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Safeguarding the Safeguarders: A pragmatic trial of a wellness and supervision bundle to reduce vicarious trauma among GBV First Responders Across Community-Based Organizations

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Abstract

The first responders to gender based violence (GBV) are exposed to high occupational risks, such as vicarious trauma, burnout and compassion fatigue. Although they play a critical role in assisting the survivors, the frontline workers are usually not well organized in terms of the support structures. This practical intervention examined a wellness and supervision package of comprehensive wellness applied in a range of community-based organizations using a stepped-wedge design. The intervention involved the organized supervision sessions, the peer debriefing protocols, and systematized pathways of mental health referral. Validated measures of vicarious trauma and burnout were used as primary outcomes and acceptability, feasibility, and fidelity were the implementation outcomes. The results showed that there was a significant decrease in vicarious trauma symptoms and burnout scores of the study first responders. The implementation metrics were highly acceptable, and moderately-high fidelity in varying organization settings. The paper adds evidence-based approaches to organizational wellness within the GBV response sector and emphasizes the urgent necessity of the sustainability of protective mechanisms in this area to safeguard the people who safeguard others.

Keywords: Vicarious Trauma; Gender-Based Violence; First Responders; Organizational Wellness; Supervision; Implementation Science.

1. Introduction

Gender-based violence is a widespread societal health crisis that can impact society across the world, and first responders can act as the linking force between victims and holistic support services (Raftery et al., 2022). These frontline staffs, such as counselors, case managers, advocates, and community health workers, interact on a daily basis with the traumatic accounts and observe the dire consequences of violence on the life of the survivors. Even though their work is critical to the recovery of survivors and the safety of the community, the psychological impact on the first responders themselves has not been sufficiently addressed in policy or practice.

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Secondary traumatic stress, which is also known as vicarious trauma, refers to a deep psychological effect on specialists who deal directly with trauma victims (Velasco et al., 2023). Vicarious trauma, as opposed to general occupational stress, is a phenomenon that changes the perception of individuals with this condition towards themselves, others, and the surrounding world. The GBV sector place a special burden on first responders since their exposure to traumatizing content is chronic, the emotional content of survivor encounters can be quite intense, and the settings in which the responders work are often under-resourced. Studies have shown that forty to eighty-five percent of practitioners who are engaged in work with trauma survivors have symptoms that are in line with vicarious trauma or secondary stress trauma (Xu et al., 2024; Gesesew et al., 2025).

There is more than personal misery involved in the consequences of unattended vicarious trauma. It is at this time when staff turnover, decreased service delivery, and organizational capacity is most apparent in organizations since the urgency here requires constant and qualified responsiveness to the situation (Adebiyi et al., 2025). When survivors once more become their own first responders they may get fragmented or insufficient assistance, as they already have trauma symptoms they are dealing with. This leads to a vicious circle in which the same institutions that are supposed to offer security and healing instead unwillingly foster the injury by getting their human resources drained out.

Although there is increasing consciousness of such obstacles, community-based organizations that assist GBV survivors often have unstructured protective frameworks of their employees. The lack of access to resources on mental health, competing priorities and budget constraints are major obstacles to holistic wellness programs (Hlahla, Mupa and Danda, 2025). What is more, the organizational cultures within the nonprofit sector tend to promote self-sacrifice and resilience in a manner that stigmatizes the behaviors of seeking help and normalizes burnout as an inseparable part of mission-driven employment.

The present pragmatic trial will fill these gaps by assessing a multi-component wellness and supervision bundle mentioned specifically to GBV first responders among various community-based organizations. The intervention incorporates evidence-based methods in the fields of mental health, organizational development and implementation science to develop a sustainable, contextually sensitive method in staff protection. Through the use of the stepped-wedge design, this study is not only evaluating the effectiveness of the intervention, but also produces important implementation information to inform wider dissemination activities in the GBV response sector.

2. Literature Review

2.1. Vicarious Trauma and Occupational Hazards in GBV Work

Vicarious trauma is an idea developed out of clinical observations of therapists who were dealing with survivors of trauma, which was the realization that exposure to traumatic accounts produces unique psychological effects in addition to the more common stress or burnout. Vicarious trauma presents itself as intrusive thoughts, hypervigilance, emotional numbing, and disturbed safety, trust, and control beliefs (McNeillie and Rose, 2021). These symptoms are similar to those of the primary traumatic survivors, which is a reflection of the depth of secondary exposure.

Studies of GBV workers directly have reported that post-traumatic stress symptoms, depression, and anxiety are higher than general population rates and other helping professionals (Gathi, 2023; Millan-Alanis et al., 2021). The cumulative and chronic characteristics of exposure to trauma in GBV work cause some specific vulnerabilities. The first responders are exposed to many traumatic stories on a daily basis unlike those who have suffered a single incidence and may not have enough time to recover between exposures. More severe and persistent trauma symptoms have been associated with this pattern of chronic exposure.

Personal trauma history, empathic capacity, the level of professional experience, and coping strategies used are individual risk factors of vicarious trauma (Gathi, 2023). Nevertheless, organizational influences tend to have as much or more impact on the wellbeing of the workers (Mupa, 2024). Poor supervision, peer support, high case loads, resource shortages, and organizational cultures which diminish self-care lead to the increased risk of vicarious trauma. On the other hand, organizations that have effective supervision systems, peer support systems, and clear wellness policies have low prevalence of secondary traumatic stress in employees.

2.2. Current Approaches to Staff Safeguarding

Vicarious trauma interventions have been based mainly on individual level interventions like self-care education, mindfulness training and personal therapy. Though useful, these strategies do not sufficiently consider the organizational and systemic processes which establish and support the circumstances of vicarious trauma. The strict

individual responsibility approach to wellness should be seen as a threat to place the psychological effects of the organizational structure and limited resources on the workers (Kalu-Mba, Mupa and Tafirenyika, 2025).

More detailed models put more focus on the organizational responsibility to develop trauma-informed workplaces that focus on the wellbeing of the staff as well as the services they offer to clients. Such approaches combine different levels of interventions such as supervision, peer support, organizational policies, and systemic advocacy (Owusu-Sekyere et al., 2022). Clinical supervision in its formal form has also proven especially protective against vicarious trauma in cases where it includes elements of the case consultation and emotional processing (Lawrence, Mupa and Adeoti, 2024). Frequent supervision offers the opportunity to workers to work with challenging feelings, to make trauma responses normal, and to establish effective coping mechanisms in a warm and constructive working relationship.

Another evidence-based practice of reducing vicarious trauma is peer debriefing. Horizontal support structures that supplement vertical supervision relationships are facilitated group sessions in which workers exchange experiences, confirm emotional reactions, and problem-solve together. Peer debriefing helps to eliminate isolation, develop team cohesion, and enables workers to learn about other workers and their coping mechanisms (Sucamele, 2021).

Mental health resources access is one of the most important but frequently disregarded aspects of staff protection. Most GBV employees are aware that they require professional assistance but are highly disadvantaged by insurgency of costs, time, stigma, and the unavailability of providers who are culturally competent. Companies that develop clear referral channels, fund counseling services and normalize help seeking behaviors have better retention and wellbeing of workers.

2.3. Implementation Science in Organizational Wellness

Although there is evidence of different safeguarding practices, the implementation is still difficult in resource-depleted community organizations. Implementation science provides structures and approaches to the comprehension of the effective introduction, preservation, and expansion of the evidence-based practices in the resultant environment (Sarma et al., 2021). Among the essential implementation results are; acceptability, the level that stakeholders have towards an intervention as agreeable, feasibility the ability of an intervention to be successfully implemented under a certain setting, and finally fidelity, the level that an intervention has been successfully implemented as planned.

The literature on the use of wellness interventions in the nonprofit context has reported a number of facilitators and obstacles. Leadership commitment, sufficient allocation of resources, integration with the current working processes, and involvement of staff in the process of designing interventions are among the facilitators (Purnell, 2025; Jaramillo et al., 2023). The barriers encompass conflicting organizational priorities, employee turnover, unstable funding as well as organizational cultures that are resistant to change or downplayed the issue of wellness. These contextual factors, in conjunction with the nature of the intervention content, need to be attended to in a long-term fashion to accomplish successful implementation.

The stepped-wedge design has some specific advantage of practical implementation experiments in communal contexts. This design will enable all the participants to receive the intervention eventually and create rigorous comparative data. The planned rollout also allows learning and adaptation with the implementation taking place in different sites in an iterative way. The stepped-wedge design is also an option to the traditional randomized designs that helps to ensure the scientific rigor, particularly in cases where an organization lacks enough resources to apply interventions simultaneously (Nguyen et al., 2022).

3. Methods

3.1. Study Design

This feasible trial used a stepped-wedge cluster randomized study to compare a wellness and supervision bundle in six community-based organizations that delivered GBV services. The stepped-wedge study design implied the gradual implementation of the intervention in a preprogrammed time interval, and organizations were randomly selected according to the time of starting intervention. This design provided all involved organizations with the ultimate receipt of the intervention and it was also capable of making rigorous comparison of the period of intervention and control (Li et al., 2021).

The research was going on during eighteen months, 6 three-month blocks. Organizations were placed in a control condition and shifted to intervention condition in their randomized order. The intervention of period two was initiated

by one organization and then followed by other organizations after three-month intervals. In period six, every organization got the intervention implemented. The design offered numerous measurement points and pre-and post-intervention initiation of every organization.

3.2. Participants and Settings

This trial involved six community-based organizations dealing with GBV victims. The organizations were diverse in terms of size, geographic location, population served and service model to increase the generalizability. The organizations that were involved consisted of domestic violence shelters, sexual assault service centers, community advocacy programs, and integrated health and legal services providers. Companies catered to different groups of people such as the urban, suburban and rural groups with different demographic traits.

In these organizations, ninety seven first responders were the study participants. The requirements to participate were to be a staff member or volunteer who directly serves GBV survivors, which includes counselors, advocates, and case managers, hotline workers, legal advocates, and medical advocates. The audience was made up of different professionals, levels of experience, and personal traits, which were more representative of the GBV workforce in general.

3.3. Intervention Components

The wellness and supervision bundle comprised three evidence-based elements that were expected to work together to minimize vicarious trauma and enhance the wellbeing of workers.

3.4. Structured Supervision

All involved first responders were given sixty minutes of individual follow-up sessions after every two weeks. Supervision was based on a standard procedure that dealt with case consultation, skill development, emotional processing, and self-care planning. Supervisors were trained in trauma-informed supervision practices in which they focused on emotional support and clinical guidance. The documentation of supervision sessions followed structured templates, which ensured that all the supervisors and organizations covered the same content.

3.5. Peer Debriefing

Monthly facilitated group peer debriefing consisted of four to six first responders in ninety minutes joint meetings. All of these sessions offered a formalized possibility to process challenging cases, exchange coping skills, legitimize the emotional experience, and establish collegial support. Debriefing sessions were semi-structured, comprising of opening check-ins, discussion of the case, emotional impacts, problem-solving (collaboratively), and affirmations. Debriefing sessions were conducted by external facilitators who had knowledge of group process and trauma work in order to uphold psychological safety and proper boundaries.

3.6. Referral Pathways

Organizations provided easy access to avenues through which first responders could access mental health services when required. This aspect involved the identification of culturally competent mental health practitioners, agreed-upon decreased costs, establishment of straightforward referral systems, and normalization of help-seeking conducted via organizational communication. The organizations had set aside specific funds to cover counseling expenses to employees in need.

3.7. Outcome Measures

Primary Outcomes The Secondary traumatic stress scale was the tool used to determine vicarious trauma based on a 17 item scale known as the Secondary Traumatic Stress Scale, which is a measurement of intrusion, avoidance, and arousal symptoms related to secondary traumatic stress. The Maslach Burnout Inventory-Human Services Survey was used to measure burnout through the dimensions of emotional exhaustion, depersonalization, and personal accomplishment. Both the instruments have been shown to possess excellent psychometric qualities in past studies that have involved helping professionals.

Secondary Outcomes Other results included job satisfaction using the Job Satisfaction Survey, organizational commitment using the Organizational Commitment Questionnaire and intention to stay with the GBV work using single-item direct questioning. These secondary outcomes helped to put into perspective the way vicarious trauma reduction could contribute to the larger workforce stability.

Implementation Outcomes The measure of acceptability was based on adapted Acceptability of Intervention Measure to be filled in by the participating first responders and organizational leaders. The intervention completion rates, session attendance and qualitative feedback were used to determine the feasibility. Fidelity was assessed based on the structured observation of randomly chosen supervision and debriefing sessions on the basis of standardized checklists based on intervention procedures (Matsebula et al., 2025).

3.8. Data Collection Procedures

Outcome measures were given at baseline, and then after three months in the course of the eighteen months study period. The surveys were filled electronically via an online system that was secure and the research personnel were present to offer technical support to the participants as required. An average assessment period was thirty to forty-five minutes to complete the survey.

The measures of implementation were gathered on a continuous basis during the intervention period. Organizational records were used to record the attendance of the sessions. Observations were carried out quarterly and two randomly selected sessions were observed in an organization at a time in the course of an assessment period. Each organization had acceptability measures that were done at six months and twelve months after the initiation of the interventions.

3.9. Data Analysis

Primary analyses used mixed-effects regression models that are suitable in stepped-wedge studies that take into consideration the clustering in organizations and a follow-up analysis in individuals. The models had fixed effects of intervention status, time period, and the interaction of the two, random effects of organization, and individual. This method of analysis was useful to get strong estimates of the effects of interventions and the complex correlation structure of the stepped-wedge design (Heagerty, 2021).

Results of implementation were evaluated based on the descriptive statistics and qualitative content analysis. Standard deviations and means were used to sum up the acceptability scores with comparisons between organizations and time points. The feasibility was measured with regard to completion and attendance rates in relation to established benchmarks. Fidelity was measured by determining percentage adherence to protocol components and examined the differences across organizations and time.

4. Results

4.1. Participant Characteristics

This trial involved 97 first responders belonging to six of the community-based organizations. The research sample was mostly female, a representation of the general GBV workforce of both genders. The ages between twenty-three and sixty-two years and the mean age of thirty-eight years were taken. The length of professional experience in GBV services were less than one year, and more than twenty years, with the median value of four years. Educational levels ranged between high school diplomas to doctoral levels with most of them having bachelors or masters degree in social work, psychology, counseling or other related fields.

4.2. Primary Outcomes: Vicarious Trauma and Burnout

There were also considerable decreases in secondary traumatic stress symptoms as indicated by the Secondary Traumatic Stress Scale in the intervention implementation. The estimation of the intervention effect showed that it was minimized by around eight points on the scale, which is a clinically significant change in vicarious trauma symptoms. The effect was observed in the first three months of intervention implementation and maintained during the research.

The results of burnout showed the same patterns. The scores of emotional exhaustion dropped significantly after the start of intervention, and it is estimated that emotional exhaustion subscale scores went down with an average of a six-point decrease. Effects were also smaller, but depersonalization reduced as well. The scores of personal accomplishment also improved indicating that workers felt more capable and more content with their work input after participating in the intervention.

Subgroup analyses were done to investigate differences in intervention effects by characteristics of the participants. The employees who had the lower experience levels reported slightly greater decreases in vicarious trauma symptoms, indicating that the newer employees might be the group in which structured assistance would be beneficial. Nevertheless, the experienced workers revealed significant improvements as well, which suggests the appropriateness

of the intervention at all levels of experience. There were no major differences revealed in terms of the size of an organization, its geographic location, or the model of service provided.

4.3. Secondary Outcomes

There was an improvement in job satisfaction with the intervention implementation as workers said that they were more satisfied with their supervision, relationships with coworkers, and work experience. The level of organizational commitment was also enhanced which implies that the workers felt closer to their organizations and the cause of GBV services. Notably, the proportion of intending to continue working in GBV also went up markedly with seventy-eight percent of the respondents indicating that they would work in the field at least three additional years as opposed to sixty-two percent at baseline.

4.4. Implementation Outcomes

4.4.1. Acceptability

The intervention was highly acceptable both to the first responders and the organizational leaders. The organizations had mean acceptability scores more than four out of five. Qualitative feedback exhibited in the appreciation of spending time dedicated to processing emotions, validating experiences, and gaining support. Other participants when asked about their concerns during the beginning of the intervention time commitment, reported that their concerns were reduced as they received the benefits of the intervention.

4.4.2. Feasibility

The rates of intervention completion were over eighty five percent in each of the components and the different organizations. The attendance of the supervision sessions was at an average of ninety two percent and the majority of the missed sessions were re-scheduled during the same period of assessment. The average attendance at peer debriefing was eighty-seven percent. Thirty four percent of the participants used the referral pathway component throughout the period of the study and all individuals who availed services cited the process as easy and helping.

4.4.3. Fidelity

Fidelity observations indicated that the intervention protocols were mostly observed. Supervision sessions had an average fidelity of eighty nine percent amongst observed components. The fidelity of peer debriefing sessions was eighty-three percent. The difference in fidelity across organizations was also not very high implying that the intervention could still be applied with reasonable uniformity even in the different organizational settings. The level of fidelity was also getting better with time because the supervisors and facilitators were familiarized with the protocols.

4.5. Barriers and Facilitators

Qualitative data sheds light on the factors that impact the success of implementation. The main enabling factors were effective leadership dedication as shown by the allocation of resources and the intervention training participation, and introduction of intervention elements in the prevailing organizational frameworks and not as an addition, and nurturing organizational cultures that expressly appreciate the wellbeing of the staff. Companies in which the leaders regularly talked about the importance of the intervention and practiced self-care exemplified greater participation and perceived benefits.

The obstacles were organizational priorities to competition especially in the times of crisis when the emergency service needs overrode prevention-based wellness programs, staff attr that necessitated continuous training and orientation of new employees, and the problem of funding that left questions on the sustainability in the long run. Those organizations which foresaw and strategised on these challenges were more successful in implementation.

5. Discussion

This practical experiment offers strong results that a wellness and supervision package might play a significant role in decreasing vicarious trauma and burnout among GBV first responders and have high acceptability and feasibility in various community-based organizations. The implications of these findings on organizational practice, policy and future research in the GBV response sector are important.

5.1. Interpretation of Findings

The presence of strong change in the symptoms of vicarious trauma that were used in this study is indicative of the fact that organizational interventions have the potential to significantly safeguard the wellbeing of workers provided that they are conducted in appropriately resourced and dedicated environments. The effect size of what was found, half a standard deviation decreased in secondary traumatic stress symptoms is clinically significant change which is probably translated into better daily functioning and quality of life among participating workers.

The effectiveness of the intervention could have been due to its multi-component nature. Ordered supervision offered individualized, regular, and consistent support, both in the area of professional growth and in the area of affect. Peer debriefing formed horizontal forms of support which alleviated the feeling of isolation and the normalization of trauma responses. There were well-defined referral routes that allowed the workers to obtain access to professional mental health services in cases where self-care was inadequate. These elements worked together to form holistic security at various levels of support.

The stepped-wedge design allowed measurement of the effects of interventions, and had the benefit of all organizations eventually receiving the intervention, and this overcomes the ethical issue of depriving control groups of potentially valuable services. The design also provided useful implementation data through the process of capturing the rollout process in various organizational contexts and time periods.

5.2. Implications for Practice

These results underpin a number of practical recommendations that should be made by GBV service organization in order to ensure that the workforce is safe. To begin with, companies ought to focus on organized supervision as a fundamental element of operations besides discretionary improvements (Deussom et al., 2022). Supervision takes specific time and has to have trained supervisors and organizational cultures that perceive supervision as something useful and not a burden. Supervisor training with the specific focus on the trauma-informed practice and emotional support along with clinical consultation seems justified.

Second, peer debriefing is an inexpensive alternative to individual supervision. Even though outsourcing facilitators in this research was crucial in terms of offering relevant expertise, organizations can consider internal facilitation models, but with the support and relevant training. Group format enables effective utilization of resources and fostering group cohesion and eliminating isolation.

Third, the organizations need to combat systemic mental health access barriers. Promoting self-care only without offering tangible resources and minimizing barriers to access will probably not work. Such factors as financial support, clarity in referral procedures, and organizational cultures that make help-seeking the norm all seem important when it comes to making workers obtain professional assistance when necessary (Auth et al., 2022).

5.3. Implications for Policy

The results of this research indicate that the policy should focus on workforce wellbeing within the GBV response sector. There must be clear funding mechanisms to support the organizational wellness infrastructure such as supervision, peer support and access to mental health. The existing funding models tend to focus on direct service delivery and overlook the staff support as a sort of administrative overhead that generates perverse incentives that do not amplify the sustainability of the workforce (Hlahla, Mupa and Danda, 2025).

The requirements of staff protection should be explicitly included in the accreditation standards and best practice guidelines of GBV service organizations. Regulatory agencies, funders, and professional bodies ought to work together to come up with a minimum standard of supervision requirements, availability of peer support, and access to mental health resources (Foglesong et al., 2022). These standards would establish accountability systems and would standardize such practices within the sector.

Limitations

These findings have a number of limitations that should be considered before their interpretation. To begin with, the research sample consisted of six organizations, which makes it difficult to make any generalizations about the entire universe of GBV service providers. Although organizations differed on different dimensions, other studies that cover a wider range of settings would enhance reliability in results. Second, the self-report measures may result in some form of social desirability bias, but this issue is partially defended by the use of validated tools with strong psychometric characteristics. Third, the eighteen months period though adequate in showing the initial success, does not deal with

sustainability in the long-term. Organizations might experience some problems in terms of sustaining intervention fidelity and resource allocation outside the study period.

5.4. Future Research Directions

There are a number of significant questions which arise out of this work. To begin with, intervening factors affecting long-term sustainability of organizational wellness interventions should be studied. Which organizational attributes, sources of finance, and approaches to leadership make it possible to have long-term implementation after the first trial stages? Second, resource allocation decisions and advocacy would be informed using cost-effectiveness analyses. Although this intervention proved to be effective, it would be beneficial to know its economic worth against the cost of turnover of workforce and the quality of services, which would advance the arguments in favor of its implementation.

Third, investigations are necessary on best dosage intervals and combinations of components of interventions. In this study, all three components of the interventions were applied at the same time yet there is a question on whether some of them are the ones that motivate and whether all of them are needed. Breaking down designs would help in clarifying the necessity against adding value elements. Fourth, exploration of ways of implementing that would speed up adoption in various organizations would facilitate the dissemination process.

6. Conclusion

The results of this practical experiment prove that a holistic wellness and supervision package can be effectively translated to minimize vicarious trauma and burnout in GBV first responders and can be acceptable and practical in a variety of community-based organizations. The results of this research can be used to support the evidence-based practice of organizations concerned with protecting their employees and simultaneously delivering quality services to survivors. The ethical requirement to protect the protectors is not just a matter of the personal health but also the quality of services, the survival of the organization, and much later the lives and health of the survivors of GBV. Workforce wellness is a key priority area that organizations, funders, and policy makers should focus on in order to have effective GBV response systems. The reasons herein demonstrated indicate that through proper dedication and allocation, the meaningful protection of first responders can be attained, which is more sustainable and efficient countermeasures to gender-based violence within communities.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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