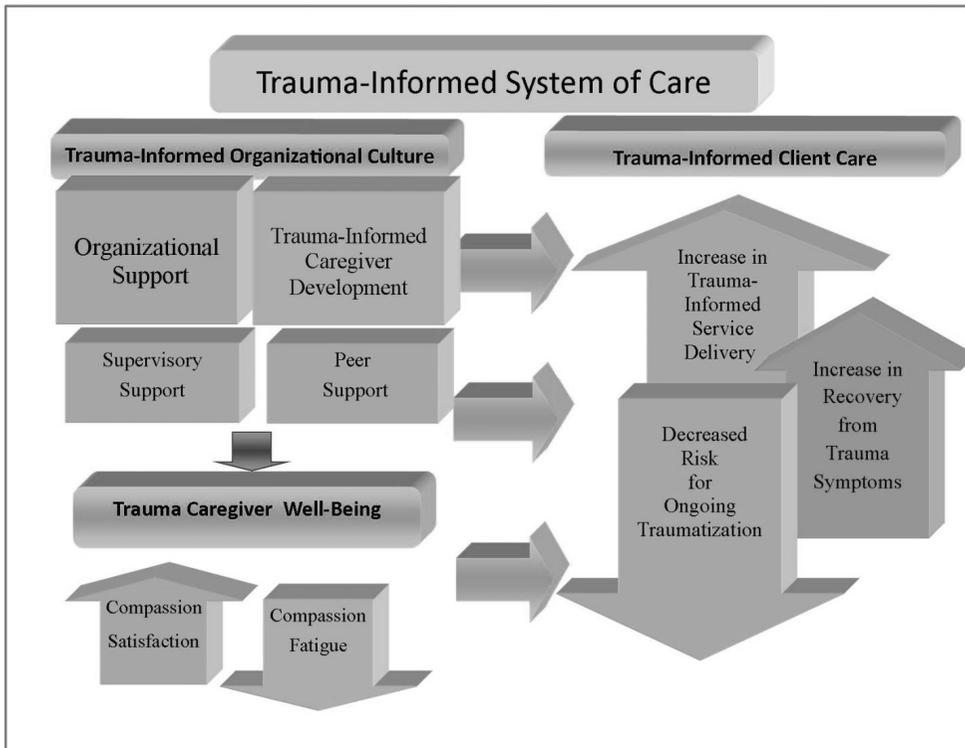
### **Embracing a trauma-informed system of care: Implications for organizations**

A trauma-informed paradigm shift requires that every involved person take an active role in ensuring that systems of care do not re-traumatize the clients, staff, organizations, and communities. Douglas (2012) recommends that organizations acknowledge the existence of compassion fatigue and create structures that support self-care. He states “Delivering care without caring is simply wrong” (p. 419) and validates that survivors of trauma should not have to receive services under such conditions, caregiving professions should not accept traumatized systems as the status quo, and organizations should invest in development to help reduce the effects of compassion fatigue.

The more that can be done to support caregivers and their emotional needs, the sooner the negative impact of emotional imbalances can be minimized for patients, organizations, and the individuals themselves (Douglas, 2012, p. 417).

Trauma-informed caregiver development, specifically trauma-specific training can be used as an adaptive strategy to address compassion fatigue and provide support for professional development that goes beyond educating trauma caregivers (Craig & Sprang, 2010). Providing opportunities for trauma caregivers to develop skills associated with trauma work including self-care and effective therapies for survivors of trauma may show powerful results in the prevention of compassion fatigue and the increase of compassion satisfaction. Cost-benefit analysis may show that high turnover actually costs more than investing in workers to ensure they have the tools available to provide adequate services while balancing work and self-care (Arledge & Wolfson, 2001).

Implementation of a trauma-informed organizational culture is an organization-wide endeavor that starts at the top. Administration and funders must be invested in a trauma-informed system and the agency mission and values must reflect a trauma-informed approach (Harris & Fallot, 2001). If the organization's values are closely tied to the helping process of trauma clients, professional caregivers may feel that their trauma-informed work is supported more by the organization (Ga-Young, 2011). This in turn may help professional caregivers feel more confident in their work with survivors of trauma, which may decrease feelings of helplessness and hopelessness strong emotions for higher risk of developing compassion fatigue (Schwartz, Tiamiyu, & Dwyer, 2007). Using systems theory as a lens to understand this study's results, Figure 1 provides a conceptualization of a trauma-informed system of care.



*Figure 1. Researcher's Conceptualization of a Trauma-Informed System of Care*

### Limitations and implication for future research

There were limitations that may reduce the internal and external validity of this study. One limitation may have been response bias. Response bias occurs when people who respond to the survey are different than those people who do not respond. Recipients of the survey who chose to participate in the study may differ in systematic ways from those who did not. Individuals who were experiencing high rates of burnout and secondary traumatic stress might have felt overwhelmed or that they did not have time to participate in the survey. Also, because the organizations did not release staff email information to the researcher, the emails containing the survey were sent out via an internal administrator. Although anonymity was explained and assured, non-respondents may not have felt safe responding (Dillman, Smyth, & Christian, 2009).

There is always error in measurement particularly measurement of mental or emotional states (Keller & Casadevall-Keller, 2010). This study did not consider personal factors and participants may have responded based on how they were feeling due to external factors not related to the organizational culture. Although this research provided some important findings further research is needed to understand the role organizational culture has on systems and workers who provide services to survivors of trauma to ultimately determine the effectiveness of a trauma-informed system of care. Qualitative or mixed-methods studies done in the future may yield more detailed, rich descriptions of the lived experiences of this exemplary group of professionals.

## References

- Acker, G.M. (2011). Burnout among mental health care providers. *Journal of Social Work, 12*(5), 475-490, doi: 10.1177/1468017310392418.
- Anda, R.F., & Felitti, V.J. (2003). The adverse childhood experiences (ACE) study: Bridging the gap between childhood trauma and negative consequences later in life. *Ace Reporter, 1*(1), 1-4. Retrieved on December 14, 2011 from <http://www.cestudy.org/>
- Arledge, E., & Wolfson, R. (2001). Care of the clinician: Effective services for trauma survivors rely on addressing the support and care needs of clinicians and administrators. In Harris, M. & Fallot, R.D (Eds.), *Using trauma theory to design service systems* (pp. 91-98). San Francisco, CA: Jossey-Bass.
- Azar, S. T. (2000). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: A cognitive behavioral approach to supervision. *Journal of Clinical Psychology, 56*(5), 643-663. doi: 10.1002/(SICI)10974679(200005)56:5<643::AID-JCLP6>3.0.CO;2-U
- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organization prevention of vicarious trauma. *Families in Society. The Journal of Contemporary Human Services, 84*(4), 463-470.
- Bloom, S.L. (1999). Trauma theory abbreviated. *Final Action Plan: A Coordinated Community-Based Response to Family Violence*. Attorney General of Pennsylvania Family Violence Task Force, Retrieved January 17, 2013 from [http://www.sanctuaryweb.com/PDFs\\_new/Bloom%20Trauma%20Theory%20Abbreviated.pdf](http://www.sanctuaryweb.com/PDFs_new/Bloom%20Trauma%20Theory%20Abbreviated.pdf)
- Bloom, S. L. (2006). Organizational stress as a barrier to trauma-sensitive change and system transformation. Adapted from: *Living Sanctuary: Complex Antidotes to Organizational Stress in a Changing World*, Retrieved on May 1, 2010 from [www.sanctuaryweb.com](http://www.sanctuaryweb.com)
- Bloom, S.L., & Farragher, B. (2011). *Destroying sanctuary*, New York, NY: Oxford Press.

- Bride, B. (2007). Prevalence of secondary traumatic stress among social workers. *National Association of Social Workers*, 25(1), 63-69.
- Bride, B., & Figley, C. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal*, 35(3), 151-153. doi: 10.1007/s10615-007-0093-5
- Choi, G.Y. (2011). Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work*, 35:3, 225-242, doi: 10.1080/03643107.2011.575333
- Clay, R.A. (2012). Celebrating two decades of progress in the behavioral health field. *SAMHSA News*, 20(2), 3-6, Retrieved from [http://www.samhsa.gov/samhsanewsletter/Volume\\_20\\_Number\\_2/twentieth-anniversary.aspx](http://www.samhsa.gov/samhsanewsletter/Volume_20_Number_2/twentieth-anniversary.aspx)
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd edition)*, Hillsdale, NJ: Erlbaum.
- Compassion Fatigue Awareness Project. (2010). *Recognizing compassion fatigue*. Retrieved June 15, 2010 from [www.compassionfatigue.org](http://www.compassionfatigue.org)
- Cozolino, L. (2006). *The neuroscience of human relationships: Attachment and the developing social brain*. New York, NY: WW Norton and Company.
- Craig, C.D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, 23(3), 319-339.
- Dale, M. (2008). Social workers owe it to themselves and clients to value a healthy lifestyle. The profession must prioritize self-care. *NASW News*, 53(10), 4.
- Dillman, D.A., Smyth, J.D., & Christian, L.M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method (3rd ed.)*. Hoboken, NJ: John Wiley and Sons.
- Douglas, K. (2012). When caring stops, staffing doesn't really matter. *Nursing Economics*, 28(6), 415-419.
- Fairbank, J.A. (2008). The epidemiology of trauma and trauma related disorders in children and youth. *Research Quarterly, Advancing Science and Promoting of Understanding of Traumatic Stress*, 19(1), National Center for PTSD, Retrieved from <http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v19n1.pdf>
- Felitti, V.J. (2002). The relationship of adverse childhood experiences in adult health: Turning gold into lead. *The Permanente Journal*, 6(1), 44-47.
- Figley, C.R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Psychotherapy in Practice*. 58(11), 1433-1441.
- Ga-Young, C. (2011): Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work*, 35(3), 225-242. [doi.org/10.1080/03643107.2011.575333](http://doi.org/10.1080/03643107.2011.575333)
- Goleman, D., Boyatzis, R., & McKee, A. (2002). The emotional reality of teams. *Journal of Organizational Excellence*, 21(2), 55-65.

- Hansung, K. & Stoner, M. (2008). Burnout and turnover intention among social workers: Effects of role stress, job autonomy, and social support, *Administration in Social Work, 32*(3), 5-25. doi:10.1080/03643100801922357
- Harris, M., & Fallot, R.D. (2001). *Using trauma theory to design service systems*. San Francisco, CA: Jossey-Bass.
- Harrison, R.L., & Westwood, M.J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research Practice, Training, 46*(2), 203–219. doi:10.1037/a0016081.
- Hatfield, E., Cacioppo, J.T., & Rapson, R.L. (1994). *Emotional contagion: Studies in emotion and social interaction*. New York, NY: Cambridge University Press.
- Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchinson, B., & Hyter, Y. (2011) A grassroots prototype for trauma-informed child welfare system change. *Child Welfare, 90*(6), 169-186.
- Hormann, S., & Vivian, P. (2005). Toward an understanding of traumatized organizations and how to intervene in them. *Traumatology, 11*(3), 159-169.
- Jankoski, J.A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare, 89*(6), 105-120.
- Morgan, G.A., Leech, N.L., Gloeckner, G.W., & Barrett, K.C. (2010). *SPSS for introductory statistics: Use and Interpretation 4<sup>th</sup>ed.*. New York, NY: Taylor and Francis Group.
- Keller, D.K. & Casadevall-Keller, M.L. (2010). *The tao of research: A path to validity*, Thousand Oaks, CA: Sage.
- Knight, C. (2004). Working with survivors of childhood trauma: Implications for clinical supervision. *The Clinical Supervisor, 23*(2), 81-101. doi: 10.1300/J001v23n02\_06
- Pearlman, L.A., & McKay, L. (2008). Vicarious trauma: What can managers do? Excerpted by CARE from: *Understanding and addressing vicarious trauma*, Headington Institute, Retrieved on November 3, 2010 from [www.headington-institute.org](http://www.headington-institute.org)
- Räikkönen, O., Perälä, M.L., & Kahanpää (2008). Staffing adequacy, supervisory support and quality of care in long-term care settings: Staff perceptions. *Journal of Advanced Nursing, 60*(6), 615-626. doi: 10.1111/j.365-2648.2007.04442.x.
- Rank, M.G., Zaparanick, T.L., & Gentry, J.E. (2009). Nonhuman-animal care compassion fatigue: Training as treatment. *Best Practices in Mental Health, 5*(2), 40-63.
- Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. The Center for Research on Violence against Women and Children: The University of Western Ontario, London, Ontario, CN.
- Saakvitne, K.W., & Pearlman, L.A. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. The Traumatic Stress Institute, New York, NY: W.W. Norton & Company, Inc.

- Scheid, T.L. (2003). Managed care and the rationalization of mental health services. *Journal of Health and Social Behavior*, 44(2), 142-61.
- Schwartz, R.H., Tiamiyu, M.F., & Dwyer, D.J. (2007). Social worker hope and perceived burnout: The effects of age, years in practice, and setting. *Administration in Social Work*, 31(4), 103-119. doi:10.1300/J147v31n04\_08
- Stamm, B.H. (2009). *The Concise ProQOL Manual*, (2nd ed.). Pocatello, ID: [www.ProQOL.org](http://www.ProQOL.org)
- Stamm, B. H. (2011). *The ProQOL*. [www.proqol.org](http://www.proqol.org)
- Substance Abuse Mental Health Services Administration (SAMHSA). (n.d.). *National Center for Trauma Informed Care. Welcome to the National Center for Trauma-Informed Care*. Retrieved on November 23, 2010 from <http://www.samhsa.gov/nctic/>
- Tehrani, N., Osborne, D., & Lane, D. (2012). Restoring meaning and wholeness: The role for coaching after trauma. *International Coaching Psychology Review*, 7(2), 239-246.
- Tyler, T.A. (2012). The limbic model of systemic trauma. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, 26(1), 125-138
- Valent, P (2002). Diagnosis and treatment of helper stresses, traumas, and illnesses. In C. Figley (Ed.). *Treating Compassion Fatigue* (pp. 17-38). New York, NY: Brunner, Routledge.
- Van Dernoot Lipsky, L., & Burk, C., (2009). *Trauma-stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler, Inc.
- Whitaker, T., Weismiller, T., & Clark, E. (2006). Assuring the sufficiency of a frontline workforce: Executive summary. Washington, DC: National Association of Social Workers.