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Effective Ways Social Workers Respond to Secondary Trauma

by

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MSW Clinical Research Paper
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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.

Abstract

Due to the traumatic material of their clients, social workers are often faced with symptoms of secondary trauma. Symptoms of secondary trauma can have an impact on a social worker's ability to form therapeutic relationships with their clients as well as interfere with their personal life. This qualitative study of six social workers, examines the ways that social workers effectively respond to the effects of secondary trauma. The findings of this study found that supervision, the importance of leaving work at work, spending time with family and friends, talking with colleagues, and extra support of agencies helped social workers respond to secondary trauma.

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In the United States, 60.7 percent of men and 51.2 % of women have been exposed to at least one traumatic event in their lifetime (Bride, 2007). Social workers are often the professionals who are dealing with these individuals who have experienced trauma. In fact, social workers are more likely to work with individuals who have suffered from trauma than any other helping profession (Bride, 2007). This statistic shows the high rate of contact that social workers have with people who have experienced trauma. “Between 82 percent and 94 percent of outpatient mental health clients reported a history of exposure to traumatic events, with 31 percent to 42 percent fulfilling criteria for Posttraumatic Stress Disorder (PTSD)” (Bride, 2007 p. 63). It is believed that exposure to clients’ traumatic narratives makes social workers more susceptible to experiencing posttraumatic stress disorder symptoms. These may include feelings of terror, grief and anger. Other symptoms of PTSD include intrusive thoughts, nightmares, insomnia, fatigue, and difficulty concentrating. DSM-5 criteria for PTSD states that along with being exposed to a traumatic event, the individual must experience symptoms from the symptom clusters of intrusion, avoidance, negative alternations in cognitions and mood, and alternations in arousal and reactivity. The other three criteria are related to the duration of symptoms, the degree of functional impairment and any potential rule out for symptoms related to a substance or medical condition (American Psychiatric Association, 2013). These symptoms can have damaging effects on their therapeutic relationship, their personal life, and their profession (Michalopoulos & Aparicio, 2011). The term “secondary trauma” is most frequently used to define this experience in social work practitioners (Newell & MacNeil, 2010). In some circumstances, the term “vicarious trauma” is used interchangeably with the term secondary trauma. Although some use the two terms interchangeably, others see an important distinction between the two.

Secondary trauma “relates to the natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or client] and the stress resulting from helping or wanting to help a traumatized or suffering person [or client]” (Newell & MacNeil, 2010, p. 60). A related term “vicarious trauma” is often used in discussions about the impact of trauma on the experience of the social worker. There has been a lack of agreement when it comes to defining the term vicarious trauma (Lerias & Byrne, 2003). Vicarious trauma “refers to a process of [cognitive] change resulting from [chronic] engagement with trauma survivors” (Newell & MacNeil, 2010, p.60). Newell & MacNeil (2010) offer the following, “conceptualize vicarious traumatization as a cognitive change process resulting from chronic direct practice with trauma populations, in which the outcomes are alterations in one’s thoughts and beliefs about the world in key areas such as safety, trust, and control” (p.60). Secondary trauma “places more emphasis on the outward behavioral symptoms rather than intrinsic changes” (Newell & MacNeil, 2010, p.60). Both secondary trauma and vicarious trauma occur as a result of being exposed to clients who have experienced trauma (Newell & MacNeil, 2010). Although there is a difference between the two terms, since they are so interchangeably used, for the purpose of this study the researcher will refer to the term secondary trauma. However, the term secondary trauma will also encompass the definition for vicarious trauma. The term vicarious trauma might be found throughout quotations from other literature throughout this study.

Due to the high prevalence of social workers that work with clients who have experienced trauma, it is likely that many social workers will experience secondary trauma at some point throughout their practice. The purpose of this qualitative study is to explore how

social workers that work with traumatized clients respond to their symptoms of secondary trauma.

Literature Review

In order to understand how social workers can effectively respond to secondary trauma, it is important to understand the current research on this topic. This literature review will start by defining and distinguishing between the terms that are often used when referring to secondary trauma. This literature review will also define secondary trauma and report on the current findings of the prevalence of secondary trauma. Next, the literature review will look at what current research says is occurring in the therapeutic relationship with the client when the clinician experiences secondary trauma. Finally, this literature review will explore ways to minimize the effects of, and cope with secondary trauma.

Trauma

In order to understand secondary trauma, it is important to understand the subjective experience of trauma. According to Baldwin (1995), “a traumatic event typically involves the actual or threatened death or injury to one’s self or others, around which feelings of fear, helplessness or horror were present” (Hesse, 2002, p. 295). Some examples of a traumatic event include “war, natural disasters, accidents, rape or sexual assault, physical or emotional abuse, or the death of a loved one, to name only a few” (Hesse, 2002, p.295). When a person experiences trauma, he or she often believes that nothing in the world is safe, predictable, or meaningful. It is common for a person to be unable to process the trauma he or she has experienced and therefore, its effects will often continue to bother the person until (and sometimes even after) they are able to get help (Margolies, 2010). There is no person or group of people who are immune to experiencing trauma; trauma is something that can be experienced by any person (Hesse, 2002).

Burnout

The term burnout is very frequently used in the workplace of many different professions. Burnout has been recognized as a problem in the mental health profession since the 1970s (I. Thompson, Amatea & E. Thompson, 2014). Pines and Aronson described professional burnout as “a state of physical, emotional, or psychological, and spiritual exhaustion resulting from chronic exposure to (or practice with) populations that are vulnerable or suffering” (Newell & MacNeil, 2010, p. 58). Burnout is often experienced with feelings of hopelessness, and the clinician often has a difficult time doing his or her job effectively (Craig & Sprang, 2010). The process of actually burning out is described as an ongoing state that occurs over time and the contributing factors include not only the individual but also the population served and the organization (Newell & MacNeil, 2010). When a clinician experiences burnout, it can have very serious effects on his or herself, his or her clients, and the clinician’s organization (Lloyd & King, 2004). Burnout consists of three specific areas, which include, “emotional exhaustion, depersonalization, and reduced sense of personal accomplishment” (Newell & MacNeil, 2010, p. 59). Emotional exhaustion is described as “a state that occurs when a practitioner’s emotional resources become depleted by the chronic needs, demands, and expectations of their clients, supervisors, and organizations” (Newell & MacNeil, 2010, p.59). The second area that can contribute to burnout is depersonalization, which is referred to as “the negative, cynical, or excessively detached responses to coworkers or clients and their situations” (Newell & MacNeil, 2010, p. 59). The final area that can contribute to burnout is a reduced sense of personal accomplishment. This final area can occur when clinicians “feel inadequate when clients do not respond to treatment, despite efforts to help them” (Newell & MacNeil, 2010, p. 59). Maslach explains that while burnout focuses more on the stressors in the work environment, other terms

are used to describe specific stressors between the client and clinician (I. Thompson, Amatea & E. Thompson, 2014).

Compassion Fatigue

Compassion fatigue used to be defined as a syndrome that consists of symptoms of secondary traumatic stress and burnout; recently Figley gave “compassion fatigue” a more broad definition that describes a clinician’s experience of fatigue they experience “due to the chronic use of empathy when treating patients who are suffering in some way” (Newell & MacNeil, 2010, p. 61). Figley explains that when the chronic use of empathy is combined with the day-to-day obstacles such as stress within the agency, problems with billing, or balancing client work with administrative tasks, the onset of compassion fatigue may occur over time (Newell & MacNeil, 2010). Compassion fatigue is not something that only occurs in clinicians who work with trauma victims, compassion fatigue can occur in clinicians that work with any type of population (Newell & MacNeil, 2010).

Secondary Trauma

The concept of secondary trauma (also known as vicarious trauma) is used to describe the cumulative and damaging effects that happen to clinicians after they are chronically exposed to their clients’ traumatic stories (Michalopoulos & Aparicio, 2011). Secondary trauma “negatively impacts the clinician’s sense of self and could result in ongoing symptoms of posttraumatic stress disorder (PTSD), feelings of anger, grief, rage, and terror, in addition to damaging effects on the therapeutic relationship”(Michalopoulos & Aparicio, 2011, p. 646). Secondary trauma symptoms also include a “decreased sense of energy; no time for one’s self; increased disconnection from loved ones; social withdrawal; increased sensitivity to violence, threat, or fear---or the opposite, decreased sensitivity, cynicism, generalized despair and hopelessness” (Dane, 2000, p.29).

Clinicians can also experience symptoms such as disturbed sleep, suppression of emotions, nightmares, anxiety, irritability, flashbacks, and suicidal thoughts (Hesse, 2002). When a clinician holds negative beliefs about his or her self, that concept is referred to as a disrupted cognition. A clinician may have a disrupted cognition as a result of doing trauma work with clients. When a clinician repeatedly hears stories about his or her client's trauma, the clinician may experience a lowered sense of his or her abilities. Clinicians who work with trauma may experience decreased capacity to trust their instincts, think highly of themselves, and/or be comfortable being alone (Way, VanDeusen, & Cottrell, 2007).

Although the terms secondary trauma and vicarious trauma are often used interchangeably, there are some authors who give them different meanings. Articles by McCann & Pearlman (1990) and Sabin-Farrell & Turpin (2003) have both distinguished what they understand as the differences between secondary trauma and vicarious trauma. Bober & Regehr (2005) used the articles by those authors to come up with a definition that distinguishes between secondary trauma and vicarious trauma. That definition states:

Secondary trauma or secondary traumatic stress refers to a set of symptoms that parallel those of post-traumatic stress disorder (PTSD) or acute stress disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association. Vicarious trauma focuses on the cognitive schemas or core beliefs of the therapist and the way in which these may change as a result of empathic engagement with the client and exposure to the traumatic imagery presented by the clients. This may cause a disruption in the therapist's view of self, others and the world in general. (p.1)

One other difference that can sometimes be found between the concepts of vicarious trauma and secondary trauma is the criteria for rate of exposure. It is often believed that secondary trauma can be present after only one exposure to a traumatic experience. In contrast, Pearlman and Mac Ian (1995) understand vicarious traumatization as multiple exposures to client's traumatic experiences (Hesse, 2002).

Multiple studies (Kassam-Adams, 1995; Ortlepp & Friedman, 2002; Schauben & Frazier, 1995) have examined the factors that have an influence on the intensity of secondary trauma symptoms a clinician experiences. Factors that influence the likelihood of such symptoms in clinicians are a) the number of trauma cases on a clinician's caseload, b) the amount of social support available to the clinician, c) the clinician's own trauma history, and d) the amount of training around PTSD (Bober & Regehr, 2005).

Prevalence of Secondary Trauma

Social workers provide services to a wide variety of people, many who put them into contact with trauma narratives. Kessler, Sonnega, Bromet, Hughes and Nelson (1995) found that "lifetime trauma exposure prevalence rates are between 50% and 70% in the general U.S. population with 8% prevalence rates of PTSD" (Michalopoulos & Aparicio, 2011, p. 647). However, multiple studies (MacFarlane, Bookless, & Air, 2001; Switzer et al., 1999; Tagay, Herpertz, Langkafel, & Senf, 2005) found that "among treatment-seeking populations, research has found up to 42% meeting the diagnostic criteria for PTSD" (Michalopoulos & Aparicio, 2011, p. 647). In Elhai, North, and Frueh (2005)'s, comprehensive literature review of 34 different studies focused on the number of trauma survivors that utilize mental health services; they found that "exposure to multiple traumatic events and a diagnosis of PTSD was positively associated with mental health service use" (Michalopoulos & Aparicio, 2011, p. 647).

In another example, Cunningham (2003) studied 182 master's-level social workers who lived both in the United States and internationally and work with trauma victims. Participants in this study were all sent self-report questionnaires that investigated how participants felt about themselves and others in the areas of trust, safety, control, esteem and intimacy. Participants were also asked about the percentage of their clients who had cancer or were sexually abused

within the last six months, their own trauma history, and how long they have worked with trauma victims. Cunningham (2003) found that clinicians who work with clients who have experienced trauma that was induced by another person, sexual abuse in this specific study, are more likely to experience secondary trauma than those clinicians who work with clients who are experiencing natural trauma. In this study, the type of natural trauma that is researched is cancer (Cunningham, 2003). In the book, *Countertransference in the Treatment of PTSD*, Danieli (1994) explains that when trauma is human induced like in the case of sexual abuse, it makes people aware of how dangerous and cruel humans can be (Cunningham, 2003).

Although there are no exact statistics of the number of social workers who work with clients that have a traumatic history, social workers have the potential to be exposed to a large number of clients with symptoms that are a direct result of their trauma (Michalopoulos & Aparicio, 2011.) In questionnaires of 183 (82% female and 17% male) child protection service workers who had worked in child protection for at least one year, Cornille & Meyers (1999), found a “positive correlation between length of career, the size of a caseload, frequency of contact with clients, and the longevity and severity of secondary trauma (Dass-Brailsford & Thomley, 2012 p. 40). They found that male staff were more likely to report high levels of distress in interpersonal relationships, depression, anxiety, and paranoid ideation than their female coworkers. However, they found females reported higher levels of somatization, hostility, and obsessive/compulsive distress (Cornille & Meyers, 1999). In Bride’s 2007 study of 282 master’s-level social workers, results found that “70.2 percent experienced at least one symptom [of secondary trauma] in the previous week, 55 percent met the criteria for at least one of the core symptom clusters, and 15.2 percent met the core criteria for a diagnosis of PTSD” (Bride, 2007, p. 67). The symptoms that respondents reported experiencing most often were “intrusive

thoughts, avoidance of reminders of clients, and numbing responses” (Bride, 2007, p. 67).

According to Kessler et al. (1995), the prevalence rate of PTSD due to all types of trauma in the general population is 7.8 percent (Bride, 2007, p. 68). The rate of PTSD in social workers in this study is 15.2 % solely due to indirect exposure; that is twice the rate of PTSD in the general population. This shows the extent to which social workers experience PTSD symptoms due to their client’s trauma (Bride, 2007). Given that PTSD symptoms are one of the key signs of secondary trauma (Newell & MacNeil, 2010), this study’s findings suggest that 15.2% of social workers experience secondary trauma due to their client’s trauma.

Therapeutic Relationship with Trauma Client

“Theoretically, vicarious (secondary) traumatization can be understood by exploring the disruption in an individual’s cognitive schemas or worldview” (Cunningham, 2013, p. 452). Cognitive schemas, as explained by Bowlby (1969) and Epstein (1991) “refer to the cognitive structures used by individuals to organize experiences and information effectively in a complex, changing environment (Cunningham, 2013, p.452). An individual’s worldview is defined by Janoff-Bulman (1989&1992) as the assumptions and beliefs the individual makes about his or her self, others, and the world around them (Cunningham, 2013). Regehr et al. (2004) developed a model “that utilizes aspects of the constructivist self-development theory in relation to the development of posttraumatic distress in child welfare workers” (Michalopoulos & Aparicio, 2011, p.647). In this model, they “emphasized the importance of individual differences and cognitive schemas in determining who will develop and who will be protected from the impact of trauma” (Michalopoulos & Aparicio, 2011, p. 648). While some professionals will be largely impacted by trauma, others will not notice as large of an impact. There are seven major schemas that have been recognized as the most susceptible to being changed by encounters with trauma.

Those seven schemas are “1) frame of reference about the self and the world; 2) trust; 3) safety; 4) power and control; 5) independence; 6) esteem; and 7) intimacy” (Hesse, 2002, p. 298). In the explanation of this newly developed model by Regehr et al. (2004), they discussed:

power and control as important schemas in determining self-efficacy related to the ability to manage trauma. In other words, those who believe they have control over their environment have lower levels of trauma symptoms when compared with those who do not believe they have control. Regehr et al. (2004) also indicated safety and trust as essential self-schemas related to an individual’s ability to obtain and maintain supportive relationships following trauma. (Michalopoulos & Aparicio, 2011, p. 648)

McCann & Pearlman (1990) and Regehr et al. (2004) found the schemas of clinicians can be disrupted when clinicians are continuously:

exposed to ways their clients are betrayed and made to feel unsafe in the face of trauma. In addition, a social worker might find himself or herself feeling helpless and unable to control aspects of her or his life when schemas of power and control are disrupted as a result of listening regularly to client’s traumatic material. (Michalopoulos & Aparicio, 2011, p. 648)

McCann & Pearlman (1990) used the model of constructivist self-development theory to explain what happens when clinicians work with clients that have experienced trauma.

Secondary trauma is “based on constructivist self-development theory, a theory of personality that describes the impact of trauma on an individual’s development and sense of self” (Dane, 2000, p.29). This theory “integrates psychoanalytic theories, specifically object relations theory and self psychology, with cognitive, developmental and social learning theories. There is an emphasis on adaptation, relation to self and others, and the development of a sense of meaning in the world” (Dane, 2000, p.29). When secondary trauma is examined through the constructivist self-development theory, McCann and Pearlman (1990) found that:

clinicians will only develop vicarious traumatization if they are unable to integrate the client’s traumatic material (i.e., if the clinician is unable to understand and make sense of the trauma his or her client has experienced using the clinician’s existing frame for understanding the world). (Michalopoulos & Aparicio, 2011, p. 647)

When a clinician has his or her own personal history of trauma, the clinician's "cognitive schemas necessary to adapt to the traumatic material might already be altered and more susceptible to the development of vicarious trauma" (Michalopoulos & Aparicio, 2011, p. 648). When clinicians are dealing with client traumatic material that is similar to their personal trauma history, it may bring up issues for clinicians that are unresolved (Salston & Figley, 2003). If a social worker in this situation is not emotionally prepared, "the social worker will feel helpless and an increased sense of vulnerability in relation to both the client's and his or her own trauma history" (Michalopoulos & Aparicio, 2011, p. 649). This will most likely have serious consequences on the well being of the social worker and on the therapeutic relationship with the client, and it may also result in the development of secondary trauma (Michalopoulos & Aparicio, 2011). A clinician who has experienced their own personal trauma will most likely be unable to form healthy relationships due to their altered view about his or herself. The view that a clinician has about his or her self is often referred to as self-schema. Since self-schemas have been determined to be necessary in managing trauma, "it is thus expected that personal trauma history and social support could play an important role in the development of vicarious trauma symptoms" (Michalopoulos & Aparicio, 2011, p. 649).

Clinicians who do not have a personal history of trauma are at a lower risk for developing symptoms of secondary trauma (Michalopoulos & Aparicio, 2011). As discussed by McCann and Pearlman (1990),

social workers without a trauma history are able to successfully integrate their client's traumatic material because their self-schemas of power and control as well as safety and trust are not disrupted. They will be more likely to trust in others, better able to access social support to protect them from the development of vicarious trauma, and more likely to feel a sense of control of their environment. The framework thus suggests that social workers without a trauma history will have more individual protective factors against the development of vicarious trauma. (Michalopoulos & Aparicio, 2011, p. 649)

The research studies on the topic of a clinician's personal trauma and his or her risk of experiencing secondary trauma have yielded different results. While some studies have found that there is a relationship between a clinician's personal trauma and secondary trauma, other studies have found no relationship. Adams et al. (2001) studied 185 clinical social workers that were members of the National Association of Social Workers. He found "no significant relationship between personal trauma history and vicarious trauma" (Michalopoulos & Aparicio, 2011, p. 650). Similarly, Brady, Guy, Poelstra, and Brokaw (1999) completed a study that included a national randomized sample of 446 women psychotherapists. The survey asked questions about the participants' demographics, involvement in personal therapy, personal trauma history, and work related characteristics. Participants were instructed to rate their emotional reactions to their clients' traumatic histories on a 4-point scale. They also responded to the Impact of Events Scale, which assessed their posttraumatic stress symptoms that were related to a life result. The participants were also surveyed using the Traumatic Stress Institute Belief Scale, which assessed their disruption in cognitive schemas and their psychological needs of safety, esteem, intimacy, trust, and control (Brady, Guy, Poelstra & Brokaw, 1999). Their findings showed no relationship between personal trauma history and secondary trauma. However, other studies have found a relationship between a clinician's personal trauma history and his or her secondary trauma. In Slattery and Goodman's (2009) study of 148 domestic violence advocates from various settings, they found that advocates with a history of trauma reported more symptoms of secondary trauma than those without a traumatic history. Killian (2008) completed a study, which included semi-structured interviews of 20 (16 female and 4 male) clinicians who worked in Texas agencies that treated survivors of child sexual abuse. The results discovered many patterns in the responses of the clinicians. Killian found that when

clinicians work with severely traumatized clients they often experience problems sleeping, become distracted easily, have a hard time concentrating and experience many changes in mood. The clinicians described their mood changes by observing behaviors in themselves where they felt on edge, had little patience for others, and felt anxious. Female participants in this study were more concerned about how these feelings and behaviors would impact their personal relationships than their male counterparts. Killian suggests that this might be a part of “women’s socialization and cultural expectations that they be caregivers and emotionally attentive to their family members” (Killian, 2008, p. 38). Killian suggests this difference might also be due to “the role overload experienced by many women trying to meet lofty expectations of them in both the professional and private spheres of their lives” (Killian, 2008, p.38).

When a clinician experiences secondary trauma, it causes him or her to question their role as a clinician, their self-worth, and their own identity (Hesse, 2002). When a clinician is affected by the trauma of their clients, it causes him or her to withdrawal from their own life experiences and a clinician may start distancing his or her self from others. There are many different symptoms that a clinician who is experiencing secondary trauma may experience and there are different ways to prevent and cope with the symptoms.

Minimizing the Effects of Secondary Trauma

Numerous researchers (Yassen, 1995; Pearlman & Saakvitne, 1995; Conrad & Perry, 2000; Astin, 1997) in the field of secondary trauma agree that a very important factor in minimizing secondary trauma is the clinician’s ability to manage work and personal engagements outside of work. Both psychological and physical self-care are also important ways to minimize secondary trauma from occurring (Hesse, 2002). Conrad and Perry (2000) suggest many strategies for minimizing secondary trauma. Those strategies include “making adequate

time for rest and relaxation; eating right and exercising, common ways of reducing stress and improving overall health; and taking time for self-reflection and creative expression, such as writing, drawing, painting, sculpting, dancing, or cooking” (Hesse, 2002, p. 303). According to Yassen (1995), other minimization tactics that have been found helpful include “having regular contact with nature, including taking trips to the park, hiking, boating, camping, or even simply caring for pets or plants” (Hesse, 2002, p. 303).

Many authors from this field (Cerney, 1995; Yassen, 1995; Pearlman & Saakvitne, 1995; Conrad & Perry, 2000) agree that limiting the number of trauma clients a clinician is exposed to can minimize or lessen the effects of secondary trauma (Hesse, 2002). This can be done by making sure a clinician also has some non-trauma clients on his or her caseload and if that is not possible, then limiting the overall number of clients on a caseload (Hesse, 2002). If a clinician’s entire caseload is of trauma clients, it is important for the clinician to use other tactics that Yassen (1995) and Conrad & Perry (2002) suggest such as “leaving as close as possible to the agreed upon time, taking regular breaks, taking a full hour for lunch, and taking regular vacations” (Hesse, 2002, p. 304). Cerney (1995), Yassen (1995) and Pearlman & Saakvitne (1995) agree that it is important for a clinician to keep realistic goals and “understand that no amount of work is going to permanently ‘erase’ the trauma for the client” (Hesse, 2002, p. 304).

Another way for a clinician to minimize the effect of secondary trauma is to maintain professional connection in terms of supervision, consultation, professional training, and support groups (Hesse, 2002). A clinician’s supervisor can be used as an important way to both minimize and cope with secondary trauma. Supportive supervisors can help by changing caseloads and assisting the clinician in setting boundaries between his or her personal and professional lives. Cerney (1995) “stresses the importance of group supervision as a way of providing added insight and learning” (Hesse, 2002, p. 305). However, when supervisors have a negative mood at work

it can cause the employees to have a negative mood at work as well (Chang, Teng, Chu, Chang, & Hsu, 2012). It can be very beneficial for a clinician to have other colleagues that they can speak with regarding how they are affected by their client's stories (Hesse, 2002). Many studies (Avay, 2001; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006; Way et al., 2004) have found that social support among trauma therapists is a protective factor against secondary trauma (Michalopoulos & Aparicio, 2011). When social support is examined through the constructivist self-development theory and the framework developed by Regehr et al. (2004), "relationships with friends, family, and significant others might prevent the disruption of self-schemas that occurs from chronic exposure to a client's trauma" (Michalopoulos & Aparicio, 2011, p. 651).

Coping with Secondary Trauma

If a clinician does end up experiencing secondary trauma, there are a variety of strategies to reduce the level of symptoms. As Pearlman & Saakvitne (1995) explain, the first and possibly the most important step is the clinician's ability to recognize and accept that experiencing secondary trauma is normal when working with trauma clients. "If a trauma therapist is ashamed, embarrassed, or in denial of painful feelings that emerge when hearing clients' stories, he or she is not likely to take measures that can reduce the pain or stress" (Hesse, 2002, p. 304). In terms of coping strategies to mitigate the effects of secondary trauma, some researchers (Pearlman & Saakvitne, 1995; Yassen, 1995) suggest that one become spiritually connected by the means of meditation, yoga, joining a religious group, or engaging in community activities (Hesse, 2002). Hesse (2002) writes about the importance of a clinician spending time with their family and friends as a crucial component to keep his or her own identity. Other suggestions include those by Conrad and Perry (2000) which include "spending time alone, praising yourself, allowing yourself to cry, and finding things to laugh about" (Hesse, 2002, p. 303). Hesse (2002) suggests

that seeking personal psychotherapy is an effective way of dealing with secondary trauma. As Pearlman & Saakvitne (1995) would agree that, “psychotherapy is a way of understanding and nurturing oneself, a gift one can give oneself whose benefits also ripple outward to family, friends, clients, and colleagues” (Hesse, 2002, p. 303). Yassen (1995) explains that when a clinician is able to get professional help, that is a sign of the personal strength of the clinician and his or her work with his or her client will be more effective because of the help the received (Hesse, 2002). Psychotherapy can be especially helpful for clinicians who have experienced trauma in their own lives, and it can also be very beneficial for them to attend support groups where they can heal from their own trauma (Hesse, 2002).

Many authors (Figley, 1995; Hesse, 2002; Pearlman & Saakvitne, 1995; Regehr & Cadell, 1999) emphasize the importance of a clinician balancing his or herself between work and personal life in order to cope with secondary trauma. Other studies (Cerney, 1995; Dane 2000; Pearlman & Saakvitne, 1995; Talbot, 1989) have suggested, “peer consultation, supervision, and professional training to reduce the sense of isolation and increase feelings of efficacy are suggested” (Bober & Regehr, 2006, p. 2-3). Hesse (2002) and Pearlman & Saakvitne (1995) also suggest reducing a clinician’s number of trauma cases. Astin (1997) and Iliffe & Steed (2000) reported that therapists’ suggestions to reduce symptoms include “peer support, physical activity and self-care, reading and watching TV shows or movies that are nonviolent, limiting their trauma counseling workload, and political activism” (Bober & Regehr, 2006, p.3).

In their study of 259 clinicians, Bober & Regehr (2006) found that while participants of the study were likely to believe in the effectiveness of dealing with symptoms by participating in self-care activities, attending supervision and using coping strategies, “there is no evidence that using recommended coping strategies is protective against symptoms of acute distress” (2006, p. 7). Lerias and Byrne (2003)’s review of literature on secondary trauma found that a clinician’s

social support is an important factor in finding out how able he or she is to deal with exposure to a client's trauma.

Conceptual Framework

Constructivist Self Development Theory

The Constructivist Self Development Theory can be used to understand how a social worker might be affected when her or she is working with a client who has experienced trauma. Saakvitne, Tennen & Afflect (1998) explain that there are five areas within a person's self that are normally affected when they experience trauma. The first of these areas is a person's frame of reference and the way they understand their self and the world around them. The second area is self-capacities and the person's ability to "to recognize, tolerate, and integrate affect and maintain a benevolent inner connection with self and others"(p. 283). The third area is ego resources which are "necessary to meet psychological needs in mature ways; specifically, abilities to be self-observing, and use cognitive and social skills to maintain relationships and protect oneself" (p. 283). The fourth area is central psychological needs which are "reflected in disrupted cognitive schemas in five area: safety, trust, control, esteem, and intimacy" (p. 283). The final area is perceptual and memory systems which include "biological adaptations and sensory experiences" (p. 283).

Regehr et al. (2004) stressed the fact that variability among individuals, including their different cognitive schemas, will influence whether a person will experience secondary trauma. Regehr et al. (2004) indicated that whether a social worker believes they have control over their environment is a large indicator of how severe their trauma symptoms will be (Michalopoulos & Aparicio, 2011). The five areas that are mentioned above are aspects of a clinician that can be changed when a person experiences secondary trauma. The Constructivist Self Development Theory is the conceptual framework for this study because it can be used to understand why a

social worker might experience secondary trauma. When a social worker is affected by secondary trauma, her or she can use coping skills to repair areas within him or herself that have been affected by the trauma. The Constructivist Self Development Theory is crucial to understanding the areas within a clinician that need to be repaired from working with clients who have experienced trauma.

Methodology

The purpose of this study was to explore the effective ways that clinical social workers respond to and minimize the effects of secondary trauma. An exploratory qualitative study was conducted to give licensed social workers the opportunity to share what they know about effective ways to respond to secondary trauma. The focus of this study was to share participants' knowledge about effective ways to deal with secondary trauma so that other professionals might benefit from their information.

Sample

This was a non-probability sample of six licensed social workers from around the Twin Cities metro area. Licensed social workers were sampled using snowball sampling. The researcher created a flyer (APPENDIX A) and asked other people to pass it around to social workers that they think might be interested in participating in the study.

Demographics

Six participants took place in this study. All six of the participants were females. Three of the participants were licensed clinical social workers and three of the participants were licensed graduate social workers. Five of the participants worked at local non-profit agencies and one participant worked for a local county.

Data Collection

The flyer that was handed out included details about the study and the contact information for the researcher. The flyer asked participants to contact the researcher via phone or e-mail if they were interested in participating in the study. Once the potential participant contacted the researcher, the researcher gave them the details of the study and also gave them the questions that they would be asked in the interview. After being given the questions for the interview, the potential participants were asked if they would still like to participate.

Before the interview took place, the participants were given a consent form (APPENDIX B) to read and sign. The participants were informed that the interview was recorded solely for the purpose of the study. Five of the six interviews took place in the participants' private office space. One of the six interviews took place over the phone where the researcher was in a private space.

Measurement

The data was collected using a semi-structured interview. The participants were asked 8 questions focusing on their experience of effective methods to respond to secondary trauma (APPENDIX C). The themes of the questions were focused around what their agency, their supervisor, and individually they do to respond to secondary trauma. The participants were asked to report different interventions that have been useful in minimizing their effects of secondary trauma.

Data Analysis

The interviews with the participants were transcribed, and the researcher found recurring themes throughout the transcriptions. Grounded theory was used to complete the analysis for this research study.

Protection of Human Subjects

Approval was given for participating in the study by signing a letter for consent. The research for this study started being collected after the Institutional Review Board at the University of St. Thomas gave approval. Safeguards were used and the identity of all participants remained confidential and no data used was defining characteristics of the participants. The interviews took place in a private office or on the phone. If the interview took place over the phone, the researcher was alone in a private space. The interview was audio recorded for the purpose of the study but no one other than the researcher listened to the recording. The recording was kept in password-protected file on the researcher's password-protected iPad. The transcriptions were kept in a locked file on the researcher's computer, and no one else had access to them. The consent forms were locked in a filing cabinet in the researcher's home. All of these documents were destroyed upon completion of this project. This study presented the risk that participants may suffer some effects if they are taken back to any of their own secondary trauma experiences. To minimize this risk, there was be a debriefing period following the interview to take the participants away from this emotional experience. The participants had the opportunity to skip questions if they did not feel comfortable asking them. The participants were informed of this, as well as the possible risk before they chose to participate or not participate in the study.

Findings

Participants focused on five themes throughout the interviews. The five themes were organized around a) the importance of supervision, b) leaving work at work, c) spending time with family and friends, d) talking with colleagues and e) how agencies could be of extra assistance.

Supervision

Participants were asked questions about whether they felt supervision was helpful in minimizing the effects secondary trauma and what their supervisor did to help supervisees respond to or minimize the effects of secondary trauma. All six of the participants (100%), reported feeling that supervision was a helpful way to respond to secondary trauma. All of the participants reported feeling that supervision was helpful so that they did not have to carry the trauma-related material alone, and supervision gave them someone to talk through things and process feeling with. One participant discussed the importance of supervision when she stated:

“I don’t know how people do it without supervision. I know that many, many, many of my colleagues who have made a transition, once they become fully licensed, to having less supervision, are really affected by the lack of supervision and then have to find other ways to get that support.”

Two of (33.3%) the participants reported feeling that supervision was more helpful when they had a good relationship with their supervisor. To explain this, one of the participants stated:

“I think a lot of it has to do with relationships with the supervisee. If you have a good relationship then people can be coming to you when things are getting too overwhelming. Those good relationships that supervisors are building with their clients, they should be building with their supervisees as well.”

All six participants (100%) in this study felt that supervision was helpful in lessening the effects of secondary trauma.

Leave Work at Work

In the study, five participants (83.3%) stated that leaving work at work was an important theme. The participants in the study were asked about what strategies they employed both at work and outside of work to help minimize the development of secondary trauma. There were a couple of different strategies that participants mentioned that spoke to their feelings about the importance of leaving work at work. Five of the participants mentioned not taking work home with them and

creating a boundary between work and home. One participant explained this boundary setting by stating:

“We recently transitioned to electronic health records, which technically means I could access that stuff from home and I really make an effort not to do that unless absolutely necessary. Just so that there is a clear divide between here and my life outside.”

While two participants admitted that they occasionally spend time working on work-related things once they are at home, one participant had a very firm stance on never taking work home.

This participant stated:

“I go home, I change my clothes, I wash my hands, I take off the day. I never bring work home and that’s another thing they do here, they really discourage us, and part of it is because of HIPAA, we can’t bring stuff around with us, but we are never expected to do work from home or answer e-mails or anything. I don’t even know my login for my remote e-mail. I’ve never accessed it outside of work.”

Five of the participants (83.3%) felt that it was very important to leave work at work in order to minimize the impact that secondary trauma has on them. One participant mentioned that often when she is out with friends, her friends will discuss work issues. This participant discussed how that makes her upset because when she is off of work she does not want to talk about work. She discussed how she feels so much better because she does not talk about work-related issues. She stated that when she is with her friends she often feels like stating to her friends *“we are not in consultation mode, there are other things to talk about”*. This participant discussed feeling that she would become overwhelmed and stressed with work if she were regularly talking about work-related issues with friends or family.

Family and Friends

A third theme found related to minimizing the impact of secondary trauma was the importance of spending time with family and/or friends. Six (100%) participants mentioned spending time with family and/or friends when asked about what they do outside of work to help

minimize the effects of secondary trauma. Throughout the interviews, it was shown that spending time with family and/or friends was an important activity for all participants. One participant shared some advice that a former supervisor had given her:

“I had a very wise supervisor once tell me that the minute you start turning down invitations is the minute you need to be worried. I think that I’ve found that to be true for myself too. I’ve found that on a few days I’ve really had to push myself to do that, to go out for dinner with some friends, to be able to connect in conversation with them and be present, when I don’t want to; but when I push myself to do that it helps.”

Another participant discussed how she makes her evening activities as important as her work activities, and she always makes sure to make plans with family or friends so that she has other things going on besides work. While all six participants agreed that spending time with friends and family is important, one participant discussed how difficult social situations can sometimes be with family or friends when the topic of work is brought up. She stated,

“I haven’t quite figured out how to do this one yet but when you are out to dinner with friends, or you are at a party and naturally people start to ask what you do for work and when you say where you work there is just a whole series of questions that follow that and that’s a tough one to deal with because I don’t want to talk about work. I think just finding nice ways to really limit the conversation in social situations and preserve that time for just having fun and relaxing.”

All six participants agreed, that they are able to relax by spending time with family and/or friends, which is very important in lessening the effects of secondary trauma.

Colleagues

Another theme that was found in this study was that positive relationships with colleagues had an effect on minimizing secondary trauma. All six (100%) participants discussed feeling that their colleagues were helpful in minimizing the impact of secondary trauma. Participants reported feeling that colleagues were supportive, helpful to bounce ideas off of, and to just talk to about the stress of work. Participants discussed that colleagues were supportive because they understood the pressures of their work situations and were easy to relate to. One participant

discussed how when colleagues even do simple things; it can make a huge difference. This participant stated:

“My colleagues are some of the best places for me to go to. I’ve found it very useful to lean on my coworkers and having a coworker drop a coffee on my desk, it’s just those little things that say I’m noticing that this is really hard for you and I don’t really know what to do other than to offer my support.”

While this particular participant talked about specific things a colleague can do to help, other participants discussed how important it is to just have colleagues to vent to. Some participants mentioned the importance of having colleagues to talk to about things that are not work related. These participants discussed how it is helpful to just get their mind off of work for a little while and be able to discuss a non-work related topic with a colleague. One participant mentioned the closeness of their team and how they look out for one another. When talking about her agency, she stated: *“It’s a place where you can say I’m just really struggling this week. I’m just really struggling today and people are supportive of that”*. The participants in this study felt that positive relationships with colleagues were a very big piece of minimizing the effects of secondary trauma.

Extra Support

The final theme found was when participants were asked what their agency could further do to assist clinicians who were suffering from secondary trauma. Four out of six (66.67%) participants discussed how having extra support, or extra supervision would be helpful in minimizing the effects of secondary trauma. Some participants mentioned having extra support or supervision for new clinicians, while others discussed ideas such as having a support group for secondary trauma, more training on the impact of trauma, and more individual supervision. The participant who discussed having extra support for new clinicians stated:

“I think new clinicians are particularly prone to the effects of secondary trauma and not that people that have been doing it for a long time are hardened or something but I think they have just developed their ability to copy that much more because they’ve had to do it

before. I think maybe ideally I would say my agency could provide people who are new extra supervision”

While that participant feels it is extra necessary for new clinicians to receive extra support, another participant who has been in the field for many year stated, *“I’ve been working for many years as a clinician and I still feel the need for regular supervision to have a place to process and I’d like to have more individual supervision.”* Although participants’ ideas varied on how they would like extra support, four out of six participants (66.67%) agreed that extra support would be helpful to reduce the effects of secondary trauma.

Discussion

Summary of Findings

The purpose of this study was to examine the effective ways social workers respond to secondary trauma. There were five main themes found throughout the interviews that emerged as the effective ways that social workers deal with secondary trauma. Those five themes were supervision, leaving work at work, friends and family, colleagues, and extra support from the agency.

The first theme that was found was supervision. The participants that were interviewed mentioned different ways and reasons that they felt supervision was helpful. Some participants discussed how having regular supervision with a supervisor helped them feel supported and gave them someone to talk through difficult situations with. Other participants also discussed the importance of having a good relationship with a supervisor to minimize the effects of secondary trauma.

The second theme that was found in the interviews was the importance of participants leaving work at work and not bringing it home with them. Some participants discussed not enjoying talking about work related issues when they are with their friends and family outside of

work. Participants in this study felt it was important to create a boundary between work and home life in order to lessen the impact of secondary trauma.

The third theme found in this study was the importance of spending time with family and/or friends. All participants mentioned the importance of spending time with family and/or friends outside of work as a way to minimize the effects of secondary trauma. One participant discussed the importance of making her time with family and friends outside of work just as important as the things she does at work. Another participant discussed how sometimes it is hard to make plans after a day of work but after doing so, she feels much better. All participants in this study agreed that by spending time with family and friends, the effects of secondary trauma were minimized.

Along with family and friends, the findings show that relationships with colleagues were also very important to the participants in this study. The fourth theme that was found was the positive impact that colleagues had on lessening the effects of secondary trauma. All participants in this study reported that their colleagues were very helpful to them. The reasons that participants felt their colleagues were important varied a bit from participant to participant. While some participants reported that their colleagues were helpful to share ideas with; others reported that their colleagues helped them by just giving them someone to talk to.

The final theme found during the interviews was the theme that participants felt the effects of secondary trauma could be minimized if extra support was given to clinicians. The participants in this study had varying ideas of how the extra support could be given. While some participants felt extra support should be given by offering clinicians more time for supervision, others felt this support could be offered through support groups, or increased training about the

impact of trauma. Although the ideas varied on how this extra support should be given, participants felt the extra support was necessary to reduce the effects of secondary trauma.

Findings and the Literature

When comparing the themes found in this study with current literature, there were some consistencies in themes. There were also themes found in this study that there is currently not a lot of literature on.

Supervision

In this study, all six participants felt that supervision was an effective way to minimize the effects of secondary trauma. That theme is also found throughout current literature. Hesse (2002) discusses the importance of maintaining professional connections in terms of supervision and consultation to prevent secondary trauma. According to Hesse, a supervisor can be helpful in preventing and minimizing secondary trauma by making changing to caseloads and helping set boundaries between home and work life. Cerney (1995) mentioned the importance of group supervision as a way of added insight; the concept of group supervision was not mentioned during the six interviews in this study. Many other studies (Cerney, 1995; Dane 2000; Pearlman & Saakvitne, 1995) have suggested that supervision helps to reduce a clinician's sense of isolation and increase their feelings of effectiveness (Bober & Regehr, 2006). The literature on the effectiveness of supervision in preventing and minimizing the effects of secondary trauma is consistent with the findings in this study.

Leave Work at Work

The importance of not bringing work home was a theme that the majority (75%) of participants felt was helpful in reducing secondary stress. Participants felt that it was important to create a boundary between work and home to minimize the effects of secondary trauma. This theme was also found throughout the literature. Many authors (Yassen, 1995; Pearlman &

Saakvitne, 1995; Conrad & Perry, 2000; Astin, 1997) agree that a clinician's ability to manage their work and their personal life is a significant factor in minimizing the effects of secondary trauma. While those authors feel a balance of work life and personal life is important to minimize secondary trauma, other authors feel this balance is important for a clinician to cope once they have experienced secondary trauma. Figley (1995), Hesse (2002), and Pearlman & Saakvitne (1995), all agree that if a clinician has suffered from secondary trauma, one method used to cope is balancing work with his or her personal life. In order to keep this boundary between work and personal life, Conrad & Perry (2002) give suggestions such as taking regular and scheduled breaks at work, and leaving as close to the scheduled leaving time as possible.

Family/Friends

All six participants in this study felt that spending time with family and friends was an important way to minimize the effects of secondary trauma. The literature agrees that this is an important way for clinicians to minimize the effects of secondary trauma. Hesse (2002) discussed the importance of clinicians keeping their own identity. Hesse also discussed that one way for clinicians to do this is by spending time with their family and friends. Lerias and Byrne (2003) reviewed literature on secondary trauma and found that when a clinician has a good social support system, they are more able to deal with exposure to a client's trauma. Other literature reported similar findings. Many authors (Avay, 2001; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006; Way et al., 2004) discussed the importance of a clinician's social support in terms of an important factor in preventing and minimizing the development of secondary trauma.

Colleagues

All six participants in this study felt that their colleagues had a very big impact on the minimizing of secondary trauma. There is some information in current literature that coincides with this theme. Hesse (2002) discussed the importance of clinicians having colleagues to talk to

when they are impacted by a client's story. Other authors (Cerney, 1995; Dane 2000; Pearlman & Saakvitne, 1995) suggested that peer consultation help to reduce feelings of isolation and increase a clinician's feelings of self-worth. Astin (1997) and Iliffe & Steed (2000) reported that when clinicians were asked to give suggestions on how to reduce secondary trauma one reoccurring suggestion included peer support. This is an area where there was not much existing literature to compare the findings with.

Extra Support

Four of the six participants in this study felt that receiving extra support was a way to minimizing the impact of secondary trauma. Although current literature does not specifically mention extra support as a way to minimize secondary trauma, the literature gives one way for clinicians to receive extra support. Hesse (2002) suggested that clinicians seek personal psychotherapy as a way to minimize the impact of secondary trauma. Pearlman and Saakvitne (1995) discussed that psychotherapy is a gift that a clinician can give to his or her self as a way of understanding and nurturing his or her self. Pearlman and Saakvitne explained that this experience could also have a positive ripple effect onto family, friends, colleagues, and clients. Yassen (1995) wrote something similar by explaining the strength a clinician has when they are able to get their own professional help and how that will have a positive impact on their clients. The one similarity from the research and the literature is the mention of support groups as an extra method of support. Hesse (2002) discussed support groups for clinicians who have experienced trauma and one participant in the study mentioned a support group for those impacted by secondary trauma. Both types of support groups are a way for a clinician to receive extra support.

Limitations

There were limitations present in this study. This study had a small response rate. This small number of participants affects the ability to find common themes throughout the social work profession on effective ways to deal with secondary trauma. If there were more participants in the study, the findings could be used across a broader scope of social workers. Another limitation in this study was that all participants were female. This is a limitation because only the perspectives of women were given. The findings may have differed if the male perspective was given as well. One final limitation for this study was that three of the participants were from the same agency. This is a limitation because their perspectives on how their agency deals with secondary trauma were all very similar. If all participants had been from different agencies, there would have been a wider range of perspectives. The final limitation for this study is that it used a non-randomized sample. The participants in this study were found using snowball sampling.

Implications for Practice

The research study explored the different ways that social workers respond to secondary trauma. The purpose of this study was to look at the different methods social workers used that they felt helped them effectively respond to secondary trauma. As previously stated, present research has found that many social workers experience secondary trauma at some point throughout their practice. Since secondary trauma is so prevalent among social workers, it is important for social workers and their agencies to know how to deal with secondary trauma. This study found that by receiving supervision, creating a boundary between work and home, spending time with family and friends, having colleagues to talk to, and receiving extra support the effects of secondary trauma can be minimized. Social work professionals can use these findings to do what they can to minimize the impact of secondary trauma. Agencies can also use this information to create policies and procedures around secondary trauma. If agencies were able to create policies

that supported an appropriate level of work and home life balance, and policies around supervision and support, they might be able to minimize the impact that secondary trauma has on their employees. Agencies would also be able to use this research about secondary trauma to change the ways they run case consultations in their agencies. Supervisors could use this research when working with their employees to normalize the effects of secondary trauma. By having supervisors that are educated on secondary trauma, and able to reassure their employees that the symptoms are normal, the social workers might be able to respond to the secondary trauma in a much more effective manner. When supervisors are able to help their employees work through their secondary traumatic symptoms, there is a greater chance that the longevity of the employee will increase and the social workers will not get burned out as quickly.

Future research might focus on ways agencies can implement policies around secondary trauma. An increase in knowledge in this area could help minimize the occurrence of secondary trauma and better prepare agencies to deal with the secondary trauma that their clinician's experience. By minimizing the impact of secondary trauma throughout entire agencies, agencies might find that the satisfaction of their employees increases. The clients would also benefit from future research on secondary trauma because if the social worker is able to manage their secondary traumatic symptoms, then there will be a stronger therapeutic relationship between the client and social worker. There are many benefits from future research in the area of secondary trauma among social workers.

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APPENDIX A

SOCIAL WORKERS NEEDED!!!

**TO VOLUNTEER FOR A RESEARCH STUDY ON EFFECTIVE
WAYS FOR CLINICAL SOCIAL WORKERS TO DEAL WITH
SECONDARY TRAUMA**

Are you a Clinical Social Worker who has knowledge about secondary trauma and has worked with individuals who have suffered from traumatic experiences?

Would you be willing to share the strategies you use to prevent or deal with secondary trauma?

Volunteers are needed to participate in a ~30 min interview where you will be asked about effective ways to deal with secondary trauma.

If you are interested please contact Amy Fogel (I am a Graduate Student interested in working with individuals who have experienced trauma and this research is in fulfillment of a requirement at the Graduate School of Social Work, St. Catherine University/University of St. Thomas.)

*****@stthomas.edu • ***-***-****

APPENDIX B
CONSENT FORM
UNIVERSITY OF ST. THOMAS

Effective Ways Social Workers Deal with Secondary Trauma
686591-1

I am conducting a study about *the effective ways that social workers deal with secondary trauma*. I invite you to participate in this research. You were selected as a possible participant because *you contacted me after receiving my flier from an unidentified person*. Please read this form and ask any questions you may have before agreeing to be in the study.

This research is being conducted by Amy Fogel. (degree) as part of my requirement as a student in the Graduate School of Social Work, St. Catherine University and the University of St. Thomas. My research advisor is Colin Hollidge, Ph. D., LICSW.

Background Information:

The purpose of this study is to interview clinical social workers that work with traumatized patients about effective ways to handle secondary traumatization.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in an interview that will last approximately 30 minutes and be audio recorded so the researcher can transcribe the interview.

Risks and Benefits of Being in the Study:

The study presents the small risk that participants may suffer some negative emotional from memories of their own secondary trauma experience or that of the their colleagues. To minimize this risk there will be a debriefing period following the interview to take participants away from this emotional experience.

The direct benefits you will receive for participating are: *None*

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create *include an audio recording and a transcript. The audio recording will be kept in a password-protected file on the researcher's password protected iPad and the transcriptions will be kept on the researcher's password protected computer. This consent form will also be kept in a locked drawer in the researcher's house. The researcher is the only person who will have access to these items and they will be destroyed at the completion of the project on May 19, 2015.*

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until *March 1, 2015*. Should you decide to withdraw data collected about you *will not be used*. You are also free to skip any questions I may ask.

Contacts and Questions

My name is *Amy Fogel*. You may ask any questions you have now. If you have questions later, you may contact me at _____ *or my chair, Colin Hollidge at* _____. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to the interview being audio recorded by the researcher.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

APPENDIX C

- Does your agency have policies or strategies to help clinicians prevent and/or deal with secondary trauma? If yes, what are they?
- What could your agency do to further assist clinicians who are suffering from secondary trauma?
- Do you feel that supervision is helpful in preventing secondary trauma? If so, how?
- What does your supervisor do to help prevent or help supervisees deal with secondary trauma?
- Are there strategies at work you employ to help minimize the development of secondary trauma? If yes, what are they?
- What do you do outside of work that helps you minimize secondary trauma?
- Have your colleagues been helpful in minimizing the impact of secondary trauma?

If yes, In what ways?
- What types of self-care strategies have you found to be effective in preventing and/or managing secondary trauma symptoms?
- Having worked so closely with trauma patients, what benefit do you feel you have received from this work?