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Addressing Secondary Trauma in Social Workers Counseling Trauma
Survivors

By

Karen James, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members

Catherine Marrs Fuchsel, Ph.D, LICSW

Jennifer Ranallo, MSW, LGSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study.

This project is neither a Master's thesis nor a dissertation.

SECONDARY TRAUMA IN SOCIALWORKERS

Abstract

Many individuals who seek therapeutic services from social workers have experienced trauma in their lives. Social workers who counsel trauma survivors may develop physical and emotional symptoms similar to those endured by their clients in a phenomenon known as secondary trauma. A qualitative study was done with 15 social workers exploring the risk factors for secondary trauma, its effects, and the measures that can be taken to prevent or respond to its manifestation. Themes found in participant answers included experiencing negative feelings, anxiety, not having enough time for effective self-care and needing support from others in the field. It is important for social workers to be aware of secondary trauma so they can recognize it happening in themselves and others. Findings in this study can help arm social workers with important self-care strategies and the awareness necessary to address secondary trauma.

Key Words: secondary trauma, trauma counseling, self-care

SECONDARY TRAUMA IN SOCIALWORKERS

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SECONDARY TRAUMA IN SOCIALWORKERS

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Addressing Secondary Trauma in Social Workers Counseling Trauma Survivors

In the last several years, working with trauma has become a major focus among social workers and other mental health professionals. A large number of clients seen for mental health concerns have experienced trauma in their lives. A variety of studies have been done on the effects trauma has on victims and how to effectively work through these experiences and consequences. Social workers often hear horrendous stories from trauma survivors and bear witness to the substantial consequences that remain in the clients' lives. Throughout this study, "social workers" and "therapists" are used interchangeably to refer to mental health professionals who counsel trauma survivors.

With the high amount of trauma victims social workers see, it is important to explore the effects traumatic stories have on the therapists who hear them. Even though the social worker did not experience the trauma, he or she is not immune to the negative mental and emotional consequences. As with all client-therapist relationships, there are varying degrees of countertransference that occur. Countertransference refers to the thoughts and feelings a therapist experiences in response to the client and the material he or she presents. With trauma therapy in particular, therapists are susceptible to taking on trauma-related symptoms in response to the stories they hear. This can be short term and immediate or become a long-term change in the social worker's internal belief system. One of the most serious effects providing trauma therapy may have on social workers has been called secondary trauma.

This is an important topic for clinical social workers to be aware of and explore. Most social workers will experience some kind of negative reaction to traumatic stories at some point in their careers. Social workers may also recognize these responses in other

professionals and coworkers. In order for clinical social workers to remain effective, they must pay attention to their own mental, physical and emotional health. Part of that is being aware of countertransference and how their minds process clients' experiences. Finding support and learning how to work through difficult personal stressors are vital in preventing social workers from burning out and leaving the field. With appropriate education, preparation and self-care, social workers can either avoid these serious reactions or address them if/when they occur.

It is important for therapists to be aware of the risks involved in diving deep into traumatic material with clients. Even more essential is figuring out what to do when difficulties come up in counseling others. One of the best ways a social worker can prepare for difficult trauma work is by understanding what other social workers have experienced and worked through. The purpose of this study is to explore those experiences and seek to understand the concept of secondary trauma on a personal level. The primary question asked is, "What is the internal experience of social workers counseling trauma survivors and how do they practice effective self-care to address negative effects such as secondary trauma?"

Literature Review

The purpose of this literature review is to develop an understanding of secondary trauma and related concepts based on existing research. The first section is an overview of trauma and its effects on survivors. Understanding trauma is important in order to appreciate the impact of counseling trauma survivors and to get an idea of how many social work clients have experienced trauma. After establishing an understanding of trauma, the next section explores and defines the effects counseling trauma survivors has

on social workers. The remainder of the review focuses specifically on secondary and vicarious trauma; discovering the symptoms, how it is measured and how prevalent it is, what the risk factors are and how it can be addressed.

Trauma

In the past few decades there has been an increase in large-scale traumatic occurrences around the world (Nuttman-Shwartz & Dekel, 2008). When these events occur, mental health responses make up only 1% of national disaster budget. However, grant awards for crisis counseling over years 2002-07 exceeded totals for the 30 previous years combined. This means there is an increased recognition that it is important to attend to psychological needs after disasters (Naturale, 2007). One way for survivors to address issues resulting from trauma is to see a mental health professional for trauma counseling. Trauma counseling is an effective intervention for natural disasters, human-caused trauma and personal trauma of various kinds (Bell, 2003).

Along with various other mental health professionals, clinical social workers are likely to work with clients who have experienced some kind of trauma. In one study, 98% of social workers reported that they currently counsel trauma survivors or have in the past (Kanno, 2010). In the general public, it is estimated that 40-80% of United States citizens will experience at least one traumatic event in their lifetime and 7-8% will be diagnosed with Post Traumatic Stress Disorder (PTSD) as a result (Bride, 2007). 84% of psychiatric inpatients and 82% of mental health outpatients report having been exposed to trauma (Bride, 2007).

Trauma can be defined in a variety of ways and depends on the perception of the individual who experienced it. The definition of provided in the Diagnostic and Statistical

Manual for Mental Disorders, 4th Edition, Text Revision is as follows:

Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response may involve disorganized or agitated behavior) (Criterion A2). (American Psychological Association, 2000, p. 463)

Traumatic experiences may include but are not limited to: witnessing violence, being in an accident, involvement in war, abuse, rape and witnessing a death. One person may view an event as traumatic whereas another person who experienced the same event may not be as severely affected. Labeling something as trauma is dependent on the stress suffered by the person involved. Following the initial stress of the traumatic event itself, a number of mental health symptoms may appear. Depending on the timeline, frequency, and number of symptoms, a trauma survivor may be diagnosed with Acute Stress Disorder or PTSD. Acute Stress Disorder completes its course within the first month following the trauma. PTSD is a longer-term diagnosis that severely impacts many areas of one's life.

A diagnosis of PTSD has six sections of diagnostic criteria. The first, as mentioned above, is the witnessing of a traumatic event. The second group of symptoms is characterized by the re-experiencing of the traumatic event. Some examples of

intrusive re-experiencing include dreams, flashbacks, hallucinations and intense psychological or physiological reactions to triggers (American Psychological Association, 2000, p. 468). The next collection of symptoms revolves around avoidance. Among others, symptoms include one avoiding thoughts about the event, an inability to remember important details, loss of interest in activities, feelings of detachment and a “sense of a foreshortened future”. The survivor will also display symptoms of increased arousal through sleep difficulty, anger, difficulty concentrating, hypervigilance or an exaggerated startle response. The final two diagnostic criteria state that the symptoms are not resolved within a month and cause “clinically significant distress” in “important areas of functioning” (American Psychological Association, 2000, p. 468). Treatment for PTSD can range from months to years.

Effects of Trauma Counseling on Social Workers

Many social workers find working with trauma survivors to be a rewarding experience. Participating in clients’ recovery can be satisfying and strengthening. Bell (2003) reported that a number of social workers reported feeling more compassionate, more grateful and less judgmental due to their work with trauma survivors. 40% of respondents in the same study reported that counseling trauma survivors had all positive effects on their personal lives. 10% believed the effects were all negative and 43% experienced a combination of both positive and negative effects (2003).

Social workers, even those who report feeling rewarded by their careers, are not immune to the negative effects of trauma. Social workers are affected indirectly by the trauma stories they hear regularly by clients. Indirect exposure to a traumatic event occurs when someone "happens to see the psychiatric symptoms, defenses, and raw

emotions that accompany someone else's psychic trauma" (Cunningham, 2003, p. 451).

Countertransference, compassion fatigue and burnout. The effects of mental health professionals constantly working with clients' emotionally taxing material have been explored numerous times throughout the last century. At the core of these effects is the concept of countertransference. Countertransference is the internal experience a therapist has during a counseling session in response to the client and what he or she talks about (Tosone, Nuttman-shwartz & Stephens, 2012). Countertransference is inevitable and can get in the way of therapy if it is not carefully monitored and addressed.

When countertransference is negative and begins to affect the therapist outside of counseling sessions it becomes a more serious issue. One such consequence of providing mental health therapy is called compassion fatigue. Compassion fatigue is "the formal caregiver's reduced capacity or interest in being empathic" or "bearing the suffering of clients" and is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (Adams, Figley & Boscarino, 2008, p.239).

The concept of burnout is similar to compassion fatigue. Burnout happens when a person experiences "psychological strain" from continued work with difficult populations. McCann and Pearlman list depression, cynicism, boredom, loss of compassion and discouragement as the symptoms of burnout (1990, p.133). Burnout is distinct from compassion fatigue in that it is not specific to trauma work, but is experienced in all direct-practice professions (Tosone, Nuttman-shwartz & Stephens, 2012).

Through the 90s, the job-related stress of working with trauma survivors has been

studied as compassion fatigue, burnout, secondary trauma and vicarious trauma (Bell, Kulkarni & Dalton, 2003). The terms are closely related and are often used interchangeably. According to Betts Adams, Matto & Harrington, some researchers assert that it is hard to distinguish between burnout and secondary trauma because assessment scores and measurements overlap (2001). Other studies have shown less correlation (Betts Adams et al., 2001). In the last decade, the distinction between burnout or compassion fatigue and secondary/vicarious trauma has been increasingly reinforced (Cunningham, 2003). While compassion fatigue and burnout are problematic amongst all types of social workers, there are specific effects that are unique to those who work with trauma survivors. These additional effects are collectively termed secondary trauma (Bell et al., 2003).

Secondary trauma. Secondary trauma has been defined as “disruptions of the therapist’s internal experience in reaction to repeated exposure to clients’ traumatic material” (Pearlman & Madan, 1995) as cited in (Betts Adams et al., 2001, p.364). Secondary trauma is different from primary trauma in that the therapist did not witness the traumatic event, but was affected by hearing about his or her client’s experience. McCann and Pearlman distinguish trauma therapy from working with other “difficult populations” because of exposure to “emotionally shocking images of horror and suffering that are characteristic of serious trauma” (McCann & Pearlman, 1990, p.131; Cunningham, 2003, p.452).

Working with trauma is especially complicated in that it “involves the interaction of the clinicians’ personal characteristics, including current life circumstances and personal history of trauma, along with the material presented by the client” (Pearlman &

Saakvitne, 1995 cited in Cunningham, 2003, p.452). In some cases, a therapist will be faced with shared trauma. This is a combination of primary and secondary trauma that occurs when social workers are exposed to the same traumatic event as clients. Examples include natural disasters, terror attacks, shootings, etc. (Tosone et al., 2012).

Effects of Secondary Trauma on Social Workers

Secondary trauma affects social workers across many areas of their lives. It is not simply a stressor that occurs during sessions or exclusively at the office. Much like trauma experiences that change survivors' lives, secondary trauma has a number of physical, psychological and relational effects on social workers. Although each person has a unique presentation of secondary trauma, the following section describes common themes present in existing literature.

Physical. Some of the most recognizable and noticeable effects of secondary trauma mirror the physical symptoms of PTSD. A variety of studies reported that social workers experiencing secondary traumatic stress suffer from overall physical tension, headaches, fatigue and feelings of heaviness (Bishop & Schmidt, 2011; Betts Adams et al., 2001; Naturale, 2007). The stress of hearing traumatic stories is also linked to nausea, eating problems, vomiting and other digestive problems (Bishop & Schmidt, 2011; Betts Adams et al., 2001). Sleep disturbance, crying, sexual difficulties and elevated blood pressure were reported by social workers counseling trauma survivors as well (Bishop & Schmidt, 2011; Betts Adams et al., 2001; Naturale, 2007).

Unfortunately, there are a few physical factors that exacerbate these negative consequences. The first factor is natural fluctuations in neuroendocrine and hormone systems that occur during sessions as social workers interact with clients. These

fluctuations pair physical reactions with the mental and emotional content and intensify the therapists' memories of client material (Adams et al., 2008). The second set of physical concerns that add to the physical responses are the poor health habits of social workers suffering from secondary trauma. For example, if a therapist is having difficulty with appetite and eating, it is possible that he or she is not getting the proper nutrition needed to keep the body healthy. Additionally, if he or she is having trouble sleeping and also suffering from feelings of heaviness, he or she is less likely to be physically active and maintaining a strong, healthy body (Bishop & Schmidt, 2011).

Psychological. The internal changes that occur as a result of trauma are arguably the most devastating consequences of traumatic stress (Cunningham, 2003). Social workers who counsel trauma survivors are vulnerable to experiencing psychological effects similar to those their clients endure. Even though the therapist is hearing of the trauma secondhand, hearing client stories can be an emotionally draining experience (Bell et al., 2003). Aside from the typical in-session reactions and reflecting what the client may be feeling, the therapist may internalize some of the emotions and transfer those feelings to life outside of his or her office. This can result in overwhelming negative feelings and an emotional imbalance for the therapist (Ting, Jacobson, Sanders, Bride & Harrington, 2005). These feelings may include irritability (Badger, Royse & Craig, 2008), grief (Betts Adams et al., 2001), anger, frustration and emotional pain (Bishop & Schmidt, 2011). If not attended to, the negative feelings can become more severe and the therapist may develop larger affect changes such as depression or anxiety (Naturale, 2007; Cunningham, 2003). If the therapist has a history including a psychiatric

diagnosis, symptoms may return even if they had previously been alleviated through therapy or other intervention (Naturale, 2007).

When a therapist is reacting to traumatic material, he or she may begin doubting his or her own capabilities. Bell reported that clinical social workers were highly critical of themselves in difficult trauma cases and began to doubt their work (2003). The therapist may get caught up in feelings of ineffectiveness or the fear of looking incompetent due to this insecurity (Bishop & Schmidt, 2011). Along with the fear of inadequacy, the therapist may experience a deepening of fear overall. This can range from a sense of vulnerability (Betts Adams et al., 2001) or feeling unsafe (Bishop & Schmidt, 2011) to hypervigilance (Ting et al., 2005) and more specific fears such as the fear of having people walk behind them (Bell, 2003). These fears may be easily connected to the client's trauma due to content similarity, but may also seem completely unrelated and surprising.

Similar to PTSD symptoms being split into three distinct categories, psychological secondary trauma symptoms can be divided into the groups "intrusive" and "constrictive" (Bell et al., 2003). The intrusive symptoms are defined as "distressing images and thoughts from client sessions that intrude on everyday life" (Betts Adams et al., 2001, p.366; Bride, 2007, p.64). Intrusive images may display as flashbacks or nightmares (Bell et al., 2003; Naturale, 2007). The therapist may also experience obsessive thoughts about the trauma or the client and feel that he or she can do nothing to stop the thoughts (Bell et al., 2003; Naturale, 2007). Constrictive symptoms are unhelpful ways a therapist may cope with secondary trauma. These include numbing, dissociation and avoidance of the client or situations that are reminders of the trauma (Bell et al.,

2003; Badger et al. 2008; Bride 2007). Like many trauma survivors, a number of social workers have fallen into the trap of substance abuse to deal with the intrusive symptoms or enhance the avoidance reaction (Hesse, 2002).

Relational. One of the major consequences of secondary trauma is its effects on relationships. Due to the psychological impacts and the decrease in trust, a therapist may experience strains in interpersonal relationships (Bride, 2007). As the therapist is more aware of power and control issues, he or she may unconsciously withdraw from personal relationships as a defense against experience trauma similar to what clients have shared (Bishop & Schmidt, 2011). This alteration in personal relationships can range from a general mistrust of others to rejecting intimacy and sexual advances from his or her partner (Bell et al., 2003; Bell, 2003).

The other side the therapist's relationship schema that suffers is the therapeutic relationship with a client (Betts Adams et al., 2001). Difficulties arise when the therapist is unable to separate his or her own experience from that of the client's. If the therapist is not emotionally present and healthy, he or she is not able to provide the best possible care for the client. If the therapist is unhappy with his or her job due to secondary trauma the quality of care decreases (Baird & Jenkins, 2003). Additionally, if symptoms are causing the social worker to miss work and have to cancel appointments frequently, clients do not receive the consistent support that is essential to the healing process (Baird & Jenkins, 2003; Bride, 2007). The therapeutic process can also be interrupted by the therapist moving on to a different position as high turnover is a secondary trauma consequence (Kanno, 2010).

In cases where the therapist and the client experience shared trauma, there may be a chance for mutual reparation and growth. However, there is also a risk of boundary confusion where the therapist loses sight of his or her professional role. Additionally, the therapist may assume that the client experienced the event the same way he or she did and has the same feelings about it (Tosone, et al., 2012).

Vicarious trauma. Despite variations in the literature, vicarious trauma can be viewed as a more long term form of secondary trauma. Much of the related research from the 21st century cites the definition provided by Pearlman and Saakvitne in the early 1990s (Bell et al., 2003; Baird & Jenkins, 2003). “Vicarious trauma is the transformation that occurs in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ ‘traumatic materials’.” Vicarious trauma is unique from standard secondary trauma, which focuses on sudden onset PTSD symptoms, in that it consists of gradual permanent changes in the therapist’s cognitive schemas (Bishop & Schmidt, 2011; Bell et al., 2003; Baird & Jenkins, 2003). Cognitive schemas, according to Bowlby, are mental systems that “organize experiences and information to function effectively in a complex, changing environment. The schemas built around “self and others” are based on 5 areas of psychological need: safety, trust, esteem, control and intimacy (Baird & Jenkins, 2003; Cunningham, 2003). Over time, the therapist adapts his or her beliefs and schemas to find meaning in new information (Bell, 2003).

Vicarious trauma happens as painful images and emotions shared by clients become incorporated into the social worker’s memory system (Baird & Jenkins, 2003). This collection of destructive material can negatively impact one’s worldview to the point where the world is deemed “unsafe” and “people are bad” (Bishop & Schmidt, 2011).

The social worker may feel that victims and helpers are powerless because bad things are bound to happen because of the dangerous world. Instead of viewing others in a positive light, one experiencing vicarious trauma may not trust others because of a negative focus on the human capacity for evil, power imbalances and a lack of control (Betts Adams et al., 2001; Bishop & Schmidt, 2011). Vicarious trauma also results in disturbances in beliefs about selves, such as feeling a lack of personal accomplishment, and gets in the way of personal and intimate relationships (Betts Adams et al., 2001). Not surprisingly, Cunningham reported that the schemas of safety, other-trust, and other-esteem are more impacted by human-caused trauma than natural trauma (2003).

Overall, secondary trauma and vicarious trauma are closely related concepts. Because they are nearly indistinguishable from one another, it can be said that vicarious trauma is the long-term manifestation of secondary trauma. Moving forward in this study, secondary trauma, secondary traumatic stress and vicarious trauma will be used interchangeably. Secondary trauma will be most closely studied because of the ability to measure and track symptoms. The gradual changes moving unresolved secondary trauma into vicarious trauma are hard to separate and measure independently.

Measuring Secondary Trauma

For a number of reasons such as evidence-based practice and acquiring insurance funding, the mental health field relies on the medical model of diagnosing a problem and finding a solution. One way to do that is to test symptoms and progress using measurement scales. Another method is assessing for symptoms meeting diagnostic criteria listed in the DSM. Since Secondary Trauma is not an official diagnosis, there is not a set of diagnostic criteria available, so measurement scales are more useful. Results

from a measurement scale can help determine whether secondary trauma is really the issue or if something else with similar symptoms is interfering. Having a standard, measurable diagnosis is also helpful in estimating the prevalence of secondary trauma and the success of interventions implemented.

Scales measuring secondary trauma. Historically, there have been a number of different tests and scales used to define and measure the effects of secondary trauma. The initial scales used were the Impact of Events Scale and the PTSD Symptom Scale (Ting et al., 2005). Although neither was intended to measure secondary trauma in therapists, they were both used to investigate the presence of PTSD symptoms experienced by therapists. In the mid-1990s, Figley introduced the Compassion Fatigue Self-Test (Kanno, 2010). While this and other scales are helpful in measuring how clinical practice in general affects therapists, they are not specific to trauma therapy.

The current scales used to measure secondary trauma are the Secondary Traumatic Stress Scale (STSS) and the Traumatic Stress Institute Belief Scale (TSI-Revision L) (Kanno, 2010; Betts Adams et al., 2001). The STSS was first introduced in a 2004 study by Bride, Robinson, Yegidis & Figley. It is designed to measure symptoms similar to PTSD, but focuses on the effects of hearing someone else's trauma rather than experiencing personal trauma (Kanno, 2010). The TSI-Revision L is intended to measure "disturbed cognitive schemas theorized to relate to an individual's exposure to personal traumatic experiences, and/or client traumatic material" (Betts Adams et al., 2001). The TSI-Revision L is geared toward the long-term effects of vicarious trauma and is less widely utilized and studied.

Secondary trauma statistics. The above scales have been used in studies by a number of researchers in the last 15-20 years. Although the results have been varied, each study presents significant findings regarding the prevalence of secondary traumatic stress among social workers. According to a study done by Kanno, it is estimated that between 50 and 70% of social workers acknowledge experiences of secondary trauma, display symptoms or qualify for at least one core symptom criterion of PTSD at some point in their careers (2010). Another study proposes that approximately 38% of social workers experience “moderate to high levels” of secondary trauma (Bell et al., 2003). These studies show that secondary trauma in its varying levels of severity affect the majority of social workers who counsel trauma survivors.

Since secondary or vicarious trauma is not a formal diagnosis, it is sometimes measured under the umbrella of PTSD because of its widely accepted definition and measurement. A 2008 study of hospital social workers found that 15% met criteria for a full diagnosis of PTSD from their work with trauma survivors (Badger et al.). Twenty percent did not meet the entire diagnostic criteria, but met the criteria in two of the symptom areas. In a similar study done the same year that focused on compassion fatigue in social workers responding to urban disasters, it was reported that 15% of social workers meet criteria for PTSD and 19% meet criteria for a diagnosis of depression (Adams et al., 2008). With these examples among other studies that found approximately a 15% occurrence of diagnosable PTSD, it is estimated that social workers are nearly twice as likely to experience PTSD as the general public which has a lifetime rate of 7.8% (Bride, 2007).

Future measurement and research. Due to limitations in previous studies and current measurement scales, further research is necessary to determine how to effectively measure secondary and vicarious trauma. Although the STSS is a valuable tool in collecting quantitative data on a variety of symptoms, it is not specific enough to be considered the ultimate measure of secondary trauma. A study done on the validity of the STSS reported that it isn't necessarily able to discriminate between secondary trauma, PTSD and depression because all three may be linked to both avoidance and intrusion (Ting et al., 2005).

Conversely, some researchers propose that there shouldn't be an objective standard to measure stress or coping because all individuals experience both in unique ways (Bell, 2003). Therefore, qualitative studies are just as valuable, if not more valuable, in exploring the effects of secondary trauma. It is important to understand the experience of secondary trauma for the social worker and not just measure the prevalence of the concept and the symptoms.

Risk Factors Involved in Secondary Trauma

Not all social workers who counsel trauma survivors are equally as likely to suffer from secondary trauma. Those who are new in the field are more vulnerable; especially in the first 6 months on the job (Betts Adams et al., 2001). Based on separate studies in 2003, Bell et al. and Baird & Jenkins agree that secondary trauma is more prevalent among younger social workers and those with less experience working through trauma. No matter the age or experience of the therapist, there are many other factors that influence one's likelihood of bearing the burden of secondary trauma.

Personal influences. A number of risk factors for secondary trauma are specific to each individual social worker. Existing literature suggests that certain events in one's history, especially if mental health related, may increase the risk of secondary trauma experiences. Additionally, social workers currently under high levels of stress in their personal lives may be at risk depending on their ability to cope.

Past experiences. One of the most studied risk factors involved in secondary trauma is the social worker's past experiences. Conflicting studies have been published. Some researchers stress that therapists who have a personal history of trauma are more likely to experience secondary trauma whereas other studies have found there to be no difference (Betts Adams et al., 2001; Bell et al., 2003; Bell, 2003). If the social worker happens to be in therapy to address trauma issues, he or she is likely to be more affected by clients' traumatic stories (Betts Adams et al., 2001). The type of trauma experienced by both the therapist and the client may also help determine the likelihood of secondary traumatic stress. For example, a study by Baird & Jenkins (2003) found that social workers who have been assaulted have increased secondary trauma when working with clients who were assaulted or abused. This could mean that certain types of trauma are more painful for therapists to work with or that it's more difficult when the therapist has experienced a similar situation as the client.

Apart from trauma, it is possible that therapists who have previously experienced a mental disorder are more vulnerable to secondary trauma (Naturale, 2007). The therapist may be unable to cope as well due to the stress of hearing the traumatic stories and may re-experience symptoms that have been under control since previous episodes. Related to trauma and other diagnoses, "wounded practitioners" who practice in an effort

to heal their own wounds are at risk for secondary traumatic stress as they seek to have their needs met through working with others who are vulnerable (Tosone, et al., 2012). These therapists have more difficulty setting firm emotional boundaries and may take on the stress of clients along with their own. Similarly, some social workers' self-worth is dependent upon helping others or being a caretaker. This increases vulnerability due to the lack of immediate change in trauma therapy and the need to solve others' problems (Bride, 2007).

Current stressors. Social workers are more susceptible to secondary trauma when they are stressed. Although any kind of personal stress can add to secondary traumatic stress, published literature points to certain examples that may be most influential. For example, social work students are vulnerable to experiencing secondary trauma in their field placements due to the stressors of being new to the field and still training along with the added stress of schoolwork, additional jobs, etc. (Nuttman-Shwartz & Dekel, 2008). Another group of social workers at risk are those from lower social economic status and other disadvantaged groups (Adams et al., 2008). These therapists have many other life stressors that compound on the stress of hearing client trauma.

No matter what the current personal stressor may be, the therapist's reactions are more influential on secondary trauma risk. For example, some people have a tendency to react emotionally without problem-solving due to having role models that did the same (Bell, 2003). If a therapist reacts more emotionally, he or she may react more strongly to traumatic material than those who take a step back and process before reacting. Therapists who are not equipped with effective coping skills are susceptible to secondary traumatic stress because they are unable to deal with the internal experiences they have

(Bishop & Schmidt, 2011). One common example of this is one's tendency to keep emotions and struggles to oneself so as to not appear incompetent. Internal and personal stressors may be more of a risk than work related stressors and other factors. It is harder to listen to clients' problems when the therapist has so many of his or her own in mind (Bell, 2003).

Job related influences. Social workers are at risk for experiencing secondary trauma simply by being social workers. Many studies have been done that emphasize the difficulty of helping others work through their most challenging life situations. Social workers dive deep into emotional material with clients on a daily basis. Apart from working with clients, social workers may experience stress caused by the agencies they are associated with. If agencies are not supportive and make unrealistic expectations, some social workers may be more stressed than others and experience a higher rate of secondary trauma.

Empathic engagement. Many researchers agree that the social worker's empathy plays a role in developing secondary trauma. During sessions, social workers must "walk an internal tightrope between empathic connection with patients and emotional separation" (Badger et al., 2008 p.70). Clients present with horrific stories and sometimes have physical marks of violence as well (Bishop & Schmidt, 2011). The trauma content along with interventions such as role playing and the normal occurrence of dramatic reenactment in session can have a profound personal effect on the therapist (Adams et al., 2008). For this reason, it is essential that the therapist establishes boundaries separating oneself from the client. If boundaries are not firmly in place, it is likely that the social worker will attach to and carry client issues due to empathic

engagement (Badger et al. 2008; Bell, 2003; Bishop & Schmidt, 2011; Cunningham, 2003). Overidentifying with clients may interfere with ability to recognize one's own stress until it becomes much more difficult to manage (Naturale, 2007). This along with the isolation of providing therapy and the stress of working with difficult clients contributes to burnout and the likelihood of secondary traumatic stress (Cunningham, 2003). All these factors can be especially devastating if the social worker has no awareness of the possibility of secondary or vicarious trauma (Bishop & Schmidt, 2011).

Organizational features. Not all secondary trauma risks are within the individual social worker. In fact, the organization or agency characteristics may be the strongest predictor of secondary traumatic stress if there is a lack of work group support, role ambiguity, demanding expectations and other weaknesses (Badger et al., 2008). Secondary trauma increases with increased work stress due to job demands along with bureaucratic and administrative factors that heighten expectations and individual responsibilities (Cunningham, 2003; Bishop & Schmidt, 2011). Having trauma victims as the majority of one's caseload is especially influential in secondary trauma (Bell et al., 2003; Baird & Jenkins, 2003; Adams et al., 2008). If the environment is especially fast paced, such as in a hospital, there may be little to no time to process and the social workers carry the stories with them and they keep adding up (Badger et al., 2008). Related to internal processing, if there is a lack of group support and inadequate resources, the social worker is more vulnerable (Adams et al., 2008). Additionally, poor clinical supervision forces the therapist to either seek out their own resources or keep his or her reactions internal and dwell on them (Badger et al., 2008; Bishop & Schmidt, 2011).

Addressing Secondary Trauma

The first step in addressing secondary trauma is awareness. Research studies completed in the last few decades have raised awareness among mental health professionals and students. More research is needed to explore more detailed and personal manifestations of secondary trauma in order to understand how it affects people. With that, it is also important for those who have had these experiences to share with colleagues and other trusted supporters. The more secondary trauma is talked about, the more awareness there will be. Talking about secondary trauma without judgment and pathologizing can normalize the reaction and provide hope for healing. Many outside the field of social work are not informed about the negative impact that hearing others' stories can have on trauma therapists. An increase in public awareness would help equip society in supporting both trauma therapists and trauma survivors alike.

Trauma education. Preparation for working with trauma survivors begins when a social worker is in school. Social workers learn about countertransference, compassion fatigue and how being a helper can shape their lives. Students build up a “professional shield” as they are informed and provided with necessary skills (Nuttman-Shwartz & Dekel, 2008). It is important for students to learn specifically about trauma as they are building their foundation of knowledge for future practice. In trauma- specific courses, social workers learn that trauma not only has specific damaging effects on survivors, but can also affect the therapist hearing about it (Bell et al., 2003). Naturel suggests that reading case studies is essential in the educational stage because they provide realistic examples, evidence-based interventions, and real outcomes (2007). Knowing how others have dealt with secondary trauma can equip social work students with tools to address

secondary trauma in themselves and others in the future. Professors at Sapir College in Israel highlight the importance of preparation and ongoing experience-processing when a student is in a field placement; especially if he or she is working with trauma (Nuttman-Shwartz & Dekel, 2008). The expectation for social workers to engage in continuing education keeps practitioners updated on the latest research and provides a defense against secondary trauma (Baird & Jenkins, 2003).

Organizational interventions. Just as many of the risks of secondary trauma are related to the agency or organization a social worker is a part of, several of the most effective interventions are at the organizational level as well. The agency is where the social worker spends much of his or her time and is the force that guides how he or she practices. Agencies that employ social workers have a responsibility to put policies and procedures in place that support their employees and effectively address secondary trauma.

Critical incident interventions. One area in which an agency can support its social workers is debriefing after critical incidents occur (Bell et al., 2003). Social workers may be called in to assist with traumatic events as they are happening. For example, many social workers responded to the terror attacks on September 11, 2001. It is essential for the team to process through their reactions and what happened in order to continue helping others. One way to facilitate this process is to follow the formal Critical Incident Stress Debriefing that many emergency responders engage in after crises (Naturale, 2007). This model includes group processing, narrative forming, education, and assessment, and then follows up with referrals when needed. Part of the processing

includes discussing what it will be like to “return to normal” as time goes by and the incident is no longer the main focus (Naturale, 2007).

Ongoing education on trauma. In most cases, a social worker is more likely to work with individual trauma than large-scale disaster relief. Therefore, agencies must be proactive and provide ongoing support rather than waiting for crises to arise before responding. Part of this support occurs at the front end when a social worker is hired. If employees at the agency are likely to be exposed to traumatic material, it is beneficial for the social worker to be aware of the possible effects they may endure. Secondary trauma is less likely to occur when the social worker is aware of the possibility of it occurring. Cunningham says, “Trauma work should be an informed choice” (2003, p.457). Since social work practice is an ongoing learning process, agencies ought to provide ongoing training and psychoeducation (Naturale, 2007). A few ways organizations can provide ongoing education include sending employees to trainings, providing in-service trainings, sending out bulletins with pertinent information, openly explaining policies and holding discussion meetings (Bell et al., 2003; Cunningham, 2003).

Group interventions. Part of addressing the possibility of secondary trauma and providing support to social workers is an agency encouraging and facilitating group cohesion. Organizations can do this by promoting social interaction such as celebrating an employee’s birthday with a card or scheduling events in which coworkers can interact outside of the workplace (Bell et al., 2003). More formally, the agency can encourage peer support groups and structured stress management (Bell et al., 2003; Naturale, 2007). Group cohesion can foster a sense of support among colleagues. A safe environment can be created in which social workers feel comfortable talking about experiences, receiving

feedback and voicing challenges or concerns without the fear of judgment (Bell et al., 2003; Cunningham, 2003).

The culture of the organization largely impacts the risk of secondary trauma. Agencies with more positive attitudes and outlooks are most supportive. According to Bell, a supportive agency culture “encourages long view perspective, celebrate small successes, points out instances of life-enrichment, takes counselor’s experiences seriously” and focuses on healing rather than labeling those affected by secondary trauma or other difficulties (2003, p.468). Another part of positive organizational culture includes valuing the social worker as a person and promoting self-care instead of creating unrealistic expectations and judging the worker by number of cases open or hours of overtime worked in a week. Management can encourage self-care by: sending memos with self-care ideas, encouraging and supporting workers to take breaks, providing books and other resources, group membership discount at a gym, allowing for time off, sharing success stories and providing positive reinforcement (Bishop & Schmidt, 2011).

Responding to the individual. Apart from the policies and procedures that support the agency employees as a group, it is important for the agency to address secondary trauma and its potential in each individual. One way an agency can do this is to provide social workers with self-assessment tools and encourage their usage (Naturale, 2007). The agency can help its employees evaluate their susceptibility to secondary trauma and become aware of effects that may be occurring. If a social worker begins feeling vulnerable to secondary trauma, the agency can help in a number of ways. These interventions can include providing counseling resources and allowing paid time off for self-care. The agency can also help diversify caseloads and work activities by providing

opportunities for social workers to do research, education, outreach, etc. (Bell et al., 2003).

Studies widely emphasize supportive supervision as the most essential organizational intervention in secondary trauma (Betts Adams et al., 2001; Bell et al., 2003; Naturale, 2007). This may include group supervision where processing happens as a group, but individual supervision is the larger necessity. In individual supervision, a social worker can talk with his or her supervisor about personal reactions to client material and how his or her practice is affecting life outside of work. When the supervisor is viewed as trustworthy and supportive, the social worker can be open about experiences working with clients as well as more personal vulnerabilities and struggles. Naturale suggests that structured supervision can be especially helpful because the supervisee is expected to present successes as well as difficulties, which makes it easier to ask for help. This expectation builds in the opportunity for support and education while easing feelings of shame, fear and disorganization in the social worker (2007). The supervisor provides individualized attention, assures best-practice and helps process ideas for individuals addressing secondary trauma. Effective supervisors show support, positive reinforcement and encouragement while normalizing individual reactions to trauma.

Personal interventions. Whether or not an organization provides a social worker with interventions and defense against secondary trauma, it is vital for the social worker to practice good self-care and address secondary trauma individually. Although each individual's experience is different, there are several concepts that provide a foundation for secondary trauma personal intervention.

Attitude and perspective. The strongest defenses against severe secondary trauma reactions are internal. The attitude and lens through which a social worker views clients and trauma influences how he or she internalizes the experience. A sense of hope for the client and feeling effective in helping are important concepts in maintaining a positive attitude and energy. One way in which a social worker may sustain the positive attitude is by seeing trauma work as “planting seeds” in the client’s life rather than measuring success by dramatic changes (Bell, 2003). It is important for the social worker to feel competent in his or her role, but to not measure self-worth by the ability to drastically change or “fix” clients’ lives (Adams et al., 2008). Another helpful perspective is to look at the client’s strengths. Instead of focusing on the terrible things that have happened to a person, the social worker asks, “What are the strengths that have helped this person survive?” and seeks to build upon those strengths (Bell, 2003, p.513). There is less of a burden on the therapist in this strengths-based approach in that he or she is no longer the expert expected to fix one’s problems, but is a collaborator exploring solutions with the client.

An additional attitude-related concept related to secondary trauma is motivation. Bell reports that maintaining objective motivation in working with trauma is an important defense (2003). If a social worker’s motivation is too personal, such as to heal his or her own wounds, the risk of secondary trauma multiplies. More objective motivation could be along the lines of desiring to help others or make a difference in the world. This objective motivation is important both when first beginning to practice social work and throughout one’s career.

Actions. As self-care is essential in helping professions, there are certain steps a social worker should take in order to remain healthy and able to counsel others. The basic foundation of self-care is for the social worker to make a commitment to self-assessment and awareness (Badger et al., 2008). This means that he or she is constantly looking out for problem areas and vulnerabilities. As the social worker is continually assessing oneself, he or she finds personal and social supports to remain strong in difficult cases (Bell, 2003). Although the list of healthy self-care coping skills could be endless, there are a few foundational physical, social and spiritual recommendations to build upon. These include maintaining a healthy diet, physical exercise, balancing work and play, rest, spiritual replenishment and building social networks (Naturale, 2007). Studies have concluded that there aren't specific coping methods that must be used in secondary trauma, but it is most important that the social worker feels successful in his or her ability to cope (Bell, 2003).

If a social worker does not have adequate coping skills to address vulnerabilities or if the effects of secondary trauma start to become intense, it is essential for the individual to ask for support. Realistically, unless there are noticeable external signs, others may not realize that an individual is struggling (Bishop & Schmidt, 2011). Reaching out for support begins with one's closest supports and social network and extends outward to more structured interventions. Apart from addressing secondary trauma at work, it may be helpful for the social worker to attend therapy (Naturale, 2007). Personal therapy is important for social workers who have experienced pre-existing conditions and are either re-experiencing symptoms or are still working through concerns. When a social worker resolves his or her own trauma experiences and other

mental health concerns, he or she may become a more competent and confident helper (Bell, 2003).

Conclusion of Literature Review

Research shows that listening to traumatic client stories can have a long lasting impact on the lives of social workers. While there are many positive results, it is vital that social workers be aware of the possible negative effects of trauma work as well. The strain of doing hard therapy work, the difficulty of hearing traumatic stories and normal life stressors make social workers vulnerable to compassion fatigue, burnout and secondary/vicarious trauma. In order to address the problem of secondary trauma, social workers need to take it seriously and actively practice effective self-care. Agencies develop policies that offer social support, educate employees and emphasize the importance of stress management (Kanno, 2010). Secondary trauma may not be preventable, but the impact can be lessened through skills, support, education and intentional interventions (Bishop & Schmidt, 2011).

There is a need for additional qualitative research in the social work field to understand secondary trauma. While it is important to know the theories around the risks, symptoms and interventions, real-life stories provide the most in-depth insight and understanding. Everyone has unique experiences and talking about them can help social workers struggling with secondary trauma by normalizing the reaction and assuring the person that he or she is not “going crazy” (Naturale, 2007). Sharing success stories can help social workers know how to handle secondary trauma. A deep understanding of secondary trauma interventions can shape the future of successful trauma counseling.

Conceptual Framework

One of the lenses used to view this research project is that of the strengths perspective. Moving forward from the literature review, the focus is on finding out what individual social workers have as resources to address issues of secondary trauma. This perspective assumes that the social worker views a client as doing the best he or she can in the given circumstances. The client is treated as a survivor, not as someone diagnosed with PTSD. The social worker and the client work together to move forward in a positive direction rather than focusing on the bad things that have happened and their consequences. The focus is on moving forward and getting through the difficult time rather than diagnosing the problem and providing a remedy. The social worker and client do not dwell in “what’s wrong” but hold on to “what’s right”.

The strengths perspective is not exclusive to working with clients, but is a general shift in outlook and one’s worldview. With the strengths perspective being all-encompassing, it can easily be applied to the social worker’s experience in a way that mirrors working with clients. When a social worker is struggling with secondary trauma, he or she is not failing but simply in need of extra support. The strengths perspective helps supporters provide the individual with resources and doesn’t shame him or her. Because of the focus on one’s strengths, the social worker will be empowered and his or her self confidence in fighting secondary trauma will be boosted. Additionally, there aren’t interventions that are set in stone, but each person is unique and has different positives to offer. This means that all social workers suffering from secondary trauma can heal if they employ the strengths they already possess.

The other lens used by the researcher in this study is trauma theory. Common trauma theories assume that there are certain internal elements that the majority of traumatic experiences have in common. Experiencing trauma changes pathways in the brain of the survivor so that he or she responds to stressors in different ways than before the event. The same can be said about the social worker who counsels the survivor. When he or she takes on the emotions and trauma responses of the client, the social worker may be rearranging his or her own brain pathways to adapt to the possibility of trauma as well.

One of the mental changes that affects trauma survivors is in the internal alarm system. After experiencing trauma, one's alarm system is hypersensitive to stressors. The person reacts quickly to stimuli rather than thinking through what is happening. When a stressor is presented, the individual may automatically fight against it, withdraw and avoid it, or freeze and not be able to respond at all. Closely related to the sensitive alarm system is that of learned helplessness. Although most people naturally have a drive to be successful despite hardships, trauma may change one's viewpoint in such a way that he or she automatically assume that bad things will happen and there is nothing that can be done about it (Bloom, 1999).

There are a few trauma-related concepts that make trauma counseling especially difficult and stressful for the social worker. One involves the survivor's memories surrounding the traumatic event. In some cases, especially those involving complex trauma that happens over time, the survivor may not remember the traumatic experience. The trauma may have been too painful to integrate into conscious memory, so the individual dissociated it (Bloom, 1999). It may take a lot of exploration work for the client and the social worker to locate the intrinsic memories and figure out what

happened. Even when a client is able to remember the traumatic event, important details may be forgotten or remembered incorrectly. Similarly, a social worker suffering from intense secondary trauma may falsely remember the traumatic story as happening not to the client but to the social worker (Bloom, 1999).

Another difficulty related to trauma is the survivor's tendency to reenact elements of the trauma by subconsciously creating situations that evoke the same feelings they experienced. This can create senses of familiarity and control or validate one's negative expectations. Reenactment often occurs in the therapeutic setting as the social worker is there to challenge the automatic thoughts and explore client reactions with him or her. Getting caught in the cycle of reenactment not only is unhelpful for the client, it can also be draining and contribute to secondary trauma if the social worker doesn't recognize it (Bloom, 1999).

Methods

Research Design

This research is a qualitative study that was carried out through the use of an electronic questionnaire. Qualitative studies explore personal experiences of a small sample of participants in order to get a comprehensive understanding of a subject (Hsieh & Shannon, 2005). The questionnaire used in this study consisted of open-ended questions that prompted the respondents to talk about their experiences with counseling trauma survivors. Many studies done in the last twenty years have focused on the prevalence, risks and symptoms of secondary trauma. While these studies have established the existence of secondary trauma and a definition of symptoms involved, there is a need for additional qualitative data to provide further understanding. Qualitative

data collected through personal stories informs readers what cases of secondary trauma look like in real people. Explaining how social workers have dealt with secondary trauma in the past provides evidence supporting the effectiveness of various interventions others could use in the future.

Sample

Survey respondents were gathered through snowball sampling. The researcher began by sending emails to a few social workers and asking them to forward the email to others who may be interested. The first emails were sent to social workers connected to the researcher through professional experience and the networking site LinkedIn. The email explained that the purpose of the research study is to add to the literature about successfully addressing secondary trauma in social workers. There was a link provided in the email to enable interested and eligible parties to take the survey. Eligible respondents were social workers who have experience counseling trauma survivors. Initially, the researcher sought participants with master's degrees and associated licensure. In order to expand the sample, social workers with bachelor's degrees were included as well. A minimum of ten participants were desired for the sample, which turned out to total fifteen respondents.

Protection of Human Subjects

Potential research study participants received a copy of a consent form detailing the purpose of the study and the risks involved in participation. Participants were given the opportunity to withdraw from the study at any point by ceasing to answer survey questions and indicating a desire to have their previous answers eliminated. Participant demonstrated informed consent by following the link to the survey and then answering

the final question stating that the purpose of the study is for a graduate student's research study. A copy of the consent statement is included in Appendix A.

Participants are also protected from harm by remaining anonymous. The researcher collected general demographic information, but did not require names of participants or any other identifying information. Any identifying information provided was volunteered by the participant and not included in the written report. Survey data and participant identity are protected by Survey Monkey's extensive privacy and security policies.

Data Collection and Data Analysis

Research data was collected through the use of a qualitative research survey. Open-ended questions prompted short-answer responses from study participants. The survey included questions about counseling trauma survivors, secondary trauma and self-care (See Appendix B). The questions asked for personal anecdotes and theoretical persuasions used in order to understand individual experiences. Potential participants received an email with an explanation of the study, a built-in consent statement and a link to the survey. The researcher purchased the Select Plan from www.surveymonkey.com in order to customize the survey according to study specifications and ensure advanced security measures.

Data collected was analyzed by the researcher and coded based on themes discovered. Themes in data were compared to information found in existing literature to ascertain parallel findings and discrepancies. This method of data analysis is called content analysis. The researcher looked for themes based on those found while reviewing related literature, therefore the analysis can be considered "directed content analysis"

(Hsieh & Shannon, 2005). A research assistant was asked to analyze the data and search for patterns and themes that may have been missed by the researcher.

Strengths and Limitations

The qualitative design of this study paints a picture of real experiences that social workers have working with trauma survivors. The information gathered and published in the final report educates readers on how a number of social workers have been affected by traumatic material and how they practiced effective self-care to address negative consequences.

Using a survey rather than a series of interviews created an opportunity for a larger sample size. Use of snowball sampling through email makes it possible for the researcher to contact many potential participants instantly. Respondents were asked to commit only approximately thirty minutes of their time rather than an hour or more for an interview. Additionally, the survey could be completed from anywhere at any time of day, so could be fit into participants' schedules wherever time was available. There was no pressure from the researcher being present, so respondents were able to take as much time as needed to provide thoughtful answers.

Some of the limitations of this study revolve around the lack of contact with respondents. First, the researcher was not able to see respondents when they answered questions, so was not able to observe facial expressions, body language and other nonverbal communication. Nonverbal communication would have helped the researcher understand answers given and would add a more personal element to the data. A second limitation was the lack of opportunity for follow-up or clarifying questions. The data is limited to the answers provided by the respondents and could not be expanded through a

conversation. A third limitation is a lack of generalization. Due to snowball sampling, the researcher was unable to accurately estimate the size of the sample. No matter the amount of respondents, it is impossible to know if they accurately represent all social workers who counsel trauma survivors in the metro area, Minnesota or the United States as a whole. The data collected is unique to those who shared their stories rather than including all possible experiences.

Findings

The purpose of this study was to answer the question, “What is the internal experience of social workers counseling trauma survivors and how do they practice effective self-care to address negative effects such as secondary trauma?” The questions included in the questionnaire reflect the themes discovered when the researcher reviewed existing literature. Study participants were able to identify if they had experienced secondary trauma in their careers and then expand upon those experiences through the other questions. The following findings are divided into sections based on the questions asked. Each question has its own set of themes derived from participant answers. The only questions not included in these findings are those about educational background and informed consent.

Practice Environments

The fifteen individuals who responded to the research questionnaire practice in a diverse group of settings. The majority of respondents currently work or previously worked with children and adolescents, while only a few work primarily with adults. Participants see clients for a variety of presenting concerns. These include chemical dependency, mental health diagnoses, learning and developmental disabilities, sexual

violence, behavioral health and family assessment. In addition to working directly with clients in sessions, one individual reported being a supervisor of other social workers providing therapy as well.

Approximately half of the study sample referred to their work in residential settings such as treatment centers and group homes. Two respondents have experience in crisis shelters, three work with child protection, two are county social workers and two are currently practicing in hospitals. The questionnaire did not include a question about years of experience, but several respondents mentioned that they were either new to the field or had been a social worker for several years. One respondent does not currently hold a social work position, but plans on returning to the field in the near future. To summarize, the biggest percentage of study participants identifies with residential settings and the most experience is with children and adolescents.

Motivation

Social workers who completed the questionnaire reported a variety of motivators for counseling trauma survivors. The majority of respondents alluded to helping others and providing hope through life's difficulties. For some it is personally fulfilling, while for others helping clients was inspired by being helped by someone when in need. While many of the participants had the specific goal of working with trauma, one said, "I didn't know I would be counseling trauma survivors when I took my current job," and another stated that he or she encounters trauma survivors as a part of "whatever comes to me through work." A few respondents reported that they were survivors of trauma or were close to others who experienced trauma. One respondent explained his or her motivation

in this way, “Because I have seen how trauma affects those close to me and I want to help out any way I can.”

One of the themes that came up among responses about motivation was the timing or stage of trauma intervention in which participants are involved. Answers ranged from providing support immediately at the time of the trauma, alleviating suffering shortly after the experience and processing the more long term and in-depth effects. One respondent stressed that everyone has their own story with different factors and specific needs, but each person has similar end goals of being happy and successful. Despite different timing and methods of intervention, each trauma survivor deserves the help and support that counselors can provide.

A few of the participants focused on the outcome of successful trauma therapy as a motivator. The following response sums up a few therapeutic goals from one counselors perspective; “I am a survivor of trauma. I believe that the therapeutic relationship helps survivors tell their story (find words for their experience), repairs connections in the brain, gives people a healthy experience and emotional response. People heal through relationships.” Much like those who responded that they are motivated by the desire to help others; this person is motivated by the specific ways in which he or she is able to change traumatized clients’ lives.

Explanation of Secondary Trauma Experiences

Of the fifteen individuals who responded to the questionnaire, only one person said that he or she did not recall experiencing or witnessing secondary trauma in his or her career. Five have personally experienced secondary trauma, five have witnessed it in

coworkers and not in themselves, one gave an example of secondary trauma experienced by family members of trauma survivors and three did not specify where they had seen the secondary trauma. When asked to explain their experiences of secondary trauma, respondents typically described how they or others were effected, reasons why they have experienced it and what to do about it.

One of the effects that respondents described was a broad range of negative thoughts and feelings. Some individuals stated that they are unable to get their minds off of work and client stories when they are at home or other places outside of work. One social worker said, "I find myself fixating on things that happen at work, and talk about work frequently with people in my personal life." Others mentioned being reminded of client trauma while watching television or constantly worrying about a client's safety if there is a threat of danger. Several participants mentioned that their secondary trauma affected relationships in their lives because of the constant distraction and lower moods.

Over half of the respondents struggle with anxiety due to secondary trauma. Some said that they had struggled with anxiety in the past, but it increased when working with trauma survivors. Others' anxiety appeared to be specific to a case and brought on by secondary trauma. Descriptions of anxiety included worry, anxious, fearing loss of control, uncertainty, etc. One specific example was, "After a major incident, I have had difficulty sleeping and become hyper-vigilant/jumpy when seeing/hearing ambulances." Similarly to this respondent, many others reported having trouble sleeping at times and that they have had other physical effects such as overeating and chest or stomach pain.

Another theme that came up in this question about secondary trauma experiences was participant's explanations as to why they experienced secondary trauma. Several

social workers reported that there are specific types of cases that are more likely to bring about a secondary trauma reaction. Some were cases involving children or another specific group. Other respondents focused on the content of the traumatic story such as traumatic grief or victims of sexual violence. A few different practitioner-specific explanations were given such as having survived personal traumas, having poor boundaries or not being sufficiently trained. One social worker said:

I am extremely aware of how my body and mind respond when I encounter individuals who I perceive that have similar types of characteristics and behaviors of the two individuals in my life who were abusive. I get anxious (talk at a quicker pace) and can feel nagging pain in my stomach/chest area.

Physical and Emotional Reactions

Similar to the specific experiences of secondary trauma, the next question asked respondents to describe their physical and emotional feelings during and after sessions with trauma survivors. One person answered in this way: “Mostly, I have felt energized and thankful in my work with victims of trauma. At times I have felt worried when I believe I have not been able to help the survivor move forward in their healing journey.” While this respondent gave examples of both positive and negative feelings, the majority of participants focused on challenging or negative feelings. The most common words in the responses were “physically and emotionally drained”. One participant explained feeling, “Sick to my stomach, racing pulse, unable to focus thoughts, nightmares, avoidance of memories related to the family or trauma.”

In addition to the common experience of feeling drained after a session, respondents brought up more long-lasting questions and doubts. For example, the following participant reported feeling “Physically and emotionally drained. Wondering if there was something else I could have done differently that would’ve helped more. Sometimes hopeless, doubtful of the goodness in the world.” Several of the participants explained that stressors add up and affect their overall attitudes. The following quote tells the story of a social worker being affected more than he or she expected when looking back at a previous job:

I was skilled at helping children tell their story. I remember it becoming second nature. I was told traumatizing and terrible information but kept my clients issues number one so that they could be heard in their own words. After disclosure and away from the client I have cried on occasion. I no longer do forensic interviewing. I thought I would miss it because I was good at it. After changing my position I realize that it was a good thing to move away from. It affected me more than I knew. I remember being very tense before interviews, needing to make sure that all the equipment was working properly, nervous that I wouldn’t be able to get a good interview, etc.

When describing their physical and emotional feelings, several of the respondents described the situations in which they dealt with the most difficult feelings. Participants explained that they are more affected when emotional responses in sessions are intense for a number of reasons. Some attributed the strong reactions to countertransference from hearing the traumatic stories and

working with difficult clients. Others focused on factors such as being tired, having too many responsibilities or being stressed for other reasons. More specific examples were asked for in the next survey question.

Some Cases are More Difficult than Others

When participants were asked to describe why some cases are more difficult for a person to deal with than others, there were three themes in the answers. The first theme was social workers' personal factors. One personal factor that came up a few times was similarity of a client's experience to the respondent's own experiences. Aside from feelings aroused by having similar situations, other countertransference that occurs for a variety of reasons with clients may make some cases more difficult. One participant gave the following reasons that certain cases can be more difficult: "My own personal triggers. The communication style of the client. The personality of the client. The trauma itself." Another said, "Things people themselves have experienced, some situations that are especially emotionally charged, can depend on relationship with client- empathy ability." Other answers included few hours of sleep, increased stressors, emotional attachment, burnout, compassion fatigue, empathy ability, etc.

A second theme among the responses related to specific cases the social workers face. The most common type of case that is most difficult for participants is children who have been traumatized. One respondent took that idea further and said, "When events happen to children where I think the parents could have intervened or failed their duties as a parent to keep the kid safe." One respondent referred to his or her earlier answer about clients who remind him or her of past abusers. Another respondent struggles specifically with clients who become disrespectful and aggressive. A few answers were

similar to the following which doesn't offer a description of specific cases, but is more general. "The ones that hit closer to home, 'This could happen to me'." These experiences that could reasonably happen to the social worker are associated with the anxiety and doubt that respondents also talked about in earlier answers.

The final theme of reasoning for some cases being more difficult than others allows for a variety of case-specific answers. Several respondents explained that not only will each person have diverse answers, but there may be different answers for each case. Not only do the reasons vary, but respondents suggested that there is usually more than one factor making a case more challenging than others. One person's answer described this theory as follows:

This is a good question. There are so many various/moving factors as to why one case will impact you significantly and why another won't. I do not believe there is a single reason and I would answer differently for each case I have been impacted by as it was difficult for different hosts of reasons.

Theories Used

Participants were asked to name the theories they use to understand client experiences. The most common theories listed were Cognitive Behavioral Therapy or CBT by six respondents, trauma-specific theories such as Trauma Focused Cognitive Behavioral Therapy or TF-CBT by three respondents and theories that focus on client self-determination such as Strengths Based or Person-Centered by five respondents. Other theories listed were Normalization, Rogerian, Schemata Theory, Behavioral Therapeutic Techniques, Humanistic and Biofeedback. The majority of participants either

listed more than one theory or stated that they used a combination of theories in their work. A few said that they didn't adhere to any traditional theories, but have adapted their approaches through experience and success stories throughout their careers.

Job affects Personal Life

In order to expand the understanding of how counseling trauma survivors affects social workers, respondents were asked to talk about how their personal lives are affected by their jobs. Similar to previous questions, respondents reported many negative feelings and symptoms that carry over from their jobs. These answers included anxiety, being emotionally drained, worrying about work when not there and having trouble being present or feeling disconnected. Several respondents reported having difficulty sleeping or dreaming about work when they do sleep.

Throughout the questionnaire answers, the theme of time has appeared prominently. One participant appeared to laugh at the idea of work affecting his or personal life saying, "I never have a personal day!" Others reported not having enough time to designate time for themselves or needing more time for self-care. Some respondents mentioned sacrificing social events and other potential plans due to working. One explained, "I work long hours. I have sometimes had to miss out on special occasions at my children's school due to crisis situations."

A significant theme closely related to time is the effect of participants' careers on their relationships. One respondent listed a variety of relationship effects, including criticism and a decrease in empathy. This respondent stated:

Some days after work I am so emotionally and physically exhausted from carrying the stress/tension around that I don't want to do anything after

work. I work a lot so most of the time my friendships were lacking. I became more critical of people when they said they were stressed. I felt like my stress was worse and lost empathy for other people who were struggling. ‘Oh, you think YOUR day was rough?’ kind of thing.

Like this respondent, others reported not only lacking time to form and maintain relationships, but also struggling within the relationships as well. A number of participants said that they and their significant others have used job stress as justification for avoiding thinking and talking about difficult subjects in their personal lives and relationships.

Two of the participants provided answers that stood out from the other respondents’ answers about their jobs affecting their personal lives. One talked about forming close bonds with coworkers and creating friendships with them outside of work. Although this idea was unique in this answer, it also came up in answers to other questions in the survey. The other uncommon answer came from a social worker practicing in a rural setting. He or she stated, “Living in a small rural community, I tend to spend more time at home and with close family in order to avoid personal conflicts of interest.” While the majority of respondents appeared to not have enough time with family and friends, this respondent is less likely to be involved in additional activities due to the possibility of dual relationships and boundary confusion.

Personal Stress affects Job

This two-part question asked respondents to explain how their personal lives affect their jobs and then to describe how to keep personal and job stress separate. Only one participant was able to say that personal stress does not affect job performance. Two

stated that they try not to let personal stress affect their jobs, but in reality it is nearly impossible for the two to be independent of one another. Most participants described what they do to separate the two sources of stress and what happens when they are unable to effectively separate them.

The most commonly reported effect personal stress has on job performance was difficulty focusing. Participants reported that thoughts about home situations and all the things they need to do can interrupt sessions and prevent them from being fully present. One person said, “Not being able to get my mind cleared when having 1:1 with clients about larger events in life, lack of focus, change in mood sometimes.” Other effects reported included less patience and empathy, lower mood, less willingness to do more and decreased ability to leave work stresses at work.

Many respondents stated that they are usually able to keep personal-life stress out of their work environment, but when there are too many stressors or more intense situations they struggle separating the two. Several individuals reported that they are more likely to let their personal stress leak into their jobs when work is especially challenging, there is too much expected of them and when they are behind on documentation while also experiencing personal difficulties. One participant reported this struggle:

Stress in personal life affects my job performance because I can't focus 100% on whatever task I'm doing. I understand that personal stress is different than job related stress, however I don't know how to keep them separate. When I'm stressed everything melts into one big stress experience.

A different participant reported recently leaving his or her job because there were too many stressors in his or her personal life and they were affecting job performance and overall happiness.

Keeping personal stress and job stress separate. Participants gave a number of strategies they use for keeping their personal lives and their jobs from affecting one another whenever possible. Many respondents reported the need to be very intentional about drawing firm boundaries between the two areas of their lives. One respondent explained leaving the thoughts, feelings, etc. in each place.

I try very hard not to allow stress in my personal life to affect job performance. One has to compartmentalize “home stuff” and leave it there when you walk in the doors of the office. Same for leaving “work stuff” at the office before you drive home.

Another respondent explained a routine whereby he or she would touch the same tree on the way in to the office and on the way out. Touching the tree symbolizes stepping into the professional role and leaving the personal baggage behind. On the way out, it symbolizes leaving work problems behind to address the next day and transitioning back into the personal self.

A few participants gave strategies that are effective in the moment. One explained:

It is hard to leave life at the door, when thinking about things that you need to do after work, etc. However, when in the moment it helps to invest in the kids and see the benefit of taking the time to remove one’s personal life from the equation and be present.

Others highlighted the importance of self-awareness and realizing when things are pulling your attention away from clients. When that happens, respondents take time to readjust their focus or turn to colleagues or supervisors for support. “It is helpful to process with teammates when struggling with either stressor. It is important to have effective communication in personal relationships as well.”

A few of the respondents who reported being in the field for many years suggested that separating personal and vocational stresses must be learned and practiced over time. This skill doesn’t necessarily come naturally and there is no textbook routine that will work for everyone.

You learn to separate it out with time and practice. I have used running as a means to relieve stress and transition. I also have about a 45 minute drive which helps with the transition from work life to home life.

Participants explained that when the transition and separation becomes too difficult to maintain, it is important to take time off to reset, relax and get personal matters in order.

Agency Support

There were three main themes that participants’ ideas about agency support can be divided into. The first theme is about supervisors and what they can do to support their employees. One respondent explained a supportive and nurturing environment; “Have open, honest, and frequent conversations regarding secondary trauma and self-care. Foster a supportive environment where staff feel comfortable going to their supervisors when they start to feel burned out or like they are experiencing secondary trauma.” Many expressed ideas in agreement with the respondent who needs, “Positive affirmations and

when critiquing is necessary to do so constructively.” Others talked about the importance of supervisors being trained, experienced and knowledgeable especially in the area of secondary trauma.

A second theme is similar to having supportive supervisors, but also suggests that the entire team “Be supportive of one another.” Many participants shared that they take time to process with teammates and collaborate on tough projects. One person who looked back on a position he or she recently left and stated, “Consideration, affirmation, and support are key things I think of when I think of what I needed from my supervisors and coworkers.” Participants reported that consulting with colleagues boosted their own confidence while learning how others have dealt with situations and problem-solving for current cases.

The final agency related theme focuses on each individual on the team. Several respondents suggested that agencies ought to provide training on secondary trauma, self-care and other helpful topics and make it easy for employees to attend. Respondents also mentioned resources that their agencies made available such as free counseling sessions and referrals, support groups, literature and other types of employee assistance. A few of the participants talked about keeping job expectations realistic and supporting struggling employees before reprimanding them. The final idea promoted by several respondents is to reward and acknowledge each social worker by giving them time off and promoting self-care. “Providing opportunities for use to process our secondhand traumas...showing that they appreciate our efforts at work by giving us time off and...we can focus on our own self-care.”

Self Care

Research participants were asked to explain the things they do to take care of themselves. One respondent provided a good summary of all answers given and added that he or she continues to look for more options as well. “Self care can range from really simple tasks to generously treating yourself... I’m trying to find ways of self-care other than spending money.” Several respondents highlighted the importance of having structure and routine in their lives. Many said that they listen to music every day on the way to and from work to help them transition and work through or express feelings. One respondent mentioned doing the following things routinely; “I use skills. I listen to music, dance and write. I also scream.”

Many respondents include physical activities as a part of their routines. One person said, “Exercise can be a good one for me but often takes place more often when I am less stressed. When I am stressed, I am tired. When I am tired, I find it hard to make time to exercise.” Building exercise into daily or weekly routines makes it easier for some participants to continue doing it when it is harder to find time. Other than exercising and running, respondents listed physical activities such as walking their dogs, taking relaxing baths, eating well and getting enough sleep.

Outside of their daily routines, participants gave several examples of ways they practice self-care by treating themselves. Many explained the importance of “taking time for myself” which could mean on a regular basis or as an occasional reward. Specific activities listed include going out to eat, buying a new shirt, painting nails, gardening, choir, indulging in junk food, watching a favorite tv show, working on hobbies, going on vacation, finding humor in life, etc. Each respondent’s answers varied, but most said that

they make a point to treat themselves to things that are not a practical part of their daily routines.

The final theme in self-care answers is relying on other people for support. Many people reported that the most important self-care they participate in is spending time with their loved ones. This ranged from taking family vacations to having dinner as a family as often as possible. Respondents described the importance of having their needs for love and affection being met through their loved ones. Many also stated that they were intentional about making time to visit their friends and attend fun social activities. One participant highlighted the importance of his or her coworkers in self-care by answering simply, “Consult, consult, consult!

Roadblocks to Effective Self-Care

Participants were asked to explain what gets in the way of practicing effective self-care. The majority listed being too busy or a lack of time as the main roadblock. This lack of time for many is due to working full time plus overtime and having many other activities in their schedules. One respondent listed, “Time, work, school, volunteering, and being a mom. Takes away from any sort of me time.” For others, it isn’t necessarily a lack of time, but not having enough energy when there could be time. For these respondents, sleeping takes priority over other helpful self-care practices.

Along with being tired, some social workers reported feeling too stressed to practice effective self-care. This comes from juggling busy schedules and trying to get everything done in a short amount of time. Respondents also attributed their high amount of stress to the content of their work and the difficult subject matter they frequently have to process. One respondent highlighted the importance of his or her perception of

stressors piling up stating, “Feeling so overwhelmed that I believe I don’t have time,” as the reason self-care doesn’t always get done.

Related both to being busy and being highly stressed, many participants described difficulties with time management. Part of the reason time management can be particularly difficult, according to respondents, is the inconsistency of schedules in some settings. Participants who work in hospitals, group homes and other residential settings reported working long hours and sometimes having to stay late or having to do quick turn-arounds because of shift work and crisis situations. One person reported, “Not having a set schedule. Working the night before while staying late then coming back at 6 or 7am.” With an unpredictable or inconsistent schedule, respondents reported that it is difficult to plan ahead and fit everything they would like to do into their lives. One said that he or she struggles with “Being too busy or when I have time off using that time ineffectively.”

Family and Friend Support

Most respondents reported that they have significant supporters in their social networks. There were a few themes that came together through responses about family and friend support. The first theme involves participants giving specific examples of what others have done in order to support them through challenging times in their careers and with secondary trauma. The majority of answers given can be summed up as spending time together and being understanding. One social worker reported, “Yes, they make me laugh and think of other things.” Another described what is helpful as family “listening, showing love and affection, allowing space when I need it.” The general consensus was

that family and/or friend support is necessary, even if not specifically in response to secondary trauma.

Interestingly, many of the participants spoke to the difficulty their families have in showing the support they need. For example, one said, “They don’t understand what my work environment looks or feels like so they are unable to offer much.” Another expressed his or her apparent frustration in this way:

My family listens and tries to give advice on how to handle things. My friends have been better at having empathy and playing more into the emotional part. I would like to have less problem solving and more empathy and support in general. Often times they minimize my experiences or don’t understand fully what happened and how I feel.

A number of social workers expressed being grateful to have other social workers or others in the mental health field in either their families or social circles. For example, one said,

I’m lucky to have a large group of social work friends outside of work who I can turn to for support when work is stressful. This is nice because they can act as consultants and I don’t worry that I’m burdening them too much with “hard stuff” like I would my husband or non- social workers.

Several participants talked about building close relationships with their coworkers because of the intense situations they go through together. A few said that they met many of their friends through work and have continued to consult with them on difficult cases and spend personal time together as well.

Conclusion of Findings

Although each social worker who participated in this study has an individual experience and shared unique answers, there were clear similarities and themes among the answers given. These themes included not having enough time for desired self-care, suffering from anxiety and other negative feelings, needing to keep job and personal stress separate and building self-care activities into daily routines. Overall, respondents appear to have a general understanding of the negative effects counseling trauma survivors sometimes has on them. Most identified areas in which they struggle at work and in their personal lives. Additionally, participants were able to explain the ways in which they care for themselves and alleviate stress. Each person who filled out the questionnaire provided insight into the experiences of social workers counseling trauma survivors and how they are able to cope.

Discussion

This discussion will begin by revisiting definitions of secondary trauma and related consequences provided in existing literature. It will then look at the prevalence of secondary trauma to assess how significant of a problem it may be. Next, there will be a comparison of participant's answers in this study to existing literature for secondary trauma risk factors and effects. After the comparison, implications for addressing secondary trauma in practice and policy will be explored. Findings from both the literature review and the current study will be woven throughout in order to give a comprehensive picture of effective intervention. The discussion will conclude with strengths and limitations of this study and implications for future research.

Definitions

The literature reviewed highlighted a few important consequences of counseling trauma survivors that social workers are likely to encounter. One concept, compassion fatigue, is “the formal caregiver’s reduced capacity or interest in being empathetic” (Adams, Figley & Boscarino, 2008). Another, burnout, is psychological strain from continued work with difficult populations (McCann and Pearlman, 1990). Finally, the concept explored in this study, secondary trauma, is the “disruptions of the therapist’s internal experience in reaction to repeated exposure to clients’ traumatic material (Pearlman & Madan, 1995). The researcher hypothesized that participants would report symptoms of these conditions whether they referred to the specific consequences by name or not. Therefore, the questions in the survey were designed to better understand social workers’ experiences in the context of developing secondary trauma reactions and long-term effects. Even if one may not be suffering from secondary trauma, individual effects and risk factors are worth exploring and addressing.

Prevalence

According to the literature reviewed, 50-70% of social workers acknowledge experiencing secondary trauma, with 15% of social workers qualifying for a diagnosis of PTSD (Kanno, 2010; Bride, 2007). This research study found that 93% of participants had experienced secondary trauma in their careers. This higher percentage can be accounted for by the addition of asking participants to describe secondary trauma they have seen in others as well as themselves. Despite the variation in numbers in previous studies and the addition of this one, the amount of social workers who have experienced or witnessed secondary trauma is significant in every case. The high percentages suggest

that secondary trauma is a noteworthy phenomenon and warrants extensive study and intentional intervention.

Risk Factors/Contributions to Secondary Trauma

Working with trauma is especially complicated in that it “involves the interaction of the clinicians’ personal characteristics, including current life circumstances and personal history of trauma, along with the material presented by the client” (Pearlman & Saakvitne, 1995 cited in Cunningham, 2003 p.452). Based on responses to this survey, participants would likely endorse the above statements and add overall job and agency challenges to this list of complications. This study divided up the risk factors found in the literature by asking one question each about motivation, most difficult cases, one’s job affecting his or her personal life and personal stressors affecting job performance.

Motivation. One of the risk factors for secondary trauma explained in the literature was having personal benefit as motivation for counseling trauma survivors (Bell 2003). This includes a practitioner needing resolution from personal trauma, finding one’s worth in creating positive outcomes and healing through helping others. Having objective motivation, such as providing hope for individuals is a defense against secondary trauma in that the expectations are less definitive and personal (Bell 2003). A social worker can successfully offer hope even when a client’s concerns are not fully resolved.

The current study asked respondents what their motivations are and found that the majority of motivation comes from helping others and providing hope. Several participants cited personal or family experiences as the original inspiration to become social workers and help trauma survivors. At the same time, many explained that they

appreciated the help they were given and wanted to provide that for others as well.

Having a history of trauma could be positive and/or negative for respondents. While it appears that their goal is to offer hope to clients, it is less likely that participants would admit that their work is motivated by a desire to work through their own trauma or increase their self-worth.

It is important for social workers to do a lot of self-exploration around their motivations and expectations in counseling trauma survivors. This is especially important for those with a history of trauma. Young social workers would benefit from beginning this process while in school and continuing as they work into their careers. Having open and honest conversations with trusted supervisors and colleagues can lessen the risk of secondary trauma as social workers become aware of their personal motivations and work to make them more objective. For those social workers who do not have specific motivation for working with trauma survivors and take whatever comes to them through their jobs, it would still be beneficial to explore their motivations for becoming social workers and what they hope to see in their clients.

Difficult cases. In the current study, a few of the participants reported that certain cases were more difficult for them to work with due to similarities in the clients' stories to their own. Literature reviewed was inconclusive about personal trauma in itself being a risk factor for secondary trauma. Some researchers stress that therapists who have a personal history of trauma are more likely to experience secondary trauma whereas other studies have found there to be no difference (Betts Adams et al., 2001; Bell et al., 2003; Bell, 2003).

Similar to having experienced trauma in the past, one participant talked about having struggled with anxiety before becoming a social worker. When he or she became especially stressed during difficult cases in combination with personal stressors, the anxiety came back in full force and was hard to manage. Naturale (2007) supports this idea, saying that the therapist may be unable to cope as well due to the stress of hearing the traumatic stories and may re-experience symptoms that have been under control since previous episodes. In order to reduce the risk of secondary trauma, social workers who have experienced mental health issues in the past must be intentional about maintaining their mental health and processing difficult cases.

Several study participants listed specific types of cases and clients that are most difficult for them. In these situations, social workers had higher degrees of countertransference in session and reported being more emotionally involved in the case. A few examples that came up in the study include clients becoming aggressive or having traits of past abusers, cases involving trauma to children, victims of sexual crimes and traumatic events that could easily happen to the therapist as well. There are research studies suggesting that when therapists experience greater countertransference, they are likely to have more difficulty setting firm emotional boundaries and may take on the stress of clients along with their own (Tosone, et al., 2012).

A few of the respondents in this study highlighted an important point about difficult cases and risk factors for secondary trauma. One participant said, "There are so many various/moving factors as to why one case will impact you significantly and another won't. I do not believe there is a single reason and I would answer differently for each case." This is a good reminder that every individual and case is unique, so risk

factors will be different for each person. Some researchers have proposed that secondary trauma cannot be measured for this same reason: each person experiences stressors and coping in unique and personal ways (Bell, 2003). Similar to every individual experiencing secondary trauma differently, most participants talked about personal stress affecting cases and making them harder to manage. The following section explores how the current study and existing literature views stress in one's personal life in relation to secondary trauma.

Personal stress. As a whole, study participants reported that they try to keep stress from their personal lives outside of the work environment. However, the majority admitted that this is hard to do and isn't always possible. Participants explained that personal stressors may affect their mood, amount of empathy and their ability to focus. Existing literature suggests that internal and personal stressors may be more of a risk than work related stressors and other factors. It is harder to listen to clients' problems when the therapist has so many of his or her own in mind (Bell, 2003). Social workers may be at higher risk for taking on client stress when they are unable to separate their own stress out, so the stress compounds and multiplies.

The literature described two groups of social workers who are at higher risk for secondary trauma due to personal stress. One of those groups is social work students. Social work students and those in entry-level positions are vulnerable to experiencing secondary trauma in their field placements due to the stressors of being new to the field and still training along with the added stress of schoolwork, additional jobs, and other activities (Nuttman-Shwartz & Dekel, 2008; Betts Adams et al., 2001). A few participants reported currently taking classes. It is unknown what level or type of classes

they are as there was not a question about current schooling included in the survey. These social workers described that their stress levels are high due to everything they have competing for time in their busy schedules. Several participants mentioned extra stress because of children's activities, volunteer commitments and family difficulties. Some of these participants may fit into the second group mentioned in the literature. The second group of social workers at risk are those with many stressors in their personal lives that compound on the stress of hearing client trauma. For example, this could include those from lower social economic status and other disadvantaged groups (Adams et al., 2008).

The flipside of personal stressors affecting job performance is job stress leaking into one's personal life. Many participants reported that they often think about work stress at home and often have intrusive thoughts about clients when away from work. Many studies confirm that if boundaries are not firmly in place, it is likely that the social worker will attach to and carry client issues due to empathic engagement (Badger et al. 2008; Bell, 2003; Bishop & Schmidt, 2011; Cunningham, 2003). Carrying client stress home increases the risk of secondary trauma due to the general increase in stress and the lack of separation between personal time and professional responsibilities. While these weakening boundaries can be risk factors for secondary trauma, they can also be part of secondary trauma's effects.

Effects of Secondary Trauma

In this study, one social worker reported feeling energized during and after sessions with trauma survivors. Being that the questionnaire focused more on immediate negative effects, others expressed the positive effects when talking about motivation to be a trauma counselor. This is similar to the literature studied in that overall, social workers

lives are enhanced by working with trauma survivors, but in the moment they are likely to experience short term negative feelings. These short term difficulties are normal and do not pose much of a problem. The issues arise when the short term issues are not dealt with and add up to create secondary and vicarious trauma.

Physical. Many studies in existing literature explored the physical manifestations of secondary trauma in social workers. These include physical tension, headaches, fatigue, feelings of heaviness, sleep difficulties, digestive problems, elevated blood pressure and more (Bishop & Schmidt, 2011; Betts Adams et al., 2001; Naturale, 2007). Respondents to the current study described physical symptoms similar to those reported in the literature. The main themes were sleep issues, lack of energy, racing pulse when anxious and eating/digestive concerns.

Internal. More than physical effects, respondents reported internal effects such as overwhelming negative thoughts and feelings. Many participants used the words “emotionally drained” when describing how they feel after difficult sessions with trauma survivors. Studies reviewed also described counseling trauma survivors as an emotionally draining experience that can result in overwhelming negative feelings and an emotional imbalance (Bell et al., 2003; Ting et al., 2005). The most common emotional consequence was heightened anxiety. Participants described anxiety as worrying about clients when not at work and worrying that traumatic events could happen to their own loved ones. These effects and others reported by participants line up with many symptoms of secondary trauma such as intrusive thoughts, avoidance, irritability, grief, anger, frustration, defeat and depression (Badger et al., 2008; Betts Adams et al., 2001; Bishop & Schmidt, 2011; Naturale, 2007; Cunningham, 2003; Bride, 2007).

Relational. A theme that came up amongst respondents answers was effects in relationships. Bride (2007) reported that due to the psychological impacts and the decrease in trust, a therapist may experience strains in interpersonal relationships. Along with the increased tension in interactions, most participants reported that their personal relationships suffer due to the amount of time they spend working and the lack of time left to tend to relationships. According to the literature, the other side the therapist's relationship schema that suffers is the therapeutic relationship with a client (Betts Adams et al., 2001). This differs from the current study in that respondents did not report that the therapeutic relationship changed due to stress or secondary trauma. Respondents did report that personal stressors did make it more difficult for them to be fully present with clients, however. Interestingly, a few participants indicated that poor relationships with clients may contribute to higher stress levels.

Outlook. The final major theme of effects reported by survey respondents are the long term changes in attitude and outlook. A few participants remarked that working with trauma survivors has changed how they view the world at times. For example, one respondent stated that he or she is occasionally left feeling hopeless and doubtful of the good in the world. Much like this respondent's report, Bishop and Schmidt (2011) proposed that continued exposure to clients' traumatic and destructive material can negatively impact a social worker's worldview to where they see the world as unsafe and people as bad. For this and other social workers, it is important to address these unhealthy attitudes so they do not add up and create more problems.

One social worker told an eye-opening story about his or her experience in doing forensic interviews with children after traumatic events. This social worker reported

being skilled at the job and being confident that he or she was in the right place at the time. After the participant changed jobs and looked back on his or her time, a clear pattern of increased anxiety and negative outlook appeared. The participant was not aware of the symptoms building up, but realized the impacts as they became problematic. Luckily for this social worker, the new awareness brought about the ability to address underlying problems and reverse the effects of secondary trauma. He or she was likely toeing the line between secondary and vicarious trauma. In existing literature, “Vicarious trauma is the transformation that occurs in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ ‘traumatic materials’.” Vicarious trauma is unique from standard secondary trauma, which focuses on sudden onset PTSD symptoms, in that it consists of gradual permanent changes in the therapist’s cognitive schemas (Bishop & Schmidt, 2011; Bell et al., 2003; Baird & Jenkins, 2003).

Implications for Addressing Secondary Trauma

As seen in the preceding section, secondary trauma is both a genuine and a serious concern. There are many ways individual social workers, the social work community and the general public can fight the effects of secondary trauma. Participants in this study shared strategies for coping with the stress that comes with counseling trauma survivors and the means by which they address secondary trauma. Themes that came up in survey answers reflect, enhance and personalize general approaches suggested in existing literature.

Agency support. One of the main areas of intervention for secondary trauma is in social work agencies. Agencies are responsible for combating secondary trauma as agency characteristics may be the strongest predictor of secondary traumatic stress.

Problems can arise if there is a lack of work group support, role ambiguity, demanding expectations, little time to process, inadequate resources and other weaknesses (Badger et al., 2008; Bell et al., 2003; Cunningham, 2003). Study participants and existing literature cite agency issues as contributors to secondary trauma and then offer suggestions for agencies to intervene.

Studies widely emphasize supportive supervision as the most essential organizational intervention in secondary trauma (Betts Adams et al., 2001; Bell et al., 2003; Naturale, 2007). Study participants placed less significance on supervision, but many did talk about it as being important. Several of this study's respondents stated that they needed to feel like their supervisors supported them and wanted them to be successful. In addition, supervisors were most helpful when they were open to having conversations about secondary trauma, countertransference and other struggles. A few respondents underlined the importance of having supervisors with adequate training and experience in order to help their supervisees most effectively.

In contrast to the literature reviewed, study participants concentrated on turning to colleagues for support more so than supervisors. Several brought up consulting on difficult cases, processing interactions and problem-solving with their co-workers. A theme woven throughout the current study's responses is social workers seeking support from their colleagues because they go through similar experiences and may have helpful resources to share. A few of the respondents said that their agencies have offered support groups for social workers to be able to meet and share with one another. Existing literature also values collegial support, suggesting that the agency can encourage peer support groups and structured stress management and group cohesion can foster a sense

of support among colleagues (Bell et al., 2003; Naturale, 2007). A safe environment can be created in which social workers feel comfortable talking about experiences, receiving feedback and voicing challenges or concerns without the fear of judgment (Bell et al., 2003; Cunningham, 2003).

In addition to supervision and a supportive team, several ideas for agencies supporting individuals were presented. Much like with supervisors, social workers desire to be valued by their agencies for more than just productivity and desired outcomes. (Bishop & Schmidt, 2011). Survey respondents reported that it is helpful when agencies actively promote routine self-care and reward employees with paid time off. This study's participants and previous studies agree that since social work practice is an ongoing learning process, agencies ought to provide ongoing training and psychoeducation (Naturale, 2007). In addition to training, offering outside resources and diverse work responsibilities can alleviate some of the stress of counseling trauma survivors (Bell et al., 2003). Survey respondents feel more supported when job expectations are clearly defined and reasonable to achieve.

Implications for policy. Implications for future social work policy begin when individuals are in school studying to become social workers. A few participants in this study value education as one of the most important safeguards against secondary trauma. One particular respondent talked about his or her education in comparison to colleagues and reported that those who did not obtain a higher degree in clinical social work were not well prepared and appear to suffer more from secondary trauma. One research study said that students build up a "professional shield" as they are informed and provided with necessary skills (Nuttman-Shwartz & Dekel, 2008). There are a few policy

recommendations involving education that could help social workers build up their professional shield.

The first policy recommendation is at the county level. One participant in this study reported that counties do not require social workers to have social work degrees. While county social workers may be less likely to counsel trauma survivors, they may come across some in their caseloads. If counties continue hiring social workers who have not had the benefit of attending social work school, they should provide mandatory training on trauma, secondary trauma and self-care. While this training would cost extra money, it would likely reduce employee turnover and burnout among county social workers.

A second policy recommendation is for formal social work education programs. Since the majority of social workers providing counseling are likely to work with trauma survivors, it would be helpful for social work programs to require students to take courses on trauma. Within the trauma curriculum, a unit about secondary trauma would help prepare students to prevent and combat the difficult consequences of counseling trauma survivors in themselves and colleagues. Beginning social workers would also benefit from a course specifically on self-care and surviving in the social work field. While there are already a lot of self-awareness exercises built into social work education requirements, the next step would be to teach social workers what to do with that self-awareness and how to problem-solve when challenges arise.

Moving forward from social work education, existing literature and study participants have several ideas for agency policies. Much like social work agencies strive to be client-centered, their personnel policies can be person-centered as well. For

example, agencies can build paid time-off into social workers' schedules and allow them to take time off after critical incidents and if they are starting to burn out. Additionally, agencies often require individual and/or group supervision. According to literature and study participants, it is helpful for agencies to add in structured stress management and teambuilding opportunities. For example, one participant talked about taking time out of some work days to engage in physical activity with coworkers such as going for a walk or to a yoga class. Other participants appreciate the support groups and counseling resources provided by their agencies. These activities could be funded by agencies or built in to employee assistance programs. It is also important for agencies to provide ongoing education and training as new evidence is discovered and practices are updated. Part of the training provided can include secondary trauma or compassion fatigue assessments with follow-up supervision for risk management and intervention.

The most far-reaching policy related implication involves educating the general public. In recent years, there has been a movement to reduce discrimination and the stigma of mental illness. A major part of the strategy has been educating people and normalizing the symptoms and treatment of various mental illnesses. It would be helpful for the people who are not in the mental health field to know about trauma and the ways it affects people. This would help prepare people deal with future traumatic events or support others who experience trauma. Additionally, if the general public is informed about secondary trauma and other difficulties counselors face, support networks will be better equipped to offer help and understanding to social workers.

Personal practice implications. Practicing self-care is important for all social workers in order to remain healthy and effective. If the therapist is not emotionally

present and healthy, he or she is not able to provide the best possible care for the client. Although the list of healthy self-care coping skills could be endless, there are a few foundational physical, social and spiritual recommendations to build upon. These include maintaining a healthy diet, physical exercise, balancing work and play, rest, spiritual replenishment and building social networks (Naturale, 2007). Studies have concluded that there aren't specific coping methods that must be used in secondary trauma, but it is most important that the social worker feels successful in his or her ability to cope (Bell, 2003). Therapists who are not equipped with effective coping skills are susceptible to secondary traumatic stress because they are unable to deal with the internal experiences they have (Bishop & Schmidt, 2011).

Study participants offered helpful insight regarding helpful coping skills. The major theme in addressing secondary trauma was learning how to keep work life separate from one's personal life. Participants listed a number of practices social workers can try in order to effectively separate the two major sources of stress. Many social workers have a routine they follow each day in order to prepare themselves for transitioning into and out of their professional role. The routines vary between respondents, but each adds certain activities into their days or weeks. Examples include listening to music while commuting, going for a run, taking a bubble bath and mentally boxing up stressors before leaving home or the office. Outside of routine, respondents suggest that social workers do things to reward themselves occasionally such as going on vacation or buying something they want but don't necessarily need.

Existing literature and current study participants find it important for social workers to have a social support system. Social supporters include family, friends and

coworkers. Studies show that people outside the mental health field are unlikely to know much about secondary trauma or even understand what social workers do on a daily basis. Even though they may not fully understand, they can still be helpful by showing general care and concern. As Bishop and Schmidt (2011) reported, others may not know that one is struggling with secondary trauma symptoms, so it is important to seek support from trusted friends, family members and colleagues. When seeking support, a social worker can communicate what they need and what would be most helpful for them. It is also helpful for social workers to consult with other social workers on a professional level and build friendships with others in the field.

Some of the most effective coping strategies against secondary trauma and other stresses are internal in social workers. One internal skill, which also extends to relationships and practice is setting intentional boundaries. During sessions, social workers must “walk an internal tightrope between empathic connection with patients and emotional separation” (Badger et al., 2008, p.70). It is essential for social workers to learn how to establish the boundaries there and with their agency. Like many other skills, time and experience may be the only way to master setting boundaries and finding appropriate balances in social work practice.

The other major internal coping strategy is all about attitude and perception. Part of a social worker’s attitude can come from the theories he or she uses to understand client experiences and concerns. The conceptual framework used when developing this study is a combination of strengths-based theory and trauma theory. Social workers may benefit from incorporating concepts from these theories into their own practice. Trauma theory is helpful in understanding the meaning behind client symptoms and struggles. It

may be easier to maintain empathy and ward off compassion fatigue when one has an understanding of the challenges brought forth by the client. Additionally, it gives the social worker a plan to intervene and support the trauma survivor.

With strengths-based practice, the therapist focuses on the client's assets rather than presenting problems. This orientation gives the opportunity for collaboration between the client and the practitioner, so both are able to feel effective and successful. There is less pressure on the social worker to "fix" the client there is always hope present when solutions are based on strengths the client already possesses. Approximately one third of study participants named one of these two theories in response to the survey. A few other participants talked about concepts that mirrored strengths-based practice, but did not call it by that name. In the future, a comparative study between different theoretical frameworks and their understanding and prevalence of secondary trauma would be interesting.

Implications for Future Research

A number of findings from this study could be researched further in order to enhance understanding of secondary trauma among social workers. The first recommendation for future research comes from the literature review. Currently, there are very few ways to measure secondary trauma and its manifestation in social workers. It would be beneficial to further explore the reliability and validity of these scales or see if there is another test that could be used.

Another area of research that would be helpful in the future is to compare secondary trauma experiences in different settings. For example, this study included several participants who have experience in residential settings. An additional study

could be done to determine whether these social workers experience secondary trauma more or less than social workers in private practice and if it has different effects. Another example from this study is the experiences of social workers in rural areas compared to those in urban settings. One respondent who identified as a rural social worker had somewhat different answers than his or her urban counterparts.

Many other exploratory studies could be done based on themes discovered in participants' answers. One recommendation is to study the experience of having social workers in one's social circle. This could be done from the angle of the social worker: making friends with coworkers or relying on other social workers for support. It could also be done from the perspective of the family and friends of social workers: how are they affected by the social worker they know struggling with work demands or secondary trauma? One could also explore agency supports such as providing additional or even mandatory paid time off, the effectiveness of trainings and resources and what good supervision looks like. Research could be done to compare secondary trauma experiences between male and female social workers or how it changes at different points in one's career. The topic of secondary trauma is full of potential for future research studies.

Strengths and Limitations

The qualitative design of this study paints a picture of real experiences that social workers have working with trauma survivors. The information educates readers on how a number of social workers have been affected by traumatic material and how they practiced effective self-care to address negative consequences. The concept of secondary

trauma is hard to measure, so it is especially important to have real-life examples to gain an understanding of the subject.

Another strength of the study is how it fits into existing literature. The questions asked were based on data collected in previous studies and as a result, answers fit well into the literature. At the same time, respondents provided a few concepts that were not addressed in previous studies and could be explored through further research. This unique data adds to the overall understanding of secondary trauma and is valuable for social workers counseling trauma survivors to consider.

Some of the limitations of this study revolve around the lack of contact with respondents. First, the researcher was not able to see respondents when they answered questions, so was not able to observe facial expressions, body language and other nonverbal communication. Nonverbal communication would have helped the researcher understand answers given and would add a more personal element to the data. A second limitation was the lack of opportunity for follow-up or clarifying questions. The data is limited to the answers provided by the respondents and could not be expanded through a conversation. Some of the answers given were shorter than what the research hoped for, so it would have been beneficial to be able to ask for more information.

A third limitation is a lack of generalization. Due to snowball sampling, the researcher was unable to accurately estimate the size of the sample. Additionally, recruitment was more difficult than expected, so the researcher may have benefitted from using a different recruitment method. No matter the amount of respondents, it is impossible to know if they accurately represent all social workers who counsel trauma

survivors. The data collected is unique to those who shared their stories rather than including all possible experiences.

Conclusion

This study, along with others before it suggest that secondary trauma is a common problem among social workers that needs to be taken seriously. It looks different in each person, but there are common experiences of physical reactions, negative emotions, relationship difficulties and the possibility of long-term worldview changes. It is important for social workers to be aware of the risks involved with counseling trauma survivors and be prepared to address the negative consequences as they occur. Although there are times when it is difficult to practice effective self-care, social workers benefit from having a toolbox of coping skills and methods of reducing stress. Secondary trauma may not be preventable, but the impact can be lessened through skills, support, education and intentional interventions (Bishop & Schmidt, 2011).

References

- Adams, R. E., Figley, C. R., & Boscarino, J. A. (2008). The compassion fatigue scale: Its use with social workers following urban disaster. *Research on Social Work Practice, 18*(3), 238-250. doi: 10.1177/1049731507310190
- Badger, K., Royse, D., & Craig, C. (2008). Hospital social workers and indirect trauma exposure: An exploratory study of contributing factors. *Health & Social Work, 33*(1), 63-71. doi: 10.1093/hsw/33.1.63
- Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18*(1), 71-86. doi: <http://dx.doi.org/10.1891/vivi.2003.18.1.71>
- Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work, 48*(4), 513-22. doi: <http://dx.doi.org/10.1093/sw/48.4.513>
- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84*(4), 463-470. doi: 10.1606/1044-3894.131
- Ben-porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence, 24*(7), 507-515. doi: <http://dx.doi.org/10.1007/s10896-009-9249-0>
- Betts Adams, K., Matto, H. C., & Harrington, D. (2001). The traumatic stress institute belief scale as a measure of vicarious trauma in a national sample of clinical social

- workers. *Families in Society*, 82(4), 363-371. Retrieved from http://search.proquest.com/docview/_23015952?accountid=14756
- Bishop, S., & Schmidt, G. (2011). Vicarious traumatization and transition house workers in remote, northern british columbia communities. *Rural Society*, 21(1), 65-73. doi: <http://dx.doi.org/10.5172/rsj.2011.21.1.65>
- Bloom, S. (1999). Trauma theory abbreviated. *Final Action Plan: A Coordinated Community-based Response to Family Violence*, Retrieved from http://www.dhs.vic.gov.au/data/assets/pdf_file/0005/587966/trauma_theory_abbreviated_sandra_bloom.pdf
- Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, 52(1), 63-70. doi: <http://dx.doi.org/10.1093/sw/52.1.63>
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4), 451-9. doi: <http://dx.doi.org/10.1093/sw/48.4.451>
- Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Work Education*, 40(2), 305-317. Retrieved from <http://search.proquest.com/docview/209784134?accountid=14756>
- Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary trauma. *Journal of Social Work Education*, 36(1), 27-38. Retrieved from

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=68709&site=ehost-live>

Fox, R., & Carey, L. A. (1999). Therapists' collusion with the resistance of rape survivors. *Clinical Social Work Journal*, 27(2), 185-201. Retrieved from <http://search.proquest.com/docview/227783929?accountid=14756>

Geller, J. A., Madsen, L. H., & Ohrenstein, L. (2004). Secondary trauma: A team approach. *Clinical Social Work Journal*, 32(4), 415-430. doi: <http://dx.doi.org/10.1007/s10615-004-0540-5>

Hesse, A. R. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal*, 30(3), 293-309. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=72066&site=ehost-live>

Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288. doi: 10.1177/1049732305276687

Hunter, S. V., PHD. (2012). Walking in sacred spaces in the therapeutic bond: Therapists' experiences of compassion satisfaction coupled with the potential for vicarious traumatization. *Family Process*, 51(2), 179-92. doi: <http://dx.doi.org/10.1111/j.1545-5300.2012.01393.x>

- Jankoski, J. A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare, 89*(6), 105-20. Retrieved from <http://search.proquest.com/docview/865923861?accountid=14756>
- Kanno, H. (2010). Supporting indirectly traumatized populations: The need to assess secondary traumatic stress for helping professionals in DSM-V. *Health & Social Work, 35*(3), 225-227. doi: <http://dx.doi.org/10.1093/hsw/35.3.225>
- Matheson, J. L., & Rosen, K. H. (2012). Marriage and family therapy faculty members' balance of work and personal life. *Journal of Marital and Family Therapy, 38*(2), 394-416. doi: <http://dx.doi.org/10.1111/j.1752-0606.2009.00137.x>
- McCann, L., & Pearlman, L. A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.
- Miehls, D. (2010). Contemporary trends in supervision theory: A shift from parallel process to relational and trauma theory. *Clinical Social Work Journal, 38*(4), 370-378. doi: <http://dx.doi.org/10.1007/s10615-009-0247-8>
- Myers, M. F., & Fine, C. (2007). Touched by suicide: Bridging the perspectives of survivors and clinicians. *Suicide & Life - Threatening Behavior, 37*(2), 119-26. doi: <http://dx.doi.org/10.1521/suli.2007.37.2.119>

Naturale, A. (2007). Secondary traumatic stress in social workers responding to disasters:

Reports from the field. *Clinical Social Work Journal*, 35(3), 173-181. doi:

<http://dx.doi.org/10.1007/s10615-007-0089-1>

Nuttman-Shwartz, O., & Dekel, R. (2008). Training students for a shared traumatic

reality. *Social Work*, 53(3), 279-81. doi: <http://dx.doi.org/10.1093/sw/53.3.279>

Perlman, S. D. (1999). *The therapist's emotional survival: Dealing with the pain of exploring trauma*. Northvale, New Jersey: Jason Aronson Inc.

Pulido, M. L. (2012). The ripple effect: Lessons learned about secondary traumatic stress

among clinicians responding to the september 11th terrorist attacks. *Clinical Social*

Work Journal, 40(3), 307-315. doi: <http://dx.doi.org/10.1007/s10615-012-0384-3>

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child

welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, 90(6), 149-68. Retrieved from

<http://search.proquest.com/docview/1016368116?accountid=14756>

Strom-Gottfried, K., & Mowbray, N. D. (2006). Who heals the helper? facilitating the

social worker's grief. *Families in Society*, 87(1), 9-15. doi:

<http://dx.doi.org/10.1606/1044-3894.3479>

Ting, L., Jacobson, J. M., Sanders, S., Bride, B. E., & Harrington, D. (2005). The

secondary traumatic stress scale (STSS): Confirmatory factor analyses with a

national sample of mental health social workers. *Journal of Human Behavior in the Social Environment*, 11(3), 177-194. doi: http://dx.doi.org/10.1300/J137v11n03_09

Tosone, C., Nuttman-shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. *Clinical Social Work Journal*, 40(2), 231-239. doi: <http://dx.doi.org/10.1007/s10615-012-0395-0>

Ying, Y. (2009). Contribution of self-compassion to competence and mental health in social work students. *Journal of Social Work Education*, 45(2), 309-323. doi: <http://dx.doi.org/10.5175/JSWE.2009.200700072>

Appendix A

Secondary Trauma in Social Workers RESEARCH INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating secondary trauma. This study is being conducted by Karen James, a student in the Masters of Social Work program at St. Catherine University and the University of St. Thomas. You were selected as a possible participant in this research because you were identified as a social worker who has had experience counseling trauma survivors. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to explore the internal reactions of social workers to the traumatic stories they hear regularly. Data collected will help readers understand the impact secondary trauma may have on a social worker and how it is addressed. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to click on the provided link that will open an electronic survey. The survey questions are open-ended and designed to explore personal experiences you have had in counseling trauma survivors. This survey will take approximately 30 minutes to complete and will not require any follow-up by respondents.

Risks and Benefits:

The study has minimal risks involved due to respondent anonymity. Participating in this survey may cause psychological distress as answers may involve personal information that is difficult to talk about. If this happens, you may discontinue your participation in the study. There are no direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. Study participants will be asked general demographic questions, but identity will remain anonymous to the researcher.

I will keep the research results in a password protected computer and only this researcher and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May of 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. If there are questions you do not feel comfortable answering, you may refuse to do so. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:

If you have any questions, please feel free to contact me, Karen, at xxx-xxx-xxxx or xxxxxxxx@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Catherine Marrs Fuchsel PhD, LICSW, will be happy to answer them (651-690-6146). If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Clicking on the given link and completing the survey indicates that you have read this information, understand the nature of this study and any of your questions have been answered. Even after beginning the survey, please know that you may withdraw from the study at any time and no further data will be collected.

Appendix B

1. What is your educational background?
2. Describe your current and previous practice environments?
3. What has motivated your choice to counsel trauma survivors?
4. Secondary trauma is defined as the trauma-related symptoms a therapist may experience as a result of counseling trauma survivors. Have you seen secondary trauma reactions in yourself or others in your career? Please explain.
5. What are your physical and emotional feelings like during and after sessions with trauma survivors?
6. What theories do you incorporate to understand client experiences?
7. Why are some cases more difficult to deal with personally than others?
8. In what ways does your job affect your personal life?
9. How does stress in your personal life affect your job performance? How does one separate personal stress from job-related stress?
10. What are the most effective ways an agency can show support to social workers counseling trauma survivors? Describe what that would look like.
11. In what ways do you practice self-care?
12. What factors get in the way of practicing effective self-care?
13. How have family and friends supported you when work has been most stressful?
14. In order to assure informed consent, please describe the purpose of this questionnaire.
 - A. To obtain goods or services
 - B. For a graduate students research project
 - C. Other purpose not listed