THE IMPACT OF HEARING ABOUT TRAUMA ON EXPERIENCED SOCIAL WORK CLINICIANS

Russell B. McCloud

THE IMPACT OF HEARING ABOUT TRAUMA ON EXPERIENCED SOCIAL WORK CLINICIANS

A dissertation submitted to

The Sanville Institute

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy in Clinical Social Work

By

RUSSELL B. MCCLOUD

June 25, 2011

CERTIFICATE OF APPROVAL

I certify that I have read

THE IMPACT OF HEARING ABOUT TRAUMA ON EXPERIENCED SOCIAL WORK CLINICIANS

by

Russell Benson McCloud

and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Alexis F. Selwood, PhD 3/23/11

Alexis F. Selwood, Ph. D., Chair, Date

Samoan Barish PhD 3/20/11

Samoan Barish, Ph. D., Faculty, Date

3/20/11

Brian E. Bride, Ph. D., Associate Professor and Interim Director, Ph. D. Program, The University of Georgia, School of Social Work, Athens, Georgia

Whitney van Nouhuys, PhD 6/9/11

Whitney van Nouhuys, Ph. D., Dean, Date

From: **Permissions Europe/NL** <Permissions.Dordrecht@springer.com>
Date: Thu, Apr 21, 2011 at 12:42 AM
Subject: RE: Permission
To: Russell McCloud <mccloudrussell@gmail.com>

Dear Mr. McCloud,

With reference to your request (copy herewith) to reprint material on which Springer Science and Business Media controls the copyright, our permission is granted, free of charge, for the use indicated in your enquiry.

This permission

- allows you non-exclusive reproduction rights throughout the World.
- permission includes use in an electronic form, provided that content is
  * password protected;
  * at intranet;
- excludes use in any other electronic form. Should you have a specific project in mind, please reapply for permission.
- requires a full credit (Springer/Kluwer Academic Publishers book/journal title, volume, year of publication, page, chapter/article title, name(s) of author(s), figure number(s), original copyright notice) to the publication in which the material was originally published, by adding: with kind permission of Springer Science and Business Media.

The material can only be used for the purpose of defending your dissertation, and with a maximum of 100 extra copies in paper.

Permission free of charge on this occasion does not prejudice any rights we might have to charge for reproduction of our copyrighted material in the future.

Kind regards,

—

Maaike Duine
Springer
Rights and Permissions

—

Van Godewijckstraat 30 | 3311 GX
P.O. Box 17 | 3300 AA Dordrecht | The Netherlands
tel +31 (0) 78 657 6537
fax +31 (0) 78 657 6377
maaike.duine@springer.com

—

From: Rotter, Eugene, Springer US **On Behalf Of** Journal Service Springer NY
Sent: Monday, April 18, 2011 2:54 PM
To: Russell McCloud
Cc: Permissions Europe/NL
Subject: RE: Permission

Dear Russell McCloud,
Thank you for your inquiry. Your email has been forwarded to our permissions and rights department at Permissions.Dordrecht@Springer.com.
Please be advise the response time is 5-10 business days. Your email will be answered in the order it was received.
If you have any further questions, please feel free to contact the above.

Sincerely,
Eugene Rotter
Springer Science & Business Media
Customer Service

From: Russell McCloud [mailto:mccloudrussell@gmail.com]
Sent: Sunday, April 17, 2011 11:53 AM
To: Journal Service Springer NY
Subject: Permission

Dear Springer,

I am completing a dissertation on The Impact of Hearing About Trauma on Experienced Social Work Clinicians. I am requesting permission to use a photocopy of the *Clinical Social Work Journal*, Volume 35, No. 3, September 2007 CONTENTS page (exactly as it is) as a representation of the increased interest in compassion fatigue in an appendix of the dissertation.

Not sure that permission is required but wanted to be sure there were no objections.

Sincerely,
Russell McCloud, Doctoral Student
The Sanville Institute
Berkeley, California

ABSTRACT

THE IMPACT OF HEARING ABOUT TRAUMA ON EXPERIENCED SOCIAL WORK CLINICIANS

RUSSELL B. MCCLOUD

A qualitative research study of five Master's-level social worker clinicians (heretofore most of the research has been quantitative and not exclusively focused on Master's-level social workers), who are not first responders or trauma specialists, with from 25 to 40 years of experience focused on understanding the phenomenon of the impact on them of listening to clients' trauma both in the moment and over time. Burnout, post traumatic stress disorder, compassion fatigue, secondary traumatic stress, and vicarious traumatization are discussed. All participants experienced lasting impact from clients' presentations of traumatic materials and the milieu in which the participants practiced influenced this impact. Participants found various and individual ways of coping with both the impact and the milieu. The lasting impact for the participants in this study was often intense but not necessarily negative as participants found significant compassion satisfaction through their therapeutic endeavors with resilient people. Concepts from attachment theory help frame an understanding of the findings. The importance of support of licensed social work clinicians through supervision is raised.

DEDICATION

This study is dedicated to my parents,

Anna and Scott McCloud,

who always encouraged my curiosity and education.

ACKNOWLEDGEMENTS

Special indebtedness is extended to the participants in this study who made this research possible.

I offer deep appreciation and gratitude to those who have supported me in pursuit of continuing education including Sanville students, faculty (notably William Dombrowski, PhD, who got me excited about research and Mary Combs, PhD, for her thoughtful, detailed reading and feedback on the Protection of Research Participants Application and the proposal) and alumni (particularly Ellen Ruderman, PhD, who has been unwavering in her encouragement from the beginning), work colleagues (especially my manager, Valerie Rausch, MSW), friends and family.

To my Dissertation Committee: Alexis F. Selwood, PhD, both Mentor and Chair; Samoan Barish, PhD, research advisor; and my external reader, Brian Bride, PhD, Associate Professor and Interim Director, PhD Program, The University of Georgia, School of Social Work; so much thanks for your time, energy, effort, and belief in me. Drs. Selwood and Barish, your steadfast insistence that I be authentic while speaking more clearly and concisely has transformed me.

Credit is also given to our Deans, both past and present, and Judith Schore, PhD, Associate Dean, who have been superb role models for continuing education excellence. Additionally, Tina Casenza, Executive Administrator at Sanville, is gratefully recognized for her able assistance in bringing this project to fruition.

Finally, the acknowledgements would be incomplete without recognition to the many people over four decades of professional practice who have come for my assistance and, with that request, have taught me much about how to help.

TABLE OF CONTENTS

CHAPTER 1: STATEMENT OF THE PROBLEM

Over a career exceeding forty years as a social worker in multiple settings and roles and with an emphasis on mental health services, I have become increasingly concerned about how Master's-level social work clinicians may be impacted by their engagement with traumatized clients. The trauma that most concerns me, and on which this research will focus, is the trauma experienced by one human being in relationship to another. Much of that material involves clients' experiences of emotional, physical, and sexual abuse. Bride's (2007) quantitative research of 282 clinicians found that clinicians reported many of the symptoms (including intrusive thoughts, avoidance symptoms, and arousal symptoms regarding client work) associated with post traumatic stress disorder (PTSD). Other examinations, which will be described in greater detail in the literature review, also have demonstrated that social work therapists can be negatively impacted by what they do in trauma work, influencing who they are as professionals and how they practice as clinicians.

This phenomenon potentially carries significant information for social work clinicians about their own attunement and empathic process when working with the traumatized and merits increased understanding as to both the type and extent of the impact on clinicians. The clinical field is now beginning to recognize how wide spread the occurrence of clinicians' traumatic stress actually is. Moreover, the field of mental health needs to understand how clinicians are grappling with and managing their experiences with traumatized clients. Some clinicians experience PTSD-like symptoms including difficulty concentrating, emotional numbness, intrusive thoughts, arousal, fear, helplessness, horror or avoidance of clients as Bride found in his research.

Goals and Purpose of the Research Project

The goal of this work is to describe and to better understand how clinicians experience and process accounts of clients' traumas. The purpose of this research is to assist clinicians' understanding of what can happen or is happening as they are exposed to clients' traumas on a repetitive basis. Moreover, this research may illuminate how the participants are dealing with such situations and any ideas they have about improved agency support.

The potential for greater conceptual clarity about some of the many factors influencing vulnerability to stress states in the study participants is present with this research. Also, how a number of clinicians have addressed and coped with their own reactions resulting from repeatedly hearing clients' accounts of stress from trauma could emerge. Methods implemented by the individual clinician as well as efforts, or lack thereof, of agencies to support clinicians' trauma work could come to light. Findings could foster more dialogue about this critical matter.

Research Question and Design Overview

Question

The question in this research study is: How do Master's-level social work clinicians process the emotional impact of hearing clients' accounts of traumatic experiences?

Design Overview

This study targets social work clinicians practicing in a setting with a mental health emphasis in a public or private agency. Disaster mental health workers and single-

type trauma specialists (e.g., domestic violence counselors, rape crisis workers, first responders in natural or terrorists' disasters) will not be the focus of this study. The design of the project includes a qualitative, exploratory approach with a purposive sample. The experiences of five Master's-level social work therapists, each with a minimum of ten years of experience in generalist practice, confronted with clients' trauma that is uncomfortable, extreme, unexpected, shocking, unforgettable, frightening, serious, grave and dangerous were queried. At a mutually agreed upon site, convenient for the participants, face-to-face interviews were audio taped and, subsequently, confidentially transcribed. I was looking for the layers, patterns, and themes in participants' responses about the internal, subjective impact upon repeatedly hearing about traumatic events from their clients. A face-to-face interactive interview is an ideal manner for participants to reveal their coping styles, support resources, and reactions in trauma work.

Theoretical Framework and Conceptual Focus

An attachment theory framework was used in this research project. Attachment theorists believe that therapy treatment is a dyadic, intersubjective, right brain process in which empathic engagement by the therapist can serve to emotionally contain and regulate the person seeking therapeutic assistance. Some professionals believe that empathic engagement (an essential ingredient in a functional attachment relationship) is the conduit through which therapists are stressed by what they hear. This stress is variously referred to in the mental health traumatology literature as burnout (BO), post traumatic stress disorder (PTSD), compassion fatigue (CF), secondary traumatic stress (STS) and vicarious traumatization (VT).

In an attachment frame, one accepts the dominance of right brain processing in traumatic stress so then concern surfaces for the subtle and unconscious process that may be occurring in the therapist's right brain. According to Pearlman and Mac Ian (1993), secondary traumatic stress results from day-to-day listening to the trauma of others. Therapists' premises about the world, its operation, and one's place in the scheme of things may be impinged upon (a key concept in attachment theory) and altered by emotionally overwhelming accounts of trauma shared by clients (Cunningham, 2003; Danieli, 2003).

"A traumatic memory will be imprinted deeply as a one-time-and-forever learning experience. . . . Once was enough for our neurobiology to get it. Now, we're hardwired for an immediate response that bypasses cognition altogether" (Naparstek, 2004, p. 82). Therapists' attunement may waiver as they disengage for self-protection, and clients may be left feeling vulnerable and powerless in that moment. For a therapist to avoid a parallel process of dissociation, particularly if the traumatic material being heard resonates with a therapist's own personal trauma history, a therapist needs a secure attachment base and style to act as the secure base for a traumatized person. The attachment relationship between them may host reparative work as long as the therapist corrects misattunements, which occur in all interpersonal relationships, through recognition of the misattunement and empathic re-engagement as rapidly as possible. Attachment type and response style to trauma provide a foundation for understanding how the repetitive experience of listening to traumatic material may be associated with prior personal and clients' traumas. Unless a therapist is securely attached, dissociated experiences may be carried and may remain outside the treatment room for a very long while.

The ideas from attachment theory of attunement in relationships, impingements, right brain processing, and secure attachment base will be used to help frame understanding of the participants' subjective process and of the analyzed data in the discussion.

Significance of Study: Contribution to General Knowledge and Clinical Practice

This research project is significant due to its qualitative methodology and an exclusive focus on experienced, Master's-level, social work clinicians (at least ten years post licensure) who are generalists in a mental health setting. The bulk of prior research and conceptual writing in the past twenty years in mental health traumatology has been quantitative and focused on disaster mental health workers and trauma specialists who are not necessarily social workers. Another contribution of in-depth focusing on a number of social work clinicians is that such a concentration will help illuminate how what seasoned clinicians experience in their trauma work is similar or dissimilar to the literature and documented research in mental health traumatology about listening to, processing, and managing repeated accounts of clients' traumas. A unique potential contribution is the identification of what study participants feel agencies might offer by way of support to their frontline, generalist clinicians. Finally, the findings from this research effort will reveal coping skills, support resources, and reactions from trauma work of the select group of participants which could foster increased attention to and dialogue about this important phenomenon and its potential repercussions in the field of social work.

CHAPTER 2: LITERATURE REVIEW

How mental health clinicians are impacted by clients' presentations of traumatic materials is the focus of this literature review. Increasingly, that developing body of knowledge is found in the field of mental health traumatology. Donovan (1991; 1993) coined the term traumatology, which took on a broader meaning than the idea of physical trauma in general medicine, by encompassing natural disasters and man-made trauma. Trauma at the hands of people can be accidental or by choice and includes "the social and psychobiological effects thereof, and the predictive-preventive-interventionist pragmatics which evolve from that study" (1991, p. 434) of trauma. "Neither countertransference nor burnout alone adequately accounts for the impact on the clinician of the graphic material presented by the traumatized client" (Cunningham, 2003, p. 451). This research project begins by examining the broad conceptual and research literature of the past three decades in mental health traumatology to explore at a deeper level the well-documented, variously labeled and differing viewpoints about the impact on therapists of listening to human traumatization. The goal of this qualitative research effort is to arrive at a richer phenomenological understanding of how five Master's-level social work therapists, who are experienced frontline clinicians in mental health settings, process that impact in their work in the therapeutic moment and on a continuing basis in their practices.

As a result of the burgeoning interest in the field of mental health traumatology in the past two decades, Morrissette (2004) notes that the field is at a time of consolidation and clarification including "information synthesis and construct differentiation" (p. xvii). Conceptual and theoretical writing along with research studies have advanced the field while triggering the collateral difficulty in identifying "relevant information and

differentiating one construct from another" (p. xviii) in traumatology. This review consists of five sections of pertinent literature to assist the reader in understanding the dynamic and ongoing evolution of our phenomenological understanding as it relates to the potentially negative impact on clinicians of listening to accounts of trauma in all its forms.

To date, the constructs that have been most frequently identified with therapists' stress from listening to accounts of trauma are detailed in Sections One and Two. Those with a potentially negative psychological and personal influence for the therapist, in other words, those stress states that may exceed a clinician's coping capacity, are compassion fatigue (CF), secondary traumatic stress (STS), vicarious traumatization (VT), burnout (BO), and post traumatic stress disorder (PTSD); one with a possible positive result, compassion satisfaction (CS); and another that could be either or both positive and negative in terms of impact on the therapist, countertransference (CTR). Section Three elaborates on professional thinking about how clients' traumatic materials get connected to clinicians. Quantitative literature dominates Section Four but the limited qualitative research projects are also highlighted. Very recent work which attempts to reconfigure and blend the ideas of the previous four sections will be reviewed in Section Five of this chapter. Perhaps, Figley (2004) has put it best in talking about how clinicians process possible stress associated with listening to clients' traumas: "Listening to clients who have been traumatized is very challenging work, leaving fingerprints on the heart which are sometimes difficult to manage or erase" (p. xi).

Section One: Starting Points

In this part, the forerunners of current conceptualizations of trauma impact on clinicians will be defined and briefly explored from their beginnings in the nineteen seventies and early eighties. The next Section will define the more recent labels for the impact of listening to clients' accounts of traumatic materials. Later segments will reference the materials offered in these first two sections.

Burnout (BO)

Although Freudenberger is credited for introduction of the term BO in 1974 (Um & Harrison, 1998), Maslach is credited with "explicating" it two years later (Figley, 1995). In 1981, Maslach and Jackson developed the *Maslach Burnout Inventory* (MBI) to measure the "cost of caring" over time, a tool still available and in use today (Maslach, 2003, p. 11). The idea, "cost of caring," was used simultaneously in separate work by Figley and by Stamm (1999) to describe CF and STS, which will be examined in Section Two below. They credit Joinson (1992) from the field of nursing for first using the concept in print to describe BO among nurses.

Maslach wrote *Burnout: The Cost of Caring* in 1982. She originally defined the core of BO as "a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people-work' of some kind" (p. 2).[1] In the Forward of the 2003 re-publication of her 1982 book, Maslach notes that "burnout was first identified within the people-oriented, human service professions" and that the core dimensions have evolved over twenty years and become "*Exhaustion* (the individual stress response), *Cynicism* (the negative reaction to others and the job) [and] *Inefficacy* (the negative evaluation of one's own accomplishments)"

(Maslach, 2003, p. xvii; [writers]). In her manuscript, Maslach (2003) describes an exhausted person: "It's not that I don't want to help, but that I can't – I seem to have a 'compassion fatigue.' I just can't motivate myself to climb one more mountain" (p. 3). Use of CF in Maslach's example of BO contributes to the conceptual conundrum Morrissette (2004) identified relative to understanding and differentiating the terms used to describe the potential stress states clinicians might experience while listening to accounts of trauma.

The stressing process in BO according to Maslach (2003) is that emotional exhaustion leads to detachment in order to keep feelings of those in need away from the listening clinician while triggering depersonalization or disdain for those seeking help. Finally, in guilt about thoughts, feelings and actions toward help-seekers, the helping professional senses personal inadequacy, failure and a mismatch between themselves and the work they wanted to do to help people and they enter a burnout syndrome according to Maslach. However, as Deighton, Gurris, and Traue (2007) point out, the work that triggered the BO syndrome is "not specific to work with traumatized people" (p. 64), as it is in other formulations of therapists' potential stress states; e.g., CF, STS and VT. Furthermore, "burnout is not a precise enough term . . . can have a blaming component . . . [and the] unspoken message is if you are burned out its already too late" (Fahy, 2007, p. 201).

Post Traumatic Stress Disorder (PTSD)

In close timing with Maslach's work in the early 1980s and fueled by the consequences of wars, industrialization, natural disasters, sexual assaults, and child neglect and abuse in all its forms, the American Psychiatric Association (APA) added a

diagnosis of PTSD into the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) in 1980. That definition has evolved through the revisions to the manual in 1987 and 2000. PTSD is currently defined as:

> the development of characteristic symptoms following [after one month] exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experience by a family member or other close associate. (*DSM-IV-TR*, 2000, p. 424)

The ideas of "witnessing" and "learning" have grown from the original *DSM idea of* "direct personal experience."

Immediately after APA's action, concerns surfaced not only for secondarily traumatized family and friends of the victimized but for human service professionals who repeatedly listen to the facts and emotions as trauma is disclosed and PTSD is diagnosed. In fact, that reality was used as an argument by Figley[2] (1995) for inclusion of another diagnosis: Secondary Traumatic Stress Disorder (STSD) in any subsequent revisions of the DSM. Stamm (1999) revealed she felt similarly. However, Van Tuinen-Youngs (2005) opposes identifying a therapist's stress from listening to accounts of trauma as a disorder in DSM noting minimal quantitative research supporting that opinion and few in the field beyond Figley who support such a diagnostic category. Morrissette (2004) notes that PTSD alters relationships but interpersonal relationships, including psychotherapeutic ones, may also regulate PTSD. Morrissette also provides a helpful

table outlining symptomatology of PTSD divided into emotional, cognitive, physical and behavioral aspects (p. 45).

Terrorists' activities have brought into focus the issue of client and clinician shared PTSD through events like the Holocaust, 9/11, and Racanelli's (2005) study comparison of New York and Israeli social workers. Until recently, writing about PTSD and STS included the idea that the trauma belonged only to the client, but 9/11 brought to the forefront in the United States that client and therapist could share the same trauma.[3] Although STSD has not been included in the DSM to date, further conceptual writing (Section Two) and a growing body of quantitative research (Section Four) focusing on the shock of trauma on psychotherapists proliferated throughout the 1990s.

Section Two: Further Conceptualization

In this segment, the definition and evolution of contemporary, frequently utilized terms in the literature to describe clinicians' risks and benefits in trauma work will be reviewed along with the interrelationships that have developed since the constructs came into accepted professional use.

Compassion Fatigue (CF)

Figley (1995, 2002a, 2002b, 2006) and Stamm (1999, 2002) produced pioneering literature related to what can happen to a practitioner in mental health service as they are exposed to clients' traumatic materials. Figley began his conceptualization with a reference to a form of burnout or secondary victimization that rapidly transformed into compassion fatigue in 1978 following his service in Vietnam and his escalating interest in returning and traumatized veterans. By 1993, the idea of the "natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced

by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7) had evolved as the definition of CF. The quoted material also became the definition of STS for which Figley said compassion stress and CF were appropriate substitutes (p. 9).

CF was described as exhaustion, hypervigilance, avoidance and numbing often experienced by professionals working with PTSD sufferers and their family members. Although distinction between the terms CF and STS has blurred to the point that they have often been used synonymously in the professional literature, originally CF was seen as a *process* (as Maslach's material on BO above inferred) and a gentler and, therefore, preferential term (Figley, 1999) to STS, which was viewed as an acute condition or *reaction.* Fahy (2007) sees CF as "a more useful [than STS] solution[s] focused term [which] encourages workers and supervisors to dialogue about solution[s] to the hazards of empathic work" (p. 201). Figley wrote that four other factors contributed to therapists' vulnerability to CF:

1. Empathy is a major resource for trauma workers to help the traumatized;
2. Many trauma workers have experienced some type of traumatic event in their lives;
3. Unresolved trauma of the worker will be activated by reports of similar trauma in clients, and
4. Children's traumata are also provocative for caregivers. (pp. 20-21)

CF became the focus of the *Clinical Social Work Journal* published in 2007 (see Appendix A for journal table of contents). Summarizing from the journal issue, again STS is viewed as a condition whereas CF is seen as a process (Fahy p. 202) in which

client and therapist share an uncertain world that exacerbates the possibility of CF (Tyson, 2007). Using Figley's model of the compassion fatigue process to illustrate, Campbell (2007) adds that residual compassion stress coupled with prolonged exposure to suffering, traumatic memories and other life demands can lead to CF. She says, "When exposure to suffering lasts too long, compassion can turn to apathy and then resentment" (p. 169).

Sounding remarkably like Maslach's configuration of emotional exhaustion, depersonalization, and inefficacy in BO, CF characterizes a professional who is less conscious, dissociates from self, and distances from others (Tyson, 2007) while showing decreased clinical effectiveness, a focus on compassion fatigue versus satisfaction and the possibility of leaving the field under duress (Bride, Radey, & Figley, 2007). These same authors assert that professionals are obligated to take responsibility for self assessment for CF (seen as normal in work with the traumatized) and Campbell (2007) believes CF must be addressed "to continue ethical practice as a mental health professional" (p. 170). Finally, to balance CF, a CS model was introduced in the special journal issue.

Over time, a person experiencing CF could develop intrusive thoughts, difficulty concentrating, emotional numbing, an increased startle response, irritability, sleep disruption, or any other PTSD-like symptom.

Secondary Traumatic Stress (STS)

In working with trauma sufferers, Figley (1995) used the term secondary traumatic stress (STS) interchangeably with CF and to describe a disorder according to Baird & Kracen (2006). Agreeing, Stamm (2002) tagged the shock on the helper in working with traumatized others as STS. Figley offers that "STS includes but is not

limited to what . . . professionals view as countertransference" (p. 14). He goes on to explain that CTR is a therapist's reaction to client transference with potentially negative therapeutic consequences that are to be prevented or eliminated while STS is seen as "a natural by-product of caring for traumatized people" (p. 11). Fahy (2007) suggests that STS mimics, in the therapist, the symptoms of PTSD with which the client presents. A person experiencing STS could develop intrusive thoughts, difficulty concentrating, emotional numbing, an increased startle response, irritability, sleep disruption, or any other PTSD-like symptom from a single contact with a traumatized client. The secondary reaction of the therapist to the client's report of experiencing trauma is STS (see Morrissette, 2004).

Figley (1999) notes STS symptoms can emerge suddenly with a sense of helplessness, confusion, isolation, and symptoms disconnected from real causes. Stamm (2002) further holds that there can be other reactions, like depression, anxiety, or substance abuse rather than STS. Collins and Long (2003) credit Figley with reviewing the literature and ascertaining that STS was demonstrated in three ways: Indication of psychological distress or dysfunction, cognitive shifts and relational disturbances. These indicators sound strikingly like VT.

Vicarious Traumatization (VT)

Over time, clinicians empathically engaging with traumatized clients normally develop vicarious traumatization (VT) which is a cumulative, pervasive and permanent shift in the therapist's cognitive schema but not necessarily accompanied by the signs and symptoms of PTSD (Adams, Boscarino, & Figley, 2006; Baird, 1999; Baird & Kracen, 2006; Harlan, 2004; McCann & Pearlman, 1990; Morrissette, 2004; Munroe, 1999;

Perlman, 1999; Pearlman & Mac Ian, 1993; Pearlman & Saakvitne, 1995; Pinto, 2001; Racanelli, 2005; Rodrigo, 2005; Saakvitne, 2002; Sharman, 2002).

Stamm (1999) says VT always arises as a result of exposure to a client's traumatic material and is about how that secondary exposure affects our lives, our relationships with self and others and our work. VT conceptualization reflects constructivist self development theory (Saakvitne & Pearlman, 1996) and evolves from internal working models established during the developmental process (consistent with attachment theory). Models are the foundation for cognitive schemas which relate to the psychological needs of safety, trust, esteem, intimacy, and control. VT may alter a therapist's beliefs in relation to self and other and impact the identity, world view, psychological needs, beliefs, and memory system of the therapist.[4]

Compassion Satisfaction (CS)

When a therapist offers help to a traumatized person who accepts the offer and uses it productively for positive gain, the professional may feel useful and awed by human resiliency and in a state of CS (Stamm, 2002). That condition may alter a therapist's cognitive schema in a positive fashion if the therapist experiences courage and stamina in the client who comes back from traumatization stronger, wiser, and more hopeful than ever. Moreover, CS may counterbalance CF leading to a balancing out of the stress accumulation for the therapist who is listening to trauma accounts. Good feelings about client outcomes may minimize the potentially negative and difficult reaction states from trauma work.

It is possible for a therapist to have both a stressful (CF, STS, VT, BO) and non-stressful experience (CS) simultaneously as one does not exclude the other (Baird, 1999;

Bride & Figley, 2007; Drake & Yamada, 1995, 1996). Danieli (2006) wrote of the complexity of trauma reminding "that vulnerability and resilience exist simultaneously rather than being mutually exclusive, as some in the field have held" (p. 34). Drake and Yamada (1996) reported that emotional exhaustion is the key ingredient in BO while personal accomplishment, the benefit Stamm highlights in CS, moderates both emotional exhaustion and depersonalization (a second factor in BO).

Radey and Figley (2007) created a model for CS that uses "discernment and judgment" (p. 207) from positive psychology with a social work perspective that holds affect, work resources, and self-care as influences on the positive or negative feelings about one's work. "Although we do not have the answers to solving all of the complex realities that clinicians face, we propose that promoting satisfaction, rather than avoiding CF, can protect them from the negative consequences of working with trauma sufferers" (p. 208).

Countertransference (CTR)

A final and, perhaps, more familiar conceptualization for mental health therapists to encounter when exposed to clients' traumatic material is CTR; the therapist's emotional reaction to the client. Mentioning Freud as context for his statement, Figley (1999) says CTR "in the context of psychotherapy is the distortion of judgment on the part of the therapist due to the therapist's life experiences and is associated with her or his unconscious, neurotic reaction to the client's transference" (p. 13). Figley adds that a more contemporary view of CTR is:

> It includes all of the emotional reactions of the therapists toward the patient – irrespective of the source. This includes . . . the life stressors – past or present –

> experienced by the therapist. But it also includes the therapist's absorption of the traumata expressed by the client. (p. 14)

Saakvitne and Pearlman (1996) note that countertransference, which affects expectations of self and clients, can be revealed as anger when goals are not met or as shame and guilt when progress is slow. Nevertheless, some have argued that CF, STS, VT and CS are mere restatements of CTR and, as such, are superfluous (Kanter, 2007; Van Tuinen-Youngs, 2005; Wilson & Thomas, 2004).

Specifically, Kanter (Kanter & Berzoff, 2009) believes that all the labels for therapists' traumatic stress beyond CTR are misleading in that they ignore the clinical profession's psychoanalytic roots as well as the countertransference literature. Racker's (1981) work on concordant and complementary identification is echoed in Van Tuinen-Youngs' (2005) work which states: "Countertransference provides the therapist with a potent theoretical construct for understanding their responses to patients' traumatic materials, by helping the therapist to understand and manage projective identification effectively" (p. 52).

Nonetheless and contrary to Kanter's assertions, not everyone who has written about the impact of trauma work on therapists has ignored the countertransference connection or its possible implications (Fauth, 2006; Pearlman & Saakvitne, 1996; Sabin-Farrell & Turpin, 2003; Salston & Figley, 2003; Stamm, 1999; van der Kolk, McFarlane & Weisaeth, 1996; Wilson & Thomas, 2004). The countertransference reaction that Kanter finds lacking in the traumatology research focusing on clinicians' reactions to clients' traumas is acknowledged within the context of past negative or unresolved experiences of a therapist's including a therapist's projections in relation to a specific

client (Stamm, 1999). CTR is a distinct construct which may be affected by the stress states of the therapist, especially, VT. Figley states therapist's qualities which help manage CTR include anxiety management, conceptualizing skill, empathic ability, self insight and self integration; the last two being most important according to a panel of experts (Figley (1999), p. 14).

Adams et al. (2006) identify conscious and unconscious, physiological and psychological impact on helpers who are engaged with the traumatized. Those writers' differentiation between CTR and the potential stress states (e.g. BO, CF, STS, and VT) of therapists is that the former, CTR, relates to therapists' reactions with a specific client and not only to clients who have been traumatized. The reactions in CTR are not necessarily carried to therapeutic work with other persons the therapists may be treating as BO, CF, STS, and VT might be. Some, like Stamm (1999; 2002), have argued that BO may be co-morbid with other potential stress states of therapists. In particular, Chrestman (1999) identified the difference in STS from the general concepts of countertransference and burnout: "The secondary post-traumatic stress reaction is a response to characteristics of disclosed traumatic events which the therapist has not experienced directly" (p. 30).[5]

Summarizing From the Literature Reviewed for Section Two

BO is not specific or limited to a clinician's potential work stress response from serving the traumatized population seeking mental health services as BO can develop in work with any population. PTSD references the past trauma symptomatology of a client from their actual trauma which, secondarily, becomes a potential issue for the therapist in the form of or CF, STS or VT as a result of the clinician's empathizing connection and attachment with the client. STS is a "harsh name" (Stamm, 1999, p. xx) drawn from the

association with PTSD (CF and STS produce signs and symptoms similar to PTSD). STS may emerge as an acute symptom state after a single contact while BO, CF, and VT represent conditions that more likely develop over time. VT may become apparent as more pervasive shifts in a therapist's feeling, thinking, and behaving over time from cumulative exposure to the traumatized and may be a precursor to BO (Weaks, 1999). VT, unlike BO, may involve feelings of helplessness, confusion, and a sense of isolation from support system (Weaks, 1999). VT sounds like an affliction that employing entities don't want any more than they want the expense of BO (when people leave the field) while CF is a more "palatable" identification as it makes caring sound noble (Stamm, p. xx). VT and STS/CF are "concerned with the negative ramification for the counselor, directly related to the exposure to the client's traumatic material" (Stamm, p. 18). Finally, CF and STS are seen as having broader impact than CTR on a therapist and their overall work. BO and VT, with their gradual impact on a therapist's life, on the relationship with the self and on their work over time make those stress states much more deeply rooted and pervasive. As such, those occurrences are more influential in changing a therapist at the level of their cognitive schema about life and living (Perlman, 1999; Saakvitne & Pearlman, 1996; Stamm, 1999). CTR is a response that is linked to a specific client-therapist dyad and, although potentially uncomfortable and dysregulating for the therapist, CTR is not necessarily subject to carryover in work with other clients.

Section Three: Mechanisms of Attachment and Empathy in Trauma Work

This section of the literature review offers an overview from a neuroscience perspective of how early attachment processes and empathy influence therapeutic endeavors with traumatized people.

Neuroscience and attachment theory hold that the right brain, the affective, non-linear, and non-linguistic brain is dominant in the first three years of life. Sensory experiences reflected, amplified, or lessened in the attuned caregiver-infant dyad are the essential food for brain development and maturation in the infant when processed in a positive affective atmosphere within that relationship. "The maintenance of positive affective states associated with dyadic experiences of affective resonance has been suggested to be crucial to optimal neurobiological development" (Fosha, 2003, p. 225). Fosha cites Schore in her statement:

> The positive affects associated with this moment-to-moment, dyadic, right-brain to right-brain affective experiences are the stuff of secure attachment (Schore, 2000). And secure attachment is at the foundation of optimal mental health and resilience, and operates as a powerful protective factor against the development of trauma. (p. 225)

Also, clinicians have learned from primate research, including infants and primary caregivers, that mirror neurons in the right brain allow us to take on the body posture, facial expression, intensity, tone and pace of the other to catch their feeling state. Empathy and caring trigger the attachment behavioral system (Racanelli, 2005, p. 86) which allows the infant to expand their worldly explorations so critical for brain maturation. Meanwhile, the reliable, affectively competent and secure caregiver stands ready for "lending a hand" (Fosha, 2003, p.227) as safe base should exploration develop into high stress states such as fear, anxiety or fight, flight or freeze.

However one chooses to label the stress and aftermath of therapists' experiences from listening to repeated accounts of trauma, there is general consensus in the literature

that empathic engagement appears to be the likely route through which, potentially, therapists are dysregulated (e.g., stressed as in CF, STS, VT or BO) by the trauma revelations of their clients (see, for example, Danieli, 2006; Figley, 1999; McCann & Pearlman, 1990a, 1990b; Perlman, 1999; Schore, 2007; Stamm, 1999; van der Kolk et al., 1996). Using a neurobiopsychosocial idea in contemporary, intersubjective psychodynamic thinking (subsequently referred to as neuroscience) with an attachment theory framework, the client's right brain unconscious mind is in communication with the therapist's right brain unconscious so that the empathically engaged therapist is susceptible to "catching"[6] the emotional intensity and profound across-the-board disruption caused by trauma in their clients' lives (van der Kolk et al., 1996; Wilson & Thomas, 2004).

Concurrently, a therapist may not be aware of being drawn into enactments and becoming strained as they are operating in an unconscious, right brain to right brain interactive process in an attempt to regulate the emotional and physiological state of the client. Schore (2007) is explicit about this:

> In order to optimally regulate patient's stressful psychophysiological CNS and ANS arousal deficits and re-establish homeostatic equilibrium, the therapist must be empathically resonating, while under relational stress, in a right dominant state of nonverbal communication and implicit interactive regulation. In order to regulate patient's state of hyper or hypoarousal, therapists must enter into the state. (p. 1)

From an attachment theory frame in relationship to empathy, "In one bold move, empathy becomes a central tool for serving the most basic adaptational aims of the

human being. And the right-brain to right-brain communication underlying empathy becomes crucial to both the developmental and therapeutic endeavors" (Fosha, 2003, p. 228). The dynamics in the therapeutic dyad are similar to a good-enough, affective connection of parent and child. In fact, "...therapist activities that promote the patient's sense of safety are essential and underlie otherwise frightening emotional explorations" (Fosha, 2003, p. 230). Moreover,

> Internal working models may guide the affective reactions and responses of such clinicians to the traumatic material of their clients. Consequently, stable internal working models, or the activation of a secure attachment behavioral system, may provide resiliency against a negative impact from the traumatic affect presented during the provision of treatment. (Racanelli, 2005, p. 70)

According to Saakvitne and Pearlman (1996), a therapist's vulnerability to negative consequences is highly complex and depends on the situation and clinician's action including

> work setting, type and number of clients and their traumas, nature of exposure to trauma, and the social, political, cultural contexts of the original trauma and the current work . . . and professional identity, resources, support, personal history, current life circumstances, coping style of the therapist. (p. 26)

In attachment terms, Saakvitne and Pearlman are discussing the impingements or variables that may interfere with attunement of the therapist with the client. The information clients share can challenge the therapist's own cognitive schemas or world views (Daniele, 1994) and intrude, especially when what is shared with intensity resonates with the therapist's own history, especially personal trauma history (Horowitz,

2006). Staying present and empathically engaged may activate the therapist's own fears and traumas "forcing them to choose whether to explore their reaction or push the patient away" (Perlman, 1999, p. 94). Empathy gets to the heart of clients' feelings surrounding trauma, especially from abuse, and provides therapists with an experience of their own feeling reactions to the trauma shared. The urge for the therapist to detach and to numb the self to the victimization and to the inhumanity of the perpetrator is strong (van der Kolk et al. 1996).

Wilson and Thomas (2004) resonate with that thinking in their discussion of the more than forty year old concept of "psychic numbing" which is misattunement. The therapist misses cues about behavior patterns projected by the client into the transference. "In some instances the presence of 'psychic numbing in the therapist' may be a 'mirror reflection' of '*psychically numbed patients*', wherein the therapist unwittingly and unconsciously takes on the same 'defensive armor' as his patients" (p. 124).

In talking about therapists' anxieties around empathic engagement while listening to clients' traumatic materials, Wilson and Thomas (2004) also discuss Dalenberg's (2000) study of treatment experiences and quote her: "The discomfort of the therapist in listening to trauma might not be an active (or even unconscious) wish to avoid, but rather a manifestation of the fear of causing further client distress" (p. 139); e.g. a reenactment and re-traumatization. Munroe (1999) went further and advocated for therapists' upfront disclosure to clients about potential stress states (e.g., CF, STS, VT and BO) developing for the therapist. He included advice that the therapist reveal that she is prepared for that possibility so that the client doesn't need to worry about protecting the therapist or about the therapist's capacity to hear what they have to share.

In something of a dissent in the literature reviewed, Jenkins and Baird (2002) questioned the empirical proof that empathy is the route to STS. Badger, Royse, and Craig (2008) surveyed hospital social workers (n=121) with the premise that remaining empathically engaged while emotionally separated might protect the therapist from a stress state. "However, dispositional empathy lacked explanatory potency in this study. Instead, these findings suggest that emotional separation, or the component of empathy representing differentiation from the patient, may more precisely represent professional vulnerability" (pp. 68-69).

Summarizing this section, the positive affective experience of right brain, dyadic, affect regulation is considered to be at the base of secure attachment, mental health, resilience and "operates as a powerful protective factor against the development of trauma" (Fosha, 2003, p. 225). Within their internal, limbic-based emotional system, the psychodynamically attuned and attachment savvy clinician through empathic engagement works to accurately identify and experience the feeling state of the client through comparison to their own internal working models, and, in some cases, to their own personal trauma history. Attunement to a client is not perfect and can be disrupted unintentionally (through misunderstanding) or intentionally (to challenge resistances and defenses) but then repaired through re-attunement by the therapist with a client. However,

> Empathy, attunement, and the establishment of security and safety are essential, but not sufficient. The bond that gets created as a result of dyadic processes, the adult therapeutic equivalent of secure attachment, serves as a matrix, a holding environment in which deep emotional processes, the kind mediated by limbic system and right brain, can be experientially accessed, processed, and worked

> through, so that they can eventually be integrated within the individual's autobiographical narrative. (Fosha, pp. 231-232)

The inference is that anxiety in the therapist may be an early warning of potential re-traumatization for the therapist and/or the client; some view this as countertransference. Additionally, a securely attached therapist may have greater capacity in the form of resiliency to stay with the feelings they are experiencing from clients and within themselves regardless of the emotional states clients present.

Section Four: Quantitative and Qualitative Research Studies

In this part, I will examine research studies that relate to the types of stress states for which therapists may be at risk as a result of ongoing exposure to clients' accounts of trauma. A number of the studies investigate multiple constructs within the same project. Moreover, the bulk of the studies are quantitative but there are a few qualitative projects, so the section will be separated into quantitative and qualitative research studies. Titles of the research are included in *italics* to facilitate understanding of how the field has been progressing toward a more complete understanding of the phenomenon: the impact of repeatedly hearing clients' accounts of trauma.

Quantitative Studies

In studying Florida social workers, Drake and Yamada (1996) found that variables within the clinical setting, including conflicting roles, could lead to frustrations and then symptoms characteristic of CF and STS; e.g., PTSD symptomology. Titled *A Structural Equation Model of Burnout and Job Exit Among Child Protective Services Workers*, their study of 228 participants excluded 62 subjects in private practice. High discrepancy between advocacy for working issues through and actual degree of working through was

associated with not only BO, but also with other work-related symptoms, including job dissatisfaction. Moreover, low degree of working through was related to CF, BO, and distress while co-worker support was found to moderate BO in this quantitative study.

On a similar path, one hundred German therapists who served torture victims were studied by Deighton et al. (2007). Their study, *Factors Affecting Burnout and Compassion Fatigue in Psychotherapists Treating Torture Survivors: Is the Therapist's Attitude to Working Through Trauma Relevant?,* established that clinic settings where there was high advocacy for working through trauma with clients but low achievement of that practice standard (again, role ambiguity and role conflict or impingements in an attachment theory framework) evoked frustration and greater vulnerability for CF in clinicians. This research supports what Drake and Yamada (1996) found also. Another quantitative study: *Role Stressors, Burnout, Mediators, and Job Satisfaction: A Stress-Strain-Outcome Model and an Empirical Test,* of 165 Florida social workers by Um & Harrison (1998)) found and supported the idea that role conflict and role ambiguity indirectly affect coping strategy through their effects on BO. They also found, similar to Drake and Yamada, social support and coping strategy oppose the growth of BO and job dissatisfaction while, reciprocally, BO has a negative impact on coping strategy and job satisfaction. Um and Harrison suggested that social workers are often involved with untreatable issues arising from complex problems for hard-to-reach people with limited resources where outcomes aren't usually seen by the helper. They also determined that a higher trauma caseload escalated the therapist's stress level and signs and symptoms of STS. Role ambiguity, role conflict, and size of trauma caseload are factors in agency settings not directly under clinician control. "These findings indicate that it is not the

exposure itself so much as what the therapist does in the face of the exposure, which represents a risk factor for work-related symptoms" (pp. 71-72), which echoes the 2006 conclusions of Adams et al. in their study 2006, *Compassion Fatigue and Psychological Distress among Social Workers: A Validation Study.*

Kassam-Adams' (1999) study, *The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists*, considered one hundred outpatient psychotherapists, with a Master's or doctor's degree in Maryland and Virginia, treating sexually traumatized clients. Most were social workers in community mental health settings, female and Caucasian with an average of more than eight years of experience. Using the Personal Strain Questionnaire and the Impact of Life Event Scale, Kassam-Adams found that STS was unlike general occupational stress. Moreover, exposure to the sexually traumatized through one's caseload, gender and personal trauma history predicted intrusive and avoidant symptoms (part of STS) in therapists.

Just a year after Um and Harrison's (1998) work, Baird's (1999) research survey, *Vicarious Traumatization, Secondary Traumatic Stress, and Burnout in Sexual Assault and Domestic Violence Agency Staff and Volunteers*, posted similar results in relationship to trauma caseload size. Baird studied eight Dallas/Fort Worth, Texas agencies using sexual assault (SA) and domestic violence (DV) volunteers and paid staff (n=105). She found that greater exposure to SA/DV survivors (trauma caseload) correlated with higher rates of STS, VT, BO, and general distress symptomatology in staff as measured by the scales for CF/CS, VT and BO. BO symptomatology (measured by the MBI) was not related to a history of personal trauma. Personnel with SA or DV history plus related therapy for the violence had lower levels of CF/STS, VT and BO than those with that

trauma history and no treatment. A hoped for goal in this quantitative research was to propel investigators in the two, presently disparate fields [at that time] of STS and VT studies to join forces in the desire to understand people's secondary/vicarious assimilation of trauma.

Harlan's (2004) study, entitled *Compassion Fatigue and Masters Level Social Workers in Direct Mental Health Service Delivery*, interviewed 103 therapists, both male and female, in Virginia with a Master's degree or higher in both public and private mental health agencies. It found that workers in a public agency work setting were at greater risk of developing CF and that BO may be a "latent variable" in the development of CF. There were no significant differences in findings based on education or on gender but Harlan concluded that the research on gender has found both significance and non-significance in other investigations and requires further study before conclusions about gender influence in the development of CF can be reached.

Sharman's (2002) Master's thesis, *Secondary Traumatic Stress in Mental Health Clinicians*, used mixed method research which reached out to 80 western Canadian mental health clinicians (n=41; varied settings including 34% case mgmt, 24 % brief therapy and 19% crisis, etc; 18% or about seven of the participants were social workers) and found discipline, work setting and personal trauma history influenced the development of STS according to the quantitative data. This investigator notes the small sample and that the percentages may have little meaning in terms of broad generalizations about Canadian or other mental health clinicians. Most found the work satisfying so BO was not an issue according to Sharman. Nonetheless, 36% of participants scored high to extremely high STS as measured by the Compassion Fatigue Self Test and 24% moderate. No statistical significance was found in CF scores based on age, gender, experience or discipline. More education correlated with lower scores on stress scales for

clinicians. The qualitative data from this study will be found below in the review of qualitative research.

Meldrum, King and Spooner (1999) in *Secondary Traumatic Stress in Case Managers Working in Community Mental Health Services*, studied case managers and found that 18% had symptoms similar to their traumatized caseloads. In *The Impact of Secondary Traumatic Stress on Novice and Expert Counselors with and without a History of Trauma*), Pinto (2001) veered away from study of the trauma therapist to focus on the generalist clinician with a sample of 82 therapists (49 novices and 33 experts - most were not social workers) who were surveyed with four different instruments. Pinto promotes that STS and VT are different phenomenon since a therapist's trauma history predicts STS but not VT. Empathic therapists with a primary or secondary trauma history compared to empathic therapists without a trauma history experienced STS and CF, plus an impact on their work with clients; trauma history did not affect BO or VT. Experience was not found to influence signs and symptoms of stress states in therapists. Racanelli (2005) adds a caveat :"however, in the case of trauma shared between clinician and client [i.e., Middle East terrorists' activities, 9/11, etc.], both internal and external realities and experiences are indeed known to carry the potential of exacerbating general stress levels in clinicians and contributing to greater vulnerability to CF" (p.51).

Pulido (2007), *In their Words: Secondary Traumatic Stress in Social Workers Responding to the 9/11 Terrorist Attacks in New York City,* studied fifty 9/11 social workers and 150 social workers in training sessions related to managing post-9/11 stress. She found that some social workers did not manifest symptoms of their experience for two to three years. Munroe (1999), *Ethical Issues Associated with Secondary Trauma in Therapists*, established that a secondarily traumatized therapist may well use denial as a

coping strategy in the midst of intrusive thoughts of traumatized clients whom the therapist may attempt to avoid. Baranowsky (2002), *The Silencing Response in Clinical Practice: On the Road to Dialogue*, suggested that clinicians stressed by clients' traumatic materials engage in denial or a "silencing response" which includes neglect, redirection, minimization, and/or shut down around the traumatic materials. Silencing is reminiscent of Lifton's "psychic numbing" as discussed by Wilson and Thomas (2004) and in Allan Schore's (2003a, 2003b) extensive work concerning empathic processes.

Bride (2007), *Prevalence of Secondary Traumatic Stress among Social Workers,* studied 282 social workers and found that "Between 82% and 94% of outpatient mental health clients reported a history of exposure to traumatic events, with 31% to 42% fulfilling criteria for PTSD " (p. 63). Bride identified that the

> purpose of the present study was to investigate the prevalence of STS in a sample of social workers by examining the frequency of individual symptoms, the frequency with which diagnostic criteria for PTSD are met, and the severity of STS levels. (p. 64)

With his participants, Bride discovered that more than 40% experienced intrusive thoughts, more than 31% avoidance of clients, and about 27% arousal symptoms of irritability and concentration difficulties. In looking at the results of assessments of Master's-level social work clinicians, Bride comments, "15.2% met the core diagnostic criteria for PTSD" (p. 68). According to Bride, that is more than twice the rate of PTSD in the general population.

What is more, 97.8% of respondents indicated that their client population is at least mildly traumatized, and 81.7% reported a moderately to very severely traumatized

client population (Bride, 2007). One conclusion from Bride's work is that therapists are routinely subjected to people with symptomatic PTSD and some social work clinicians develop symptomatic behaviors that are similar to those affected clients. Fear, helplessness, or horror in response to the traumatic experiences reported by their clients was reported by 86.7% of responders. Bride concludes that social workers are addressing clients with traumatic stress often at the level of PTSD. He adds that "different results might have been obtained if a structured clinical interview [qualitative research methodology] had been used" (p. 68).

In summary, consensus is lacking in the literature about the impact on clinicians of hearing accounts of trauma. This body of quantitative research, mostly in the past 15 years, as well as the conceptual and theoretical writing preceding and concurrent with it, has identified an array of potential variables (or within attachment theory, impingements) influencing the development of traumatic stress states in clinicians. Factors including age, gender, trauma history of the therapist, experience as a therapist, amount of trauma treatment experience, education, training, salary, geographic location, organizational setting, organizational role(s), co-worker support, size of trauma caseload, coping strategy, onset of signs and symptoms of PTSD, shared trauma by client and therapist, CTR and CS potentially influence therapists' responses to trauma material and their vulnerability for one or more of the stress states, e.g. CF, STS, VT and BO. A therapist's stressed state may also be accompanied by CS according to pioneers Stamm and Figley who developed the fatigue and satisfaction self test. The realm of trauma work including therapists' stress states include both conscious and unconscious processes making awareness, discussion, and research sometimes seem difficult and subjective.

Qualitative Studies

According to Stamm (1999), a qualitative, content analysis study by Arvay (1998) entitled *Narratives of Secondary Traumatic Stress: Stories of Struggle and Hope*, found themes related to STS as follows: "(a) struggling with changing beliefs, (b) intrapsychic struggles, (c) struggling with the therapeutic relationship, (d) work related struggles, (e) struggling with social support, (f) struggling with power issues, and (g) struggling with physical illness" (xxiv-xxv). These findings include aspects of BO (b, c and d), CF (b and e) and VT (a, b, c, d, e and f) reflecting the complexity of what is involved in trauma work including comorbidity.

The qualitative portion of Sharman's (2002) mixed methods thesis mentioned above (pp. 28-29) used an open-ended questionnaire which revealed that hearing clients' accounts of abuse was the most difficult part of therapists' work, and their typical reactions were sadness and anger, but disgust and fear were also present. Further qualitative research to explore therapists' reactions to client trauma was recommended. "Although this survey contained some open-ended questions designed to gather qualitative data, it would be useful to interview a small number of clinicians identified as being at risk for STS to fully understand their experiences" (Sharman, p. 51). Sharman supposes that such work could more fully explore coping styles, reactions and positive aspects of being a clinician.

The Ting, Sanders, Jacobson, and Power (2004) research, *Dealing with the Aftermath: A Qualitative Analysis of Mental Health Social Workers' Reactions After a Client Suicide*, studied the reactions of clinician survivors, who were mental health social workers, following a successful client suicide. This study sampled twenty five licensed clinical social workers from across the United States with a mean of 21 years in practice. According to the participants, work with mental health clients, especially suicidal clients,

spilled over into their personal lives. Such stressful work was seen as directly linked to failed personal relationships. The generalist clinicians who were the focus of the investigator's research were faced with suicidal clients who were sometimes successful. Twelve themes emerged in the phenomenological analysis with some of those connected to expected universal reactions to grief and loss, including denial and disbelief, anger (at agency and society), grief and loss, justification (rationalization), and acceptance. However, Ting et. al discovered other reactions that were more characteristic of PTSD or STS including intrusive thoughts and feelings, avoidant behaviors, isolation, self-blame and guilt, a sense of professional failure and incompetence, feelings of responsibility and changes in behavior (professional practice and professional environment). The researchers concluded that participants felt the inability to prevent suicide was interpreted as incompetence. They recommend a need to understand the:

> cumulative effects of multiple suicides on clinicians and to understand the long-term effects. In addition, researchers need to understand the relationship between exposure to multiple traumatic experiences and professional burnout and secondary traumatic stress or compassion fatigue, which have implications for practice and policy. (p. 340)

Reviewing qualitative research, the number of studies is limited and they emphasize the complexity, comorbidity, and depth of impact on clinicians exposed to clients' traumatic materials. Hearing accounts of abuse is especially difficult for clinicians. Existing research recommends further study to provide more in-depth understanding of the effect on clinicians of repeated exposure to trauma materials.

Section Five: Recent Literature and Attempts Toward Conceptual Synthesis

In this part, efforts by several researchers who have been working with the ideas in mental health traumatology for an extended period will be reviewed. Interestingly, one of the original pioneers in the field, Figley, continues to work at the issue of understanding the impact of repeated exposure to trauma material on clinicians and on what to call it. As will be seen in this Section, working on the clear differentiation and meaningful integration of stress states therapists may encounter from therapeutic work with the traumatized, as well as the impact of that confrontation on the individual clinician and their practice, continues in the literature as does the theorizing about the component parts.

Baird and Kracen (2006) analyzed studies for the degree of evidence produced (e.g., persuasive, reasonable, or some) for the most commonly researched factors contributing to the development of both STS and VT. They synthesized the findings of published research and dissertations written in the English language from 1994–2003. "Persuasive evidence" for amount of exposure to trauma material and "reasonable evidence" for personal trauma history were identified as important in the development of STS. Findings indicate that "persuasive evidence" exists for personal trauma history, "reasonable evidence" for perceived coping style, and "some evidence" for supervision experiences, as important predictors of VT.

In Figley's recent integration work with Adams and Boscarino (2006), the "lack of conceptual clarity about what constitutes CF and how it differs from other adverse work outcomes such as job burnout" (p.104) is acknowledged. Figley's and his colleagues' view of CF has shifted to mean *a combination* of STS or VT (taken as

equivalents) and BO (as a separate and distinct phenomenon) that is psychologically distressing to therapists and contributory in the development of CF in therapists. Consistent with Baird's and Kracen's (2006) work, negative life events, trauma history, and work environment are explored as factors (or impingements) in therapists' vulnerability to CF. Compassion Fatigue describes a caregiver's reduced empathic interest in suffering clients which naturally evolves "from knowing about a traumatizing event experienced or suffered by a person" (Adams et al. , p.103). "Thus, these analyses seem to indicate that exposure to traumatized clients does not, in itself, lead to CF" (p. 104), which replicates the identified conclusion from Um and Harrison's (1998) quantitative study that what matters is what the clinician does with the exposure.

Some of those writing about the stress of traumatic exposure on therapists have made efforts to integrate prior thinking, conceptualizations, and research. Reviewing the literature relating to CF, VT, STS, and BO, Deighton et al. (2007) concluded there is considerable overlap in the concepts of CF/STS and VT to the extent they might be measuring different aspects of the same thing. Examining Figley's writings, the trio distinguished CF from VT, saying the former "is based on the idea of a syndrome resulting specifically from empathizing with people who are experiencing pain and suffering" while the latter, VT, sometimes viewed as interchangeable with STS, "results from exposure to clients' material, empathic engagement with clients and a sense of responsibility for them and which may culminate in not only cognitive but also affective and relational changes" (p. 64).

In another perspective utilizing and highlighting Schore's work, Wilson and Thomas (2004) collapse the concepts of CF, VT and STS into the model of "*traumatoid*

states," defined as "occupationally related stress response syndromes (OSRS) . . . [where] affect dysregulation and empathic identification play a pivotal role in the development of traumatoid states" (p. 143).[7] These states may be transient, acute, or chronic in nature, and the result from "repetitive and prolonged exposure to traumatized clients" (p. 171). Of note, Adams et al. (2006) concluded that CF combines the interchangeable concepts of STS and VT along with BO to trigger the development of CF. The idea of BO as part of CF is seen in Figure 8.1 of the Wilson and Thomas work.

Thomas' (1998) study randomly surveyed members of the International Society for Traumatic Stress Studies (ISTSS) and the International Society for the Study of Dissociative Disorders (ISSD) generating a sample of 354 clinicians used for statistical analysis. Results of Thomas' work are highlighted in a book coauthored with Wilson (Wilson & Thomas, 2004). The study identified five factors reflecting empathic strain: Factor I: Intrusive Preoccupation with the Nature of Trauma Work Experience; Factor II: Avoidance and Detachment; Factor III: Overinvolvement and Identification; Factor IV: Professional Alienation; and Factor V: Professional Role Satisfaction. These factors were found to lead to two types of countertransference: Type I: Avoidance, and Type II: Over-Identification. The researchers conclude: "the results of this study clearly indicate that there are different patterns of reactions to trauma work. These different "styles" of reaction to trauma work reflect personality, client and process variables which influence the tapestry of the therapeutic setting" (p. 171). What clinicians do in the face of trauma exposure is the focus of this qualitative research.

CHAPTER 3: METHODS AND PROCEDURES

The question addressed by this research study is: How do therapists, who are social workers, process the emotional impact of hearing clients' accounts of traumatic experiences? This investigator introduced his concern and interest in Chapter 1 as evolving over a 40 year period of practice, which represents a certain bias that was self-monitored by the investigator and kept under review by the dissertation committee. As determined in the preceding chapter on the review of related professional literature, there is quantitative evidence that therapists are impacted by repeatedly hearing accounts of trauma. However, the subjective experiences of individuals who are clinical social workers, but not working as trauma specialists or as mental health disaster workers, has not been thoroughly examined.

This chapter includes a description of this study's design, sampling procedure, human subject participants, data collection procedures, data analysis, reliability and validity, limitations of the study and all recruitment materials, consent form, and related documents.

Design

This qualitative research study is an exploratory process to understand the phenomenon of the impact on therapists of listening to accounts of trauma from clientele over time. "Qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods" (Strauss & Corbin, 1998, p. 11). "The experiential life of people is the area qualitative methods are designed to study" (Polkinghorne, 2005, p. 138). To understand how clinicians are impacted by clients'

accounts of traumatic experiences, talking to clinicians about such times offers the best possibility for gaining understanding and clarity about below-the-surface, experiential data. Locating the core meaning of an experience by approaching it from different accounts is part and parcel of a qualitative approach. "Qualitative research is emergent rather than tightly preconfigured" (Creswell, 2003, p. 181) and deeply values the individual participant's response to issues that are important to the professional field, including clinicians and academics attempting to understand phenomena.

Furthermore, qualitative research to understand the impact on a therapist listening to clients' traumatic experiences will give depth, understanding, and vibrancy to the prior quantitative research concerning the fate of the helper in the helping process. Most of the literature reviewed in Chapter 2 on the topic of potential stress states for therapists working with traumatized persons has been quantitative and not limited to long-experienced clinicians who are social workers. Sharman (2002) recommended qualitative research with clinicians to better understand their experiences and to explore coping styles and reactions as well as positive aspects of being a clinician. Also, Racanelli (2005) recommended qualitative investigation as potentially "better able to integrate variability, as well as greater dimensionality of experience among clinicians" (p. 51). Although much of the focus has been on trauma specialists and disaster mental health workers, Bride's (2007) quantitative study of social workers showed many non-specialized therapists are exposed through their work to a majority of clients with traumatic histories or a PTSD diagnosis. These results support a "focus of qualitative inquiries . . . on describing, understanding, and clarifying a human experience" (Polkinghorne, 2005, p.139). "Listening . . . may be an important direction for researchers interested in exploring

compassion fatigue and associated conditions" (Fahy, 2007, p. 203). Therefore, another compelling purpose of this research project is to augment the quantitative research and to follow through on the recommendations in prior quantitative and related professional literature.

The inquiry reflects the experiences of five therapists, who are front line social workers in a clinical treatment setting with at least a Master's degree and 10 years of post licensure experience. Those participants were purposively chosen based on the investigator's perception that they would contribute to developing in-depth, clarifying, and deepening understanding of the phenomenon under investigation. Phenomenological strategies of inquiry in qualitative research represent a collaborative approach with participants to jointly understand the meaning of an experience (Creswell, 2003; Polkinghorne, 2005). The lived experience of the participants will contribute to the profession's understanding of the impact of trauma work, day after day, for the generalist, Master's-level social work clinician comprising the sample under research.

In this investigator's view, a viable and preferred method to investigate the subject of therapists' traumatic stress is a grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) approach (including sampling, data collection, data analysis, and presentation of the findings). Such a methodology in human research is an ideal method of understanding participants' lived experiences in daily practice with all their complexity, variability, and interrelationships. Through a rigorous process of category development, experience is broken down into its component parts while being expanded (open and axial coding) then reintegrated (selective coding) for greater understanding of a phenomenon under analysis. This approach is not seeking a particular outcome but rather

an in-depth and in detail exploration and recording of the therapists' process when engaged with the traumatized as it is reflected in discussion with the investigator. This inquiry goes beyond the surface questions of a survey characteristic of quantitative research by allowing time for reflection and discussion of feelings and thoughts. Moreover, the richness of developing data is realized with a grounded theory approach in the retention of participants' direct expressions in the analysis and in the interpretation of the meaning of data. Understanding from a grounded theory approach may offer immediate, direct application to practice since practice is the source of the information.

Participants and Sample

The practice sample, purposive and diverse with regard to location of practice and gender, was recruited from social work clinicians not primarily in private practice. Full time private practitioners were excluded based on the assumption that such a therapist, unlike agency-based clinicians, may limit the number of clients in their practice who have been traumatized (Arvay, 2001). Participants were recruited through the investigator's professional network of clinicians. They were apprised of the research project for completion of the doctorate (Appendix B). The requirement that potential participants have at least ten years of practice experience beyond their Master's degree and licensure in social work amplified the opportunity for broad experience and interface with traumatized clientele.

The names of voluntary, self-selected participants forwarded to the investigator were contacted and screened (Appendix C) by the investigator via telephone or in person, based on the potential participant's preference. Following a successful screening, including participant's risk assessment and the likelihood of data-rich material,

participants were emailed or mailed a letter of thanks for their interest in participating in the research (Appendix D). That letter also included information about the research project as well as its methodology, risks, and benefits of participation and the Informed Consent Form (Appendix E), all of which were discussed in the screening process. The consent contained an advisement that reflecting on practice might lead to discomfort. Furthermore, participants were reminded that if they become uncomfortable in the research process at any time, they could withdraw from the project, without explanation, up until publication. Moreover, at any time, the participant could contact the investigator by telephone or email for assistance in managing their uncomfortable reaction (Appendix G). For those individuals who were referred for the study but not chosen as a result of the screening process or because enough participants were recruited, a letter was sent thanking the non-selected participant for their offer of participation (Appendix F).

At an agreed-upon location (convenient for the participants) determined via telephone and email contact, the investigator scheduled a 90 minute appointment for a conversational interview with a guided, open-ended question format (Appendix I). At the beginning of the interview, the investigator re-emphasized the voluntary nature of the confidential, qualitative research including the participant's right to withdraw at any time. Participant's questions regarding the research were answered and the participant's signature on the informed consent form (copy left with participant) was obtained before the formal inquiry about trauma work began. The interview was audio recorded and, subsequently, professionally transcribed. At the end of the interview, the investigator asked permission to call the participant for a multipurpose conversation of brief duration (not more than approximately 15 minutes) within two weeks after the participant's

interview. This call was made to affirm that the participant was doing well following participation and to ask the participant additional clarifying questions resulting from interview reflection and analysis.

Data Collection

Audio-recorded and transcribed interviews were the source of data along with the narrative account written by the investigator immediately after the participant interview. The investigator and the audio tape were the instruments of collection of data in this qualitative research overseen by the dissertation committee. Interview notes and transcriptions were identified by numbers rather than names to ensure confidentiality throughout the process of discovery, review and analysis of data. All records were held in the investigator's personal locked files, and on the laptop computer and flash drives to which he alone has access. All records will be held securely for five years (per APA guidelines), then shredded and eradicated by the investigator to further protect participant confidentiality.

During the conversational process, guide questions (Appendix I) were used to facilitate discussion of information below the surface and yet relevant to this project. The investigator listened closely to the words, observed the body language, and heard the emotional tone and the prosody of the participant to develop meaning - just as is done in a clinical assessment. Polkinghorne (2005) says that though the goals in research and clinical assessment differ,

> There is considerable overlap between the skills involved in research interviewing and those needed . . . in counseling and psychotherapeutic work. Both practices

require an ability to form an accepting relationship, skill in active listening, and focus on the other's experiential world. (p. 142)

The emphasis of the interview targeted the moments that had the largest impact in the participants' experiences with traumatized people – moments they had not previously openly considered or discussed in detail. The investigator compared the transcription to his recollection and written account for fullest understanding. Categorization developed through open and axial coding procedures carried out by this investigator and followed by selective coding geared toward establishing a fluid relationship in the categorization and coding processes. Findings will be presented in Chapter 4. Abstraction, interpretation, discussion, implications, and recommendations for future research will be presented in Chapter 5.

This approach is part of grounded theory development characteristic of qualitative research where the subjective experience of the participant is sought. The goal is to reach greater understanding of a phenomenon which will contribute information for theory development beyond the phenomenological explanation developed in this research. The process of discovery is dynamic, requiring this investigator to be open to the vitality of the process including constantly comparing the data from one interview to the next. Shifts in questions, focus and process throughout the research project is feasible. Creswell (2003) comments: "The thinking process is also iterative, with a cycling back and forth from data collection and analysis to problem reformulation and back. Added to this are the simultaneous activities of collecting, analyzing, and writing up data" (p. 183).

Reliability and Validity

Qualitative research through its exploration and identification of the essence of a human being's experience is not intended to meet the tests of significance to which quantitative research is held. Creswell (2003) highlights that believability derived from coherence, insight, verification, and trustworthiness are the hallmarks of and standards for qualitative research. Reliability is not a key element in qualitative research but "consistent patterns of theme development" (p.195) across participants can be a measure of reliability. Others have suggested that an interview is a reliable means of collecting data (Mishler, 1986; Strauss & Corbin, 2000).

Creswell posits that validity as accuracy from the perspective of the investigator, participant, or reader is seen as a strength of qualitative research, and he recommends "rich, thick description to convey the findings" (p. 196). He further recommends bias disclosure of the investigator, presentation of negative or discrepant findings, and an external auditor (the dissertation committee, especially the external member of the committee in this research project) as some of the means for establishing validity of the research. Locke, Spirduso, and Silverman (2000) suggest that the researcher remains aware that the reader will question why they should believe the accuracy of the data (e.g., is the evidence presented persuasive?) and that the investigator must disclose "how could I be wrong?" (p. 103). They recommend accurate and complete descriptions, disclosure of investigator biases and how that may influence the research. They also stress the importance of how the participant's reactions to the investigator may influence the collection of accurate data as ways of addressing validity in qualitative research. "The validity and trustworthiness of qualitative research is related to the selection of viable

sources that promote a deepening of the understanding of the experience inquired about" (Polkinghorne, 2005, p. 141).

Limitations

This research is limited to a description of a phenomenon experienced by five, Master's-level social work clinicians who are currently practicing in the United States. Due to the qualitative research design and sample size, the results are not generalizable to all of the participants' peer Master's-level social work clinicians or to Master's-level social work clinicians throughout the United States and world. All clinicians in this study are, potentially, indirectly known to the investigator through his professional network through practice in the United States for the past 44 years. Other professional networks, unfamiliar to the investigator, exist.

Moreover, since the sample is voluntary and self-selected, not all persons in the sample represent the full width and depth possible when exploring Master's-level social work clinicians' reactions to working with the traumatized. Some potential participants may have screened themselves out due to the sensitive nature of the topic under study. Finally, qualitative research engages the investigator with the participants as they move toward understanding a phenomenon through a thoughtful process. The bias of the investigator is a factor in the analysis and interpretation of the data. "It also means that the investigator filters the data through a personal lens that is situated in a specific sociopolitical and historical moment. One cannot escape the personal interpretation brought to qualitative data analysis" (Creswell, 2003, p. 182).

CHAPTER 4: FINDINGS

> This is the not the worried well that come here. This, this is not you and me going into therapy in any way. These people are about as damaged as any people could be and it's all, you know, set in, in, in the, in the amygdala at, you know, from the early age when the first time the father flings them across the room or they see him raping their mother or, you know, what, whatever, you know, whatever terrible things. (Barbra, Study Participant)

Through the investigator's professional networks, a sample of five, self-selected Master's-level social work therapists were identified and suggested. Participants Anne, Barbra, Chloe, Doris, and Edward are fictitiously identified to protect their privacy as well as that of their agencies and clients. Only one of the prospective candidates was known by the investigator prior to screening for their participation in this qualitative research project. Using attachment theory as the theoretical backdrop for this phenomenological investigation, this study was designed to explore and describe the impact on social work clinicians, with at least 10 years of experience following licensure, of listening to peoples' traumas both in the moment and over time. Brackets [ ] are used throughout this chapter to insert the investigator's ideas, comments, and explanations.

For more than 25 years, the impact of listening to trauma has been a documented phenomenon, known by various labels (e.g., secondary traumatic stress, vicarious traumatization, compassion fatigue), in the helping professions as was described in Chapter 2. Most of the previous research in this area has been quantitative, including an array of professional disciplines with varying educational experiences, focused more on trauma specialists and first disaster responders rather than front line, Master's-level social work clinicians practicing in agencies. Interviews with the participants in this research focused on developing an in-depth understanding of social workers' lived experiences treating clients who bring significant trauma into the treatment setting.

Individuals who participated in this research are described with limited information to protect their privacy as well as the confidentiality of their clients and agencies. Participants' reactions to the focus in this research project, this study's definition of trauma, and the participants' views of their work are described as Theme One. The following provides a portrait of each of the participants

Anne has been in practice for more than 30 years and currently works at a supervisory level, with occasional practice in a private agency where she has been for some years. The emphasis in her program is mental health services for adults. She clarifies that her clinical career has taken her across the life spectrum from services for children to seniors. Anne clearly enjoys her present work with licensed professionals, staff working toward licensure, and social work student interns. In the past, Anne had a private practice, which she found somewhat isolating. Anne has children.

Barbra practices in a community mental health agency where she has been working in direct client services for the past five years. Barbra and her second husband relocated from a distant part of the country to be near her married daughter and grandchild. Barbra's career extends for more than 40 years and has included public social services and non profits, from line services through supervision, management, and administration. She also had what she described as a large and flourishing private practice in the past. Barbra candidly describes her own personal transformation and integration from poor choices to a quality life balanced by vastly improved choices supported through therapy, 12-step programs, and a compatible partner. Avocationally, Barbra has used her skills with group work, community organization, and political action to address systemic and broader community issues.

Chloe has been practicing for more than 25 years and is currently working primarily with children in a public mental health center. Much of her know-how has been drawn from more than two decades of work in a hospital where she most enjoyed her assignment in critical care. Chloe finds her current position of five years slow-paced and too bogged down by both bureaucratic practices and clients who don't respond or only respond for reasons like money. Chloe reports that she was very active in liberal causes early in her career and that she has previously acted as a mentor for social work interns. She has children and marks becoming a parent as the time when she started to become less liberal in her social perspectives. Being primarily focused on her own children at this time, Chloe wonders if she could manage the remembered intensity of hospital work with the same efficacy she demonstrated in the past. Nevertheless, she imagines herself returning to a hospital location in the future.

Doris was an only child who moved often prior to marriage. She attended both of her parents before their deaths. Doris has a broad spectrum of experiences over three decades from hospital settings, to child guidance and protective services as well as private practice, which she maintains on a part time basis with a small number of clients. Her current, full time position is in a private, behavioral health program where a lot of her work is on the phone or in emergency rooms. In the past, she had been active in professional social work organizations and instrumental in developing continuing education opportunities for professionals. She characterizes herself in practice as pragmatic, direct, non-analytic, and not laissez-faire; "Everybody gets a dose of CBT [cognitive behavioral therapy] from me!"

Following college, **Edward** did volunteer work before what he thought would be graduate education in psychology. Those opportunities opened his eyes to the field of social work and captured his interest. Edward is working in an outpatient mental health setting. He does both group and individual work as well as supervision and coordination of student internships. He is a senior staff member at the center where he works and enjoys peer respect. Edward has children.

In developing the research proposal, the investigator considered that the population of interest, experienced social work clinicians, would be best represented by participants with a minimum of ten years experience post-licensure. No upper limit on years of experience was specified to qualify for inclusion in this research. As the sample evolved, the participants were all in their fifth or sixth decade of life. Moreover, the parallel between the investigator's age and years in practice [in the social work field since 1967 and as a Master's level professional from 1970] with the participants may represent a specific perspective reflected in the data collected as well as its analysis. As the findings are revealed in this chapter, the reader may contemplate whether age and life stage, including the investigator's, may have influenced participants' trauma sensitivities and the processing of their associated reactions.

All participants received an overview of the study in the letter inviting their involvement (see Appendix E) and an opportunity to ask questions about the research in their screening contact with the investigator. At the beginning of each participant interview, the investigator read the definition of traumatic material as used in this study: material which feels uncomfortable, frightening, serious, grave and dangerous to the listening participant and it may require the participant to re-orient himself in real time.

The participant had an opportunity to refresh their memory about the focus of the inquiry, to ask any question(s) about how trauma was being defined for purposes of this study, and to opt out of the project. Each participant reflected openly about the research focus and definition of trauma but none opted out.

When asked to "think back" about their work with traumatized clients, all the participants had strong memories. Barbra, who has chosen to continue working in direct client services, said she had "20 or 30 stories right off the top of my head." The way she spoke of client trauma seemed to the investigator to indicate deep caring for her clients. She said: "it's impossible to describe what these people have gone through . . . the abuse and the neglect and drugs and . . . just the chaos and the lack of bonding, lack of attachment." (Barbra)

Similar to Barbra, Edward practices direct service and said: "So as far as trauma, uh, there's been so many. . . . Death of a child, um, horrible circumstances. That kind of stuff is probably the worst. Right?" (Edward)

Anne's "think back" at first focused on her own ability to deal with the trauma she had heard in direct service. She said: "I don't think it ever, I don't think I ever experienced anything where I just couldn't [do the work with a client]. I think I think I was able – as hard as it was in cases." After that remark, Anne paused and reflected on her comment and then she added:

> Actually, you know, come to think of it, I just thought of another client I worked with for the longest time. [He] had been critically injured as a teenager in a car accident and was paralyzed and had massive injuries as a result. His whole life

changed - that was, but I still despite how horrible it had been, I, I was able to work with him and really, I think, do quite a bit. (Anne)

Chloe finds her current work with children in a public mental health center frustrating because of bureaucratic practices and clients whose response seems tied to money received. The investigator observed that she did not find any of her current clients relevant to the definition of trauma as used in this research. Rather, Chloe picked examples from her work in a hospital. She said:

> God, it's been so long, uh, long ago . . . one of my jobs was to be present when families are told their loved ones are either, have uh, either expired or are critically injured. So I know there were, day in and day out, cases of being present when people were pronounced dead. (Chloe)

Doris, who currently does much of her clinical work over the phone, at first did not feel the investigator's definition of trauma applied to her work. She said: "the description, well I don't know if it actually hits me but I have worked with ummm child abuse and sexual abuse victims, which, I think, is highly traumatizing. . . ." Then as a memory came into her mind, she commented: "I remember one little girl – I'm, it's very interesting, just having a visual picture of her right now . . . actually, I have a sense of chills right now" (Doris). The way she spoke made the investigator wonder to what extent the cognitive, visual, and sensate aspects of the trauma to which Doris had been exposed had been integrated.

Participants drew examples with lasting impact from their work with trauma from across their careers. Participant descriptions about client trauma impacts ranged from instances in current treatment to experiences of effect more than 30 years earlier. Anne,

Barbra, and Doris all had private practices in their careers, and Doris described her "current part time private practice of about a dozen clients" outside her regular full time position. With private practices, clients could more easily return for ongoing trauma treatment and its aftermath. Nonetheless, the instances of trauma participants talked about most were selected from practice in an agency setting.

As participants went on to talk about client trauma, three themes emerged from the interviews with the five participants. The first theme is that: Aspects of certain participant-client engagements have created an enduring impact, some of which are positive and empowering and others that are negative and interfering, for the participants. The second theme that grew out of the interviews is: The milieu has a profound impact on the participant-client engagement and how the participants have been able to process their clients' traumas. The third theme is: How the participants coped with the impact of client traumas seems to effect whether they experience stress or satisfaction; participants' resiliency is influential. Each of these three themes will now be elaborated with examples from the participants' interviews.

Theme I: Enduring Impact

The following seven dynamics appear to make the biggest impacts in the participants' qualitative experiences: when the client's situation is familiar or similar to the participant's experience or, stated differently, too close to home; when service delivery is interrupted or protracted; when client trauma triggers intense feelings for the participant; when there is a challenge to or rift from core social work values and beliefs; when the participant's own life is disrupted by the impact of being immersed in the clients' trauma; when a client triumphs through resilience, strength, and growth; and

when the help was successful – effective for the client and empowering for the participant – and could be shared.

In addition, based on the ways in which the participants told their stories, the investigator observed that the last two elements, client resiliency and participant efficacy, seemed to help the participants deal with the traumas they heard day in and day out. When participants told their experiences, their eye contact increased and they became more animated, lit up, detailed and poignant in their statements. As difficult as trauma work could be, participants could identify satisfaction in doing that work.

Anne liked and believed in her work as much as she admired the strength of people who had been terribly traumatized. She had less empathy and concern for those who portrayed themselves as victims and repeated their "victimizations" by not learning from prior, poor choices. Her colleagues were mentioned frequently as the sounding board for her in her clinical practice.

Barbra became impassioned when she discussed her advocacy roles over the years. She enjoyed seeing people and organizations make a difference in the lives of those who were in need regardless of the precipitant.

Chloe became exhilarated when she talked about her more than two decades in hospital work. She loved to listen and found peoples' stories fascinating. Although the pace and the life and death scenarios were demanding, she felt much more comfortable with that work than outpatient clinical work with children and families.

Doris spoke objectively about her boundaries with people she served and people she did not serve. Her commentary was punctuated with humor and giggles. She spoke with confidence about her "everything but the kitchen sink" approach with a strong

cognitive behavioral component in her clinical practice. She also spoke about the telephone work creating a safe barrier for her while she thought outpatient clinic work would not suit her.

Edward was steady in his clinical practice despite a lack of team, collegial and supervisory support as he faced clients' traumas in his clinical work. Increased volume of clients seeking services was experienced as detrimental to the therapeutic process of a client with a social work therapist.

The client traumas that stayed with participants could leave an indelible impression that might be experienced as stressful or not stressful or both. All five participants had worked with children during their career and four of them identified as parents. Some persistent impressions had to do with children while others related to clients in a place in their lives familiar to the participants or to participants' loved ones. The factors that combined into lasting impacts reflected an intensity that will be expanded upon in the comments of the participants themselves. Some *in-vivo* examples are included in more than one theme and factor, although in an abbreviated format, with the original page reference after the first instance.

Too Close to Home

Anne talked about four kinds of "upsetting" losses frequently besetting clientele of the agency where she worked. Her realization about her own aging process and potential losses was displayed after "young" staff approached her for funds to purchase adult sized diapers and for consultation regarding a dementia client. The anxiety of significant other passing was openly revealed in Anne's comments about two men whose wives of six or more decades had deceased. She was not surprised that the grief was so

relentless that the men were hallucinating. That exposure led her to consider another hurt, that of a parent when their adult child dies.

> I said you know the thought of having to be in diapers as an adult that is like the most upsetting because I think: 'Okay, it's not that far off for me!' (Anne)
>
> And he was, he had been a college professor . . . and here this man is in an assisted living not even remembering like who he is or where he is or understanding anything and that's like: 'Oh my word!' . . . and it was just all lost (sadly). . . . and I've talked to some of my colleagues that are my age and this is what we're - 'Oh my!, are we going to be this way?' (Anne)
>
> And then I think about how can you be married to somebody for I mean 62 years, 64 years . . . Right and then lose that person and what that must be like. So that, that's kinda of that's, traumatic hearing those stories over and over. And we get that quite a bit. And then, also very traumatic is we've got some clients who've lost their adult children . . . and that's, that's pretty, you know being a parent. Seeing that: 'Oh My God! What is that like?' That's, that's, that's upsetting to hear stories like that. So we do get quite a bit of that. (Anne)

Anne went on with compassion about past treatment of a teenager who, at that time, was the same age as one of her children. That reflection triggered sadness and joy. Through no fault of his own, the nineteen year old had massive losses including death of a relative and personal injuries including partial paralysis from an accident caused by a woman who was driving under the influence.

> His whole life changed. . . . something that awful, . . . that was pretty upsetting . . . something beyond again beyond anybody's control and, here is somebody he was

> the same age, as actually, as of one of my children which, I think, really made it hard. Because, I could sorta, you see the paralleling of what my child is doing in their life and he's going to be stuck in this wheelchair and [sad/resigned sigh] his whole life is just so changed! . . . he's the same age and seeing what, what it's like for my child going off and going off to college and doing whatever and he's stuck in this wheelchair! (Anne)

Early in Barbra's career when there was national economic distress and few employment options, she disclosed her anxiety about working, or as she put it, being "stuck" in a children's residential treatment facility. Barbra and her only child were living on the campus where Barbra was employed and where she saw the "impacts of trauma" in kids' lives. She described them running out in the woods for marijuana smoking and to have sex. The young social worker feared for her latency-aged child's well-being with such a too-close peer surrounding of negative influences.

> there were no jobs, and I got stuck in that job and it was deadly. Living on campus um . . . I had to . . . raise my child uh, in this terrible environment. Because these kids were kids that were, you know, running out in the woods, smoking dope and, and it was, it was grueling, grueling work. The setting was incredible, but the kids were crazy. I mean, and it was . . . I, I needed to get my child out of that environment. He was 11 and I did not want him going into adolescence with that kind of a peer group. I did not, I mean, I just needed to get him out of that campus! (Barbra)

After that, Barbra drew an honest, self-disclosing parallel from the tension in her earlier life of being married to someone "crazy," functioning as a single parent with a

weight problem and feeling alone to the ordeal she saw in a client who had been traumatized very early in life by parental neglect. Barbra had been treating the client for ten years. Humbly, Barbra did not see herself as superior to her client. She reached out to the woman in the same way she herself had been held and supported while working through her own issues.

> I mean, she still, she weighed 367 pounds when I met her and could not funct, function in groups just became, come so paranoid and so uh, so uh, uh, attacked by any kind of, any kind of interaction. Um, and so, we worked for, she wanted to do something about her relationship with weight. She would not go to alcohol, to OA [Overeaters Anonymous] or to any kind of Weight Watchers or anything at all. She began to talk about the gastric bypass surgery. It took her five years! . . . if you could see her, she is this bedraggled, obese, stringy haired woman who wears the same thing all the time. (Barbra)

> And, yet, my life [had been] crazy, you know, married to a crazy man, I was overweight. And I finally escaped and left him and it really was escaping. He was crazy! . . . And I got into, Overeaters Anonymous and therapy with an incredible therapist. And I had years of therapy and . . . of 12 Step. I met my current husband during that time . . . And so, I think that transformative experience really made me think that I, it's not a, I'm up here and you're down there. (Barbra)

Chloe described her worried preoccupation with an unfolding scenario involving one of her children's teammates that left her unsettled and thrown back to her two decades of work related to the aftermath of gang violence on youth. The disclosure

seemed fresh and unresolved. The teammate was not someone Chloe was treating but similar to so many whom she had treated as well as an age peer to her child. Simply, he and his experience were too close to her child.

> My child plays soccer . . . one of the star players, just such a gifted athlete, last summer was arrested and is now on trial. . . . He had such a future in front of him. Arrested, apparently he'd been hanging out with his gang, got in the car, drove the car, taking another gang member. . . . Whole life changed that day. Now, he's on trial for attempted murder. It's weird, that happening, you know. . . . it was kind of a matter of fact way that my child was dealing with it but I was devastated and became very preoccupied thinking about this young man and how he had his whole future ahead. And it turned out his father and uncle got killed by gangs. And his trial is coming up right now. But it's weird, I need to think about what it is about it but I find myself thinking about that young man quite a bit and it takes me back to my work [left prior job of 22 years five years ago]. . . . And I thought, here I am this mother [with a child the same age as this teammate who is hanging out with or a member of a gang], obsessing about this gang member. It must have something to do with the work I do and the work I did that I'd be so preoccupied with it. (Chloe)

Doris helped with her father's care in the home prior to his death. Subsequently, Doris' mother had a stroke in a distant state and came to live with Doris and her spouse. With the assistance of nurses, Doris provided in-home care for her mom prior to the mom's death. Understanding the stress of parent caretaking ending in the loss of that parent was very well-known to Doris. "That's another place where I will do some self

disclosure. . . . and a, I have, my phrase is, 'I've walked that path before.'" Doris self-disclosed to a client in similar, familiar circumstances [caring in home for a parent who dies] and provided support as well as a bridge to mutual understanding and beyond for Doris and her client.

> And one time, I had a woman who asked me: "Will I come and live with her?" It was this lady I'd never talked to and she'd lost her mom and something else and she had a child and she was, I guess, the caretaker for her mother and I, I selectively disclosed and I remembered someone saying: 'Whatever disclosure you make is, the question is it in the best interest of the client?' And it was so funny she asked, "No!" she said "Can I come and live with you?" Like she said it was really sweet. Yeah. (Doris)

Doris was, like Anne, thinking about her own aging in the context of a client that kept in telephone contact with her.

> Yeah! I think – there is one lady who calls me – she's like, I think she's 88 or 89; she's rapidly deteriorating and I think about getting older and how to do it with some grace . . . and some saviness and just having a great deal of empathy for her. (Doris)

Edward described his too close experience in talking about the unexpected death of an infant of a client that had a history of anxiety and hypochondria.

> If you can imagine this, this hit me very hard being a parent myself and I, at that point you know, I really cared about this patient. She's a lovely person and seeing special people . . . That was devastating and it hit me very hard emotionally. (Edward)

Service Delivery Is Interrupted or Protracted

When the collaborative endeavor of client-participant treatment was interrupted or concluded without a planned ending, feelings of helplessness and uncertainty developed for participants since they did not know if the trauma had been addressed sufficiently for the client to move forward. The not knowing seemed to create tension for the participant and sometimes triggered emotions which were intense. All participants disclosed situations in which they had worked without closure but Anne's and Chloe's were the most extreme. On the other hand, prolonged, directed and goal-oriented service seemed to bring about participant satisfaction.

Anne talked about two cases involving child abuse where the end of treatment was unclear. In the first situation, the child was protected for the year that Child Protective Services monitored but then the family dropped out of treatment. In the second circumstance, the investigator experienced Anne talking with some torment, possibly even guilt, because she became detached from an older child in crisis due to changing jobs. Anne clearly took responsibility for disrupting the relationship. The investigator sensed that what seemed distressing for Anne in both matters was her lack of control in the treatment, in short, her helplessness.

> There was a child that I worked with . . . a horrible situation . . . three year old she was in foster care . . . she was so frightened of the dark so they [Child Protective Services] assumed the abuse had taken place during the night – maybe satanic ritual, they weren't sure but it was horrible this kid was so traumatized. Initially they took the kids . . . and the mother had left the father, I think they arrested the father. Um, the mother eventually got the kid back. . . . after the year was up, once

the case was over, she went back with the father! And that's the last we ever heard.

So you know this poor child was going to be just tortured again! And that was another one that kind of stayed with me. Yeah, and that's what stays with you, My GOD! Where is this child? How old is she now? This was in the 1990s, 1995, so 15 years later, she's probably 18 or 19 by now. What happened to her? No way of knowing and that is something else that stays with you. . . . (Sigh) There isn't a whole lot to do. Yeah, yeah. I, I use the experience of what I went through and you know when they talk when other students or interns talk . . . about how things upset them and abuse and things go on that really upset them and they feel powerless I can use that as an example. . . . But there isn't really much. It's just one of those things that's there and like GEE! Where is she and what happened to her? (Anne)

It was, it was really hard, I think and that was pretty traumatic for me too cause I left. She [the older child client] had just moved to this other foster home and I, I changed jobs so I had to leave her behind. And, I had actually offered to work . . . I checked with the Board of Behavioral Sciences like, okay, what can I do as far as any kind of continued relationship with her? And, they said, you know, you can offer free services - that would be okay. And, I did, but the, it was too far where I was seeing clients in private practice and the foster mother didn't want to bring her and you know, I felt, I felt really bad. I felt like I was abandoning her but I had offered to see her for free in this practice and . . . It was, that was, that was tough. After I left I heard she had a suicide attempt. (Anne)

Chloe was also tortured about what happened with a client even though service terminated because of death. She seemed to reproach herself as she talked about how troubling the unexplained death had been to her. In most other cases she had been able to get some sense of resolution.

> I remember I had a child and I never found out the exact circumstances, who, and it's weird that I wouldn't have known, found out or persevered in finding out what happened to them, but I remember I had a child who hung themself. And I never found out the exact family, obviously became a, you know, coroner's case and investigation. But, and I'm not sure why I never found out more of the things going on in that family, later on. Of course, I tried but for some reason I didn't. (Chloe)

Barbara spoke about how she had not completed service with the client she had been seeing for ten years. However, rather than the anguish experienced by Anne and Chloe, Barbara seemed hopeful and focused on service yet-to-come based on the forward movement she witnessed in her client over the years. Service that continues or is intermittent offers the participant to be that agent of positive change.

> [S]he lives in a constant, constant state of anxiety and obsessing and, and she is damaged. Because I could go over deep breathing, meditation, visualization, I have gone over it a million times. Well I fear that, I fear how you're, you're going over and over with the worries, you know. "Did you write the worries down?" "No." "Have you practiced the visualization?" "No." You know, she forgets. She really, really doesn't have that capacity to carry it over. She's just, she's been fascinating for me to learn about um, you know, just how, what happens to

> someone who is so, so damaged.... Her quality of life has improved. I'm still working, I mean, I'm still working, I want her to pay her library fines. She paid off all her credit cards. I mean, she's done some really wonderful things! (Barbra)

Doris talked about a family that came in and out of treatment and, contrary to her usual method of operating, the fact that she held the chart open based on interest, intuition and the efforts she had made to provide "a connection to help put some sense of calm and structure and order there [in that family]." Sure enough, the client family came back after a decade.

> I just got a call from a woman I should have shredded her chart but she had a minor child and she had an incredibly crazy ex-husband. That child was maybe three or four; probably four - she's now 15. Right, but she's come back and she, I think he had left her. So, I mean, it's interesting that I will get people that rotate back . . . And I'm going, I'm really sorry but I shredded your chart already, you know, it was seven years. Aaa, but in that case, I just cause she had a daughter at home, he was the step father, and that girl had a lot of trouble. It was just an incredibly dysfunctional, so she called me back . . . to see if I still taking her insurance and have openings. In that kind of situation, it's with somebody who's been from a really dysfunctional family and you've made a connection to help put some sense of calm and structure and order there. (Doris)

Edward presented a client he had worked with over a period of five years. Based on client information Edward received, corroborated by the client's spouse, the events experienced by the client were over the top emotionally and cognitively. Death, considered the worst type of trauma by Edward, was dramatic, intense and multiply

experienced by his client. The difficulty seemed to call up robust emotions as well as challenge Edward's human and social work beliefs and values. The initial trauma of the client was followed by additional ordeals overwhelming the client and putting her already-shaky emotional state into an ever more fragile place of uncertainty for the future.

> Um, and this is uh, the mother of all grief stories. Uh, this one blew my socks off. But this was probably uh, I just saw this woman recently. She came back in to see me about some follow-up issues that have stemmed from the initial tragedy. . . . probably happened four or five years ago . . . What happened was . . . father had died, who was sort of the glue that kept the family together, of natural causes. Mother was mentally unstable and very, very difficult. . . . mom really couldn't live on her own anymore and went to live with one of the sons. . . . Um, all of them were successful people except for one black sheep brother; always chemically dependent, alcoholic, living on the street off and on.
>
> Well, what happened was, the um, brother and his large family out in the [name of place] area who'd taken mom on, snapped one night. No one knows exactly . . . there's a lot of mystery to it. But he snapped one night. He killed everybody in the house. His mother, his wife, at least four children. . . . One son wasn't there 'cause he was in Iraq or Kuwait. . . . Unbelievable! Unbelievable! When the story first hit it was like a Manson murder. Like this successful nice family murdered in their home. But then they realized it was a murder/suicide all this came out. He didn't really leave a suicide note. . . . So, it was stunning, it was a stunning story.

Well, she [the client] was devastated and prob, the main thing I probably did was to normalize her feelings. How overwhelmingly horrible this is. And what an incredible, unfathomable experience and how (3 second pause) do you explain what he did? What must have been going through his head? How could he have done that to his children? . . . You kind of normalize the experience as best you can for her. You share her uh, disbelief and lack of understanding and um, there are no good words uh, but it was real power, I remember talking about that. I don't talk about work much outside of work. But that's a story that I talked to my wife about. And just shared the, the story with her. Um, . . . And so she [the client] went through a major depression. . . . And has been kind of in and out of that depression ever since.

So I saw her pretty regularly. Um, gave her a lot of support. The added, more stressful thing for her was after the, this murder/suicide, she was very quickly ostracized from the rest of her siblings because they, they blamed [her for keeping in contact with] the black sheep brother for causing additional stress to the, the siblings and to mom because of the, his behavior - which never really seemed to add up that much. Um, there must have been some old grudges or some old things going on too. But they, more and more began to ostracize her from the [family] experience. But more and more she felt they were kind of cutting her out. Which was just devastating to her at that time.

And recently she's come back in because um, some people have a black cloud over their heads; some families. . . . One, one of her sisters and brother-in-law, one of the sisters that was most anti-her, actually and would have nothing to

> do with her at some point. Um, but who she still tried to reach out to occasionally despite the rejection. Her and her husband and two of their children were driving on the freeway . . . and um, they got into a horrible accident. . . . Mom and dad were killed. I believe the two kids survived with minimal scratches and bruises. Unbelievable! Dad died instantly. Mom, from what she's [client's] heard and too bad she's heard, apparently didn't die instantly. But died in the car, the car was on fire. Kids um, got out the broken window. People began to stop and help the children. . . . out of the car. But the mom couldn't be saved and she died in the car, burning. And the dad was dead I think on impact. Yeah, and the trauma compounded by her [client's] estrangement. . . . From the sister that died, that never got resolved. Another big memorial service and another big everyone has to get together for a funeral and her being ostracized by the remaining siblings; dwindling numbers at this point. But um, so that really brought her back in on a more regular basis and I've seen her now probably three times since she came in and told me that story. (Edward)

Client Trauma Triggers Intense Feelings for the Participant

So far, according to participants' reflections, the impact from certain traumas lingered when they were too close to home or when service was interrupted or protracted. Additionally, trauma impacts endured when they were startling in their nature and magnitude. What was the "worst" trauma varied among the participants but included child sexual abuse, child neglect, violence, and death.

Anne stated clearly that the nastiest trauma for her was the sexual abuse of children, but other horrible traumas such as domestic violence and forced emigration with

murder and cannibalism were easily identifiable and disclosed, although not detailed below. This participant described the lasting emotional impact as continued anger toward the perpetrators and the mothers who ignored it [abuse], feeling bad for the client rather than empathy and feeling helpless to protect the client. Two of Anne's sexual abuse clients are discussed below.

> Horrible sexual abuse her entire life, well from infancy all the way until she left home at the age of 17 . . . we happen to be talking the other day about her and we still; because both of us still think about her. Because of what she has been through. Hearing, like 17 years if it, just about every day. And it was just really horrible! (Anne)
>
> Well, initially, I mean anger toward the perpetrator, who was her father, was the perpetrator; just anger toward somebody whom I never met and someone she [the client] hadn't seen in years either. And I think just sort of you know, feeling bad for her more than an empathy, I mean countertransference, like you know, I wish I could make it better for you and – and just anger towards the perpetrator. (Anne)
>
> Yeah, which I saw a lot, you know, kids, adults who had been molested as children and the mothers who just ignored it (cough)! (Anne)
>
> I, I guess she'd been molested by a cousin in the foster home and finally did say that it happened. So the foster mother, whom I think had been her legal guardian, like 'How dare you say that about my grandson?' and gave up the guardianship, gave up the whole thing and she [the child] was then put into another foster home and (big sigh) aaa, ha . . . After I left I heard she had a suicide attempt. (Anne)

For Barbra, neglect was the worst trauma. It generated deep feelings within her and led to lasting visuals of her client's suffering. She spoke in attachment terms about the catastrophe of neglect which is so often upstaged by abuse.

> The woman that, that really has touched me, and I've had her for ten years, was not a victim of uh, physical or sexual abuse. She was a victim of severe, severe neglect. At any rate, I just envisioned her, she was third . . . of four kids. And her mother was an angry, furious, enraged alcoholic who would, would put a padlock on the refrigerator. Who never gave her a minute empathy connection, you know. And I, my, just I, I, I carried this vision with me for years of her just languishing in her crib, crying and crying and crying and no attachment, no attention. And absolutely in this dark hollow world of being alone and, and being abandoned continually. (Barbra)

Chloe, who loved listening to people's stories, was troubled by clients' traumas that involved violence. "I still believe you can only see so much and experience so much violence and not be affected" (Chloe). Also, the participant established that what she viewed professionally as most dreadful in peoples' lives changed as her own life unfolded. One brutal story to which Chloe could not put an ending, she described as uncharacteristic of her practice, "weird" and that left her puzzling audibly as to why "I never found out the exact circumstances" [of how the client died, detailed by Chloe on page 63 above]. Another disclosure involved prolonged grief work related to the violence her clients frequently encountered. Chloe identified how close contact with clients over time could be taxing for the clinician while leaving an ongoing impact.

> [A]fter I became a parent, children became the hardest . . . So, once I became a mother, children were the ones that were the hardest um, you know, to see a child murdered. That was the hardest. Um, to have to see a child who was murdered, who you find out was probably abused before, that was the hardest. (Chloe)
>
> A lot of the work was with the families to kind of, you know, the grief. . . . I just have . . . of like, talking to mothers on a daily basis . . . the mothers um, whose sons aren't gonna recover or maybe be permanently paralyzed. So, I remember a lot of times developing a rapport with those families; seeing them almost every day and know, the infection is healing. Particularly, when you get injured that way, there's a lot of infection that, that, and ultimately, a lot of times, that's what kills them. Hope could be there one day and then the next day be gone. I mean, and this could go on for months. (Chloe)

For Doris, who does most of her full time clinical work over the phone, both suicidal and child abuse cases stirred up the most intense feelings for her. Doris talked about the difficulty and anxiety of facing suicidal issues and callers:

> I think probably what has gone through the day with me is when you get a suicidal caller . . . get somebody's attention with suicidal callers. And you would go (louder as a surprise) "Oh you're thinking about overdosing on your medication, what do you have at home? Do you have a gun? Oh that's so good you don't have a gun!" . . . you want the other person to know what the hell you're talking about. And the two most difficult, somebody, who is shitfaced, stoned, drunk – whatever, calling from a pay phone having to pause to throw up

> . . . and very crazy. . . . And, another one who was in his car or truck and . . . proceeded, had taken something, and proceeded to get on the freeway – those were two toughies. And the adrenalin pumps and it takes a lot to calm down. (Doris)

Doris also talked about the lasting traumatic stress and anger that resulted from working with child abuse.

> But I have worked with umm child abuse and sexual abuse victims, which I think is highly traumatizing and there have been some situations . . . I remember one little girl because I was the coordinator for child abuse . . . one little girl . . . she was failure to thrive. . . . she was brought a tray of food and . . . And, then she goes: "All for me?" (Doris)
>
> And, there was another little kid who had been burnt who had been over in orthopedics for a long time before she came to pediatrics and she was probably turning psychotic and that was very, very, very sad (pause) I,I get, that pisses me off! That people need to do that, ummm and [that] there's that level of craziness! (Doris)
>
> [A]nother kid whose grandfather was a police officer and whose father who backed him into the corners of the room and took a hairbrush to him and the skin was so swollen. There was no – you couldn't [ends the description]. . . . that was like, let's see, I left there in 79 so from 74-79 – the end of 79 when I was doing this and I have an immediate visual on that and that was like 36 years ago! [incredulous and almost as a question to herself] (Doris)

According to Edward: "The ones that hit the most are uh, deaths" (Edward). Edward described ongoing traumas in one person's life that he found "stunning" and "unfathomable" and that occurrence is detailed above (pages 66-68). Recall the tenor of Edward's remarks:

> She came back in to see me about some follow-up issues that have stemmed from the initial tragedy. Um, but I would say this [initial tragedy] probably happened four or five years ago. . . . Um, and this is uh, the mother of all grief stories. Uh, this one blew my socks off! Unbelievable! Unbelievable! When the story first hit it was like a Manson murder. Like this successful nice family murdered in their home. But then they realized it was a murder-suicide; all this came out. He didn't really leave a suicide note. . . . Just horrible. Oh, my God! So, it was stunning; it was a stunning story! . . . And so she went through a major depression. The main thing I probably did was normalize her feelings. How overwhelmingly horrible this is. And what an incredible, unfathomable experience and how do you explain what he did? What must have been going through his head? How could he have done that to his children to um, he had all kinds of issues with his mom. Um, so what can you really do? . . . You share her uh, disbelief and lack of understanding and um, there are no good words. (Edward)

The other death episode discussed is labeled as "Un-fuckin' believable!" by Edward. He described a close bond with the bereaved client and seemed angry to be somewhat helpless and again without an explanation to assist the client in managing an inexplicable and, perhaps with this parent, unnecessary trauma. The concept of fairness seems to be absent in this tragedy.

And chronic illness, oh yeah, yeah, yeah. One of the other, one of the other examples I, I won't go into details, but a case I'm working with right now um, a woman, a young, a younger woman who I was seeing for anxiety issues and somatisizing and some hypochondria, uh, had a baby. . . . So she had a nightmare pregnancy; had the baby, had some postpartum issues. Not too long after that came in and started seeing me. Dealing with anxiety, uh, cause she couldn't get a job and some other things.

Well, she got pregnant again. Had to go off her medication which was working pretty well. And, "I got to see you a lot, I need to be coming in frequently during this pregnancy because I remember what happened to me and I can't be on medication and what if it happens again?" Well, by a blessing, the pregnancy was actually pretty smooth. Didn't get diabetes again. Uh, handled it pretty damn well. Pretty damn well!

Had the baby, baby was great, everything's fine. Um, at about three months, the baby was showing signs of kind of failure to thrive, really tired a lot and kind of lethargic. Just wasn't quite right. And the doctors were pooh-poohing at first, baby's are different; some sleep more than others. It's not that big a deal, she, and she knew she was a hypochondriac so she was trying to lighten up.

Well, baby got a little bit worse, little bit worse; they did some studies. They did a brain scan. Had a tumor in the brain, cancer. Un-fuckin' believable! Baby was dead in three weeks. Nothing they could do. Dead in three weeks! If you can imagine this, this hit me very hard being a parent myself and I, at that point you know, I really cared about this patient. She's a lovely person. . . . That

> was devastating and it hit me very hard emotionally but she's just devastated. And it's like she'll be sitting there, you know, "Edward, how am I ever not, all those worries and all those fears and all my catastrophizing; how am I suppose to use these cognitive techniques and counter them? It can happen. It did happen! The worst possible thing!" (Edward)

Challenge to Core Values and Beliefs of the Social Work Profession

The historic core values of the social work profession (service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence) ground and guide clinical direction. Practice is often directed toward at risk, poor, and exploited people whose basic needs could be better met and whose quality of life could be improved. Inherent in professional practice is a commitment to look at the relationships, systems and circumstances that put people in harm's way while empowering the individual and stimulating change that benefits human beings.[8]

The juxtaposition of clients engaged in ordinary daily tasks overshadowed by trauma was brought up by all five participants. They were challenged when circumstances arose in clients' lives that clashed with the mission, core values and ethical standards of the profession. Anne was disturbed when a mom, who was trying to promote the important relationship between a father and his child, was beaten by the drunken dad to the point that mom required hospitalization. Barbara was struck with the social injustice she found surrounding the mansions of the wealthy that depended on servants, kept "back to the shacks" in poverty, to maintain their lifestyle and dwellings. She was also misdirected by people in authority to forget her integrity. With Chloe, there was a challenge to social justice as well as the dignity and worth of the individual person when

a victim did not want to testify against a perpetrator who shot and nearly missed killing her while he plea bargained a light sentence. The importance of human relationships was brought into question when Doris mentioned the triple deaths that faced a child who was herself expressing suicidal ideation. When Edward was called upon to serve people who experienced catastrophic death in their families, he was confronted with the reality that although "social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems," even solid and trusted institutions, like the family and the medical establishment, sometimes fail to protect vulnerable people. Social justice and the dignity and worth of the person were not realized when a highly educated and professional man killed his immediate family without explanation and an anxious mom was dismissed by doctors while a lethal, and ultimately fatal, tumor was growing in her baby's brain.

With perplexed discomfort, Anne talked about the good faith effort of a mother to make sure the child saw the father from whom mom was separated.

> I've worked with, you know, one adult who . . . it was the ex-partner, I guess, the father of her child that when she took the child over to visit him, he really beat her. Beat her up badly but she had no control. She had no idea he was going to be drunk and was going to do that. She was just taking the child to see the father and I felt real bad. That left me really upset because she was this really nice, kind woman who had the sense to get out of the relationship because this guy was such a total loser and in that she had no clue that he was going to be drunk and was gonna beat the day lights out of her and, I mean, she even ended up in the hospital. So that was pretty awful. (Anne)

Barbra spoke of early career experiences where she saw beyond the veneer of wealth that was supported on the backs of the poor, set-free slaves.

> I saw poverty; you know, just, just the most dire poverty. A um, bedroom community uh, or actually, a rural community . . . it was really the horse country. There was [the well-known wealthy by surnames] and they all had their estates, but when I had a call and drove down their, you know, mile long, you know um, lane and went back to the shacks that were in the back, there were children [of the servants and help] . . . malnourished. You know, children eating um, flour and water. That's all the family could afford. (Barbra)

Barbra also talked about a welfare board member who directed her when she worked in public assistance and social services prior to separation of financial grant determination and social services.

> 'I saw Miss Jones,' you know, 'She was in the A and P and she had a chicken and a steak in her basket. How can she afford? Now, Miss Barbra, how many, how much does she get a month from us? I want you talk to about what, talk to her next time about how in the world she could afford to have a steak in her, in her basket.' That was the mentality. (Barbra)

As well, Barbra reported being directed to commit fraud by a supervisor and when she didn't, there were consequences.

> And then she comes to us and said she wanted us to pad our cases, that, that we needed to open up the, foster care, we needed to, we needed to open a case for foster kids, for the parents and for the foster parents, which was, which was fraud. And, of course, I led the, I led the way on that one as well because, you know, I

> wasn't gonna commit fraud. . . . And I was, and I was not gonna do anything unethical . . . but she fired me anyway . . . and I, I appealed . . . and all of these people coming, coming . . . to speak on my behalf at this appeal. . . . And, of course, there had never ever been an overturn of a welfare board. And so, I lost. (Barbra)

When Chloe entered the field she described herself as a liberal and someone who was always looking for the roots of aberrant behavior which she believed often explained acting out. Social work principles of social justice and the dignity and worth of the individual person resonated with her. However, as the years passed and she saw the outcome of the deviant conduct coupled with her own parenting, her self-labeled "liberalism" mostly vanished. She said that after seeing the destruction to families from violence and gangs she no longer struggled with sentences of imprisonment without the possibility of parole or, even, the death penalty. She commented at length about her beliefs and the shifts that occurred with her own family as change agent.

> So, because, it's in the past, I can't tell you necessarily the time frame, but there were also periods of time where it was very hard on me or when I knew I needed to go on vacation. Or um, one thing I know is, and I probably need to process it and analyze it, when I started at that hospital, I was a very liberal, very um, had belonged to the civil liberties union and by the time I left the hospital, people have pointed out to me that I'm a very conservative, I have very strong feelings about certain things. (Chloe)

> Um, about, first, I'll give you a good example. I remember, I saw a young woman, I think she was like 20 something, who was shot many, many, many,

many times and she had a child. The child was with her. I don't think the child was shot. I don't remember. Anyway, in the end, she did recover. The person that tried to kill her, but in the end, was not successful, I remember they plea bargained. And they got like, a couple years in jail or prison, wherever they ended up.

So, I remember I used to be this person that used to say, "Oh, they had a traumatic life. You have to understand why they do these crimes. Um, the law is not fair. You know, they don't take into account their harsh childhood." By the time I left, I'm a different person. I'm very conservative. People who do crimes, I feel now, you need to be put away before you destroy another family. (Chloe)

Um, even where I work now, my colleagues are much more liberal than me. And my, some are like me, really very hard to understand, you know. But after seeing so many lives damaged, destroyed, I don't have a problem with someone being locked up for life or I actually started off not believing in the death penalty but I don't have a problem with it now. (Chloe)

There was, I remember, there was a young Hispanic lady walking with her child, the child was maybe three, who was gunned down by a gang. Just, they were out to try and kill someone in the morning; it was in the day and I just remember being really torn up about cases like that. The total senselessness! And I remember thinking, "Oh, do these kids' mothers know what they've been out doing?" And really wondering you know, about, despite their circumstances of growing up and stuff, how can you go and blow someone away like that. She's walking with a child, you know! (Chloe)

> Which I saw over and over again. Saw many people uh, who, you know, were nearly killed or killed and then finding out along the way that the person who did that got very little in the way of punishment/consequences. But the other thing is in her case, I'm remembering, she [the victim] didn't really want to testify against that person, now that I remember. And the thing is, a lot of those people, this is just their life, this was their community. This is not, a lot of the people I saw that died - this was the fourth person in their family that got killed the same way. So, that was the other thing. This was, was like, an accepted lifestyle and life to them and then the fear and all the things and, but, yeah, this was an accepted way of living. This was their life there. (Chloe)

Understandably, Edward appeared to struggle to wrap his brain around multiple tragedies in families where social institutions fell short. He recounted the example of the "successful" family wiped out by murder and suicide, mentioned earlier in the chapter. After that, Edward gave an account of a young woman and her pregnancies who was dealing with anxiety and hypochondria. This excerpt seems to reveal institutional conflict with the dignity and respect of the individual and to run contrary to the ideas in the profession's roots of service and competence.

> Um, at about three months, the baby was showing signs of kind of failure to thrive, really tired a lot and kind of lethargic. Just wasn't quite right. And the doctors were pooh-poohing at first, baby's are different; some sleep more than others. It's not that big a deal, she, and she knew she was a hypochondriac so she was trying to lighten up. Well, baby got a little bit worse, little bit worse; they did

> some studies. They did a brain scan. Had a tumor in the brain, cancer. . . . Baby was dead in three weeks! (Edward)

Seemingly, the client's intuition and fears were devalued by the authoritative medical professionals as an institution and the woman lost her infant.

Life Disruption for Participant

All participants revealed that the trauma that they chose to discuss had impacted them as people. They carried those experiences into their lives as emotional expressions, intrusive thoughts or as particular behaviors. Sometimes, professional practice changed. Some impact exposures to clients' traumas were more apparent than others. Anne, Chloe, and Doris acknowledged early-career dreaming about clients. Anne described intrusive thoughts that continued after many years.

> I still actually think that there are clients that I think about just wondering about what has happened, clients that I haven't seen for a long time. In fact, I was just talking about one client that had extreme trauma, abuse; horrible! And it was just really horrible! And I still think about some of them but without the effect that I had initially where it was just hard not to think about them and it was just painful to think about them. (Anne)
>
> My agency works with a lot, hearing those stories where there is no control on anybody's part and it happened, this horrible thing happened. And, it's really awful to hear it and you take it in and it's just really awful. (Anne)

Anne described how she had compassion for some clients but was frustrated by others.

(Exhale; Sigh) I think what I, I think I've always felt like when there's a greater connection with the client I feel it much more there's a lot more countertransference going on versus I've had a few clients over the years who've told me about traumas and it's like [kkkkkk sound] 'What did you get yourself into? You knew this was going to happen! Why did you do this? Why did you, you know, go off with this person or get into?' These, these were adults that knew better . . . but maybe poor choices. I think those people I just felt very differently than for the ones that experienced trauma that they had no control over. (Anne) But yet others who kinda they know better and they know what could happen because it's happened be[fore] and 'Why are you saying? Why are you letting this happen' and then you come back for help, you know; the helpless victim – Oh, poor me! . . . Like, well you knew it . . . [w]as going to be that way. Exactly, so I think I would have more compassion for the people who were kind of were innocent victims that really didn't know versus the ones who just made stupid choices (voice rising; silence). Now, I don't let them see any of that I try to be very, you know, the usual professional and not say anything like that obviously. But I think there was a higher level of compassion for the ones that sort of had no control over the situation.. . . this road before! (Anne)

Why is it happening again? Exactly! It's hard! That, that - Those were times I think I felt very frustrated because this, this adult who should have known better was just making these poor choices over and over and over again and then you know, having bad things happen. And I think there is a level of frustration rather than empathy, you know, rather than the compassion that I felt toward

> those that had no control over it. . . . I found it much harder to do the work. And I just couldn't form the same type of emotional connection I could with the others. But I still was able to. I mean, even though I wanted to scream sometimes. But, I - I don't think it ever, I don't think I ever experienced anything where I just couldn't. I think I think I was able – as hard as it was in cases. (Anne)

Barbra reported on a woman in her forties, with whom she closely identified, who she had been treating and carrying for a decade.

> And I, my, just I, I, I carried this vision with me for years of her just languishing in her crib, crying and crying and crying and no attachment, no attention. And absolutely in this dark hollow world of being alone and, and being abandoned continually. (Barbra)

For the most part, Chloe learned to shut down her own feelings and she stayed focused "on their [clients'] needs" with little awareness of or attention to her own state in moments of crisis for clients. But when her safety was threatened, she was aware of being frightened and took precautions to protect herself.

> It's there; you automatically do what is needed. Like, for example, when you're present when the doctor informs a family that their child or relative just passed away, you anticipate how they're gonna react because you hear it so often and, again, it's almost like just being there is important. Someone has to be there. But you're not sitting there thinking oh, am I, you don't think of how horrible it is in terms of how it's affecting you. You don't think of yourself as focused on your, on, my needs. You're focused on them and anticipating their needs and what they're gonna do.

> Now, I know there were situations, for example, when you do become aware of how you feel. For example, situations you become frightened because some people um, like for example, if you had a gang member's death, you had to have heavy security there. You know, a lot of times the families would threaten us. Well, they would blame us. Um, I mean, it was very common. Like, in some [situations] that families would throw things um, like I said, would threaten the doctors, would um, there'd be total chaos. (Chloe)

Doris extended herself to clients in whom she was interested and with whom she had made a connection. As described earlier, Doris did not shred the chart of a client she hadn't seen for more than seven years [her standard practice] because:

> It was just an incredible dysfunctional, so she called me back . . . It that kind of situation, it's with somebody who's been from a really dysfunctional family and you've made a connection to help put some sense of calm and structure and order there. (Doris)

With other clients, she immediately set strict limits.

> So, I feel strongly that I have the right to refuse if I don't feel like I would never take a risk, I have not been, I've been incredibly fortunate that I've not had any actual trauma but it's just, it's just something I don't need to deal with (Doris).
>
> And, at that point I had, I guess my first borderline and she was acting out . . . she was trying to get her way about something and she said, she alluded to the fact that she was going to have somebody "get me." I said, "I'm sorry, you are OUT [strong tone/emphasis] of therapy!" That became my instant rule, if I can't be safe I can't help you! And, you have just . . . by your threat and, personally, in my gut, know

> you're not going to do it but we don't joke around about that stuff. I kicked her out! And then, in the parking lot with her mother and sobbing, "Can't you give her another chance?" I said I give people just one more chance but don't ever do it again! With the same kid, she was probably in her early twenties that had a temper tantrum in my office and took the plant and (fsssss: mimicking something airborne) and I said, 'You'll be back here tomorrow to clean that up!' (Doris)

Encounters with a couple of clients led Doris to fear for her own safety and she changed her behavior.

> This man would follow women in the mall, and every time I left [the mall], man I made a bee line to get on the freeway (chuckle). . . . Um, I had a patient who was a deputy sheriff (cough/throat clearing) and he would run people's plates . . . for the longest time, my aaa vehicle registration and my license went to my private practice. And, obviously now that I'm just part time [in private practice], I have a post office box [location] for my license. (Doris)

Doris also talked about how dysregulated she got when she had to deal with suicidal callers.

> I think probably what has, has gone through the day with me is when you get a suicidal caller . . . And the adrenalin pumps and it takes a lot to calm down.

Edward described the difficulty of managing client trauma in very personal terms. He worried that the work drain interfered with his roles at home with his wife and children.

> I'm a guy; and hold things in; and don't talk that much about stuff. Yeah. And the down side of me as a husband and father is I don't want to go and hear a lot more

> of that. But yet, I have people that want my attention and would like some of that that I'm giving all day long to other people. Being totally present in the moment and giving them my full attention for just a minute. And hanging on their every word fully being with them. I don't do a lot of that at home. I mean, I do it, I hope, some. . . . So it does, it does take a lot out of you.

Anne and Chloe reported on dreaming while Doris seemed to corroborate the phenomenon that was being described. Anne made a connection between dreaming about her clients and being consumed by them and she sees that same pattern in new social workers.

> Okay, initially when I first started, I remember . . . taking clients home every night and dreaming about them, vividly. And I remember asking my supervisor, which is the same thing I tell people I supervise now: 'When does it get to the point that it doesn't consume you?' He said just a process and over time it just happens where you will still have compassion for them but you won't be thinking about them every waking minute day and night. Over time, it has just happened . . . it was just the process. . . . what my supervisor told me I always tell them [supervisees] because they're now bringing home all the cases and dreaming about them. (Anne)

Chloe, as previously mentioned, seemingly shuts down her own feelings and acknowledges dreaming but had no feelings about her client dreams.

> Um, in the early years, I do remember I would sometimes dream about; (pause) but after a while, I never dreamt about the clients. And I don't know what, I mean,

I'm not saying the dreams made me feel any particular way, I just remember I just dreamed very, very early years, like in the beginning. (Chloe)

Doris implied that she used to dream by completing the investigator's sentence asking about taking experiences home after work.

[Investigator:] Have you ever been aware of, of taking all the emotional stuff that you've been containing, on a shift or a week, home with you? Did it come up in your personal life? I mean, some people have said in the beginning they used to [participant interrupting and talking simultaneously, softly)] Dream about it! (Doris)

When a Client Triumphs Through Resilience, Strength, and Growth

Resilience in clients evoked admiration in participants even if they didn't always understand how their clients had developed such an attribute. That elasticity was a factor that could not always be predicted when a traumatized person presented to a participant but participants acknowledged it as a significant strength in some clients. Although Anne talked most directly about this factor as an element of continuing effects, Barbra talked about a woman with a disordered attachment who still managed to accomplish many things that added quality to her life while Chloe and Edward discussed clients with horrific losses who went on.

Anne said:

Could, it [resiliency] could be. Because I think if you did see, I mean even this little girl who had been so traumatized. The time I worked with her she did much better, I saw real growth. I mean she did much better! Eventually this little lamp [sand tray object] was not moving along with the characters and she was able to

play out the trauma with some of the others. . . . she was able to sleep at night without screaming . . . I saw growth there with this woman and she just did so much better she went totally you know being totally just staying in her bed all day to actually being a full time student and identifying herself as graphic arts major - You know, so yeah. I think that, that's what gets you through when you see the growth versus I think if we never got to see it, I don't know. I, I don't know. If it was anything short term and you never saw the growth how you would handle it? I think it was. Yes!, seeing the people do better and feeling like I had a hand in them doing better made it a little easier to deal with when you heard the horrible things. (Anne)

Right, right, the others - the resilience. Yeah, but, but there's, you know, I've talked about this with colleagues sometimes you see amazing resilience and sometimes you don't. And, it's like what makes, what makes it so different that some people despite horrible, horrible things still have that resilience while others don't? And, you know, I don't think you could say, it's because, well you know, okay, as an adult if they had some horrible trauma that they had their whole lives they've, they've had this great upbringing they've been, they've learned to be resilient. They, they've had everything; all the nurturing, everything it's taken so they have that resilience so when something horrible happens they're able to cope with it. But then, you've got others who they've never had anything good happen and it's been from the day they're born its horrible! But yet, they still can have resilience. Some, yeah, but some that haven't really had that many horrible things

happen but they have no resilience. It's like where, (pause) where's it coming from? (Anne)

Anne elaborated with a previously mentioned [pages 62-63 above] client example:

[C]lients how some of them have the resilience (pause) and others just (pause). Yeah, I got actually I had a letter from a teenage girl that I had worked with; she found me. . . . and she had been in foster care and was . . . I guess she'd been molested by a cousin in the foster . . . After I left I heard she had a suicide attempt.

Well, somehow, this kid she bounced back. . . . four or five years later. … And she said, "I don't know if you remember me" and I said, I wrote back and I said, "You know there are some people, kids that just get into your heart and you don't forget them and you were one of them and I've always thought about whe what's happened? I'm so glad that you're doing fine!" I mean it was jus . . . . How she managed? Cause she, that was a trauma, I mean, being thrown out of this home that she'd been in from the time she was a young child and, because she disclosed. . . . The truth, yeah! And it was just horrible; it was horri, jus awful! The fact that she found me and wanted to let me know how she was doing four years later. . . . but the fact that she managed despite it all. You know, she did have a suicide attempt. She was, you know, not doin' so well and they moved her out and she managed to be okay (voice rising). (Anne)

Chloe seemed astonished at the level of acceptance of gang culture and how families were able to absorb losses of three or four members to gang violence and be resilient enough to continue their lives in the same community.

> Which I saw over and over again. Saw many people uh, who, you know, were nearly killed or killed and then finding out along the way that the person who did that got very little in the way of punishment/consequences. But the other thing is in her case, I'm remembering, she [the victim] didn't really want to testify against that person. Now, that I remember. And the thing is, a lot of those people, this is just their life, this was their community. . . . his is not, a lot of the people I saw that died, this was the fourth person in their family that got killed the same way. So, that was the other thing. This was, was like, an accepted lifestyle and life to them. (Chloe)

As outlined above [pages 60-61 and 65-67], Edward talked about clients who moved through death of family members and still went on despite the shattering reality that was then imposed on them as survivors.

> So, as time went by and the initial bomb went off about the murder suicide, it was now the way she was being treated by her siblings. And so she went through a major depression. And has been kind of in and out of that depression ever since. And I saw her regularly for awhile. Then, she was doing pretty darn good and I would see her once in a blue moon. (Edward)

All participants could identify that traumatized clients were able to move forward and that having a hand in that journey was gratifying. In other words, participants

identified a level of satisfaction in their practice despite encountering horrific traumas that sometimes stayed with them. Anne commented:

> I saw real growth. . . . I think that that's what gets you through when you see the growth versus I think if we never got to see it I don't know. I, I don't know. If it was anything short term and you never saw the growth how you would handle it. I think it was. Yes, seeing the people do better and feeling like I had a hand in them doing better made it a little easier to deal with when you heard the horrible things. (Anne)

Barbra mentioned her role with the client she had been carrying for a decade.

> I think I, I really, I have helped her resolve the abandonment stuff to a small degree. I don't think it will ever, ever, ever go away. But she's been able to make some gain in her life. Her quality of life has improved. (Barbra)

Chloe's love of listening led her to celebrate humanity.

> Well, um, the thing I like about it is you see the humanity and you see people coming together and pulling together and helping each other. And, I said, that's what I really like. To see the goodness in man out of all the horrible things that people can do to each other. (Chloe)

Doris felt helping people change negative behavior was of benefit.

> But I think you're basically in a position to help people stop the abuse. . . . I think what I was able to do with the kid who was beaten with the hairbrush was to give to the dad and to the kid what they needed, I mean, in, in a very real way.

When the Client Was Helped, the Participant Felt Empowered

Anne emphasized that clients had an opportunity for benefit and growth when someone paid attention and let the client get their whole story out and, thereby, form "a connection" supporting potentially effective outcomes in treatment.

> You know, sometimes just being there for the client. I think the clinicians that are able to really be there for the clients and just sit there and listen to their stories and form that connection I think they are able to ah sometimes just be more effective than (trailing off). I, I thi - in trauma work, I think in just in anything, but in our clients have stories to tell and some of them have never – their whole lives, they've never been able to talk about it. I think the fact that she felt safe enough talking about it because I, I don't know if she ever really told her whole story to anybody before, maybe pieces but not the whole thing.
>
> And somebody that's just able to go and sit and be there and, you know, 'you know I understand' and just listen . . . and provide some support. It's very powerful I think. And, it sometimes is the first time anybody has actually giving them any attention. (Cough) So I think that if they're able to connect at that level that sort of is very healing.

So, for Barbra, feeling effective with, empowering of and helpful to clients involved imparting knowledge and building the base for skill development so clients and communities could find their own way. Barbra felt empowered through the process of social change.

> [T]he highlight of my week is I have a room packed with people who say, "How come I didn't learn that?" . . . "Why, why didn't anybody teach me that?" I've

> been in therapy since I was 13 and nobody taught me 'I' messages or nobody taught me you know, nobody taught them anything. . . . if we could teach people tools. Tools for living. It's like, now it's been integrated and an integral part in treatment is to help per, people access what they need to do to be able to think and solve problems and, and manage, manage their feelings.

Chloe echoed Anne on the importance of listening to clients and added, "I found their stories fascinating." From Chloe's perspective, being able to listen in the times that were toughest for the client established the connection and laid the base for cooperative client-clinician endeavors.

> Um, I always found it fascinating to listen to people about their lives. Um, so I was probably one of those people who didn't mind taking a lot of time to listen, um, because I, like I said, I found their stories fascinating. . . . Um, just listening or being there for somebody crying. You know a lot of people in the hospital setting, they go the opposite direction when there's grief. Um, but I guess I just learned that it was important that not everyone can do that and I could do that. . . . Um, I guess the, in my situation, my job was not to hide and run away, where a lot of people they don't want to hear the wailing, they don't want to experience that, that horrible ummmmm Yes! Gut wrenching, that's what it is! . . . And, like I said, I always had a fascination; I always loved listening to peoples' stories. Because when people are in a crisis like that, you can make a difference, you know, helping them understand the system . . . I think one thing that I liked about my job was I felt like I could be effective very quickly.

I think I still could feel positive in that I was making a difference just being an advocate for them, just getting, being able to connect them with the doctors. Yeah, and they appreciated that I was forthright and, you know, explained, you know, what was going on and it was, we weren't trying to, you know, necessarily point the finger at them and say they were the worst parents in the world. (Chloe)

Doris described feeling empowered, effective, and like an advocate as she pragmatically went about creating calm, structure, and order as well as making the extra effort to facilitate problem solving in complex situations with the "the adults who interested me enough."

I do not have great patience for an intense persistent recounting of the blow by blow for the past 20 years. I'm very much a problem-solving type person. . . . And I've gotten more um proactive in defining what I see my value to them and what my style has been. You know if I give you a little snapshot of something to do today that makes a tiny bit of difference, then I've been helpful. And, I try to educate people, a lot of people who want to talk about nothing and I don't have patience.

[T]here may be other things that come along that may traumatize them – like having to tell the story to the police, having to go to court to testify although actually I kept the little kid out of the court. . . . I actually called back to the hospital, to the on-duty administrator. I kept her [little kid] out of court from testifying. (Doris)

So, I have people who chose to stay . . . um and probably those who have stayed are the adults who interested me enough . . . Aaa, but in that case, I just cause she

had a daughter at home, he was the step father, and that girl had a lot of trouble. It was just an incredibly dysfunctional, so she called me back . . . In that kind of situation, it's with somebody who's been from a really dysfunctional family and you've made a connection to help put some sense of calm and structure and order there. So, it's interesting that I have people who will call and I can vaguely remember but it's like I don't remember all the details . . . But, so I guess, you know, um and so I probably kind of like a healthy anchor. Yeah! I mean, you're a problem solver; you're, you help to empower other people. Um, I used to testify in court all the time. . . . I actually enjoyed it and there was a lot of work . . . But, it's part of the memory, that in spite of the trauma that there was somebody willing to go to bat for the kid. (Doris)

I have good I have good cognitive behavioral skill. Teaching adults. Everyone gets a dose of that from me. (Doris)

Edward also talked about being there for the client even when no action could repair the trauma in the moment. As time evolved, Edward remained steadfast in supporting the client as they moved toward their own empowerment, effectiveness, and advocacy.

Like I said, that was four or five years ago. And you know, you've always got a few really special patients that really, really, really need to get in. That you can always at least somehow see them every other week. Like by some grace of God. Making sure you stay right on top of your cancellations and so, I saw her, you know, as regularly as you can see anybody back in those days. Better than now. So I saw her pretty regularly. Um, gave her a lot of support.

I think so. I mean, I, I feel that her coming in to see me, I, you just kind of pick that up with some people; that it is really important to her. She really makes an effort to be sure she's got an appointment. . . . Um, so what can you really do? . . . You share her uh, disbelief and lack of understanding and um, there are no good words.

Both Anne and Barbra told stories of success. Anne mentioned client successes by the teen who was an accident victim and the same age as her child and about a molested child who was resilient and grew strong as she moved into adulthood. Barbra shared the triumphs of her 10 year client.

[B]ut I still, despite how horrible it had been, I, I was able to work with him and really, I think, do quite a bit. I mean he was like so depressed he was having psychotic features when, right when I started when he had just gotten out of the hospital and ended up going back in and then I started working with him. Got to the point where he actually got a driver's license and was able to go to school part time. (Anne)

Yeah I got actually I had a letter from a teenage girl that I had worked with; she found me. . . . and she had been in foster care and was . . . molested by a cousin in the foster . . . After I left I heard she had a suicide attempt. Well, somehow, this kid she bounced back. She was put somewhere else. I guess it was maybe five yea, four or five years later. And that was one of those kids that you always thought about and I get this letter in the mail with a picture of her letting me know that she, at that point, was a young adult. She had gotten involved with like Patients' Rights. Cause she'd been put into some sort of a group home in a

different county. She'd been in [name of] county when I worked with her and put into [name of] County and she was working, she was, she was going for therapy at one of the centers . . . And, she was, you know she'd gone up to Sacramento to speak on, on young adult patient rights and, and really ac . . . involved - she'd gotten her degree . . . .(Anne)

Finally, Anne mentioned a person who struggled with a past history of sexual abuse but went on to a career after a prolonged period of depression and isolation.

[S]o I saw growth there with this woman and she just did so much better she went totally you know being totally just staying in her bed all day to actually being a full time student and identifying herself as graphic arts major.

And, and she actually did some projects and things that were amazing. I mean you could see that she was talented. And I said, do either one, but you're really good in art, you know, why don't you try art? Well, that, that was it; that changed her life. She went back took the class. She was one of the best in this drawing class. And she took her work, her work was put on exhibit and from there she took other medium you know acrylics and oil painting and the whole thing and eventually she was so good she would bring in each week she would bring in a painting that she had done to share with me. I mean, phenomenal art and she was able to really express herself through this art ah and eventually there was a juried art show at the school and she submitted three, they students were allowed to submit three pictures and she submitted three and some didn't get anything accepted and some really even talented people didn't get a single thing accepted and she got all three accepted.

And so at the art show, she actually came and told me about it and I actually went during the art show to see it. Which she was just thrilled that somebody cared that much, I mean her stuff was just remarkable. But she was also able to express a lot. I mean, there were painting about the abuse and paintings about her son's illness it really she then decided she was going majoring in graphic are, graphic design and she was going to take classes in that as well and she suddenly saw a future for herself. That you know. She was putting everything behind her.

Barbra commented on not giving up on the severely neglected woman with whom she has been working for ten years. The client's multiple successes seemed to motivate the treatment.

I've never, I adore that woman. I, there's just something I love about her. And she um, stopped smoking dope, she got the gastric bypass, she bought herself a cello, violin, excuse me. She was very talented musically um, um, saxophone and violin, very talented.

She's really done some really cool things. someone who, she knows I love her. That's all it is, is I love her. I can't use fancy, I mean, I, I try to teach her things, cognitive restructuring, I don't think so. It's love! It's listening before suggesting and you've got to take it extreme, I mean, you never directly say anything to her because she's so oppositional because she's, you know, three years old emotionally, you know.

Theme II: Milieu Factors

All participants spoke about some aspect of their professional environment such as co-workers, supervisor(s), systems and administration, which was often off-site. The milieu represented a force, which could be positive, negative or both, to be reckoned with by participants in the delivery of services for those clients who had been traumatized. The highlights of those remarks follow participant by participant.

Alone among the participants, Anne clearly identified that the "group" clinical setting in an agency was and had been a necessary resource for her in working with traumatized clients. She talked about the use of supervision and colleagues as a way to integrate difficult work. In another instance, she described some younger, less-experienced members of the team who did not support her clinical work and who tried to make her wrong, but Anne went with social work principles and her professional intuition to provide the level of service she felt would facilitate the client's growth and rehabilitation.

> Or if you're really, that's one great thing about being in a group setting, in a like a clinical setting rather than private practice when you feel like, Oh my God! You have to share it with somebody, you've got, you've got to! "You wouldn't believe what I just went through!" Right there in the trenches to be able to share it with other people. . . . You know when you get this awful you hear this horrible thing you need to just unload on somebody else that can just listen without passing any judgment and maybe give you some suggestions or advice.

In another example, Anne commented on the issue of support during treatment of a severely injured and paralyzed teen.

> The other, the other, my colleagues. I think my supervisor . . . I'd meet with my supervisor and then my colleagues because he [the client] would come [to the office]. Yeah, initially I would go out to his home and then when he became a little more mobile, he'd come into the office. Everybody knew him and everybody liked him so, because, the coll – you know, we would talk about it. And, and I was able to at least, ummm, you know, get the support that I needed that way because it was, it was, that was, you know (voice rising), it was tragic!

In Anne's first two examples about the worker-surrounding milieu, she described a supervisory hierarchy that was there for the front line social work clinician. However, in her third example about an apparently unusual situation and which was about Anne, the support was not hearty. Nonetheless, she seems to have been comfortable even without that reinforcement.

> Although in my program where I used to work we had group consult for licensed and unlicensed so there were people who were right out of school as well as experienced, licensed-for-years people and we'd get together in small groups and discuss cases. So we . . . where I am now, even my staff once they are licensed, because some of them are getting licensed, . . . a clinical supervisor under me who works with the staff who are licensed and unlicensed and I just work with the student interns. But then we also do group supervision on an every weekly basis. So I'm involved with that as well. So my licensed staff is still getting supervision. . . . it is the agency policy . . . Initially, I wasn't having, I wasn't doing individual supervision for people as they got licensed . . . we were just doing the group supervision but my supervisor said just because they're licensed they still should

be getting the individual supervision as well. . . . I found in the group consult when I was stuck on a case - and I had been doing it for years - I was supervising, you know, up to five people at a time; but still, if I was stuck on a case and it was really good to get input from somebody else.

We had a, what would be group consult and we'd have to present. . . . were both clients of this agency and something had come up at one of our group consults . . . I told the story about the art work, I said I went to the exhibit and it was just and she [the client] was just so excited that I had gone to this exhibit and then some of the staff who hadn't been there that long . . . 'You mean you, you did something like that?' I said you know I didn't go with her but this was a really huge piece and for her it was so powerful that it meant something so that somebody else would go and see her work and it was that was very therapeutic. And it was not any, I, I didn't see it as any sort of boundary issue. . . . some of the other staff said 'Well, you're not supposed to do things like that!' So you know you have to do sometimes what you think is clinically appropriate or best. (Anne)

With many job experiences in her career, Barbra spoke about supervision that was intrusive in that she was directed by a welfare board member to question how a welfare recipient was spending her grant that included a portion for food and to commit fraud related to foster care. [page 78 above] Thereafter, she spoke negatively about administration in her present practice setting but tenderly about her current, local work environment. The funding difficulties related to service delivery in non-profits also got some attention from Barbra.

[W]e had a fire in [date], yeah. . . . our building burned down. . . . and they're [administration] threatening that if we don't keep up our productivity, they will deploy us to um, [location more than 25 miles away] or beyond. So, the administration in this, in this department is loony, fear driven, loony, crazy. And there's too many bureaucrats who don't have enough to do. So, their idea, of course, is to create forms, policies, new procedures.

Anyways, but I'm extremely lucky because the sanity in this, in, in, in our, this operation here. And we, we're getting old together. We're old . . . you know. And so, we are able to insulate and support each other and we have uh, a fairly good administrator here, not great, not, not like [upper management/top agency administration in a distant location]. She doesn't really know how to assert, but she's not, she's not harmful to us. She's not vindictive. And we have a lovely new supervisor that we really love. Uh, so fact one is that we have a lot of, it's a healthy, you know, we don't gossip, you know, we don't gossip, we support, we, we affirm, we, we, we encourage each other. We, you know, we, and, and we, I, I think we're very kind and respectful to each other. So, we have a good, I would say, a pretty healthy working uh, environment. And that's one thing that gets you through. Because, hey, all the crazy people in the world aren't as crazy as [upper management/top agency administration].

Although Barbra found professional success in her non-profit experience, that setting was sufficiently wearying to lead her into private practice for five years.

You know, you're beggars at the gate. "I can do it cheaper than uh, than this child and family can. I can do it cheaper than," you know, "We can do it cheaper than,"

> you know, it was this competition. So, who, a race to the bottom kind of thing. That's what nonprofits are, you know, it's the race to the bottom. You, you don't pay your staff anything, you don't provide any [trailing off]. And, you know you're gonna have a big uh, over uh, you know, . . . the staff leaves a lot? [turnover] Yeah. . . . So, I just said I need to um, to, to take care of me. This [non-profit] is, this is uh, like a job that is just overwhelming. So, I went into private practice and did that for five years.

Inspiration was Chloe's feeling when she was exposed to the hospital as a graduate intern. However, Chloe depicted a detachment from the social work department through which she was hired and where, according to the hospital's organizational chart, she practiced for more than 20 years. Over time, Chloe talked about how the positive, strong role models at the hospital left and she felt profoundly alone and, perhaps, without the training and supervision from the social work department that would have helped her deal with the many feelings and experiences confronting her position on the interdisciplinary team. Nevertheless, she expressed feeling connected with the interdisciplinary team focused on trauma work.

> Well, when I started there as a graduate student, the director, who became my supervisor, she was a very um, [person's name] and then the consultant there, [name], they were all people who loved their work and were very committed to that community, that hospital. So, I think that made me really, made me inspired to want to be there to stay there. But then as time went past, they left and then I don't think there was anyone there. Actually, I felt like I was a lone person working, you know.

> And maybe and I could ask for someone [from social work department] to come and help me. So, basically, I was it. . . . In other words, it wasn't just me. It was the nurses' staff, it was the nursing manager, it was the head of the I.C.U. and the head of the attending physicians. So, we worked as a team. So, it's not just me doing crisis work; I'm working as a team with other people.
>
> But in terms of my own department, the social work department, I became, not isolated, but very separate from them because their work was more like the normal, kind of very routine kind of work. So, I was part of the department, but I functioned very much on my own. It wasn't often that I needed to um, and actually, I could probably count on one hand the times that I asked for extra support. And it'd be, if it was like, a day where I had an appointment or maybe a crisis that was gonna go way into the evening or something like that.

However, in Chloe's current job her feeling is much different. She did not express the same connection or efficacy in her present work. "Here it's not that way and I feel like there I was in control of a lot of things and the team, we controlled everything." Chloe's dissatisfaction in her current position is shared with her supervisor.

> Well one of the things that I talk to my supervisor about is change is slow and very minimal. And that's very frustrating to me. Here, I have to deal with the [name of agency], foster parents who wanna check or who don't wanna do this or that. Yeah. . . . It's sad to say because a lot of them want the check. I mean it's just the whole system that is constantly frustrating and blocking.

Doris's milieu issues bearing on delivery of services included feeling alone, the high volume of work, reactions to her assertiveness and an experience of non-support from the social work department when she was facing personal trauma in her life.

> The other thing that I've found very interesting is that when you work the ... team, you're out there all alone. Um, in that there isn't anyone immediately available, you are the consultant. Now that's the way it seems to me. I mean, it's not . . . When, when I, when I - Like tomorrow when I work the . . . team and I'm in the emergency room, it's like I'm the consultant that comes in. Ahhh, it's interesting because the other gal who also does this on a per diem basis . . . and um, we'll work her tomorrow and the two of us kind of collaborate back and forth. She's an RN and now a PhD psychologist and we've known each other a long time. So basically, I self-select who I want to talk to.
>
> Oh yeah, yeah, I mean (cough) Um, some days I'm not so good at it. I mean, I was actually semi-shouting at someone, this was Saturday, it's like the third day of treatment usually the fourth day is when I'm short-tempered. . . . So, I will, I can say when I'm feeling overloaded, I can be short. . . . I would say there are days, the most recent day that was the busiest, I had nineteen cases; that meant that there were nineteen new people that called and you have to do extra documentation . . . Nineteen! . . . So, I probably didn't document any of that [additional, not new callers] but that has been the most recent one that was the most hectic and they were really intense. (Doris)
>
> I actually got kicked off the team because I was too assertive. And I made the head of [department] sit down with me and my supervisor . . . But yeah I think,

> you know, I personally am not afraid or I have acquired a lot more skills. I mean there was a point in time when I wasn't quite as outspoken or quite as assertive but I it's like the older you get, it's like "HEY! Don't mess with me!" (Doris)
>
> I basically said if we treated patients the way that management treats us . . . we'd be fired in an instant! (interrupting) Oh yeah! Yeah, no, the trauma was the personal trauma. . . . and the [name of] team was fantastic because they set him [dying father] up for [specific treatment] and one of the fellas made a house call so that - it was within the time frame when we knew he was dying. Yeah, so it was that particular team and that's where my attachment was not the social work department. And, and I found out later from someone that they're [social work department] still crazy. But, um, yeah that's, that's something that like still sticks in my thought. So, if you wanna talk about a trauma, not a client-related, but just a personal one . . . and the way, um, your professional organization the environment that you work in could help or hinder. (Doris)

A different supervisory experience influencing service activity in Doris' current practice setting gains some positive recognition.

> Well, I think that's kinda where [names supervisor]is. I mean, you know, bottom line is there are parts of her that - she doesn't put up with slackers! And, as a manager you have to do that carefully, but, you know, she gets, rolls up her sleeves and digs in. But, um, yeah, I mean, you know, and she's worked shifts every since she has been a manager and I don't think it hurts.

Edward found an experience early in his career while he was volunteering that left him opposed to inpatient work but, as will be seen in the examples, ironically connected

to his current practice experience. His depiction of the present practice milieu revealed changing dynamics over the years that affected service delivery. He went on to describe his more recent team experience differently but there remained a hint of that old issue of social workers as "secondary support staff." It sounded vastly different from what Anne had portrayed and definitely limiting to Edward. His feelings about management and administration seem to reflect resignation, if not anger, about their disconnect with front line clinician issues.

> Uh, what I, what I saw there [inpatient psychiatric facility] was a social worker's job in those settings was basically an underling of the doctors. . . . You couldn't do a darn thing with any patient without checking out the doctor first. . . . very weird. You could never get these guys on the phone. Um, just odd. . . . Very weird. . . . I didn't like that experience. And I thought the social workers that were hired that worked there, also there was a, they were very secondary support staff.

[Participant talking about system dysfunctionality] "I don't think they [off-site management and administration] really want to know! It upsets the applecart." (Edward) He went on to report:

> And what I tell people now um, I've been doing this probably for the last year. I just say to them, "It sucks. Our access sucks. It's terrible." And um, this access issue you don't have to kind of sugar coat it or try to pretend like we can still do some meaningful therapy. There's just something you know a little proper intervention can really do a lot. And you're like handcuffed.

Edward went on to explain that even in the past when staff were less stressed and had time for supervision and consultation, it didn't happen.

> Well things weren't as bad then as they were now. Like I said, that was four or five years ago. And you know, you've always got a few really special patients that really, really, really need to get in. That you can always at least somehow see them every other week. Like by some grace of God. Making sure you stay right on top of your cancellations. . . .
>
> Well people weren't as stressed. So you're more likely to talk about a case. Um, there wasn't any structured supervision or anything like that. There's always been, there's been going back over the decades, there's been times where um: 'Hey let's have a clinical meeting where we can talk about cases. Let's set that aside and do it.' And it never really gets rolling and it peters out quickly.

Edward continued to describe his dissatisfaction with an ever-changing workplace. Giving and getting collegial encouragement sounded complex in Edward's setting. Support comes briefly and intermittently and seemingly with little consistent substance but some momentary sustenance. Like Doris, Edward reacted at some length to the jolt he experienced from the volume of clients in his practice setting. He illustrates how the back-to-back volume of clients and the stories they bring are difficult to chronicle. It seems that the participant faults himself for being unavailable to his colleagues.

> There's one doctor that's been here . . . I have never met him. He's one of our per diems and I, I think I've seen him once or twice in the hallway 'cause I've been busy and he's been busy. Um, but I never met him. And there's about three that I

think now, I think I got their names down. And um, I've had to talk about a couple of cases with them. So that's been nice and they seem real nice but you're just on the go and there's so many of them. And we have a lot of part-time ones now. Eight hour day, if everyone actually comes in, nightmare! And when you fall behind in your notes and maybe at the end of the day I'm trying to catch up and I'm going back, I just had this happ, I had a couple of weeks that were like that for me. It was so bad these last two weeks. . . . just, they grind me down much more now than they used to. Much more than they used to. Um, but I had this happen the other day where I'm, I fell way behind in my notes that day and I'd go back and I have to give my 8:00, 8:00 AM appointment notes and now it's like 7:00 PM. And I've seen all these other people since 8:00. And I can't remember and like I jot, I've uh, I use steno pads. So I jot things down. But, going back and reliving that 8:00 AM appointment and you realize how much has happened between then and there and how many other stories you've heard and whatever you've tried to do clinically in-between and if you think too much about it, it can be overwhelming. If you just uh, live very existential and in the moment, it kind of works, up to a point. What keeps it from working is going back and having to do the charting. Which is a big part of what we do. If I'm, I, I think about this all the time; I can have, I can see ten people in a day. And I can do it, I've been doing it for so long. I'm with that person for that fifty minutes. They have my full attention. I'm with ya , you know, talking to you, you're listening to me. And I feel like I'm there for you. Over, bring in the next one. Over, bring in the next one. But, you're also having to do all the charting and all the writing and having to

actually think about it in a little more detail. And that's where I can feel overwhelmed, that kind of does it. Not that being in the moment and not processing is healthy in any way whatsoever. It's a survival mechanism.

Um, when you're writing a note you can write in a, in a way, you kind of feel (Unclear) forced to, there's so little creativity left in our world. But when you're writing under the format we have to follow, you can distance yourself emotionally. Present a problem, what did they say, make sure you get a quote in there, what was the intervention. How was the response to the intervention? Dah-dah-dah-dah-dah-dah, very cognitive, right. So in a way that does act as a protection. Uh, but at the same time, I try, I got to get some flavor in there of what was going on with the person so when I reread that note as I'm getting ready to bring them in, in the middle of a busy, busy day two months later, I get an essence of what's going on with them. The note's for me. Uh, very few of my (Unclear) notes are ever read by anybody. (Edward)

You know, you walk into, there are clinicians here who I feel very close to but I know how damn busy they are. You know, and I know how busy I am and I know there's been times where I'm trying to get caught up in my notes and I'm, I get a little obsessive about that sometimes and I'm busy and someone pops in my door and starts making maybe a little small talk. Maybe that could be an overture to something deeper, and I'm not being as present with them. [I'm thinking] Gee, I really would like to get that note done. God, you know, five minutes till the next person comes in! (Edward)

> Yeah, but boy, I, I know I think real well, we share a wall. You know, we talk a lot 'cause we're next door to each other, you know. And um, you know, I would just step in there and she would just step in here sometimes and we just vent for a fifteen seconds and move on. Usually make some kind of black humorous joke. (Edward)

Theme III: Coping With Exposure to Traumatic Material

Just as the trauma participants reacted to most intensely varied, so too did the coping and management strategies differ across the participants. Information from each participant will be disclosed.

Anne expressed how really listening then separating one's self from trauma clients presented contributed to coping and management.

> I said, you know, sometimes just being there for the client. I think the clinicians that are able to really be there for the clients and just sit there and listen to their stories and form that connection I think they are able to ah sometimes just be more effective than (trailing off). I, I thi - in trauma work I think in just in anything but in our clients have stories to tell and some of them have never – their whole lives they've never been able to talk about it. And somebody that's just able to go and sit and be there and, you know, 'You know, I understand!' and just listen, and provide some support. It's very powerful I think. YEAH! (enthusiastically)

The investigator observed that knowing she was helping by just listening helped Anne cope with the trauma she heard. Then Anne talked about the coping strategy of separating herself.

> Well, but then how do you work with people who are telling you stories about molest and abuse when they were children or as children they're telling you this story. I, it's the process and eventually you can separate yourself enough.

Anne also shared that this is what she tells her supervisees [pages 62 and 86 above]. Recall that this participant also found her colleagues and her supervisor indispensable in managing her reactions to clients' traumas.

> The other, the other, my colleagues. . . . my supervisor, I'd meet with my supervisor and then my colleagues; because, the coll – you know, we would talk about it. And, and I was able to at least, ummm, you know, get the support that I needed that way.

In addition to coping that comes with time and experience in working with trauma and the built-in support from people at work, Anne found client resilience in confronting the hard times from trauma supported her own capacity in managing and coping with clients' traumas.

> Could, it [client's resiliency] could be. . . . I saw real growth . . . I think that that's what gets you through when you see the growth versus I think if we never got to see it I don't know. I, I don't know. If it was anything short term and you never saw the growth how you would handle it. I think it was yes seeing the people do better and feeling like I had a hand in them doing better made it a little easier to deal with when you heard the horrible things. (Anne)

In talking about her management of traumatic exposure, Barbra eloquently described herself as having missed, perhaps by happenstance and in extent and intensity, the many traumas that befall clients, while still possessing some tools to help clients in

their journeys. She views her professional voyage and its management, including clients' traumas, in a metaphysical manner. A self-disclosed workaholic, Barbra makes known how her lifelong focus on changing systems, through social and political action, serves as a means of coping with clients' traumas.

> It's an eyes out, it's an eyes out and I look at the fact that I have a look good family, I have, you know, I had college education. I had, you know, I had all of the wonderful opportunities. And my abuse and neglect is this much [showing a miniscule amount with her thumb and finger] compared to the abuse and neglect that these people have suffered. And so, I think that whenever they sit down, I, I think I have really a spiritual connection because I have no pretense that I'm any different or any better than they are. I just have some tools and skills and my experiences that might help them on their journey. And that, you know, it's that, it's throwing, throwing the star, the, the starfish back out into the ocean. You know, there's one teeny-tiny thing that I've been able to do. That I've been part of the solution, I've been part of, what I call, the life force. . . . There's a life force! [emphatic] And then when I align myself with that life force and when I am in harmony with what I see as the greater good of helping, of being a help and, and doing everything I can, then I'm fulfilling my destiny. Everything I do, I have to feel has meaning, Freud says uh, that, that in order to not think and to despair, you either have to numb yourself with a substance, which he tried with cocaine, you know, or enter into nepotism or hedonism, you know; just forget. That's what the vast majority of people do is they just don't even think about what's going on.

Or having an amazing . . . To love and to work, exactly. EXACTLY! And he, to me, that's what I do. I don't do it for them, I do it because it gives my life meaning and my mind happiness because I refuse to go into despair and I tried to numb my body for 20 years . . . You know? And it didn't work. I, I we, was a food addict, you know. And, and so, that didn't work and I refuse to go into that again. And I, I am not interested in hedonism or nepotism or anything like that. And so, I have no other choice except to find many, many, many purposes; many meanings in my life so that every single day when I wake up, my life has meaning because I won't, I won't go, I won't go into that dark night and not rage. I will continue to rage.

And so, I began to respond the way that I have responded my entire life. I became politically active. (Barbra)

And um, and, and so, again, again, my life has always been seeing this and then trying to do something that will have an impact systemically on it, . . . So, that, that's how I've dealt, you know as, as I say, you know, throughout my career. . . . And, of course, I was working nonstop. I'm a little workaholic. And that's all, also how I deal with trauma, you know. . . . So, I've always had that terrible super ego and, that says, You gotta do more. You gotta do more! YOU GOTTA DO MORE!! You know, look, look, look at the suffering in the world. You've gotta do more, you know. (Barbra)

So, I got a lot, that was a lot of fun. I worked um, getting to do a lot of community organization and working with enormous you know, just the whole, whole area on community development. So, I'm very, very, very involved politically. (Barbra)

> Well, I'm a systems person, you know, and, and anytime I see that the system is not serving, I go after it. . . . I, I, I think that that's what happens is that I, if, if I feel that it's a systemic issue that the client can't handle, that it's a broad based systemic issue, I have great skills in, in, in working with systems and trying to iron out, you know, those, those, those kinds of problems (Barbra)

Barbra, Chloe, and Doris left jobs, but not the profession, when the employment venue felt crippling, disrespecting, and stifling. Chloe shared that she "did leave, not because I didn't like my job . . . I just didn't feel comfortable anymore. So, I left." Chloe went on about her philosophy, which had a metaphysical flavor not unlike Barbra's, in managing and coping with what traumas she heard.

> Obviously they, you know, you can't forget things [client trauma] like that. So, they stay there which also makes me think about what do you believe about life? What do you believe about death? You have to have beliefs. Yes, values, beliefs. I know one thing I'm acutely aware of is I didn't grow up where I was like raised like, "Oh, you're this religion and this is what you believe!" you know. But I do know one thing, I don't feel afraid of death. And I don't think, after all the deaths that I've experienced there, horrible things, I, my own personal belief is that there's something beyond physical death. Um, and I don't think I could have done that kind of work without coming to that kind of belief or philosophy or what happens to you. Because what's happened makes no sense! (Chloe)

She went on to characterize her life as neither not "horrible," nor a life where she had been a "victim of child abuse." Her curiosity about peoples' lives was what sustained her in difficult times with her professional occupation.

> I just had a life that just made me curious about people and what they experienced and um, open minded and, and just kind of fascinated to know peoples' lives. That was my, the thing that I liked the most about that job was hearing about people's lives. (Chloe)

Chloe disclosed about her strategy in managing trauma work. "Yeah, I always would try to focus on the positive. Otherwise, I wouldn't be able to stay there and do my job." This veteran hospital social worker found she could not talk to her professional friends about her practice but she found another pathway.

> My friends couldn't even relate to it. My best friend is a clinical psychologist who sees only private clients in [upscale community]. And she can't, yeah; she can't imagine why I ever wanted to work there, period. . . . Um, interestingly enough, I could talk to my own children about it . . . I would come home and talk to them about things.

Also, Chloe shared that once she had children she became less fit as a result of less traveling and scuba diving, which she characterized as "bad" and "unhealthy" because it had been beneficial to her in managing her exposure to client traumas in her professional endeavors.

> Because, it's in the past, I can't tell you necessarily the time frame, but there were also periods of time where it was very hard on me or when I knew I needed to go on vacation. . . . I had that strength maybe because I've experienced a lot of my own life, my own path.
>
> Well, for many, many years, I was a very fit person and very, I used to scuba dive um, travel. So, I think that was very beneficial. I'm a single parent.

> Once I had my children, a lot of that went out the window. I think that's very bad. Um, very unhealthy. (Chloe)
>
> [T]here [prior employment in hospital] I was a preceptor , , , and I enjoyed it! And I think they liked being with me because they felt I was one of the social workers there who liked my job whereas a lot of the people there didn't like their job. Here we have interns but it's like maybe two but they don't really need me and this is not my expertise so I don't think I would want to be their preceptor anyway. (Chloe)

Based on Doris' disclosure, some of the trauma events she described took place from 31-36 years before 2010. Interestingly, Doris shed some light on her recall ability when talking about an early experience as a volunteer home visitor prior to her professional social work career where her supervisor told her:

> [A]nd the one thing I learned from her was to absorb everything that you could without really a lot of note taking and then, she'd say, drive a block or two then pull over and write down everything that you remember.

Doris revealed what she liked about her present job that assisted her management of clients' traumas and which seemed connected to that early experience: "You see I, I have a buffer because I know they can't see me and I can't see them. . . . So, um, in this work and in the other work employment that I've had, they've all been kinda brief." However, Doris does work in the emergency room and she has a dozen clients, some for years, in her private practice.

> You, you age faster when you work in a clinic. So, I actually went at one point over to [outpatient clinic] cause I knew the [manager] um she had worked at

> [name of organization] when I was there. At the end of the interview, it was like taking my heart and squeezing it and I thought whatever stresses I had at the [current employment], I'm just going to stay there; (forced chuckle) it's better! (clears throat) Because these are patients [in the outpatient clinic] that I wouldn't want to treat. They're extremely complex and particularly the kids and the [limited]frequency with which they get seen.

Also, Doris looked to humor as a management tool to sustain herself in the face of clients' traumas. She was also secure in setting limits and in expressing her voice (recall she reported being kicked off a team for being "too assertive") and style in managing the volume of trauma exposures. Additionally, she counted on a professional network of friends with whom she could process.

> I mean, you know, I have fun. It's gotta be fun! Ya gotta have a little fun! . . . And I think part of being a healthy adult is keeping a healthy child inside of you. (giggle) I went, we had this conference and it had just snowed . . . I started a snowball fight. So yes! Humor, humor is - I mean, you know, I mean, you gotta have a little bit of it. So, um, that's important. (Doris)

> And, at that point I had, I guess my first borderline and she was acting out and so I said 'I think you need to find somebody else so you can appreciate how good you've had it.' Damn girl wouldn't go! And she also got really crazy and this was after the [natural disaster] and, I don't know she was trying to get her way about something and she said, she alluded to the fact that she was going to have somebody "get me." I said, "I'm sorry, you are OUT [strong tone/emphasis] of therapy!" That became my instant rule, if I can't be safe I can't help you! And,

> you have just, by your threat and, personally, in my gut, know you're not going to do it but we don't joke around about that stuff. I kicked her out. And then, in the parking lot with her mother and sobbing, 'Can't you give her another chance?' I said I give people just one more chance but don't ever do it again! With the same kid, she was probably in her early twenties that had a temper tantrum in my office and took the plant and (fssss: mimicking something airborne) and I said, 'You'll be back here tomorrow to clean that up!' And (chuckle) the cleaning crew cleaned it up. 'Oh the cleaning crew cleaned it up. Okay, you can dust' - she's an asthmatic - with the dust so [trailing off]. (Doris)

Unexpectedly, Doris did not count on her social work department for management of trauma. She was attached to the team that cared for her dying father but not to the social work department in the facility where she worked and where her father died. In her current position, Doris has a different, potentially corrective, experience with a department manager who is a social worker and whom she seems to admire. "She rolls up the sleeves and digs in. But, um, yeah, I mean, you know, and [supervisor] worked shifts every since becoming a manager and I don't think it hurts."

Dissimilarly to Chloe, Doris said she had long time, close friends who were social workers whom she used to help manage her trauma exposure.

> Oh yeah! Um, I don't have siblings so I have a couple of really close friends. And um, most of them are social workers . . . And, um, they've been around for a long time. Um, and a, I think that's what probably led into it formally, in a consultation group or informally for trauma; that's what gets somebody in the helping professions through so they don't burn out.

Recall that Edward talked about the over-time dysfunctionality in the system where he practiced and felt top administration really didn't want to know. In discussing the challenges to managing client trauma, Edward went on to report how operations have changed yet stayed the same, how charting might help him but it seldom became part of team members' communication, which could benefit clients, how the volume of work diminishes therapeutic opportunities, how a fundamental change in clinical process around supervision and consultation could support him, and how he feels what happens at work may spill into his personal life.

> So in a way . . . when I reread that note as I'm getting ready to bring them in, in the middle of a busy, busy day two months later, I get an essence of what's going on with them. The notes for me. Uh, very few of my notes are ever read by anybody. That's it, I mean really. Who does? And the only person that you hope would read them and to my disappointment and dismay I find out lots of times they aren't, is the MD who's gonna see that person for a medical evaluation or a follow-up. And um, some of the doctors barely even read their own notes and they just kind of start fresh with the person.
>
> Could I use something more? Oh, yeah. Yeah! It'd be something like we're doing right now. I mean, I've never talked to a fellow clinician, what I've just shared with you in this kind of detail. When would I? When would the opportunity be? You know, you walk into, there are clinicians here who I feel very close to but I know how damn busy they are. (Edward)
>
> Yeah, like I can be with you right now because I don't have any charts I gotta do. I'm not waiting for the message to come. Bing! You know, it's right there. Bing! I

> mean, when that bell rings, it's like: 'Please! Don't ring that bell.' Yeah, oh yeah. It blows me away [if the bell rings] and if the bell doesn't ring it blows me away because I might be thinking what if we have a mainly one very somewhat incompetent secretary that does reception around here. She may not ding you at all. So it's you know, is my patient not here and I can maybe go a little longer with this person or are they really out there and they just haven't dinged me. And that adds another level of anxiety. You know what I mean? Yeah, and you've got someone who in the last, what you were hoping would be the last five minutes of the session, all of the sudden opens up and shares something and breaks down. Well, hold that thought. I'll see you in about six weeks. (Edward)

In further response to the investigator's inquiry about managing client trauma, Edward, with a smile, offered: "At the, at the level of awareness we might have? I find denial and repression works real well." He went on to describe the difficulty of managing client trauma in very personal terms and he worried that he might be compromising his roles at home (page 85 above).

> But you know, you go home and it's like I want to tune out, turn off, do something mindless. Um, try not to be too impatient 'cause I'm tired. . . . So it does, it does take a lot out of you.

Summary of Findings

In this study, the remembered impact experiences of the participants in relationship to client-presented traumas began as an interaction with an individual, a couple or a family, self-described as in difficulty. Three themes emerged from the participants in vivo expressions. The first theme is that: Aspects of certain participant-

client engagements have created an enduring impact, some of which are positive and empowering and others that are negative and interfering, for the participants. The second theme that grew out of the interviews is: The milieu has a profound impact on the participant-client engagement and how the participants have been able to manage their clients' traumas. The third theme is: How the participants managed the impact of client traumas seems to affect whether they experience stress or satisfaction; participants' resiliency is influential.

Having looked at each of these themes that emerged from the data, Chapter 5 will present a discussion and interpretation of the findings, recommendations and the implications of this study as well as offering suggestions for future research.

CHAPTER 5: DISCUSSION

Goals and Purpose of the Research Project

The goal of this qualitative research project has been to describe and better understand how five, self-selected, experienced Master's-level social worker clinicians working in direct, therapeutic service to clients, experience and process accounts of clients' traumas. One purpose of this phenomenological research is to assist clinicians, supervisors, managers, and administrators in understanding what can happen or is happening when experienced social workers are exposed to clients' traumas on a repetitive basis. Moreover, the investigator hoped this research might shed light on how the study participants dealt with such situations and any ideas they might have about improved agency support for their work. Another purpose was to augment the limited, professional, qualitative research literature focusing exclusively on experienced, Master's-level social workers who were not first responders in disasters or trauma specialists such as rape crisis or domestic violence counselors.

Design and Methodology

In looking for the layers, patterns and themes in the participants' internal subjective experience, a professional, face-to-face conversation was used, audio recorded and guided by questions, which evolved with each interview and were designed to illuminate participants' reactions to presentations of clients' traumas. "The purpose of data gathering in qualitative research is to provide evidence for the experience it is investigating. . . . the evidence is the ideas and thoughts that have been expressed by the participants." (Polkinghorne, (2005), p. 138) A constant comparative process was used from one interview to the next until the data was saturated. The individual, interactive

interview was an ideal manner for participants to reveal their reactions, coping styles, support resources and satisfactions in trauma work.

Theoretical Framework and Conceptual Focus

An attachment theory framework was used as the context for comprehending and interpreting the results of this research project. The attachment concepts of attunement and engagement, impingements, right brain processing, and the secure attachment base lead to a deeper understanding of the participants' subjective process and will also be used to focus the following discussion and implications of the research project.

Attachment theorists believe that psychotherapy is a dyadic, intersubjective, right brain to right brain process during which the empathic engagement of the therapist can contain and emotionally regulate the client seeking treatment. In addition, some professionals, including this investigator, believe that empathic engagement, which is a two way street, is the avenue through which therapists are themselves stressed and perhaps traumatized (Figley (2002); Rothschild (2004; 2006); Saakvitne & Pearlman (1996); Schore (2003b; 2007); Stamm (1999); van der Kolk et. al (1996)). In the mental health traumatology literature, discussed in Chapter 2, the stress states caused by listening to traumatized clients are variously referred to by the terms burnout (BO), post traumatic stress disorder (PTSD), compassion fatigue (CF), secondary traumatic stress (STS), and vicarious traumatization (VT).

As will be described below, the findings of this research show a considerable overlap of the concepts of PTSD, CF, STS, and VT while suggesting that BO, which may be co-morbid, is caused more by the mismatch of a worker and the work they do. Most

significantly, CS appears to be what diminishes BO as well as the impact of repeatedly listening to traumatized clients for the participants in this study.

In recent literature, Deighton et al. (2007) concluded there is considerable overlap in the concepts of CF/STS and VT to the extent that they might be measuring different aspects of the same phenomenon. And, Wilson and Thomas (2004), utilizing and highlighting Schore's (2003a and 2003b) work, definitely reflect the notion that there is a confluence of co-occurring phenomena which eventuates in a potential transient, acute, or chronic stress state ("traumatoid state") for the therapist from "repetitive and prolonged exposure to traumatized clients" (p. 171). They dub these as "occupationally related stress response syndromes" (p. 143).

In an attachment theory framework, all those potentialities or impingements in the moment or over time may coalesce and dysregulate the therapist. Then, using terminology from the literature, participants experienced CF (compassion fatigue): "natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). This feels like the essence of social work. Simultaneously, participants may also experience VT or STS. This supports Figley's (1995) view when he said, "Over time, clinicians empathically engaging with traumatized clients normally develop vicarious traumatization [VT]" (p. 14) or STS [secondary traumatic stress], an acute reaction after a single exposure to traumatic material. As Stamm (1999) said, stress states are not exclusive and may be co-morbid. In fact, in the recent work by Adams et al. (2006), CF has shifted to mean a combination of STS or VT (taken as equivalents) and BO as a separate and distinct phenomenon that is

psychologically distressing to therapists and contributory in the development of CF in therapists.

What is striking about the participants in this research is that if stress states did develop for them, which seems likely from the descriptions of experiences they shared and the definitions in the literature, none of the five experienced "burnout" or disabling PTSD. These participants continue going strong in their practices at 25 to more than 40 years. This fact is consistent with the literature where the "right brain to right brain communication underlying empathy becomes crucial to both the developmental and therapeutic endeavors" and ". . . therapist's activities that promote the patient's sense of safety are essential and underlie otherwise frightening emotional explorations" (Fosha, 2003, pp. 228- 230). Racanelli (2005) states, "Consequently, stable internal working models, or the activation of a secure attachment behavioral system, may provide resiliency against a negative impact from the traumatic affect presented during the provision of treatment" (p. 70). Fosha finalizes the thinking about therapists who endure by saying: "And secure attachment is at the foundation of optimal mental health and resilience, and operates as a powerful protective factor against the development of trauma" (p. 225).

Overview and Synthesis of the Research Findings

As discussed in Chapter 4, three major themes emerged from the research findings. All participants experienced lasting impact from clients' presentations of traumatic materials whether it is best described by the terms BO, PTSD, CF, STS, or VT (the stress states) or a combination of all five. Secondly the milieu in which the participants practiced had a profound influence on this impact, helping to increase the

negativity of the trauma exposure or to ameliorate that impact. Each participant had a number of different ways of handling the effect. For example, Anne talked with her lunch group at work; Barbra took on community organization and political action; Chloe joined liberal organizations and talked with her children; Doris carefully selected who she talked to and emphasized having fun, especially at work; and Edward liked to tune out and do something mindless after work. There was lasting emotional impact from trauma work that was reduced or exacerbated by the service milieu and, over time, participants found ways of coping with both the impact and the milieu.

The most significant finding is that despite the many signs and symptoms characteristic of the five stress states mentioned earlier in the prior paragraph that each of the participants mentioned, although mostly not by name, it was satisfaction in doing their therapeutic work that was predominant. This fulfillment, called compassion satisfaction (CS) in the literature, made the difference and enabled the participants to repeatedly listen to traumatized clients, year after year and still not be overwhelmingly stressed. BO and PTSD were effectively kept at bay because the participants found confirmation in the resiliencies of their clients that life goes on despite horrific challenges. Barbra called it a "life force" and Chloe referred to it as values and beliefs about life. Participants not only gave strength through their empathic engagement with their clients, but they gained strength from their clients who, despite trauma, moved forward with their lives.

Lasting Impact

The investigator found lasting impact from exposure to clients' trauma material in the expressed emotions, thinking, and behavior of the participants. For example,

participants felt really angry, tormented, upset, highly traumatized, and stunned. While only one of the five participants used the language of attachment theory, all described their attuned empathic response, often over time, with clients whose trauma left a mark on them. The investigator believes that this outcome is the result of the right brain to right brain connection of the therapist with the client during the empathic attunement and attachment in formation of the therapeutic relationship.

Additionally, participants not only experienced shifts in their emotional states and interactive perceptions (internal working models) as they moved into right brain dynamic synchrony with their traumatized clients but also, as time passed with the client, alteration in their cognitive, left brain beliefs. Anne was angry with mothers who allowed their husbands to abuse children and impatient with adults who made stupid choices; Barbra was left reeling by a mother who never offered any attachment to her child; Chloe was shocked that the community accepted the gang culture of violence and death as the norm for their community; Doris found dysfunctionality in relationship to children very upsetting; and Edward was left without words over losses that people endured. As the participant-client attachment evolved, the participants' world view could be challenged by the complex content of clients' traumas. Held beliefs about basic trust and safety, goodness, fairness, and justice were challenged as they heard one horror story after another.

Moreover, ordeals that happened to people who were similar in age to the participants, their children, their parents and their friends were especially disturbing and complicated participants' responses. Traumas seemed more difficult to experience, contain and handle when the client was innocent like a child, an elderly person or a non-provocative adult minding their own business. As one participant said, "but for the grace

of GOD, there go I!" Words or phrases that participants used to reflect their dysregulation included "upsetting" and "angry" for Anne; "impossible to describe" for Barbra;" "the total senselessness", "gut wrenching" and "really torn up" for Chloe; "tense," "highly traumatizing" and "very, very, very sad" for Doris; and "something horrible," "stunning" and "Un-fucking believable" for Edward. Trauma is difficult for participant clinicians to hear and to cope with because the emotional well-being of the person seeking assistance has been threatened or shattered and that client is emotionally dysregulated and seeking re-regulation through the clinician.

While personally unsettling, or dysregulating in attachment terms, in the moment, those emotional then cognitive shocks did not appear to trigger a participant's disengagement. The investigator believes that the participants remained a secure attachment base for their clients because they themselves were and are securely attached. Clearly, the secure attachment base was not the milieu for most participants. However, the investigator suggests that participants are securely attached professionals and part of that secure attachment is based in social work's core beliefs, which each of the participants manifested in their work with traumatized clients. Although none of the participants discussed a conscious process of placing their work with traumatized clients within the context of the attachment to core beliefs and practices of the profession during the interviews, the investigator's impression is that those standards became the secure base that emotionally grounded and re-regulated participants while guiding their practices. Participants' secure base in the social work profession has developed over decades of successful practice and aids in the development of an attached relationship with clients. That connection assisted the client in their emotional re-regulation, cognitive processing, and final integration of their trauma into a coherent life narrative. Using that

professional creed of social work as foundation, the participants' capacity to hold and to regulate the clients and themselves upheld participants' resilience which, in itself, was sustaining in the dyadic relationship.

In this study, the participants' reactions are consistent with the literature regarding right brain-to-right brain attunement and the attachment process. In a 2007 presentation, Schore has said:

> In order to optimally regulate [a] patient's stressful psychophysiological CNS and ANS arousal deficits and re-establish homeostatic equilibrium, the therapist must be empathically resonating, *while under relational stress*, in a right dominant state of nonverbal communication and implicit interactive regulation.

I am inferring that the therapist becomes, and not always comfortably, dysregulated in service to the client. That state was reflected in the words, body language, prosody, deep thinking, and emphasis in the participant interviews. The emotional intensity and profound across-the-board disruption caused by trauma in their clients' lives impacts the therapist (van der Kolk, 1996; Wilson & Thomas, 2004). Additionally, Sharman's (2002) mixed methods research revealed that listening to accounts of trauma was the most difficult part of clinical work and that sadness and anger were typical reactions although disgust and fear could also surface as they did in this study. All participants revealed some lasting residue from the impact of exposure to clients' traumas.

The clients that participants chose to discuss were ones that "stayed with them" because their traumas continued over a period of time and were multifaceted. A significant corollary to the client's trauma experience over time is that the participant also experienced the trauma over time with each successive appointment of that traumatized client. As Anne remarked, these client traumas were the ones "that could stay with you."

As was seen in Chapter 4, Anne, Barbra, and Chloe experienced intrusive thoughts; all participants experienced arousal symptoms; Barbra, Chloe, Doris, and Edward mentioned safety factors as an issue in practice; Doris identified fear (and changed how she left shopping malls and where she got her mail as a result of clients' behaviors that could traumatize others), and Anne, Chloe, and Edward spoke about feelings of helplessness at times in work with clients. Interestingly, the lasting impact in the participants in this study was often intense but not necessarily negative as participants found significant satisfaction through their therapeutic endeavors. They attained compassion satisfaction (CS).

This finding is consistent with Stamm's (2002) ideas about compassion satisfaction. Clearly, the capacity of the client to endure, grow, change, and integrate traumatic encounters with therapeutic support worked to mitigate the exhaustion and depersonalization that contributes to BO while leading participants to satisfaction that seemingly fortified them for what was to come from their current or future clients. Seemingly, a therapist can balance difficult reactions (i.e., impacts), including BO, PTSD, STS, CF, and VT, with satisfaction when a client accepts an offer of help and the therapist can witness the client's positive gain, resiliency, and reintegration. Radey and Figley (2007) suggested promoting that satisfaction to balance the potential negative in trauma work.

However, three participants, Anne, Chloe and Doris seemed less attuned to and tolerant of those adult clients with recurring patterns of behavior leading to victimization. Experiences labeled as trauma by the client that included self-imposed circumstances that were negative and occurrences where adults failed to gain insight, to integrate learning from prior experience, or to heed the advice of caring others (including the participant)

sometimes got little empathy. Anne said it was hard to work with people who made "stupid choices" and who "should have known better" and "what was going to happen." Doris described herself as having "little patience" for those who whined and failed to accept personal responsibility. Chloe was disheartened that people accepted the trauma that accompanies violence and death as the community standard and didn't move to change the repeating cycle. Also, she was disappointed that the motivation for some adults caring for kids was reduced to dollars and cents. The investigator contemplates this might be a place for discussion with peers, supervisor, clinical consultant, or workshop leader about the nature of trauma and the neurological impact that can help explain repetitive, self-destructive client behaviors. Additionally, the investigator believes this seeming lack of tolerance may be present due to the absence of CS with those clients.

Milieu

The participant's experience of being supported in a way that had meaning for them as a front line clinician in their job setting varied considerably. At some point in their careers, four of the five participants experienced a disconnection between themselves and the hierarchy above. They harbored negative experiences with current or former work places which could include a lack of relevant supervision, misguided and/or non-supportive understanding from management and administration, overwhelming work volume as well as, and most significantly, no venue for processing the difficult trauma work and the impact, going forward, on the participant frequently confronted with traumatized clients. Administrative actions sometimes demonstrated a lack of understanding of what the job required of its practitioners and how those demands were impacting the participant. Impingements to processing the impact of clients' traumas

included: intrapersonal processing; interpersonal factors with co-workers, teams, supervisors and clients; action or inaction from management and administration that seemed to interfere with the work; and outside organizational actions beyond the influence of the participant or their agency.

Systems meant to support (attune and hold in attachment terms) participants (colleagues, team, supervisor, manager, administrator, social mores and cultural values) often did no better than agencies meant to support clients. At times, secondary and tertiary interventions by participants and the agency involvement they prompted seemed inadequate for the degree of trauma to which clients were exposed. Agency support for most participants also seemed deficient. Some systems even seemed to exacerbate the participants' traumatic experience (recall Barbra, Chloe, Doris and Edward) or, at a minimum, did little to help participants manage their traumatic exposure on a day to day basis. Chloe and Doris withdrew while Edward didn't want to "bother" his peers with talking, which he thought might help, because he knew "how busy they are." Moreover, celebrating a clinician for a job well done seemed rare. Doris was particularly angry and hurt that she received no acknowledgment on a personal, human level from the social work department of the hospital where she continued to work while her father was dying in that same hospital. Clearly, failures of the systems which are ostensibly in place to ensure the protection of dependent, vulnerable, and innocent people who require adult and agency nurturance, care, supervision, and protection to survive could and sometimes did stress and impinge upon the participants who then experienced emotional dysregulation and cognitive dissonance that wasn't fully processed nor integrated through their agencies' so-called support systems.

Only in one of the five participants' settings did there seem to be a supervisory structure through the managerial level that was consistently available, applied, and effective in helping the participant process interventions with clients' traumatic materials. Even in that instance, the focus was on the participant's management of the client's trauma rather than the center of attention addressing the continuing impact of emotional dysregulation and cognitive dissonance, going forward, of working with trauma on that individual professional. As a result, Anne "followed her instincts" in one instance when those in group supervision questioned her actions in relationship to boundaries. Barbra acted to change the systems through community organization, union intervention, and political action mostly accomplished outside her full time work. Chloe talked to her kids because professional peers were judgmental about her work and its location. Doris carefully selected who she talked to, based on experience with an individual and the quality of their clinical work. Edward accepted the system inadequacies while dedicating himself to clients and the supervision of interns. Some of the participants' trauma examples had occurred years earlier and, in one case, decades. This fact suggests to the investigator that the emotional upheaval and the cognitive quandaries from those experiences had not been fully processed.

Nonetheless, each participant described at least one engagement with a client who had been betrayed by the "system(s)" and for whom the participant's engagement and relationship acted as a reparative experience. Every participant had some experience where they worked to alter failing structures, most frequently families (microcosm), but could be frustrated from a social work values perspective by lack of time to trigger system(s) repair beyond the clients themselves. All five participants expressed some

frustration with failures of the micro and macro systems designed to nurture, to protect and to act as safety nets for people.

Sometimes, the demand in today's mental health marketplace for short term, evidenced-based treatment results in a setting with a high volume of treatment requests appears to have little connection with social work's core practice principle of beginning where a client is. The notion of developing a helping relationship over time that is anchored in the dynamic, evolving dyad, of facilitating a client's movement from minimal self-understanding and functionality to greater self awareness and real-time functionality seems to get lost. Moreover, respect for the client's pace more than for the agencies' expectations, which are often dictated by political mood and cultural stance at any moment in time, may also disappear.

Nevertheless, participants continued the difficult work with trauma despite these impingements. Anne had to pass people on to case management when relational work and recall were no longer possible with aging clients. Barbra worked overtime with advocacy, including community organization and political action when clients weren't being fully served. Chloe stayed present as clients came to grips, sometimes over a period of months, with catastrophic, life-altering injuries and deaths of loved ones. Doris stepped over boundaries to protect children when systems could potentially add to the child's trauma load. Edward made space in an oversubscribed service for those clients who needed a secure attachment figure when multiple traumas dysregulated their lives.

Three participants (Barbra, Chloe and Doris) described instances in their careers where they had exited the work milieu when the interfering impingements were too great. Although frustrations with teams, systems, and management were acknowledged by all participants, the emphasis in their stories about their reactions to clients' traumas was on

the satisfaction in the work to aid resilient human beings find stability (e.g., emotional regulation) again.

Coping Mechanisms

All participants developed coping mechanisms to manage dysregulating trauma work in settings that were not necessarily fully, or even appropriately, accommodating to them. Participants went outside their respective workplaces for relevant training to continue their professional growth, find support and to continue integrating social work theory with practice. Four of the five established a collegial network that was supportive and could assist with the integration of the difficult trauma work with their ongoing practices. Most had worked as a volunteer in the community or with professional organizations not in their work place to address larger social issues. Three of the five commented on their mentoring work with social work interns. One mentioned the importance of humor, appropriately manifested in the work place. Each had some means for regulating themselves even if they recognized that it was inadequate.

Anne used lunchtime discussions with her colleagues to process some of the issues that came up in the treatment of clients who had been traumatized. Also, she was the only participant whose agency had supervision, both individual and group, regardless of the educational attainment or experience of the front line clinician. At this career point, Anne was also a supervisor of supervisors and a mentor for student interns. During the interview, Anne put her hand in her jacket pocket and pulled a few dollars out and smiled; "From a conference I went to last week" suggesting her continuing education effort for coming to grips with the ongoing and difficult work with clients.

Barbra was explicit about using community organization, including political

action, throughout her career to address the systemic issues of the clients she served. Part of her approach was to educate and empower those who needed services to become more self-actualizing. She wrote manuals and developed training programs geared to enhancing the skills of clients and communities in taking responsibility for their destinies. In the most recent decade, Barbra left administration and management behind to work directly with people in a setting where her colleagues were kind and supportive of each other. When administration threatened Barbra and her colleagues with service interruption to clients, Barbra applied her organizational skills to protect clients and clinicians from a seemingly whimsical, nothing-to-do-with service or clients' change.

In some ways, **Chloe** appeared to have the least support during the period of her work from which she drew most of the examples of trauma work she discussed. In that setting, early on, she was inspired by the leadership people in the hospital whom she had observed during her own internship there. When they left, there was a vacuum and although she was technically a part of the social work department, her functions led her to feel quite separated and not particularly supported by that sector. Early in her career, she joined liberal organizations that were championing understanding for the lower echelons of society. To cope with trauma work, Chloe used physical activity, diving, and travel. As she gained experience, she herself became a mentor for interns and felt effective in that role.

Doris was clear that fun was a primary tool for coping with job-related stress. Her interview was peppered with smiles, giggles, laughter (including at herself) and humorous anecdotes. She talked about when colleagues changed jobs "and it wasn't going to be fun anymore" or when things like legislative mandate changed the social service landscape as funds vanished. Doris looked for new avenues for her skills that

offered more fun, including private practice. She was well networked with "social worker" friends. Doris had a stint of developing professional seminars for continuing education credit through a professional organization where she donated time and effort. Also, Doris was "very selective" of the people with whom she consulted; they had history with her and experience, training and clinical practice she respected and trusted. Doris encouraged appropriate fun like birthday or other milestone celebrations in the workplace and wasn't shy about recruiting people for the workplace she helped make enjoyable.

Edward believed clinical consultations within his discipline and across professions would have helped guide him in work with traumatized clients but time constraints made him reluctant to bother busy peers. Equally, the agency's failed history of having consistent and ongoing clinical consultations led him to self reliance. Edward himself was a go to person for many staff members and he also mentored interns in a caring fashion that included supervision. On a workday basis, he and a next door, fellow clinician would "pop-in" on each other for a "few seconds" of interaction punctuated with "some humor." On a rare occasion, he would talk with his spouse about traumatized clients with whom he was working. Edward was open and honest about using denial and repression to the extent possible. In order to cope with the rigors of his clinical practice, he also mentioned tuning out into some "mindless" or occupying undertaking after work to free himself from thinking about clients while allowing right brain, unconscious processing to lead him to fresh ways of thinking when work began anew.

Although they may interfere with internal processing of trauma, a certain amount of denial or a "silencing response" can also be an effective coping strategy when dealing with extreme trauma as long as it is not the only coping strategy and is used in moderation. Chloe reflected several times in her interview that she didn't know "why"

and that she possibly needed to take the time to figure it out. Doris seemed to surprise herself when she had clear recall of "visuals" on clients and a body "chill" as she talked about a traumatized client's service more than thirty years earlier. Although Edward said that he used denial, he also said it didn't work because he had to document the treatment and, thereby, erased the denial. Although there was evidence of some denial in the studied participants, Munroe's (1999) finding that a secondarily traumatized therapist may well use denial as a coping strategy in the midst of intrusive thoughts of traumatized clients whom the therapist may attempt to avoid was not seen with the participants in this research project. Baranowsky's (2002) suggestion that clinicians stressed by clients' traumatic materials engage in denial or a "silencing response" was supported by the three participants who revealed feeling "shut down." In general, the participants in this study focused on their clients' strengths, resiliencies, growth and change that took place within the therapeutic relationship, rather than on the trauma itself.

All participants, with the exception of Chloe, talked positively about collegial support as part of their coping mechanism although what each described was quite different in terms of quantity and quality. Although there were elements of burnout, such as exhaustion, cynicism, or inefficacy in all the participants at some point, the participants were not burned out by those feelings or their trauma work. Participants had some PTSD-like symptoms including intrusive thoughts (Anne, Barbra, Chloe, Doris, and Edward); arousal thought regarding client trauma work (all participants); fear (Chloe, Doris) and helplessness (all participants). However, they did not report all the PTSD-like symptoms that Bride's (2007) participants did. Nonetheless, those uncomfortable feelings, perhaps symptomatic of a stressed state (BO, PTSD, CF, STS, and VT) appeared to be fleeting among the participants in this research project as well as balanced out by satisfactions

from their work with traumatized clients. These research participants were able to cull out and to stay focused on the resiliencies of their clients.

These findings are consistent with Drake's and Yamada's (1996) quantitative study in which co-worker support was found to moderate BO. Also, Drake and Yamada (1995; 1996) reported that emotional exhaustion is the key ingredient in BO while personal accomplishment, the benefit Stamm highlights in CS, moderates both emotional exhaustion and depersonalization (a second factor in BO). As previously mentioned, Radey and Figley's (2007) model of CS proposed that "promoting satisfaction, rather than avoiding CF, can protect them [clinicians] from the negative consequences of working with trauma sufferers" (p. 208).

Through a focus on resiliency of clients and increasing understanding of aberrant human behavior, the participants remained rooted in core social work values and sustained in their faith in human potential for positive growth and change. That stance provided hope and a world view that accepted the reality of trauma in the serendipity of life, which confirmed the more hopeful view that clients could use help from a therapist and move through the catastrophe and productively forward with their lives. The fact that the participants had 25 to over 40 years of experience as social work clinicians demonstrates sustainability in the front line of social work service. Moreover, the participants volunteered for this research project knowing they would have to share their experiences about the impact of trauma on them as professionals. This venue gave them an opportunity to voice their optimism and share information that can boost the social work profession's awareness about what is happening for clinicians in the trenches and what supports and maintains front line clinicians in that work.

In another way of coping, participants talked about their own life journey at a broader, perhaps philosophical level leading to clarity about the values and beliefs underlying their practices as well as their capacity to do trauma work. Anne mentioned her anger toward the mothers that did not protect their children from sexual abuse. She then extended herself in extraordinary ways, providing a reparative experience to an adult who had been a child in such an unsafe home.. Barbra used her own experience of personal problem solving and positive change through the therapeutic process to attach to her clients in a real and empathetic manner. After becoming a parent, Chloe's views on penalties for perpetrators of violence shifted from benevolent understanding to the place where gang violence, destructive of families, needed incarceration or more. Doris' walk of providing compassionate care for both of her dying parents in her own home was so genuine that a client caller asked if she could come and live with Doris. By putting his personal problems in perspective, for example when a client presented the trauma of losing an infant child, Edward gave richly and fully to his clients by staying on top of cancellations to make space for clients in trauma. Conceivably, the participants in this study had journeyed through the disillusionment of idealism early in their careers to reality while developing wisdom and understanding about human behavior, life in general, and organizations that allowed them to meaningfully support traumatized clients.

In this study, participants experienced some of the symptoms characteristic of a stressed state. However, they each developed means of managing those feelings that benefited the clients they served. Trauma work was balanced with different activities that worked for the individual participant and included voluntary professional activity, mentoring of newer social workers and social work interns, community organization, political activity, teaching, and even, for some, deepening their work, and drawing closer

to their traumatized clients. Although support from colleagues, supervisors, managers, and administrators could positively influence their respective processes, these internally motivated and securely attached participants also moved forward in support of their traumatized clients without it. They did not turn away from the difficult work with traumatized clients. They remembered that work but, more importantly, they stayed focused on the client's reconstitution while recognizing the benefit of therapeutic endeavor. The satisfaction they experienced in their work was sustaining to that effort and future work with traumatized clients. Even with organizational flaws, including inadequate support in processing the impact of trauma work and systems failures and professional blind spots in education or training, participants grew stronger in their commitment to the mission of social work manifest in each traumatized client. Participant outcomes from this research are supported by earlier referenced work of Um and Harrison (1998) who said "that it is not the exposure itself so much as what the therapist does in the face of the exposure, which represents a risk factor for work-related symptoms" (pp. 71-72). It also echoes the similar conclusions of Adams et al. (2006).

Conclusions

Limitations

This qualitative research project has drawn out the experience of five, self-selected Master's-level social work clinicians with decades of practice experience. Interest has been focused on the depth and the breadth of their subjective experiences in direct clinical practice when confronting clients' traumatic materials. The findings are not intended to generalize to all Master's-level social work clinicians with the same or different lengths of experience across all practice areas nor has it been designed to

produce statistical data. A comparison of the differences in experiences between those in clinical practice versus those in administration has not been under scrutiny. Moreover, other factors such as the influence of demographics, graduate education, theoretical stance, advanced clinical training, financial compensation, and other forces that may have led to the development of coping skills in handling clients' traumatic materials has not been examined.

As Polkinghorne (2005) reminds: "The focus of qualitative inquires is on describing, understanding, and clarifying a human experience. . . . The unit of analysis in qualitative research is experience . . . interest is about the experience itself not about its distribution in a population" (p. 139). He also relates that "People do not have a clear window into their inner life [and] . . . reflection on an experience serves to change the experience" (p. 139). So what has evolved in this project is description of the rich experiences of five participants as filtered through the capacities and biases of the investigator to put the information together meaningfully. Although not originally planned, the results describe the experience of a relatively homogeneous population of participants with 25 to 40 years of practice coupled with an investigator who shares a comparable amount of time as a practicing social work professional. The participants were well prepared to provide "significant accounts of the experience under investigation . . . [by] describing the aspects that make up an experience" (Polkinghorne, p. 140).

Some researchers and writers, including Polkinghorne, have suggested the usefulness of conducting more than one interview or an interview that lasts two or three hours to arrive at the deepest and broadest understanding of the phenomenon under investigation in a qualitative research project. However, that stance was beyond the

purpose and scope of this study which, hopefully, will spark more qualitative explorations and dialogues within the profession.

Significance of Study

This research project employed the more uncommonly utilized qualitative methodology with an even-more-rare exclusive focus on five, experienced, Master's-level, and social work clinicians to describe the phenomenon of the impact on them from their trauma work. As was seen in the review of the professional literature in Chapter 2, a qualitative research effort has been recommended in some quantitative studies which provide the bulk of the research related to therapists' stress (BO, PTSD, CF, STS, and VT) in working with traumatized clients. The findings from this research effort revealed study participants' subjective trauma responses, coping skills, support resources, and satisfactions from trauma work in a manner which quantitative research does not. A specific contribution is the identification of what the study participants felt agencies could offer by way of support to frontline social work clinicians who are not trauma specialists and first responders. Moreover, this work may potentially foster ongoing research into this critical area of social work practice.

Implications

What was clearly missing for most if not all of the participants in this research was focused supervision on the impact of trauma work on them. Although Anne had available help (colleagues, the lunch group, and supervisor) which she acknowledged using in working with the traumatized, she made no mention of supervision in relationship to her own potential traumatization from the work in which she was engaged and how that might affect her future work. None of the other participants talked about

supervision with such a center of attention either. However, Barbra mentioned the kindness and support of her unit's peers, Doris mentioned her professional friends, and Edward spoke about colleagues whom he felt were so busy that he did not want to bother them. The realm of trauma work, including therapists' potential stress states, consists of both conscious and unconscious processes making awareness, discussion, and research sometimes seem difficult and subjective as well as all the more essential for the well being of frontline clinicians.

Study participants clearly identified what they felt agencies might offer by way of support to their frontline clinicians. The suggestions are divided into individual, departmental, and agency designations although clearly there is overlap and, often the recommendations could apply to more than one of the headings.

Individual

Suggestions included valuing each team member not just the physician, seeking out the important input of front line clinicians who have a long history of experience with the agency and providing structured individual and group supervision on a consistent basis.

Departmental

The ideas for departments started with the notion of establishing a strong social work department where clinicians are connected and supported as well as integrated with other professional groups and departments in the agency. Also, team building was proposed, including time, venue and openness for clinical presentations and discussions focusing on the impact of the work on the clinician, especially with trauma, as well as on how to handle the potential stress in such work. Another idea was balancing caseloads so

that the department's trauma work would be spread equally across supervised and supported staff. That balancing would require frequent re-examination of trauma situations facing staff to ensure fair distribution. Finally, there was a proposal to get a handle on staff turnover, including root causes and possible remedies, utilizing the collaborative resources from line clinicians to top administrators.

Agency

Being forthright and addressing systemic issues in agencies, supervisors through administrators should engage meaningfully with frontline clinicians before making significant service and service delivery decisions. Such an interaction would provide a forum for changes in policies and procedures so that change doesn't appear to be random and bureaucratic. Participants observed that while recognition by agency personnel who are not on the front line might improve access and increase volume, it does not necessarily mean more quality services are being delivered. The final part of the plans for agencies included continuous monitoring of the organization and its structure and operations to ensure that help not hindrance is occurring for front line clinicians.

At some time, all five participants experienced a lack of recognition and validation from the social work departments or their umbrella agencies as part of their career experience in dealing with traumatizing situations. In some instances, participants even withstood negative judgment for the work they did when the effort called for was beyond some work and professional peers' comfort zones (Anne and Chloe). Some participants withdrew from disclosing their efforts to protect themselves from inconsiderate or judgmental peer, supervisory, department and agency reactions (Barbra, Chloe, Doris, and Edward). Full validation and recognition for participant therapists who

helped their clients achieve mastery and meaningful lives, despite catastrophic trauma, was not readily experienced for the participants in this study.

Sometimes, a participant had to be their own support. That could mean there was a selected person or were selected people whom the participant felt understood their endeavors and who provided the affirmative acknowledgment for a job well done. For Anne it was her supervisor, colleagues and her lunch group; for Barbra, colleagues provided that acceptance; Chloe took her own counsel and talked with her children; Doris carefully selected colleagues and close friends from the profession with whom she surrounded herself, she disclosed, as a result of being an only child; and for Edward, quick affirmation from a next door colleague with an adjacent office and, on rare instances, from his spouse.

Harlan's (2004) research found that workers in a public agency work setting were at greater risk of developing CF and that BO may be a "latent variable" in the development of CF. Barbra and Chloe were situated in public organizations. However, the difference between the two participants was that Barbra was working where she wanted to be while Chloe felt misplaced and dissatisfied in her work venue. Barbra found satisfaction in her work but Chloe's satisfaction came from the post she held up until five years ago. Compatibility of agency function as well as clinician interest and skill is a factor for consideration by clinicians, social work departments and agency supervisors, managers and administrators on a continuing basis.

Recommendations

Although self-help[9] for dealing with stress states is accessible online and in the literature, where information has rapidly increased in recent decades, that approach may

be isolating for the clinician. This investigator recommends individual and group supervision, peer support, and consultation related to bringing the phenomenon of the ongoing impact of working with trauma and handling those experiences into the light of open, consistent examination and vigorous discussion. Including discussion of countertransference issues[10] in the ongoing processing of trauma work may help professionals better understand what is occurring for frontline clinicians as well as how to support them in that work.

Equally, education and skills building workshops at the job site and in the larger continuing education community related to the most current information on the neurobiology of the client and the therapist confronting trauma, about trauma as well as attachment and other evolving theories as applied to effectively working with traumatized clients and their therapists could be invaluable. Such education could assist clinicians in understanding how people get stuck in their own trauma-producing behaviors. An attuned therapist who allows a traumatized client to attach can help that individual client understand the complexity of the biopsychosocial functioning of human beings including shut down, activation, and social engagement. That therapeutic effort might assist as well as empower the client to take in new information and, thereby, increase clinicians' effectiveness.

The idea that there is a cost to caring must be integrated into agencies' policies and practices. That position includes sufficient regulation and balance of trauma caseloads as well as adequate, focused time for discussing and processing the impact on the individual social work clinician, going forward, of working with traumatized clients. Moreover, agencies' supervisors and administrators, in conjunction with their front line clinicians, must explore, understand and apply technological applications to reduce

paperwork pressures on that frontline therapist. Too, there is no substitute for front line supervisors helping experienced as well as new clinicians understand and apply the social work tenets of focusing on clients' strengths and resiliencies rather than on the details of the trauma while developing client-centered and realistic expectations of therapeutic outcomes.

Figley (1999) reminded us that the signs and symptoms of CF (exhaustion, hypervigilance, avoidance, numbing, intrusive thoughts, an increased startle response, irritability, sleep disruption or any other PTSD-like symptom) are the natural consequences from trauma work. He also identified four other factors which contributed to vulnerability for CF, and all five participants demonstrated two of those: empathic engagement and sensitivity to children's trauma. The other two triggers were trauma in the trauma workers' lives and unresolved worker trauma activated by similar reports of client trauma. Four of the participants alluded to or briefly mentioned traumatic events in their lives but only one participant suggested activation of a similar trauma experience. Saakvitne and Perlman (1996) identified that those who empathically engage with traumatized clients quite normally develop VT. VT is a cumulative, pervasive, and permanent shift in the therapist's cognitive schema but not necessarily accompanied by the signs and symptoms of PTSD. Although at times, work with trauma may include the signs and symptoms of PTSD or CF, Fahy (2007) sees CF as "a more useful [than STS] solution[s] focused term [which] encourages workers and supervisors to dialogue about solution[s] to the hazards of empathic work" (p.201). Clinicians, supervisors, managers, and administrators who pretend that frontline clinicians are not impacted by their trauma work must re-examine that belief based on the evidence that they are affected by the trauma and, then, appropriately support that frontline social worker.

Another idea for helping clinicians deal with potential stress states (BO, PTSD, CF, STS and VT) involves agencies providing an informed consent, before hire, for social work therapists who will work with trauma in the position that she or he is seeking. Agency disclosure to a therapist about the possibility of impact, including both negative and positive effects, from clients' disclosures of traumas would be both honest and useful. Therapists could be alerted that to deal with that potentiality, an ongoing, sustaining structure of peer support, individual and group supervision, consultation, and continuing clinical education and professional development focusing on the impact of trauma work on therapists will be required to protect professionals and to better ensure the highest quality of effective services for clients.

A further contribution from this research is that the findings may foster increased attention to and dialogue about this important phenomenon, the impact of repeated exposure to clients' traumatic materials, its' potential repercussions in the field of social work and the need for ongoing qualitative inquiry.

Future Research

This study is significant in that it has revealed detailed information about the complexity of participants' clinical practice with traumatized clients. What is clear from the work, the literature, the interviews and the completion of this project is that trauma is enormously complex and that to engage in its treatment is more so. Stamm (1999) cites Avary's (2001) work related to immediate, acute reactions in therapists to client's presentation of trauma (also known as STS). Many types of struggles or impingements contribute to the development of a stress state. Elements of BO, CF, and VT stress states,

which front line clinicians may experience, are reflective of the strain as well as the complexity of what is involved in trauma work including comorbidity.

This study found there was lasting emotional impact from trauma work that was reduced or exacerbated by the service milieu and, over time, participants found ways of coping, even if they recognized that it was inadequate, with both the impact and the milieu. The most significant finding is that the lasting impact in the participants in this study was often intense but not necessarily negative as participants found significant satisfaction through their therapeutic endeavors. Despite the many signs and symptoms characteristic of the five stress states (BO or burnout, PTSD or post traumatic stress disorder, CF or compassion fatigue, STS or secondary traumatic stress, and VT or vicarious traumatization), each of the participants revealed or mentioned, although mostly not by name, no participant left the field as a result of their stress. Participants' fulfillment, called compassion satisfaction in the literature, coupled with resilience which, in itself, was sustaining in the dyadic relationship, made the difference and enabled the participants to repeatedly listen to traumatized clients, year after year and still not be overwhelmingly stressed. In general, the participants in this study focused on their clients' strengths and resiliencies as well as the growth and change that take place within the therapeutic relationship rather than on the trauma itself. Therefore, they were impacted by the trauma but not traumatized to the point of not being able to continue to do the work with traumatized clients.

The investigator suggests that participants are securely attached professionals and part of that secure attachment is based in social work's core beliefs. Furthermore, those standards became a significant part of the secure base that emotionally grounded and re-regulated participants whilst guiding their practices. Clearly, the capacity of the client to

endure, grow, change, and integrate traumatic encounters (resiliency) with therapeutic support worked to mitigate the exhaustion and depersonalization that contributes to burnout while leading participants to satisfaction that seemingly fortified them for what was to come from their current or future clients.

Only in one of the five participants' settings did there seem to be a supervisory structure through the managerial level that was consistently available, applied, and effective in helping the participant process interventions with clients' traumatic materials. Even in that instance, the focus was on the participant's management of the client's trauma rather than the center of attention addressing the continuing impact of emotional dysregulation and cognitive dissonance, going forward, of working with trauma on that individual professional participant.

The fact that the participants had 25 to more than 40 years of experience as social work clinicians demonstrates sustainability in the front line of social work service. In this study, participants experienced some of the symptoms characteristic of a stressed state. However, they each developed means of managing those feelings that enabled continuing work with traumatized clients. Trauma work was balanced with different activities that worked for the individual participant and included voluntary professional activity, mentoring of newer social workers and social work interns, community organization, political activity, teaching, and even, for some, deepening their work and drawing closer to their traumatized clients. The satisfaction they experienced in their work was sustaining to that effort and future work with traumatized clients.

It is apparent and imperative from this research that the direction suggested by Ting (2006) and associates in the literature be vigorously pursued: "[the] need to understand the relationship between exposure to multiple traumatic experiences and

professional burnout and secondary traumatic stress or compassion fatigue, which have implications for practice and policy" (p. 340). Augmenting this research spotlighting Master's-level social work clinicians with decades of experience, studies of less experienced social workers along with varying demographics ought to be pursued. Determining what array of education, supervision/consultation, caseload make-up, years of experience, and ongoing professional education/training combine for the most resilient therapists who regularly realize compassion satisfaction would be beneficial.

APPENDIX A: TABLE OF CONTENTS: *CLINICAL SOCIAL WORK JOURNAL*

The focus of this Special Issue of *The Clinical Social Work Journal* is Compassion Fatigue[11]

Clinical Social Work Journal

Volume 35, No. 3 September 2007

CONTENTS

Special Issue: Compassion Fatigue

Guest Editors: Brian E. Bride, Ph.D. and Charles R. Figley, Ph.D.

Indexed or abstracted in: CareData, Current Contents Social & Behavioral Sciences, Family & Society Studies Worldwide, Psychological Abstracts, PsycINFO Database, PsycLIT, SCOPUS, Social Science Index, Social Sciences Citation Index, Social Scisearch, Social Services Abstracts, Sociological Abstracts, and Ths ISI Alerting Services.

Instructions for authors for *Clinical Social Work Journal* are available online. Go to www.springer.com/10615 and then click on *Instructions for Authors*.

APPENDIX B: RECRUITMENT LETTER

, 2009

Dear ,

I am entering the data collection phase in my doctoral candidacy at **The Sanville Institute** which has approved this research project.

My qualitative research study examines how Master's-level social work clinicians experience listening to accounts of trauma at the time of disclosure and over time and across clients to repeated accounts of clients' traumatic experiences.

I am looking for five, Master's-level, social work clinicians participants with a minimum of ten years post-licensure experience who work in agencies addressing mental health needs of the community rather than primarily in private practice or as trauma specialists (such as rape crisis workers or domestic violence counselors). I will spend no more than 90 minutes in an audio tape-recorded, loosely guided conversation with the selected participants.

If you can think of persons or a person who might be interested in participating, I would appreciate hearing from them directly or hearing from you with the name(s) so that I may contact them directly. My email is mccloudrussell@gmail.com and my phone numbers are (951) 776-9184 or (714) 325-4085.

I very much appreciate your time and attention as I move toward completion of the doctorate.

Sincerely,

R. Benson McCloud, LCSW

20204 Lakeridge Drive

Perris, CA 92570

APPENDIX C: SCREENING TOOL

Have you been a voluntary participant in other human research projects? When?

Are you aware of what my qualitative research, which has been approved by **The Sanville Institute,** is about? Does it raise any red flags for you?

Is there anything pending in your personal or professional life of which you are aware that would interfere with your participation in this study.

Ordinarily, when you are working with clients who have experienced significant trauma, what is your mechanism for managing whatever comes up in the work for you with such persons?

Are you currently in treatment for trauma or have you been in such treatment in the past twelve months?

Please describe what you have, if anything, by way of regular supervision and/or consultation.

Please say, if you would, what motivates your interest in participating in this research.

Based on your self-awareness, would there be any undue distress for you in talking about people (clients) with whom you have worked that have come to you for help with their accounts of trauma?

APPENDIX D: LETTER INVITING PARTICIPATION

, 2009

Dear ,

Re: Qualitative Research Study in Clinical Social Work Titled "The Impact of Hearing about Trauma on Experienced Social Work Clinicians"

Thank you for your interest in participation in a qualitative research project. If you are reading this, a professional colleague of yours probably has already spoken to you about the fact that I would be following up with you. Thank you for your time and consideration. This study is part of my educational requirement at **The Sanville Institute** for achieving a degree of Doctor of Philosophy in Clinical Social Work.

My research examines how therapists experience listening to accounts of trauma at the time of disclosure and over time and across clients to repeated accounts of traumas.

Therapists' reactions to repetitively hearing from traumatized clients are a sensitive subject about which I hope this research will stimulate more frequent and open discussion. In the professional literature, the impact of that repetitive hearing has been described variously and without consensus in the past twenty years as secondary traumatic stress, compassion fatigue, vicarious traumatization, countertransference, burnout and traumatoid states.

The focus of my qualitative research is not on what to call the experience but on what therapists are actually experiencing as they interface over years with traumatized clients. To date, most of the research has been quantitative and some of those studies have recommended qualitative inquiry to get at the lived experience of clinicians; in short, to better understand the phenomenon.

I will speak with potential participants who have rich experience and who have been recommended by professional colleagues. Participants will be Master's-level licensed clinical social workers with at least ten years of clinical experience beyond licensure (who are not currently in full time private practice and not working full time as a trauma specialist) and who are interested in contributing to the expanding base of knowledge in this area of social work practice. This study is completely voluntary and if you are selected to participate you will not be personally identified in any way in the study. At the end of the screening contact (in person or over the telephone), you would decide on an identification number known only to you the participant and the investigator. You may withdraw your consent at any time up until the publication of the research.

What would be asked of you is as follows:

1. A screening contact with me about the study by telephone or in person (whichever is preferred and convenient from your perspective) of approximately fifteen minutes or less.

2. At a mutually agreed upon space, a private, sixty to ninety minute audio-recorded conversation (for which you would sign a consent; audio recording is part of the research design and typical in qualitative research) will be conducted with you about your clients, over the years, who have presented stories of trauma. That exchange will include how you have experienced that telling and managed your subjective responses at the moment of disclosure and subsequently.

3. The tape will be transcribed with your self-selected number, known only to you and me. That information will be kept securely by the investigator. At the end of the research project, information will be securely held by me for the five years that is required for ease of subsequent investigators. Then the transcript will be shredded, the tape erased and both appropriately disposed of as other confidential materials in our field are.

4. A follow-up telephone call from me of no more than fifteen minutes within two weeks after our recorded conversation.

Discussion of traumatic material, whether recent or old, may stir up feelings of discomfort including anxiety, sadness, tears, anger and so on as well as intrusive thoughts. That is certainly one of the risks for you. Equally, discussion of these matters, in a confidential format and for the purpose of expanding clinical knowledge in this area, can also feel quite liberating. I want you to remember as you decide about participating that you may withdraw from this voluntary study at any time and for whatever reason(s) by calling me (951-776-9184) or emailing me (mccloudrussell@gmail.com) at any time. This research proposal has been approved by the dissertation committee, the Institute's Human Participants' Committee and **The Sanville Institute**.

I am pleased that you are considering participation in this valuable research. I will be contacting you by phone or email if you let me know you are interested by calling or emailing me at the designations in the prior paragraph. If interested, please let me know in your communication by telephone or email whether you would prefer a telephone screening or a face to face contact for that purpose. I very much look forward to hearing from you soon.

Sincerely,

R. Benson McCloud, LCSW

20204 Lakeridge Drive Perris, CA 92570

Encl: Copy of Informed Consent Form for your consideration

APPENDIX E: INFORMED CONSENT FORM

I, hereby willingly consent to participate in the study,

The Impact of Hearing about Trauma on Experienced Social Work Clinicians.

This doctoral research project will be conducted by Russell Benson McCloud, LCSW Investigator, under the direction of Alexis. F. Selwood, Ph.D., Principle Investigator and faculty member, and under the auspices of **The Sanville Institute** which has approved this research.

- I understand the procedures to be as follows:

1. Voluntary, self-selected participation in a research project screening of approximately 15 minutes or less over the telephone or in person with the investigator.

2. Voluntary, self-selected participation in an audio tape-recorded interview of 60-90 minutes in a convenient location with the investigator.

3. Receiving a follow-up telephone call of no more than 10-15 minutes within two weeks after completing the interview with the investigator.

4. A voluntary decision on my part about receiving the research results following completion of the study.

5. Potential publication of the study or parts of it in which the anonymity and confidentiality of the research participant will be preserved. Such publication would exclude any reference to my name or personal identity. Moreover, any clients I discuss in the context of the research interview will have their confidentiality protected also; no identifying information including agency or service will be disclosed.

- I am aware of the following potential risks involved in the study:

1. I might feel vulnerable talking with the investigator on tape despite the agreed-upon procedures for ensuring anonymity and confidentiality.

2. A self-examination and reflection on particularly difficult cases involving clients' traumas could trigger some discomfort in the form of tears, anxiety, vulnerability, negative self-thoughts, labeling, intrusive thoughts; even of feelings about my own trauma history.

3. Sometime after the interview with the investigator has been completed, I may still have some uncomfortable recollections about past work with traumatized clients that could feel troubling as I anticipate future work with traumatized persons.

4. If I have elected to receive the results of the research study and find those results both interesting and relieving, I might still be discomforted in recalling other situations related to the research that I wished I had discussed or other forgotten situations that now may emerge.

- Provisions to be made in case of emotional discomfort:

1. The investigator will remind me that participation is by choice; voluntary. I may drop out of the research process at any time, without explanation or recrimination, up until publication of the study.

2. The investigator and I will be monitoring my comfort levels in all contacts and I may take a break at any time or discontinue my participation in the process altogether.

3. The investigator has left his contact information and I have been encouraged to contact the investigator should stress related to my participation in the research project arise for me.

4. I know that the investigator will be contacting me in a couple of weeks and I may discuss any emotional discomfort I may be feeling with him at that time.

5. The procedures for this research project include up to three free consultations with a qualified person made available through the investigator to work through any lingering emotional discomfort in relation to my participation in this research study should that occur.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my anonymity and confidentiality (including any agency or client that I may mention) will be protected - that is, any information I provide that is used in the study will not be associated with my name or identity.

Signature: _____

Date: _____

If you would like a copy of the results of this study, please provide your name and address:
Name: _____
Address: _____

APPENDIX F: LETTER OF THANKS FOR OFFER OF PARTICIPATION

, 2009

Dear ,

Thank you for your interest in the research study that I am conducting as a doctoral candidate at **The Sanville Institute**, which has approved the project. At this time, I have recruited a sufficient number of participants for the project. However, if interviewing additional clinicians becomes appropriate, I may contact you again to determine if you would still be interested and available to participate.

Your interest in the work I am doing is very much appreciated. If you would like to know about the results of the dissertation, please contact me at 951 776 9184 or at

mccloudrussell@gmail.com

Again, thanks for your time and offer of participation

Sincerely,

R. Benson McCloud

20204 Lakeridge Drive

Perris, CA 92570

APPENDIX G: CONTACT INFORMATION LEFT WITH PARTICIPANT

(Two-sided sheet of paper to be left with Resource Information, Appendix H)

Research Study: The Impact of Hearing about Trauma on Experienced Social Work Clinicians

Investigator: R. Benson McCloud at (951)-776-9184 or (714) 325-4085 or via email at mccloudrussell@gmail.com

Research project approved by **The Sanville Institute**

APPENDIX H: RESOURCE INFORMATION LEFT WITH PARTICIPANT

Bride, B. E. (2007) Prevalence of secondary traumatic stress among social workers, *Social Work, 52*(1), 63-70.

Bride, B. E., & Figley, C. R. (Eds.). (2007). Compassion fatigue [Special issue]. *Clinical Social Work Journal, 35*(3), 151-214.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers - A literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 417-424.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings, *Social Work, 48*(4), 451-459.

Figley, C. R. (Ed.). (2006). *Mapping trauma and its wake: Autobiographic essays by pioneer trauma scholars.* New York, NY: Routledge, Taylor, & Francis.

ISTSS (International Society for Traumatic Stress Studies).

Morrissette, P. J. (2004). *The pain of helping: Psychological injury of helping professionals.* New York, NY: Brunner-Routledge.

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

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma: Self-care strategies for managing burnout and stress.* New York, NY: W. W. Norton.

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professional who work with traumatized clients.* New York, NY: W. W. Norton.

Schore, A. N. (2003). *Affect dysregulation and disorders of the self.* New York, NY: W. W. Norton.

Schore, A. N. (2003). *Affect regulation and repair of the self.* New York, NY: W. W. Norton.

Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.). Baltimore, MD: Sidran Press. See website as well.

Van der Kolk, B., McFarlane, A., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York, NY: The Guilford Press.

Wilson, J. P., & Thomas, R. T. (2004). *Empathy in the treatment of trauma and PTSD.* New York, NY: Brunner-Routledge.

APPENDIX I: INTERVIEW GUIDE

(Only to be used selectively, as needed, in areas where information is not flowing.)

Often on a daily basis as generic clinicians, we encounter human events that evolve from trauma. Traumatic material for the purposes of this conversation is material which feels uncomfortable, extreme, unexpected, shocking, unforgettable, frightening, serious, grave and dangerous. It may require re-orientation. More specifically, I am interested in understanding what happens to you as a therapist when listening to accounts of traumatization in the moment as well as listening to repetitive stories of trauma over time and across clients.

Over time, how much of your practice would you estimate involves working with traumatized clients? Currently? Changed?

Have you done anything to alter the flow of the traumatized clients you see? If you would, explain how you have gone about that.

In your work as a therapist, when and how do you become aware that a person's sharing of traumatic material is impacting you? Please elaborate on your subjective experience.

> What is the impact for you of listening, containing and processing traumatic events that clients share?

What, if any, sort of reaction(s) does listening to traumatic material trigger in you? Please describe how you manage that experience.

Now, thinking about yourself over time, take a moment and recall your reaction(s) to a particular story of trauma that a person shared.

> What was your internal response? Example?
>
> Did you experience the telling in your body and in your brain? If so, how?
>
> What, if any, were your internal signals?
>
> What were your impulses, if any?
>
> Did the experience trigger immediate reaction(s) and if so, to the best of your recall, what was that/were they?

Were there subsequent reactions to the information and how did/do you classify and understand those responses?

Focusing on that client who was traumatized, recall whether or not the trauma information you heard and/or the reaction you felt revealed itself in some manner in your personal life?

If so, would you elaborate on that experience? If not, would you please speculate on why the trauma story didn't surface in your personal life?

How would you say that your work with traumatized persons (including containing the person's feelings around the trauma as well as processing and/or interpreting those feelings at an appropriate-to-the-therapy time) has changed you/your professional practice over the years or has it? Please explain how you understand what has/has not happened.

Has your work with traumatized persons over the years affected your personal life? Please be specific in identifying exactly what has/has not changed for you either professionally or personally.

What, if anything, has helped you manage your exposure to traumatic material in both your professional and personal life?

Reflecting on your personal attachment history and style, please comment if and how it influences your practice in relationship to trauma material clients share. Please give an example. Please talk, if you would, about what you use as a secure base when working with people who have traumatic history.

When you are hearing trauma material, do you believe your attunement and empathic engagement are impinged upon? If so, please elaborate with an example and, if not, please explain with an example.

Have you experienced time(s) when the flow of clientele involves one trauma situation disclosure after another? Please talk about how you manage such situations. What does your brain-body connection reveal? How did/do you manage and/or how did/do you manage to stay empathically engaged?

Please talk about your process of emotional containment of repetitive accounts of trauma. Please freely associate to BO, PTSD, CF, STS, VT, CS, CTR, empathy and attunement.

In your opinion, if traumatic stress can be transferred from client to therapist, how do you understand the mechanism for that transmission?

Do you think or feel that your personal relationship to trauma, including your own trauma history if you have one, has impacted your reactions to clients' traumatic materials? Please say more.

In this context, has your sense of safety, efficacy, trust, love, relationship and or spirituality been affected and, if so, how? Please say more.

If you could suggest to practitioners who are currently in graduate school preparing for the work and career that you have about how to prepare to work with clients' accounts of trauma, what would you advise?

APPENDIX J: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE

PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project: The Impact of Hearing about Trauma on Experienced Social Work Clinicians

Principal Investigator: Alexis F. Selwood, Ph. D.
(print name and degree)

Investigator: Russell Benson McCloud (print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the *Student and Faculty Handbook*), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__X__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Alexis Selwood, PhD 8/27/09
Signature of Principal Investigator/date

Russell B. McCloud 8/27/09
Signature of Investigator/date

Action by the Committee on the Protection of Research Participants:

Approved __X__ Approved with Modifications _____ Rejected

Signature of Representative of the Committee on the Protection of Research Participants/date
Mary Coombs, Ph.D. October 7, 2009

(Signature of Dean & date)
Whitney McNeely, PhD November 18, 2009

REFERENCES

Adams, R., Boscarino, J., & Figley, C. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*(1), 103-108.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Arvay, M. J. (2001). Secondary traumatic stress among trauma counselors: What does the research say? *International Journal for the Advancement of Counselling, 23*, 283-293.

Badger, K., Royse, D., & Craig, C. (2008). Hospital social workers and indirect trauma exposure: An exploratory study of contributing factors. *Health and Social Work, 33*(1), 63-71.

Baird, S. A. (1999). *Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff and volunteers* (Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. AAT 1405439)

Baird, K., & Kracen, A. C, (2006). Vicarious traumatization and secondary traumatic stress: A research syntheses. *Counseling Psychology Quarterly, 19*(2), 181-188.

Baranowsky, A. B. (2002). The silencing response in clinical practice: On the road to dialogue. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 155-170). New York, NY: Brunner-Routledge.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63-70.

Bride, B. E., & Figley, C. R. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal, 35*(3), 151-153.

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-163.

Campbell, L. (2007). Utilizing compassion fatigue education in hurricanes Ivan and Katrina. *Clinical Social Work Journal, 35*(3), 165-171.

Chrestman, K. R. (1995). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for*

clinicians, researchers, & educators (2nd ed., pp. 29-36). Baltimore, MD: Sidran Press.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers - A literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 417-424.

Creswell, J. W. (2003). *Research design qualitative, quantitative and mixed method approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*(4), 451-459.

Dalenberg, C. (2000). *Countertransference and PTSD*. Washington, DC: American Psychological Association Press.

Danieli, Y. (2006). It was always there. In Figley, C. R. (Ed.), *Mapping trauma and its wake: Autobiographic essays by pioneer trauma scholars* (pp. 33-46). New York, NY: Routledge.

Deighton, R. M., Gurris, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: Is the therapist's attitude to working through trauma relevant? *Journal of Traumatic Stress, 20*(1), 63-75.

Donovan, D. (1991). Traumatology: A field whose time has come. *Journal of Traumatic Stress, 4,* 433-436.

Donovan, D. (1993). Traumatology: What's in a name? *Journal of Traumatic Stress, 6,* 409-411.

Drake, B., & Yadama, G. (1995). Confirmatory factor analysis of the Maslach Burnout Inventory. *Social Work Research, 19*(3), 184-192.

Drake B., & Yadama, G. (1996). A structural equation model of burnout and job exit among child protective services workers. *Social Work Research, 20*(3), 179-188.

Fahy, A. (2007). The unbearable fatigue of compassion: Notes from a substance abuse counselor who dreams of working at Starbuck's. *Clinical Social Work Journal, 35*(3), 199-205.

Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Research, Practice, Training, 43*(1), 16-31.

Figley, C. R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York, NY: Routledge Taylor and Francis .

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the cost of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for*

clinicians, researchers, and educators (2nd ed., pp. 3-28). Baltimore, MD: Sidran Press.

Figley, C. R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self care, JCPL in session. *Psychotherapy in Practice, 58*(11), 1441-1443.

Figley, C. R. (Ed.). (2002b). *Treating compassion fatigue*. New York, NY: Brunner-Routledge.

Figley, C. R. (2004). Foreword. In J. P. Wilson and R. B. Thomas, *Empathy in the treatment of trauma and PTSD* (pp. ix-xi). New York, NY: Brunner-Routledge.

Figley, C. R. (Ed.). (2006). *Mapping trauma and its wake: Autobiographic essays by pioneer trauma scholars*. New York, NY: Routledge Taylor & Francis.

Fosha, D. (2003). Dyadic relationship and experiential work with emotion and relatedness in trauma and disorganized attachment. In Solomon, M. & Siegel, D. (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 221-281). New York, NY: W. W. Norton.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago, IL: Aldine.

Harlan, K.B. (2004). *Compassion fatigue and Master's level social workers in direct mental health service delivery* (Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. AAT 3121065)

Horowitz. M. (2006). A life in but not under stress. In C. R. Figley (Ed.), *Mapping trauma and its wake: Autobiographic essays by pioneer trauma scholars* (pp. 85-94). New York, NY: Routledge.

Jenkins, S. R., & Baird, S. (2002) Secondary traumatic stress and vicarious traumatization: A validational study. *Journal of Traumatic Stress, 15*(5), 423-432.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 116-122.

Kanter, J. (2007). Compassion fatigue and secondary trauma: A second look. *Clinical Social Work Journal, 35*(4), 289-293.

Kanter, J., & Berzoff, J. (2009). Compassion fatigue and countertransference: Old Wine in new bottles? Workshop conducted at the *11th Annual Conference of the AAPCSW Conference,* New York, NY.

Leiter, M., & Maslach, C. (1997). *The truth about burnout.* San Francisco, CA: Josey-Bass.

Locke, L. F., Spirduso, W. W., & Silverman, S. J. (2000). *Proposals that work: A guide for planning dissertations and grant proposals* (4th ed.). Thousand Oaks, CA: Sage.

Maslach, C. (2003). *Burnout: The cost of caring* (2nd ed.). Cambridge, MA: Malor Books.

McCann, I. L., & Pearlman, L. A. (1990a). *Psychological trauma and the adult survivor: Theory, therapy and transformation.* New York, NY: Brunner/Mazel.

McCann, I. L. & Pearlman, L. A. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149.

Mishler, E. G. (1986). *Research interviewing: Context and narrative.* Cambridge, MA: Harvard University Press.

Morrissette, P. J. (2004). *The pain of helping: Psychological injury of helping professionals.* New York, NY: Brunner-Routledge.

Munroe, J. F. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, & educators* (2nd ed., pp. 211-229). Baltimore, MD: Sidran Press.

Naparstek, B. (2004). *Invisible heroes: Survivors of trauma and how they heal.* New York, NY: Bantam Books.

Pearlman, L. A. (2002, November). Trauma and the therapist: Exploring vicarious traumatization. A six-hour workshop presentation in *The Loathing Self: Body Image Disturbances in Eating Disordered Trauma Survivors* at the 12th Annual Renfrew Center Foundation Conference, Philadelphia, PA.

Pearlman, L.A., & Mac Ian, P. S. (1993). Vicarious traumatization among trauma therapists: Empirical findings on self-care. *Traumatic Stress Points: News for the International Society for Traumatic Stress Studies, 7*(3), 5.

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). NewYork, NY: Brunner/Mazel.

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

Pinto, R. M. (2002). *The impact of secondary traumatic stress on novice and expert counselors with and without a history of trauma* (Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. AAT 3065833

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145.

Pulido, M. L. (2007). In their words: Secondary traumatic stress in social workers responding to the 9/11 terrorist attacks in New York City. *Social Work, 52*(3), 279-281.

Racanelli, C. (2005). *Attachment styles and compassion fatigue among the mental health clinicians of traumatized victims of terrorism.* Available from ProQuest Dissertations and Theses database. (UMI Publication Number: 3162028)

Racker, H. (1981). The meanings and uses of countertransference. In R. Langs (Ed.), *Classics in psychoanalytic technique* (pp. 177-200). New York, NY: Jason Aronson.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion, *Clinical Social Work Journal, 35*(3), 207-214.

Rodrigo, W. D. (2005). *Conceptual dimensions of compassion fatigue and vicarious trauma* (Master's thesis). Available from ProQuest Dissertations and Theses database. (UMI No. AAT MR16881)

Rothschild, B. (2004). Mirror, mirror: Our brains are hardwired for empathy. *The Psychotherapy Networker*, Sept-Oct. Retrieved from http://home.webuniverse.net/babette/Mirror.html

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma.* New York, NY: W. W. Norton.

Saakvitne, K. W. (2002, November). Self of the therapist: How therapists' life events influence our therapeutic work. Presentation in *The Loathing Self: Body Image Disturbances in Eating Disordered Trauma Survivors* at the12th Annual Renfrew Center Foundation Conference, Philadelphia, PA.

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professional who work with traumatized clients.* New York, NY: W. W. Norton.

Sabin-Farrel, R. & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers. *Clinical Psychology Review, 23*(3), 449-480.

Salston, M. D. & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167-174.

Schore, A. N. (2000). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7-66.

Schore, A. N. (2003a). *Affect dysregulation and disorders of the self.* New York, NY: W. W. Norton.

Schore, A. N. (2003b). *Affect regulation and repair of the self.* New York, NY: W. W. Norton.

Schore, A. N. (2007, February 2-3). *The science of the art of psychotherapy.* Coordinated with the UCLA David Geffen School of Medicine at the Skirball Center in Los Angeles, CA.

Sharman, K. D. (2002). *Secondary traumatic stress in mental health clinicians.* (Master's thesis). Available from ProQuest Dissertations and Theses database. (UMI No. AAT MQ83976)

Solomon, M. & Siegel, D. (Eds.) (2003). *Healing trauma: Attachment, mind, body, and brain.* New York: W. W. Norton.

Stamm, B. H. (Ed.) (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.). Baltimore, MD: Sidran Press.

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the Compassion Satisfaction and Fatigue Test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107-122). New York, NY: Brunner Routledge.

Strauss, S., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Thomas, R. B. (1998). *An investigation of empathic stress reactions among mental health professionals working with PTSD.* Unpublished doctoral dissertation, Union Institute, Cincinnati, OH.

Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006). Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide, *Social Work, 51*(4), 329-341.

Tosone, C. (2007). Therapeutic intimacy: A post 911 perspective. *Smith College Studies in Social Work, 76*(4), 89-98.Tyson, J. (2007). Compassion fatigue in the treatment of combat-related trauma during wartime, *Clinical Social Work Journal, 35*(3), 183-192.

Um, M., & Harrison, D. (1998). Role stressors, burnout, mediators, and job satisfaction: A stress-strain-outcome model and an empirical test. *Social Work Research, 22,* 100-115.

van der Kolk, B., McFarlane, A., & Weisaeth, L. (Eds.) (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York, NY: The Guilford Press.

Van Tuinen-Youngs, E. (2005). *Secondary traumatic stress and countertransference in the trauma therapist: A comparative analysis.* (Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. AAT 3215604)

Weaks, K. A. (1999). *Effects of treating trauma survivors: Vicarious traumatization and style of coping* (Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. AAT 9944511)

Wilson, J. P., & Thomas, R. T. (2004*). Empathy in the treatment of trauma and PTSD.* New York, NY: Brunner-Routledge.

ENDNOTES

[1] In her 1997 co-authored book with Michael Leiter, *The Truth About Burnout*, BO is identified as a phenomenon related to the social environment where work is accomplished and is the result of a "mismatch" between the job and the people who do the labor. In the Foreword of the 2003 re-publication of her original book, *Burnout, the Cost of Caring*, first published in 1982, Maslach states: "These mismatches occur in six different areas: work overload, lack of control, insufficient rewards, breakdown of workplace community, absence of fairness, and value conflict" (p. xxiii). Seemingly, contemporary use of the term BO has strayed considerably from its initial meaning of emotional exhaustion, depersonalization and inefficacy. The negativity and everyday usage associated with the term may account for its lack of attention and follow up in the field of traumatology.

[2] Charles F. Figley, PhD, who is based with the Greencross Foundation and the Traumatology Institute and College of Social Work at Florida State University, has been a preeminent force in the evolving conceptual literature about the consequence of helping work on the helper. Figley is a Vietnam veteran, and his war experiences sparked his interest in the impact of trauma on both soldiers and citizens. He was the founding editor of the *Journal of Traumatic Stress* which began in the mid nineties. Also, he is the Series Editor for the Brunner-Routledge Psychosocial Stress Series which began in 1978 and which holds a number of Figley's books including *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (1995), which was the first (and the 23rd in the series!) to specifically focus on therapists' traumatization from working with traumatized people.

[3] See Dr. Carole Tosone's work on shared trauma such as her 2006 article: "Therapeutic Intimacy: A Post 911 Perspective."

[4] For example, the belief in personal invulnerability that allows one to use public transportation at night, or the belief that the world is an orderly place, may well be challenged by the stories and experiences relayed to persons who practice counseling or psychotherapy with survivors of trauma.

[5] This is not the case for certain traumas which may have been shared by client and therapist such as the 9/11 terror attacks, wars and certain natural disasters (See reference in endnote 3 above).

[6] Rothschild (2004) posits that we humans are hardwired as a species for empathy and that the route to empathy is through the body. She goes on:

> If we're truly designed to mirror each other's feelings, we therapists may be exquisitely vulnerable to "catching" our clients' depression, rage and anxiety, and succumbing to the ravages of "compassion fatigue"(para. 3). I believe that this brain-to-brain communication occurs at an unconscious level between clients and therapists all of the time (para. 29).

See also Stamm, 1999, p. xxxiii for similar usage).

[7] See Figures 8.1, p. 146; 8.3, p. 151 and 10.14, p. 208 in Wilson and Thomas (2004).

[8] The Preamble of the National Association of Social Workers' Code of Ethics (2008):

> The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living. Social workers promote social justice and social change with and on behalf of clients. . . . Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems. The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:
>
> - service
> - social justice
> - dignity and worth of the person
> - importance of human relationships
> - integrity
> - competence.

[9] For example, one can access the Compassion Fatigue Self Test online. B. Hudnall Stamm frequently updated list of publications can be found at the following web site: http: //www.isu.edu/~bhstamm. Also *The Professional Quality of Life* survey is available there. There is a workbook, *Transforming the Pain: A Workbook on Vicarious Traumatization* by Pearlman and Saakvitne. Assessing "the cost of caring" over time is the *Maslach Burnout Inventory* (MBI) and it is another tool which continues to be available.

[10] Figley (1999) speculates countertransference is moderated by therapists' qualities and skills in relationship to anxiety management, conceptualizing skill, empathic ability, self insight and self integration in assisting traumatized clients. (see p.18 above)

[11] This Contents page from the *Clinical Social Work Journal, Volume 35, No. 3, September 2007* is reprinted with the kind permission of the copyright holder: Springer Science and Business Media.