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Secondary Trauma: Agency support as a Protective Factor

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Secondary Trauma:

Agency support as a Protective Factor

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Abstract

Secondary trauma is something that any clinician could experience if they work with clients who have a trauma history. This is where the clinician exhibits symptoms of Posttraumatic Stress Disorder by hearing about the details of a client's trauma. There has been much research done on possible protective and predictive factors for secondary trauma. One of these protective factors is receiving supervision. Supervision is time spent with a clinician's supervisor to debrief about clients, talk about work in general, receive feedback from documentation and client interactions, and receive psychoeducation from the supervisor about relevant client issues. It is the debriefing about clients that can be especially helpful for secondary trauma. A quantitative survey was sent to clinicians who work with clients who have experienced trauma. This survey asked questions about supervision, self-care, outside hobbies, etc. This survey also included the Secondary Traumatic Stress Scale, which measured symptoms of secondary trauma in three categories: intrusion, avoidance, and arousal. There was a significant negative correlation between receiving supervision and arousal symptoms. No other analysis comparing secondary trauma to supervision was significant. There was a significant relationship between spending quality time with friends and lower rates of secondary trauma, however.

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Introduction

Social work is a field with many different facets. A social worker can be employed in a school, hospital, mental health facility, case management agency, or a number of other agencies. As the setting varies, the clientele will also. One client characteristic that can be constant among all these disciplines is having a trauma background. It is likely that regardless of the setting, some of the clients on a social worker's caseload will have experienced a traumatic event at some point in his or her life.

Trauma

There are many experiences that can be traumatic. Trauma has been defined as "...an experience that is sudden and potentially deadly, often leaving lasting and troubling memories," (Figley 173). Other research has contested the necessity for the event to include the threat of death since people have been traumatized by non-life threatening events. Some of these possible events include parents divorcing, being bullied by classmates, or having an alcoholic or mentally ill parent (Briere & Scott, 2013; Cozolino, 2002). All of these can be considered traumatic.

People from many different populations can experience trauma. It has been estimated that the lifetime prevalence for being exposed to a traumatic event ranges from 40- 81% (Bride, 2007). This can be much higher for some subsets of the general population. For example, 97% of homeless women with a diagnosis of a mental disorder reported experiencing abuse in their life (Goodman, Dutton, & Harris, 1997). It has also been reported that 60-90% of people in treatment for substance-abuse reported having

experienced sexual or physical abuse (Cohen & Densen-Gerber, 1982). This increases the likelihood of a clinician coming across a traumatized client.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a mental illness that can occur after experiencing a trauma. It is characterized by nightmares, flashbacks to the event, elevated arousal, (Bryant, Marosszeky, Crooks, Baguley, & Gurka, 2000; McHugh & Treisman, 2007), intrusive thoughts, emotional numbing, (Bodkin, Pope, Detke & Hudson, 2007) and avoiding places where the trauma occurred, or that remind the person of the trauma (Spitzer, First & Wakefield, 2007). These negative effects can be very debilitating.

The prevalence of PTSD can vary among populations. In May of 2006, the Center for Disease Control and Prevention (CDC) studied police officers who responded to Hurricane Katrina in New Orleans, Louisiana. 19% fit criteria for PTSD. Mount Sinai School of Medicine studied the mental health of rescue workers who responded to the September 11th terrorist attack. They found approximately 20% of participants suffered from PTSD (CDC, 2004). Research was done on middle school-aged survivors of the May 12th, 2008 earthquake that occurred in Wenchuan county in China. 28.4% of respondents were at a high risk for PTSD.

Secondary Trauma

While PTSD can occur within the traumatized person, secondary trauma can occur within those around the traumatized person. Secondary trauma refers to what can happen when a survivor tells his or her story to caregivers, family members, friends, and clinicians. Those who hear the stories may also exhibit symptoms of post-traumatic stress disorder (PTSD) simply by hearing the events described (Elwood, Mott, Lohr &

Galovski, 2010; Figley & Figley, 2009). Some of the symptoms of secondary trauma include intrusive thoughts, traumatic memories or nightmares, insomnia, chronic irritability, angry outbursts, fatigue, difficulty concentrating, avoidance of traumatized clients, and hyper vigilance (Newell & MacNeil, 2010). Note the similarities to the symptoms of PTSD. There can be other terms for this phenomenon. Secondary trauma can also be called secondary traumatic stress (Figley, 1999), vicarious traumatization (McCann & Pearlman, 1990), and secondary traumatic stress disorder (Figley, 1995).

The criteria for secondary traumatic stress is similar to that of PTSD. The categories are intrusive thoughts of the traumatic event, avoiding places and/or people that are reminiscent or the traumatic event, and arousal symptoms such as anxiety, irritability, difficulty sleeping, and bursts of anger, hyper vigilance, etc. Research done by Bride (2007) showed 55% of master's level social workers reported experiencing at least one of the criteria. 43% reported experiencing all three criteria. 47.1% of participants reported working with clients who were moderately traumatized and 34.5% reported working with clients who were severely traumatized. The prevalence of secondary trauma poses a problem for the social work field.

Supervision

Supervision is an important aspect of the social work field. It is a requirement for social workers who are seeking a license to receive a certain amount of hours in supervision. It is also a part of most social work jobs. It can be individual supervision, with just one clinician and the supervisor, or group supervision, where there are multiple supervisees and one supervisor (Zeira & Schiff, 2010). There are three main functions of supervision: administrative, educative, and supportive. Its overall objective is to help

prepare clinicians to provide efficient, effective and ethical services to clients (Kadushin, Berger, Gilbert, de St. Aubin, 2009). It also provides administrative accountability for employees, to make sure all job duties are being performed adequately and timely. This can include documentation, assessments, treatment plans, and other paperwork. Supervisors also provide evaluations of job performance on an overall basis, and, ideally, provide feedback throughout the year as well. Supervisors are also supposed to provide education to supervisees about best practices with clients. Finally, supervision should be a place where clinicians can get support around stressful situations, difficult clients, frustrations, and other difficult emotions social workers can experience while working in the field. Supervision has been shown to increase job satisfaction and job performance in many employees (Bogo & McKnight, 2005). Overall, supervision is meant to provide support to clinicians so they can be most effective in their work with clients.

Some researchers have created a distinction between supervision and clinical supervision. Clinical supervision is required of all people seeking social work licensure. It is also offered at many agencies. It has been defined as having the educational and supportive aspects, but not the administrative. This type of supervision is focused on client-centered work, and improving the skills and knowledge of the clinician (Bogo & McKnight, 2005). This is especially important with social workers seeking a license.

Stress and Self Care

Stress has been defined as "…the perception that the demands of an external situation are beyond one's perceived ability to cope," (Myers, Sweeney, Popick, Wesley, Bordfeld, & Fingerhut 55). College and graduate students often report high levels of stress (Clements & Minnick, 2012). Students, as opposed to other populations, are under

pressure and stress specifically related to academic performance (Myers, et al., 2012). They often have little free time. It is likely that "student" is not the only role the person will play; most have employment, some are parents, spouses, or other caregivers. Social work students have the added stress of field placements. These internships are often unpaid, and are required for licensure. These internships take place in social services agencies, so social work students are also dealing with similar emotions and stressors that fully employed clinicians do (Moore, Bledsoe, Perry & Robinson, 2011).

Radey and Figley defined self-care as "…a potential mechanism to increase clinicians' positive affect and physical, intellectual and social resources," (210). Stress can lead to burnout in social work clinicians. Practicing self-care can help to mitigate some of these negative effects of stress (McGarrigle & Walsh, 2011). There are healthy and unhealthy strategies to cope with stress. Some people use alcohol, smoking and illegal drugs as a coping mechanism. College students especially may drink to excess to relieve stress. Alternatively, leisure activities such as relaxing and spending time with friends can be positive and healthy coping strategies (Clements & Minnick, 2012). One study asked people to name what self-care activities they engage in. The most prevalent was physical exercise. Some of the other popular responses were focusing on physical health, engaging in hobbies/other fun activities, relaxing, and seeking the support of friends, family, co-workers, significant others, etc. (Hansson, Pernilla, & Forsell, 2005). Being educated in stress-management skills can also be an effective intervention for coping (Clements & Minnick, 2012). There are a variety of things individual clinicians can do for self-care that can prevent or combat the effects of stress.

While there are many things clinicians can do individually for self-care, agencies can also be structured to provide self-care for employees. This is especially important in the social work field. Some of the things agencies can do can include limiting and diversifying the amount of clients assigned to an employee, providing regular and supportive supervision, offering benefits, and staff development opportunities. Ultimately, if a work environment is warm and inviting, and promotes consultation and support, it can help with self-care (Radey & Figley, 2007). Ideally, if a clinician works for a supportive environment, and practices self-care outside of work, the clinician should have lower stress levels.

Importance to Social Work

Clinicians who work with traumatized clients are at risk for secondary trauma. This is the focus of this research. It will look at supervision, consultation, and self-care as possible protective factors. The participants of this research will be licensed independent clinical social workers (LICSWs) who work with traumatized clients.

Social work is an expansive field with many disciplines. Across all of these disciplines, it is likely that clinicians will come across clients with a trauma background. Because of this probability, it is important for clinicians to be aware of the possibility of experiencing secondary trauma. This research is important because identifying the protective and risk factors can help to mitigate the effects of secondary trauma.

A Review of the Literature

The Social Work Profession

People in the social services work with very challenging populations. Clients can be survivors of domestic violence, disasters, crime, and sexual, emotional, and/or physical abuse (Bride, 2007). Professionals hear horrifying stories and talk to struggling people every day. They are expected to tackle these problems head-on, and change the lives of others. While this can be a very rewarding profession, it can be psychologically taxing.

Researchers have developed a number of terms for what clinicians can experience after working with clients. One term is compassion fatigue, which has been defined as "the trauma suffered by the helping professional" (DePanfilis, 2006, p. 1067). Another is burnout, which DePanfilis (2006) defines as the "emotional exhaustion, depersonalization, and reduced sense of personal accomplishment" (p. 1067). Secondary trauma is when a clinician experiences PTSD symptoms simply by hearing the details of a client's trauma. Finally, DePanfilis (2006) identifies compassion satisfaction as "the fulfillment from helping others" (p. 1067). This fulfillment is what keeps social workers coming back to work.

Social Work Ethics

The National Association of Social Workers (NASW) has a set of ethics that social workers have to heed in their professional practice. There are professional consequences if these ethics are breached (National Association of Social Workers, 2008). It also sets the tone for what social workers stand for and what we believe in.

An ethical principle that is relevant to this research is service. According to the NASW (2008), "social workers' primary goal is to help people in need and to address social problems." Each of the other principles is also client-centered: social justice, dignity and worth of the person, importance of human relationships, and integrity. There is an ethical standard about providing supervision and consultation to colleagues, but it is only in the context of education and providing services to clients. Therefore, it is of no interest to this study. None of the ethical principles or standards includes anything about self-care of the clinician. Many of the other principles' aims are to further the treatment and assistance of clients. This sends the message that clinicians are not supposed to prioritize their own self-care, or seek the support that is so important.

Predictive Factors

Not every clinician who works with traumatized clients experiences secondary trauma. Research has found some predictive factors for this phenomenon. A study was done on social workers who worked with victims of the September 11th terrorist attack. It sought to identify factors that led to higher rates of secondary trauma. There were two main outcomes of this study. Social workers who responded to different kinds of trauma were correlated with higher rates of secondary trauma. This was hypothesized to be because of higher exposure to traumatized clients. A second finding was that younger social workers tended to have higher rates of secondary trauma (Kanno, 2010).

One study on sexual assault counselors found that having a personal trauma history and being younger in age was correlated with higher incidents of secondary trauma (Ghahramanlou & Brodbeck, 2000). Another study found providing trauma-

focused therapy/treatment (Elwood, Mott, Lohr & Galovski, 2011) was also a risk factor for secondary trauma.

Protective Factors

As secondary trauma has been researched, a few protective factors have emerged. If a clinician focuses on self-care outside of work, takes coffee and lunch breaks during work hours, gets enough sleep, seeks support and supervision from coworkers, engages in exercise, hobbies, self-expression, spirituality, meditation, psychotherapy (Newell & MacNeil, 2010), limit caseloads (Elwood, Mott, Lohr & Galovski, 2011), spends fewer hours with the traumatized client, (Kanno, 2010) they are less likely to experience secondary trauma. Certain demographics also had lesser rates of secondary trauma. If a clinician was married, and/or lived with other people, they reported fewer symptoms of secondary trauma (Byrne, 2006). It is important for social workers to be aware of these protective factors, and incorporate them into their daily lives.

Another study was done on clinicians who aided victims of the September 11th terrorist attack in 2011. Some of the survivors had lost family members, friends, and colleagues. Others had been injured personally, or were in the vicinity when the attack occurred. Many of the clinicians reported feeling very stressed, depressed, and anxious during this time period. When asked about resources offered by the agencies they worked for, almost 50% of participants responded there was no support during this time. Another 25% said support was offered, but they did not feel like they could use it. The remaining 25% said they received support, and that it was very beneficial (Pulido, 2012). Though clinicians would be the first to urge clients to talk about their issues and seek support from others, social workers may not take their own advice.

Agency Support

Having support at work is important in most careers, but it is especially important in the social work profession. Many studies show a positive correlation between work support (support from supervisors and coworkers) and job satisfaction (McCalister, et al., 2006; Talbert-Hersi, 1991; Kanno, 2010). Another study looked at the relationship between support at work and absenteeism. The results suggest social workers miss fewer days of work when they feel supported by coworkers and supervisors (Unden, 1996). These studies show agency support can have a very positive effect on the professional and personal lives of social workers.

There has been a lot of research done that suggests agencies should be doing more to prevent secondary trauma. One study looked at the narratives of two different clinicians who worked with victims of terrorism attacks (Tosone, Nuttman-Schwartz & Stephens, 2012). One clinician, "TS," who worked with victims of the September 11th attack, stated that the agency provided supervision, but that consulting with peers was the most helpful. Another clinician, "OS," living in Israel during Qassam rocket attacks, had an interesting experience while working with a victim. "OS" and the client had a role reversal; the client was very worried for the safety of the clinician. The clinician was immediately wary of this, but after a while, began talking to the client about their own experiences and worries. In a sense, they got through these acts of terrorism together, instead of the clinician only looking out for the client. These authors urged for the use of both supervision and peer support in agencies. They encouraged clinicians who are not being offered these supports to be self-advocates.

Gaps in Research

This study will be looking at the relationship between rates of secondary trauma and agency support. Most of the research done on this topic has been following specific events, such as natural disasters and terrorist attacks; little research has looked at clinicians in general. This makes it difficult to know the true prevalence of secondary trauma for clinicians who are not responding to a disaster.

Conceptual Framework

A conceptual framework explains the lens used by the researcher to view a social problem. This framework is important because it can shape the research question and subsequent hypothesis. This study will look at the relationship between secondary trauma and having a supportive workplace. The researcher will use the trauma theory and the ecological theory to ground the research.

Trauma Theory

Trauma theory states that once someone experiences an event that is personally traumatic, his or her life is deeply affected. It is not the trauma itself that is harmful, it is the reaction in one's mind and body to the experience that can be damaging (Bloom, 1999). People can experience PTSD symptoms such as flashbacks, insomnia, elevated arousal, emotional numbing, and intrusive thoughts (Saakvitne, Tennen, & Affleck, 1998; McHugh & Treisman, 2007; Bodkin, Pope, Detke & Hudson, 2007). People often use therapy and/or medication to treat the effects of a traumatic event.

There is an evolutionary principle that relates to trauma. This is called the fight-or-flight response. Our bodies are biologically programmed to shield us from harmful agents. Each time we are faced with danger, our bodies elicit this fight-or-flight response. This creates neural pathways that become more sensitive to perceived danger (Bloom, 1999). This is related to trauma because experiencing a traumatic event will likely elicit the fight-or-flight response. This can make people more sensitive to even minor threats.

This theory is relevant to this research. Without trauma theory, social work would not be concerned with the effects of experiencing a trauma. Similarly, because of trauma

theory, it has been proposed that hearing about traumatic events in detail can have such a profound effect on a clinician that it can cause vicarious traumatization.

Ecological Theory

Ecological theory states that people are affected by their environment. People do not exist in a vacuum; our behaviors, thoughts, feelings and actions can be a result of environmental factors (Forte, 2007). This theory also refers to the idea that we can be shaped by our upbringing, background and culture (Ohmer, 2010). This theory can involve both protective and risk factors.

This is relevant to secondary trauma for a few reasons. Part of every employee's life is the work environment. A clinician's work environment includes work with clients and other job duties. Ecological theory proposes people are affected by their environment. If a clinician can be affected so deeply by a client's story that it manifests PTSD, it is part of ecological theory. Second, one of the best protective factors for secondary trauma is supervision (Newell & MacNeil, 2010). This suggests we can be affected by outside sources. This is another part of ecological theory.

Method

Research Question

The research question for this study is: do rates of secondary trauma decrease if agencies provide support to clinicians? Secondary trauma was operationally defined by using the Secondary Trauma Stress Scale (Bride, 1999). Agency support was defined as regular supervision (weekly or bi weekly), consultation, and debriefing with colleagues. The hypothesis is: higher rates of agency support is associated with lower reports of secondary trauma.

Research Design

This was a quantitative study. Participants completed a survey (Appendix A). This survey was administered using Qualtrics, and was distributed via e-mail. Qualtrics is an website that allows one to create a survey. The survey contained questions about the kind of work the clinician does, their experience with traumatized clients, and the services that are offered by the agency. There were also questions about how often the clinician receives supervision, how often they consult with coworkers, and other demographic questions.

Participants also took the Secondary Trauma Stress Scale (Appendix B) to compare rates of secondary trauma. This was developed by Bride, Robinson, Yegidis, and Figley in 2004. It is a series of statements on a Likert scale. These statements pertain to feelings and experiences of the clinician, such as "I felt emotionally numb." It also asks about how the clinician feels about the client, such as thinking about the client outside of sessions, dreading sessions with certain clients, having dreams about clients,

etc. The participant was asked to rate the severity of the feeling/experience he or she has had in the past seven days. The relationship between the protective factors (supervision, consultation, self-care) and the rates of secondary trauma was analyzed using SPSS version 21.

Sample

Clinicians were found using the Minnesota Board of Social Work's list of Licensed Individual Clinical Social Workers. This list of e-mail addresses were e-mailed by the Board to the researcher. This e-mail list was destroyed after the survey had been distributed. Clinicians who did not report on the survey that they work with clients who have experienced trauma were not included in the analysis.

Protection of Human Subjects

There was minimal risk to participants. The participants were not asked to relive unpleasant experiences or cases that may have invoked secondary trauma. They were asked questions about their current mental symptoms, not the possible causes. This research study was reviewed and approved by the Saint Catherine University Institutional Review Board before any data collection took place. All participation was voluntary. Clinicians were assured of confidentiality and were told they can choose not to answer any questions. There was also an explanation of informed consent. Before they could proceed to take the survey, participants had to read the consent form (Appendix C), which was printed on a screen. The participant had to check that they understand what they read, and that they consented to be a part of this study. Data was stored on the researcher's laptop on a password-protected Word document. It was only shared with the

research supervisor and two other committee members. No one else had access, and no identifying information was shared. All data will be destroyed after May 19th, 2014.

Findings

Of the 99 surveys that were administered, 32 were returned. There were a number of demographic questions and other variables that were compared with the scores of the secondary traumatic stress scale. This scale measured scores in three groups of symptoms: intrusion, avoidance, and arousal. Intrusive symptoms indicate symptoms that are added, such as anxiety, reliving trauma, dreams about the trauma, etc. Avoidant symptoms can include experience numbness, hopelessness, and avoiding clients. Finally, arousal symptoms are sleeplessness, feeling jumpy, having difficulty concentrating, etc.

Descriptive Statistics

Table 1 shows many of the descriptive statistics studied in this research. One was the race of the participants. The majority were Caucasian. 9.3% of participants were African-American, and 3.1% were Hispanic. None of the respondents reported being Asian-American, Pacific Islander or Native American. Participants were also asked about their marital status. The majority of respondents reported being married, with the remaining 33.3% being single. 75% said they do not live alone, with the remaining 18.8% reporting they do. There were a few questions pertaining to supervision, consultation, and meeting with clients. Most (34.4%) of respondents said they meet with clients weekly. Interestingly enough, only 28.1% of respondents reported receiving supervision. 87.5% of participants said they consult with co-workers about clients, however.

Table 1: Demographic Characteristics (N=30)

	N	*%*
Race		
African-American	3	9.3%
Caucasian	26	81.3%
Hispanic	1	3.1%
Marital Status		
Married	20	62.5%
Single	10	31.3%
Living Alone		
Yes	6	18.8%
No	23	71.9%
Meeting with Clients		
Once per week	11	34.4%
Twice per week	3	9.4%
Every other week	2	6.3%
I do not meet with clients	4	12.5%
Meetings are not scheduled	4	12.5%
Other amount of time	8	25.0%
Receiving Supervision		
Yes	9	28.1%
No	21	65.6%

Inferential Statistics

To score the Secondary Trauma Stress Scale, there were three categories: Intrusion, avoidance, and arousal. These categories indicate the types of symptoms associated with secondary trauma. Symptoms of intrusion include reliving the client's trauma, experiencing anxiety when thinking about work with clients, having dreams about clients, etc. These are all things that are added to the clinician's life. Symptoms of avoidance included feeling numb emotionally, feeling hopeless about the future, being less active, wanting to avoid working with clients, etc. Finally, symptoms of arousal were having trouble sleeping, feeling jumpy, having trouble concentrating, etc. Different questions in the survey pertained to different categories. These scores on the likert scale

were added up to come up with the three scores. These scores were analyzed with other variables to compare rates of secondary trauma.

Chi Square

A chi square test was done comparing receiving supervision to the intrusion, avoidance, and arousal scales. The hypothesis was if a clinician receives supervision, the rates of secondary trauma will decrease. The null hypothesis was that there is no significant relationship between supervision and symptoms of intrusion. The p-value for the relationship between supervision and intrusion symptoms was .210. Since this is larger than .05, the null hypothesis was not rejected. This means that receiving supervision was not significantly related to intrusion symptoms ($x2(8)= 10.850$, $p=.210$).

The second hypothesis was that if a clinician received supervision, symptoms of avoidance would decrease. The null hypothesis was that there was no significant relationship between supervision and avoidance symptoms. The p-value for the relationship between supervision and avoidance was .059. This was the closest to a significant relationship; but since it is larger than .05, the null hypothesis was not rejected. This means receiving supervision was not significantly related to avoidance symptoms ($x2(10)=17.792$, $p=.051$).

The third hypothesis was that if a clinician receives supervision, the rates of arousal symptoms would decrease. The null hypothesis was that there is no significant relationship between supervision and arousal symptoms. The p-value was .061. Since this is more than .05, the null hypothesis was not rejected. This means receiving supervision was not significantly related to arousal symptoms ($x2(11)=19.017$, $p=.061$).

A chi-square was also done on some other variables. One question on the survey asked about other activities that were a part of the participants' life. The participant had a list to choose from, and could check all that apply. One of these activities was spending time with friends. The hypothesis was if the clinician spent quality time with friends outside of work, rates of secondary trauma would decrease. The null hypothesis was that there was no significant relationship between time spent with friends and rates of secondary trauma. The p-value for time spent with friends and avoidance symptoms was .002. Since this is less than .05, the null hypothesis was rejected. This means there was a significant relationship between spending time with family and friends and avoidance symptoms ($x2(10)= 28.000$, p=.002). The hypothesis was if the clinician spends time with friends outside of work, the rates of secondary trauma would decrease. The null hypothesis was that there is no significant relationship between quality time spent with friends and arousal symptoms. The p-value was .003. Since this is less than .05, the null hypothesis was rejected. This means there was a significant relationship between receiving supervision and experiencing arousal symptoms ($x2(11)=28.000$, p=.003).

Correlation

The relationship between supervision and symptoms of secondary trauma was explored. There were three separate hypotheses analyzed in this correlation: that if a clinician receives supervision, rates of intrusion will decrease, rates of avoidance will decrease, and rates of arousal will decrease. The null hypotheses are that there is no significant relationship between receiving supervision and rates of avoidance, arousal, and intrusion. The correlation between supervision and intrusion was nonsigificant (r= -.226, p=.247). Since this is more than .05, the null hypothesis was not rejected. The

correlation between supervision and avoidance was nonsignificant (r= -.354, p= .064).

Since this is more than .05, the null hypothesis was not rejected. Finally, the correlation

between supervision and arousal was significant (r= -.389, p<.05). Since this is less than

.05, the null hypothesis was rejected. There is a statistically significant relationship

between receiving supervision and experiencing symptoms of arousal.

Discussion

The purpose of this research study was to test the relationship between supervision and secondary trauma in clinicians who work with traumatized clients. This was explored using a quantitative survey. The survey that was used asked questions pertaining to variables including supervision, consultation with colleagues, and self-care activities. Participants were also asked to take the Secondary Traumatic Stress Scale. The results were analyzed using a chi-square test, a correlation test, and various descriptive statistics.

Much of this data was not supported by the research reviewed in the literature. The chi-square test did not yield any significant results for supervision having an effect on rates of secondary trauma. Newell and MacNeil, for example, suggested that receiving supervision is a protective factor for secondary trauma (Newell & MacNeil, 2010), however this research did not yield consistent results.

There was a significant correlation between receiving supervision and experiencing symptoms of arousal. The other symptoms of secondary trauma, however, such as intrusion and avoidance, did not have a significant correlation with receiving supervision. It is important to note here that correlation does not show causation. While a correlation means there is a relationship among the two variables, it does not mean one causes the other.

There was one very positive and surprising outcome from this research. A chi-square test suggested a significant relationship between spending quality time with friends and lower rates of secondary trauma symptoms. This was consistent with the

research of Newell and MacNeil (2010), as well. Their research suggested focusing on self-care outside of work, which can include time with family and friends, can be a protective factor for secondary trauma.

Strengths of Research

There were some strengths to the survey method. The researcher used a validated instrument, the Secondary Traumatic Stress Scale. Also, the survey was distributed via the internet. Online interviews are anonymous, as opposed to an in-person interview. This can make the participant feel more comfortable answering the questions. The survey was meant to take no more than 15-20 minutes, which should have made it easy for respondents to complete. Also, the questions were designed to not be embarrassing in nature, so the participants should not feel uncomfortable partaking in the study. All of these aspects contributed to the good response rate. Out of 99 surveys sent, 32 were returned. This was a 32% response rate.

Limitations of Research

There were a few limitations to this research project. The sample size ended up being only 32. This was limited by a few factors. The respondents were required to work with clients who have experienced trauma. Since the sample was a random list of LICSWs in Minnesota, it is possible there were some who would have completed the survey, but did not fit the criteria. Also, since the research had limited time and resources available, only 99 LICSWs were contacted. It would have been ideal to be able to contact more people, but time did not permit.

The demographics of the sample were also limited. Of the 32 respondents, only 9 reported receiving supervision. This is a very small number, and only 28% of the

respondents. Since my main hypothesis assumes most clinicians are receiving supervision, this skewed the results. Also, a large majority (81%) of participants reported being Caucasian.

Finally, the research base was limiting. Most of the data was collected after major events, such as the September 11th attack. Many of the remaining traumatized victims and their families required services, so it is an understandable research base. It does not show overall rates of secondary trauma, however. The instrument used in this research also did not measure the rates of secondary trauma.

Human Error

Human error was also a limitation of this research. There were two errors in the survey that was distributed. One question, "have you experienced trauma in your own life," was supposed to have three options: Yes, no, and prefer not to answer. This survey was developed electronically, on a program called Qualtrics. When the researcher entered three options, the program automatically changed these options to: Yes, maybe, and prefer not to answer. This mistake was not noticed by the researcher, and so the question was not able to be used. Also, there was supposed to be a question asking about the gender of the participant. The first question the respondents viewed was a statement of consent. The respondent needed to check the box stating they read and understood the information, and consent to participate. If this box was checked, they could proceed to the following question. If this box was not checked, the survey was invalid. Due to a mistake by the researcher, if the first box was checked, the question that the respondent skipped to was the question regarding race. This meant the question about gender was skipped. This is limiting because gender is a popular demographic variable.

Implications for Future Research

Secondary trauma is a serious issue in the social work community. Due to the likelihood of a clinician working with a client who has a trauma history, it is important for a clinician to know how to prevent secondary trauma. While supervision has been posited to be one of the preventative factors, secondary trauma is an area that requires much more exploration.

While this study yielded mostly insignificant results, there were a variety of limitations, including low numbers and human error that could explain this. This study could easily be replicated with a larger, more specific respondent base. Instead of using a random list of LICSWs, a researcher could obtain a list of clinicians known to work with traumatized clients. This could return significant results.

Conclusion

A clinician can experience secondary trauma by hearing the details of a client's trauma. This is exhibited by PTSD-like symptoms, such as intrusive thoughts, insomnia, fatigue, difficulty concentrating, angry outbursts, avoidance of traumatized clients, and hyper vigilance (Newell & MacNeil, 2010; Elwood, Mott, Lohr & Galovski, 2010; Figley & Figley, 2009). This research study was looking at the relationship between receiving supervision and secondary trauma. The hypothesis was if a clinician received regular supervision, rates of secondary trauma would decrease.

While supervision was the main variable that was tested, others were explored as well. The most important finding from this study was the relationship between self-care and secondary trauma. If a clinician spent time with family and friends outside of work, there was a significant decrease in arousal symptoms. There was also a significant correlation between receiving supervision and experiencing symptoms of arousal. There were no other significant results of this research, however.

Ultimately, this is a very important topic to this field. Clients who have experienced trauma deserve mental health treatment. Providing effective mental health services to these clients should not result in secondary traumatization of the clinician. Because of this, it is imperative that this topic is further explored.

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Appendix A: Survey Questions

Gender: ____male ____female ____transgender____ prefer not to answer

Race (check all that apply): ____Africa-American ____Asian-American _____Caucasian ____Hispanic _____Pacific Islander _____Native American _____Other _____prefer not to answer

Marital Status: ____married _____single

Do you live alone? ____no ____yes

Years' experience working in the field: ____20+ ____15-20 ____11-14 ____6-10 ___5 or less

Do you work with clients who have experienced trauma? ___yes ___ no

How often do you meet with clients? ___1x per week ___2x per week ___every other week ____I do not meet with clients ____client meetings are not scheduled

Do you receive supervision? ____yes ____no

If yes, how often? ___ 1x per week ____ every other week ___monthly ____not scheduled

Do you consult/debrief with co-workers about clients? ____yes ____no

Have you discussed secondary trauma in supervision/orientation/ other training? ___yes ____no

Have you experienced trauma in your own life? ____no ____yes

Which of these activities are a part of your life? (check all that apply)

____ exercise

____ spirituality/religion

____ quality time with family/friends

____volunteer work

____ attending therapy

____ getting at least 7 hours' sleep most nights

____ other hobbies

Appendix B: Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven** (7) days by choosing the corresponding number next to the statement.

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

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb…………..............	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients....................	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)...................	1	2	3	4	5
4. I had trouble sleeping...........................	1	2	3	4	5
5. I felt discouraged about the future............	1	2	3	4	5
6. Reminders of my work with clients upsets me..	1	2	3	4	5
7. I had little interest in being around others...	1	2	3	4	5
8. I felt jumpy...	1	2	3	4	5
9. I was less active than usual......................	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to...............................	1	2	3	4	5
11. I had trouble concentrating......................	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.........	1	2	3	4	5
13. I had disturbing dreams about my work with clients...	1	2	3	4	5
14. I wanted to avoid working with some clients...	1	2	3	4	5
15. I was easily annoyed............................	1	2	3	4	5
16. I expected something bad to happen..	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.....................................	1	2	3	4	5

Appendix C: Letter of Informed Consent

Introduction:

You are invited to participate in a research study investigating the rates of secondary trauma in clinicians. The study is being conducted by Natalie Oleson who is a student in the School of Social Work at St. Catherine University. The purpose of the study is to look at supervision as a preventative factor to secondary trauma. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this research is to explore secondary trauma. Secondary trauma can occur in clinicians who work with clients who have experienced trauma. This study will look at the relationship between supervision and secondary trauma. Approximately 99 people are expected to participate in this research.

Procedures:

If you decide to participate, you will complete a short survey about your agency, client population, and supervision. You will also complete the Secondary Traumatic Stress Scale, which is a tool to measure secondary trauma in clinicians. It should take approximately 15-30 minutes to complete.

The results of this research will be presented at a symposium on May 19th, 2014.

Risks and Benefits of being in the study:

The study has minimal risks. You will be asked very general questions about your work life, and client experiences. The questions are mostly yes/no; there is little need to elaborate. There are no benefits or compensation for completing the survey. Your participation in this study is entirely voluntary. You may choose to skip any question on either survey.

Confidentiality and Anonymity:

Any information obtained in connection with this research study will be kept anonymous. This study will be discussed with a committee of three other people, but no identifying information will be included. In any written reports or publications, no one will be identified or identifiable and only general data will be presented.

I will keep the research results on a password protected document on my computer. Only I will have access to the records while I work on this project. After the results are presented on May 19th, 2014, all data will be destroyed.

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 in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Natalie Oleson, at 612-849-2280 or at Oles9402@stthomas.edu. You can also contact my research supervisor, Pa Der Vang, at 651-690-8647, or pdvang@stkate.edu. 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 Dr. John Fleming, Acting Chair of the College of St. Catherine Institutional Review Board, at (651) 690-6951.

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

Statement of Consent:

You are making a decision whether or not to participate. By completing the survey, you are consenting to be a participant in this research. You are indicating that you have read this information and your questions have been answered. Please know that you may withdraw from the study at any time.

Appendix D: Recruitment Script

Date

Dear _____

`   My name is Natalie Oleson. I am a graduate student in a social work program at Saint Thomas University/Saint Kate's University. I am conducting research about secondary trauma. Participants must currently work with traumatized clients. If you choose to participate, please fill out the attached survey. There are two short surveys; it should take you between 15-30 minutes. All information will be kept and anonymous; there is a consent form also attached with more information concerning this. Data will only be shared with my advisor and two committee members, and no information identifying the participants will be involved. This research will also be presented at a symposium. There will be no direct incentives or benefits for you as a participant, but it is a very important topic for the field in general.

Thank you very much for your consideration,

Natalie Oleson