

2010

Awareness of vicarious trauma among novice social workers

Jennifer L. Griswold

Follow this and additional works at: <http://scholarworks.smith.edu/theses>

Recommended Citation

Griswold, Jennifer L., "Awareness of vicarious trauma among novice social workers" (2010). *Theses, Dissertations, and Projects*. Paper 1171.

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact elanzi@smith.edu.

Jennifer L. Griswold
Awareness of Vicarious Trauma
Among Novice Social Workers

ABSTRACT

This descriptive study was undertaken in order to determine if novice Master's of Social Work graduates were aware of the concept of vicarious traumatization. This study defines inexperienced social workers as those with zero through three (0-3) years field practice post graduation. This study asked the following research questions: How familiar are recent Masters of Social Work graduates with the term vicarious traumatization? What do they know about vicarious traumatization? Where and when did they learn about vicarious traumatization?

Participants were recruited by the snowball data collection technique by contacting a professional network of colleagues in person and by e-mail. Forty-nine respondents completed a semi-structured survey accessed at SurveyMonkey.com. The majority of respondents were Caucasian females and had attended Smith College School for Social Work.

The findings of the research showed that the majority of the respondents were aware of the concept and definition of vicarious traumatization. The majority of the respondents reported they learned about vicarious traumatization during their graduate programs and most of the respondents reported an understanding of the symptomology that a person experiencing vicarious traumatization may present.

AWARENESS OF VICARIOUS TRAUMA AMONG
NOVICE SOCIAL WORKERS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Jennifer L. Griswold

Smith College School for Social Work
Northampton, Massachusetts, 01063

2009

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully appreciated.

I wish to thank my research advisor, Mary Beth Averill, PhD, for her boundless, patient help as I navigated my thesis experience; my dear friend Sarah Buckner for staying the course with me through the peaks and valleys during the past three years; my friends who believed in me and inspired me with their own immeasurable talents; Penni Martorell for being there for me without hesitation; my family for believing in me as I am; and my mom, Mavis C. Griswold, for her love and support and her unwavering belief that I could accomplish my academic journey.

TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	3
III. METHODOLOGY	17
IV. FINDINGS.....	20
V. DISCUSSION AND CONCLUSIONS	25
REFERENCES	28
APPENDICES	
Appendix A: HSR Approval Letter	30
Appendix B: Business Card.....	31
Appendix C: Email Letter	32
Appendix D: Informed Consent Form.....	33
Appendix E: Introduction to Survey	35
Appendix F: Survey	36
Appendix G: SPSS Frequency Tables	42

CHAPTER I

INTRODUCTION

There has been an increased awareness in recent years that the effects of traumatic life events can be long-lasting and devastating. In addition to the effects of traumatic experiences on individuals who experience the trauma, it is theorized that those who provide direct support or services may be negatively affected as well. Therapists and helpers who provide direct services may be emotionally affected by their clients' trauma histories, which may negatively impact the helper's emotional well-being as well as the helping relationship (Rosenbloom, Pratt & Pearlman, 1995).

This descriptive study explores the knowledge base that inexperienced social workers, having graduated with a Masters in Social Work, have about vicarious traumatization. This study defines inexperienced social workers as those with zero through three (0-3) years field practice post graduation. This study asked the following research questions: How familiar are recent Masters of Social Work graduates with the term vicarious traumatization? What do they know about vicarious traumatization? Where and when did they learn about vicarious traumatization?

There is minimal research focused on inexperienced social workers working with clients who experience trauma and the subsequent effects on the novice social worker and the therapeutic relationship. A literature search has yielded few resources that indicate when or how an inexperienced social worker or social work student would be introduced to the concept of vicarious traumatization. A lack of research demonstrates that there is a need for

further exploration into the knowledge base of awareness and the impact of vicarious traumatization for students and inexperienced clinical social workers. Research has indicated that experienced clinicians have developed the skills to cope with vicarious traumatization while inexperienced social workers are at greater risk for experiencing vicarious traumatization due to limited experience working with trauma material (Pearlman, Saakvitne, Adler, Elliott, Fournier, Neiman, Pratt, Streifender, & Thompson, 1995).

In the documentary film, *Vicarious traumatization II: Transforming the pain (1995)*, the presenters emphasized the importance of students receiving information, training and theory about the costs and benefits of working with clients who have experienced trauma at the beginning of their career in the academic setting. The presenters in the film theorized students and inexperienced social workers need a solid foundational knowledge regarding vicarious traumatization in order to be better able to implement self-care and protection, as well as to understand the possible negative impacts on social workers, their clients and their professional relationship (Pearlman, Saakvitne, Adler, et al., 1995).

This research topic is important to explore because vicarious traumatization has been shown to negatively impact the social worker, the client and the therapeutic relationship (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Rosenbloom et al., 1995). More information available to inexperienced social workers, MSW programs, agencies and supervisors regarding vicarious traumatization will most likely increase opportunities to develop coping skills, protective skills and techniques to counter vicarious traumatization at the beginning of a social workers career.

CHAPTER II

LITERATURE REVIEW

The literature review begins with examining studies focusing on the definition of primary trauma, the prevalence of trauma in the total population and defining different types of trauma. In addition to primary trauma, studies discussing secondary trauma which affects family, friends and helpers of the primary trauma survivor, emerges as a possible precursor to vicarious traumatization in the literature. The definition of vicarious traumatization, its theoretical origins and effects on the clinician when working with client's trauma material are discussed.

What is Trauma?

The research available explains trauma in a variety of ways specific to type and experience. For the purpose of this study and literature review, this report will focus on the definition and explanation of psychological or emotional trauma.

Psychological trauma (Allen, 2005; Everstein & Everstein, 1993) is distinguished by the exposure to a potentially traumatic event and the individual's response to the event. Allen further explained this concept as an individual's witnessing an "objective" event, such as an act of violence or an accident, and the response, or "subjective" effects of the event, which may differ for each individual (p. 4).

Allen (2005) offered the example of a person being in a car wreck as the objective traumatic event, which may result in the subjective response, such as the person being too fearful to drive as the "lasting adverse effects" (p. 4). Everstein and Everstein (1993)

further differentiated the experience of psychological trauma by describing “the event as cause and the trauma itself as the effect” (p. 3). Trauma also has been explained by McCann and Pearlman (1990a) as “exposure to a non-normative or highly distressing event or series of events that potentially disrupts the self” (p. 6). These authors enumerated three criteria for identifying and defining a traumatic experience: “(1) is sudden, unexpected, or non-normative, (2) exceeds the individual’s perceived ability to meet its demands, and (3) disrupts the individual’s frame of reference and other central psychological needs and related schemas” (p. 10).

Cunningham (2004) discussed the high prevalence of individuals who have experienced trauma, ranging from individual incidents of violence and trauma (sexual abuse, sexual assault, abuse, natural disasters) to witnessing violence and traumatic events (witnessing domestic violence, shootings, or car accidents). According to Cunningham (2004), the percentage of individuals having experienced or having witnessed single to multiple episodes of violence and trauma ranges from 33% to 96% of the total population. In a study of urban adolescents (Rosenthal, 2000), 65 % of the adolescents reported being victims of violence and 98% reported witnessing a violent act. In a study of rural young adults, Scarpa (2003) reported 76% to 82% of respondents reported being victims of violence and 93% to 96% were witnesses of violence. Bride (2007) noted “although exposure to traumatic events is high in the general population, it is even higher in subpopulations to whom social workers are likely to provide services” (p. 63). In a study of psychiatric inpatients by Escalona, Tupler, Saur, Krishnan, and Davidson (1997), 84% of the inpatients had experienced at least one traumatic event and 45% had experienced three or more traumatic events. Studies by Davidson and Smith

(1990) and Switzer, Dew, Thompson, Goycoolea, Derricott and Mullins (1999) reported 82% to 94% of outpatient mental health clients having experienced exposure to traumatic events with 31% to 42% meeting PTSD criteria.

Burnout, Compassion Fatigue, Secondary Traumatic Stress,

Vicarious Traumatization

According to Rothchild and Rand (2006), the terms burnout, compassion fatigue, secondary traumatization and vicarious traumatization are popular terms that are often used interchangeably to describe negative risks that clinicians may experience in the therapeutic relationship. However, the authors reported that due to the conflicting nature of the terminology in the professional literature, they described the terminology “as a compromise between conflicting definitions as they exist throughout the professional literature” (p. 14).

According to Rothchild and Rand (2006), the term burnout was first used by Pines and Maslach (1978) who referred to mental health workers, and defined burnout as “a syndrome of emotional and physical exhaustion, involving the development of a negative self-concept, negative job attitudes, and loss of concern and feeling for clients” (p. 233). Similarly, Rothchild and Rand defined burnout as a condition in which a person's “health is suffering or whose outlook on life has turned negative because of the impact or overload of their work” (p. 14).

Figley (1995) reported the term *secondary traumatic stress* resulted from a long history of work devoted to the study and treatment of traumatized people. Figley related the term to people such as family, friends, treatment providers and human service personnel, who come into close, consistent contact with trauma survivors. Figley

theorized that people, who are close to the victim, may become indirect victims of the primary trauma and experience emotional disruption. Figley (1999) defined secondary traumatic stress as “the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 10).

Figley (1995) noted that the first time inclusion of post-traumatic stress disorder in the 1980 publication of the American Psychiatric Association's DSM-III was a major milestone in the study of trauma. Figley (1995) explained that the term post-traumatic stress disorder is used commonly in referring to people traumatized by many types of traumatic events. He stated that “nearly all of the hundreds of reports focusing on traumatized people exclude those who were traumatized indirectly or secondarily and focus on those who were directly traumatized” (p. 3). However, Figley (1995) reported that the DSM-III and the DSM-III-R, “clearly indicate that mere knowledge of another's traumatic experiences can be traumatizing” (p. 4) and the lack of recognition in the field of trauma study of people who are indirectly exposed to trauma are also victims, creates a “conceptual conundrum” (p. 4) because the numbers of victims are grossly underestimated.

Secondary traumatic stress has been increasingly considered an occupational hazard of providing direct services to traumatized populations (Bride, 2004; Figley, 1999). In an empirical study by Bride (2007), the prevalence of secondary traumatic stress in a sample of social workers was investigated by looking at the frequencies of individual symptoms, how the diagnostic criteria for PTSD was met, and the severity of secondary traumatic stress levels. This study focused on social workers who were

working with populations who experienced trauma through childhood abuse, violent crime including domestic violence, war, terrorism and natural disasters. Six hundred master's-level social workers were randomly selected from over 2500 licensed workers in a southern state in the United States. The results of the study (Bride, 2007) indicated that “social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized populations, many social workers are likely to experience at least some symptoms of STS, and a significant minority may meet the diagnostic criteria for PTSD” (p. 63). The mean age of the participants of this study was 44.8 years. Participants were primarily white females. The highest percentage of participants identified substance abuse or mental health as their principal field of work followed by school place settings, community organizing, public welfare, and clients with developmental disabilities. Participants averaged 16.15 years worked in the social work field. Ninety-seven percent of the respondents in this study reported their clients were “at least mildly traumatized, and 81.7 percent reported a moderately to very severely traumatized client population” (p. 67). Concurrently, participants reported working with client trauma material from rarely to not at all 11.1%, 36.8 % occasionally, 39.6 % as often and 12.5% as very often (Bride, 2007).

Bride (2007) concluded that social workers who are directly engaged in practice with traumatized populations “are highly likely to be secondarily exposed to traumatic events...” (p. 68) and are liable to experience some symptomology of secondary traumatic stress including intrusive thoughts, the most frequently reported symptom by 40.5% of the participants. The next most frequent symptom reported by respondents was experiencing psychological distress or physiological reactions when working with

traumatized clients, followed by disturbing dreams and feeling that they were reliving the clients' reported trauma events.

Avoidance symptoms were experienced by the respondents with 31.6% reporting avoidance of clients, resulting in the second most frequently experienced symptom, followed by avoidance of people, places or things that reminded participants of their work with traumatized clients. Less frequently reported avoidance symptomology included feelings of detachment of others, difficulties with remembering the work related to clients, emotional numbing, lessened interest in participating in activities and feeling as though their future is shortened (Bride, 2007)

Arousal symptoms were also reported including irritability and difficulties with concentration reported by 27.7% and 27% of the respondents. Difficulties sleeping, hypervigilance and an exaggerated startle reflex were reported less frequently (Bride, 2007). This study also looked at respondents who met the diagnostic criteria for PTSD as a result of exposure to client trauma material. Results showed that 45.0% of the respondents did not meet any of the diagnostic criteria for PTSD while 55% met one or more, one-fifth of the respondents met two of the diagnostic criteria and 15.2% met all three criteria required to diagnose PTSD (Bride, 2007).

One limitation of this study is the un-measurable subjective perspective of the respondents' opinions regarding what constitutes trauma for their clients. The foundation for this study began with reports from the respondents of their exposure levels to client trauma material on which the study is built upon. Without an instrument to define and measure client trauma material, the foundations of the study are questionable. Another limitation of the study are the respondents to the study. According to Bride (2007), it is

possible the respondents, who numbered 47% of the total 2,886 social workers contacted to participate in the study, may have been experiencing secondary traumatic stress and therefore may have been more likely to respond.

The term compassion fatigue has been described by Figley (1995) as “identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD” (p. xv). Figley (1995) explained that there is a “fundamental difference” (p. xv) in responses for people who have experienced or are exposed directly to a traumatic event versus “those exposed to those in harm's way” (p. xv). Figley noted that professionals who work with traumatized populations as well as family and friends of the victims are “vulnerable to secondary traumatic stress (compassion stress) and stress disorder (compassion fatigue)” (p. xv).

What is Vicarious Traumatization?

McCann and Pearlman (1990b) described vicarious traumatization as a countertransference issue in which “Persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons” (p. 133).

Vicarious traumatization may be a reaction of the therapist to the clients’ painful and graphic trauma material, and how the therapist relates to the information may be based on their distinctive beliefs, expectations and assumptions about themselves and others.

In supplementary research, Saakvitne and Pearlman (1996) described vicarious traumatization as a cumulative process “through which the therapists’ inner experience is negatively transformed through empathic engagement with clients’ trauma material” (p. 279). Saakvitne and Pearlman (1996) suggested that vicarious traumatization can lead to

changes in the therapist's self and professional identity, view of the world, self-capacities and abilities, spirituality and psychological beliefs and needs including safety, trust, esteem, intimacy and control.

The term vicarious traumatization emerged through the Constructivist Self Development Theory, described by McCann and Pearlman (1990a) as a comprehensive personality theory resulting from an integration of theories including developmental, self psychology, social learning theory and other cognitive theories. The authors discussed their ongoing work with survivors of trauma and their realization of "the need for a heuristic model that would integrate the literature on trauma and individual psychological development" (p. 5). The authors discussed theory as a tool that allows for both the client and the therapist to explore and understand the client's experience, what to look for when working with a client and ways to help clients understand their experiences by minimizing the "many pitfalls that may be encountered along the way, posing risks to both client and therapist" (p. 6).

McCann and Pearlman (1990a) proposed that the "major underlying premise of constructivist self development theory is that individuals possess an inherent capacity to construct their own personal realities as they interact with their environment" (p. 6). Explained as cognitive structures or schemas, these personal realities allow individuals to make sense of their experiences through their beliefs, assumptions and expectations about the world and self. Thus, when individuals experience trauma, their responses and adaptations to the traumatic event are unique, and result from the intricate process of the person's personal meanings and images of the traumatic experience, including the social

and cultural contents, personal histories and the specific trauma events experienced (1990b).

McCann and Pearlman (1990b) hypothesized “that trauma can disrupt these schemas and that the unique way that trauma is experienced depends in part upon which schemas are central or significant for the individual” (p. 137). They expanded this concept to the therapist’s experience working with trauma survivors and suggested that the therapist’s most significant or fundamental schemas can also be disrupted by exposure to the client’s trauma material.

Impact of Vicarious Traumatization

Much of the research indicates that clinicians who are newest to the field experience the greatest difficulties navigating the stressors of vicarious traumatization (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Saakvitne & Pearlman, 1996). Pearlman and Mac Ian explained that seasoned clinicians show a great deal less distress and ill ease than inexperienced clinicians resulting from vicarious traumatization as a result of self selection out of the field of trauma work, better self care, seeking personal and professional development, and having awareness about vicarious traumatization.

Cunningham (2004) discussed that during their training, students of social work programs experienced effects of trauma by sitting in a classroom and hearing stories of trauma. As discussed earlier, the main characteristic of vicarious traumatization is the disruption of the clinicians' personal schemas about their worldviews which over time may confront and disrupt the clinicians' belief systems (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995). Various symptoms or manifestations of vicarious traumatization include nightmares, disrupted sleeping patterns, anxiety, unwanted and

distressing imagery emerging between client sessions, and higher levels of stress (Cunningham, 2004).

An empirical study by Pearlman and Mac Ian (1995) explored the relational aspects of trauma therapy and the therapist, including the therapist's current psychological functioning. The purpose of this study was to operationalize and measure vicarious traumatization. According to the researchers, literature pertaining to trauma suggests providing trauma therapy can have negative effects on the therapists that are different from those effects associated with providing general psychotherapy. Pearlman and Mac Ian used a questionnaire to investigate independent measures that examined the therapist's exposure to trauma material such as past and present work with trauma survivors and number of hours per week spent working with trauma material. Other variables used in this study included the therapist's history such as personal trauma, age, income, education, work setting, and if the therapist was receiving general or trauma related supervision.

The participants (N=136) were primarily white (93%) male and female self-identified trauma therapists with a mean age of 43 (range 23 to 74 years). Fifty eight percent of the participants were in the psychology field, 27% from the social work field, 5% from psychiatry, and 4% from psychiatric nursing with the remainder from other professional degree fields. The participants had been working with trauma survivors ranging from 0.08 to 38 years with an average of 9.59 years (Pearlman & Mac Ian, 1995).

The measures applied to this study included The Traumatic Stress Institute Belief Scale, which measures disrupted cognitive schemas based in CSDT that is used to assess the hypothesized areas of psychological needs that may be susceptible to traumatic

occurrences and vicarious traumatization. Items on the scale measured disruptions in safety, trust, intimacy, esteem and power. A 6- point Likert scale was utilized (1= disagree strongly, 6= agree strongly), to evaluate statements such as “You can’t trust anyone” and “Other people are no good.” Another scale, Impact of Event Scale, was implemented to assess avoidant and intrusive signs and symptoms of PTSD. Participants were asked to decide on a 4-point Likert scale how true the items were when applied to the trauma material of their clients. The Symptom Checklist-90 was used as a measure to differentiate general distress from trauma-distress mirrored in the other dependent measures. The Marlowe-Crowne Social Desirability Scale was implemented to assess the participant’s need for approval from authority figures (Pearlman & Mac Ian, 1995).

The results of this study by Pearlman and Mac Ian (1995) showed among the dependent and independent measures, a significant difference for those participants without a trauma history on the TSI Belief Scale score. The mean TSI Belief score for the entire sample was 184, which the researchers reported was the lowest score to date of the groups studied over a period of several years. The findings suggested the greater one’s clinical work load is dedicated to trauma work, the less disruption in a clinician’s self-trust schemas. Length of time also correlated in the sample as a whole with the participants who were newer to the work. Those newer to the work experienced more disruptions in self-intimacy, self-trust and self-esteem, as well as general distress symptoms which were rated higher overall as measured by the SCL-90-R (Pearlman & Mac Ian, 1995).

Therapists with and without a personal trauma history differed on the results of this study (Pearlman & Mac Ian, 1995). Those participants with a personal trauma history

showed higher rates of disruption than participants without a personal trauma history. Also, participants with a personal trauma history were more likely to be affected by the length of time they had been working with trauma material and, although to a lesser degree, affected by the rate of trauma survivors on their caseloads. These participants also had less experience working with trauma survivors with only moderate exposure to trauma material. Therapists with a personal trauma history who were newer to the field (those therapists with less than 2 years work experience) showed an increase in disrupted schemas and symptoms as measured by the SCL-90-R scale. Explicitly regarding disrupted schemas, the participants who had worked the least amount of time and were not being supervised had the highest rate of schema disruption. Therapists without a personal trauma history showed a higher rate of disrupted schemas, were working in a clinic setting, had less training and had discussed the effects of working with trauma material in their own personal therapies (Pearlman & Mac Ian, 1995).

Pearlman and Mac Ian (1995) described this study as an exploration of the relational aspects of trauma therapy, the therapist and the therapist's psychological functioning at the time of the study. The authors advised that caution should be taken when generalizing the interpretations of these findings due to the participants' self-selection as "trauma therapists" (p.9).

Countering Vicarious Traumatization

According to Rosenbloom et al. (1995), "an initial step toward self-care for the helper is to have a framework for understanding the impact of doing trauma work" (p. 66). Helpers who do not have an understanding of the possible negative effects for the helper and the client when working with their client's trauma material may be left

“feeling weak, incompetent, or emotionally unstable” (p. 66). The authors suggested it is more practical and ultimately more helpful for the workers to recognize the certainty of being affected by this type of work. Thus, with a foundational knowledge of the concept, theory and probable impact of vicarious traumatization when working with trauma material, the worker will be better able to work effectively with their clients as well as recognizing their need for self-care.

Limitations of Research on Vicarious Traumatization

In regard to the research conducted on vicarious traumatization the major difference between research participants is based on the length of time they have practiced as a clinician. Test participants are often classified as inexperienced versus experienced clinicians (Cunningham, 2003; Pearlman & Mac Ian, 1995). There is further clarification of test participants based on personal experience with trauma and the amount of trauma material they have been exposed to working with client trauma material (Bride, 2007; Figley, 1995). To date, research that I have looked at with practicing clinicians and students includes more females than males and they have been primarily white (Bride, 2007; Cunningham, 2004; Pearlman & Mac Ian, 1995).

CHAPTER III

METHODOLOGY

A descriptive study design was used to ask the following research questions:
How familiar are recent Masters of Social Work graduates with the term vicarious traumatization? What do they know about vicarious traumatization? Where and when did they learn about vicarious traumatization?

Once this researcher received the Human Subjects Review Board approval letter (Appendix A), the researcher recruited participants by the snowball data collection technique by contacting a professional network of colleagues in person and by e-mail. The people contacted in person were given a business card (Appendix B) with the study title and a website link on the front of the card and the researchers' contact information on the back of the card as a reference if they chose to participate in the study. People contacted by e-mail were sent an Initial Email Letter (Appendix C) that provided information about the study, qualifications needed to participate, how to access the study and researcher contact information.

All persons contacted were directed to www.surveymonkey.com/vicarioustrauma to participate in a study if they self-identified as eligible after first reading the Informed Consent Form (Appendix D). People who decided to participate in the study could access the introduction to the survey (Appendix E) followed by the survey (Appendix F) by clicking on the next button at the end of the Informed Consent Form. The researcher also asked the recruits to contact people they knew who may have been eligible to participate

in the study and to give them the online link to access the informed consent form and the survey.

A quantitative analysis of a self-designed semi-structured survey research tool was used to conduct the research for this study. The survey consisted of demographic, multiple-choice, and open-ended questions and took 10-15 minutes to complete. The survey was made available on SurveyMonkey.com, an online survey design and implementation website. This survey was administered to graduates of Masters of Social Work programs currently in practice from zero-three years to assure that those who answered this survey fell under the definition of inexperienced clinician which during the time of data collection was three or less years of post graduate work.

For this study participants who met the following criteria were excluded: clinicians of other disciplines than social work, and clinicians who have been in clinical practice for more than three years. Of the 48 participants who completed and submitted the survey, four surveys were excluded from analysis because of missing data; one participant from the excluded surveys did not have their MSW degree.

This type of research tool was appropriate in that it maintained participant anonymity and increased ease of administering the survey to assure an adequate sample size. The snowball sample data collection technique was used to collect data for this study. The snowball technique was useful as a way to contact only participants who were professionals in the MSW field.

Descriptive statistics were implemented to describe the sample itself and to generalize the data collected through the on-line survey. The researcher did not utilize

standardized measures or other measures designed by someone else. Frequency tables (Appendix G) were generated by SPSS and used to organize the raw data.

This researcher is aware that the overall sample may not be an adequate representation of Clinical Social Workers of all diverse backgrounds. However, I have acknowledged this limitation in all conclusions of data as well as the final product. I am also aware that bias may be magnified in the results of this study because the original participants may have contacted likeminded people through the snowball sampling technique.

CHAPTER IV

FINDINGS

This descriptive study explored the knowledge base that inexperienced social workers, having graduated with a Masters in Social Work, have about vicarious traumatization. This study asked the following research questions: How familiar are recent Masters of Social Work graduates with the term vicarious traumatization? What do they know about vicarious traumatization? Where and when did they learn about vicarious traumatization? The major findings of this study indicate that the majority of respondents to the survey were aware of the term *vicarious traumatization* and had a basic understanding of the possible psychological and physiological effects vicarious traumatization may have for the person experiencing this phenomenon. This chapter will include demographic data about the respondents followed by an in depth explanation of the descriptive findings.

Demographics

Analysis of demographic information revealed 84% (n=37) of the respondents identified as Caucasian followed by 9% (n=4) as Black and Bi-racial with one respondent identifying as Persian and one as Hispanic and Native American. Seventy-three percent (n=32) of the respondents were between 20-39 years-old followed by 16% (n=7) from 40-49 years-old with 11% (n=5) from 50-69 years-old. Thirty-nine of the respondents were female and five were male.

One-half of the 44 respondents reported having graduated in 2007 from their MSW programs followed by 25% (n=11) in 2008, 16% (n=7) in 2005 and 9% (n=4) in 2006.

Of the 44 respondents, 36% (n=16) had undergraduate bachelors of psychology degrees followed by 26% (n=10) with bachelors of social work undergraduate degrees. Out of the 18 people that remained, approximately 27% (n=12) had Social Science degrees, followed by 9% (n=4) with Arts and Humanities degrees, 2% (n=1) with a Business degree and 2% (n=1) with a Science degree.

The largest number of respondents, 62% (n=26), completed their MSW degree at Smith College School for Social Work followed by Salem University at 11% (n=5) with 4% (n=4) having graduated from George Warren Brown School for Social Work at Washington University St. Louis, MO. The eight remaining respondents reported receiving their MSW degrees from Boston College, CSU Sacramento, Simmons College, Springfield College, University of Connecticut, University of Illinois, University of Denver and the University of Michigan.

Forty three percent (n=19) of the respondents had a LCSW and one participant had a LICSW. The remaining respondents were either not licensed, working toward licensure or had various other licenses depending upon geographic location and differences in state or country licensing requirements.

Thirty-seven people indicated they have worked as an MSW for three or fewer years. Of the remaining seven people, five reported having worked for more than three years, having ranged from 10-33 years. The assumption is they worked prior to receiving Masters of Social Work degrees.

Seventy-two percent (n=32) of the respondents reported their MSW program concentration was clinical. The remaining respondents reported concentrations in casework, group work, children and families, community organizations, administration, policy, program evaluation, generalist and advanced generalist.

At the time of participation, 41% (n=18) of the respondents reported working in an outpatient clinical setting followed by 18% (n=8) working in Community Mental Health Centers. Twelve percent (n=5) of the respondents reported working in hospital settings with an additional 14% (n=6) working for state government. Other work settings reported were foster care, child protective services, private practice, family service agencies, substance abuse programs, homeless shelters and domestic violence services. Work settings also reported were school settings, elderly and aging services, emergency and crisis services and university research settings.

Major Findings

Ninety-three percent (n=41) of the respondents reported they were aware of the concept of vicarious traumatization and 87% (n=39) reported being familiar with the definition of vicarious traumatization. Sixty-four percent (n=28) of the people became aware of the concept while attending graduate school, followed by 9% (n=4) during their undergraduate program. One respondent indicated they learned about vicarious traumatization in graduate school and recognized the importance of being aware of the concept and theory due to the possible negative affects to themselves as the clinician, and the therapeutic relationship. Other settings people reported they first became aware of vicarious traumatization include post-graduate programs, pre-graduate and post-graduate work settings, magazine articles and attendance of a pre-graduate school National

Association of Social Workers presentation. A respondent reported they first became aware of vicarious traumatization in their post-graduate workplace but noted it may have been more helpful to be aware of the concept in their educational setting in order to be prepared for the possible negative affects for them prior to entering the workplace.

The majority of respondents surveyed (98%, n=43) agreed that receiving supervision at work is very important. Additionally, 91% (n=40) agreed that it is very important to access supervision outside the work setting if it is not provided at work. Ninety-three percent (n=41) of the respondents indicated that weekly, bi-monthly and impromptu supervision is very important.

One-hundred percent (n=44) of the respondents indicated that having time to talk about work at work is important and agreed that time for group case conferencing at the work place should be provided as either planned, impromptu or a combination of the two styles. Respondents indicated that personal psychotherapy is important in helping to decrease or prevent vicarious traumatization with 48% (n=21) reporting somewhat important, followed by 37% (n=17) with very important.

The last question of the survey offered a list of possible symptoms a person may have if they are experiencing vicarious traumatization. The respondents were asked to indicate the frequency with which they thought each item listed may be experienced by a person with vicarious traumatization. The choices were never, rarely, sometimes and often. For every item on the list, the highest percentage of respondents, 46%-77% (n=44) answered sometimes.

Of the highest percentage of responses, 77% (n=34) chose sometimes for nightmares followed by 73% (n=34) for experiencing images of the client's description of

trauma and substance abuse. Seventy-one percent (n=31) chose sometimes for tardiness and workaholism, followed by 68% (n=30) for poor work performance and absenteeism. Fatigue was identified by 96% (n=42) of the respondents as a symptom with often chosen by 50% (n=22) of the respondents followed by 46% (n=20) with sometimes. A heightened sense of vulnerability was chosen by 90% (n=41) of the respondents with 46% (n=20) listed as sometimes and 44% (n=19) as often. An increase in traumatic imagery was chosen by a total of 91% (n=40) of the respondents with a combination of 39% (n=17) as often and sometimes at 52% (n=23). One respondent added that symptoms depend on the clinician's response to the client's trauma material, subject to the clinician's personality and experience.

CHAPTER V

DISCUSSION

The purpose of this descriptive study was to explore the knowledge base that novice social workers, having graduated with a Masters in Social Work, have about vicarious traumatization. This study defined inexperienced social workers as those with zero through three (0-3) years field practice post-graduate school. This study asked the following research questions: How familiar are recent Masters of Social Work graduates with the term vicarious traumatization? What do they know about vicarious traumatization? Where and when did they learn about vicarious traumatization?

The findings of this study indicate the majority of novice post-graduate social workers are aware of vicarious traumatization and have a basic understanding of the effects it may have on the social worker. Nearly all of the respondents (93%) indicated they were aware of the concept of vicarious traumatization, and most (87%), reported being familiar with the definition of vicarious traumatization. The majority of the respondents learned about vicarious traumatization during their graduate and undergraduate school education. Forty-three of the respondents agreed that receiving supervision at work is very important and 40 respondents agreed that it is very important to access supervision outside the work setting if it is not provided at work.

Additionally, all 44 respondents indicated that having time to talk about work at work is important and time for group case conferencing at the work place should be provided. Almost half the respondents indicated that personal psychotherapy is important

in helping to decrease or prevent vicarious traumatization. One-half to seventy-five percent of the respondents were aware of symptomology that a social worker/clinician may have if experiencing vicarious traumatization.

To date, this researcher has not been able to find previous data or research asking social workers with a recent Master's of Social Work degree if they are familiar with the concept of vicarious traumatization, and if they are aware, where or when they became familiar with the concept. Much of the research regarding the affects of vicarious traumatization for social workers and other human service workers differentiates between experienced and inexperienced workers, indicating experienced workers are less affected by vicarious traumatization than inexperienced workers (Cunningham, 2003; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995). These studies indicate that because they have more time and experience in the field working with client trauma material, experienced social workers have developed coping skills for working with traumatized clients and/or inexperienced workers leave the social work field due to an accumulation of secondary traumatic stress/compassion fatigue (Cunningham, 2003; Figley, 1995; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Stamm, 1999).

These findings cannot be compared to any other study due to the lack of any studies specific to this topic. However, these findings show that the majority of respondents indicated they have a basic knowledge and understanding of vicarious traumatization, which is in direct opposition to this researcher's expected findings that the majority of participants would not be aware of the concept of vicarious traumatization.

Implications for Practice and Policy

Due to the high percentage of respondents to this study having indicated they learned about vicarious traumatization in graduate school, it is imperative that Master's of Social Work programs continue to provide education on this topic. For those graduate programs that do not offer instruction regarding vicarious traumatization, these data could be valuable for awareness of the need for adding curriculum to their program regarding this topic to provide critical foundational information for their students.

These data are also valuable for workplace settings to ensure that they have policy and practice procedures to ensure that their new employees are aware of vicarious traumatization and have the knowledge to work effectively with their clients and to implement self-care techniques for the health of the worker and well as retention of social workers in the field of service (Allen, 2005; Figley, 1995, 1999; McCammon, 1995; Rothchild & Rand, 2006).

Conclusion

This research topic is important to explore because vicarious traumatization is theoretically shown to strongly impact the social worker, the client and the therapeutic relationship (Figley, 1995; McCammon, 1995; McCann & Pearlman, 1990a, 1990b). The more information available to inexperienced social workers, MSW programs, agencies and supervisors regarding vicarious traumatization, will most likely provide opportunities to develop coping skills, protective skills and techniques to counter vicarious traumatization for inexperienced social workers at the beginning of their careers.

References

- Allen, J. G. (2005). *Coping with trauma: Hope through understanding*. Washington, DC: American Psychiatric Publishing, Inc.
- Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis: An International Journal*, 7 (1), 29-46.
- Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, 52 (1), 63-70.
- Cunningham, M. (2003, October). Impact of trauma work on social work clinicians: Empirical Findings. *Social Work*, 48 (4), 451-459.
- Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal of Social Work Education*, 40 (2), 305-317.
- Davidson, J., & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress*, 3 (3), 459-475.
- Escalona, R., Tupler, L. A., Saur, C. D., Krishnan, R. R., & Davidson, J. R. T. (1997). Screening for trauma history on an inpatient affective-disorders unit: A pilot study. *Journal of Traumatic Stress*, 10 (2), 299-305.
- Everstein, D. S., & Everstein, L. (1993). *The trauma response: Treatment for emotional injury*. New York: W. W. Norton & Company:
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.
- Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educator* (2nd Ed.) (pp. 3-28). Lutherville, MD : Sidran.
- McCammon, S. L. (1995). Painful pedagogy: Teaching about trauma in academic and training settings. In B.H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educator* (2nd Ed.) (pp. 105-120). Lutherville, MD: Sidran.
- McCann, I. L., & Pearlman, L. A. (1990a). *Psychological trauma and the adult survivor*. New York: 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.
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26* (6), 558-565.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. London: W. W. Norton.
- Pearlman, L. A. (Presenter), Saakvitne, K. (Presenter), Adler, P. (Presenter), Elliott, D. (Presenter), Fournier, R. (Presenter), Neiman, C. (Presenter), Pratt, A. C. (Presenter), Streifender, S. (Presenter), & Thompson, C. (1995). *Vicarious traumatization II: Transforming the pain* [Documentary film]. (Available from Cavalcade Productions, Inc., P. O. Box 2480, Nevada City, CA 95959)
- Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital and Community Psychiatry, 29* (4), 233-237.
- Rosenbloom, D. J., Pratt, A. C., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2nd Ed.) (pp. 65-79). Lutherville, MD: Sidran.
- Rosenthal, B. S. (2000). Exposure to community violence in adolescence: Trauma symptoms. *Adolescence, 35* (138), 271-284.
- Rothchild, B., & Rand, M. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W. W. Norton and Company.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W. W. Norton & Company.
- Scarpa, A. (2003). Community violence exposure in young adults. *Trauma, Violence and Abuse: A Review Journal, 4* (3), 210-227.
- Stamm, B. H. (1999). *Secondary trauma stress: Self-care issues for clinicians, researchers and educators* (2nd ed.) Lutherville, MD: Sidran.
- Switzer, G. E., Dew, M. A., Thompson, K., Goycoolea, J. M., Derricott, T., & Mullins, S. D. (1999). Posttraumatic stress disorder and service utilization among urban mental healthcenter clients. *Journal of Traumatic Stress, 12* (1), 25-40.

Appendix A
HSR Approval Letter

March 22, 2009

Jennifer L. Griswold

Dear Jennifer,

Your revised materials have been reviewed and they are now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

Appendix B

Business Card

FRONT:

Please go to the website below where you will find an Informed Consent Letter and
a survey
'Awareness of Vicarious Trauma in Novice Social Workers.'

www.surveymonkey.com/vicarioustrauma

BACK:

Thank you for your participation and time.
Jennifer Griswold, MSW Candidate
Smith College School for Social Work
jgriswol@smith.edu

Appendix C

Email Letter

Dear Participant,

My name is Jennifer L. Griswold and as part of the graduate program of Smith College School for Social Work, I am conducting a research project about the knowledge base of novice MSW workers regarding the concept of vicarious traumatization and the possible impact of vicarious traumatization on novice social workers.

Because you are a practicing novice MSW who has worked in the field for three years or less, your participation is requested. You will be asked your year of graduation from your MSW program, your level of licensure and your age. You will also be asked questions about your experience, training and education. Your experience will be valuable to this study as your experience can contribute to the development of our field. The research will be used to complete a Master's of Social Work thesis and possible presentation and publication.

Participation in this study is completely anonymous. I will have no knowledge of your name or email address. Your participation is completely voluntary. However, by completing and submitting the survey you are providing your consent to participate in this study. You may exit the survey at any time prior to submitting the survey without consequence if you decide not to participate.

If you choose to participate, please click on the link below to access the Informed Consent Form and the survey:

www.surveymonkey.com/vicarioustrauma

If you have any questions please do not hesitate to contact me at the information below.

Thank you,

Jennifer L. Griswold

Appendix D

Informed Consent Form

Dear Participant,

My name is Jennifer L. Griswold and as part of the MSW graduate program of Smith College School for Social Work, I am conducting a research project asking people to participate in an on-line anonymous survey. The research focuses on the knowledge base of novice Master's of Social Work clinicians regarding the concept of vicarious traumatization and the possible impact of vicarious traumatization on novice social workers.

Because you are a practicing novice MSW who has worked in the field for three years or less, your participation is requested. You will be asked your year of graduation from your MSW program, your level of licensure and your age. You will also be asked questions about your experience, training and education. Your experience will be valuable to this study, as your experience can contribute to the development of our field. The research will be used to complete a Master's of Social Work thesis, presentation and possible publication.

Participation in this survey will take 10-15 minutes to complete. There may be minimal risks involved in participation in this research study. You will be giving of your personal time. Given the nature of this study, issues may arise for you that could bring about memories of difficult treatment sessions. I will provide a list of resources for you to read more about vicarious traumatization if you wish to.

You may gain awareness of vicarious traumatization by reflecting upon your personal experience. You may learn more about yourself professionally and personally. Further benefits of participating in this study might include the satisfaction that comes from contributing towards a body of research about the social work field and the possibility of knowledge enhancement of a neglected topic of research. There will be no financial benefit for participation in this study.

Participation in this study will be completely anonymous. I will have no knowledge of your name or e-mail address. The SurveyMonkey website will not collect any identifying information and if you access the survey via your e-mail, your e-mail address will be protected by SurveyMonkey. By completing and submitting the survey, you are providing your consent to participate in this study. You may skip any question on the survey. You may exit the survey at anytime if you decide not to participate. Participation in this study is completely voluntary, but once the survey has been submitted, it cannot be withdrawn because I have no way of identifying your information/answers. This researcher will keep all data and notes secure for three years as in accordance with Federal regulations at which time the data will be destroyed.

If you have any questions regarding this research, please do not hesitate to contact me at the number and e-mail address provided below or you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY ELECTRONICALLY SUBMITTING YOUR ANSWERS BY CLICKING “SUBMIT” AT THE END OF THE SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Please complete the survey within two weeks of receiving this e-mail. I suggest you print and keep a copy of this consent form for your records.

Thank you for your time and I very much appreciate having you as a participant in my study.

Sincerely,

Jennifer L. Griswold

*Please remember to keep a copy of this document for your own personal records.

*If you choose to participate, please proceed to the survey.

Appendix E

Introduction to Survey

This survey is meant for Master's Level Social Workers who have completed their degree between the years 2005 and 2008.

The following questions are primarily multiple-choice. If you choose "other" you must enter text into the text box in order to continue with the survey.

Appendix F

Survey

1. Please identify your socio-cultural background

- Asian
- Black
- Bi-racial
- Caucasian
- Hispanic
- Multi-racial
- Other (please specify)

2. Age range

- 20-29
- 30-29
- 40-49
- 50-59
- 60-69
- 70+

3. Gender

- Male
- Female
- Other (please specify)

4. Indicate the Major completed during your undergraduate studies

- Bachelor's in Social Work
- Bachelor's in Psychology
- Other (please specify)

5. At which college or university did you complete your Master's of Social Work?

6. In which year did you complete your Master's of Social Work?

- 2005
- 2006
- 2007
- 2008

7. Licensure level completed

- LCSW
- LICSW
- Other (please specify)

8. Please indicate the number of years you have worked as a social worker.

- Less than one year
- One
- Two
- Three
- Other (please specify)

9. What other graduate degrees, if any, have you completed?

10. Please indicate the concentration of your Masters of Social Work degree:

- Clinical
- Casework
- Group Work
- Community Organization
- Administration
- Policy
- Other (please specify)

11. Indicate the setting(s) in which you currently are employed. Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Outpatient Clinic | <input type="checkbox"/> Domestic Violence Services |
| <input type="checkbox"/> Hospital: Adults | <input type="checkbox"/> Domestic Violence Shelter |
| <input type="checkbox"/> Hospital: Pediatric | <input type="checkbox"/> Family Shelter |
| <input type="checkbox"/> Hospital: NICU | <input type="checkbox"/> State Government |
| <input type="checkbox"/> Hospital: PICU | <input type="checkbox"/> Federal Government |
| <input type="checkbox"/> Hospital: Cancer Center | <input type="checkbox"/> Foster Care Program |
| <input type="checkbox"/> Hospital: Geriatric | <input type="checkbox"/> Residential Setting |
| <input type="checkbox"/> Community Mental Health Center | <input type="checkbox"/> Child Protective Services |
| <input type="checkbox"/> Family Service Agency | <input type="checkbox"/> Jewish Family Services |
| <input type="checkbox"/> Substance Abuse Program | <input type="checkbox"/> YMCA/YWCA Program |
| <input type="checkbox"/> Services | <input type="checkbox"/> School |
| <input type="checkbox"/> Homeless Shelter | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> Other (please specify) | |

1. Are you aware of the concept "vicarious traumatization"?

- Yes
- No

2. If you are aware of the concept of "vicarious traumatization," are you familiar with the definition?

- Yes
- No

3. If you are aware of the concept of "vicarious traumatization," where did you first learn about vicarious traumatization?

- Undergraduate program
- Graduate program
- Post graduate program
- Post graduate work setting
- Other (please specify)

4. How important do you think it is for a work setting to offer supervision?

- Not important at all
- Somewhat unimportant
- No opinion
- Somewhat important
- Very important

5. If no supervision is provided at the primary work place, how important do you think it is to access supervision outside the primary work setting?

- Not important at all
- Somewhat unimportant
- No opinion
- Somewhat important
- Very important

6. How often do you think someone should have supervision?

- Weekly
- Bi-monthly (every other week)
- Monthly
- Impromptu
- Other (please specify)

7. Do you think a work setting should provide opportunities for case conferences wherein case conferencing is an opportunity to share case questions, concerns and present situations in a group setting?

- Yes
- No

8. If you think the work setting should provide case conferences, how often do you think they should occur?

- Weekly
- Bi-monthly (every other week)
- Monthly
- Other (please specify)

9. Do you think it's important to have time to talk about one's work at work?

- Yes
- No

10. If there is time to talk about work at work, please indicate how you think this should occur.

- Planned
- Impromptu
- Other (please specify)

11. How important do you think personal psychotherapy is for preventing or decreasing "vicarious traumatization?"

- Not important at all
- Somewhat important
- No opinion
- Somewhat important
- Very important

12. How often do you think one should attend personal psychotherapy to decrease or prevent "vicarious traumatization?"

- Never
- Weekly
- Bi-monthly (every other week)
- Other (please specify)

1. Indicate the frequency with which you think a person who is experiencing vicarious traumatization would have the following:

	Never	Rarely	Sometimes	Often
Images of client's description of trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding reading newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding watching electronic media or news	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in traumatic imagery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashbacks of client's trauma material	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoidance of efforts to elicit or work with the client's trauma material	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workaholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypervigilance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in missed or canceled appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased use of supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lateness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of alienation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling unappreciated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A shift from feeling dependence and trust to chronic suspicion of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A shift from feeling safe to a heightened sense of vulnerability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A shift from feeling powerful to an extreme sense of helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A shift from feeling independent to a loss of personal control and freedom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal from family, friends or colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of excessive responsibility for client's life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pessimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor work performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Absenteeism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tardiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to concentrate or focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Is there anything else you would like to add?

Thank you for participating in this survey.

You can access further information about vicarious traumatization in the resources listed below:

Allen, J. G., (2005). *Coping with Trauma: Hope through understanding*. Washington, DC, London, England: American Psychiatric Publishing, Inc.

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

Saakvitne, K. W. & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton & Company.

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

Appendix G

SPSS Frequency Tables

race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	black	2	4.5	4.5	4.5
	bi_racial	2	4.5	4.5	9.1
	caucasian	37	84.1	84.1	93.2
	multi-racial	2	4.5	4.5	97.7
	other	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

race_Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		42	95.5	95.5	95.5
	native american	1	2.3	2.3	97.7
	Persian	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-29	15	34.1	34.1	34.1
	30-39	17	38.6	38.6	72.7
	40-49	7	15.9	15.9	88.6
	50-59	4	9.1	9.1	97.7
	60-69	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	5	11.4	11.4	11.4
	female	39	88.6	88.6	100.0
	Total	44	100.0	100.0	

major as undergrad

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	bachelors in social work	10	22.7	38.5	38.5
	bachelors in psychology	16	36.4	61.5	100.0
	Total	26	59.1	100.0	
Missing	System	18	40.9		
Total		44	100.0		

Other undergrad major

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25	56.8	56.8	56.8
anthropology	1	2.3	2.3	59.1
art history and french	1	2.3	2.3	61.4
arts	1	2.3	2.3	63.6
BA Communications	1	2.3	2.3	65.9
BA in Religion	1	2.3	2.3	68.2
BA in Sociology and Creative Writing & Literature (Double Major)	1	2.3	2.3	70.5
Bachelor's in Anthropology	1	2.3	2.3	72.7
bachelor in Business Admin	1	2.3	2.3	75.0
Bachelor in Spanish/Integrated International Studies	1	2.3	2.3	77.3
Double Major with Women's Studies	1	2.3	2.3	79.5
fine art	1	2.3	2.3	81.8
Health Science	1	2.3	2.3	84.1
major sociology minor social work	1	2.3	2.3	86.4
philosophy and anthropology	1	2.3	2.3	88.6
Social Sciences	1	2.3	2.3	90.9
sociology	1	2.3	2.3	93.2
sociology & women's studies	1	2.3	2.3	95.5
studio art	1	2.3	2.3	97.7
Therapeutic Recreation	1	2.3	2.3	100.0
Total	44	100.0	100.0	

college or university complete Master's of Social Work?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Boston College	1	2.3	2.3	2.3
	CSU Sacramento	1	2.3	2.3	4.5
	George Warren Brown School of Social Work	1	2.3	2.3	6.8
	salem state college	1	2.3	2.3	9.1
	Salem State College	2	4.5	4.5	13.6
	Salem State College School of Social Work	1	2.3	2.3	15.9
	Salem State College, Ma.	1	2.3	2.3	18.2
	Simmons College	1	2.3	2.3	20.5
	smith	3	6.8	6.8	27.3
	Smith	6	13.6	13.6	40.9
	smith college	3	6.8	6.8	47.7
	Smith college	1	2.3	2.3	50.0
	Smith College	3	6.8	6.8	56.8
	Smith College School for Social Work	6	13.6	13.6	70.5
	Smith College School of Social Work	1	2.3	2.3	72.7
	Smith College SSW	2	4.5	4.5	77.3
	Smith Colleger SSW	1	2.3	2.3	79.5
	Smith School for Social Work	1	2.3	2.3	81.8
	Springfield College	1	2.3	2.3	84.1
	The Brown School of Social Work at Washington University in St. Louis	1	2.3	2.3	86.4
	University of Connecticut	1	2.3	2.3	88.6
	University of Denver	1	2.3	2.3	90.9
	university of illinois at chicago	1	2.3	2.3	93.2
	University of Michigan	1	2.3	2.3	95.5
	Washington University in St Louis, MO	1	2.3	2.3	97.7
	Washington University in St. Louis	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

grad_year

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2005	7	15.9	15.9	15.9
	2006	4	9.1	9.1	25.0
	2007	22	50.0	50.0	75.0
	2008	11	25.0	25.0	100.0
	Total	44	100.0	100.0	

licensure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LCSW	19	43.2	95.0	95.0
	LICSW	1	2.3	5.0	100.0
	Total	20	45.5	100.0	
Missing	System	24	54.5		
Total		44	100.0		

license_Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25	56.8	56.8	56.8
associate clinical social worker	1	2.3	2.3	59.1
ASW -- unlicensed clinical SW in california, collecting hours	1	2.3	2.3	61.4
ASW (California) collecting hours to be licensed (LCSW). Equivalent to LICSW in MA.	1	2.3	2.3	63.6
I haven't applied for licensure yet.	1	2.3	2.3	65.9
LMSW	1	2.3	2.3	68.2
lsw	1	2.3	2.3	70.5
LSW	2	4.5	4.5	75.0
LSWA	1	2.3	2.3	77.3
MSW	1	2.3	2.3	79.5
MSW: ct doesn't have graduated licensure	1	2.3	2.3	81.8
no licensure, certified alcohol and drug abuse counselor	1	2.3	2.3	84.1
none	2	4.5	4.5	88.6
None	1	2.3	2.3	90.9
None at this time	1	2.3	2.3	93.2
not yet licensed	1	2.3	2.3	95.5
Registered Social Worker - Canada	1	2.3	2.3	97.7
RSW (registered SW) CCC (certified clinical counsellor) i practice in canada it's a different system here	1	2.3	2.3	100.0
Total	44	100.0	100.0	

years worked

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than one year	3	6.8	6.8	6.8
	one	13	29.5	29.5	36.4
	two	13	29.5	29.5	65.9
	three	8	18.2	18.2	84.1
	more than three	7	15.9	15.9	100.0
	Total	44	100.0	100.0	

yrs_worked_Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		31	70.5	70.5	70.5
	1 year, 7 months	2	4.5	4.5	75.0
	1.5	1	2.3	2.3	77.3
	10	1	2.3	2.3	79.5
	10 years	1	2.3	2.3	81.8
	12	1	2.3	2.3	84.1
	18 months	1	2.3	2.3	86.4
	26	1	2.3	2.3	88.6
	33 years	1	2.3	2.3	90.9
	4	1	2.3	2.3	93.2
	I've had my degree since April 2008, but I'm enrolled in a PhD program, so I've completed some hours, but I haven't been a full-time social worker.	1	2.3	2.3	95.5
	more than 3	1	2.3	2.3	97.7
	One year and Five months	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

What other graduate degrees have you completed?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	19	43.2	43.2	43.2
AA & BA	1	2.3	2.3	45.5
BA in Psychology	1	2.3	2.3	47.7
MA in Women's Studies	1	2.3	2.3	50.0
MALS wesleyan univ	1	2.3	2.3	52.3
MS, Education	1	2.3	2.3	54.5
n/a	4	9.1	9.1	63.6
none	11	25.0	25.0	88.6
None	4	9.1	9.1	97.7
Psy.D.	1	2.3	2.3	100.0
Total	44	100.0	100.0	

Concentration

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid clinical	32	72.7	72.7	72.7
casework, group work, cmnty org, admin or policy	10	22.7	22.7	95.5
other	2	4.5	4.5	100.0
Total	44	100.0	100.0	

concentration_Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	40	90.9	90.9	90.9
advanced generalist	1	2.3	2.3	93.2
children and families	1	2.3	2.3	95.5
generalist	1	2.3	2.3	97.7
Program Evaluation	1	2.3	2.3	100.0
Total	44	100.0	100.0	

Outpatient Clinic

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	18	40.9	100.0	100.0
Missing	System	26	59.1		
Total		44	100.0		

Hospital: Adults

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	2	4.5	100.0	100.0
Missing	System	42	95.5		
Total		44	100.0		

Hospital: Pediatric

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

Hospital: NICU

		Frequency	Percent
Missing	System	44	100.0

Hospital: PICU

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

Hospital: Cancer Center

		Frequency	Percent
Missing	System	44	100.0

Hospital: Geriatric

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

Community Mental Health Center

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	8	18.2	100.0	100.0
Missing	System	36	81.8		
Total		44	100.0		

Family Service Agency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	2	4.5	100.0	100.0
Missing	System	42	95.5		
Total		44	100.0		

Substance Abuse Program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	3	6.8	100.0	100.0
Missing	System	41	93.2		
Total		44	100.0		

Homeless Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	2	4.5	100.0	100.0
Missing	System	42	95.5		
Total		44	100.0		

Homeless Shelter

	Frequency	Percent
Missing System	44	100.0

Domestic Violence Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid checked	4	9.1	100.0	100.0
Missing System	40	90.9		
Total	44	100.0		

Domestic Violence Shelter

	Frequency	Percent
Missing System	44	100.0

Family Shelter

	Frequency	Percent
Missing System	44	100.0

State Government

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid checked	6	13.6	100.0	100.0
Missing System	38	86.4		
Total	44	100.0		

Federal Government

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid checked	1	2.3	100.0	100.0
Missing System	43	97.7		
Total	44	100.0		

Foster Care Program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	2	4.5	100.0	100.0
Missing	System	42	95.5		
Total		44	100.0		

Residential Setting

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	2	4.5	100.0	100.0
Missing	System	42	95.5		
Total		44	100.0		

Child Protective Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	5	11.4	100.0	100.0
Missing	System	39	88.6		
Total		44	100.0		

Jewish Family Services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

YMCA/YWCA Program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

School

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	4	9.1	100.0	100.0
Missing	System	40	90.9		
Total		44	100.0		

Private Practice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	4	9.1	100.0	100.0
Missing	System	40	90.9		
Total		44	100.0		

setting_Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	34	77.3	77.3	77.3
Area Agency on Aging/City Government	1	2.3	2.3	79.5
crisis	1	2.3	2.3	81.8
Crisis Services	1	2.3	2.3	84.1
Emergecny Room Mental Health and Addictions	1	2.3	2.3	86.4
Hospice	1	2.3	2.3	88.6
Hospital: Psyc hiatric	1	2.3	2.3	90.9
I work for forensic psychiatric services in an outpatient clinic (concurrent disorders and major mental health disorders) and also for the sexual assault service offering support/advocacy/crisis intervention to women who choose to attend hospital within 1 week of the ass ault	1	2.3	2.3	93.2
My three paid jobs in sw capacity: (1) I conduct program evaluation as a consultant for a teen health care facility, (2) I teach intergroup dialogue facilitation, and (3) I work part-time on a research project assessing heterosexism and campus climate at Univ of Michigan.	1	2.3	2.3	95.5
Not currently in the Social Work field	1	2.3	2.3	97.7
university, research setting	1	2.3	2.3	100.0
Total	44	100.0	100.0	

Are you aware of the concept "vicarious traumatization"?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	41	93.2	93.2	93.2
	no	3	6.8	6.8	100.0
	Total	44	100.0	100.0	

If you are aware of the concept of "vicarious traumatization," are you familiar with the definition?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	39	88.6	92.9	92.9
	no	3	6.8	7.1	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Undergraduate program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	4	9.1	100.0	100.0
Missing	System	40	90.9		
Total		44	100.0		

Graduate program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	28	63.6	100.0	100.0
Missing	System	16	36.4		
Total		44	100.0		

Post graduate program

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	checked	1	2.3	100.0	100.0
Missing	System	43	97.7		
Total		44	100.0		

Post graduate work setting

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid checked	2	4.5	100.0	100.0
Missing System	42	95.5		
Total	44	100.0		

learned_concept_Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	36	81.8	81.8	81.8
as floor staff in a residential treatment ctr, pre-grad school	1	2.3	2.3	84.1
community training	1	2.3	2.3	86.4
employment	1	2.3	2.3	88.6
I'm assuming it's the same thing as secondary trauma, which I am familiar with (from MSW classes).	1	2.3	2.3	90.9
internship training	1	2.3	2.3	93.2
magazine article	1	2.3	2.3	95.5
NASW presentation attended prior to grad school	1	2.3	2.3	97.7
staff training	1	2.3	2.3	100.0
Total	44	100.0	100.0	

How important do you think it is for a work setting to offer supervision?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid somewhat important	1	2.3	2.3	2.3
very important	43	97.7	97.7	100.0
Total	44	100.0	100.0	

If no supervision is provided at the primary work place, how important do you think it is to access supervision outside the primary work setting?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	somewhat important	1	2.3	2.3	2.3
	somewhat important	3	6.8	6.8	9.1
	very important	40	90.9	90.9	100.0
	Total	44	100.0	100.0	

supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	weekly	34	77.3	82.9	82.9
	bi monthly	3	6.8	7.3	90.2
	weekly AND impromptu	3	6.8	7.3	97.6
	bimonthly AND impromptu	1	2.3	2.4	100.0
	Total	41	93.2	100.0	
Missing	System	3	6.8		
Total		44	100.0		

superv_Other

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	39	88.6	88.6	88.6
as the occasion or need arises	1	2.3	2.3	90.9
consultation weekly even after liscensure.	1	2.3	2.3	93.2
depends on the person and their work environment and numerous other issues	1	2.3	2.3	95.5
more than weekly if needed	1	2.3	2.3	97.7
Probably depends on a person's individual needs. It seems like it would be important to meet regularly, but how regularly would depend on a particular person's unique needs, personal development and goals--and how they are impacted by the work itself. Context matters--and so does a person's own relevant life experience. (Especially if it makes a person more prone to experiencing vicarious trauma.)	1	2.3	2.3	100.0
Total	44	100.0	100.0	

Do you think a work setting should provide opportunities for case conferences wherein case conferencing is an opportunity to share case questions, concerns and present situations in a group setting?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid yes	44	100.0	100.0	100.0

case_conf_Weekly

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	weekly	20	45.5	51.3	51.3
	bi monthly	12	27.3	30.8	82.1
	monthly	7	15.9	17.9	100.0
	Total	39	88.6	100.0	
Missing	System	5	11.4		
Total		44	100.0		

case_conf_Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		37	84.1	84.1	84.1
	again i'd say this varies based on need	1	2.3	2.3	86.4
	As necessary	1	2.3	2.3	88.6
	as needed - case by case	1	2.3	2.3	90.9
	as needed	1	2.3	2.3	93.2
	case conferences should occur as often as necessary	1	2.3	2.3	95.5
	impromptu	1	2.3	2.3	97.7
	Impromptu if appropriate	1	2.3	2.3	100.0
Total		44	100.0	100.0	

Do you think it's important to have time to talk about one's work at work?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	44	100.0	100.0	100.0

talk_about_work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	planned	14	31.8	31.8	31.8
	impromptu	9	20.5	20.5	52.3
	both	21	47.7	47.7	100.0
	Total	44	100.0	100.0	

talk_Other

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		43	97.7	97.7	97.7
	in individual supervision and in peer settings as well as in larger staff settings-so that all staff can see how work affects employees across the board	1	2.3	2.3	100.0
	Total	44	100.0	100.0	

how often

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18	409	409	409
Again depends on the person, the type of work and how the work impacts the person	1	23	23	432
as individually needed	1	23	23	455
as needed	2	45	45	500
As needed according to individual history	1	23	23	523
As needed. Supervision should also be placed where people can talk about their reactions to tough cases.	1	23	23	545
as needed. i give every client a week but might go more if i could afford it	1	23	23	568
As often as necessary, depending on what is going on in the workplace	1	23	23	591
At least bi-monthly but more if needed	1	23	23	614
At least bi-monthly but more importantly, when a clinician feels vulnerable due to their work and/or life stressors	1	23	23	636
At least once a week	1	23	23	659
case dependent	1	23	23	682
depends on the individual and their needs in order to maintain healthy clinical practice, self-awareness, lifestyle, etc	1	23	23	705
depends on the nature of the case and the clinician	1	23	23	727
Depends on the person and their level of self-awareness and time spent in their own personal therapy. Some need weekly, some can benefit from bi-weekly	1	23	23	750

Depends on the person the person sees and what form of treatment works for them, if any	1	23	23	73
It depends on the nature and the severity of the person's things you	1	23	23	75
If highly, (some) or groups, (some) cases of (some) people, (some) psychology, (some) therapy	1	23	23	88
It depends on the individual's personality, (some) isn't the way to personality "individualization "	1	23	23	84
It depends on the individual's personality	1	23	23	84
It really depends on the person. For some people, (some) therapy, (some) relaxation, (some) the effects of different factors in (some) personality individualization	1	23	23	86
Mostly	1	23	23	90
Mostly	1	23	23	92
Mostly	1	23	23	95
Mostly	1	23	23	97
It really depends on the individual. I think that the effects of (some) factors in (some) personality	1	23	23	100
Total	4	100	100	

How important do you think personal psychotherapy is for preventing or decreasing "vicarious traumatization?"

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	somewhat important	2	4.5	4.5	4.5
	no opinion	4	9.1	9.1	13.6
	somewhat important	21	47.7	47.7	61.4
	very important	17	38.6	38.6	100.0
	Total	44	100.0	100.0	

How often do you think one should attend personal psychotherapy to decrease or prevent "vicarious traumatization?"

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	weekly	8	18.2	36.4	36.4
	bi-monthly	14	31.8	63.6	100.0
	Total	22	50.0	100.0	
Missing	System	22	50.0		
Total		44	100.0		

Images of client's description of trauma

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	1	2.3	2.4	2.4
	sometimes	32	72.7	76.2	78.6
	often	9	20.5	21.4	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Sleep difficulties

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sometimes	26	59.1	61.9	61.9
	often	16	36.4	38.1	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Nightmares

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	2	4.5	4.8	7.1
	sometimes	34	77.3	81.0	88.1
	often	5	11.4	11.9	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Avoiding reading newspapers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	9	20.5	21.4	21.4
	sometimes	26	59.1	61.9	83.3
	often	7	15.9	16.7	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Avoiding watching electronic media or news

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	8	18.2	19.0	19.0
	sometimes	26	59.1	61.9	81.0
	often	8	18.2	19.0	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Increase in traumatic imagery

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	1	2.3	2.4	4.8
	sometimes	23	52.3	54.8	59.5
	often	17	38.6	40.5	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Flashbacks of client's trauma material

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.6	2.6
	rarely	3	6.8	7.9	10.5
	sometimes	25	56.8	65.8	76.3
	often	9	20.5	23.7	100.0
	Total	38	86.4	100.0	
Missing	System	6	13.6		
Total		44	100.0		

Avoidance of efforts to elicit or work with the client's trauma material

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	2	4.5	4.8	7.1
	sometimes	29	65.9	69.0	76.2
	often	10	22.7	23.8	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Headaches

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	4	9.1	9.5	9.5
	sometimes	28	63.6	66.7	76.2
	often	10	22.7	23.8	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Gastrointestinal Distress

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	5	11.4	11.9	11.9
	sometimes	30	68.2	71.4	83.3
	often	7	15.9	16.7	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Substance Abuse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	4	9.1	9.5	9.5
	sometimes	32	72.7	76.2	85.7
	often	6	13.6	14.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Workaholism

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	2	4.5	4.8	4.8
	rarely	3	6.8	7.1	11.9
	sometimes	31	70.5	73.8	85.7
	often	6	13.6	14.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Compulsive eating

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	6	13.6	14.3	14.3
	sometimes	29	65.9	69.0	83.3
	often	7	15.9	16.7	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Hypervigilance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	1	2.3	2.4	2.4
	sometimes	26	59.1	61.9	64.3
	often	15	34.1	35.7	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Palpitations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	5	11.4	12.2	14.6
	sometimes	29	65.9	70.7	85.4
	often	6	13.6	14.6	100.0
	Total	41	93.2	100.0	
Missing	System	3	6.8		
Total		44	100.0		

Increase in missed or canceled appointments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	8	18.2	19.0	21.4
	sometimes	24	54.5	57.1	78.6
	often	9	20.5	21.4	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Decreased use of supervision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	9	20.5	21.4	23.8
	sometimes	24	54.5	57.1	81.0
	often	8	18.2	19.0	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Chronic lateness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	9	20.5	21.4	23.8
	sometimes	28	63.6	66.7	90.5
	often	4	9.1	9.5	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Feelings of isolation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	sometimes	25	56.8	59.5	61.9
	often	16	36.4	38.1	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Feelings of alienation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	1	2.3	2.4	4.8
	sometimes	26	59.1	61.9	66.7
	often	14	31.8	33.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Feeling unappreciated

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	2	4.5	4.8	4.8
	sometimes	27	61.4	64.3	69.0
	often	13	29.5	31.0	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

A shift from feeling dependence and trust to chronic suspicion of others

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	5	11.4	11.9	11.9
	sometimes	26	59.1	61.9	73.8
	often	11	25.0	26.2	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

A shift from feeling safe to a heightened sense of vulnerability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	2	4.5	4.9	4.9
	sometimes	20	45.5	48.8	53.7
	often	19	43.2	46.3	100.0
	Total	41	93.2	100.0	
Missing	System	3	6.8		
Total		44	100.0		

A shift from feeling powerful to an extreme sense of helplessness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	2	4.5	4.8	7.1
	sometimes	25	56.8	59.5	66.7
	often	14	31.8	33.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

A shift from feeling independent to a loss of personal control and freedom

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	4	9.1	9.8	9.8
	sometimes	25	56.8	61.0	70.7
	often	12	27.3	29.3	100.0
	Total	41	93.2	100.0	
Missing	System	3	6.8		
Total		44	100.0		

Withdrawal from family, friends or colleagues

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	3	6.8	7.1	7.1
	sometimes	27	61.4	64.3	71.4
	often	12	27.3	28.6	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Feeling of excessive responsibility for client's life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	1	2.3	2.4	4.8
	sometimes	20	45.5	47.6	52.4
	often	20	45.5	47.6	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Irritability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sometimes	26	59.1	61.9	61.9
	often	16	36.4	38.1	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Anxiousness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sometimes	21	47.7	51.2	51.2
	often	20	45.5	48.8	100.0
	Total	41	93.2	100.0	
Missing	System	3	6.8		
Total		44	100.0		

Fatigue

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	sometimes	20	45.5	47.6	47.6
	often	22	50.0	52.4	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Aggression

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	5	11.4	11.9	14.3
	sometimes	28	63.6	66.7	81.0
	often	8	18.2	19.0	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Pessimism

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	1	2.3	2.4	4.8
	sometimes	26	59.1	61.9	66.7
	often	14	31.8	33.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Poor work performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	6	13.6	14.3	14.3
	sometimes	30	68.2	71.4	85.7
	often	6	13.6	14.3	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Absenteeism

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	7	15.9	16.7	19.0
	sometimes	30	68.2	71.4	90.5
	often	4	9.1	9.5	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Tardiness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	never	1	2.3	2.4	2.4
	rarely	7	15.9	16.7	19.0
	sometimes	31	70.5	73.8	92.9
	often	3	6.8	7.1	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Inability to concentrate or focus

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	rarely	1	2.3	2.4	2.4
	sometimes	26	59.1	61.9	64.3
	often	15	34.1	35.7	100.0
	Total	42	95.5	100.0	
Missing	System	2	4.5		
Total		44	100.0		

Is there anything else you would like to add?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		30	68.2	68.2	68.2
	30-39 says 30-29...i wish age could work that way :)	1	2.3	2.3	70.5
	coffee dependency	1	2.3	2.3	72.7
	confusion	1	2.3	2.3	75.0
	Having learned about vicarious trauma in my workplace was helpful, however learning about vicarious trauma in my graduate or undergraduate education may have prepared me or increased my awareness of vicarious trauma	1	2.3	2.3	77.3
	I'm not sure that I understand what you're looking for in the previous questions. I could imagine someone who's experiencing vicarious traumatization could have any of the above reactions, depending on who they are....	1	2.3	2.3	79.5
	i think all of the above could be signs/symptoms of vicarious trauma for a clinician and are issues to be mindful of in practice	1	2.3	2.3	81.8

I think people react differently to vicarious traumatization, so the severity of the individual's reactions to it will vary. I do think it affects most social workers, whether they realize it or not.	1	2.3	2.3	84.1
I think some of the symptoms differ from the different types of content that influences the traumatization.	1	2.3	2.3	86.4
I think symptoms very much depend on the content of the client's trauma and then also how each clinician would deal with that would depend on their own personality & experience.	1	2.3	2.3	88.6
Increased liability	1	2.3	2.3	90.9
no	2	4.5	4.5	95.5
This last question was hard--because I feel like people MAY have any of these symptoms--that would certainly be understandable. But I hesitate to say all survivors of VT would have all of these, often. ...Make sense?	1	2.3	2.3	97.7
Yes, I learned about VT through my graduate program and I recognized the importance of being aware of the theory about VT and the possibility it may have negative affects for myself as the clinician and the therapeutic relationship.	1	2.3	2.3	100.0
Total	44	100.0	100.0	