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Jennifer K. Mello
Invisible Victims: The Effects of
Secondary and Vicarious Trauma on
Milieu Staff Members

ABSTRACT

This study was undertaken to determine the prevalence of Secondary Traumatic Stress (STS) and Vicarious Trauma (VT) in non-clinically trained milieu staff members working in close collaboration with victims of trauma. This study also aimed to discover the extent to which these individuals experience these effects, and will hopefully help bridge the existing gap in the literature around VT and STS in non-clinically trained populations of helpers. In a study of 49 participants including milieu staff members from both inpatient and residential school settings, prevalence of PTSD symptomology as a result of Secondary Traumatic Stress was explored through the use of a survey, the format of which varied based on the identified setting. The results of this study indicated that a significant portion of participants was found to be suffering from secondary or traumatic stress in their current place of employment. Of additional significance was the degree of secondary stress they were experiencing, the majority falling into moderate to severe categories.

**INVISIBLE VICTIMS: THE EFFECTS OF SECONDARY AND VICARIOUS TRAUMA
ON MILIEU STAFF MEMBERS**

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

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2014

ACKNOWLEDGEMENTS

First and foremost I would like to thank my thesis advisor, Claudia Bepko for her continued encouragement and support throughout this process. Thank you for bearing with me! I would also like to thank Ann Wheeler for her never-ending patience in answering all of my ridiculous thesis questions this year. I say this with complete confidence, I couldn't have done it without you. I would also like to acknowledge my loving family for their continuous love and support. My accomplishments are also a product of all of your hard work. A special thanks to Mom for believing that what I do makes a difference. Last but not least, I would like to thank all the milieu staff, the invisible victims. It's about time you received the acknowledgement you deserve for helping to make the rest of our jobs easier. For all those on the floor doing the hard work, this project is for you.

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CHAPTER I

Introduction

In the field of psychology and social work, the experience of trauma has long been viewed as an impactful one. Recently, more research is being done around the experiencing of trauma secondhand, most commonly referred to as secondary or vicarious trauma. Typically, this research focuses on mental health professionals and their experiences of taking on the trauma symptoms displayed by the clients with whom they work. However, other populations of helpers in the mental health field, working in arguably closer proximity to victims of trauma, are essentially overlooked in this research. The current literature has yet to adequately acknowledge the risk these individuals may also face when interacting closely with victims of trauma.

For this study I examined the experiences of individuals who are currently employed clinically untrained staff members within a milieu-based therapeutic setting, referred to for the purposes of this study, as milieu staff members. A therapeutic milieu is defined as a treatment environment (a) with individuals and groups who have been diagnosed with mental illness, emotional behavioral disorders, and co-occurring developmental disabilities; (b) includes a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff; (c) takes place for the continuous scheduled hours of operation for the program-more than four hours for a full-day program (Adapted from the State of California, Department of Mental Health).

Thus, this research study will focus on the topic of Vicarious Traumatization (VT) and Secondary Traumatic Stress (STS) as they relate to milieu staff members working in therapeutic residential and hospital inpatient treatment settings for adolescents suffering from mental illness. This study hopes to determine whether or not milieu staff members do indeed experience the effects of VT and STS, and if so, to what extent they experience these effects. Aside from bringing awareness to the lack of literature available with a focus on the population in question, another goal of this study is to contribute to, and enhance the existing body of literature on this topic. In addition, this study may serve to spark dialogue in the social work community around secondary trauma and expanding the existing schema to include those non-clinically trained helpers as potential casualties. The following literature review will serve to further clarify the distinction between STS and VT and explore the history of trauma and its impact on the individual.

CHAPTER II

Literature Review

Trauma is understood to have a substantial impact on the individual, affecting their lives in a variety of significant ways. In recent decades we have come to understand the impact of trauma on not only the survivor, but on those close to them as well. One thoroughly researched example of this phenomenon can be seen in the trauma survivor's relationship with their therapist or other trained professional. In order to provide some context for exploring these complex relationships, it may be helpful to first understand the theory behind trauma and the various ways it can have an impact, both psychologically and neurologically. Van der Kolk (1987) and Herman (1992) explore trauma by drawing connections between specific traumatic events and their consequences, as well as exploring the most beneficial ways of clinically addressing these unexpected consequences with survivors. Additionally, Weber, Killgore, Rosso, Britton, Schwab, Weiner, & Rauch (2013) provide evidence of the neurological changes associated with the development of PTSD symptomology.

The American Psychiatric Association often recognizes trauma as conceptualized within the context of Post Traumatic Stress Disorder (PTSD). The Diagnostic and Statistical Manual (DSM-V) (American Psychiatric Association, 2013) defines trauma in Criterion A as occurring in response to an event, witnessed, experienced, or exposed to, involving actual threat of death, serious injury, or sexual violence to oneself or other close family members or friends. Most

notably, the latest definition of PTSD includes “experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse)” as qualifying criteria (p.271). Thus, in essence, “trauma refers to the enduring adverse impact of extremely stressful events” (Allen, 2001, p.4). Van der Kolk (1987) states that specific traumas such as abuse, rape, war, civilian disasters, etc can lead an individual to the development of specific, and often psychologically damaging, symptoms such as denial, aggressiveness, numbing response, startle response, and re-experiencing. He also suggests that victims of trauma, even those who appear to be functioning adequately, often restrict the amount of time spent with others and experience a “reduced capacity to modulate feelings” (p. 14). As a result of the potential emergence of symptoms in the survivor, van der Kolk goes on to conceptualize some ways of addressing and resolving the trauma response.

He first notes the importance of “retrieving a sense of communality” (van der Kolk, p. 155). Van der Kolk (1987) notes that victims can benefit from both individual and group supportive psychotherapy, but places particular emphasis on group therapy, which allows for the cultivation of a cohesive environment that is found to be quite beneficial to survivors. He states that submergence in a group can allow for the sharing of a common experience, thus creating an environment of interpersonal support (van der Kolk 1987). One difficulty many survivors face is that of re-establishing trust. Van der Kolk (1987) notes that both group and individual therapy, and the relationships formed within, can provide a certain degree of safety and an opportunity for survivors to disclose their trauma within a trusting relationship. Most likely, the survivor’s experience of reliving the trauma will prove to be difficult, and could trigger some or all of the responses indicated above such as numbing, denial, etc. This necessitates the introduction of

stress management interventions, van der Kolk's (1987) third treatment suggestion, which include aerobic exercise, reduction of dietary stimulants, relaxation exercises, and the development of adaptive coping strategies (p. 225). These interventions serve to reduce avoidant behavior, social isolation, and depressive affect (van der Kolk 1987). Survivors' task of reliving the trauma, though taxing, has the benefit of allowing them to find meaning in the traumatic event, ultimately altering the way they experience it. Similarly, Herman (1992) introduces the idea of "reconstructing the trauma narrative," within her three stages of recovery, as a way for survivors to find meaning.

Herman (1992) identifies three fundamental stages of recovery for survivors: establishing safety, reconstructing the trauma story, and restoring connection between survivor and community. First and foremost, she focuses on the importance of establishing safety, noting that until survivors' safety has been adequately secured, no other therapeutic work can possibly be successful, nor should it even be attempted. Herman (1992) defines the concept of a psychological trauma as an "affliction of the powerless" (p. 33), suggesting that the predominant principle of recovery involves promoting autonomy, thus restoring power and control to the survivor. She also emphasizes the fact that trauma is unique in the way it affects every aspect of human functioning. Due to this, she suggests that treatment must be comprehensive, addressing the biological, social, and psychological components. In helping the survivor regain control, one must consider Herman's notion that recovery can only take place within the context of relationships.

Herman's (1992) second stage of recovery involves reconstructing the trauma narrative through detailed recounting of the traumatic event. The survivor's history prior to the traumatic event provides a context through which he/she may find meaning in the event, transforming the

trauma story as it becomes a part of their past. Herman (1992) notes that this allows the survivor to begin the process of rebuilding life in the present, after which they are charged with the task of building a future. Herman (1992) notes that in order to build a future, the survivor must “reconnect” in the third stage of recovery. This involves developing a new self, creating new relationships, and essentially “reclaiming his/her world.” Based on both Herman (1992) and van der Kolk’s (1987) recommendations for treatment, the ultimate goal for therapists engaged in trauma work with survivors appears to be to effectively manage, and hopefully reduce, the psychological impact of the traumatic event on their overall functioning. Neither makes reference to a “full recovery.” In fact, Herman (1992) concludes that “resolution of the trauma is never final; recovery is never complete” (p. 211). In addition to the adverse psychological impact of trauma, experiencing such an event can also significantly influence brain function.

Shin & Liberzon note that PTSD is associated with neurobiological differences in the brain at the functional, structural, and neurochemical levels (as cited in Weber et al., 2013, p. 413). These functional abnormalities are often found in the following brain regions: the amygdala, the hippocampus, and the medial prefrontal cortex. These regions make up a neurocircuitry that is associated with PTSD symptom and severity (Weber et al., 2013). Weber et al. (2013) explores the differences in grey matter volume in these areas in individuals with PTSD as compared to a control group. Utilizing functional magnetic resonance imaging (fMRI) he discovered that increased gray matter volume, particularly within the hippocampus and amygdala, was associated with increased severity of PTSD symptoms. This reduction of gray matter volume is linked with “emotional appraisal and regulation regions of the prefrontal cortex” while the increase volume is seen in structures involved in “immediate threat processing, attribution of affective salience, and contextual memory functions” (Weber et al., 2013, p. 415).

This data is consistent with symptoms we often see displayed, in a clinical context, in individuals suffering from PTSD including emotion dysregulation, heightened fear response, difficulty with memory, etc.

This study also serves to provide an important link between the symptoms as seen in fMRI images of the brain, and the way symptoms are displayed on a psychological level. An important finding of the study focuses on the presentation of the three symptom clusters mentioned earlier, that are necessary in meeting criteria for a PTSD diagnosis: re-experiencing, avoidance, and hyperarousal.

Weber et al. (2013) state the following:

There was minimal overlap in the brain regions that were predicted by the three symptom clusters...this is in line with the clinical observation that symptoms may occur independently of each other and suggests that different symptom clusters may not only be present as clinical entities, but also with differential neurocorrelates (p. 416).

The psychological and physiological changes that occur in an individual suffering from PTSD can be difficult for them to manage alone, and the impact on their overall functioning is severe. However, these experiences often do not occur in a bubble, and the individual sufferer may require support from those around them including family, friends, and trauma workers in the community.

Working with trauma survivors, though important work, is often taxing and can also pose some serious risk to the “helper.” A significant portion of the literature on this subject refers to this risk associated with trauma work as an occupational hazard, as these interactions can result in the development of VT and STS (Baird & Jenkins, 2003; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). These terms are often used interchangeably

throughout the literature to refer to the change that takes place in the trauma worker as a result of witnessing or experiencing the survivor's traumatic experience secondhand (Bride, 2007; Hesse, 2002; Newell & MacNeil, 2010). Vicarious Trauma and Secondary Traumatic Stress are quite similar, though they do have some differences in meaning. In other words, they represent two different ways of understanding the same phenomenon, but each with a slight variation in focus. This distinction may exist as a result of the relative newness of second hand trauma as a concept, and as a way of attempting to better understand its impact on select populations. The following literature explores the emergence of this concept and provides a framework through which to better understand it.

Pearlman and Saakvitne (1995) coined the term Vicarious Traumatization to describe a change in the trauma worker as a result of exposure to and 'empathic engagement' with a survivor's traumatic experience/material. It is noteworthy to include that according to Pearlman and Saakvitne (1995), the phenomenon is relevant to all trauma workers, including emergency medical technicians, fire fighters, police, criminal defense lawyers, medical personnel, battered women's and homeless shelter staff, sexual assault workers, suicide hotline staff, AIDS volunteers, prison personnel, and trauma researchers, as well as journalists, clergy, and others who engage empathically with victims and survivors" (p. 31). However, in slight contrast to VT, Secondary Traumatic Stress refers to the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or client] and the stress resulting from helping or wanting to help a traumatized or suffering person [or client]" (Figley, 1995, p.7). Secondary Traumatic Stress focuses more specifically on the symptoms experienced by the helper as a result of their engagement with the survivor. These

symptoms coincide with the symptoms discussed by van der kolk (1987), that are associated with PTSD as described in the DSM-V (APA, 2013).

Understanding the reactions of “helpers” is most easily done within the context of Constructivist Self Development Theory (CSDT). Constructivist Self Development Theory was established by McCann & Pearlman (1992) as a foundation from which to better understand the effects of trauma on the individual. As a result, VT and STS can also be understood within the framework of CSDT. According to McCann and Pearlman (1992) CSDT explores an individual’s adaptation to extreme trauma “as a result of a complex interplay between life experiences...and the developing self” (p. 190). The authors note that a number of factors must be considered when examining ones individual ability to reconcile a traumatic experience. In other words, McCann & Pearlman (1992) emphasize an interplay between person and situation. The authors theorize that individuals carry certain assumptions about self and the world, and that a disruption in worldview can sometimes occur following a traumatic event. It is now understood that working with trauma survivors can have a similar effect for therapists (Hesse, 2002). When considering the effects on the therapist, it might also be helpful to consider how these same assumptions may also ring true for individuals such as milieu staff members.

The main focus of the literature around this particular phenomenon has been around the effects on therapists, or clinically trained professionals in the field. Pearlman & Mac Ian (1995) assessed the prevalence of VT in 188 self-identified trauma therapists. They utilized questionnaires to acquire data about participants’ personal trauma history, exposure to client traumatic material, and psychological well being. This study also took into consideration participants’ years of experience when determining the extent to which they were effected by VT. The study found that therapist’s personal trauma histories were such an impactful variable

when considering the effects of VT, that participants were divided into two groups, those with a trauma history and those without. Therapists with a trauma history were found to have more disruptive schemas and higher levels of general distress than those without. One strength of the study was its focus on implications for the field and suggestions that sufferers may find helpful for preventing and combating symptoms -- for example, increased supervision for trauma therapists. However, to its detriment, the study focused its sample on trained trauma therapists, excluding data from any number of other helping professions.

Unfortunately there is a major gap in the literature in terms of research with an exclusive focus on exploring clinically untrained populations for effects of vicarious and secondary trauma. Though it is much more common to find literature with a sole focus on therapists with the exclusion of other prevalent trauma workers in the field, select studies do include clinically untrained trauma workers in addition to clinically trained professionals in their sample (Baird & Jenkins, 2003; MacRitchie & Leibowitz, 2010). In a study conducted by Baird & Jenkins (2003) 101 employees from a sexual assault and domestic violence agency completed surveys to determine the degree to which they displayed symptomology consistent with that of VT, STS, and/or burnout. Of these 101 participants including counselors, therapists, psychologists, interns, crisis workers, hotline workers, case managers, caseworkers, supervisors, directors, and educators, 46.5% held a masters degree in a mental health field (62.4%) (p. 76). This indicates that a portion of the participants were not formally clinically trained employees and may fall into the category of clinically untrained trauma workers. The results of the study indicated that the participants with more education had lower vicarious trauma scores. This could be indicative of the potential for clinically untrained trauma workers with less education to have a greater propensity towards or vulnerability for suffering from VT or STS.

Similarly to Baird & Jenkins (2003), MacRitchie & Leibowitz (2010) looked at STS in trauma workers, defined as those who are both “counselors, therapists, social workers and those who have no relevant related qualifications (e.g. non-professionals or lay workers)” (p. 150). Unlike Baird & Jenkins (2003) and McCann & Pearlman (1992), MacRitchie & Leibowitz (2010) purposefully includes “helpers” in the field that do not have clinical training in their sample of participants. The study’s primary focus is on the role of empathy and social support in the transmission of STS in trauma workers in South Africa. Participants completed a questionnaire and the study’s results showed that the higher participants’ perceived amount of social support, the lower the risk of STS. The results of the study also indicated that the higher their level of empathy, the higher their risk for STS. The implications for this study are great in that it shows the importance of social supports being made available to trauma workers in the field. It also suggests that clinically untrained trauma workers have the potential to be negatively impacted by conditions such as VT and STS.

In an article by Wies & Coy (2013), a sample of 42 Sexual Assault Nurse Examiners (SANE’s) were administered a demographic questionnaire and the STSS to measure the secondary impact of gender based violence. In the article, Wies & Coy (2013) note that “SANE’s are exposed to a working environment that demands a professional response to devastating acts of trauma and violence perpetrated towards adults and children” (p. 25). Respondents of the survey were registered nurses (RN’s) and only 7.1% reported having a Masters degree (in an undisclosed field). 90.5% of the SANE’s surveyed reported working full time, primarily in emergency rooms and rape crisis centers in Ohio. This indicates that the majority of participants were clinically untrained helpers working with victims of trauma, and most likely being exposed to traumatic material on a regular basis. Results of the study indicated that 38.1% of participants

were found to suffer from VT. Similarly to MacRitchie & Leibowitz (2010) the article included non-clinically trained helpers in the population surveyed, however, unlike Baird & Jenkins (2003), MacRitchie & Leibowitz (2010), and Pearlman & Mac Ian (1995), these untrained helpers and their specific relationship to VT is the primary focus of the article.

Studies by Dunkley & Whelan (2006), Figley (1995), Newell & MacNeil (2010), and Pearlman & Mac Ian (1995) suggest that other factors can also influence the development of VT and STS and contribute to the severity of its impact on the clinician or other professional helper. These include personal trauma history, years of experience, amount of exposure to traumatic material, and existing worldviews. On a positive note, similar to Pearlman and Mac Ian (1995), much of the literature provides recommendations for prevention and suggestions for those at risk and/or currently suffering from VT and STS. Education around these topics and awareness of the potential for developing VT and STS (Figley, 1995; Hesse, 2002; MacRitchie & Leibowitz, 2010; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995), ongoing training and supervision (Dunkley & Whelan, 2006; Hesse, 2002, Pearlman & Mac Ian, 1995), self-care, and the utilization of supportive professional relationships through which to process and share (Pearlman & MacIan, 1995) are just some of the things researchers say may be beneficial for helpers. Regardless of the supported method, the research unequivocally emphasizes the importance of mental health workers taking protective measures, in some form, against the harmful effects of VT and STS. However, despite the research that has been done on the topic of trauma and secondary effects, unexplored territories and unanswered questions remain. The effects of VT and STS exclusively on trauma workers without trauma specific training opportunities and/or advanced clinical training are more or less overlooked in the literature and essentially unexplored

in the research on this topic. Further exploration in this area is critical in order to shed some light on the scope of VT and STS on another population of helpers.

CHAPTER III

Methodology

In an effort to contribute to the research on this topic, the focus of my study is on the effects of vicarious and secondary trauma on clinically untrained milieu staff members. The aims of the study were to determine whether or not this specific population experiences the effects of vicarious and secondary trauma. If so, to what extent do milieu staff members experience these effects? I attempted to design a unique study with a focus on milieu staff members and with these specific research questions in mind. Use of a demographic questionnaire and the selection of the Secondary Traumatic Stress scale (Bride, 2004) are discussed. Characteristics of respondents, resulting data, and ethical considerations, in addition to limitations of my study are identified.

Procedure

This study was conducted using a quantitative method and utilized non-probability snowball sampling to identify two agencies employing milieu staff members in different settings. A fellow Smith School for Social Work graduate student recommended an inpatient unit setting that was willing to participate in the study. In addition, this author was able to identify residential school setting that employed several familiar contacts, that was also willing to participate. After initiating contact with these agencies, permission was obtained to recruit participants and

distribute surveys. Data was collected for this study upon approval from the Smith College School for Social Work's Human Subjects Review Committee (see Appendix A).

Residential school setting. For the therapeutic residential milieu setting the author recruited participants by attending a milieu staff meeting at the agency and explaining the nature of the study. The author proceeded to distribute consent forms to individuals, noting that they could choose to participate and return the form to the author, retaining a copy for themselves, or decline to do so (see Appendix B for copy of consent). The author collected signed consent forms, and surveys, envelopes, and then a list of local resources were distributed to participants. Participants were directed to complete the survey, which included a demographic questionnaire (see Appendix C), followed by the *Secondary Traumatic Stress Scale* (Bride, 2004; see Appendix D). A list of resources from the local community was provided in addition to the survey in the event that participants were in need of additional support should they wish to speak to someone to obtain more information, or talk about feelings of distress they may have experienced as a result of participation. Participants returned completed surveys, anonymously, to the author by placing the survey in a sealed envelope and depositing it in a basket located in the agency's front office. Data was then collected and analyzed.

Inpatient hospital unit setting. After obtaining permission from the agency to recruit participants, the author was given the email addresses of milieu staff members employed at the agency on the inpatient unit. A recruitment email was sent with a link to a confidential online survey created utilizing SurveyMonkey. This link provided a more in depth description of the study as well as a consent page (see Appendix E for copy of consent). If individuals chose not to provide consent and participate in the study they were directed to a list of local resources through which they could obtain additional support, in the event that any of the information referenced on

the consent page was triggering for them. Participants who chose to provide consent and participate in the study were directed to complete a demographic questionnaire followed by the *Secondary Traumatic Stress Scale* (Bride, 2004). At the completion of the survey participants were directed to a list of local resources through which they could obtain additional support or information. Data was then exported from SurveyMonkey and analyzed.

Measures

In determining a measurement tool for this study, two different scales were carefully considered. These scales included the *Secondary Traumatic Stress Scale* (STSS) (Bride, 2004) and the *World Assumptions Scale* (WAS) (Janoff-Bulman, 1989). The *Secondary Traumatic Stress Scale* (Bride, 2004) was ultimately chosen as the best measurement tool for this study as it most efficiently determines the presence or absence of concrete symptoms associated with STS and VT. The effects of vicarious trauma and secondary traumatic stress are often evidenced by symptoms falling into clusters such as intrusion, avoidance, and hyperarousal (Figley, 1995, p. 572). This suggests that including a quantitative measure that determines whether or not symptoms fall into these clusters and meet the criteria for STS is important. Considering that the goal of this study is to assess the prevalence of STS and VT in a particular population, this scale appeared to be the most suitable way to accomplish this.

Demographic questionnaire. A demographic questionnaire was included to obtain specific data about participants' age, gender, years of experience with traumatized individuals, years employed as a milieu staff member, setting in which they are currently employed, percentage of the workday spent with traumatized individuals, and level of training received on working with traumatized individuals. Lastly, a question about what specific training was obtained by participants, if any, is included.

Secondary Traumatic Stress Scale. The *Secondary Traumatic Stress Scale* (Bride, 2004) is a 17 item self-report scale that is commonly used to assess the extent to which an individual is experiencing symptoms associated with STS. This is determined using a 5-point Likert Scale. The instrument is comprised of three subscales: intrusion, avoidance, and arousal with questions designed to assess each. For example, Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16).

Respondents

The criteria for participation in this study were as follows. Participants were required to be non-clinically trained milieu staff members who are currently working in a therapeutic residential school milieu setting or inpatient hospital unit milieu setting. Participants must also have worked directly with traumatized children and/or adolescents, ranging in age from 3-21. (N=9) individuals responded to the email and (N=8) individuals both consented and filled out the electronic survey. In addition, (N=41) individuals filled out paper surveys, totaling (N=49) individuals overall who completed surveys for the study and were included in the analysis. Of the 49 participants, 53.1% were female and 46.9% were male. Ages ranged from 21-73, the average age reported being 37. The amount of time participants reported working as milieu therapists ranged from .16-26 years, the average being 7.4 years of employment.

Limitations

This study was limited in that it employed a self-report measurement tool and relied on the interpretations of individual milieu staff members. Though every attempt was made to include a diverse sample of organizations and settings, my resulting sample is limited to those participants employed at two specific agencies located on the east coast, one, a therapeutic residential school milieu setting, and the other, a therapeutic inpatient hospital unit milieu

setting. Due to this, my data is not generalizable to all milieu staff members. It is also important to recognize that the individuals who chose to complete the survey could have potentially been motivated by high interest in, and/or strong opinions about, the research topic.

Ethical Considerations

There were various risks and ethical considerations associated with this study. For example, participants in this study were potentially members of an at-risk population, in that they may have experienced the adverse effects of secondary trauma. In addition, the subject matter was on a particularly sensitive topic. Due to this, when designing the study, this author had to be particularly mindful of the possibility that participants may become re-traumatized as a result of participation. In considering this, potential risks were outlined for participants prior to consenting and participating in the study. In addition, a list of local resources was provided at the conclusion of the study should any participant have any further questions or have experienced emotional distress over the content or subject matter. In addition, another ethical consideration involved this author having held a position at one time that was similar to the role of a milieu staff member. However, this information was not shared with participants and did not in any way interfere with the study.

Data Analysis

As described above, data was collected from each agency using different methods. In terms of the inpatient setting, participants were contacted via email and asked to participate in the study by filling out an anonymous online survey through Survey Monkey. The data from the online survey was collected utilizing this program and uploaded to an excel spreadsheet where individual participants' responses were linked to identification numbers. Email addresses and identifying information linked to participants were not collected nor made available to this

author, thus maintaining the confidentiality of respondents. In the residential school setting, participants filled out anonymous paper surveys that were distributed by this author at a weekly staff meeting. After completion, respondents placed surveys in sealed envelopes and deposited them in a basket placed at the main office building where they were collected by this author at a later time. Due to this, this author was unable to link completed surveys with specific participants and thus, participant confidentiality was maintained. Participants responses were assigned to identification numbers and then recorded by this author in an excel spreadsheet.

Following data collection, this author consulted with a statistician at the Smith College School for Social Work to determine the best statistical tests to analyze survey data. Descriptive statistics were run on the demographic data to determine frequencies and means. In addition, we ran a Cronbach's Alpha to determine the reliability of the intrusion, avoidance, and arousal subscales of the STSS. Based on methods described by (Bride 2007), participant's total scores on the STSS were compared to a recommended cutoff score of (N=38) to determine whether or not they met criteria for PTSD. In addition, participants' total scores were compared to normative scores to determine whether or not they fell into the mild, moderate, or severe range.

CHAPTER IV

Findings

This study used a quantitative method design for the purposes of determining the prevalence of VT and STS in milieu staff members working directly with victims of trauma in the 3-21 age range. It also served to explore the extent to which these individuals suffer from VT and STS. In the following chapter, the results of data analysis are presented and discussed. After discussing the demographic data collected, the results of the STSS will be explored, followed by comparisons between severity of PTSD suffered and certain demographic variables.

There were a total of 50 individuals who accessed the survey. Nine of these individuals accessed the electronic survey, while 41 individuals filled out a paper survey. One individual was disqualified from the data set based on their declination to provide consent. Thus, the sample size was (N=49). Participants were asked to fill out a short demographic survey followed by the STSS. Some participants elected to skip certain questions on the survey and thus, that information was not included in the data set. Ages of participants ranged from 21-73, the average age reported being 37. The amount of time participants reported working as milieu therapists ranged from .16-26 years, the average being 7.4 years of employment. Participants reported a minimum of .83 years of experience in the field and a maximum of 40 years, with an average of 11.49 overall years of experience in the field. The descriptive statistics of this data can be found in Table 1.

Table 1

Descriptive Statistics of Demographic Data, (N=49)

Demographic	Minimum	Maximum	Mean
Age	21	73	36.94
Years Experience in Field	.83	40	11.49
Years Employed as Milieu Staff	.16	26	7.44

Of the 49 participants, 53.1% were female and 46.9% were male. Sixteen point three percent of study participants were currently employed on an inpatient hospital unit, 83.7% in a residential school setting. The majority of participants, 61.2% noted that 90-100% of their workday is spent working directly with traumatized individuals. Ten point two percent of participants noted spending 70-90%, 2% spending 50-70%, 8.2% spending 30-50%, and 18.4% spending 10-30%. In addition, participants were asked whether or not they had undergone any formal trauma training. The majority of participants, 57.1% stated that they had not, while a small percentage, 26.5% indicated they had received formal trauma training of some kind. Sixteen point three percent of participants noted that they were not sure if they had received such training. These percentages can also be found in Table 2.

Table 2

Descriptive Statistics of Demographic Data 2, (N=49)

Demographic	Frequency	Percentage
Gender		
Female	26	53.1
Male	23	46.9
Setting		
Hospital Inpatient	8	16.3
Residential School	41	83.7
% Workday		
10-30%	9	18.4
30-50%	4	8.2
50-70%	1	2.0
70-90%	5	10.2
90-100%	30	61.2
Formal Training Received		
Yes	13	26.5
No	28	57.1
Not Sure	8	16.3

Individuals who indicated that they had received formal trauma training were asked to fill in the specific type of training they had received. This list included Trauma Informed Care (TIC) training and Attachment Self-Regulation Competency (ARC) training. It is important to note that some individuals who selected “yes” to receiving additional trauma training neglected to fill in the type of training they received. In addition, those individuals who selected “yes” to having formal trauma training but then indicated training that was not considered formal trauma training were not included in the data set as having had formal trauma training.

In addition to the demographic portion of the survey, participants were also asked to complete the Secondary Traumatic Stress Scale (STSS). As previously noted, the STSS is comprised of three subscales B, C, and D. These subscales are composed of groupings of questions designed to assess for the presence of criterion associated with a PTSD diagnosis. Questions included in subscale B were designed to assess intrusion symptoms, subscale C: avoidance symptoms, and subscale D: arousal symptoms. The Secondary Traumatic Stress Scale

utilizes a 5-point Likert Scale (ranging from “never” to “very often”) to discern the extent to which an individual is experiencing these symptoms. The individual is asked to select a response for each of the 17 items on the scale (each corresponding to a different PTSD symptom) after which a total score is calculated by summing the items from each subscale (Bride, 2007, p.67). Some participants elected to skip certain questions on the scale and as a result these scores were not included in the data analysis. These descriptives are illustrated in Table 3 below.

Table 3

Descriptive Statistics of STSS

	Valid Scores	Missing Scores	Mean	Minimum	Maximum
Subscale B	49	0	10.14	5	19
Subscale C	47	2	13.81	7	27
Subscale D	48	1	11.17	5	19
Full STSS	49	0	34.33	16	63

Results

According to Bride (2007), STSS scores can be interpreted utilizing a variety of methods. For the purposes of this study, this author elected to utilize methods two and three to interpret the data collected. Method two places scores into categories of PTSD severity associated with percentiles, which allows for more gradation. As noted by Bride (2007) these categories and percentiles are as follows: scores less than 28 (at or below the 50th percentile) are categorized as “little to no STS.” Scores ranging from 28-37 (at the 51st-75th percentile) are interpreted as “mild STS.” Scores from 38-43 (at the 76th-90th percentile) are interpreted as “moderate STS.” Scores from 44-48 (at the 91st-95th percentile) are interpreted as “high STS.” Finally, individuals scoring 49 and above (at the 95th percentile) meet criteria for “severe STS.”

After participant total scores were calculated, individual scores placed participants into one of the previously mentioned categories. Individuals interpreted as having “severe STS” consisted of 10.2% of study participants. Individuals interpreted as having “high STS” consisted

of 8.2% of total participants. Individuals interpreted as having “moderate STS” made up 20.4% of the participant population. Individuals interpreted as having “mild STS” consisted of 32.7% of participants. Finally, 28.6% of participants’ scores fell into the “little or no STS” category. This data is also illustrated in Table 4 below.

Table 4

Data Analysis Utilizing Method 2

	Frequency	Percentage
Little or no STS	14	28.6
Mild STS	16	32.7
Moderate STS	10	20.4
High STS	4	8.2
Severe STS	5	10.2

Method three, as noted by Bride (2007), consists of interpreting individuals’ total STSS score by comparing them to a cutoff value of 38. Individuals at or above this score are interpreted as having PTSD due to STS, and individuals below this score are interpreted as not having PTSD due to STS. A cutoff score of 38 was recommended based on the fact that it falls on the lower threshold of the moderate range, as illustrated by the ranges presented earlier (p. 68). Based on this method, 61.2% of study participants held scores falling below 38. However, 38.8% of participants in this study held scores falling at or above 38. The results of this study indicate that a total of 19 study participants (or 38.8% of total study participants) met criteria for PTSD due to STS. This data can also be viewed in Table 5 below. Further interpretation as well as implications of findings will follow in the Discussion section.

Table 5

Data Analysis Utilizing Method 3

	Frequency	Percentage
Below 38	30	61.2
Above 38	19	38.8

CHAPTER V

Discussion

This section will further explore both the prevalence and the severity of STS in the population of milieu staff members surveyed for this study. In conjunction with closer examination of these findings, I hope to highlight some strengths and limitations of this study in the hopes that these factors can be taken into consideration for future research in this area. In addition, I will discuss the implications of this research for both the field of social work, as well as those who identify themselves or will identify in the future, as being members of the population of helpers explored here. It is also my wish that this study will spark conversations around who can potentially suffer from VT and STS, and the probable consequences for sufferers due to the lack of acknowledgement on the part of the social work community to recognize and legitimize their challenges.

As previously noted in the findings chapter, 19 total participants or 38.8% of those surveyed were found to meet criteria for PTSD due to Secondary Traumatic Stress. These results are consistent with my hypothesis that non-clinically trained milieu staff members can potentially suffer from VT and STS. These results are also strikingly similar to those of Wies & Coy (2013) whose study also utilized the STSS and found that 38.1% of their participants were suffering from VT. Unfortunately, due to the limited amount of research on VT and STS in populations other than clinical therapists, the results of the research done by Wies & Coy (2013) were found to be most comparable to my findings. Not only does the study focus solely on non-clinically trained individuals and employed the same methodology, but the study also had a

similar sample size of 42 participants. Most notably, this data indicates that these phenomena are prevalent in a population outside of clinically trained helping professionals. These findings are substantial as they indicate that a significant portion of non-clinically trained “helpers” is experiencing symptomology while actively working in the field. These findings also challenge the notion that Secondary Traumatic Stress and Vicarious Trauma are outcomes exclusively associated with trained clinicians.

In an effort to bridge the literature gap as well as call attention to various other factors that may contribute to the development of VT and STS, this study addresses factors that other studies should have considered. For example, aside from shifting the focus of the population, this study also assessed participants’ completion of formal trauma training. Results indicated that a surprising 57.1% of participants stated that they had not completed formal training. An additional 16.3% noted that they were “Not Sure” if they had received formal training in this area. Similarly to this study, MacRitchie & Liebowitz (2010) inquired about length of service as a trauma worker. However, they neglected to ask participants about formal training around trauma. In limiting their exploration of other factors that may contribute to the development of VT and STS, I feel that they missed an opportunity to seek alternative causes outside of the individual.

This study was also somewhat unique in that the results were interpreted utilizing more than one method. Unlike MacRitchie & Liebowitz (2010) and Wies & Coy (2013), an overall percentage of participants meeting criteria for STS were presented as well as percentages reflecting the severity of STS. I feel that this enhanced my results and provided more specific and detailed information about the extent of participants’ struggles with these issues. This data has potential positive implications for both the field of social work, future research, as well as

individuals employed as milieu staff. I feel this data helps move the profession in a direction that supports the inclusion of a wider array of helping professions in the population of potential sufferers of VT and STS. Not only does this data draw attention to an under published and often disregarded group of individuals, it hopefully helps to initiate a movement towards examining the way we discuss, learn about, and propagate information regarding VT and STS as well.

In addition, I am also hopeful that this study contributes to the scarce collection of preexisting literature on the topic of VT and STS in non-clinically trained helpers specifically. Once again, it is my goal that this study incites curiosity in the reader and prompts the social work profession as well as the psychology profession at large to further explore this topic in research and beyond. I feel that the possibility that milieu staff workers can potentially suffer from debilitating symptoms associated with secondary traumatic stress has implications for their well being as well as the quality of their work. It also calls into question the resources that are made available to them and the lack thereof. Not only are these individuals most likely unaware of the source of their discomfort and/or symptoms, as they lack the education around the possibility of contracting such symptoms in their line of work, they may also lack the resources to address and potentially resolve these issues. Another discomfoting aspect of this reality is the fact that these individuals may be compromised in their ability to effectively do their jobs, which will more than likely trickle down to the quality of care received by the clients with whom they are so closely working.

In the spirit of preventing these detrimental primary and secondary side effects, I will offer some considerations for individuals in the field and recommendations for interventions on the part of the larger agency or system within which they work that may be helpful. Based on the fact that 61.2% of participants noted that they work closely with traumatized individuals for 90-

100% of their workday, and 57.1% of participants noted that they have not had any formal trauma training, I suggest that all non-clinically trained milieu workers receive some form of formal trauma training as a part of their agency orientation. For example, Trauma Informed Care (TIC), which can serve as a resource for staff allowing them to feel better equipped to work closely and conscientiously with victims of trauma. In addition, I feel that providing milieu staff and other non-clinically trained staff with regular, consistent, and mandatory supervision would provide yet another helpful resource in beginning to address any issues that may come up for them in this line of work. It could also serve as a system of checks and balances to assist any staff member who may be struggling with secondary or vicarious stress, or who may shows signs or symptoms of struggle in this area. I recognize that not every agency or facility will have the resources to implement these changes, however I do feel that these suggestions are paramount to protecting and prioritizing the safety and efficacy of these helpers and should be considered as a way of providing a precautionary safety net, if you will.

If future research supports the notion that VT and STS can develop in a wider range of helpers, I feel that educating these individuals about VT and STS would be vital. For the same reasons that we value educating clinical professionals about these topics, other helpers can also benefit. Learning the basic definitions of these terms in addition to being made aware of common symptoms associated with them, how to recognize these symptoms, how and where to seek resources, and suggestions for methods of prevention are important facets of this process. I would like to think that providing this information in addition to introducing preventative measures could reduce the prevalence of VT and STS in non-clinically trained workers. In learning to recognize the signs and symptoms, individuals may be more likely or willing to seek help when needed, as opposed to attributing these symptoms to other factors or discounting them

as inconsequential. In addition, it may encourage them to embrace self-care, or take time off from their jobs to prioritize their own mental health.

Despite the positive conclusions that could potentially be drawn from this study, there are also a host of limitations. Although this study aimed to bring awareness to a population that is under researched, the limited number of respondents is noteworthy. Not only the limited number of overall respondents, but also the limited number of respondents for the inpatient unit setting more specifically. Future research should consider including a larger sample size in order to further validate and substantiate results. In addition, this study was conducted within a very limited time frame. A longitudinal study focusing on following participants over time could prove to be informative and would allow for a much longer recruitment period with which to expand sample size as well.

Results of this study cannot speak to all milieu staff members in all settings. The milieu staff surveyed here are only representative of a small population of helpers from two specific organizations in the United States. These organizations and the specific type of milieu settings, for example hospital inpatient and residential school, are not representative of the various other possible milieu settings in which milieu staff could potentially work. It is also important to note that in addition to the statistics presented in previous chapters, additional statistics were run comparing certain demographic variables to STSS scores. However, these results were not statistically significant and therefore were not included in the findings or explored further in relation to implications for future research or the field.

In closing, the types of “helpers” working with traumatized individuals have grown and roles have expanded (Figley, 1995, p. 574). This knowledge calls for the validation of the existence of a non-trained workers susceptibility to VT and STS, which in turn, highlights a need

for increased research and study in this area and on these helpers. As a profession, we need to cast a wider net and begin to challenge pre-existing notions that clinical professionals are exclusively affected by secondary and vicarious trauma. In addition, we as a profession should first acknowledge the potential for this to occur, and also commit to reaching out to these individuals and providing education and support around VT and STS.

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APPENDIX A:

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 23, 2014

Jennifer Mello

Dear Jenny,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten', enclosed in a rectangular box.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor

APPENDIX B

Residential Setting Informed Consent



SCHOOL FOR SOCIAL WORK

Consent to Participate in a Research Study
Smith College SSW • Northampton, MA

.....

Title of Study: The Effects of Vicarious Traumatization and Secondary Traumatic Stress on Milieu Staff

Investigator(s): Jennifer Mello, Smith School for Social Work

.....

Introduction

- You are being asked to be in a research study of the effects of working as a milieu staff member in a residential milieu setting with victims of trauma.
- You were selected as a possible participant because you are a non-clinically trained milieu staff member who is currently working directly in a residential milieu setting with traumatized children and/or adolescents.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to understand the ways in which working with victims of trauma in a residential setting can impact milieu staff members.
- This study is being conducted as a thesis requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: fill out an anonymous paper survey addressing your work as a milieu staff member.

Risks/Discomforts of Being in this Study

- The questions you are asked are on a particularly sensitive topic and may cause you to feel uncomfortable, or unintentionally provoke an emotional response. It is possible that you will experience this due to the nature of the survey. As a result, a list of local resources will be provided to you in the event that you wish to obtain more information or talk to someone about any distress you may be experiencing.

Benefits of Being in the Study

The benefits of participation in this study are that milieu staff members may develop increased knowledge and awareness around trauma and its effects on them.

Confidentiality

- This study is anonymous. I will be collecting and retaining information about your name on the consent form you provide if you agree to participate. This information will be kept separate from the data you provide on the survey itself. You will be asked to hand your signed consent form to the researcher. However you will be asked to place your completed survey (that does not contain your name or any other identifying information) into a sealed envelope and place it in a basket provided at the front office. As a result, the researcher will be aware that you participated, but will not be able to connect your data to your name.
- The data will be kept for at least three years according to Federal regulations. They may be kept longer if still needed for research. After the three years, or whenever the data are no longer being used, all data will be destroyed.

Payments

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. However, due to the fact that identifying information will be kept separate from survey data, there will be no way for the researcher to connect your survey data with your name. As a result, if you wish to withdraw from the study you must do so prior to submitting your survey in the basket provided at the front office. If you choose to withdraw, the researcher will not use any of your information collected for this study.

Right to Ask Questions and Report Concerns

- You have the right **to** ask questions about this research study *and to have* those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Jennifer Mello at XXXXXX@smith.edu or by telephone at XXX-XXX-XXXX. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.
- Your signature below also verifies that you are a non-clinically trained milieu staff member who is currently working in a therapeutic residential milieu setting. You are an individual who works directly with traumatized children and/or adolescents ranging in age from 3-21.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

APPENDIX C

Demographic Questionnaire

1. Please indicate your age:

2. Please indicate your gender:
 - A. Male
 - B. Female
 - C. Other _____
 - D. Prefer not to answer
3. Please indicate the number of years of experience you have working with traumatized individuals:

4. How many years have you been employed as a milieu staff member?

5. Which best describes the setting in which you are currently employed?
 - A. Hospital inpatient unit
 - B. Residential living facility/school
6. *Approximately* what percentage of your workday is spent working directly with traumatized individuals?
 - A. 0%
 - B. 10-30%
 - C. 30-50%
 - D. 50-70%
 - E. 70-90%
 - F. 90-100%
7. Have you ever undergone formal training for working with traumatized individuals, including Trauma Informed Care?
 - A. Yes
 - B. No
 - C. Not sure
8. If yes, please list any formal training you have received for working with traumatized individuals:

APPENDIX D

Secondary Traumatic Stress Scale

SECONDARY TRAUMATIC STRESS SCALE

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

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

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

APPENDIX E

Inpatient Hospital Setting Informed Consent

Dear Participant,

My name is Jennifer Mello and I am a Clinical MSW candidate in the Smith College School for Social Work Program. I am conducting a research study to fulfill a thesis requirement that focuses on the relationship between milieu staff members and victims of trauma in the milieu setting. You meet criteria for this study if you are a non-clinically trained milieu staff member who works directly in a milieu setting with individuals who have been victims of trauma ranging in age from 3-21. I am asking participants to fill out a short electronic survey, anonymously, about their experiences as a milieu staff member working in this environment. This survey will take approximately 5-10 minutes to complete. Ultimately, this research may be published or presented at professional conferences. Participation in this study is on a voluntary basis but would be greatly appreciated! You can skip any question and stop at any time. You also have the right to withdraw from the study prior to clicking the “submit” button, simply by navigating away from the survey page or closing your web browser, and your data will not be included in the study. However, since the survey is being collected online and is anonymous, once you click on the “submit” button at the end of the survey, you will be unable to withdraw from the study.

All research materials including analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. The questions you are asked are on a particularly sensitive topic and may cause you to feel uncomfortable, or unintentionally provoke an emotional response. It is possible that you will experience this due to the nature of the survey. As a result, a list of local resources will be provided to you in the event that you wish to obtain more information or talk to someone about any distress you may be experiencing. Any questions you may have can be directed to my email or answered by phone (listed below). If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974. Thank you for your time and consideration.

Sincerely,
Jennifer Mello
Smith College School for Social Work
XXXXX@smith.edu
XXX-XXX-XXXX

I agree to participate

I decline to participate