

**CLIMBING THE MOUNTAIN TOGETHER: SOCIAL WORKERS'  
CONSTRUCTIONS OF POSITIVE REACTIONS FROM TRAUMA WORK**

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## **Dedication**

*This study is dedicated to the social workers who provide trauma care to their clients. Your time, strength, imagination, heart, and love touches so many lives. It is my honor to tell your story and provide a deeper understanding of why this work is so powerful and life changing.*

## **Acknowledgments**

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## Abstract

This qualitative study explored with 15 social workers the positive reactions they experienced in their work with traumatized clients. All the interviewees described their positive reactions, growth, and satisfaction with their work. The social workers' level of experience influenced the timing of their positive reactions and contributed to their confidence and timing in their clinical work with traumatized clients.

Participants also experienced negative reactions from their work with traumatized clients but their positive reactions seemed to help them to increase their resiliency in their work. The study also found most social workers reported using an evidence-based treatment and described an eclectic, relational framework in their work with traumatized clients.

Organizational components which contributed the social workers' positive reactions in their work consisted of trauma-informed supervision, trainings, shared mission between social worker and organization, and strong staff morale. Trauma-informed supervision is a term developed from this study's findings and refers to incorporating elements of trauma-informed care in the supervisory setting. Personal components identified by the social workers were the use of trauma skills and interventions for personal coping, varied jobs and varied activities within the same job, hobbies, and a clear division between professional and personal life. All of the interviewees planned to continue doing trauma work in the future. Younger social workers reported they wanted to pass their clinical license exam and enter into private practice. Social workers who had been in the field longer reported wanting to do macro trauma work with larger populations. Implications for practice, research, and organizations are discussed.

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## Chapter 1

### Overview

When social workers are asked what they do for a living, many are met with some variation of “Wow, it takes a special person to do that work,” “How do you do it? I could never do what you do,” or “That must be really hard on you.” Often we are justifying why we do what we do, why we love what we do, and how conversely our work gives us enormous satisfaction and personal growth, especially when working with traumatized individuals. This is not to suggest the work is easy or without negative aspects; yet many social workers working in trauma work experience immense positive satisfaction along with the negative.

Social workers interact on a regular basis with individuals and families dealing with trauma. This work can be rewarding but it can also be exhausting. As a client discloses traumatic life events, clinicians may be exposed to graphic and explicit descriptions of abuse and trauma. Through the therapeutic relationship, social workers, together with clients, examine the circumstances around the trauma, as well as other relevant issues, in order to help reduce suffering. Because trauma therapy involves a close working relationship, clinicians have the potential to be affected in both professional and personal realms.

The psychological effects of trauma work develop as the product of the verbal and relational/non-verbal interactions over time between the client and the therapist. Researchers have given a great deal of attention to negative reactions in social workers and other professionals and therapists result from this type of work. These experiences are known as compassion fatigue, shared trauma, secondary traumatic stress, and vicarious traumatization. Burnout is another term used to depict negative reactions

experienced by therapists but this is not necessarily related to working with trauma survivors and can occur in any work setting. More recently, researchers have begun to explore positive reactions to working with trauma survivors. Constructs used to describe these reactions are compassion satisfaction, post-traumatic growth, vicarious transformation, and vicarious resilience.

In this study, I explored social workers' reactions to working with traumatized clients. I emphasized the positive sequelae of working with trauma survivors, as most of the existing literature describes negative outcomes and risk factors for social workers in this area of practice. Using semi-structured interviews, I asked social workers to describe, in their own language, how working with high-risk, traumatized clients and their families affected them. The participants were social workers who worked with traumatized clients and their families, in partial hospitalization programs or in intensive outpatient or outpatient treatment in non-profit and private clinical settings.

The intent of this project was to add to the research on social workers' positive reactions to trauma work. Reactions are defined by this writer as internal response experienced by the social worker as a result of his or her work with traumatized clients. Growth in the social worker is a reaction and satisfaction is an outcome from trauma work with clients. By exploring positive experiences, I attempted to create a more balanced view of this work. This is still an underdeveloped area in the field and further inquiry into the topic was warranted to understand the positive effects of trauma work and to retain therapists in the field. In the study, I inquired how social workers experienced positive reactions from working with traumatized clients and what contributed to the social workers' growth. The specific research questions I explored were:

- How do social workers who report experiencing positive reactions from working with clients who experience trauma describe their reactions?

- What is the nature of the reported growth or satisfaction?
  - Is the growth related to being a better therapist, a better person, resolving one's own trauma, or something else?
  - Does growth/satisfaction precede, follow, or run parallel to the client's growth?
- How, if at all, do workers describe their experience of the relationship between positive and negative reactions?
- What in their work environment or self-care facilitates the process of growth or satisfaction? How? What impedes it? How?
- What in their personal environment facilitates the process of growth or satisfaction? How? What impedes it? How?
- What aspects of the therapeutic environment facilitate the process of growth or satisfaction?
  - How, if at all, does the relationship between the social worker and client affect their mutual growth?
- How, if at all, does the social worker's theoretical orientation affect his or her work with clients who have experienced trauma?

## Chapter 2

### Literature Review

Psychological trauma is an emotional response to a horrific event, or series or experiences (traumatic stressors) of events such as an accident, rape, or natural disaster or long standing physical, emotional, or sexual abuse. This experience can overwhelm the individual's ability to cope with the traumatic event(s) and can have immediate effects on the individual or longer lasting adverse effects on their sense of self and functioning. In turn, this can affect the person's physical, social, emotional, and spiritual well-being. Trauma can be a single event (acute traumatic event) or a series of chronic events (complex trauma). Complex trauma exposure occurs mostly through the caregiving system and can happen repeatedly. Complex trauma is the most common trauma experienced by clients seen by clinicians in generalist practice (Smyth, 2013). Symptoms of this type of trauma are the inability to regulate emotions, self-destructiveness, dissociation, amnesia, suicidality, shame, hopelessness, despair, and somatic complaints. Other forms of trauma exposure can be more subtle, such as racism, poverty, sexism, oppression, and all can accrue over time (Kinniburgh, Blaustein, & Spinazzola; 2005; SAMHSA, 2014; Smyth, 2013; "Trauma-informed care", n.d; 2013; "Trauma", 2009; "Trauma, n.d; "What is Trauma", 2014).

Trauma is widespread throughout the world. In the United States, 70 percent of adults, or 223.4 million people have experienced at least one traumatic event in their lives. More specifically, 61 percent of men and 51 percent of women have reported at least one traumatic event in their lifetimes. In the public behavioral health sector, 90 percent of clients report trauma exposure, and 70 percent of adolescents in addiction treatment have trauma exposure. Every 15

seconds a woman is beaten and every 6 minutes a woman is raped. Trauma can have devastating impacts on those involved. Sadly, 48 percent of children in the United States have experienced one traumatic event, and children with trauma exposure are 2 ½ times more likely to repeat a grade. In addition, 90 percent of sexually abused children and 77 percent of children exposed to a school shooting will develop Post Traumatic Stress Disorder (PTSD). Furthermore, 33 percent of American youth exposed to community violence will develop PTSD (Acharya, n.d.; Levers, 2012; “Trauma”, 2009). This national epidemic has great societal and economic implications, affecting healthcare, mental health, criminal justice, public health, and child welfare systems. The widespread presence of trauma almost guarantees that social workers (as well as other human services and criminal justice professionals) will be exposed to traumatized clients and their trauma material during clinical work (Acharya, n.d.; Levers, 2012; “Trauma”, 2009).

Courtois (2014) reported that five categories of trauma have been identified thus far; impersonal trauma, interpersonal trauma, identity trauma, community trauma, and cumulative/lifelong/continues/complex trauma. Impersonal trauma is any random act and includes natural disasters, accidents, chronic illness, debilitating injuries, and disabilities. Interpersonal trauma refers to intentional acts committed by other people. Courtois developed this category further with attachment trauma (relational trauma) included in this category and betrayal, secondary, and institutional trauma as sub-categories. Attachment trauma deals with interpersonal relationships; neglect, domestic violence, emotional, physical, sexual abuse are examples of this phenomenon. Betrayal trauma is when an individual is exploited in a close relationship, such as parent and child or between spouses, or within a fiduciary relationship. Secondary trauma is the lack of protection, intervention, or assistance by individuals who should provide these functions formally or informally. Identity trauma is the last in the interpersonal

sub-category. This form of trauma has to do with the individual's identity, such as, gender, race, ethnicity, and sexual orientation. Community trauma and cumulative/lifelong/continues/complex trauma are the last two types of trauma outlined by Courtois. Community trauma is due to one's "membership" to a specific community or group. Cumulative/lifelong/continues/complex trauma is the repeated forms of trauma that individuals may experience throughout their lifespan.

Trauma work focuses on safety, posttraumatic stress reduction, attachment work, behavioral and affect regulation, interpersonal relational work, and identity work (Courtois & Ford, 2007, 2013; Herman, 1992; Levine, 2010; Pearlman & Saakvitne, 1995; Rothschild, 2006; Van der Kolk, 2005). SAMHSA (2014) stresses the need for health care providers to provide *trauma-informed care* (TIC) to all clients seeking treatment and be willing to explore the past trauma:

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they don't often recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or the agency's directives. (p.3)

*A trauma-informed framework* is a philosophy, not a treatment. Therapists and organizations that operate from this framework recognize the prevalence of trauma and understand the varied impact of trauma on people's lives. In the *Encyclopedia of Social Work*, Wilson, Pence, and Conradi (2013) identified guiding principles essential to *trauma-informed approaches*. These are

physical and psychological safety of the client, partnership and collaboration with the client, identification of trauma-related client needs, enhancement of client well-being and resilience, enhancement of family well-being and resilience, enhancement of well-being and resilience of those working in the system, and partnership with agencies and systems that interact with clients. This commitment to TIC starts with assessing client care and continues to the therapist and organization. Assessment, therapeutic trauma interventions, treatment evaluations, supervision, training, and organizational support are important factors in TIC treatment

(<http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/>).

*Trauma-focused treatment* refers to treatment interventions or modalities and is aimed at reducing trauma symptoms in individuals. This type of treatment is a component of trauma-informed care (Courtois, 2014). Specific *trauma interventions* are programs created with the following guiding principles:

The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers (“Trauma-Informed Approach and Trauma-Specific Interventions”, 2014, p. 2).

Examples of trauma-specific interventions are Acceptance and Commitment Therapy (ACT), Addiction and Trauma Recovery Integration Model (ATRIUM), Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Cognitive Restructuring (CR), Dialectic Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR) Essence of Being Real, Risking Connections, Sanctuary Model, Seeking Safety, Trauma, Addition,

Mental Health, and Recovery (TAMAR), Trauma Affect Regulation, and Trauma Recovery and Empowerment Model (Courtois, 2014; “Trauma-Informed Approach and Trauma-Specific Interventions”, 2014).

TIC and social work’s guiding core values of service are complementary. The National Association of Social Workers’ Code of Ethics identifies social justice, dignity and worth of the person, importance of human relationships, integrity, and competence as guiding core values when working with clients (Code of Ethics of the National Association of Social Worker, n.d.). Competence would include knowledge and skills in trauma-informed practice. Other fundamental areas in social work practice are individual self-determination, identification of client strengths, client autonomy, client resilience, and seeing each client as a unique individual (Abrams & Shapiro, 2014).

SAMSHA (2014) identifies steps for providing TIC as:

meeting the client in a safe, collaborative, and compassionate manner; preventing treatment practices that re-traumatize people with histories of trauma who are seeking help or receiving services; building on strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff. (p.3)

Within the therapeutic relationship, individuals work through their traumatic events and their impact on their mind, body, and spirit. This work can be very demanding on both client and therapist. Some constructs developed to describe the impact of this work are compassion fatigue, secondary traumatic stress, shared trauma, and vicarious traumatization. Burnout is another negative outcome that workers can experience from trauma work. Over the past 15 years, these constructs have been studied to help therapists anticipate and prepare for potential risks when

working with this population. More recently, research has identified the positive reactions therapists may experience when working with traumatized clients. The terms compassion satisfaction, vicarious resilience, and posttraumatic growth are used to describe experiences of this sort. Terms used to depict the negative and positive effects will be defined in the next few sections.

In this section, I present research on negative and positive reactions that therapists develop in their work with traumatized clients; and describe research on these topics. I begin with a discussion of available literature on therapists' negative reactions to working with traumatized clients.

### **Literature on Secondary Exposure to Trauma**

Clients come to therapy for a wide variety of reasons and issues, but most often to address and reduce symptoms of depression, anger, anxiety, and substance use issues but many share the common experience of having been traumatized. In various settings and treatment levels, clinicians work with clients who have histories of sexual abuse, childhood neglect, violence, and abuse. In therapy, clients reveal traumatic events and in turn, social workers are often exposed to vivid and explicit accounts of abuse and trauma. This work can be exhausting but it is extremely rewarding as well. Due to the intimacy of this working relationship, clinicians have the potential to be affected on both professional and personal realms. "The client and the social worker are real people, each displaying and bringing to the helping process distinctive personality traits and particular styles of relating" (Goldstein & Noonan, 1999, p.200). In this relationship, each individual has an impact on the other.

The effect of trauma work on the clinician often develops from verbal interactions between the client and therapist but they can also result from relationship dynamics and

behaviors. Terms used to describe these effects are burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma. *Burnout* refers to the worker's experiencing a gradual accumulation of hopelessness and physical exhaustion, and is associated with decreased job performance and effectiveness. Newell and MacNeil (2010) stated, "The actual process of *burning out* is best described as a progressive state occurring cumulatively over time with contributing factors related to both the individual, the population served, and the organization" (p. 59). This phenomenon can happen at the individual, organizational, or client level. High caseloads, unsupportive work environments, difficult populations, change in worker ideals, and insufficient rewards contribute to worker burnout (Canfield, 2005; Collins & Long, 2003; Farrell-Sabin & Turpin, 2003; Rothschild, 2006; Stamm, 2012). Another important aspect of burnout is the dilemma of the "gap between what the helper is expected to do and what he or she is able to do" (Pearlman & Caringi, 2009, p. 204). Tosone, Nuttman-Shwartz, and Stephens (2012) described burnout as an overall experience that is the result of clinical work and is different from the other negative constructs that develop from trauma work.

*Compassion fatigue* and *secondary traumatic stress* have been used interchangeably in the research literature but are defined separately in this review. The term *compassion fatigue* is used to describe the negative aspects experienced by anyone in a caregiving position and is similar to burnout in that it can accumulate gradually and occur over time (Newell & MacNeil, 2010; Rothschild, 2006; Stamm, 2012; Tosone et al., 2012). Adams, Figley, and Boscarino (2008) defined *compassion fatigue* as "the formal caregiver's reduced capacity or interest in being empathic..." (p. 239). Sabin-Farrell and Turbin (2003) stated burnout and compassion fatigue could be experienced when working with any client population whereas secondary

traumatic stress and vicarious trauma are specific reactions from working with traumatized clients.

*Secondary traumatic stress (STS)* is defined as the negative responses workers experience due to secondary exposure to traumatic client material and interactions that are based on posttraumatic reactions (Bride et al, 2007; Farrell-Sabin & Turpin, 2003; Ting et al., 2005; Tosone et al., 2012). This term is also used to explain the stress experience “from helping or wanting to help a traumatized person” (Arvay, 2001, p.283). This can be experienced by mental health providers, as well as family and friends of the trauma victim. Secondary traumatic stress can occur suddenly and has symptoms similar to posttraumatic stress disorder (Bride, Radley, & Figley, 2007; Stamm, 2012). Newell and MacNeil (2010) assert that “The focal features of STS are the behavioral symptoms that mirror the PTSD presented in the primary victim(s) of trauma, not changes in cognition” (p.61). Rothschild (2006) developed two categories for secondary traumatic stress. The first included family members or close associates who had a loved one exposed to trauma, and the difficulties experienced when observing a loved one’s experiencing posttraumatic reactions and coping with them. The second category related to the experience of mental health providers who bear witness to a traumatic event “they are meant to mediate. While not primary casualties of the event, they may become secondary victims by becoming overwhelmed by what they see and hear in person” (Rothschild, 2006, p. 14). *Shared trauma* is another terms used to describe this experience of clinician and client exposed to the same trauma. Two examples of this collective experience are September 11<sup>th</sup> and hurricane Katrina (Tosone et al., 2012).

*Vicarious trauma* also results from the therapist’s exposure to client trauma material but is “not considered a pathological process as is secondary traumatic stress” (Tosone et al., 2012,

p. 232). Pearlman and Mac Ian (1995) defined vicarious trauma as the reaction of “empathic engagement with clients’ trauma experiences and their sequelae” (p. 558). Vicarious trauma emphasizes the changes in the clinician’s “meanings, beliefs, schemas, and adaption...” (Ferrell-Sabin & Turpin, 2003, p. 453). Courtois and Ford (2013) stated that when a professional experiences vicarious traumatization, he or she experiences great distress that “should therefore be anticipated and prepared for. If not identified and managed, vicarious trauma has been found to impair professional judgment and ability to function effectively...” (p.271). All of these constructs are expressed in mental health symptoms, somatic symptoms, interpersonal relationship problems, impaired cognitions, reduced empathy, and many other subtle signs of impairment. This in turn could affect the quality of life for the worker, which in turn impacts the quality of work with her or his clients (Marriage & Marriage, 2005; Pearlman & Mac Ian, 1995).

Much of the research and literature on psychological effects from trauma work focuses on identifying and validating the existence of these effects. Early research consists of exploratory and descriptive studies. Many studies discuss coping skills, predictive traits, and protective measures for trauma workers. Overall areas addressed in the research literature are the need to educate young practitioners of risks and signs of the effects of trauma work, ongoing trainings and supervision focused on this topic, and strategies for self-care, including varied caseloads, team-approached case reviews, personal self-care, and organizational practices incorporating a trauma-informed approach (Cunningham, 2003; Neuman & Gamble, 1995; Pearlman & Mac Ian, 1995).

Sabin-Farrell and Turpin (2003) examined 11 quantitative studies and four qualitative studies from 1994 through 2002 to determine evidence of vicarious trauma in four areas: 1) emotional, behavioral, physical reactions, 2) symptomatic responses, 3) cognitive changes in

beliefs and attitudes, and 4) interpersonal and occupational functioning. All of the studies reviewed trauma therapists working with clients with difficult problems, that is, domestic violence and sexual abuse. The authors concluded that the research base on negative psychological symptoms due to trauma work is “inconsistent and ambiguous” (p. 472). The authors cited problems with the standardized measurement tools and questioned the survey methodology in most of the studies they reviewed. Additionally, the studies examined trauma work symptoms in comparison to other sources of work stress, leading the authors to question the validity of reactions from trauma. The review article also identified potential legal implications for the organizations that employ professionals who treat trauma. In the end of their review, the authors suggest that validation of vicarious trauma could have “health and safety issues” and “if not addressed” possible legal problems and compensation for psychological work distress could result (p. 475). The review highlighted qualitative studies that looked at positive reactions from trauma work and implied that these positive reactions could have a balancing effect on the negative effects of the work. The authors call for further research on this phenomenon. This dissertation research is a response to this call.

Further research on the effects of trauma work has identified risk and protective factors that indicate whether a clinician may experience traumatic symptoms. Certain factors can put a clinician more or less at risk for experiencing traumatic symptoms. Identified risk factors are: higher caseloads of clients with trauma, personal (clinician) trauma history and lack of resolution of any problematic posttraumatic experiences, lack of formal training in trauma, lower level of experience with trauma, fewer years in the profession, insecure or disorganized attachment style, and maladaptive defense styles. Other factors in the research on protective features indicate two levels of influence. One level is at level of the individual worker. The protective factors at this

level are spirituality, the clinician's organized religion, meditation practice, and peer support. Protective factors at the organizational level consist of providing clinicians with a diverse caseload, supervision infused with trauma education and self-care coping skills, anticipation and preparation for the work, personal therapy, ongoing trauma-informed trainings, and professional peer supports groups (Cunningham, 2003; Harrison & Westwood, 2009; Neuman & Gamble, 1995; Pearlman & Mac Ian, 1995; Sabin-Ferrell & Turpin, 2003).

Although this information is important, it does not identify the skills clinicians need to cope with current symptoms of trauma work. A disproportionate weight is placed on individual characteristics with less attention given to prevention and intervention for clinicians. Some findings indicated interventions and solutions for symptoms stemming from trauma work may be more structural within the organizational settings that employ social workers in the form of supervision, in-service trainings, and trauma-informed clinical team-meetings (Harrison & Westwood, 2009). However, Brockhouse, Msetfi, Cohen, and Joseph (2011) found organizational support did not predict growth.

### **Specific Negative Effects of Trauma Work on Social Workers**

Social workers regularly work with traumatized populations in their various roles. Because of this, researchers have begun to look at the impact of trauma work on social workers. In the following section, I will summarize the literature on the specific negative effects on social workers who work with traumatized clients. In the first study to research the prevalence of secondary traumatic stress in social workers, 282 master's level social workers were randomly selected to complete a survey on the negative impact of working with traumatized clients. Of these, 97.5% reported that they worked with traumatized clients. Seventy percent of the social

workers reported experiencing a least one symptom of secondary traumatic stress and 15% met criteria for PTSD (Bride, 2007).

Cunningham (2003) examined the impact on social workers of working with clients exposed to two types of trauma- human-induced (sexually abused clients) and naturally occurring trauma (cancer clients). The study found the social workers working with sexually abused clients experienced vicarious trauma more than social workers working with cancer patients did. The author posits that the exposure to client trauma material that occurred at the “hands of another human” accounted for the higher score of vicarious trauma (p. 456).

Researchers have also examined the roles of personal trauma history, social support, and years of clinical experience in the development of vicarious trauma in social workers (Choi, 2011; Michalopoulos & Aparicio, 2012). Social workers who reported lower levels of vicarious trauma had more clinical experience and greater social support. Further, social workers with personal trauma histories did not have higher scores of vicarious traumatization. In addition, workers with personal trauma histories that had received trauma treatment had vicarious trauma scores that were similar to workers with no trauma treatment.

Other studies have explored the relationship between personal and work variables by measuring burnout and intrusive thoughts of client material in social workers. Clinicians who were younger and with a lower annual salary reported more somatic symptoms, perceived less social support, and scored higher for burnout and vicarious traumatization. Personal trauma history, weekly face-to-face client contact, or self-reported level of intrusion of client material did not influence social workers’ scores measuring vicarious trauma (Adams, Matto, & Harrington, 2001). Empathy, emotional separation, occupational stress, and social support have also been measured in relation to secondary stress. In a study examining trauma among hospital

social workers, emotional separation (ability to be emotional differentiated from another while being empathic) and occupational stress were the strongest predictors of secondary traumatic stress (Badger, Royse, & Craig, 2008). Having higher levels of sociopolitical support (level of peer or coworker support and general organizational support) resulted in lower levels of secondary traumatic stress in social workers. On the other hand, another study found having access to resources and being in an organizational culture that values “human capital and cooperative working environment” and the overall quality of supervision did not predict and therefore protected against secondary traumatic stress (Choi, 2011, p.236).

In a study that only investigated social workers, countertransference, vicarious traumatization, and posttraumatic growth were examined (Gibbons, Murphy, & Joseph, 2011). Participants reported feeling that they serve an important role in society yet did not feel valued or respected for their service. Participants who scored higher on “feeling valued in professional role” scored lower on burnout and higher on posttraumatic growth and job satisfaction. This study reported on negative reactions from trauma work (burnout, secondary stress, vicarious traumatization) and positive reactions from trauma work (compassion satisfaction and posttraumatic growth), yet notes the limited research focusing solely on social workers’ reactions. The study authors call for qualitative research to provide further information regarding social worker response (Gibbons et al., 2011).

### **Literature on Vicarious Growth in Trauma Work**

Focusing solely on negative reactions in trauma work can have the effect of denying the existence of positive reactions social workers experience, including personal growth. When

describing positive experience, terms that are used include compassion satisfaction, vicarious transformation, vicarious resilience, posttraumatic growth, and vicarious posttraumatic growth.

Stamm (2012) defined *compassion satisfaction* as “the pleasure a helper can experience from being able to help others and to make a positive difference in the world” (p. 2). She stated that compassion satisfaction and compassion fatigue are related concepts that are a part of the experience of being a helper. A concept similar to compassion satisfaction is *vicarious transformation*. This is when a worker can “see how the suffering can be healed, and how they can help in that process, (so that) the vicarious traumatization becomes vicarious transformation” (Stamm, 2012, p.2). Hernandez, Engstrom, and Gangsei, (2010, 2007) developed the term *vicarious resilience* to describe this experience. This is described as the “unique and positive effect that transforms the therapists in response to client trauma survivors’ own resiliency” (Hernandez et al., 2007, p. 237).

Calhoun and Tedeschi (2013) defined *posttraumatic growth* as “change that the individual experiences as a result of the struggle with a traumatic event” (p. 6). The authors cite five general elements common in positive growth experienced from traumatic exposure, namely personal strength, relating to others, new possibilities in life, appreciation in life, and spirituality. These five factors are organized into three conceptual categories: “a changed sense of oneself; a changed sense of relationships with others; and a changed philosophy of life” (p. 6).

A significant amount of the literature on posttraumatic growth has examined individuals who have survived traumatic events (Calhoun & Tedeschi, 1998, 2004, 2013; Gibbons et al., 2011). More recently literature has focused on posttraumatic growth in trauma therapists. Much of the research on the positive reactions from trauma work examines the relationship between negative and positive reactions. Further, many studies of positive reactions in trauma therapists

have a quantitative focus and identify variables found to be related to negative and positive reactions from trauma work (Arnold, Calhoun, Tedeschi, & Cann, 2005; Bauwens & Tosone, 2010; Cohen & Collens, 2013; Hunter, 2012).

Currently there is no published working definition of *vicarious posttraumatic growth*. The research literature uses the term to explain positive reactions from working with trauma victims experienced by the worker but it has not been fully defined as a concept. Yet, there is a model developed to explain the process of vicarious posttraumatic growth in workers and theoretical explanations on what contributes to the experience. The construct posttraumatic growth was used primarily in research studies of examining the positive growth clients experienced from trauma and vicarious posttraumatic growth applied to the therapists' positive growth experience when working with traumatized clients. It is not known whether the worker's growth parallels the client's, precedes or follows the client's, or has its own characteristics and trajectory (Arnold et al., 2005; Ben-Porat & Itzhaky, 2007; Cohen & Collens, 2013; Hunter, 2012; Splevins, Cohen, Joseph, Murray, & Bowley, 2010). It is important for therapists to be able to offer and sustain hope of recovery to their traumatized clients as a starting point and throughout the treatment.

### **Quantitative Research on Posttraumatic Growth**

As indicated, much of the research on the positive reactions from trauma work examines the relationship between negative reactions and positive reactions (Craig & Sprang, 2010; Gibbons et al., 2011; Lawson & Myers, 2011; Rossi, Centrano, Pertile, Rabbi, Donisi, Gringoletti, Curtolo, Tansella, Thornicof, & Amaddeo, 2012). Research literature has found that workers who had more psychological distress, more years working with traumatized populations,

and were female staff members who experienced recent “negative life events” had higher levels of burnout and compassion fatigue and lower levels of compassion satisfaction (Spang, Clark, & Whitt-Woosley, 2007). Overall, the research indicates a negative correlation between compassion fatigue and compassion satisfaction. This suggests that therapists who experience compassion fatigue are less likely to experience compassion satisfaction (Samios, Rodzik, & Abel, 2012).

The findings of several studies indicate that the following factors contribute to compassion satisfaction and decrease the negative aspects of trauma work among practitioners: having specialized training in trauma, utilizing evidence-based practices, the age and years of experience of the practitioner, utilization of self-care techniques and spiritual practices (Alkema, Linton, & Davies, 2008; Craig & Sprang, 2010; Linley & Joseph, 2007; Sprang et al., 2007).

Linley and Joseph (2007) explored positive aspects (personal growth, compassion satisfaction) and negative aspects (compassion fatigue & burnout) of therapists’ well-being with 156 randomly selected therapists. Their study considered nine occupational factors (personal psychotherapy, clinical supervision, personal trauma history, therapist gender, therapeutic training orientation, therapeutic practice orientation, length of time working as therapist, and current workload) developed from the literature.

Linley and Joseph (2007) also looked at four psychological factors in relation to growth in therapists (sense of coherent personality construct, empathy, bond from the working alliance, and social support). Therapists engaging in personal therapy had higher levels of positive psychological changes and less burnout. Therapists who reported greater levels of personal growth were ones who received clinical supervision, had personal trauma histories, and were female.

Therapeutic training and practice orientation also influenced positive and negative therapist well-being. Linley and Joseph (2007) found that therapists who were trained in humanistic and transpersonal orientations reported higher levels of personal growth and positive change associated with their therapeutic work. The study also found therapists trained in a cognitive-behavioral orientation reported less personal growth and positive change and higher levels of burnout symptoms. Therapists who had been doing therapeutic work for longer periods of time reported more negative psychological changes and higher scores for burnout. The study also found therapists' positive well-being was associated with the sense of coherent personality construct, empathy, therapeutic bond, and social support.

Rossie et al. (2012) assessed burnout, compassion fatigue and compassion satisfaction among Italian community-based mental health staff. They found social workers and psychiatrists had the highest levels of burnout and compassion fatigue. Workers with higher levels of psychological distress scored higher in burnout and compassion fatigue and lower in compassion satisfaction. In addition, burnout and compassion fatigue scores increased for each extra year working in a community mental health center, and women who had experienced a negative life event within the year had higher scores of compassion fatigue.

Bauwens and Tosone (2010) explored the shared experience of trauma (personal and professional exposure) on therapists and the long-term effects of 9/11. Therapists reported that 9/11 was the catalyst for better self-care, learning new skills, and changing clinical modality. Therapists also reported on positive improvements in the therapeutic relationship, compassion, and connectedness with clients; and on the negative effects of disappointment with professional organizations, sense of vulnerability, and feeling ill-equipped to deal with the aftermath of 9/11.

## **Qualitative Research on Posttraumatic Growth**

Arnold et al. (2005) reportedly completed the first qualitative research study on posttraumatic growth. Prior to this study, research on the effects of trauma work was mainly aimed at studying negative reactions. In contrast, Arnold et al. (2005) gave a more balanced view of trauma work by exploring both the negative and positive impact of trauma work on psychotherapists. Through their study, the authors validated the positive sequelae of therapists working with trauma survivors. It is important to acknowledge that the therapists interviewed did not work exclusively with trauma clients, which limits this study's transferability to studies of therapists with similar caseloads. In this study, I included therapists whose caseloads are largely but not exclusively with survivors of trauma.

In a metasynthesis on qualitative studies of vicarious trauma and vicarious posttraumatic growth, Cohen and Collens (2013) reviewed 20 published qualitative articles to examine the effects of trauma work on therapists. The study used a systematic method to gather information from qualitative research on vicarious trauma and posttraumatic growth and analyzed the research for main themes. The review included articles that were qualitative or mixed methods, examined the impact of trauma work on trauma workers, and were published in peer-reviewed journals from 1995 through 2010.

The overall aim of the review was to address the recent interest/research on posttraumatic growth and address the lack of established models to explain the process of posttraumatic growth in relation to vicarious traumatization. Four main themes found in the metasynthesis were (1) emotional and somatic reactions to trauma work, (2) coping with the emotional impact of trauma work, (3) the impact of trauma work (i.e., changes to schemas and behaviors), and (4) the process of schematic change and related factors (Cohen & Collens, 2013).

In regard to the first theme, “emotional and somatic reactions to trauma work,” the review outlined the following emotions: sadness, anger, fear, frustration, helplessness, powerlessness, and shock (Cohen & Collens, 2013, p.572). Somatic responses listed were numbness and nausea, tiredness, feelings of detachment, and difficulty performing therapeutic work, that is, maintaining boundaries and establishing trust. One study reviewed found social workers describing their work as “dominating their entire lives” (Shamai & Ron, 2009, p. 48) and reported feeling dirty, craving sweets, wanting physical contact with family members, avoiding public places, sleep problems, and images or disturbing thoughts. Reactions remained with therapists well after the sessions ended.

Other studies reviewed indicate therapists experienced personal changes identified as fatigue, loss of energy, and changes in well-being (anxiety, emotional fatigue, despair) (Bell, 2003; Ben-Portat & Itzhaky, 2009; Goldblatt, Buchbinder, Eisikovits, & Arizon-Mesinger, 2009; Naturale, 2007). The review cites conditions such as insomnia, irritability, and feelings of being overwhelmed as evidence of therapist’s struggle to turn off these negative reactions (Cohen & Collens, 2013).

The second theme, “coping with the emotional impact of trauma work,” identified organizational factors as important in “managing and mitigating the potential harmful effects of the work” (Cohen & Collens, 2013, p. 572). These factors consist of diversifying work roles to include duties other than one-on-one counseling, providing training and supervision on vicarious trauma, peer support, self-care, spirituality, and an overall positive outlook.

One study referred to in the metasynthesis applied the strengths perspective when viewing reactions from work with victims of domestic abuse (Bell, 2003). Using this framework, the authors encouraged participants to view their overall experience of working with their clients

as positive. Forty percent of the therapists interviewed reported their work with trauma survivors increased their personal growth in compassion and gratitude and decreased judgmental feelings compared to 10% of the sample who felt their work impacted them negatively. Finally, 43% of the sample identified both negative and positive reactions from their work. I plan to use the strengths perspective in my study of social workers working with clients traumatized by a variety of situations.

The third theme identified in the metasynthesis, “impact of trauma work (i.e., changes to schemas and behavior)” focused on the cognitive changes, positive and negative, in internal schemas from working with trauma (Cohen & Collens, 2013, p. 575). The negative areas identified in this were perception of safety, increased awareness of potential personal vulnerability, mistrust of other people, intensifying “problems and difficulties” with personal family, feeling less attentive or emotionally available, and increased distance from friends (p.576).

An example of this theme is found in a qualitative study which looked at the impact of intimate partner violence on 14 female Israeli social workers’ marital relationships and gender identity (Goldblatt et al., 2009). The study looked at the social workers’ boundaries between work and personal relationships and “by doing so, they bring the two domains closer and make them mutually permeable” (p. 368). Social workers expressed how their work serves as a catalyst to re-examine their personal and social views. The study found the social workers question their personal relationships and roles as a result of their changing world view from their work. As the clients examine personal views and make decisions regarding their roles as women, the social workers are similarly exploring their personal views and relationships. The study suggests this

shift happens as a result of having a personal narrative similar to that of their clients. As the authors state:

The intensity of this involvement with issues that seem highly relevant for the workers often blurs the boundaries between themselves and the clients to a point where the focus of the narrative shifts, and this inevitably raises the question of who is at the center of the discussion, the client or the worker. (Goldblatt et al., 2009, p. 370)

Clinical questions aimed at helping a client re-evaluate relationships and roles served as self-defining personal questions for the social workers. This in turn influenced the quality of the social workers' intimate relationships in positive and negative ways.

Goldblatt et al. (2009) found that social workers felt their work gave them an opportunity to clarify and re-define their gender identity and how it is expressed in their intimate relationships. The study's outcome supports the mutual interplay between client and clinician. The authors state, "It appears the boundaries between work and private life among the workers interviewed become increasingly permeable" (p. 375). The social workers in the study demonstrate how their work evokes both negative and growth-producing reactions on personal and social levels. Either way, it is clear that this work is life-changing for the workers. Positive changes identified were views on human resilience, overall appreciation of life, changes in personal qualities and attitudes (greater compassion, more acceptance towards others), and increased sense of self-worth, empowerment, and self-validation. Therapists also reported experiencing changes in meaning associated with their professional role, greater value of their profession, and experiencing more faith and trust in the therapeutic process.

Lastly, the metasynthesis focused on the process of change and growth in therapists. Experience and time were two important key factors; more experience and time were related to

less negative emotions and distress. Another important factor was the ability to experience co-occurring positive growth along with intense, difficult emotions. This suggests that witnessing another's growth could facilitate the therapist's own growth (Cohen & Collens, 2013).

Other qualitative research examined the therapist's view of satisfaction and risks associated with the therapeutic bond in clinical work (Hunter, 2012). Cited components that create an optimal therapeutic bond can be positive for creating change but can also generate negative reactions on the part of the therapist. Negative reactions are identified as vicarious traumatization, compassion fatigue or secondary stress disorder. The article noted a movement in the literature from a focus on negative reactions, citing the emergence of positive reactions from more recent studies.

From this review of the literature, this writer notes a paucity of research, especially qualitative, that specifically targets social workers and their potentially positive reactions to trauma work. It is also important to note the current research makes it hard to tease out connections of variables for negative and positive reactions from trauma work due to small sample sizes, mixed sample criteria, and generalized correlation between variables. It appears this is still an underdeveloped area in the field and further exploration of the topic is warranted to understand the positive experience of trauma work. To do so, I considered the following research questions:

#### Research questions

- How do social workers who report positive reactions to working with clients who experience trauma describe their reactions?
  - What is the nature of the reported growth or satisfaction?
  - Is the growth or satisfaction related to being a better therapist, a better person, resolving one's own trauma, or something else?
  - Does growth/satisfaction precede, follow, or run parallel to the client's growth?

- How, if at all, do workers describe their experience of the relationship between positive and negative reactions?
- What in their work environment facilitates the process of growth or satisfaction? How? What impedes it? How?
- What in their personal environment or self-care facilitates the process of growth or satisfaction? How? What impedes it? How?
- What aspects of the therapeutic environment facilitate the process of growth or satisfaction?
  - How, if at all, does the relationship between the social worker and the client affect their mutual growth?
- How, if at all, does the social worker's theoretical orientation affects his or her work with clients who have experienced trauma?

## Chapter 3

### Theoretical & Valued-based Perspectives

Qualitative researchers using a grounded theory approach are advised to develop “theoretical sensitivity,” that is, awareness of concepts that further understanding of the meaning of the data (Strauss & Corbin, 1990, p. 41). The researcher develops sensitivity by becoming familiar with existing theories and research, as well as professional and personal experience and by interacting with and questioning data during the research process (Strauss & Corbin, 1990). Four theoretical perspectives that have sensitized me to vicarious reactions in trauma work are relational theory, positive psychology, attachment theory, and the strengths-based perspective.

#### Relational Theory

Relational theory provides a framework in which to view the exchange of traumatic reactions between the client and the clinician. This theoretical approach has emerged as a new tradition influenced by interpersonal theory, object relations theory, self psychology, and feminist theory (Aron, 1996; Bachant, Lynch, Richards, 1995; Horowitz, 1998; Miehl, 2011; Mitchell & Aron, 1999; Rasmussen, 2005). Aron (1996) states:

Thus, the relational approach is an attempt to bridge theories that have traditionally emphasized either internal object relations or external interpersonal relations, the intrapsychic or the interpersonal, constitutional factors or environmental factors, one-person psychology versus two-person psychologies. (p. 17)

Both client and the therapist enter into the therapeutic relationship with experience, expertise, and knowledge and the clinician approaches the relationship with authenticity and openness (Miehls, 2011).

Relational theory highlights the mutual influence of the therapist and client in their relationship. In therapy, the client and therapist are “always interacting with one and other in any clinical situation” (Berzoff, 2011, p. 222). This is in reaction to classical theory that characterizes the therapist as a somewhat invulnerable observer and interpreter of what the client brings to the relationship (Bachant et al., 1995; Borden, 2000; Horowitz, 1998; Pearlman & Saakvitne, 1995). It is the therapeutic relationship that is always affecting and evolving in the therapist-client dyad. This reciprocal relationship is channeled through the transference from the client towards the clinician and the countertransference from the clinician towards the client. Both individuals in the therapeutic relationship bring past and present experiences into the clinical relationship. The therapist and the client are co-creators of the relationship and are vulnerable; the therapist is an equal participant in the relational dynamics that develop in the therapy but is the member of the dyad in charge of being aware of and analyzing them.

Winnicott maintained that the infant does not exist separate from the mother (or primary caregiver); each individual exists “in dynamic tension” in relation to the other (Ogden, 1994, p. 63). Relational theory applies this view to the relationship between the “analyst” and the “analysand” (Ogden, 1994). In therapy, the client and therapist co-create the clinical relationship through their interactions. Within this co-created relationship, therapist and client affect each other within the intimacy and intersubjectivity of the therapy relationship. Ogden (1994) explains how meaning between the client (analysand) and the therapist (analyst) is created through

intersubjectivity, which involves past and present co-creation. Ogden (1994) explained this phenomenon in this way:

...the creation of an experience (in and through the analytic intersubjectivity) that had not been previously existed in the form it was now taking. The conception of the analytic experience is central to the current paper; the analytic experience occurs at the cusp of the past and the present and involves a “past” that is being created anew (for both analyst and analysand) by means of an experience generated between the analyst and analysand (i.e., within the analytic third. (p. 76)

Aron (1996) identified this relational process as “A communication process (which) is established between patient and analyst in which influence flows in both directions” (p. 77). Aron described this approach as a two-person psychology where each person influences the other. Accordingly, in working relationally with trauma survivors, clinicians pay particular attention to their countertransference and to ways they in which they are affected by their clients.

Awareness of countertransference is essential in trauma work. Many individuals dealing with trauma are unable to open up about the trauma experience or feelings associated with the event. “This means the therapist has to be vulnerable and open but also has to be willing to be baffled, discouraged, and to not know what’s going on much of the time” (Berzoff, 2011, p. 225). Through this shared experience, the potential for therapeutic growth happens, as well as potential pain for the therapist. Through the therapist’s awareness of his or her countertransference, he or she can gain understanding of the client’s internal state and monitor his or her own reactions. It is through the therapeutic relationship and transference and countertransference that:

...feelings may be painful, the connections might be difficult to discern, and the realization about oneself and the client could be disturbing; nonetheless, this process opens the potential therapeutic space and creates interpretive possibilities that lead to less rigid, and more flexible kinds of interactions between therapists and clients and hold the possibility for the kind of reparative, compensatory object relational experiences....  
(Ornstein & Ganzer, 2005, pp. 568-569)

Relational theory has many tenets that are similar to those espoused by the social work profession and are appropriate with vulnerable and oppressed populations (Chenot, 1998; Horowitz, 1998; Miehls, 2011). Trauma survivors constitute a vulnerable population seen by social workers because of the nature of their exposure and the various trauma reactions that survivors experience. Chenot (1998) speaks of common values in both and highlights four central components: inherent worth of the human being, uniqueness of the individual, beginning where the client is, and focus of the relationship in the therapeutic setting. Horowitz (1998) elegantly states:

It seems probable that clinical social workers had for years apologetically thought of social work theory as common sense and unsophisticated, though it always explained a lot. ...perhaps social workers should consider that we've been relational, postmodern, and "cutting edge" for eighty years without knowing it. (p. 378)

Relational theory and social work are compatible with each other, each viewing the relationship as the space for change and healing of past and present issues. As stated previously, it is this relational space that creates the opportunity for growth within the dyad and is the area of exploration for this study.

## Positive Psychology

Positive psychology is the “scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development” (Duckworth, Steen, & Seligman, 2005, p. 630). Positive psychology questioned the unbalanced focus on mental illness and advocated for the practice of increasing positive emotions, engagement, and meaning to increase overall well-being (Duckworth, Steen, & Seligman, 2005; Gable & Haidt, 2005; Peterson, 2006; Seligman & Csikszentmihalyi, 2000). Duckworth et al. (2005) stated that prior to World War II American psychology had three overall goals: cure mental illness, increase well-being and happiness in “untroubled people,” and explore genius and extreme talent. After World War II psychology primarily focused on the first objective due to funding from large foundations and the Veterans Administration Act of 1946 (Duckworth et al., 2005; Peterson, 2006; Seligman & Csikszentmihalyi, 2000).

Seligman stated that happiness could be broken into three components: positive emotions, the pleasant life; engagement, the engaged life; and meaning, the meaningful life (Duckworth et al., 2005; Peterson, 2006; Seligman, Rashid, & Parks, 2006). In the first domain, the pleasant life, positive psychology was interested in individuals having positive emotions about their past, present, and future. Positive emotions about the past included satisfaction, contentment, fulfillment, pride, and serenity. Positive emotions about the present referred to satisfaction from immediate pleasures. Lastly, positive emotions about the future were hope, optimism, faith, trust, and confidence (Duckworth et al., 2005; Seligman et al., 2006).

The second component within positive psychology theory is the engaged life. This developed through involvement and absorption in work, intimate relationships, and leisure activities. Importance is placed on individuals fully engaging in their lives and drawing from

individual strengths to increase their overall happiness (Duckworth et al., 2005; Seligman et al., 2006).

The third area, the meaningful life, is the use of personal strengths and talents to serve the larger community. The meaningful life “derives from belonging to and serving something larger than oneself...” (Duckworth et al., 2005, p. 636). In conclusion, positive psychology theory aimed to increase positive emotions, heighten gratification, and strengthen belonging and service to the larger community. Duckworth et al. (2005) stated, “...we believe that the job of the therapist of the future will not be simply to relieve the negative, but to help clients build the pleasant life, the engaged life, and the meaningful life” (p. 641). Positive psychology supports the idea of utilizing a more balanced view of individual struggles and creating space for individual growth, seeing the individual as having inherent potential for growth and healing. Much of the focus of research on trauma work has emphasized the negative reactions (vicarious traumatization, compassion fatigue, and secondary traumatic stress). This study offers positive psychology in attempt to sensitize the reader and highlight the nature of positive reactions in trauma work.

### **Attachment Theory**

Attachment theory was developed from the research findings of John Bowlby and his theoretical explanation of the impact of early experiences and relationships on individuals (Applegate & Shapiro, 2005; Coady & Lehmann, 2008; Kinniburgh, Blaustein, & Spinazzola, 2005; Purnell, 2010; & Schore & Schore, 2008). Bowlby developed his ethological theory of attachment after observing the impact that separation from the primary caregiver had on young children. Bowlby stressed the importance of the “affective, relational bond between caregiver

and infant and the salience of this bond (i.e., attachment) for the infant's growth, development, and well-being" (Applegate & Shapiro, 2005, p. 63). Conversely, negative experiences and/or disruptions in the caregiver system can result in psychological difficulties (Pearlman & Courtois, 2005).

Attachment theory asserts that infants are wired to attach to their caregivers. In this relationship, infants follow a biological drive to "initiate, maintain, and terminate interaction with the caregiver and to use the person as a secure base for exploration and self-enhancement" (Coady & Lehmann, 2008, p.150). When infants and caregivers form a secure relationship, the infant experiences emotional closeness, protection, and soothing. Conversely, when this secure relationship is unattainable through disruption in the caregiver-infant dyad, complications can develop. Pearlman and Courtois (2005) stated:

Attachment insecurity and trauma also have been found to have a profound and often a severe impact on neurophysiological development, leading to restricted capacities and somatic and emotional dysregulation as well as on psychosexual development, especially identity formation, affective competence and regulation, and ability to relate to others. (p. 451)

This can have a potential impact on relational attachment and on quality of life across a lifespan.

Bowlby explained that individuals develop their sense of self and others through the Internal Working Model (IWM), which represents one's internal and external world. From his research, he identified two attachment styles; secure and insecure (Palambo, Bendicson, & Koch, 2010; Pearlman & Courtois, 2005). Ainsworth added to attachment theory with her classification of three attachment styles: secure, anxious and avoidant. A fourth category, disorganized, was added for children that were originally described as "unclassifiable" (Coady & Lehmann, 2008).

Each category referred to a specific attachment style. Anxious, avoidant, and disorganized stemmed from an infant-caregiver relationship that was incongruent in meeting the needs of the infant in a consistent and predictable way.

Attachment theory expanded to include adult attachment styles, based on knowledge that attachment schemas (beliefs about self and others) for traumatized clients can aid the healing process in trauma treatment. Pearlman and Courtois (2005) explained how client attachment styles can play out in therapeutic trauma work. The authors showed how clients with insecure-preoccupied attachment styles can display high levels of “affect-based behavior,” displaying intense emotions and a diminished ability to self-regulate (p. 453). Clients who have insecure-dismissing attachments struggle with “intimacy, defensive self-reliance, denial of distress” and possible “hostility and oppression towards others” (Pearlman & Courtois, p.453). These clients are less likely to seek treatment and minimize their emotions. Lastly, Pearlman and Courtois (2005) stated that clients with insecure-fearful avoidant attachment styles are seen most frequently in trauma treatment. For this attachment style group, caregivers and primary attachment figures “have been the contradictory source of both comfort and danger and they often anticipate the same from the therapist whom they approach with both longing and fear” (p. 454). The authors propose an attachment-relational approach when treating this population and stress the importance of the therapeutic relationship in the healing process. Pearlman and Courtois (2005) stated the healing in trauma treatment happens in the therapeutic relationship between client and therapist:

We contend that the ensuing difficulties (e.g., with emotions, emotion regulation, self-worth, the ability to form and sustain satisfying relationships, and spiritual connection) can be best addressed through the therapeutic relationship that becomes both the “testing

ground” for their emergence and the context in which they are experienced, explored, shared, understood, and ultimately resolved. (p. 450)

In the therapeutic relationship, attachment between client and therapist helps to create a foundation, or secure base, for growth and change in the client. This is inherent in all clinical work but is especially true when working with traumatized clients.

### **Strengths Perspective**

The strengths perspective developed from the strengths model of case management with people with severe and persistent mental illness in the 1980’s. This model focuses on identifying and enlisting individual and community strengths (or positive attributes) and grew out of a reaction to the institutionalized services offered (Saleebey, 2009). Two fundamental components of the strengths perspective are liberation and oppression. Liberation, according to Saleebey (2009), is the idea of unlimited possibility, “the opportunity for choice, commitment and action...” (p. 7). This is the belief that all individuals have abilities to change, grow, transcend adversity, and contribute to the betterment of society. The other side of liberation is oppression. It is essential to understand the powers that impede individuals, groups, and communities (Saleebey, 2009; 2011).

Saleebey (2009) identified certain principles of the strengths perspective. This model holds the idea that every individual, group, family, and community has strengths. The growth in therapy centers around strengths instead of deficits. There is recognition that trauma, abuse, and adverse life events may be harmful but they also provide opportunity and growth. This belief challenged the notion that people are victims as a result of past adversity. In accordance with this perspective, the worker does not assume to know an individual’s capacity for growth. Social workers and helpers must be curious, respectful, and collaborative with clients’ experiences and narratives

during the helping process. Strengths-based therapists share the responsibility of the clinical work with the client, each viewed as equal.

This perspective also encompassed the belief that it is critical not to limit the individual, group, family, or community's capacity for change and the importance of developing a collaborative alignment in order to create growth and change. Saleebey (2009) explained the importance of collaboration by stating:

We make a serious error when we subjugate clients' wisdom and knowledge to official views. There is something liberating, for all parties involved, in connecting to clients' stories and narratives, their hopes and fears, their wherewithal and resources rather than trying to stuff them into confines of a diagnostic category or treatment protocol. (p. 17)

This focus on potential, growth, and resilience as a model for therapeutic work helps to sensitize me to the potential growth in therapists who work with traumatized clients, whose perspectives are central to the proposed research. As discussed with relational theory and positive psychology theory, it is within the mutual, interactive therapeutic relational space that the growth is possible (Saleebey, 2009; 2011).

## Chapter 4

### Methodology

#### General Approach

Quantitative research categorizes variables, investigates relationships, and measures data. In comparison, qualitative research examines a phenomenon in its natural environment, emphasizes content and context, and is interpretative. Qualitative research is appropriate to use when exploring a topic where little is known, there is emotional complexity, there is a need to deepen quantitative research, or where one wants to portray lived experience (Bloomberg & Volpe, 2012; Marshall & Rossman, 2011; Rubin & Babbie, 2011; Wertz, et al., 2011). Based on my review of the literature, little is known about the lived experienced of social workers and vicarious posttraumatic growth in trauma work, making qualitative research fitting for this study.

One approach to qualitative research is social constructivism. This is a view that reality is socially and culturally constructed. Further, in this approach it is the researcher's function to deeply understand the multiple perspectives of the participants. Constructivist researchers also acknowledge that their own personal histories influence their interpretations (Bloombers & Vople, 2012; Marshall & Rosssman, 2011; Rubin & Babbie, 2011). This study will employ a constructivist approach to a modified constructivist grounded theory as the qualitative research tradition. Charmaz (2011) states that grounded theory "views data as mutually constructed by the researcher and the researched. Neither data nor the subsequent analyses are neutral" (p. 169). Modified grounded theory was used explore, in-depth, an understanding of trauma work and the positive aspects social workers experience. This study can help to inform theory and provide insight for future clinical practice with traumatized clients, as well as education and organizational systems.

## Research Sample

For the purpose of this study, it was critical to explore the positive reactions from trauma work of social workers who have had experience in working with clients who had been traumatized. For this study I interviewed 15 master's-level social workers who were working with traumatized clients to explore their personal reactions to this type of social work. The study utilized purposeful, snowball sampling. This sampling technique began with strategically identifying participants that met study criteria (see inclusion criteria below) and through these contacts identified further participants. In qualitative research, this type of sampling is used to describe a specific experience and is not intended to generalize to the larger population (Bloomberg & Volpe, 2012; Malterud, 2001; Mays & Pope, 2000; Marrow, 2005).

I started my recruitment for my study by informally approaching social workers at trauma trainings and other continuing educational events to begin build a potential sample. After I obtained IRB approval, I recruited participants through strategic emails to the MSW alumni groups, and through my fellow DSW cohort members. (See Appendix A) When I formally began recruitment, I explained verbally or in an email letter (Appendix B) the proposed research study and the need for social workers who work extensively with clients who had been traumatized. I explained that I was exploring the impact of working with clients (and families) struggling with traumatic life events for a research study. Further, I explained I would be interviewing social workers with experience working with this population and asking questions related to ways this work has affected them. For applicants who were interested in being interviewed, I arranged a telephone screening interview (described after the inclusion and exclusion criteria, below). The researcher modified the original sample criteria to include social workers in private practice and

modified the original interview guide to explore the social worker's choice to work in private practice. Initially, I wanted to focus solely on social workers working in agencies in explore how the work environment impacted participants' growth and satisfaction. I modified this criterion in order to get a diverse and experienced group of participants in the field of trauma work. In response, I changed my interview guide to explore this phenomenon of social workers leaving agencies to enter into private practice.

Inclusion criteria:

- Master's-level social worker
- Working in outpatient or intensive mental health outpatient settings
- Working in agencies or private practice
- Three years (or more) post-MSW experience working for current employer
- 50% (or more) of caseload is with traumatized clients
- Has experienced positive reactions when working with traumatized clients

Exclusion criteria:

- Recent personal trauma
- Currently struggling with personal reactions to clients' trauma narrative(s)

I chose these criteria because of the limited research on the impact of trauma work on social workers working at the outpatient or intensive outpatient level. The length of employment at current work setting was chosen to ensure the social worker's experience with that client

population and within their organization. In my experience as a clinician and supervisor, I have observed that therapists have experienced personal reactions from their work and organizational influences in this timeframe. On the basis of literature pointing to the influence of the organizational context on vicarious traumatization, I initially wanted to interview social workers who work in organizational settings (as opposed to private practitioners) but changed the sample criteria to get a varied sample. As a result, I included participants who worked in agency settings and in private practice. Additionally, the 50% (minimum) of the social worker's caseload is with traumatized clients in order to get a sufficient experience of the worker's reactions from this type of work. Social workers who have experienced recent personal trauma and/or are having difficulties with clients' trauma narratives would be excluded from the study to protect them from further difficulties.

I conducted a short screening interview by phone of all potential participants prior to the interview to ensure that eligibility criteria were met. (See Appendix C for a copy of the screening form.) The social worker was asked screening questions on the following topics:

- Education/degree/year received MSW
- Licensed or non-licensed
- Gender
- Age
- Place of employment
- Time at current employment
- Type of setting
- Caseload (% of clients with trauma experience)
- Recent personal trauma

- Current problems with personal reactions from clients' trauma material

Once I determined that a participant met eligibility criteria and agreed to be interviewed, I scheduled the interview at a convenient place for the individual. The interview was conducted at my office, the interviewee's office, or another location requested by the interviewee. Interviewees received an email and phone call prior to the scheduled interview as a way to decrease the attrition rate. All social workers received a 25-dollar Amazon gift card for participating in this study.

### **Data Collection Methods**

The study used semi-structured, intensive interviews in order to hear from clinicians, in their own language, how working with high-risk, traumatized clients affected them. Participants were asked open-ended questions. The interviews lasted 1 to 1.5 hours and were electronically recorded. Interviews were held at a private location in order to ensure confidentiality. Prior to the interview, participants completed a consent form and a subject information form on demographics. The interview included questions about the social worker's positive experiences when working with traumatized clients, their theoretical framework, personal and professional coping skills, organizational supports, and future plans. The interview guide can be found in Appendix D.

Interviews were recorded by a hand held audio recorder and downloaded to a password protected computer. Files were saved by case. The interviews were transcribed by a secure transcription service. Once transcribed, I listened to the interviews while proofing the transcriptions to check for errors, and corrected any mistakes.

## **Method of Data Analysis**

This study used a modified grounded theory approach to explore and organize the interview data. Rubin and Babbie (2011) state that grounded theory “begins with observations and looks for patterns, themes, or common categories” (p. 438). Grounded theory provides an approach in which participants speak about a specific experience or phenomenon in their own language. This experience provides an opportunity for a richness lacking in quantitative research on this topic. Four sources of data were collected from each interview. These were a face sheet with demographic information, digital audio recording, verbatim transcript of the interview, and my written field notes from each interview.

Data analysis was conducted in stages; initial coding, focused coding, and memo-writing. The initial coding stays close to the data and initial codes are “provisional, comparative, and grounded in the data” (Charmaz, 2014, p. 117). The codes may incorporate the interviewee’s language. In this stage, the researcher moves through the interview word-by-word, line-by-line in order to stay close to the data and begin to categorize the data. Next, the researcher further reduces the data by identifying reoccurring themes in the data. As Charmaz (2014) states “Focused coding requires decisions about what initial codes make the most analytic sense to categorize your data incisively and completely” (p. 138). The last component is memo-writing. Memo-writing continues throughout the analysis process and serves to define codes, compare data and codes, order and categorize data, identify gaps, and “provide sufficient empirical evidence to support your definitions of the category and analytic claims about it” (Charmaz, 2014, p171). Coding and memo-writing were conducted throughout the data collection process.

## **Methods of Data Management**

All recorded interviews, transcripts, and other identifying and personal information were kept under lock and key throughout the process and will be properly disposed of at the completion of the project. Participants' information was strictly confidential and any field notes utilized did not have identifying markers on them. Instead, there was a key that allowed me to identify the respondent and this key was kept in a confidential and protected place. All interviews were saved on this researcher's password-protected computer.

## **Reflexivity Statement**

As a clinical social worker, I have spent the last sixteen years working with clients who have been affected by trauma and seek help in outpatient and intensive outpatient settings. I found the work extremely difficult but also extremely rewarding. My work with my traumatized clients gave me enormous satisfaction and I experienced strong connections with these clients. When I started my initial planning for my dissertation study, I was influenced by the message reflected back to me by the research literature on work with traumatized clients. Similar to the research literature's initial emphasis on negative reactions from trauma work, I found myself focused on secondary stress, compassion fatigue, and vicarious trauma. This limited view began to widen once I began to explore the research literature and my own feelings regarding this work. It became clear to me, as a social worker, that to focus on the adverse effects of trauma work would be incongruent with the field of social work's values.

My background has both positive and negative potential for this study. My clinical experience helped me "stay" with the social worker's content of their experience but it also had

potential to introduce bias when interviewing, coding, and analyzing the themes. To offset potential bias, I maintained a reflective journal on my personal reactions and engaged in peer debriefing with a colleague. Bloomberg and Volpe (2012) describe peer debriefing as the process of a colleague reviewing the researcher's field notes and questioning the researcher on any assumptions or offering alternative views. I also discussed my feelings with my peer debriefer.

### **Role of Researcher**

This writer was integrally involved in all aspects of the proposed study. I recruited potential participants, conducted initial screening of all potential participants, and scheduled all interviews. I also conducted all interviews, coding and analysis of themes and writing up the results.

### **Protection of Human Subjects and Ethical Issues**

I was granted IRB approval for my procedures and informed consent form prior to implementing the study. Before scheduling the interviews, I conducted a brief screening interview with potential participants (discussed earlier) to determine whether they met eligibility requirements. Prior to conducting the interview, I explained the purpose of the study, asked the participant to read the consent form, elicited questions, and asked the individual to sign the consent forms. The form indicated that participation was voluntary and that the research study was being conducted for a doctoral dissertation. They were told the interviews were not an evaluation of the therapist's clinical competence and that the data would be used to gain a better understanding of the personal experience of social workers working with traumatized clients.

They were also told there was no benefit to them but their participation could help further understanding of the reactions of social workers to trauma work. Participants had the right to stop their involvement in the research study at any time during the interview or study duration. This researcher was available to the social workers after the interview if the material evoked negative reactions, and referrals to local therapists would have been provided if they had been needed.

### **Limitations**

This study contains limitations related to the nature of qualitative research and to the design of the study. Inherently, qualitative research has a subjective aspect to the data analysis, giving the researcher responsibility on the coding, analysis, and interpretation of the data. One of the study's limitations was that I sought out social workers who have experienced positive reactions in their clinical work with traumatized clients. If I had included participants working with traumatized clients regardless of their experience of positive reactions, my study would have reflected more negative or mixed reactions. I also did not ask the social workers about the types of trauma their clients had been exposed in the interview. Another limitation was my potential bias towards positive growth in social workers due to my experience as a social worker working with traumatized clients. This limitation was mitigated by memo writing and through processing interviews with my peer debriefer. This limitation could also influence the participants' responses. Participants responses could be influenced by knowing that I was a clinical social worker and feeling that their responses were under scrutiny by a colleague. This limitation could have a direct impact on the data quality produced from the interviews. In order

to prevent this, I used a non-judgmental attitude and probed for both positive and negative reactions during the interviews with participants.

Another limitation in this study is its generalizability. Because of the small sample size and the study's limited geographical area, the study focused on understanding on a deeper level positive reactions experienced by social workers and not from a random sample or a large data set. The information obtained from the participants were also based on therapists' recollections during a one-time interview, adding an additional limitation to the study.

## **Chapter 5**

### **Findings**

The purpose of this study was to explore with master's-level social workers their positive reactions to working with traumatized clients. Specifically, the social workers were asked to describe their theoretical orientations, their reactions (positive and/or negative), their experience of the therapeutic relationship, the influence of the work environment on positive reactions, their self-care strategies, and how they envision their careers in the future. This chapter discusses the key findings from 15 in-depth interviews. From these interviews, six main themes emerged: (1) social worker characteristics, (2) reactions to working with people exposed to trauma, (3) therapeutic/clinical relationship, (4) organizational context, (5) what contributes to positive growth, and (6) outlook for the future. Within these themes, sub-themes were identified. These will be indicated in relation to each theme.

#### **Social Worker Characteristics**

This section will begin with a description of socio-demographic characteristics of the participants. Then I will discuss several sub-themes that emerged, specifically social worker's history of trauma, prior education/training of social worker, theoretical orientation of social worker, and social worker's attitude towards his or her job.

**Socio-demographic characteristics.** The interview sample was comprised of 15 master's-level social workers practicing in Delaware and Pennsylvania. All worked clinically and, as indicated in the criteria for participation, all had caseloads comprised of half or more traumatized clients.

Of the 15 interviewees, 9 were female and 6 were male. In comparison, the National Association of Social Workers membership records is 80 percent female and 20 percent male (National Association of Social Workers Member Mailing [NASW] & Email Lists, 2016). Five of the study participants were African Americans with the remaining ten Caucasian. This proportion is higher than that of the NASW's membership, which was 11 percent African Americans and 82 percent Caucasian. Additionally, of the 15 participants, nine work in agency settings (profit and non-profit) and six work in private practice. Of the nine participants working in an agency, three reported that they had a private practice in addition to agency work.

Table 1

*Socio-demographic Description of the Interview Sample (N=15)*

<u>Category</u>	<u>Percent</u>	<u>Frequency</u>
<b>Gender</b>		
Male	40%	6
Female	60%	9
<b>Race</b>		
Caucasian	67%	10
African American	33%	5
<b>Age Distribution</b>		
30-39		5
40-49		2
50-59		3
60-69		4
60+		1
<b>Traumatized Clients Distribution</b>		
Percentage Range		
50%		3
51%-70%		4
80%-90%		5
100%		3

Social Workers with History of Trauma		
Yes	47%	8
Not mentioned	53%	7
Agency Description		
For Profit Agency	19%	3
Non-Profit Agency	44%	7
Private Practice	37%	6
Service Description		
Intensive Outpatient Therapist	20%	3
Outpatient Therapist	80%	12

Table 2

Statistics	Mean	Median	Range
Years			
Age	49	51	30-73
Years since MSW	19	14	3-41
Years in Current Position	11	4	3-34

**Client trauma type.** 11 of the participants identified a client that had experienced complex trauma as their example of a case in which they had experienced positive reactions and/or growth. Two participants did not state the trauma type and two reported their clients experiencing single episodic trauma. This information came out while the social workers talked about their identified client example and the interview guide did not ask for this information directly.

**History of trauma.** Approximately half of the participants self-reported personal trauma exposure, and this exposure influenced their decision to work with traumatized individuals. This number could be higher as I did not ask specifically about personal trauma. For many, the

experience of trauma exposure and the supports, or lack of, fueled the social worker's passion for this type of work. Participants who disclosed personal trauma exposure reported either exposure prior to entering the field and/or being trained in trauma work, or more recent exposure to simple trauma. Some examples of past trauma exposure are:

I had a foster brother who killed my favorite cat, threatened to kill me. I was scared. We stopped having foster kids at that time. It was painful. It was painful to see him drive away. I think my whole life has been chasing, trying to help in a more efficient way... (Pause.) Because that was very sad. I was very sad seeing him, to be in over our heads. Heart's in the right place, and over our heads and not be able to help. (Dave M.)

What brought me to this particular agency or field of work, probably like most people you have your own trauma. My boyfriend was killed in 2007 and I went ... Philadelphia has a very similar agency to this in Philadelphia that I got connected to. They offered free counseling, free advocacy and I thought clearly after months of treatment and that kind of stuff. I thought, "Okay. I think this is my calling. I think this is what I need to do to give back." (Helen D.)

The participants in the study that reported experiencing personal trauma, indicated that their experience helped lead them to a career in social work and trauma work.

Besides influencing their career direction and passion for trauma work, working with the trauma population has reportedly helped participants become educated about their own past trauma experiences as well as the behaviors that they have observed in trauma survivors. One social worker explained that his trauma education and trainings helped him understand and cope with sexual abuse in his family of origin:

I think about one thing this job has taught me in working with this population, it's taught me to better cope with my family history of having sexual abuse. My older brother, who's 14 months older than I am, was sexually abused by our stepfather and learning about this population and some of the behaviors that abused kids manifest or exhibit, I saw that in my brother when I was younger. I didn't know why he had the stuttering and being 12 and 13 years old wetting the bed and being sexually active at such an early age. Now I know that this is the result of it all. Also my brother's battle with addiction all his adult life. (Joe M.)

Other social workers reported more recent personal trauma exposure and felt their experience and with education about trauma helped them cope and helped them feel hopeful for the future. As Pam R. said, knowing and trusting the process of trauma treatment can help social workers cope during very difficult times.

I've had a daughter that ... that was raped by a really non-student, horrible, but I was also able to get in there and not just be freaked out myself but, "Let's go to the police." We went through the whole stuff... The point being that I also know and believe that that's not the end of the world. She didn't need to be plucked out and taken home but we needed to intervene and help her establish safety and grounding and get her into therapy.... (Pam R.)

All of the participants who reported personal trauma also attributed this exposure to personal growth, careers choices, and the ability to deal with trauma when they experienced it.

**Prior education/trainings.** The age range for the sample was 30-73 and all participants reported feeling they did not have enough training on trauma in their graduate education. Older social workers explained there was little research or knowledge on trauma exposure when they were in school or during the early years of their careers:

Very limited. Very, very limited. When I first started working with traumatized people, which would be the mid-1980s, there was very little written about it. Most, if anything ... Most of the information we were getting were only from two sources. One was from the posttraumatic stress work being done with Vietnam veterans at that time, which was just in its infancy. It was not very useful. The only other source that I had access to was the dissociative disorders people who were just making strides into identifying dissociative processes. (Jane B.)

I do remember I had gestalt therapy when I was in grad school, back in the '70's, that was ... well, Fritz Perls was around then, and it was getting really, really popular, so some of the tools we would need moving forward, I know from back then. I want to say that we only really started talking about sexual abuse around the same time, so it was formed in the early '90's. It's really only been within the last five to ten years that we're talking about trauma in the form of models. (Emily R.)

Both are examples of social workers working with trauma survivors without much training and practiced during a time when trauma work was in its infancy. The participants in

this age group sought further education to deal with the symptoms they were seeing in traumatized clients but found limited clinical modalities to work with their clients.

Younger social workers interviewed reported having had very little education on trauma and trauma interventions. Many felt that the little trauma education provided in their MSW programs was not applicable to the work in the field.

I remember having to take a crisis intervention course in undergraduate school and probably exposed to maybe some of the trauma areas in graduate school. Just very little. Whatever the little snippets were you got in school. Read a couple of chapters, you reviewed it, maybe wrote a short essay about it and that was it. (Joe M.)

Not good. Not good. No disrespect to my college, but I was not prepared at all. I knew trauma is when something really bad happens and that was probably what I knew which is so terrible, but it's really amazing. Thank God that there's growth and that experience and supervision has changed that. (Helen D.)

The majority of participants began their careers as trauma workers with little understanding of the vast symptoms displayed by the clients and wanted to understand what they were seeing. An overwhelming majority reported having to find their own trainings and resources, as well as feeling that on-the-job experience helped them with their work. Many social workers had to explore trauma interventions on their own time and with their own money:

I did a lot of personal exploration. I will say that I made an effort to do that kind of work. I'm not sure that I know that for many trauma therapists. You have to do that work because there's not a lot of training. You get thrown into this work often. (Norm A.)

The way that I decide on the next piece of training is because I become aware that I'm looking at something. I'm seeing something. I recognize what it is and I don't really know what to do about it. I became really aware that people that had these trauma histories were very dysregulated and had a lot of somatic issues, including from rages and terrible impulse control to chronic illness and everything in between addictions. The talking cure was insufficient. I started reading. I'm always reading. (Jessie C.)

These participants recognized gaps in their knowledge and training and assumed the responsibility of remedying this situation.

**Theoretical orientation and interventions.** When asked about their theoretical orientations, three interviewees reported using psychodynamic theory along with various interventions. The remaining 12 participants gave examples of interventions they used when working with their traumatized clients when responding to questions asked about their theoretical orientation. It appeared that these participants conflated theoretical orientations and interventions when answering questions related to their clinical theoretical orientation. What was identified as theoretical framework by interviewees was mostly interventions and the mixing of the two terms.

The majority of interviewees reported using an evidence-based approach as an intervention in their clinical work with trauma survivors, although only one participant reported using a straight evidence-based approach. The majority of the social workers interviewed reported using a blend of approaches. Cognitive behavioral therapy (CBT) and trauma-focused cognitive behavioral therapy (TF-CBT) were the most commonly reported the intervention used in their practice. The participants who reported following an evidence-based treatment protocol (or manual) reported that the orientation helped provide structure to the therapy and increased their confidence. As two social workers said:

One of the nice things for me about having a manualized kind of treatment model is that the treatment itself lends itself to providing structure. That's one of the things I talk about with the family even just meeting them; these are the kind of things that you can expect to happen; these are the kind of things that I'm going to do. Even treatment planning with the family you begin to set a structure that for a family ...giving them a sense of structure can be very comforting. (Norm A.)

I know what I'm doing. That gives you that sense of that boost of confidence and also that boost that you can give to the family because the family then responds, great, you may know what you're talking about. That in and of itself, although it might be a little ego boosting, is often very important and it feels good to know that someone's going to trust me with their child's whole life for three or four months. (LaTonia L.)

In each example, the social workers felt confident in the clinical process and in the trauma work with clients and families, and this in turn seemed to help clients feel confident.

Other participants reported using a looser form of the evidence-based approach because of traumatized clients' varied symptomology and the need to be responsive to individual differences:

Yeah, it's not just straight cognitive therapy. I am not like a real straight cognitive therapy. It's pretty structured and I try to plan but I am a little bit more, I don't know the word, looser in a sense. (Mike D.)

I am a fan of the TF-CBT, but sometimes pressuring people into something structured isn't what the kid likes, so then I have to try and pick here, pick from there and make it my own. Usually that tends to work... Me, picking from here and picking a little bit from there, it's pretty much what the field does to make it work because not every client is the same, not everyone is structured like they're saying. This might work for one client, you come to another one and it's totally off, so you got to figure it out. As you go, we're just trying different ways, different routes. (LaTonia L.)

In each example the social worker focused on meeting the client's needs, whether this is through treatment guidelines or a more eclectic view.

When the participants were asked to describe their modalities, they cited evidence-based treatment but described blending different modalities. Emily R. spoke of being eclectic:

I am so eclectic at this point it's not funny. At (name of agency) we use a great deal of gestalt; we're always trying to bring everything into the room because of the very high degree of disassociation with our clients, so I'm using almost all the trauma-based modalities... It's like having 4 different recipes for pork chops. If you want the one with the orange rind tonight ...it's just like having tools at your disposal, and one size does not fit all, you have to use things that work, or that are relevant for the particular client you're working with. (Emily R.)

All but one of the participants reported using an eclectic approach, combining an evidenced-based treatment approach such as CBT with mindfulness work, pet therapy, Native American imagery, solution-focused work, sensory motor, and somatic work. Here Heather P. described the use of language, Native American imagery, and pet therapy in the growth of her client:

Her parents used to tell her ... Because she would be stealing from them and things like that, they used to tell her that she was a snake in the grass. We used the Native American

imagery of snakes being powerful and carrying multiple lives and having thick skins and being able to shed old skins and develop new. She actually found a small garter snake which she then adopted as a pet and she would bring in here all time into therapy sessions. (Heather P.)

Many seasoned social workers appeared to embrace their eclectic approaches, feeling this gave them a greater repertoire of interventions to use with traumatized clients.

In addition, participants talked about using a relational framework when working with traumatized clients. They spoke of the importance of listening, believing, and creating safety and hope; fostering mutuality between client and social worker; and having unconditional regard for the client. Mike D. spoke about relationship-building as a first step in trauma work:

I mean when somebody comes in with trauma the first thing you want to do is kind of let them feel comfortable and like bond with them. Let them talk. Validate them, let them know you are not judging them, listen as best as you can and then as you hear their story obviously you are going to try and use your tools to try and help them wherever you feel they need. (Mike D.)

Other participants described elements of relational theory in their work with clients. Norm A. highlighted the mutuality in his work with traumatized clients:

I'm never really sure where the boundaries, where they shift whether it's more towards the client, more towards me. I think going back to that concept of partnership that we both agree that we're going to walk into this room together. I think as a therapist I try to be really attuned to my clients so that is big. Being attuned to my client is not the work. That's just simply me making sure that I'm going where they need to go and allowing them the same spaces and the same methods of going where they need to go so that's the client's piece. It's like two people holding on to each other on a very rocky cliff and they're both trying not to fall off.

For clinical work with traumatized clients, relationship-building is connected to hearing the client's story. When speaking of guiding principles she used when working with traumatized clients, one experienced social worker said that she gives clients many opportunities to tell their story and believes that telling and re-telling the story helps clients gain mastery. She believed that the therapist needs to be a witness for the client, react to his or her story, and have the client

feel that the therapist “gets” it. Lastly, she said, the therapist needed to experience the good and bad with the client.

You want to give them as many opportunities as you possibly can to tell their story, to tell about what happened to them, because you want to be able to continue to desensitize and help the client gain the mastery over what's happening with them. (Pause.) You always want to witness for a trauma survivor. If they come in and say something bad happened last night, well, tell me all the details, and tell it to me more than once. It's really important that I react to what you told me, too. I'm not going to sit here and be the blank screen like the old-fashioned psychoanalyst, because you need to feel me witnessing you. (Emily R.)

Besides listening and believing, many social workers interviewed spoke of the importance in being active in sessions with clients, not passively watching the client's experience.

### **Reactions to Working with People Exposed to Trauma**

Although the focus of this research was on positive reactions to working with trauma survivors, participants spoke about both positive and negative reactions. In this section, I identify the sub-themes of positive reactions, negative reactions, and the relationship between positive and negative reactions.

**Positive reactions.** All of the participants reported experiencing positive reactions in their work with traumatized clients. They described feelings of joy, enrichment, emotional connection, and honor over being trusted, increased motivation, greater awareness, feeling validated as therapists, and feeling that their work is meaningful. Two participants conveyed their positive reactions this way:

How would I describe it? It was powerful, very connected within the boundaries of the work. I suspect I'll always be in her head, and I suspect she'll always be in my head or heart, whatever. Positive, but always towards a purpose goal. I'm not sure how I would describe it. (Charlie C.)

I think the positive impact is no different than being a teacher. As a therapist that's pretty much what we do, all we do is talk or listen. Just like a teacher, you don't always know who's going to become the Rhodes Scholar or this or that, but you do hope that you've

given people the skills to live a relatively happy life or at least balance their checkbook or be able to pay their bills or get a job or something like that as a teacher. As a counselor, we do the same thing. We want people to be open and available to their own psychic experiences and we know that trauma blocks that. When you are doing this work, I think one of the most powerful things is that I'm helping people to allow themselves to be themselves. (Norm A.)

One social worker spoke about experiencing positive reactions early in treatment, viewing the client's entering into treatment itself was a victory. She reported that her clients waited years after the trauma to seek help, especially clients who had been traumatized during childhood.

I have to (pause) in just thinking about most of my cases (pause) most of our clients, by the time they get here, (pause) it's been so long in the process before they got here that they're so grateful to be here (pause). I want to say most of the positive feelings start for me, pretty early on, honestly. It's the best work. It's the best work. (Pause.) I think we accomplished our goal just by getting them in the door sometimes, because I'm aware of how long the process was. I had some administrative interns doing demographics for me this last year, and we had about 200 responses in the last one she did ... 87% were abused before the age of 13, the first time. About half of them went on to getting abused again. The average person in that study waited 23 years to come forward. These are women that are waiting a very, very, very long time to get treatment. (Emily R.)

Some participants spoke about how they experienced positive reactions in their work with traumatized clients as protective and even energizing. As two interviewees said:

Yeah, I don't feel burnt out. I think that the positive work, or the positive effects from doing trauma work, I feel that has helped me from now burning out. It's probably the reason I'm still here. I'll leave it at that. I think that knowing that I have good experiences from doing this work has ... and that I'm allowed to keep doing this work, specifically with the trauma group ... (Heather P.)

I find that when I'm having a therapeutic work day, where there's a lot of joy, a lot of celebratory happenings in different sessions, that it creates an enormous sense of good ... I want to say good will, but that sounds corny. It's like an energy that I feel in my core self. I leave feeling very ... It's very invigorating. It's probably a dopamine response of some kind because it's so energizing. A lot of times, my family or my partner or my children would say, "But you worked nine hours. You should be exhausted." If it's a particularly tough nine hours, yes, that's true, but if there's a lot of that celebratory stuff happening, it's mildly euphoric. It's really exciting. (Jane B.)

Many social workers reported feeling positive reactions towards their clients in relational terms. Two participants spoke of having parental feelings and unconditional regard towards their clients.

Yeah, and I wanted to protect him, so that's part of what I had to talk about. I just do this work in order to ... I couldn't spare him. As a mother, your instinct ... (Mary S.)

I think, when I think of her, it's this feeling of just amazement and I'll tell you why. She has been through a struggle of a life but remain the most joyful, kind, young person that I've ever met.... I realized I'm not pushing her because I feel she's fragile and my supervisor was, "You know, you got to go there. That's why she's coming in. She's probably waiting for you." I was really nervous but we did and it was ... I'm not a mom but I would say I felt such a joy working with here, seeing her really do the work and be committed. She's this 14-year old girl who has no one but her mom. (Helen D.)

Both interviewees expressed having parental feelings towards their clients but each in different ways. Mary S. demonstrates the social worker's internal struggle with these feelings and Helen D. instead uses this aspect in the clinical relationship to help aid the client's personal growth.

Also parental, Emily R. took pride in her client's ability to assert herself:

She had called me up because they were having an argument and he put his hands on her, and she was going to tell him that she's had enough, you're not allowed to do that ... and that was my shining moment, because it was the first time I had ever heard her say no to anyone; you can't hurt me anymore. She was doing it. I think that's why she called me, because she knew I would recognize that she was taking care of herself. And she did; she did a good job. She didn't allow any violence. (Emily R.)

The interviewees also talked about how the positive reactions they experienced influenced their personal life. Two reported they became better parents:

I mean, it has helped me understand my kids better. There's certain things I wish I knew. The older daughter... When she was in her mid-20s, she spent two or three years boxing. Not as her profession but as her workout... She had this big black guy who she was boxing with who apparently has been in and out of jail a few times. I was horrified but I knew instinctively. She said to me once, this is my therapy. I knew instinctively she was right. I said, "I believe it." I just instinctively knew it but now I actually understand it. It really was her therapy. I mean, she had so much rage in here and she could just punch the fuck-- shit out of him for hours and a long time. It was fine and she would scream and yell and hit him. Then she stopped. She was done with it. (Jessie C.)

I will tell you that prior to working in this environment, I think I was probably too critical of my children. But after doing this work for a while, my kids are angels compared to some of the children around here and their problematic behaviors. I've learned that life isn't a textbook and I learned that you shouldn't therapize your family. My daughters, they didn't tell me this, they told my wife this about two years ago, that "Sometimes we just want to talk to dad and we don't want, every conversation doesn't have to turn into a therapy session." It was like, "Oh! Okay. All right!" It's changed my approach at home. A softer and more gentle person. (Joe M.)

Each example highlighted ways the clinical work has influenced the social workers in their personal lives with their families. Participants described ways they have changed their personal relationships for the better as a result of their work with traumatized clients.

Another participant identified experiencing greater positive emotions and reactions in his personal life and less negative reactions as a result of his work with traumatized clients. Dave M. stated:

My fear has decreased a lot in my life. My guilt, my shame have decreased a lot. Just hearing other clients' stories, hearing the tremendous amounts of guilt that they experienced, the shame that they experienced about the things that it makes sense to me why they feel guilty. It makes sense to me why they feel shame, but it's totally not justified. (Pause.) I find that my guilt and my shame decrease in my own life along with my clients'. I'm finding that my joy which is also a justified emotion, which I actually find has increased a lot in my life as well. My justified emotions increased, my unjustified emotions decreased. My joy really is through the roof. My love is through the roof. My sadness, my anger, my love and my joy have all increased through this work. My fear and my guilt and my shame and my envy and jealousy and those kinds of emotions, I just don't have time for them anymore. (Dave M.)

Another participant said that it was unrealistic to separate one's work and personal lives and that the carry-over is beneficial:

I think they carry over greatly to my personal life. I'm not of the school of thought that you remove your head once you come to work and put on a new one and then as you walk out the door grab the old one and put it back on. In my personal life I think the one thing it has done is make me very sensitive to people harming others and making me very sensitive to not do harm to other people (Norm A.)

This highlights the positive impact on the social workers' personal lives and ways in which their work with traumatized individuals has changed their thought process or beliefs in positive ways, thus the opposite of vicarious traumatization.

One interviewee had difficulty expressing his internal experience about positive reactions in his work with traumatized clients. This therapist had a large caseload, reporting seeing over two hundred clients per month. Mike D. said about his caseload, "I mean I have a lot of clients. I see probably 200 some people a month. That doesn't mean they are different people. But I see like 50 some people a week." When asked about his experience of positive growth and/or satisfaction, he struggled to formulate this experience. It may be that it is difficult to identify particular positive experiences when seeing so many clients. He did report finding satisfaction in the intellectual aspects of his job.

Overall, participants reported immense satisfaction in their work with traumatized clients.

As Dave M. stated:

My job is to be an expert in overcoming trauma. That's my job. It's the coolest job in the world. Because I do find that translates to my everyday life, that things just really just roll with in a different way, that I'm not sure I could do if I weren't an expert in this field. I just love that. I think it's the coolest job. It's the coolest job. (Dave M.)

Participants also believed their work had great meaning and gave them great satisfaction in their lives. Furthermore, they felt honored to be trusted with such personal, emotionally charged material. As two interviewees explained:

It sounds so cheesy because people said all the time. Being a part of someone's recovery and healing I think is just incredible. There's no other word to describe it... They trust me who they don't even know, and the space to go to these ugly places. That is, "Wow! I'm part of that." It's just cool. It's the greatest job in the world. Greatest job. (Helen D.)

I think that in general, just knowing that you're doing some type of work that matters. That it just feels good over all, even though you're doing really hard stuff, somebody has to be doing it. So I feel good about what I do... (Mary S.)

Oh, it feels like an honor. It feels like a privilege. It feels inspiring. It feels awesome, really. (Pam R.)

It is noteworthy that the participants described their work with humility and pride. Each example describes the strong positive reactions social workers experience in their jobs.

Some participants talked about the financial aspect of their job. They seemed uncomfortable when discussing financial compensation, feeling this was a contradiction with their values as social workers. For the social workers who worked in private practice, earning a higher income was one of the main reasons for this career option. As they explained:

Yeah, and I think I'm at a point in my career where I used to say, "Oh, it's not about the money." I work really hard. I pay a lot of money out of pocket to be better. There's nothing wrong with saying I deserve to be compensated for the work that I do. (Pause.) I think a lot of social workers are always, "Oh, we don't do it for the money." Yeah, it's true but I'm also learning that I deserve to. (Pause.) I don't need a lavish life. I don't even need a house but I do deserve to be able to pay bills and be able to live a comfortable life especially if I'm good at what I do. That's what I deserve. (Helen D.)

I needed to support my family and it's the most lucrative. I was doing counseling anyhow so... private practice, I guess the money was good and it felt comfortable and I didn't mind it. I am comfortable in this way. My motivating factor is money. (Laughs.) Well, it's also rewarding. I mean it's also doing the same thing I was doing before (Pause.) Social workers are not supposed to think about money, right? (Mike D.)

Thus, besides being satisfied with the work itself, social workers in private practice appreciated the financial benefits.

**Negative reactions.** Even though they were not asked about their negative reactions, all the participants reported experiencing negative reactions from their work with traumatized clients. It seemed positive and negative reactions are a part of the experience. They spoke of having responses to trauma that were similar to those of their clients. As a number of participants reported, these included intrusive thoughts, nightmares, changes in core beliefs, and isolation from friends and /or family:

I think the thing that happened to me early on was I was noticing that I was having a lot of nightmares and flashbacks about just hearing stories. I think within the first month of becoming a therapist, I had a client who, serious physical and sexual abuse by the primary caregiver. I don't want to give too many details. She was describing that in such vivid details that I was having nightmares about that story. (Dave M.)

I actually had a bit of an acute response with this kid where I actually had nightmares for a day or two and had some anxiety in which case I went and had that addressed through supervision and some other things. (Norm A.)

Exhausting in an energetic sense because sometimes I would find it very difficult to sit and bear witness to people sharing their direct trauma because it can be so overwhelming. From an energetic perspective. From a psychological perspective, it sometimes gets to a point where you feel very contaminated or I do. I feel very contaminated that like, "Oh my God, there's no nice place left in the world or no nice person left in the world." (Joe M.)

Each participant gave examples of vicarious traumatization. Dave M. suggests his negative reactions were related to his experience as a new therapist working with traumatized clients.

Norm A. experienced similar negative reactions but reported dealing with his reactions in supervision. For both participants, they spoke about the negative reactions as a past experience and as experiencing some resolution. Conversely, Joe M. described the negative reactions in a present sense and appeared to still struggle with his work shifting worldview.

One social worker described a shared trauma experience when she witnessed the destruction of a city street by the city government. The destruction followed prior attempts by the police to deal with the group, MOVE, who were creating a disturbance in the neighborhood. In an attempt to cope with the trauma of witnessing the city's violent response, Jane B. resigned from her position. As she explained:

I enjoyed working on the street and enjoyed getting to meet the people and developing relationships. I really liked that, but then I was on duty the night that Mayor Goode decided to bomb Osage Avenue. We were on the front line of that. To this day, I still have a hard time talking about that. That was a horrific day, night and day because we worked all the way around the clock. I had never been a circumstance where I had seen our government basically attack our own citizens. (Pause.) We had had many dealings with the MOVE people so I knew them. They weren't strangers to us because the

neighbors were always calling us because they were always doing bizarre things and driving everybody crazy on the block, but when we were standing there with Fire and Rescue and they were screaming on the bull horns that we have to stand down, that we couldn't go in and we watched the whole block burn down, that was it for me. I was like, "I'm out of this." I think I worked another week and then I was done. (Jane B.)

This participant saw no way to work through this experience of shared trauma and betrayal trauma within her agency and therefore chose to resign in order take care of herself.

Other negative reaction the social workers described related to feelings of being scared, overwhelmed, feeling bored, exhausted, unsafe, and unsure. These reactions seemed to decrease as the social worker became more experienced and trained in trauma work. One social worker talked about how the experience for the client can be very scary and overwhelming:

It's not safe and it can be scary. There certainly were times, many times with I would say combat vets and people that were with some dissociative features that had some violent pieces to them, that can be scary or suicidal. (Pam R.)

In talking about her positive experience, this participant reported her initial response was not positive. Jessie C. described her intense emotions related to the intense work:

I stayed in at the first year because I was in training. I wanted to learn how to do the work. I wanted to help her but I would sometimes dread these sessions. (Pause.) ...She comes twice a week. (Pause.) ...Initially, it worked in her schedule to come on Fridays and I told her I couldn't see her on a Friday. It had to be a Thursday. Because I was too exhausted, I couldn't deal with it. I just could not deal with her on Friday afternoon. I never felt that way with anybody of course. It was so exhausting. The first year was not very satisfying at all. I mean it was scary. (Jessie C.)

Jessie C. was also scared for different reasons. She was worried about being responsible for the outcome for the client. This was an interviewee who was an experienced clinician but was in her first year of training in trauma work, which she sought because of the client.

Other negative reactions described by social workers related to a sense of responsibility for the client's well-being. Heather P. described the feeling:

It's definitely hard for me, yes, knowing that, in my mind, it's going to be the best for them, but you're kind of alone in that feeling, because they don't think that. You're having to deal with a lot of responsibility. You're dealing with a lot of ... Let's just say, I'm feel like I'm dealing with a lot of responsibility, a lot of personal commitment. I worry what if the outcome is negative. What if she feels worse? You worry "is it my fault?" (Heather P.)

Thus, it appears that some participants were traumatized secondarily as a consequence of working with a traumatized client or witnessing a traumatizing event. Others who had negative reactions seemed to be responding to the content of the client's talk and were concerned about their ability to be effective with the client.

**Relationship between negative and positive and their timing.** Participants talked about experiencing a positive and negative reactions in their work with traumatized clients at different times. Some participants reported experiencing positive growth and satisfaction in line with their client's growth, others experienced positive reactions before the client, and other social workers experienced negative reactions before experiencing positive ones.

One social worker reported that her reactions developed slightly after her clients, feeling once her client experiences positive growth she begins to experience it. Heather P. spoke about this process:

I think if their experiencing it, I would probably experience soon after. I think if it takes them 2 or 3 sessions to feel that I would probably mimic that...

Other social workers talked about experiencing a mixture of positive and negative reactions early in their work with the client. Charlie C. reported feeling different reactions than his client early in their work but felt their reactions aligned over time:

Early on, because early on it was different though. Early on, it wasn't sitting with someone who's sitting with all of these things that had happened because they were dissociating more, and they weren't in touch with it. (Pause.) I think it was still positive, though not as much because I didn't know where anything would go yet. (Pause.) I was feeling is an awareness of what it was like for her, so I wasn't feeling terrified because I

was here in this room. I was grounded here. It was always attenuated by that. I was never traumatized by it. I knew I was listening to it, so in that sense, I think it was very different. I think, as it went along, what I was experiencing, she was experiencing became more similar. I never thought of it this way, actually, which is interesting, but because she developed a perspective, so she could have the experience but still with the perspective of who she was now, that was more like what the experience I was having. Still, mine wasn't as powerful. As she could have the other experiences, she could be proud of herself, see herself as strong instead of whatever. That would be similar how I might be experiencing her and things like that. I think, in some ways, they became more similar. (Charlie C.)

Another social worker talked about experiencing positive growth and satisfaction when her clients are doing well but did not have negative reactions when her clients were not improving.

As Latonia L. stated, social workers should not make that assumption:

The more positive and slight improvements you see with the client, it makes you feel good that you're doing good as a therapist. I don't want therapists to think that because a client is doing bad, you're a bad therapist. You can't make that assumption. (Pause.) Don't make it personal, don't make it personal, but definitely take that win when you can get it. Pat yourself on the back when you see it happening. No one else is going to do it.

Other participants identified believing in the process or intervention as an element that gave them satisfaction even if the client was struggling. One social worker talked about this experience in her work with a traumatized client:

When you do PE (Prolonged Exposure), so you have this like you know terrible first, second session, when they leave their office like in distress because you brought it all up to the surface and then they come back in that fourth one and you can see this change and like in a moment your like, yeah, oh my gosh, look at you. And it does, it just makes me feel so good when they return back and you can see like they shifted that energy and it's different. ... So you're feeling like you're really making a difference for them. (Mary S.)

### **The Therapeutic/Clinical Relationship**

Twelve of the 15 social workers interviewed indicated that the therapeutic relationship was one of the most important component in their work with traumatized clients. These social workers gave little description of the own reactions or how they internally experienced growth in

their relationship with their clients. Interviewees offered abundant information on the client's experience and what techniques they actively used to enhance the therapeutic relationship. Some social workers commented it was difficult for them to identify their internal experience because there is not much dialogue around the ways their clinical relationship with clients enhanced their personal internal growth. Two participants offered these examples:

It's strange to talk about it because you're not used to talking about it. (Norm A.)

Probably not, although because I don't talk about this. I just gave you the longest review of what these 3 years have been like that I've had to anybody. (Jessie C.)

In these two examples, therapists stated they had little experience talking about how their work with trauma clients transformed them in positive ways. This was apparent when respondents focused on what they did to enhance the therapeutic relationship instead of their internal experience and how the relationship transformed them. Example of these identified techniques were the worker's use of self, holding space, attunement, being able to sit with the trauma, and components of the therapeutic relationship (i.e., mutuality, safety and trust, unconditional regard, and repairing the relationship). These elements are discussed after the information on the therapist's transformation from the therapeutic relationship. I chose to include the data on creating an optimal therapeutic relationship in trauma work to highlight the value of this work as identified by social workers who experience positive reactions. Social workers did talk about the effects the therapeutic relationship had on their internal transformational growth but the data was small in comparison to content on the process of creating strong therapeutic relationships in trauma work.

**Social worker's transformation.** The participants who described their transformation identified internal growth related to having a better outlook on life, ability to view trauma work more positively, and experiencing peace and calmness.

Participants described experiencing transformation in the way they viewed their personal struggles and influencing their perspective on their lives. Charlie C. reported feeling a greater appreciation for his life:

I think it probably helps me keep a little bit broader perspective on my own difficulties that come up in my life. I'd say that's one, not like, "Why whine about this? Think about what happened to that person," but just, "Is this really so scary, so horrible?" I'd say that's probably a main thing at any rate.

Other interviewees described feeling transformed by the positive experience with their client and credited this experience in influencing their ability to see more positive elements in their work with other traumatized clients. Mary S. spoke of this experience:

...but there was a positive experience, but I think in general with this type of work, I think I'm more likely now to have a positive experience or that I can see a more positive experience. I think for so long I could have gotten stuck and so it's been really helpful for me to found that positives out of that for me.

Social workers identified feeling calm, tranquil, peaceful, and having internal stillness when their client made connections and had personal growth in treatment. Heather P. described her internal process when her client has growth:

I would describe it almost like a calmness in me, like a calmness that kind of comes over there. I should start with there is always a little bit of anxiety, there's always fear, nervousness that comes from doing work... there are not very concrete things so a lot of it is questioning yourself a lot in the beginning. I started to feel a little bit of calmness with her when she was able to make connections. I think a lot of my serenity comes from hearing from her and hearing from other clients that there has been a connection for them. And whether that connection is okay ...and whatever the connection, is I think is super important and when that occurs I tend to feel a little bit lighter...I think that's when I feel that relief that okay there's a start, there's movement for them. ...I feel at that point I tend to feel a little more confident that the work we are doing, the direction we are going is helping her, regardless if her symptoms flairs up.

For Heather P. when her client made a connection in their treatment, she experienced an internal shift, feeling calmer and lighter. This internal shift also helped her feel more confident.

**The social worker's use of self.** Participants identified use of self as mutual connections with clients through showing human elements in sessions and using countertransference to deepen the understanding of the client's experience. The social workers described many examples of "use of self" in therapeutic relationship with traumatized clients. Social workers engaged in "use of self" is through reflection on their own experiences and making plans to use these experiences to benefit clients. Dave M. offered this example:

The more that I have for them, the more I try with myself, the more I try with me, the more I have to offer them. I noticed that the stuff that I'm trying with me is also working with them. Not always, but it's just really helpful. It's also helpful to realize and not be ... I'm not angry at my clients because then I find things that work and I still don't do them. (Pause.) I don't get frustrated or angry with my clients. I do think a lot of it starts with me doing stuff with me. (Dave M.)

In this example, Dave M. spoke of the importance of practicing the therapeutic coping skills in his personal life as a way to be more effective with his clients. This social worker understood the challenges in consistently practicing interventions by using the skills personally and felt this helped him be more understanding with his clients.

Another interviewee gave a specific example of using breathing as a coping method and how he modeled this in session with a client:

I just, "Just give me a minute" and I held my chest, took a deep breath. They were like, "That's what you tell us to do all the time." I said, "See how it works?" I said, "I don't tell you guys to do anything that I wouldn't do." (Latonia L.)

Other social workers talked about using their countertransference as a way to understand their client's experience and help guide their work together. Pam R. spoke of the need to have access to one's inner self in order to work with traumatized clients.

Again, you have to open parts of yourself when you're working with that level of trauma to be available. Maybe what Harry Aponte would call the use of the self of the therapist, but you have to have that. You don't use it in order to feel better. You don't take advantage of the client, but you have to open that part of yourself. There's not a lot written about that, because it's hard to talk about and you can sound really wifty. If I'm working with somebody with trauma and we get down to a really deep level, I can have feelings and hunches and senses of what's happening that I can test out in a respectful way, but I have to have access to that. You don't find that in lectures. (Pam R.)

On the other hand, Helen D. commented on how a supervisor helped her gain awareness of countertransference reactions, which, unmonitored, could interfere with the relationship:

Again, with really good clinical supervision myself that I had. I was aware that there was definitely some transference and for sure countertransference going on. Being aware of that was really helpful. I did really genuinely care for her. My supervisor challenged me to not allow that to hinder the treatment. It really didn't. I'm not saying that because, "Hey, I did a great job." Because I think I did okay. I say that it was just ... I don't even know how to describe it, but the relationship was she trusted me and I knew that. (Helen D.)

Social workers identified their use of self as a critical element in the therapeutic relationship, believing it helps to forge trust between the client and the therapist and inform treatment. They also consider that the therapist holds the main responsibility in ensuring that the use of self is appropriate and safe used with the client's well-being in mind.

**Holding space.** The majority of the social workers interviewed talked about the importance of creating a safe environment for clients to work on their trauma exposure. Generally, participants identified holding space as listening and believing the client's trauma story in a way that models safety and emotional regulation. Other forms of holding space for the client were related to the social worker being able to "hold" or witness the client's trauma. Participants talked about their ability to listen, bear witness, and experience the client's trauma story in an authentic and humanistic manner. Interviewee Charlie C. described his ability to experience the client's trauma story and not become paralyzed by the content:

...the most important thing I could bring to the room with someone else is not something really clever for me to say but a way of being with them, not that what you choose to say and don't say isn't important, but that the most important thing is the essence of the acceptance, ability to sit with and see it all. I think, generally speaking, I'm able to sit with people who experienced this and not become hopeless or paralyzed or overwhelmed, but to truly believe that there's phenomenal growth that can take place and happiness that's possible. (Charlie C.)

In this example, the social worker was able to sit with the client in silence, if needed, while the client disclosed their trauma without becoming overwhelmed. This allowed the client to focus solely on his or her own experience. Sitting with the client and his or her trauma can be difficult for the social worker but Pam R. talked about why this is so important:

There were parts of it that were really hard, because you're hearing and witnessing really horrific stuff that you want to shut your eyes and you really can't. In some ways, you have to stretch yourself in order for you to be able to hold what you're hearing and witnessing and experiencing with them.

In addition to witnessing the client's trauma in sessions, another social worker spoke of the importance of allowing the client the opportunity to tell and re-tell his or her story in the therapist's presence. Sandy T. reflected on the importance of listening and believing a client story:

I feel like a lot of the people that I've worked with, the just need someone to listen to them, to believe them. A lot of people dealing with sexual trauma it seems like, the ones that I've been exposed to, they weren't believed. That has a lot of how they deal with the trauma moving forward. The fact that just building a relationship with them in general is letting them know, being really sincere in the fact that you're believing what they are saying to you and you're there to listen to them and acknowledge this shouldn't have happened. I think the fact that I was able to give those people that, I was able to ... just that in itself for me was the positive reaction that I didn't have before. (Sandy T.)

Again, this social worker highlighted the importance of the ability to create a healthy relationship that consists of listening to the trauma and believing the client. In this example, the intervention was the interpersonal interaction between client and social worker. Both examples speak to the

importance of the social worker listening to the client, using all senses and demonstrating to the client that they were “heard” and believed by another human being.

Other examples of holding space related to the mutual connection or attachment created between the client and the social worker. Heather P. spoke about the strong attachment and connection she felt when working with trauma survivors, feeling that she quickly feels a connection for them and from them. She stated that in her role as the therapist, she is able to provide healthy attachment between herself and her clients:

I do feel like with clients with trauma, that tends to be a deeper emotion that I can feel from them, and feel for them. I think that because they're so raw, you can see that, or sense that pretty quickly. I feel there's a great sense of wanting to help them feel safe, almost make that relationship that they didn't have, or that they're searching for, and then to have a healthy end, or a healthy relationship, that's something that not a lot of people can do for other people, and that's what makes me feel good about what I do. (Heather P.)

Heather P. gave an example of the emotional holding space that happens between client and social worker. This emotional space consisted of safety and healthy relational boundaries.

Each social worker demonstrated the importance of connection and attachment in their clinical work with traumatized clients. Heather P. highlighted the strong emotional bond between therapist and the traumatized client. Jessie C. highlighted the importance of safe physical connection in clinical work.

**Attunement.** Adjusting to the client’s needs, or attunement, in trauma work was a skill that many social workers talked about in their work with clients. Two social workers described the mutual ebb and flow between the client and the therapist:

Again, there’s that delicate dance, but yet you have to be real clear where you have to join with somebody in that and not be overpowered by that or frightened by that. (Pam R.)

That’s an interesting question because I’m never really sure where the boundaries, where they shift whether it’s more towards the client, more towards me. I think going back to

that concept of partnership that we both agree that we're going to walk into this room together. I think as a therapist I try to be really attuned to my clients so that is big. Being attuned to my client is not the work. That's just simply me making sure that I'm going where they need to go and allowing them the same spaces and the same methods of going where they need to go so that's the client's piece. It's like two people holding on to each other on a very rocky cliff and they're both trying not to fall off. (Norm A.)

Another social worker used the metaphor of swimming to describe attunement and related it to guiding principles in clinical EMDR treatment of individuals with traumatic memories. She stated:

...I'm used to being in the deep end and in the shallow end; you're kind of swimming back and forth. It's the joy mixed with the ugliness as well. You're kind of have to keep them in close proximity of each other, to help yourself balance. This is actually another one of those guiding principles in trauma treatment; that you have to toggle.... This is something I learned from being an EMDR practitioner, because with EMDR you're always making the brain go back and forth. You're reprocessing information. When you toggle, you're touching the bad and coming back to the good. You're touching the unsafe, and coming back to the safe. Back and forth, back and forth. (Emily R.)

Here the social worker described the delicate balance in trauma work between overwhelming the client and challenging them, all within the context of a safe and healthy therapeutic relationship.

Jessie C. described the attunement process in sessions as playing attention to the client's whole experience; the emotional and physical reactions:

I'm not just listening to hear the narrative and connecting the narrative with the emotions. I'm also paying attention to the whole somatic experience that she's having. I'm inviting her to be more aware of it and bring some mindfulness into what's going on. Also, this stuff is working with her dysregulation and trying to keep her and that get her in and out of that window of tolerance and for her it is about connection. (Jessie C.)

This sense of being tuned into another person can also feel spiritual and have a meditative component to it. Charlie C. described this process:

A sense of feeling grounded where you're really tuned into your client. When you think about mindfulness kinds of things, it's really a very meditative practice to listen to other people and then to respond empathetically. That in and of itself, being able to respond empathetically and move anything that may be a part of my stuff out of the way to open those channels up for a client, that experience in and of itself is where I was talking about that spiritual connection. (Charlie C.)

Each participant highlighted the importance of the social worker's awareness of the emotional climate in the therapeutic relationship and spoke of responding accordingly to the client's emotional needs.

**Components of the therapeutic relationship.** Fourteen of the social workers interviewed described the importance of the therapeutic relationship in trauma work. Participants identified sharing the responsibility of therapy, safety and trust, unconditional regard, and repairing the relationship as critical components to having a solid therapeutic relationship in with traumatized clients in therapy.

Many participants spoke of a mutual or shared responsibility in the therapeutic relationship. One participant spoke of the equality between the client and therapist in the therapeutic work; both client and therapist do the work:

He said, "At any point, I would have bolted, but I kept trusting, and so I kept doing the work." That is a big responsibility, I think, on the therapist's part. At the same time, you can't see it as power because you don't have power over them. You're connecting on a very equal level. That's different than being the kind of therapist that is, "I'm one up from you. I have all the education and all the experience." I'm saying, "I have all the education, the experience and the skill. I'm going to roll up my sleeves and get in there and do the dirty work with you." (Pam R.)

LaTonia L. emphasized the non-hierarchical nature of the relationship, even with parents and children:

I know that there are some frameworks out there that want you to be like, "I'm the professional. I know everything. You came to me." That doesn't really work with my population. I do understand that kids need structure, they need guidance. I'm assuming that parents, they want advice. If they have a problem, they want you to help them solve it. I get that, but don't be the person where you're the high and mighty. You're up there above everyone and you're telling them what to do because then the dynamics of the relationship won't work. (Pause.) I really think that's what (is) the most important. Once you built on that relationship, you get that positive relationship where it can be really fluid with everyone, then you have better results.

This was an example of mutual work between the social worker and client, each in the “trenches” together.

Another participant also saw the relationship as mutual but thought that the therapist had more responsibility in the therapeutic relationship:

It’s like two people holding on to each other on a very rocky cliff and they’re both trying not to fall off. (Pause.) And we have to get to the other side or our goal is to get to the other side. We must hold onto each other and figure that out. One may have more responsibility than the other like tandem when you jump out of the airplane, that tandem parachuting, the person who is the trainer, they have the higher level of responsibility but the goal of both of us is to land safely on the ground. We’re both in this precarious situation of falling out of the sky. I think in that way that that partnership really speaks to that. There’s a give and take in that. (Norm A.)

Most of the participants spoke about safety as an aspect of the therapeutic relationship.

They regarded safety as emotional (in the therapeutic connection), as well as physical. Mike D. spoke about the emotional safety in sessions:

Well the first step is I have to get the person to feel safe and comfortable and to get them to know that I am not here to judge them or lecture them. And if I can get them to open up with what is going on, then later I can help them maybe re-look at what they are doing or thinking. But I can't do that in the beginning.

Mike D. highlighted the importance of safety in the process of engaging with the client, especially in the beginning of treatment.

Heather P. asserted that besides safety, building trust with a traumatized client was critical in the treatment process:

And I think individually with the specific client I was referring about that’s a lot of work that I do with her is kind of talk about what these emotions are and how you’ve been affected, and let me hold it for a little bit whether I reflect or validate you and that’s kind of sometimes what the work is for them to be safe with you, um I think as far as with specific client it took a long time for her to trust and when I build that trust with somebody I feel like there has been a breakthrough and so trust is something typically hard to earn with certain patients and once it’s earned I very much value that and use that to their advantage and my advantage as well like how we can kind of work together with that trust factor.

In this example, Heather P. saw the trust gained with her client as a significant step towards change and growth in the client. This trust can be used to facilitate future growth in the therapeutic treatment.

Another element of the therapeutic relationship identified by the participants was unconditional regard. In this component, participants spoke about protection, parental feelings towards the clients, and feeling proud of their client's growth.

I really said to myself after doing clinical supervision. I realized I'm not pushing her because I feel she's fragile and my supervisor was, "You know, you got to go there. That's why she's coming in. She's probably waiting for you." (Pause.) I was really nervous but we did and it was ... I'm not a mom but I would say I felt such a joy working with here, seeing her really do the work and be committed. (Helen D.)

You want them to see it, but you also have to let them know what you see because sometimes they won't see it. Sometimes they'll be stuck, they're downers, they're hopelessness so they can't see any positives. You have to shed that light to them. You have to be that light. (LaTonia L.)

Here we have two examples of unconditional regard. Helen D. demonstrated the healing ability of this when working with traumatized clients, using her strong emotion, with help of her supervisor, towards the client to help the process. LaTonia L. asserted the importance of being a mirror to clients that are unable to see their personal growth. Each is an example of the therapist's genuine feelings towards the client.

Participants also identified repairing of the therapeutic relationship as another critical element when working with traumatized individuals. Sandy T. stated:

Eventually, I learned that she was also sexually abused by her sister's boyfriend who was a live-in boyfriend. It was tough because it was never reported, so it was something I had to report. There was a little bit of relapse in our therapeutic growth because I had to report that. (Pause.) I could tell it was like after we got through that ... it took a couple of weeks to get through that phase of it ... it was like tons of weight just lifted off her shoulders. She felt like she can say whatever she needed to say. (Sandy T.)

In this example, we are able to see the growth in the therapeutic relationship between client and social worker when they are able to repair a rupture in their therapeutic relationship.

Out of the 15 participants interviewed, only one reported the therapeutic relationship was not an important factor in his work with traumatized clients. He asserted the model he used was the most important element in the therapeutic work, further stating the treatment would be effective with or without the therapeutic relationship:

You're asking a lot of questions about the relationship. I'm convinced that you could probably do this treatment online and not even have the relationship. I think it'd be just as effective. I don't even think you need that. I think the only thing that the relationship does is help increase motivation and decrease drop-out. Sorry if that's not what you wanted. I'm not sure that the relationship is what's getting, is the ingredient. I think the relationship is the sugar, not the medicine. I think more and more really is the skills. It's helping, I think. ...I think sometimes we teach a lot these things that are Disney-worldish, that sound really great. Like relationships are fabulous and they will cure everything. I think that's really appealing to social workers. It's just not helpful for clients. It winds up smacking people in the face because then they realize that they're not effective and then you have to really wrestle, what kind of a relationship do I really have? If I'm not actually helping this person, that sucks. (Dave M.)

Even in his quote discounting the importance of relationships, Dave M. credited the relationship for increasing motivation and reducing attrition. Despite this statement, this social worker did talk about his affection towards his clients and gave numerous examples of how the relationships with his clients positively impacted him: In this example, Dave M. talked about his admiration of his client:

She's also just so genuine. She works so hard. I could tell you so many stories of things that she does that are just ... She goes all in. She goes all in and works so hard. She goes all in while also having experienced a lot. She's been through a lot. I admire that about her, how much she does not give up, just keeps going no matter what.

## Organizational Context

The organizational context had great influence over the social workers' feelings of satisfaction with their clients and their work. Participants talked about positive factors, such as supervision and training, a shared mission with the organization, job flexibility, peer support and strong staff morale. Negative factors in the organizational context that adversely influenced social workers' feelings of satisfaction were: lack of supervision and trainings, different agenda or goals between social workers and the organization, high productivity expectations and significant paperwork requirements.

**Positive factors.** Participants reported that certain characteristics of the organizational environment greatly contributed to their sense of satisfaction with their work with traumatized clients. Among these characteristics were supervision and trainings, a shared mission, job flexibility, connection to co-workers and workplace. Helen D. talked about the importance of supervision in fostering her professional growth:

I have a clinical supervisor who, to me, she's brilliant. Not just brilliant, she is really encouraging of me and my skills even when I don't know what I'm doing. ...Being with her and really challenging myself rather than- ... She not only is helping me with clients but she is helping and she says, "We're going to walk through what kind of therapist you are. What are the different modalities? What kind of do you do with the core of who you are and how is that woven into what you do as a clinician?" It sounds so corny and nerdy but she inspires me to know more and do better. I'm pretty good at being compassionate and kind and I can talk to anyone, but you need someone to really encourage you to continue education when school is done. If I want to be a great clinician I better know what the terms are, what the theories are and continue that. She really makes me excited to do that.

In this example, supervision provided the social worker a safe space to grow professionally and gave her inspiration. This social worker had to seek private supervision because it was not offered at her agency. Supervision helped the social worker experience positive growth but she was financially responsible for this service. Hence, this can also be seen as a negative.

Mary S. described how processing her work with supervisors and co-workers helped her grow as a therapist:

Yeah, I've really been very lucky in that...I've got in with a good supervisor or good co-workers and always having that part to be able to process so that's what I'd would encourage somebody coming in, have a group to talk with, process that stuff out, get really get in and think about what you're doing in terms of your practice like does it have a, do you have a plan in mind, what are you going to do, how are you going to help this person, think about it.

Mary S. believed in the importance of good supervision and peer support, offering this as a critical component to doing trauma work.

Other social workers identified trainings as an important element to their satisfaction with their work. Charlie C. stated:

There's a lot of training. For attachment work, we brought Dan Hughes in, not only for a two-day workshop, but he met with staff, I think was it once a week or once every other week for months and months. We brought Cheryl Langtree in to do a two-day training. We bring a lot of people in, and the other thing is that we all get supervision.

Here Charlie C. indicated that the trainings provided by his agency contributed to his experience of positive reactions in his work at his agency.

Many participants identified having a shared mission or being on a collective team as indicators of experiencing positive reactions or satisfaction in their work. Norm A. explained:

I think probably the most important piece and reason I had a lot of great experiences as a trauma therapist is just the construction of the CD-CP (Child Development-Community Policing) model is that for example on a weekly basis we have an hour and a half meeting that brings together family services, child mental health, the police department, alert community leadership and we literally are able to talk about the cases and talk about the variety of services and resources that are out there. Having a really big support network, and not only a big support network but an effective support network, lends itself to having that positive response. I think as part of that positive response that I'm not afraid to actually talk about my experience as a therapist with others that are not necessarily therapists. (Norm A.)

This social worker identified how having a multidisciplinary team meetings helped create a supportive community network for clients and therapists. He valued the opportunity to process his reactions with clinical and non-clinical professionals.

Some participants associated job flexibility with experiencing greater satisfaction in their work. For some social workers this was the ability to hold roles other than that of clinician. For Heather P., this flexibility and sense of ownership helped her feel greater satisfaction in her work:

I think that's a big part of it I think here we're very lucky that we're given a lot of flexibility and a lot of leadership throughout our groups; no one is saying what are you doing for this group and how's it going it kind of happens and then you process it so there's the ability to kind of do our own thing so that's been helpful. You know I get weekly supervision from my supervisor and I'm filling her in on how things are going, so definitely feels like I have ownership and leadership over that type of work.

Participants described their connection in the work place as another important element when talking about experiencing satisfaction in the work place.

Feeling connected to other people I work with, so not feeling too isolated. One of the difficulties, the work as a full-time clinician is really overwhelming. You have to schedule so many appointments, and there's so much paperwork and everything else. Any of the things in which other people I'm with share sort of a mission or commitment to something, and I can go to them and ask a question or vent or whatever. They'll do the same thing with me, and I think those are the most important things. Training and other things also, but I think it's more the ability to become reenergized over and over again during the course of a day because a lot gets drained. (Charlie C.)

Another interviewee described the connectedness with co-workers as feeling like a family:

Yes, it's definitely a family. We got everyone to see us as a family. We support each other through the good times and the bad times. There's a moment where someone's talking about something else going on and they break out and cry. We'll pass them a tissue and give them a hug, make sure they're okay. (LaTonia L.)

In each example, we are shown the importance of co-worker connection in the work place.

Charlie C. feels his co-workers reenergize him and understand the demands of the work, and this

decreases his feelings of isolation in his job. LaTonia L. described her co-workers as a family unit, supporting each other through good and bad times.

**Negative factors.** Participants identified many ways they were negatively impacted by their organization and how this adversely affected their feelings of satisfaction and growth in their work with traumatized clients. Some social workers identified the lack of clinical supervision as a major barrier to feeling satisfied in their work. Many reported paying out of pocket for supervision. One participant spoke about this experience:

The only thing that stinks is that because of funding cuts they no longer pay for my clinical supervision, so I pay for mine and I get it. (Pause.) I don't know necessarily if they see, when I say they I mean my executive director. If she sees the necessary need for it, she's not in the field, she hasn't been in the field for 25 years ...but this is important and I need this in order to provide support to all of the staff as well as my clients. There's some frustration there, and I pay for it and I get great supervision. (Pause.) There are resources but if I didn't pay for it I wouldn't get. (Helen D.)

Here the social worker had to seek supervision outside her agency and was financially responsible. The social worker felt ethically responsible to get supervision for herself in order to provide solid clinical work to her trauma clients and to provide appropriate supervision to her staff. She understood the importance of supervision as a clinician but also as a supervisor.

Participants also reported that organizations had different motivations in regard to the work with clients. Specifically, they identified productivity and paperwork expectations as barriers to therapist satisfaction in their work and in their organization. One participant talked about the different roles between therapists providing direct care and the agency:

Let me say that we are going through a lot of change here and we've been through a lot of change. I've been here for... it will be five years in July. There have been a number of directors, a number of supervisors. I don't know if I told you this, but we're a for-profit company. You have the business owner who's looking at it strictly from the business model. Profit, profit, profit. Then you have your clinical side. (Joe M.)

Another participant discussed the productivity expectations for therapists by the agency:

Productivity is a four-letter word to a therapist because our role is not about quantity, it's about quality. ... That has a big impact on the other side because that means if there's a 30 percent no-show rate, I have to schedule basically every hour to hit that. It makes each case harder, and it makes the shape of the professional life harder. You have to schedule so many appointments, and there's so much paperwork and everything else. (Sean Q.)

Each example demonstrated how the organization contributed to the social worker experience of negative reactions in their work with traumatized clients by having an unrealistic business model for this relational work.

Interviewees reported that productivity and billable hours had a greater value to agencies than the workers' satisfaction or health:

I remember having a conversation once with the director who was making everybody dictate in detail every minute of their day. You had to be doing 65% face to face administrative. He would, "You're doing great. You have 85% direct face to face," because they were giving me everybody. I said, "That's not great. You should be really worried about me." He was like, "What are you talking about?" That kind of thing. "I'm burning out. You're dumping all of the hard cases on to me and I have 85%. That's not good just because somebody down the hallway who doesn't know what they're doing has 20% face to face. That's what you need to be paying attention to and you need to be bringing me down or you're going to lose me." Organizations don't often get that. I mean, they're looking at numbers and bottom line and stuff like that. (Pam R.)

These examples show the conflict that can arise between therapists' values and their agency's motivation (or mission), quality of care, and financial returns. For many social workers in agency positions, these are some of their reasons for wanting to leave and enter private practice.

Participants strongly cited the influence organizations can have on their personal growth with job satisfaction, which in turn impacts client care.

### **What Contributes to Positive Growth**

All of the participants described strategies they employed to help them cope with their work with traumatized clients. Categories identified were the social worker's experience and his and her coping strategies.

**Experience.** Participants identified experience as contributing to their feelings of satisfaction and personal growth. Experience helped therapists feel confident in the trauma work and trust the “process,” even when the work was difficult for the client. Experience also helped therapists know what to look for and how to proceed in the trauma treatment. One participant reported that his experience in trauma work gave him confidence, especially with his timing and ability to follow the client’s cues:

I think the more I've learned, the more it's influenced me in a couple ways. One is I think, as I understand the physiological components, it gives me more confidence in my ability to understand what's going on with them. It's helped me move more quickly and more confidently, still not trying to rush it, but to be less cautious about moving towards accessing the experiences, the traumatic experiences, still planning for it and all the rest. I think I held off in the past longer than was necessary because my own anxieties about “Is this right, is it wrong, what will this do?” I think it's really helped focus my work tremendously. .... I think I can follow the cues much better. I think I used to, every time I would be dealing with it, I'd be asking somebody, "Do you think this is too early? Is this too late?" I think I wouldn't really have a sense of what would make it too early or what would be too late. It was more like it was a magical thing. I think it's helped me really enormously in that area. (Charlie C.)

This example demonstrates the importance of experience and how it helped the therapist with his flow, learning to move the therapeutic work at an appropriate pace.

One social worker reported her experience has given her faith in the process of the trauma work. She has the understanding of what needs to happen in the trauma work and through her experience with past clients, believes that her clients can improve. This participant stated:

And I guess in doing this kind of work, you have to have faith or belief that this thing can happen you know? When you stop, when you lose your edge like that at times, you are like, you feel like you are not on top of it today but you got to, you got to believe that this can happen. You got to believe in the process. ...And it's faith... It's good to see the big picture. To see the overall picture because if you see one person go through something you get more confidence or faith that somebody else can go through something or that you know you can go through something. So the more you do it you might see more of the bigger picture. (Helen D.)

Participants also asserted that they learned from their experience to have more realistic goals for the client and herself.

It's what I learned on my own as far as taking a step back with myself. Well, I also learned it through their experience plus hard work you spent. Coming out into the field, I wanted so much, I wanted 100%, I wanted perfection. Then learning that not getting a 100% doesn't mean you failed. That's really key in everything; you can't think less of yourself if you're not successful with everything. You can't go out there with the goal thinking you're going to get a 100% success with people. That's not likely to happen with this population. (LaTonia L.)

Similarly, another participant reported more experience helped her have realistic expectations for influence on the client's treatment success and outcomes. As Heather P. said:

... the stuff they have been through is intense and my hope is that if I can give them a little bit of hope and help them work through a piece of this than I've done my job and I've accomplished that. It's unrealistic to think you can fix, change, help anyone 100% in a short period of time. Um I think early on I was naive in wanting to save everybody and take their trauma from them but being here for um just about four years, next week actually will be four years, I've learned that is not my job that is not my duty I cannot take it all and so I've been trying to honor the work that I've done with specific clients and focus on that piece because you can get sucked in into the negatives really quickly....

These interviewees not only attributed her experience to having more realistic goals for their clients but also for themselves. This not only influenced their feelings of satisfaction but those of the client.

**Coping strategies.** Participants universally expressed the importance of coping strategies in their feelings of satisfaction and positive growth. This section in the interview produced the most of data in this study. Areas identified in coping strategies were: self-care, therapists "practicing what they preached," having hobbies, religion and spirituality, having a mindfulness practice, career diversification, peer connections/support, physical exercise, and having clear boundaries between professional and personal life. One participant talked about the overall importance of self-care as a therapist:

Yeah, we tell clients all the time, you can't take care of someone else if you can't take care of yourself first. So whether you have an eating disorder, substance abuse, mental health, if you don't take care of yourself you can't go out and be a helper for anybody else, it's the same for me and any other clinician. So I think that's a very important thing over the years, I can't help them if I'm not taking care of myself first. And that's difficult to start to do, but that's like a piece of that kind of positive experience, that when I can kind of be able to do something positive for myself, that I either share it or I feel confident and better about sharing and helping others. (Heather P.)

This statement demonstrated the challenge many social workers experience when in the helping role and working with a demanding population. In order to combat the negative reactions, social workers understand the importance of self-care in their overall therapeutic experience for both client and social worker.

Many participants reported using clinical interventions on themselves for personal growth and coping. One participant explained this process:

I think as I became more skilled, I was my own laboratory in some ways. It's so bad that I broke my toes and my first thought was, "Oh cool, what skills can I practice now because I now have a great story to help my clients." I've gotten into that point in my life where anytime I have an adversity, I am sad and frustrated and kind of excited in a weird way.... The more that I have for them, the more I try with myself, the more I try with me, the more shows I have to offer them. I noticed that the stuff that I'm trying with me is also working with them. (Dave M.)

Another participant talked about this importance of trying the interventions out personally to have an understanding of how difficult the work can be for clients:

Right and truthfully the way you apply it for yourself (pause) is it's easier to tell somebody else what to do (pause) but doing it for yourself you got to do it the hard way, the same as they do. So you know how it's hard and then when there is a personal breakthrough it's motivating. The whole thing is motivating. (Mike D.)

Both examples demonstrated the strength in having experience with the coping strategies used in trauma work. Not only did Dave M. use the therapeutic coping skills with his traumatized clients but also with himself. By doing this, he is able to experience the intervention personally and in turn use this awareness to help his clients when using the same therapeutic coping strategies.

Participants identified having hobbies as an important part of their strategy to handle the difficult nature of trauma work. Examples of hobbies they mentioned are engaging in non-clinical activities such as playing music and creating art. Two participants reported playing in bands in their personal time and this helped them disengage from the stress from their clinical practice. An example of this strategy was explained by Norm A.:

I have two careers literally. I have one career that I'm a social worker. My other career is that I'm a professional musician. Those two go hand in hand for me that I have a place where I actually as a professional musician most of when I'm playing, I'm not thinking about anything I'm doing. I'm listening to what I'm creating or sounds I'm creating. How that other role as a trauma therapist plays into that and those positive reactions is that what I found is that in either writing or performing that there's this same concept of I'm sharing something with someone that hopefully is healing, which gives me a different motivation as I'm performing.

One social worker spoke about the importance of her art and ways it has influenced her clinical work:

I think my art helps a lot. I notice that if I don't paint regularly, my clinical work suffers. It doesn't seem to work the other way, meaning if I'm not doing clinical work, my painting suffers. I'm not sure why that happens, but I definitely have noticed that. I think my creative life is very important to informing and reinforcing my professional life. (Jane B.)

Even though this interviewee's art and Norm A.'s music were not related to their clinical work, they found these hobbies helpful means of coping. Other participants reported needing to engage in activities that had nothing to do with their clinical work with traumatized clients. One social worker stated:

I do a lot of just reading on my own, nothing to do with theory practice work. That's something big that I do. I watch trashy reality TV show, that's what I do. If I'm totally honest and not embarrassed, I do that. Those are probably two that I do the most. (Helen D.)

Another social worker spoke about the importance of having down time to recover from the intensity of work:

I love my weekends because that's just time for me to be me. Sometimes, being me is doing nothing. Doing nothing is doing something to me sometimes because the work is just so intense and it's so up and down especially I'm on call for crisis so I'd never know when something's going to come up. That keeps you on edge, but then having that break, just being low, be mellow and relax, that's what I'm doing. (LaTonia L.)

Here we have two examples of the social workers re-energizing in their down time as a way of coping with the intense nature of trauma work. Helen D. engaged in reading and television programs that were not related to trauma work and LaTonia L. described the importance of having down time to relax.

Religion and spirituality were other areas participants identified as important in their coping repertoire. As described by Mike D.:

And so that is really important to me. Like I said I used to be in Christian ministry so in Christian ministry you are helping people but your medium is more your faith and that. So although I don't do that now, I still have that kind of foundation. ....Your faith gives you direction, gives you, yeah insight. Bigger picture of what you are doing, why you are doing it. So that's important thing to me. (Mike D.)

Helen D. felt a connection between her spirituality and her work with traumatized clients, believing that she was meant to do this work. She stated:

I think my own spirituality, I identify as a Christian and there's this like, I know, innate purpose that I have to help people who've suffered from trauma. I just know. There's too many things that have fallen in line that I know it and I feel it. (Helen D.)

Each example emphasized the connection the participants made between their spirituality and their work with trauma populations. This was not only form of coping used by the participants but a guiding force and reason for their work.

Other social workers identified practicing mindfulness as a coping mechanism that helps them cope with the difficult nature of trauma work. Participants identified meditation, yoga, and

“being present” as some of these mindful coping strategies. One social worker spoke in this way about his meditation practice:

I think the biggest thing, actually, is my meditation. I think that's totally crucial. I think both because through Buddhist approaches and meditation, I think that's one of the reasons that I really believe in change. I think I believe in it more because of that than because of the research on the brain or anything else, and because I've experienced enough for myself that I understand it. It's possible. I think that's completely crucial. That's, I think, the reason I can have a perspective when I'm listening to these stories. (Charlie C.)

Another social worker described how his practice of mindfulness helps him in his work:

I started paying attention and being a lot more mindful with that. I started noticing as I'm walking down the hall, I'm not actually walking down the hall thinking about all of these things that I needed to do. There's nothing I could do about that. It's really important to practice my mindfulness skills, to when I'm walking down the hall just walk down the hall. ....I just noticed this. I noticed my life get better when I notice it trying to bring it back. To just walking down the hall and not ruminating about all of those things. ... When you start paying attention, you realize most of my life is not traumatic. Those traumas wind up infiltrating, for us and our clients. (Dave M.)

One social worker talked about her yoga practice:

Well, I have a regular yoga practice which has been an enormous ... I dabbled in yoga since my 30s but I've been in a more serious yoga practice about 8 years. The difference in my own body relationship is profound. ... That's really important self-care. (Jessie C.)

Here participants' examples on mindfulness were related its use as a coping strategy but also as a tool when working with traumatized clients.

Participants identified job diversification as another component that influenced their satisfaction with their work with traumatized clients. Examples of diversification that they gave were with roles within their agency, jobs that were not clinical (i.e., teaching), and having more than one job at a time. One social worker attributed her diversification to her being able to continue her work with traumatized clients and not experience debilitating negative reactions. She stated:

A good diversification for me, or a good strategy for me has always been to diversify what I do, so I can't let myself do too much work, because I've learned that lesson, I told you, a couple times before, and it's not pretty. I get seriously depressed, it's really hard to do anything, you certainly can't do psychotherapy. I always diversified what I did....(Emily R.)

Approximately half of the participants taught in universities or developed trainings for clinicians. Jane B. reported that her teaching helped her understand her own clinical work more precisely. Jane B. stated:

I think I do a fair amount of teaching, and I think that has a big influence on my professional life because I think when you have to teach something, it forces you to articulate your process to others so vicariously, you really get very clear about what you're doing. I always see that when I teach a subject that I know intimately and the audience gets it, I come away with deeper ideas or understandings or views on the subject, which I then apply in my work and vice versa. (Jane B.)

Another participant spoke about how his teaching enabled him to see fewer clients and how that helped him stay effective with traumatized clients.

I see myself continuing to do this work, continuing to teach. I think teaching is a big part of this for me, too. I don't know that I've really spent enough time on this. I think that teaching helps keep me sharp. ...It's fabulous. It's so fabulous. I want to keep doing that because I find that's a really useful way for me to stay current, to get ideas. I want to keep teaching. I think it also truthfully it limits how many people I need to see. That's a big part of this. I might be more effective because I only have 12 clients. (Dave M.)

Another means of coping identified by participants as a component of their positive feelings towards their work was their connections with their peers or supervisors. Many social workers reported experiencing positive feelings because of the shared experience of working with traumatized clients, coping with job stressors, the ability to celebrate client successes with their co-workers, and sharing coping strategies. One participant spoke about her peers:

Sometimes, we just vent to each other. It could be in the moment where you go to a house, you schedule the appointment and then the family's not there. You're just like, "I just talked to these people, why they are not here? Let me call interviewee and see what's going on. Let me call (supervisor) and tell her this is happening." Just that moment of relief. I think we give that to each other a lot. Sometimes, that's all we really need is someone to listen because we're listening to people all the time. "Someone to listen to me

first, I want something to say.” Little things like that or we’ll even just crack jokes on each other, like, “Yeah, you really lost it back there.” (LaTonia L.)

Jessie C. talked about the importance of sharing positive moments with traumatized clients with other therapists. She stated sharing an important client moment with another therapist:

Recounting that moment when we laughed together (therapist & client) which is the thing that you have to be a therapist to appreciate that. (Pause.) A big deal is that you had a laugh with your client. I mean, really it was a miracle. I mean I appreciate this opportunity a lot because I mean, ... We do this work in a lot of isolation and these triumphant, tiny moments of healing happening is huge. (Jessie C.)

Participants also identified peer support and peer consultation as critical to their coping with the difficult elements of trauma work:

That’s one of the things that we talk about regularly. ...that’s one of the things we would always talk about, that’s part of the agenda, is what are ways to cope with this. We actively are talking about how did you cope with last week. We’re talking about the case so this case happened. How do you cope with that? How do you deal with that, this child who’s suicidal after his brother just committed suicide. How do you sleep? What’s helping you to sleep at night or are you? Bringing up the conversation and then helping folks to access their own resources. (Sean Q.)

Separation between personal and professional life was also considered a valuable coping skill for social worker and help to enhance feelings of satisfaction and positive reactions. One participant talked about her conscious transition in and out of her work:

Do people think about how they get into the work and what they get out of the work? I think about that all the time. I think it's odd, but I've become very ritualized about how I begin to work in the morning, what kinds of things I do and say and what kind of tai chi I work on and energy state I create before I come into the work. Then when I'm leaving, what do I need to go to get out of the work? (Jane B.)

Another social worker talked about not bringing any physical items from her job into her home as a way to create a clear separation between her professional and personal life. She stated:

...being able to cut it off and not bring your work home. The physical things that I do is I don't bring any work home with me. That's one of the things that helps me. I don't bring

work home. If I have to have something, you know you have a bag if you're going from 1 office to the next, that stays secure. It's in the garage, but it doesn't come inside of my house because it's like ... I could leave my phone and not be reached or anything like that. Those are the things that I put into place to make sure that I cut that off. (Sandy T.)

Participants reported coping strategies for their personal and professional life. Personally they used coping strategies to help mitigate the negative reactions from the trauma work. This not only benefited the social workers but also gave them a repertoire of interventions to use with clients, ones that they had tried personally. Interviewees discussed several coping strategies related to the social worker's professional life. These included diversifying their roles and jobs, allowing the social workers professional "space" from the intense trauma work. Participants also cited their connections with peers or supervisors as another way they coped with the stress from the intense work. Lastly, having clear divisions between their work and professional life helped them disconnect from work.

### **Outlook for the Future**

When asked about their future plans, all the participants reported that they planned to continue doing clinical work with traumatized clients. Examples given of the participants' future plans were taking and passing their clinical license exam, entering into private practice, teaching at a university level, and creating new programs for traumatized clients.

Four of the 9 participants that worked in mental health agencies reported future plans of obtaining their clinical license and leaving their agency to work in private practice. Additionally, three of the 9 participants who worked in an agency were licensed and had small private practices. Reasons cited by social workers were greater earning potential, more autonomy, and "fewer hands in the pot." Helen D. describes her "dream" of having more creativity in private practice and freedom:

You can be as creative as you want. You have the liberty to pick your space. Whereas nonprofits, I think ... Unless I find a really great one, then I'm sure. (Pause.) There's something to focusing on the quality of the work rather than all of these other BS or grants and funding and politics and just bullshit. That is not attractive to me. It's not attractive to me when I know I'm doing good work and it's not reflective because the numbers are not reflective. I hate that. (Pause.) I would love to go into practice with three or four clinicians that I've met through here that are creative and having this really awesome place with colors and toys and ... I don't know. I just dream of this wonderful space where it just brings healing. I don't know.

Other examples of social workers wanting to become licensed and work in private practice are:

Five years. I really see myself in private practice and possibly teaching on the side. I've always wanted to do that. More autonomy to do what it is I want to do. Fewer hands in the pot. (pause) That's where I see myself in five years. Doing a private practice. (Joe M.)

I would like to ... I don't know if it's going to be within a 5-year time frame. It would be ideal to have that, but to be doing private practice, play therapy for survivors of sexual assault. That's what I would like to be doing. Not just sexual like physical abuse, domestic violence, but I really want to have that specialty in the sexual trauma.... (Sandy T.)

In both examples, participants spoke of their desire to enter into private practice. Joe M. seemed to want to diversify his work between private practice and teaching. Sandy T. reported wanting a private practice focusing on trauma survivors.

Other participants talked about wanting to create community programs or trauma-informed educational programs as future professional plans. One example of this was:

I'm thinking how do we get that out in the community and I'm thinking about you know if (name of town), they are starting to build low-income housing, it had been (an) abandoned site and they're creating a new community, what if they could bring that program like into the community that at the start or having those people there you once your application is in you start doing trauma-informed work cause I think that's going to help bring that community up, you know, because those people to be where they are, what's their story. What have they been through, what trauma have they endure and if they don't get treatment for it how will that impact the community. So that's where I'm

thinking about this trauma work, what's a deeper way, like in here we can do like the one on one work. Is there a bigger way of being able to impact...(Mary S.)

Here we have examples of the social worker wanting to take her knowledge of trauma theory and clinical experience and use it at the macro level to help communities and their members; as she stated "paying it forward." She asserted that by treating the trauma on a community level, the larger community will benefit.

Jane B. reported wanting to retire but not able to due to the economy. Instead she wanted to focus on developing an educational program to incorporate trauma-informed care.

I was hoping to be retired, but the economy is not cooperating with me on that so I think where I'm going to be is ... I'm in the process of trying to create this different entity that utilizes a lot of what we've learned here and a lot of what I think the educational system has abandoned. We're focusing on trying to create 1 or 2 non-profit entities that can maybe restore those. One would be an educational based entity and the other more of a therapeutic based entity. What we're trying to do is incorporating a lot of what we've learned.

A handful of participants, primarily older, reported wanting to cut back on their caseloads. As Charlie C. stated, "I'm in my 60s. In five years, if I had my total choice, I would be working here three days a week, four days a week, doing supervision and consultation and some cases."

Other participants did not have plans of retiring or reducing their clinical hours, partly for financial reasons and partly out of the desire to continue working. For example, Mike D. stated

And I will probably be working until I drop. (Pause.) Financially I need to. And I enjoy it and I am the kind of person that, I would always have to have something to do. I feel good. I feel young. I don't feel old and ancient as long as I can keep my teeth...

These examples suggest participants want to continue, in some capacity, working in the trauma field. The younger participants speak of continuing their careers by obtaining their

clinical license or moving into private practice. Many of the seasoned participants looked at their future to create greater change for themselves and their clients before leaving the field. Finally, participants closer to retirement reported wanting to stay in the field or reduce their hours and caseload.

## Chapter 6

### Discussion, Implications, and Conclusions

The purpose of this study was to explore with social workers' their positive reactions experienced in their work with traumatized clients. This study was in response to the perception in the mental health field on trauma work and in the research literature that this work has a negative impact on clinicians. I chose to focus on the positive in order to offer a more balanced view of trauma work and to contribute to the research on the positive reactions social workers experience when engaging in this type of work. It is my hope that the findings of this research will be used to encourage the social work field to prepare and guide young social workers to work with traumatized clients and to value and support seasoned trauma social workers to continue this critical work.

This research study used a constructivist approach with a modified grounded theory method of inquiry to gather qualitative data by conducting 15 in-depth interviews with social workers working primarily with traumatized clients. The study explored the following research questions:

- How do social workers who report experiencing positive reactions from working with clients who experience trauma describe their reactions?
  - What is the nature of the reported growth or satisfaction?
  - Is the growth related to being a better therapist, a better person, resolving one's own trauma, or something else?
  - Does growth/satisfaction precede, follow, or run parallel to the client's growth?
- How, if at all, do workers describe their experience of the relationship between positive and negative reactions?
- What in their work environment or self-care facilitates the process of growth or satisfaction? How? What impedes it? How?
- What in their personal environment facilitates the process of growth or satisfaction? How? What impedes it? How?

- What aspects of the therapeutic environment facilitates the process of growth or satisfaction?
  - How, if at all, does the relationship between the social worker and client affect their mutual growth?
- How, if at all, does the social worker's theoretical orientation affect his or her work with clients who have experienced trauma?

Topics presented in the findings chapter are congruent with my research questions. My aim in this chapter was to provide the reader with insight relating to these topics and connect this information back to theory and current research data.

### **Personal Trauma**

Eight of the 15 interviewees reported experiencing some type of personal trauma. This number could be higher because I did not specifically ask about personal trauma; instead, the participants disclosed this information organically in the interview in relation to questions around their career choice. The participants indicated that they did not see trauma exposure as a deficit but rather, in many cases, as a part of the social workers' passion for working with the trauma population. The research literature is divided on this view with some research finding personal trauma putting a therapist more at risk for negative reactions (Cunningham, 2003; Pearlman & Mac Ian, 1995; Sabin-Ferrell & Turpin, 2003) and other research finding personal trauma experience did not increase vicarious trauma scores (Adams et al., 2001).

Participants viewed their personal traumas as a positive contribution to their growth as an individual and as a professional. This finding followed the theoretical view of posttraumatic growth, a traumatic event developing into part of the social worker's growth (Calhoun & Tedeschi, 2013) and is also consistent with positive psychology and the strengths perspective.

The interviewees who reported personal trauma exposure experienced negative reactions from their trauma but also reported creating meaning out of it. For many, this meaning was tied to their work with traumatized clients.

Most of the social workers reported the use of self as a tool in their work with clients. This acted as both a strength and a risk factor for them. Social workers with past trauma histories ran the risk of experiencing countertransference or other negative reactions when activated by client trauma material. Social workers also used themselves to create a mutual, relational space sitting with their own personal reactions while the client was experiencing his or her reactions. This space was described by many of the participants as a key element in mutually satisfying clinical work. The study highlights the fine line between positive and negative growth for both client and therapist. In this study, personal trauma history appears to contribute to the social workers' satisfaction and growth.

### **Theoretical and Other Practice Frameworks**

Social workers' theoretical framework and clinical intervention contributed to their positive growth in their work with traumatized clients. The majority of the social workers combined theory and intervention when responding to questions around their theoretical orientation. This study did not explore this conflation with interviewees. Future research would be needed to delve more deeply into social workers' understanding of theoretical orientation, models, interventions, and perspectives. In my study, many of the participants cited using a type of evidenced-based approach in their work, although only one participant reported using unmodified evidence-based treatment. The rest of the participants used a blend of approaches and frameworks, or an eclectic framework. According to the findings in this study, younger

social workers gained more self-confidence when using a structured approach in the trauma treatment. The manualized treatment approach gave them a model to follow and this gave them comfort. Younger social workers felt they did not get enough trauma training in their MSW programs and felt unprepared to handle the complexities of trauma work. One possible explanation could be a systemic move towards the use of evidence-based treatment and teaching less humanistic and transpersonal orientations in MSW programs. This also could be an area of exploration for future research. Research literature is divided as to the influence of evidence-based treatment on the therapist's growth and satisfaction. Some research indicates evidence-based treatment correlates with greater satisfaction in trauma work (Alkema et al., 2008; Craig & Sprang, 2010; Linley & Joseph, 2007; Sprang et al., 2007) whereas other research found therapists trained in evidence-based treatment reported less satisfaction in their work (Linley & Joseph, 2007).

Other social workers followed a looser or more eclectic approach, finding a "one size fits all" view to trauma treatment not realistic. This was especially true for the more seasoned social workers who combined elements of evidence-based treatment with alternative forms of trauma treatment. This finding supports Rothschild's (2010) view of work with traumatized clients. Rothschild cautions therapists not to "be overly influenced by the evidence base. It is meant as a guide, not as law" (p.157). The author highlights the importance of the therapist having a varied framework for working with traumatized clients, noting there is no one single method when doing trauma work. The findings in this study support the perceived value of using a varied approach by clinicians who have trauma training, trauma-informed supervision, and general experience working with traumatized clients. For younger, less experienced social workers, the findings suggest the need for specific trauma training and trauma-informed supervision to

provide them with the skills and support needed to feel confident and effective with traumatized clients.

The majority of the participants spoke of using a relational framework when working with traumatized clients, although they cited EBT as their theoretical framework. (Only one social worker reported using a straight EBT and strongly discounted the influence of the therapeutic relationship in the client's change process.) The commonality of the relational framework is consistent with the common factor model which can be included with other models, including evidence-based approaches (to be discussed in the Therapeutic/Clinical Relationship Section) (Coady & Lehmann, 2008).

### **Reactions to Working with People Exposed to Trauma**

As expected, all 15 interview participants reported experiencing positive reactions along with negative reactions from their work with traumatized clients. Participants also reported experiencing satisfaction with their work. This study focused on the participants' positive reactions and satisfaction. They described their satisfaction as part professional and part personal. The study found many social workers experienced their satisfaction reactions as increased confidence in their skills as therapists and feeling positive emotions connected with their satisfaction around their work. The participants experienced carryover of their positive reactions to their personal lives, feeling they were better people as a result.

Resiliency emerged as a positive response that influenced the social workers professionally and personally. This helped them feel more hopeful in the face of negative emotions and experiences in both their personal and professional worlds. It was not clear from the study whether the participants were more resilient by nature or if their work enhanced their resiliency.

The social workers described powerful satisfaction and pride in their work with traumatized individuals. For many, their work gave them a purpose in life. They conveyed the belief that their job was more than a career; it gave them a sense of meaning. They felt it was an honor to be trusted by clients who had experienced trauma, especially when the trauma had been experienced within the bounds of a relationship. The social workers seemed to believe healing or “medicine” was through the relationship. It is important to highlight this finding in educational programs and for new social workers to provide a balanced view of trauma work. There are inherent positive and negative reactions from this work and in understanding this, social workers may be able to gauge their reactions better. If social workers are aware of both positive and negative reactions, they can identify imbalances in their own reactions sooner when working with clients. This could help attract new social workers and retain experienced ones in the trauma field.

The social workers experienced negative reactions in their work with traumatized clients but their positive experience helped them overcome their own negative reactions and belief in the potential for growth and change for the client. This was especially true for the seasoned social workers. Experienced social workers had positive reactions prior to the client’s expressing such reactions, even as the client experienced painful, negative reactions. Their past experiences working with traumatized clients informed their interventions and increased their confidence in their ability to help the clients. They understood the client’s negative reactions were a part of the client’s journey, believing that clients needed to feel the negative emotions in order to heal and experience positive emotions. This experience, or belief in the process, was a part of the social worker’s resiliency, especially when treatment was difficult.

The younger, less experienced participants' reactions ran closer to the clients' reactions. Early in treatment they experienced doubt, confusion, and worry over creating harm to the client. This initial experience was negative for the social worker. Less experienced social workers also felt a sense of personal responsibility for the client's well-being, worrying that the client was being further harmed in treatment. Once the client began to experience growth and positive reactions, the less experienced social workers began to experience satisfaction and growth. Thus, the less experienced social workers' positive reactions followed their clients' positive reactions. As the clients' trauma symptoms began to decrease and positive reactions increased, the social workers felt their sense of satisfaction and positive reactions increase. This suggests that for younger social workers, supervision should be an essential element during times of uncertainty in treatment. Many younger participants who felt negative reactions during the trauma treatment did not have a professional place to process their emotions. This finding is important for both organizations and the social work field to see this as a way to retain social workers in trauma work.

The extent of the social workers' experience also contributed to their positive reactions in their work with traumatized clients. Social workers with more experience were more confident in the trauma treatment, especially when the client was experiencing negative reactions. Their experience helped them trust the therapeutic process by giving them confidence to pace the flow of treatment. The social workers' past experience with clients informed their work with current ones and helped them understand the process and hold hope for the client. Experience also helped the social workers to set realistic goals for the client and also have more realistic expectations for themselves. By doing this, the social workers could provide the client space to succeed or not, providing the client self-determination.

When the social worker and client developed obtainable treatment goals, this increased the positive experience for both parties. The goals enhanced resiliency by creating treatment success as a basis for future successes. Social workers understood that clients' positive outcomes, small or large, influenced future therapeutic work with their clients.

The study found that all of the social workers reported that their positive reactions from their professional work carried over into their personal lives and affected them in positive ways. Participants had a more positive worldview, experiencing a greater range of positive emotions and fewer negative emotions, and greater commitment to their interpersonal relationship with family and friends. These reactions are the opposite of those associated with vicarious traumatization (Marriage & Marriage, 2005; Pearlman & Mac Ian, 1995) and secondary traumatic stress reactions (Bride et al., 2007).

Most of the social workers reported that they experienced reactions of vicarious traumatization and secondary traumatic stress. These reactions consisted of intrusive thoughts, flashbacks, difficulty sleeping, and somatic negative responses. Participants also experienced positive reactions, such as feeling joy, energetic reactions, increased motivation, belief in working towards a greater good, and spiritual connectedness to clients and trauma work. Participants experienced elements of these negative constructs but their positive reactions allowed them to mitigate the negative reactions. Many social workers were able to continue working with traumatized clients despite experiencing negative reactions because of their positive reactions. The social workers' experience of positive reactions and growth in their work with traumatized clients is a piece of their resiliency, helping them offset negative reactions from their work. The study notes the importance of educating social workers in ways to enhance

positive reactions in trauma work and the continued research on positive growth in trauma social workers.

### **Therapeutic/Clinical Relationship**

Most of the participants validated the importance of the therapeutic relationship when working with traumatized clients and felt transformed as a result of the trauma work with their clients. Interviewees readily gave examples of techniques used to enhance client's experience in the therapeutic relationship yet found it difficult to articulate how they were personally transformed by their work. Social workers identified having a better life view, the ability to view trauma work more positively, and social workers experiencing peace and calmness as ways they felt transformed by their work. It appeared the social workers were not provided opportunities to talk, in the past or present, about how they were positively changed as a result of their work with traumatized clients. Some of the interviewees stated the study's interview was the most they had talked about their work in this light. This has implications for MSW education, supervision, and social work practice. Inclusion of the strengths perspective and positive psychology can offer a framework to begin inclusion of the social workers' internal reactions, growth, and satisfaction in trauma work (Duckworth et al., 2005; Saleebey, 2009; Seligman et al., 2006).

The study identified techniques used by the social workers to create an optimum therapeutic alliance with the traumatized client. These were the client-therapist shared responsibility, social worker having unconditional regard towards the client, creating safety and hope, and being fully present with the client. This finding supports the research on common factors in psychotherapy; most evidence-based treatments share similarities in their "active ingredients of therapy" (Drisko, 2003). General common factors identified in effective

psychotherapy are: extra-therapeutic factors, the therapeutic relationship, technical factors, and expectancy (placebo) effects. The therapeutic relationship accounts for 30% of the treatment's effectiveness (Cameron & Keenan, 2010; Coady & Lehmann, 2008; Drisko, 2003, Hagemoser, 2009; Lambert & Ogles, 2014; Laska, Gurman, & Wampold, 2014; & Norcross, 2011).

Fraser, Solvery, Grove, Lee, and Green (2012) state that all effective treatments are delivered by therapists in relationships that include a strong working alliance, cohesion, empathy, collaboration, goal consensus, positive regard, congruence, repair of ruptures, self-disclosure, and feedback. The extra-therapeutic factors, which are related to the client's ability to access affordable and quality therapeutic care, account for 40% of the client's outcome. The other factors are related to technical issues (15%) and expectancy (15%) (Cameron & Keenan, 2010; Coady & Lehmann, 2008; Drisko, 2003, Hagemoser, 2009; Lambert & Ogles, 2014; Laska, Gurman, & Wampold, 2014; Norcross (2011).

Additionally, social workers used countertransference to help guide the trauma treatment. The participants experienced their own personal reactions during sessions with clients. This could interfere with the client/therapist relationship if the therapist is not able to monitor it. Countertransference is ideally mitigated in trauma-informed supervision or peer consultation groups but unfortunately, many social workers reported not receiving clinical supervision or having to pay out-of-pocket for this service. This was especially true for the less experienced social workers interviewed for the study. Participants with past personal trauma exposure did not report experiencing more negative reactions than participants who did not report personal trauma exposure. The research on this is divided. Some studies found personal trauma history did not impact a therapist's vicarious traumatization score (Adams et al., 2001) where other research identified it as a risk factor, placing the therapist at greater risk for experiencing negative

reactions (Cunningham, 2003; Harrison & Westwood, 2009; Neuman & Gamble, 1995; Pearlman & Mac Ian, 1995; Sabin-Ferrell & Turpin, 2003). In this study, participants felt their personal trauma exposure enhanced their work with traumatized clients. More research is needed on this topic to gain a better understanding of this phenomenon.

Social workers created a protected emotional environment within the boundaries of the clinical relationship. This environment allowed traumatized clients to tell, and re-tell if needed, their trauma story and to have the client's trauma experience validated, which was critical to the healing process. The social worker created a safe space within the therapeutic environment, enabling a secure attachment for the client. The emotional environment consisted of safety, healthy relational boundaries, and creating mutual connections or intersubjectivity (Ogden, 1994). Social workers were exposed to the client's trauma narrative and experienced this on a personal level with the client. Social workers relaxed their boundaries and opened themselves up to the client's emotions. Again, the social worker used a relational framework, staying close to the client's emotional state and was a witness for the client. In order for this to happen, the social worker experienced his or her own mixed reactions and the reactions of the client. In doing this, the social worker risks experiencing negative reactions in the form of compassion fatigue and vicarious traumatization. This study highlights the importance of relational skills for social workers to enhance their satisfaction and positive reactions in trauma work.

Attunement, the social worker's ability to adjust the pace and tenor of the therapeutic work to match the client's needs, is another important component of trauma work. This was demonstrated by the social worker's use of silence where they did not feel the need to fill gaps in conversation with the client. They also carefully monitored the client's internal experience and matched their work accordingly. Social workers did this by either increasing or decreasing the

intensity of the trauma work, challenging the clients without overwhelming them. In becoming attuned to the client, the social worker employs relational skills, many of which are at the foundation of social work and trauma-informed care (Borden, 2000; Chenot, 1998; <http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/>; Ornstein & Ganzer, 2005).

Additionally, social workers spoke of creating a strong attachment, as well as experiencing unconditional regard, towards their trauma clients. This manifested in different ways for participants. Some reported having parental feelings towards clients; others spoke of having genuine affection towards their trauma clients. Many felt the positive growth experienced by both client and therapist was connected to this strong connection. Moreover, social workers believed that therapeutic growth for the client was enhanced by the relational element. Because parental and affectionate feelings could be inappropriate for the therapist and client, trauma-informed supervision is recommended to process this experience.

Components of the therapeutic relationship identified by the social workers were: shared responsibility for treatment outcomes, safety, and trust between client and social worker. These components were also co-created by the client and social worker but many participants believed the social worker held more responsibility in this.

One social worker in the study reported feeling the relationship was not as important as the intervention and believed social workers placed too much value on it. From this person's perspective, having clear, measurable data on interventions and the client's measurable symptoms were paramount. This participant was the only social worker who reported using straight evidence-based treatment for trauma work. This social worker held a caseload of severely traumatized and symptomatic trauma clients and this could be a reason he did not place

as much value on the relationship. By placing emotional space between himself and his clients, the social worker may be reducing the negative impact of his work. Also, for a therapist using evidenced-based treatment, aspects of the intersubjectivity and therapeutic relationship are harder to operationalize and measure, thus making it more difficult to gauge the treatment's effectiveness. This social worker did credit the therapeutic relationship for increasing motivation and decreasing attrition in trauma treatment.

Another example of a participant unable to identify his personal reactions in relation to the therapeutic relationship with traumatized clients was with a social worker who had an extremely high caseload, seeing over 200 clients per month. One could deduce it was more difficult for the social worker to form strong therapeutic relationships or attachments when serving so many clients. This also could be seen as a way to cope with potential negative reactions to client's trauma material, as it is more difficult to create strong individual attachments with such a high number of clients. As a result, the work becomes less relational, focusing instead on problem-solving or skill building.

### **Organizational Context**

All of the social workers interviewed had experience working in mental health agencies, including the participants who were currently working in private practice. The social workers described ways their organizations contributed to the enhancement of their positive reactions and conversely how organizations increased their dissatisfaction with their work. Areas identified for enhancing positive reactions were supervision, clinical trainings, peer support, and strong staff morale. Areas identified that decreased feelings of satisfaction were lack of supervision and

trainings, incompatible mission or goals between the social worker and the organization, high productivity expectations, and significant paperwork requirements.

Most of the participants reported that supervision was an element that greatly influenced their experience of positive reactions in their work with traumatized clients. Social workers identified elements of effective supervision that were similar to elements found in trauma-informed care. This form of supervision created a safe space for the therapist to grow as an individual and professional. Social workers also identified needing to feel a sense of trust towards their supervisor and the supervisor genuinely caring about the social worker's well-being. Here again we see similarities between trauma-informed care and trauma-informed supervision. Other elements identified were feeling challenged and motivated in supervision, as well as having a place to strengthen their clinical skills. From this study's findings, this type of supervision will be referred to as trauma-informed supervision. Supervision that focuses on trauma-informed work is influenced by relational and trauma theory (Miehls, 2010).

Many participants working in agencies did not receive supervision or the supervision was not considered a place where the social workers could talk about their struggles with their work. The younger, less experienced participants in the study made up most of the sample from agencies and this was a great dissatisfaction for this group. Some participants had to personally pay for their supervision, believing it was unethical to engage in clinical work with traumatized clients without it. The seasoned social workers felt supervision was important for new social workers in general, especially those working with traumatized clients.

One interviewee reported not having supervision and not seeking out this service personally. He cited working independently in a private practice group and not having time as the reasons for not seeking out supervision. This social worker would have to pay out of pocket

for this service and did not want to take time away from his clinical work, seeing over 200 clients per month. The participant did report seeing a therapist for his own growth and support.

Trainings were another important feature the social workers identified as a way their organizations contributed to their feelings of satisfaction in their work. A few participants had training opportunities provided by their agencies on trauma work and they indicated this was a part of their positive reactions in their work. This was especially true for participants who received ongoing trainings in a specific trauma intervention, feeling they are able to have a deeper knowledge and tools to work with their traumatized clients. Social workers felt this was very important because all participants reported not having had sufficient training on trauma in clinical work in their MSW programs. More experienced social workers reported having no training in trauma in school due the lack of information and research on trauma at the time. Many sought further trainings to address the challenges they experienced in their clinical work. More recent graduates reported having had some education on trauma in school but universally felt the knowledge was not helpful in their current work with traumatized clients. Both groups either sought out training on trauma and/or personally educated themselves on the topic. Here the findings identify an area that would have a direct impact the therapist's overall satisfaction. Providing trauma training to trauma therapists would not only enhance their satisfaction and effectiveness but contribute to the retention of social workers in agencies.

Conversely, the social workers associated not having supervision, or not having trauma-informed supervision, with having feelings of dissatisfaction or experiencing negative reactions. This writer is defining trauma-informed supervision as the elements of supervision that support growth and safety, and address the therapist's reactions, positive and negative. When participants did not have trauma-informed supervision, they felt less satisfaction with the organization. This

dissatisfaction seemed to intensify when there were high demands on the social workers. Examples of this were significant paperwork responsibility, high productivity expectations for billable hours, and high numbers of traumatized clients on the social worker's caseload. These areas highlighted the discrepancies between the mission of the organization and the social workers' priorities. Social workers felt that providing treatment to traumatized clients had inherent challenges and this was intensified with the organizational constraints placed on them. Peer support and high staff morale helped social workers offset the negative impact of these the negative organizational elements. Many social workers credited their colleagues as enhancing their experience with the organization, feeling that their peers understood the demands of the job in relation to the intensity of the work and expectations of the agency.

### **What Contributes to Positive Growth**

Social workers gave many examples of professional and personal elements that contributed to their growth and satisfaction in their work with traumatized clients. All of the participants strongly expressed the value of having ways to cope with their negative reactions to the intense work and all actively engaged in some form of coping or self-care. There are themes discussed in this section that were identified in prior sections but I will explore them in relation to how each theme added to the social workers' positive growth. Those themes are the use of peer support and the adoption of trauma interventions for self-care. The social workers' theoretical framework will also be discussed in relation to their positive growth.

All social workers, regardless of their age or experience, reported using personal coping strategies to help with negative reactions. Personal coping strategies practiced by social workers were: self-care, using clinical interventions or techniques, hobbies, spirituality, mindfulness

practice, and physical exercise. Professional coping strategies they identified were: career diversification, peer connection/support, and clear boundaries between the social workers' personal and professional life. The majority of the participants reported having limited formal education regarding negative reactions from trauma work and specific techniques to mitigate the risks of trauma work. The importance of self-care for trauma workers was identified in this study and supports the past research (Cunningham, 2003; Harrison & Westwood, 2009; Neuman & Gamble, 1995; Pearlman & Mac Ian, 1995; Sabin-Ferrell & Turpin, 2003).

Participants perceived benefiting on two levels from personally practicing clinical trauma interventions and coping strategies. On the professional level, the coping strategies helped the social workers in their clinical work by giving them a better understanding of the skills, which in turn helped them teach these skills to traumatized clients more effectively. On the personal level, social workers were able to use trauma-informed interventions and techniques to help reduce negative reactions and enhance positive ones. The participants described this as a symbiotic relationship, their professional practice informing their personal life and their personal life informing their professional life. Again this highlights strengths, resiliency, and the use of positive reactions to mitigate negative reactions.

Social workers also thought that their hobbies help to inform and enhance their clinical work with traumatized clients. Two participants gave examples of this, one citing her art as her coping method and the other citing his music. One participant felt a connection between his music and his clinical work with traumatized clients, believing that through each he was offering healing, as he was using similar skills in both his personal and professional worlds. The other participant believed her clinical work suffered when she did not paint regularly. For both

participants their artistic hobbies not only acted as a self-care strategy but were also very important in influencing their clinical satisfaction with their traumatized clients.

### **Aspirations for the Future**

All of the social workers interviewed reported wanting to continue working with traumatized clients, despite experiencing negative reactions. The less experienced social workers felt they would continue this work in larger agencies or in private practice. The more experienced social workers also reported wanting to continue working with this population but at a macro level. Examples this sub-group gave include creating a trauma-informed community housing program, an educational setting geared to providing education along with trauma-informed care, and creating trauma programs focused on the needs of the adolescent LGBT population. The more experienced social workers wanted to share their knowledge and impart healing with larger groups of the trauma population. Other findings related to the social workers' choice of work in the field. Younger workers were all working in agencies with traumatized clients and stated that their future goals were to obtain their clinical license and then enter private practice. More experienced social workers reported wanting to change their practice to a more macro focus, having the desire to create change with a larger trauma population.

### **Unexpected Findings**

Early in the study, I started to see a phenomenon with social workers and private practice. As stated previously, I modified my inclusion criteria to include social workers who were working in private practice. Initially, I was interested in exploring how organizations helped or hindered the social workers' experience of positive reactions. I quickly realized I would not have

an experienced, varied sample of interviewees if I only included social workers who worked in agencies. Many social workers with trauma work experience who responded to my interview request worked in private practice. Hence, I adjusted my criteria in order to get a varied and experienced sample for my study.

Once I began interviewing participants, I again noticed another phenomenon. When I asked younger, less experienced social workers about their future plans, they reported planning to remain in agencies in order to accumulate clinical hours and clinical supervision to be eligible for the clinical licensure exam. Further, these social workers reported plans of leaving the agencies to enter into private practice once they obtained their clinical licenses. They explained that they wanted more freedom in their work and wished to earn a higher income.

This does not appear to be a new phenomenon in the field. When the more seasoned, experienced social workers were asked about their employment history, all reported starting in large agencies prior to entering into private practice. It could be inferred that many social workers gain experience and skills in working with traumatized clients and then leave this sector to work in private practice.

Another unexpected finding that emerged from my study was trauma therapists using trauma interventions personally to combat their negative reactions. This coping strategy was something that developed organically and was not formally taught to the therapists. This phenomenon helped the therapists to be more effective in their teaching of the therapeutic techniques to clients and gave them greater resiliency in their work. Here the professional life of the therapist informs the personal, and the personal life informs the professional. This finding could be applied to current trauma trainings and trauma-informed supervision. Social workers could learn tools to help with their client's symptoms by personally practicing the interventions

on themselves. This philosophy of learning could be infused into MSW programs, trauma trainings, trauma-informed supervision, and organizations.

Lastly, all participants reported wanting to remain working in the trauma field. This finding is significant because it speaks to the social workers' overall satisfaction in their work despite inherent challenges from trauma work. The finding supports the positive nature of trauma work and the positive impact it has on trauma social workers. The study's findings in this area is understood through the lens of positive psychology, the strengths perspective, and general social work practice. The ability to identify the positive and the negative in life experiences has been a historic element to social work practice and is enhanced by these theoretical and value-based perspectives. The participants in this study worked from a positive and strengths-based viewpoint in their work with clients and in their personal life. It was not clear if one area was inherent in the social workers but it was clear that work and personal realms influenced each other.

### **Implications for Clinical Practice, MSW Education, Organizations, and Research**

In this section, I discuss implications for practice, education, and organizations together, as each informs the other. All three share intersecting areas and influence each other. Within each system there is the need to provide training and education on trauma work, provide trauma-informed care and trauma-informed supervision, and organizational supports in order to attract and retain social workers into the field of trauma. I will also discuss implications for research.

Social work educational institutions need to provide formal trauma training to social workers during their educational programs. The Council on Social Work Education (CSWE) has introduced a conceptual framework for trauma-informed social work practice that provides

knowledge and practice behaviors for their 10 core competencies (CSWE, 2012). This is an attempt to prepare social work students for practice with trauma populations. Further research is warranted to examine MSW programs, their curricula, and student feedback to gauge if educational systems are providing students education in trauma-informed practice. As previously stated, this type of trauma-informed framework is a philosophy not an intervention or treatment.

Organizations should also invest in this type of trauma training for therapists working within the trauma populations. The findings in this study indicate a need for trauma-informed clinical trainings for social workers starting in their social work educational programs and continuing in their employment settings. Trauma-informed training would provide social workers with a strong skill set that would increase the likelihood of their satisfaction when working with trauma population. Educational and organizational systems should be teaching theoretical and skill-based education around the therapeutic relationship. Trainings also should include general principles in trauma work, as well as relational techniques. It is especially important to teach this to younger social workers starting out in the field, who lack experience and confidence in working with traumatized clients. It would benefit social workers to be taught trauma-informed guidelines along with the fundamental relational aspects of social work. This is also an opportunity to teach specific trauma interventions to social workers and provide them with the opportunity to develop similar coping interventions for their own self-care. In doing this, social workers have more concrete tools to use with traumatized clients and ways to reduce the impact of trauma work.

Abrams and Shapiro (2014) recommend educating social workers in trauma throughout their master's program. The authors describe the natural connection between social work values and skills and trauma-informed care. They suggest using a pedagogy of experienced trauma

clinicians teaching the complexities of trauma work through a case-based method. In this paradigm, students are able to work through a trauma case in a safe environment, process reactions, and develop needed skills. Young social workers are not only educated on theory and interventions but also are presented with models of what is needed in supervision to create optimal self-growth and satisfaction. The social workers can advocate for themselves once they are in the field; this is especially important with the findings showing many social workers in this study did not receive supervision.

Organizations should also provide trauma-informed supervision and trauma trainings for social workers and other trauma therapists to promote their growth and satisfaction. It is especially important for organizations to provide this in order to retain social workers in agencies and not lose them to private practice. An important component of this is the provision of guidance and supervision. Trauma-informed supervision is an extension of the trauma-informed care provided by the social worker and each complements the other. Miehl (2010) suggests that supervisors use a combination of relational and trauma theory to inform their supervision. The author cautions the supervisor to be aware of the power difference in the supervisory relationship, and instead to expect that both supervisor and supervisee create his or her own view of the client to inform practice.

Therefore, organizations need contribute to the trauma workers' development and growth as individuals and professionals. Maltzman (2011) articulated that there is an inherent risk for trauma therapists to develop secondary trauma or vicarious trauma and there is a need for systematic self-care "as an integral, and valued, component of the organization" (p. 308). The author identified adapting information on secondary trauma, vicarious traumatization, and self-care in initial orientation and job training. The study supports this finding and challenges

organizations to step up to this need. Agencies and organizations should develop address these areas to meet the needs of their trauma therapists in order to retain a portion of their workforce. Another area Maltzman (2011) identified for organizational support was “internal emotional check-ins” by therapists to monitor reactions and identify needs (p. 311).

Additionally, supervision is a place where workers could feel “supported, validated, and valued by the organization, most particularly by their direct supervisor” (Maltzman, 2011, p. 313). Here again this study validates his recommendations. As indicated by the participants, the clinical relationship is a place for potential distress and psychological damage. It is also a place for growth and healing for both client and social worker. There are many ways to improve this phenomenon in clinical work and in educational and organizational settings. This is where all elements of clinical practice, education, and organizations come together to create an optimal environment to support the social workers’ health and growth, which in turn supports optimal health and growth in traumatized clients.

Lastly, based on the limitations of this study the following recommendations for research are discussed. First, future research on positive reactions from trauma should include a more diverse sample. The current study was diverse with respect to gender and did have racial diversity between Caucasians and African Americans participants. Future research should include samples of other races to provide a greater scope on this topic. Secondly, further studies should have a larger sample size to determine if the findings are similar to this study’s findings. Lastly, a longitudinal study should be conducted in order to follow a sample of participants over a period of time. This type of study could help researchers study how trauma social workers developed skills to enhance their positive growth, whether participants left larger organizations

for private practice, what supports social workers used in personal and professional growth, and if social workers continued in the trauma field.

### **Conclusion**

I hope that at the conclusion of this study the reader is able to understand the complexities of trauma work and how immensely rewarding it can be for social workers. The study highlighted the positive reactions social workers experience in their work with traumatized clients. The factors that influence their positive reactions consist of trauma education and training, relational components in the clinical relationship, the social worker's level of experience, coping strategies, and professional and organizational elements.

This was a study of social workers who initially reported having positive reactions when working with traumatized clients. The social worker's level of experience influenced the timing of their positive reactions; younger, less experienced social workers experienced positive reactions closer to the timing of the client's positive reactions. In comparison, social workers with more trauma work felt positive emotions prior to the client's expression of these emotions.

The social worker's previous experience working with this population also contributed to their confidence and the timing in their clinical work with traumatized clients. More experienced social workers reported that their past work with traumatized clients informed their current work and helped them trust the process of the work, even when the work was difficult.

Even though social workers experienced negative reactions to their work with traumatized clients, many felt their positive reactions helped to increase their resiliency in their work. The study also found that although most of the social workers reported using evidenced-

based treatment, they described an eclectic, relational framework as well. Organizational components that contributed to the social workers' positive reactions consisted of trauma-informed supervision, trainings, a shared mission between social worker and organization, and strong staff morale. Personal components the social workers identified were use of trauma skills and interventions for personal coping, varied jobs and hobbies, and a clear division between professional and personal life. Lastly, all of the social workers interviewed stated they planned to continue doing trauma work in the future. Younger social workers reported they wanted to pass their clinical license exam and enter into private practice. Social workers who have been in the field longer reported wanting to do macro trauma work with larger populations.

An important area to be further explored is the development and application of trauma-informed supervision for social workers. This is a critical area to understand further in order to help retain existing social workers in the field with trauma experience. If this area is not improved, traumatized clients, already a vulnerable population, could be further marginalized by not getting quality care.

This study has added to the existing research by gaining a better descriptive understanding of the positive reactions experienced in trauma work. It provided evidence for the importance of trauma education in social work programs, in-service training, and examples of coping strategies used by social workers working with traumatized clients. The study supports the use of foundational social work principles, particularly the worker-client relationship, and trauma theory as having complementary elements of practice for all levels of social work practice. It is critical for social workers to have education and trainings in this practice area given the high incidence of trauma exposure.

Lastly, further investigation is needed to examine ways to improve the social worker's experience when doing trauma work and further develop effective coping strategies. Again, tools developed to help traumatized clients have the potential to act as coping tools for the social workers, potentially increasing their resiliency in relation to the negative aspects of trauma work. If the positive aspects of trauma work are further researched and discussed, social workers can attain a more balanced view on the impact of this work. As described by the participants in this study, trauma work is more than a job. It has the potential to be life altering for client and social workers, providing great worth and meaning.

## Appendix A

### Email to Targeted Agencies

Dear Colleague,

My name is Meg Myers and I am a doctoral candidate at University of Pennsylvania. I am contacting you regarding potential interviewees for a research study that I am conducting as part of the requirements for my doctoral degree in clinical social work.

I am seeking to interview social workers who have had positive experiences in their work with clients exposed to trauma in an outpatient or intensive outpatient mental health setting. Examples of traumatic exposure are childhood physical and sexual abuse, domestic violence, community violence, war, rape, chronic illness, and disease. I am interested in talking with master's level social workers about their reactions to working with traumatized clients. I am looking for 15 social workers that meet criteria for my study. The criteria include having an MSW, three years or more working at his or her current agency, and with at least half of the caseload with traumatized clients. Only social workers who are not currently experiencing trauma in their personal lives will be included in the study. Participants will be screened prior to the interview to see if they meet criteria for the study. Participation in this study is voluntary and all information from the study will be kept confidential.

The interview will last for approximately 60-90 minutes and will be scheduled at a time convenient to the participant. Payment for participation in the study is a \$25 Amazon gift card.

If you know of anyone who may meet the criteria and is willing to participate in the study, please respond directly to this e-mail or contact me via my cell phone at 484-667-3309.

Thank you for your time.

Sincerely,

Meg Myers MSW, LCSW, ABD  
Doctorate of Clinical Social Work Candidate  
School of Social Policy and Practice  
University of Pennsylvania

## Appendix B

### Email Letter Describing the Study

Dear Fellow Social Worker,

My name is Meg Myers and I am a doctoral candidate at University of Pennsylvania. I am contacting you regarding your potential participation in a research study that I am conducting as part of the requirements for my doctoral degree in clinical social work. Participation in this study is voluntary and all information from the study will be kept confidential.

I am seeking to explore the positive experiences of master's level social workers who work with clients who have been exposed to trauma who are in treatment in an outpatient or intensive outpatient mental health setting. Examples of traumatic exposure are childhood physical and sexual abuse, domestic violence, community violence, exposure to war, rape, chronic illness, and disease.

I am looking for 15 social workers to interview that meet criteria for my study. The criteria include having an MSW, three years or more working at your current agency, and with at least half of your caseload with traumatized clients. Only social workers who are not currently experiencing trauma in their personal lives will be included in the study. You will be screened prior to the interview to see if you meet criteria for the study. The screening process will be conducted over the phone.

I am asking you to participate in an individual interview that will last for approximately 60-90 minutes and will be scheduled at a time convenient to you. If you participate in the study, you will receive a \$25 Amazon gift card.

If you believe you meet the criteria and are willing to participate in the study, please respond directly to this e-mail or contact me via my cell phone at 484-667-3309.

Thank you for your consideration.

Sincerely,

Meg Myers MSW, LCSW, ABD  
Doctorate of Clinical Social Work Candidate  
School of Social Policy and Practice  
University of Pennsylvania

**Appendix C****Screening Form**

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Referral source \_\_\_\_\_

Date of screening interview \_\_\_\_\_

My name is Meg Myers. I am a doctoral candidate at University of Pennsylvania. I am contacting you regarding your potential participation in a research study that I am conducting as part of the requirements for my doctoral degree in clinical social work. I am seeking to explore the positive experiences of social workers who work with clients who have been exposed to trauma who are in treatment in an outpatient or intensive outpatient mental health setting. Examples of traumatic exposure are childhood physical and sexual abuse, domestic violence, community violence, exposure to war, rape, chronic illness, and disease. I am interested in interviewing master's level social workers about their reactions to working with traumatized clients.

In order to determine whether your situation corresponds with our research criteria, I would like to ask you a few questions.

1. Do you have an MSW degree? \_\_\_\_\_
2. Where do you work? \_\_\_\_\_
3. Is this an outpatient or intensive outpatient mental health setting? \_\_\_\_\_
4. What is your title? \_\_\_\_\_
5. How long have you worked at your current agency? \_\_\_\_\_
6. Do you work with clients dealing with trauma? \_\_\_\_\_
7. How long have you worked with traumatized clients? \_\_\_\_\_
8. What percentage of your caseload is with traumatized clients? \_\_\_\_\_
9. Clinicians have a variety of reactions to working with traumatized clients. Have you ever had positive reactions to working with such clients? \_\_\_\_\_

10. Are you currently dealing with a personal trauma? \_\_\_\_\_

11. Are you currently experiencing negative reactions to a client's trauma story? If yes, explain how it is affecting you.

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12. Do you have any questions about this study? (ENCOURAGE AND ANSWER QUESTIONS.)

13. Are you willing to have a confidential interview with me?

\_\_\_ YES                      \_\_\_ NO

14. (If clearly meets criteria for study.) When is it most convenient for me to interview you?

---

(If not sure whether the person meets the criteria, state:) I WILL GET BACK WITH YOU SHORTLY ABOUT WHETHER YOU MEET THE CRITERIA FOR THE STUDY AND ABOUT ARRANGEMENTS FOR AN INTERVIEW.

THANK YOU FOR RESPONDING TO THESE QUESTIONS.

---

**FOR OFFICE USE ONLY**

Does the interviewee meet criteria for study? \_\_\_ YES    \_\_\_ NO

IF NO, or partially, explain \_\_\_\_\_

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Comments: \_\_\_\_\_

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## Appendix D

### Interview Guide

#### A. Organizational Context

- 1) What services does your agency offer clients (and their families)?
- 2) What area do you work in?
- 3) What percentage of your caseload is working with traumatized clients?  
Follow-up:  
What kinds of traumas do they present?
- 4) What theoretical framework do you use when working with traumatized clients?  
How do you find this framework (these frameworks) helpful in working with traumatized clients?
- 5) What influenced you to work with this population?

#### B. Positive Experiences Working with Traumatized Clients

I am interested in exploring with you your positive reactions to working with clients who have experienced trauma. This may include reactions that are mixed, both positive and negative.

I would like you think about a client dealing with trauma who evoked a significant positive personal reaction from you? (Pause while interviewee thinks about a client.)

Would you describe the client's situation and how you were affected? (Please do not mention the client's name). What about this case affected you?

1. (If not mentioned) What kind of trauma was this client experiencing?
2. How would you describe your relationship with this client?
3. Why do you think this case had a positive impact on you?
4. Can you describe ways that it has had a positive effect on you?  
(Follow-up) Could you describe your personal reactions? Tell me about the effect it had on you? (Probe for concrete details).
5. At what point during the client's treatment did your positive feelings emerge?
6. At the times you had positive reactions, what was going in the treatment? What was going on in the relationship?
7. How typical is it for you to have positive reactions to clients dealing with trauma?  
Is this unusual? Why do you think you reacted positively to this client? If unusual, what about this case elicited positive reactions?
8. How, if at all, have any of your positive reactions carried over into your personal life?  
(Probe) If so, how? What has been the effect of this?
9. How, if at all, have your positive reactions carried over to your work with other clients?

10. How, if at all, have your positive reactions carried over to your feelings regarding your agency?
11. Do the positive reactions take a while to develop? If so, at what point do your reactions take a positive turn?
12. How does your client's growth in therapy affect you?
- ~~13.~~ What in your professional life influences your growth or satisfaction in your work with clients? Can you think of some examples?
14. What in your personal life influences your growth or satisfaction with your work with clients? Do you implement any self-care strategies, such as spending time with family or friends, regular exercise, listening to music, other creative endeavors, spending time with pets? What do you find works best for you?

C. Knowledge Development and Support

1. What was your knowledge of trauma theory and practice when first starting your current job? (follow-up) How did you get this information? (probe) Can you tell me more about this?
2. Have you had any additional training on working with survivors of trauma?
3. What, supports, such as supervision and training, are available to therapists at our agency? Have you ever used them? Can you give me some examples? Do you think any of these supports increase the likelihood that you will have positive reactions to your clients? If so, which supports? In what ways?
4. Can you tell me about ways your colleagues talk about effects of working with this population?  
(Probe) What are some examples? Have you learned any coping from them? What kinds of coping methods have you learned from them?  
How, if at all, do your work colleagues support one another?
5. Where do you see yourself regarding your career in five years? (Probe: Do you see yourself continuing to work with people dealing with trauma?)

Debriefing Questions-

1. Is there anything else about your reactions to traumatized clients that you would like to add?
2. Is there anything you talked about earlier that you would like to clarify?
3. Is there anything else that I didn't ask about that would be helpful to understand this experience?
4. What would you tell new workers entering into this position?
5. What advice do you wish someone gave you?

## Appendix E

### Consent form for interview

#### **Introduction and Purpose of Study**

I am a doctorate student in the DSW program at the School of Social Policy and Practice at the University of Pennsylvania. I am conducting a research study as part of the requirements for my doctoral degree in clinical social work. I am seeking to explore the experiences of social workers who work with traumatized clients in an outpatient or intensive outpatient mental health setting. I am interested in talking with master's level social workers about their positive reactions to their work with traumatized clients. Participation in this study is voluntary and all information from the study will be kept confidential.

I am inviting you to participate in this interview.

#### **What is involved?**

I am exploring positive reactions in social workers who work with clients who have been exposed to traumatic life events for my dissertation study and am asking questions related to ways this work positively affected you. I will ask you questions about your overall professional identity (education, job, roles, client base, and experience), the impact on therapists working with clients coping with trauma symptoms, and ways the therapist has experienced positive reactions from their work with clients struggling with trauma symptoms.

The interview will last about an hour. I will make an audio recording of the interview and may take written notes.

#### **Confidentiality:**

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personally identifying information about you or information about where you live or work in my write-up of the interview.

Nothing with your name or other identifying information (names and places mentioned in the interview) will be used in my study. I am the only person who will be able to listen to the audiotape. I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview in my dissertation or any other writings that come out of this project. You will be given a pseudonym in these writings.

**Risks of participating:** The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that the content of what you discussed in the interview is upsetting to you after the interview is over, please be in touch with me. I will provide you with some names and numbers of individuals or agencies that can provide further assistance.

**Benefits of participating:**

Although being interviewed will not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you.

**Payment**

If you decide to participate you will be given gift card (value \$20) when the interview is completed.

**If you have questions about the project after the interview is over, please feel free to contact me:**

If after talking with me you still have concerns, you can contact Dr. Roberta Sands who is supervising this work:

Roberta Sands, Ph.D.

rgsands@sp2.upenn.edu

**Your participation is completely voluntary:**

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not be told whether you participate or not.

If you do decide to be interviewed today, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

By signing this consent form, you are indicating that you have had all of your questions about the interview answered to your satisfaction and that you have been given a copy of this consent form.

Participant signature: \_\_\_\_\_

Participant printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer signature: \_\_\_\_\_

Interviewer printed name: \_\_\_\_\_

Date: \_\_\_\_\_

**Appendix F**

**Face Sheet Information**

Gender \_\_\_\_\_

Ethnicity \_\_\_\_\_

Age \_\_\_\_\_

Year when received MSW \_\_\_\_\_

Post MSW education level, if any  
\_\_\_\_\_

Job title \_\_\_\_\_

Job responsibilities  
\_\_\_\_\_  
\_\_\_\_\_

Years in current position \_\_\_\_\_

Type of agency \_\_\_\_\_

Services offered to clients (in your dept.)  
\_\_\_\_\_  
\_\_\_\_\_

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