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Mira Levi Elwell
Social Work as Healing Vocation:
The Exploration of Clinicians' Trauma
Histories and Implications for Practice

ABSTRACT

This qualitative exploratory study examines the experiences of social workers who believe they came to the vocation in some part due to a personal history with trauma. Thirteen licensed clinical social workers (LCSWs) with histories of trauma were interviewed about their clinical practice focusing on career choice, countertransference, and disclosure.

Clinicians discussed how personal experiences with trauma influenced and impacted their decisions to enter social work as a profession. Clinicians also discussed working with clients who were survivors of trauma, decisions surrounding self-disclosure, and the impact and importance of therapy and supervision of one's own.

Study results indicated that positive past therapeutic relationships were a major factor in clinicians' decisions to pursue social work as a career. With a few exceptions, self-disclosures were rarely made to clients, and when self-disclosures were made, it was highly dependent on the subjective experience and decision making process of the individual clinician. Finally, clinicians with trauma histories generally felt as though personal experiences as survivors benefited treatment of clients with trauma histories making it easier to empathize and understand clients and their experiences.

SOCIAL WORK AS A HEALING VOCATION: THE EXPLORATION OF CLINICIANS'
TRAUMA HISTORIES AND IMPLICATIONS FOR PRACTICE

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

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Northampton, Massachusetts

2012

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This thesis is dedicated to Emily L. Richardson whose absence I feel every day, and whose memory continually inspires me to do this work.

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CHAPTER I

INTRODUCTION

Carl Jung (1951) was the first psychoanalyst to use the term “wounded healer” to talk about the dynamic of the wounded practitioners healing the wounded in his book *Fundamental Questions of Psychotherapy*. He explored the nuances of what it means to use one’s own history with trauma in treating others, and how that experience can be beneficial in the client-therapist relationship, as well as difficult and at times, even harmful.

Since Jung initially began considering this phenomenon, we have come to understand trauma and the effects of trauma very differently. We have a better understanding of how personal history can play a role in how each of us constructs our realities, and how trauma and its residual effects can be passed down from one generation to another. With that understanding, we have come to see that trauma can be worked through and ultimately, healing can take place.

We experience trauma in a multitude of ways--as individuals, in ways that touch us personally, but also in societal and cultural contexts, where trauma can be inflicted and experienced in more insidious ways. As social workers, we are called upon to treat and to help heal, but for many of us, our own experiences with trauma inform how we practice with our patients and clients. Developing a further understanding of the role that trauma plays and how it affects our ability to work with others is central to the research.

This study explores the experience of clinical social workers who have decided to pursue social work in part as a result of their own experiences as survivors of traumatic events. Issues

surrounding career choice, decisions concerning self-disclosure to clients with similar trauma histories, and issues of countertransference are all investigated in this study.

There is a dearth of both anecdotal and statistical information about clinicians who have experienced trauma, particularly as it can and does impact clinical practice. Within the social work profession, issues of countertransference are discussed with regularity, but there is still stigma attached to discussing or acknowledging the prevalence of trauma among clinicians. Limited research has been done on the topic, with the focus primarily on survivors of sexual assault. Although this is an area of great importance, and has been found to be prevalent in the social work profession, other areas of trauma are rarely, if ever, addressed. For the purpose of this study, the DSM-IV definition of trauma will be used primarily, but not exclusively. Trauma will be defined as:

A stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal.

In addition to the DSM-IV definition, other more nuanced forms of trauma are included in this study, including forms of mental and emotional abuse and neglect, and intergenerational trauma.

This study will explore three different ways that personal trauma has impacted or influenced thirteen LCSW's decisions to pursue social work as a career and how their practice has in turn been influenced by this trauma history. These thirteen participants were interviewed about how their personal experiences with trauma played a role in their decision to

become a social work professional, how countertransference is experienced in working with client's who are also survivors of trauma, how decisions surrounding self-disclosure are negotiated and influenced in a clinical setting as a result of a clinician's trauma history, as well as how these issues are managed more personally for clinicians. Interviewing participants allowed me to hear in-depth experiences of practicing social workers' relationship to their own histories and their individual thoughts and feelings surrounding self-disclosure and countertransference in the work they do with clients who are also trauma survivors.

Research addressing the ways that personal life experience can affect career choice has been done before, but there has been limited research about the prevalence of trauma in the lives of social workers, and how the presence of trauma might be a help or a hindrance to therapeutic intervention with clients who have has similar traumatic experiences. By engaging survivors of trauma who are also licensed clinicians in a dialogue, a greater understanding of the benefits that can come with a shared understanding of how trauma can affect someone, as well as the precautions and safeguards that must be taken to ensure the well being and clinically appropriate ways will lead to a greater understanding of how the wounded practitioner can help the wounded heal.

CHAPTER II

LITERATURE REVIEW

In beginning my research about how a clinician's own history with trauma may have been a driving force in their decision to pursue social work as well as the impact it might have on their practice, I found that there is an abundance of information from multiple perspectives. Literature on the subject is primarily divided into three areas of interest—career choice, countertransference, and disclosure.

In “A Perilous Calling: The Hazards of Psychotherapy Practice,” Edited by Michael B. Sussman (1995), a variety of theoretical essays address all aspects of the therapist's life and work from the viewpoint of therapist's themselves. Issues of countertransference are explored, as well as looking at the psychotherapist as an “interminable patient” to other psychotherapists. In one essay in particular, Nancy Bridges (1993) discusses the countertransference implications of therapists in psychotherapy with another clinician, exploring the complicated relationships and boundaries that exist when treating a fellow therapist in the field. These issues arise regularly with therapists who have trauma histories of their own, as treatment around one's own trauma are often explored before or during entering the field as a professional.

“Holland's (1966, 1973, 1985) theory of vocational choice holds that people are motivated to seek out occupational environments consistent with their personalities” (Miller, Heck, & Prior, p. 508). The validity of this theory has been challenged, especially in regards to how it applies to women, but there is substantial data to argue that based on factors such as birth order, family values, and trauma history clinical social workers do find their way into the field for a reason

(Biggerstaff, 2004; Lackie, 1983; Miller, Heck & Prior, 1988; Pearlman & Saakvitne, 1995). This thesis explores how trauma history, in particular, can be central to a clinician's entrée to the field.

Dan Stone's (2008) article *Wounded Healing: Exploring the Circle of Compassion in The Helping Relationship* looks at how alternatives to traditional Western healing practices can be beneficial in the therapeutic relationship by integrating Eastern philosophies, many of which focus on the relationship of the healer and the one being healed. Stone looks at Reiki, Buddhism, love, and positive psychology as vehicles for supporting clients through using one's self in the process of healing.

Stone also cites Goldberg's belief that "those drawn to psychotherapy are impelled by the instinctual disposition...of a psyche whose vulnerability has never fully healed" (p.49). Using the self, learning to heal from the wound can be incredibly beneficial to those experiencing similar pain and can also bring further understanding of pain and resilience to both parties. Stone also reflects on the more delicate and potentially harmful effects of working with clients who have experienced similar traumas. Stone explores the issue of burnout/compassion fatigue, and boundary issues. Stone writes "To talk about the nature and levels of caring in a professional helping context is to venture beneath the surface of quantifiable variables and measurable outcomes into the risky depths of human relationships" (p.49). Stone's article explores the many ways that the "wounded healer" can be beneficial to the client or patient being worked with, but does not discuss the risks associated with discussing and disclosing these aspects of the clinician's life to the client.

Exploring similar themes, Jeffrey Hayes (2002) looks at the important factors that can contribute to a clinician's general knowledge base, including "scientific study and philosophical reading that are disseminated by others, or pronouncements made by authority figures, (as well as)

one's own clinical and life experience" (p. 94). Hayes addresses how the use of one's own personal experience in therapy can only go as far as the therapist will allow it. Freud (1910/1959) said, "No psycho-analyst goes further than his own complexes and internal resistances permit" (p. 94).

Countertransference

Hayes (2002) notes that the effects of the therapist's life experiences on psychotherapy are still greatly unknown. He looks at some of the studies that have been dedicated to countertransference dating back to the early 1900's with Freud, and steadily gaining momentum throughout the 1950's and then again in the 1980's. Hayes remarks "Researchers have concentrated their efforts to date almost solely on the deleterious consequences of CT (countertransference) and how to avoid or manage them (e.g., Van Wagoner, Gelso, Hayes, & Diemer, 1991) while disregarding the potential therapeutic value of CT" (p. 95). Hayes concludes the article by noting the importance of therapists engaging their own "work" before being able to effectively treat others, as the process of healing and understanding is an ongoing one.

Sheldon Heath (1991) explores the necessity of therapists engaging in their own psychotherapy prior to seeing patients.

Personal psychotherapy or psychoanalysis is recommended in order that one may see how one responds to patients and how one's own personality reacts and interacts. Nevertheless, a therapist's very problems may make for an empathetic identification with patients or clients, and for an understanding that makes the therapist a better one (p. 52-52).

Heath continues by citing Waksman (1986) who quoted Wender about career choice and why therapists are drawn to the profession.

It is the perception of the call or demand of the internalized object which may ask for, demand, claim, beg for attention, care, reconstruction, reparation...for the damage, thoughtless or (by) manipulations to which it has been subject. (p. 409)

Wender continues,

Vocation may be understood as the impulse to give coherent and appropriate expression to the reparatory requirements which have arisen in response to the unconscious perception of the damaged internal object (p. 409).

In their book Trauma and the Therapist, Pearlman and Saakvitne (1995) explore why so many survivors of trauma, especially sexual abuse, become therapists. Pearlman and Saakvitne cite Briere (1989) who believes that “at least 33 percent of female, and 10 to 15 percent of male therapists have sexual abuse histories and that a much larger percentage has been victimized physically and emotionally in childhood.” (p. 174).

Pearlman and Saakvitne (1995) investigate further what qualities are routinely found in clinicians who have experienced some form of trauma in early life. “Their personal history can make survivors well-suited to the role of therapist in a number of ways, including their acute sensitivity to the affects, needs, and unspoken defenses of another, and their highly developed capacity for empathy.” (p. 175). In looking at the intersections of trauma and those who become clinicians, Pearlman and Saakvitne write “countertransference issues for therapists who are themselves adult survivors of childhood sexual abuse and incest are under addressed in the literature. In fact, the existence of these therapists is treated as a shameful secret in the profession.” (p. 176).

Multiple studies (Biggerstaff, 2000; Kinsella, 1998; Mensinga, 2008; Nelson-Gardell & Harris, 2003; Sussman, 1995; Watkinson & Chalmers, 2008) have been done exploring what brings clinicians to the field in the first place.

Marilyn A. Biggerstaff (2000) writes about the many reasons that social work students made the decision to embark upon a career of social service. Biggerstaff discusses the need for a more “multidimensional” view of why people come to social work as a career. Biggerstaff

explores personal and family experience, desire to be a therapist, prestige of the profession, social change mission, and service motive as possible reasons for becoming a social worker. Biggerstaff's quantitative study, collected from 589 MSW students, who were primarily white (83%) and female (83%) illustrates that people come to the field for a variety of reasons, including but not limited to drug and alcohol abuse in the family of origin, mental or physical illness, traumatic life events (including divorce, suicide, and death), the incidence of psychological traumas, perceived power, and personality type.

Biggerstaff's empirical study provides a more holistic view of who decides to become a social worker, and for what reasons, focusing on how personal and professional values are enacted by many people choosing social work as a career. Unfortunately, no discussion is dedicated to how that impacts practice for individual clinicians. Surely, a clinician who came to the field due to an experience involving a personal trauma will have a very different perspective and idea of practice than someone who came to the field purely to enact social change.

In addition to the many ideas and theories surrounding the effects that countertransference can have in practice with clients, there are several empirical studies (Elliott & Guy, 1993; Kinsella, 1998; Mason & Sanders, 1994; Murphy & Halgin, 1995; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995) about exploring the implications for clinicians who have come to the work based on personal life experiences, including trauma.

In a study conducted by Csikai, Stephen, and Rozensky (1997) looking at the factors that went into choosing social work as a career, 145 beginning level BSW and MSW students from the University of Pittsburgh social work program were asked about their decision making process in a 26 question questionnaire which was scored using a 5 point Likert scale ranging

from strongly disagree to strongly agree. It was found that among beginning level bachelor and masters social work students, most participants chose to study social work for altruistic, not professional reasons. The students were given a social work idealism test, and those students who scored high tended to attach greater importance on altruistic reasons, such as helping those less fortunate, and less on professional issues such as prestige and pay scale, as did younger students and female students. Unfortunately, by using a questionnaire with a Likert scale, students were unable to address or respond to any more nuanced reasons that they might have chosen to pursue social work as a career.

In a study conducted by Elliott and Guy (1993), the childhood experiences of trauma and adult functioning was examined in mental health and non-mental health professionals. Elliott and Guy surveyed 2,963 women, working in mental health and non-mental health oriented fields. The survey consisted of a three-part instrument, which included an exploration of trauma, family environment, and problems in interpersonal relationships. When looking at childhood environments, Elliott and Guy (1993) found that

51% of the women in this sample reported the occurrence of one or more of the following before age 16 years: physical abuse, sexual molestation, parental alcoholism, hospitalization of a parent for mental illness, or the death of a parent or sibling. . . The women in the mental health professions differed from those in the other professions regarding the prevalence of childhood trauma, with mental health professionals more likely than the other professionals to report one or more traumas (p.85).

The results of the study supported other research on the topic, addressing “the high prevalence of trauma and family dysfunction among mental health professionals” (p. 88). However, due to the fact that the sample was exclusively female, it is very difficult to generalize the results to the larger mental health worker population which would include men, despite the large sample size.

A similar study, conducted by Murphy and Halgin (1995) looked at career choices made by 56 clinical psychologists, and 53 social psychologists from two professional organizations. All 109 participants were asked a series of questions about what influenced their decision to become a professional therapist. According to the results of the study, “psychotherapists were more likely to enter their career to resolve personal problems than were social psychologists” (p. 424). Additionally, “the incidents of personal problems influencing career choice was higher for therapists than for social psychologists,” and “psychotherapists’ career choices were more likely to have been influenced by a history of distress in their families of origin than were social psychologists’ career choices” (p. 424). Murphy and Halgin’s (1995) study was one of the first to look at the similarities and differences among a group of psychologists, however, all responses were gathered from organizations that participants has chosen to belong to, thus making it difficult to generalize to a wider population of mental health workers or specifically to social workers,

In a study conducted by Kinsella (1998) examining the career choices of traditional versus non-traditional (generally older students, often with part-time enrollment status, living off campus, occasionally with experience in another field) college students, 84 students from a college in Southern Florida were examined quantitatively taking into account age, gender, enrollment status, and marital and parenthood statuses. In looking at what career choices students were making, Kinsella found that older, non-traditional students tended to choose social service and social work type programs “primarily because of a life event.” Younger students tended to choose areas of study that family members had encouraged them to explore, such as education and business. Kinsella writes,

Older non-traditional students indicated an interest in helping others and 45% cited a personal life event that led them to a career in either Human Services or Social Work.

Life events included recovering alcoholism, addictions, loss of a friend to AIDS, sexual abuse, physical abuse, domestic violence, disabilities, personal injury, life crisis, death of a child, divorce, family suicide, depression, and a previous opportunity to volunteer or work in social work.

Kinsella's study gives us some information about the specific type of people pursuing social work at this school (primarily older students), but the study fails to delve deeper into how the trauma or life event actually impacted the student's decision to pursue a social services career. Although the sample size was not insignificant, it is only generalizable to the population of other small colleges.

Similarly, a qualitative study conducted by Mason and Sanders (2004) looked at the decision of 22 social work masters level students to work in a setting with gerontological clients. Mason and Sanders interviewed students using open-ended questions and found that more than half of the students surveyed ($n = 12$, 55%) had chosen to work with older clients based on life experiences with older adults prior to entering social work school. Mason and Sanders do not explore further what reasons people cited as wanting to work with older adults, outside of general "life experience," but the study does illustrate how a positive or negative experience in one's life have the potential to impact career choices and decisions.

For some clinicians, the effects of working with certain populations prove to be especially difficult. In an empirical study conducted by Pearlman and Mac Ian (1995), 188 self-identified trauma therapists were interviewed about their experiences. Participants completed questionnaires regarding their exposure to clients discussing trauma, as well as their own psychological well-being. Pearlman and Mac Ian found that therapists with the least work experience in the area of trauma experienced the greatest psychological difficulties, and those reporting a personal trauma history (60% of respondents) showed more negative effects from

the work than those without a personal history. As stated in their study,

Our study results replicate findings from other studies that indicate that, despite more extensive trauma histories than the general population, psychotherapists seem to be functioning well psychologically (Elliott & Guy, 1993; Follette et al., 1994). It is evident, however, that the subsample of therapists with a personal trauma history showed greater disruptions than those without a personal trauma history.

Additionally, Pearlman and Mac Ian addressed how length of time in the field and whether or not therapists were getting supervision played a role in how trauma therapists were able to cope with their professional responsibilities.

The newest therapists in the trauma history group were experiencing the most difficulties. This finding is consistent with the burnout literature, which shows that being younger or newer to the work is correlated with the highest levels of burnout (Ackerley, Burnell, Holder, & Kurdek, 1988; Deutsch, 1984) and with the most negative reactions to doing therapy (Rodolfa, Kraft, & Reilley, 1988). In our study, these newest trauma therapists were not receiving supervision, and they tended to be working in hospitals. Only 17% of those therapists working in hospitals, where the most acutely distressed patients are treated, were receiving any supervision.

In a similar empirical study conducted by Nelson-Gardell and Harris (2003), they surveyed 166 child welfare workers about the detrimental effects of exposure to working with clients with abuse histories. Social workers with histories of primary trauma were seen to have a heightened risk for secondary traumatic stress (STS). The Nelson-Gardell and Harris study was conducted in two parts, resulting in 166 respondents total. Nelson-Gardell & Harris looked at amount of time in the field, as well as educational experience, but neither seemed to impact whether or not a child-welfare worker would suffer from secondary traumatic stress. The sheer fact that a child welfare worker had prior experience with abuse or assault made them significantly more predisposed to likelihood of suffering from STS.

The Nelson-Gardell and Harris study did not include information about whether or not the child welfare worker had ever been in any kind of treatment to deal with the personal

trauma, or whether supervision was included in the work experience, which would certainly affect the likelihood of potential re-traumatization in practice with clients. Additionally, the participants were all self-selected, limiting the possibility of generalizing the results to the larger population of child welfare workers or to other types of clinicians.

In a discussion expounding on the risks and issues encountered by clinicians who have experienced personal trauma themselves, Pearlman and Saakvitne (2005) note “for some, the role of therapist can become an extension of a self-defeating pattern of overextending oneself in relationships at one’s own expense” (p.175). Pearlman and Saakvitne explore at length issues of countertransference in the therapeutic relationship when the therapist is also a survivor of trauma. They discuss how there is a lack of literature about survivor therapists, and as a result,

The professional neglect of this group is an abandonment with significant personal and professional consequences. For therapists, the dangers of this silence include isolation, vicarious traumatization and unchecked countertransference reenactments... This neglect leaves survivor therapists on the own to struggle with their feelings and to work out delicate countertransference issues. Without a literature or other professional acknowledgement of their existence and special issues, the fear of making mistakes common to all therapists can be greater for survivor therapists. Many feelings, including shame about their survivor status, confusion about boundaries, and conflict about disclosing parallel the difficulties faced by survivors in their relationships outside of therapy (p. 176).

Pearlman and Saakvitne write expansively about the subject of countertransference and other issues encountered by clinicians who have experienced trauma. They focus primarily on survivors of sexual assault, and as a result, a large portion of “survivor” therapists are neglected, leaving their stories untold, and the ramifications of other traumas unexplored. This study will include the experiences of clinicians who have experienced a wide range of trauma, including but not limited to sexual assault, bullying, combat trauma, childhood abuse and neglect, substance abuse, and witnessing a violent crime. Including a wider definition of

traumatic experiences will increase the information available about clinicians and trauma, as well as speaking to the prevalence of trauma among social work professionals.

Mental Health Issues

An article on disability entitled *Disability, Professional Unsuitability and the Profession of Social Work: A Case Study* by Alisa M. Watkinson and Darlene Chalmers (2008) looks at how both mental and physical disability can play a role in how social workers are perceived in the profession. The article addresses the “more complex issues regarding student’s with disabilities” of a psychological nature (p. 511). Exploring how past life experience, accessibility to one’s own emotional state, ability to manage challenges that may arise, and general competence and performance must all be taken into account when addressing one’s suitability for a social work career.

Stanley, Manthorpe, and White (2007) discuss depression among social workers, as well as motivations behind coming to the profession. In their article, “Depression in the Profession: Social Workers’ Experiences and Perceptions, they write about a two-part mixed-method study where Stanley, Manthorpe and White looked at over 500 social workers (70% female, 30% male, 28-58 years old) and issues surrounding vocational choice and personal mental health issues. In the first part of the study, 500 social workers filled out and returned a questionnaire about their personal mental health and experiences with depression. In the second stage of their study, 50 social workers across the UK were randomly selected and interviewed over the telephone about their personal experiences with depression, given the chance to tell their stories. This study examines how depression is an issue for many practicing clinicians, where those with the most depressive tendencies worked, how the depression was handled by the social worker, and what the response by colleagues and

supervisors was to disclosures about depression, if applicable. The article mostly addressed depression as a result of issues in the workplace and feeling “burnt out” by the demands of the job, as opposed to individuals with a predisposition to depression before entering the field. Stanley et al. (2007) did note, “[e]xplorations of social workers’ motivations for entering the profession have found that they often include responses to prior experiences of illness, disability, or loss” (Cree 1996, p. 283). All of the participants were self-selected to participate in the study, and thus, all identified trauma and depression in their own lives. The study highlighted the need for continued exploration and study dedicated to mental health professionals coming to the field because of prior mental health or traumatic experiences, to gain a more clear understanding of the prevalence of mental health issues and trauma in the field overall.

Disclosure

As much as countertransference can be an issue for clinicians who have experienced trauma in their own lives, the issue of self-disclosure is a challenge as well. For many clinicians, the decision to self-disclose to supervisors, fellow clinicians, and clients has come up at one point or another during practice. The issue is complicated, and depends entirely on the client-clinician relationship and the necessity of making such a disclosure. Some literature has addressed this topic directly when talking about empathy and the beneficial use of self in the therapeutic encounter, skills learned and honed through a clinician’s personal life experience (Csikai, Stephen & Rosensky, 1997; Myers & Hayes, 2006; Pearlman & Saakvitne, 1995; Stanley, Manthorpe, & White, 2007).

Other points of view (Myers & Hayes, 2006; Wells, 1994) are equally as valuable, especially looking at how countertransference and self-disclosure can be problematic for

clients. In Myers & Hayes' (2006) article they write about a 1994 study conducted by Tricia L. Wells who interviewed eight participants who had been clients of a therapist who self-disclosed in session. Myers & Hayes write,

...A qualitative study conducted by Wells (1994) revealed that 7 out of 8 clients had a negative first reaction to self-revealing statements made by their therapists. The disclosures tended to contain intimate details about the therapists' lives that related to concerns presented by their clients (e.g., therapists sharing their own struggles with substance abuse, romantic relationships, and familial conflict). Clients' initial reactions included feeling "stunned," "offended," "scared," and "pissed off." Reactions to subsequent therapist disclosures depended upon the quality of the therapeutic relationship; relationship quality was directly associated with how favorably disclosures were perceived (p. 175).

As noted by Wells, "although not necessarily detrimental to the therapeutic process, therapist self-disclosure may represent the therapist's need to heal certain vulnerabilities, such as a need for identification with or separation from the client. Self disclosure may also be an attempt to gain the client's approval or validation." (p. 8)

Well's study addresses the deleterious effects of self--disclosure, as well as examining how disclosures made in specific circumstances could be seen as helpful and/or comforting. However, Well's study does not address how self-disclosure about trauma to a client who has experienced a similar trauma was perceived. General self-disclosure of a clinician to a client is vastly different than self-disclosure about a very specific and pointed topic. Well's study fails to address whether clients had initiated the sharing of information, or whether the clinicians were sharing information regardless of the clients needs or desires. Additionally, the small sample size makes it difficult to ascertain whether her findings would apply to a larger group under different therapeutic circumstances. This study will address the thought processes that have gone into how and why clinicians make the decisions that they do surrounding self-disclosure, offering a different and valuable perspective.

In a qualitative study of clinician's who had experienced sexual trauma before becoming a therapist conducted by Norris (2006), six women were asked whether they would disclose their own history of sexual assault to a client who had also been victimized. One participant in Norris' study stated,

I'd have to feel that disclosing would have some sort of therapeutic ramifications for the client...I think I really need to feel like it was for my own gain in some way and that it was gonna somehow fit into what I was working on with that person. That situation, as of yet, hasn't presented itself in my eyes (p. 22).

Another participant in Norris' study discussed her decision not to disclose to her clients by addressing boundaries in the therapeutic relationship.

It's something I haven't even questioned. To me, it's just personal...I don't think it's my right to give them a role in which they have to perceive me. It just goes against everything that I believe about personal and professional boundaries...I just don't feel like people should have to know and worry about their therapist (p. 22).

Norris' study addresses several important aspects of looking at self-disclosure in session when both therapist and client are survivors of trauma. Unfortunately, Norris' study only had six participants, and thus has limited transferability to the field as a whole, and thus the data is not generalizable to survivor clinician experiences in general.

Like many of the authors cited in this literature review, I think personal experience plays a large role in many clinicians' decision to enter the field of social work. However, most of the literature about the experiences of clinicians with a history of trauma surrounds those who have been in some way sexually victimized. Although the implications for practice of clinician's that have experienced personal sexual trauma have been addressed and discussed in literature, there is a lack of information about those clinicians whose trauma was not sexual in nature. This study explores and discusses other traumas, as well. Additionally, as Pearlman and Saakvitne (1995) note, generally those clinicians who have done the "work" of their own

healing/therapy have a much better outcome in working with client's who have experienced some form of trauma. However, there is little research on about the importance of supervision and therapy of one's own prior to practicing as a clinical social worker. Although it is encouraged in social work schools, it is not mandatory before practicing with clients of one's own. As Judith Herman (1992) writes in her book Trauma and Recovery,

Ideally, the therapists support system should include a safe, structured, and regular forum for reviewing her clinical work. This might be a supervisory relationship or a peer support group, preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to the treatment of patients with histories of trauma" (p. 151).

These issues are addressed and explored in my research filling a gap in the literature.

Trauma theory

For the purposes of this research project, research will be conducted and presented through the lens of trauma theory. Trauma theory provides a framework in which to understand trauma and its effects. By exploring how and why trauma has occurred, and how traumatic experiences can become integrated into one's understanding of the world, we can better understand how a traumatic experience can be assimilated into all aspects of a humans life, and at times identity. Several theorists have contributed to the emergence of a newer and more inclusive definition of trauma theory including Herman, Russell, Burstow, Brown and Root (Burstow, 2003, p.1293). Bonnie Burstow (2003) writes about the links between feminist theory and trauma theory, and how with the increased awareness surrounding violence to women, the term "trauma" came to define more than just what happened to men in combat, as had been the previous understanding (Herman, 1992, p. 3).

Trauma theory can be applied to a number of other theories as a supplemental framework for understanding trauma, including psychodynamic and feminist theories. By

including trauma theory in diagnostic situations, we are able to see how horrible events in people's lives, regardless of the context, can produce the same results and can have the same psychological consequences. -

Working with survivors of trauma poses different challenges for therapists than working with non-trauma survivors. As Bashram (2008) notes, issues surrounding sexuality, boundaries, power and control, repression, and disassociation are often encountered when working with survivors, and need to be negotiated in treatment. The challenges are increased when the clinician is also a survivor of trauma, when issues of countertransference and re-traumatization need to be taken into account as well.

By acknowledging the presence and effects of trauma more holistically, and through the framework of trauma theory, clinicians can understand and treat trauma more directly.

In the following chapter, methodology will be discussed and analyzed.

CHAPTER III

METHODOLOGY

How did a clinician's personal history with trauma impact their decision to pursue social work as a career, and what implications does that have for clinical work with clients? This qualitative study included interviews with 13 clinicians who have obtained an MSW degree. Individuals who expressed that their own history with trauma or loss was paramount to their decision of pursuing social work as a career were the focus of this study. This thesis will explore the many ways that countertransference might be impacted by a clinician's decision to pursue social work based on a personal history with trauma. Participants were recruited using a snowball method. In beginning to look at collecting empirical data, there are several factors to take into consideration. Sample size, data collection, and data analysis will all be explored.

Table 1*Participant Demographic Table*

Gender (n=13)	
Female	n=9 (70%)
Male	n=4 (30%)
Race (n=13)	
White/Caucasian	12 (92%)
Declined to answer	1 (8%)
Mean age of all participants	
	49
Highest level of education	
MSW	7 (54%)
Masters Degree in another area of study	6 (46%)
PhD	1 (8%)
Settings	
Hospital outpatient psychiatry/psychology	3 (23%)
Private practice	8 (61%)
College counseling	1 (8%)
School based social work	1 (8%)
Humanitarian aid/education	1 (8%)
Community mental health	1 (8%)
Multiple settings	3 (23%)
Not currently practicing as a social worker	1 (8%)
Experiences in therapy in relation to receiving MSW	
Before	2 (15%)
During	2 (15%)
After	2 (15%)
Before, during, and after	9 (69%)
Clinicians who primarily work with trauma	
Less than 50% of the time	3 (23%)
More than 50% of the time	10 (77%)

Sample

Thirteen (n=13) licensed clinical social workers were interviewed for this qualitative study using interview protocol with a flexibility to adjust to an individual's specific history and circumstances. There was a small quantitative element exploring the demographic information (including gender, age, race/ethnicity, institutions studied at, and work setting) of participants to explore more in depth clinician's individual life experience, which may add to the transferability of data to a wider pool of clinicians.

Of the thirteen LCSWs interviewed, nine (69%) identified as female, four (30%) as male. Twelve (92%) of the participants identified as white or Caucasian, and one (8%) participant declined to answer. Participants ranged in age from 35 to 66, with the average age being 49.

Several of the participants had worked in other fields prior to coming to social work. Five (38%) participants had other master's degrees besides an MSW in literature, counseling, education, and applied psychology. One (8%) participant had a PhD in literature.

Of the 13 participants, eight (62%) work in private practice. Three (23%) of the participants who work in private practice also work in other settings, including two (15%) who work in a school-based setting, and one (8%) who does humanitarian aid and education. One (8%) participant works at a community mental health non-profit, and three (23%) work in outpatient hospital settings. One (8%) participant is not currently working as a clinical social worker.

All thirteen (100%) participants identified a personal history with trauma as impacting their decision to become a social worker in some capacity. All thirteen (100%) participants engaged with a therapist of their own at some point after beginning their MSW, and ten (77%)

of the participants interviewed worked clinically with survivors of trauma.

Interviewing participants allowed me to hear in-depth experiences of practicing social workers' relationship to their own histories and their individual feelings surrounding self-disclosure and countertransference. I engaged 13 participants in an in-person or phone interview (for non-local participants) to glean information about their primary motivations (specifically related to trauma history) in pursuing social work as a vocation and how those reasons have affected their therapeutic practice.

After receiving approval from the Human Subjects Review Committee (Appendix A), recruitment for the study was obtained as the result of an online call for participants (Appendix B). Additionally, I made available an online flier (Appendix C), and all of my informed consent paperwork (Appendix D) which included my statement of purpose, the parameters of the study, an acknowledgment of the sensitive nature of some of the issues being discussed and addressed, as well as confidentiality information. I sent an e-mail to colleagues, classmates, and MSW's I know in the field, with the request that they forward it widely to people whom they believe might be interested or willing to participate. By requesting those known to me to forward the recruitment letter around, I was able to gather participants from a wider pool, without relying on my small professional circle alone which resulted in collecting a snowball sample. Individuals who were interested in participating contacted me via e-mail.

In the flier and the e-mail calling for participants (Appendix C, Appendix D), I asked for participants who met the following criteria: They are at least 18 years of age, their primary language is English, they are currently licensed social workers, and they believe that their own history with trauma or loss was part of their decision to choose social work as a profession. Inclusion criteria was re-stated in the informed consent paperwork (Appendix D), and again at

the beginning of each interview (Appendix E).

Data Collection

In the interview, I obtained demographic data including, but not limited to age, race/ethnicity, geographical location, length of time in the field, and the prevalence of trauma, defined by the DSM-IV as “exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” in the population of people being interviewed. Participants were given an informed consent (Appendix D) to sign before any data was collected, which further detailed the study, reiterated that participants will be asked about career choice in relation to a personal history with trauma, and let participants know that they may withdraw from the study at any point up until May 1st, 2012.

Data was gathered in-person for participants living local to San Francisco, California, or via telephone for participants living elsewhere. Data was collected through a series of 19 open-ended interview questions (Appendix E) pertaining to the prevalence of trauma in the participant's life, its impact on their decision to pursue social work professionally, and the implications for countertransference issues in practice. Participants were asked to address issues surrounding self-disclosure, treating clients who have experienced similar traumas, and what role clinician's see their trauma playing in the work they have chosen to do. Questions asked in the interview included, “As someone who has identified a reason for choosing social work as a career due to a personal history with trauma, how do you feel as through the trauma

impacted your decision? “Have you ever worked with a client or clients who have had similar traumatic life experiences to you?” and “Do you feel as though the shared experience made it easier to treat/relate to your client, or more difficult? Please explain.” A complete list of questions asked in the interview can be found in (Appendix E). All of the interviews lasted between 15-45 minutes.

The interviews were all recorded by hand-held device, with verbal permission of the participants prior to recording. The personal identity of all participants was protected in a number of ways. A pseudonym was assigned to discuss responses and to protect identity of all participants. I was the primary handler of all data collected. After all identifying information was removed, my research advisor had access to the data collected during the interview, including any transcripts or summaries created. I will keep the audio record, the transcripts, consent forms and other data in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will remain locked and secured if still being used or destroyed if no longer needed. Should this study be presented or published at any time, the data will be presented as a whole and when brief illustrative vignettes are used, any identifying information will be disguised and a pseudonym will be used

Data Analysis

I used content analysis to explore the interview data. First, I transcribed the interviews. Post-transcription, I coded the interviews, identifying commonalities, intersectionalities, and differences between participant responses. I discussed my findings with regard to other relevant research on the subject, as well as noting how future studies might explore this topic further.

CHAPTER IV

FINDINGS

This study explores the experience of clinical social workers who have decided to pursue social work in part due to their own experience as trauma survivors. The study explores issues of career choice, decisions to self-disclose to clients, and issues of countertransference. The sample of 13 subjects included in the study was obtained by an online call for participation via e-mail. Interviews were conducted primarily over the phone, though one was conducted in person due to the geographic proximity of the participant. Audio recordings of the interviews were transcribed by the interviewer, and then coded. Demographic information such as age, gender, and work setting was gathered, as well as information in four general areas: career choice, intersections of trauma and social work, self-disclosure, and countertransference.

Demographic Data

There were 13 (n=13) participants in this study. Nine (69%) identified as female, four (30%) as male. Twelve (92%) of the participants identified as white or Caucasian, and one (8%) participant declined to answer. Participants ranged in age from 35 to 66, with the average age being 49.

Of the 13 participants, eight (62%) work in private practice. Three (23%) of the participants who work in private practice also work in other settings, including two (15%) who work in a school-based setting, and one (8%) who does humanitarian aid and education. One (8%) participant works at a community mental health non-profit, and three (23%) work in

outpatient hospital settings. One (8%) participant is not currently working as a clinical social worker.

Clients were not asked to disclose the nature of their trauma, but several participants disclosed details of their trauma (n=10, 77%) at some point during the interview process. Trauma experiences disclosed were childhood abuse or neglect, combat trauma, witnessing a violent act as a bystander, drug and alcohol dependence of a family member or self, sexual assault, suicide or attempted suicide of a family member or friend, illness, change of physical ability later in life, domestic violence, and bullying.

Of the 13 clinicians interviewed, ten (77%) said that they worked primarily with clients who had experienced some form of trauma, and three (23%) said that their experience as clinicians had been working with a mix of trauma survivors and those who had never experienced trauma. All 13 clinicians (100%) interviewed had been in therapy at some point in their lives, either before, during, or after obtaining their MSW, or before during and after obtaining their MSW.

Initial Decision to Pursue Social Work

Participants were asked why they were initially interested in pursuing social work as a career. Several participants (n=8, 62%) related that it had been their own therapy that had somehow informed their decision. One participant, Neil, discussed how a positive therapeutic experience had made him consider social work as a career for himself, after leaving a job in publishing. All participants were given pseudonyms to protect confidentiality.

I was experiencing anxiety...and I met this therapist and we had short term therapy...she was very interesting, very engaging, very active and stimulating...I would come out of these sessions, and my head would almost kind of hurt, it's like wow, she's really working through something, I don't know what she's doing but she's kind of got into my thinking, into my thought process...I was thinking back on my experience with this counselor, and was like, "well, counseling is like literature, you

have to get into people's minds...I always liked the parts of books that are more of the exposition about what this person is actually thinking. So, I was like "why don't I apply for jobs in mental health, and I'll become a counselor?"

Another participant, Alexis shared her experience,

Well, I didn't really know that it was social work that I wanted. I wanted to be able to counsel people...I went into therapy for my own purposes and while I was working with my therapist, it became obvious that I had sort of a talent for having insight, and an openness to wanting to help other people, because part of my therapy was a lot of group work and a lot of weekend workshop type things. My therapist actually pointed out to me that I was good at this...at helping other people...and she thought I would be a good therapist, and at the time that was pretty important to me to have someone give me that kind of feedback about myself. So, I was actually already starting to counsel people, and I decided to get a degree so I could be legitimate.

Another participant, Zazie, had a similar experience.

Historically, I think I have always been a good listener. I think I have always been interested in people. I have always really been good at analyzing situations. I have always been pretty non-judgmental and more curious about, you know, what make's people tick, and their history, kind of in the same way I was pursuing a degree in comparative literature, I was curious about how people create meaning and how they formulate narratives and how things historically are interpreted. So, it was always an interest of mine.

Other participants talked about how their jobs in another field had been unsatisfying, and how social work appealed to them as a second, or alternative career. One participant, Molly, had been a college professor for several years before coming to social work.

I was teaching at a Community College and I was teaching students who were not at all interested in anything that I loved or that I had to offer them, so I felt...eventually I felt like I just needed something that was more meaningful and I had meanwhile been in therapy myself for many years and had found that very meaningful, and I decided that I wanted to be a therapist. So, I think it was a kind of a natural outgrowth.

Gabrielle shared that her experience as a trauma survivor made her prior career path no longer feel sustainable.

Part of choosing social work was that following the traumatic event, my life was so shaken up on so many levels that what I was doing before just no longer...it no longer felt like I could be doing it. In trying to think about what would be a good fit for me, and having interacted with these young social workers in these support groups, and also

having a long history of doing my own psychotherapy, I felt like it would be a good fit for me. It very much came out of a feeling like what I was doing with my life before the traumatic experience no longer fit me. I was looking for work that would be more meaningful.

Graeme, a veteran of the Iraq War discussed how social work became a viable option only after returning from active duty.

I was doing psychology at first because I wanted to be a high school guidance counselor, and after I came back from Iraq and I was going to the vet center for some counseling, and I realized that I wanted to go into working with veterans instead of high schoolers. I talked to some of the guys at the vet center, and some of the guys said, “look, the VA hires social workers, that’s the quickest way to get in,” so I was like, “ok, sign me up.”

Lance’s trauma caused him to consider changing career paths while obtaining another degree. He discussed how living with someone who committed suicide had caused him to reevaluate the direction in which he was heading.

Very early on in that program, like within the first month, the trauma occurred, and I think it kind of fueled both my time in that program, and I just recognized that I really needed to switch what I was doing. I was working in a technical field. I guess it clarified to me that I wanted to do something clearly social services, which could have been psychology, but I think it just kind of crystallized that I did want to do something that hopefully would impact...make a different in people’s lives that were in pain. So, I think that in psychology you can do that...but I wanted to have it grounded in a social systemic view rather than a more kind of, individual view.

Some participants discussed how their initial interest in social work had come from an altruistic place of “wanting to make the world a better place.” Olivia discussed how her own therapy had helped her come to that decision.

I had sessions with a woman because I had a lot of stress, trauma, and unresolved problems from the past. I did a lot of work with her, and I thought that she really motivated me to change my life in the past, so I said, “well, you know, I always wanted to change the world, so maybe I could do it on this level.”

Angela came to social work because of her social ideals.

I think it was because of my interest in justice. I wanted people to have access to assistance if they needed it, in all ways, so I did homeless outreach, I have worked with

domestic violence, I am very interested in that, so that's why social work seemed right. I wasn't sure exactly what segment of the population I wanted to serve, but I knew that that was one thing that I wanted.

Lance, who had been in school for Applied Psychology, came to social work because, "...Of my long standing interest in social change and my desire to get into clinical care for people in distress."

Sally, a survivor of childhood abuse came to social work because of her own childhood experience.

I think that as a kid I definitely wanted to help people that were less fortunate than I. I think part of that was part of my so-called religious development, but at the time that's how I saw it. I had a wish to take care of others.

Several participants (n=5, 38%) cited their experience as survivors as trauma as what brought them to the field initially. Bea, whose brother has schizophrenia, discussed her experience of collaborating with mental health professionals during a period when her brother was particularly ill, as well as her own experiences as a child, which served as her entree into the field.

My brother has schizophrenia and he became really psychotic...and I remember we were dealing with all of the stress around it and we were dealing with a lot of mental health workers and some of them were actually pretty helpful...I remember that the ones that were very straightforward with us were probably the ones that kind of made it easier to not feel so worried and concerned. There was that part of it, and the other part was that...I kind of had a difficult childhood. My father was very abusive, that's really what it was, and the thing is, when they divorced, like a lot of families, our family was...super chaotic for years and my grandparents were very unsympathetic about how sad I was. So for me, something that has really motivated me a lot was...that I wanted some sympathy from adults. I remember being like, if I could have just one person be like "I feel so sorry for you, you now, it must be really tough for you," it would have been really helpful. There's some part of me that wants to provide that to kids in a way, so that's a motivator in a way.

Gabrielle, a cancer survivor discussed how finding meaning in the work she chose to do was central to her decision to pursue social work as a career.

After my traumatic experience (of being diagnosed with cancer at age 28), I was exposed to a few young social workers from some support groups that I was a part of following the traumatic experience, and I think that partially from meeting those young social workers, I began to imagine myself in that role, especially as it pertained to potentially working with clients who had experienced trauma...So, when thinking about the kind of work that I wanted to do, part of what I realized was that I wanted to do work that was meaningful every day, and that I wanted work that would be very satisfying, so much so that if I were to die young, I would have felt that I would have had a satisfying career, because I really didn't know if I was going to have a long life when I got involved with social work.

Personal Trauma as it Has Impacted Clinical Work

Many clinicians found that their trauma played a role in their decision to become a clinical social worker in some way, whether through their own therapy, or in their reflection in the aftermath of the trauma. Participants were asked how specifically their trauma had played a role in their decision to pursue social work.

Lance discussed how his trauma helped him become more attuned with his clients, "I don't know how good of a witness I am to my life. It (the trauma) really opened up myself more to an awareness of people's pain."

Molly discussed the presence of trauma in her life as it informed her career choice.

I think the presence of trauma in my life is much more intergenerational. A lot of it came through my mother, my father, and my grandparents and there was a very strong sense of their trauma being transposed onto me. So that it created a situation where I felt highly traumatized, and yet it was very hard to put a finger on what happened, which I think is often the case...in effect it's a form of attachment trauma...it's often the case, I think, that people can't say exactly what it is. I was very, very preoccupied from the beginning of my training with wanting to work with childhood abuse and trauma. I just knew that I wanted to do it. I see now that obviously I identified with that and I continue to identify with it.

Sally, another survivor of childhood trauma relayed how her experience of helping her alcoholic mother inspired her to help others in need.

I was a helper in the family and there was a lot of dysfunction. There was quite a lot of trauma. It was chronic trauma that I can't point to any one thing but there was constantly...my mother's illness, or my father's womanizing, or there are always these disruptions in my family. I think of it as traumatizing because I had to so focus on my environment to survive that I really lost a sense of myself. I think part of it was my role trying to help my mother. She was an alcoholic...she was a so-called sick alcoholic...I really think that I, very early on...I was aware of her, the power differential between my parents and...I felt like I was her champion, and so that's where I think I got the idea of being a champion for people. I think the whole idea of helping people less fortunate than I, is really about helping myself. Of course I didn't see that then, or helping my mother, that was kind of the extension, or helping my sisters and brothers. It was a ministry to people to take care of others, to protect them, to keep them safe.

Angela, another survivor of early childhood abuse, saw her own inability to find support as an adolescent as an opportunity to help others.

My trauma was early childhood abuse, and I started having trouble (in college) and I sought help and I had a very hard time getting help...in my 20's, I ended up in drug and alcohol rehab because my PTSD...I was medicating it with drugs and alcohol, and when I got done with rehab I still needed help and I didn't feel like I was getting the treatment that I needed. Then I decided when I was in the rehab, which was not something that people encourage, was that I was going to go to school and get educated about trauma for myself, but also that when I was done healing that I would make sure that other people wouldn't end up in the same boat...that they'd be able to access treatment if they wanted it, so that's when the idea blossomed... For me, I needed focus. Part of getting better for me was to have a goal and to educate myself. No one in my family had gotten out of high school, so school seemed like a goal and something that I was interested in, and I pushed myself through graduate school. When I got hung up and couldn't get help because of financial reasons and the help just wasn't available, I thought, "well, I am going to see about getting help and educate myself, and I am also going to help some people, too."

Olivia stated that her own trauma led her to wanting to work with people similar to herself.

The trauma that I experienced in my life, which was/is violence against women, abusive household, alcoholism, and then further on down the road, I experienced trauma with failed relationships, I think they led me towards working with a population that could relate to things that I experienced.

As a survivor of trauma, Jesse saw the lack of professionals working with trauma as a chance to become more involved himself, as well as looking at how his own experience has been a benefit in the therapeutic encounter.

It (traumatic experience) certainly taught me empathy...I think through my own experience I started to realize that the need for professionals out there who really understood the deep impact of trauma outweighed the amount of people out there who were actually practicing in that mode. I felt not just a moral obligation, but also a professional obligation to pursue it. With the shared experience, you have a deeper understanding of what the person on the other side of the couch is going through.

Bettina discussed how her own experience with trauma and her healing around those experiences has impacted her practice with other survivors of trauma.

I think that if you go through trauma and do all the work and have a good recovery from trauma, and a solid base in that recovery, that when you are working with people who are traumatized, you never sometimes even have to disclose, but on some level, they know that you get it. I think that most trauma therapists, my guess, and in knowing many trauma therapists that are my buddies, that a trauma history is pretty common. I actually don't know any trauma therapist who doesn't have a history with trauma.

In reflecting on her own experience, Bea sees her trauma as a way to understand better how and why people do the things that they do. Bea has managed to use her experience as both a trauma survivor and a therapist to find healing and establish meaning in her own life and in the lives of others.

I think initially there was a desire to deal with my own issues indirectly, because I wasn't able to deal with them. I don't know if that is necessarily a good reason to do it, but it was what it was. I think too, the idea of sublimation, it does help emotionally in terms of making sense of my own life, and so I feel like I can do that for other people and that it can be different. It also helps me re-visit my own childhood in a way. As an adult, you have so much more of an objective view about why people do what they do, even if it's really bad, so in a way, you are not stuck in this childhood mind where everything seems really scary, and overwhelming, and you don't know why things are happening and you take everything really personally. When you're an adult and you look at someone else's situation, I have a lot of sympathy, but I also see the aggressors who are their own tragic figures.

Graeme has taken his own questions as a trauma survivor and brought them into the work he does with others.

I feel that the reason I went to do this line of work is to find answers. I wanted to see how people deal with this stuff, how they get by day-to-day and how they keep going day-to-day. A lot of it is because of my own questions about how I make it day-to-day.

Gabrielle discussed how her diagnosis of cancer at the age of 28, and the subsequent upheaval of her life led her to social work. Gabrielle discussed how one of her reasons for pursuing social work was the accessibility of obtaining the degree.

The way the diagnosis interrupted my life and what I was doing made it very difficult to go back to what I was doing. I had to move to a different country to get the cancer treatment. I spent a year, a little less than a year, having the medical treatment, and then at that point my life was so turned upside down without that being something that I chose, that all of a sudden I was left to figure out what I was going to do with myself...It led me to think about how useful the support groups had been to me while I was getting my cancer treatment...When I was back in the United States following my cancer treatment, I was a little bit unsure of what I was going to do, and a friend of mine told me that her master of social work program was only 18 months long, and I realized that in my mind that was a very short time in which I could get a masters degree. I thought to myself, well, I might as well get a masters degree while I am figuring this out, and I think that was related to the trauma, because of the trauma I was so...everything was so up in the air and my life up until that point as I planned it was no longer feasible, it no longer felt right, so I was really open to kind of, figuring out how my life was going to come together in a new way. I wouldn't be able to commit to a three or four year program in another field. It felt really accessible, and that is a really interesting thing to consider for a trauma survivor who doesn't know which way is up, having something be accessible is also pretty attractive.

Working With Clients Who Have Had Similar Traumas and Disclosure

Of the 13 clinicians interviews, ten (77%) said that they had worked with clients who had had similar traumatic life experiences, while three (23%) said that they had never worked with a client/s who had had similar experiences. Of the 13 clinicians interviewed, four (31%) said that they had disclosed this similarity to their client at some point during treatment. Six (46%) said that they didn't or wouldn't make a disclosure during treatment. Two (15%) participants said that it was wholly depended on the particular situation, with clinicians who

had and had not disclosed often saying that the specifics of the situation were paramount to the decision of disclosure, regardless of their decision. Two (15%) clinicians discussed unavoidable disclosures; disclosures about them or their trauma that are made regardless of whether the clinician discloses directly.

Participants who did disclose some fact about their shared trauma with a client stated several reasons for coming to that decision. Graeme reflected on how his own experiences as a trauma survivor informed his decision to disclose to clients.

To have a one-sided treatment is really difficult for the client. You know, they really respond well to see that they have a human being on the other side of this. I find that this work is intense, emotionally draining, and also very interesting. The decision to disclose my personal experiences is not made in a vacuum, but comes from an in the moment assessment of what feels appropriate. This is based on many factors, but one major one is my own personal comfort with disclosure. As I mentioned, previously, a part of the modeling in therapy involves displaying the human reaction of the therapist while establishing that anxiety or other uncomfortable affective reactions can be experienced and handled. A large part of that process is allowing myself to "go there" with the client when we feel that it is the appropriate time. Some things that I must constantly be aware of are any co-transferential processes that are in play, my affective read of what my client is experiencing, and my own personal motives for disclosure at that particular time.

Olivia has disclosed in an attempt to normalize the situation for her client.

If you have an experience that is similar to this client, they think that they are the only ones that experience it and you say, "look, you know, I've experienced this, and it has had certain effects on my life as well, which is why we are working towards this goal."

Jesse also uses self-disclosure to connect with clients.

I use self-disclosure sparingly, but when it is appropriate, it's a great opportunity to gain an empathetic connection, but also to normalize their experience as well. It's a case-by-case, actually I would say it's a moment-by-moment decision. Typically what I am looking for is whether or not that disclosure is going to positively impact the client's experience. When I see people in a shame spiral because they are blaming themselves, when I see people in shock because how could something like this happen to them, when I see people very often coming to terms with their role in the traumatic experience, and again you see that self-blame start to rise up. Also, when I see the profound sense of isolation that comes from being a trauma survivor, I've found it to be very, very helpful that they know that they are not the only person in the room, right

then and there, who has experienced something like that. It's always in the interest of the client that I am looking for when I use self-disclosure. I think a lot of time people with trauma histories can fall into the trap of using their profession for their own treatment, and just disclosing to gain some kind of group therapy moment in that process, and that really isn't appropriate at all, but when it's in the service of the client, when it's to get them to another level of understanding, another level of insight, to break down some of the stigmas, to break down some of the inappropriate responses to trauma, then self-disclosure can be really, really wonderful.

Other clinicians have not disclosed to clients about their trauma. Angela felt that disclosing her shared trauma would not benefit her client, based on her own feelings about the client-therapist relationship.

I wanted my client to have her own experience. I didn't think it would have been helpful. I think people know whether I tell them or not that I can understand their pain, but I think it could also be not valuable to them. Everybody's experience is different and I didn't want them to feel that they had to take care of me, because I was talking about something that happened to me, or that I was saying that because I had been through this that I knew how they felt, because I don't think that is true. So, I choose not to disclose. There have been times when clients have asked me have I had bad things happen, similar things, and when people ask me directly, I say yes but I don't provide a lot of detail, and my client's don't seem to want it. I don't need to be the same to be effective. I also do addiction work, and I learned the hard way that self-disclosure in the addiction field is really popular, and I have also felt that it wasn't really helpful. Early in my career I disclosed my history with addiction to a client and she really helped me understand how unhelpful it really was. She was a heroin addict who was homeless and had HIV, I had gone to college. I looked a lot better, in terms of what she knew about my background, my situation was a lot different. What did my addiction have in common with hers? I think she was right. She helped me not to disclose about my addiction history or about my trauma history, so I don't, unless directly asked. If someone asks me something directly, I will tell them, but I don't want to get distracted from their treatment. Surprisingly, people don't. Or not surprisingly. When I go to therapy, I don't want to know about my therapist. I want to talk about me! I want to know that they can understand me and are compassionate, but I can see that without them telling me about their background.

Bea has not used self-disclosure, despite working with several clients who have had similar trauma histories to her own. Bea felt that she had worked through some of her own feelings and issues around her trauma history, that sharing those parts of herself in session felt

unnecessary. When asked to expound upon the reasons that she does not disclose to her clients, Bea shared the following.

I think the biggest thing is that it would not have served them any purpose. I think it would have served me a purpose. I think it would have made me feel like I really understood them, I really identified with them. I don't think it really helps them...A lot of times people, I find that clients, if you really care about them, and you show that you care and you are really sincere and you are emotionally present, I think they realize that you understand what they are going through. I don't think they need the facts to know that you have a trauma history. I guess that's my thing, that it wouldn't have served a purpose for them, that it would have served a purpose for me...I think I've settled a lot of issues around my own history, I feel less likely to want to talk about it. I mean in general, not just as far as being a clinician...even with my friends and family, we don't talk about it as often because I think I feel like I've worked through it.

Similarly, Bettina felt that her clients could sense her understanding of their pain, without the direct knowledge of her own trauma.

There are things that I will disclose, like if I am working with kids who are traumatized by adoption, I will say that I am adopted, and I think that kind of serves as good role modeling, but as far as physical or sexual abuse, not only have I not disclosed it, but I have almost found that I have never really needed to. I think when you do the work, and if you do it well, and you are compassionate enough and you're sensitive enough to be able to reflect back some of the things that they are feeling, and to acknowledge it, I've always found that client's almost get a sense of it, but they themselves don't want to ask, because they don't want to know right now, because they are focused on their own recovery. So, you almost don't need to.

Molly will disclose certain things about herself to clients, but never about her trauma history.

I would never disclose to a client that I had had a seriously traumatic experience. I do self disclose some things to some clients, but it's very selective and it is very titrated. I can't imagine a situation where it would be useful. If someone asks me a questions like "do you have children?" or "are you married?" or "are you gay or straight?" in the first session, that is a kind of demographic question, I will answer it. I would not necessarily answer once treatment was well in place, I would then explore with them why they wanted to know that. I do a lot of what could be viewed as...normalizing certain levels of trauma, like saying that it is something shared by many people, and I will sometimes intentionally use a "we" so that they don't feel so much that they are in an unequal position...so they don't feel like I am in a position of authority and that I am the healthy one...I think that for a patient to know that a therapist has had very severe trauma is problematic and it is very hard to predict what it will mean to them, and if I

can't predict it, and it could have a very negative effect, I would probably protect them from that to the extent that I am very aware...I put almost nothing on the internet...I censor the information that is available to people, and that limits my life in a lot of ways because I want to preserve a space for them that is shaped by what they need.

For some clinicians, disclosures are unavoidable. In the cases of Zazie and Neil, information about them is easily found or seen by clients, regardless of their intention to share it. For Neil, his traumatic experience was written about publically.

One thing about me is that you can Google my name and it will come up on Wikipedia. It discusses the story of the trauma, it was a news story...clients have come in and talked about "oh, I didn't know that this happened to you," and they acknowledge that they have looked me up and read this story about me.

Generally, Neil does not disclose for these reasons,

The reason I don't disclose is that for one, very rarely is their experience that similar to mine...I witnessed a shooting and someone dying. So, there have been a couple teenagers I have worked with who have witnessed shootings and have been around guns, but at this point I just don't see it as my task to share that, even with those couple teenagers who maybe witnessed a shooting. For other clients, it's easy to say our traumas were of a different variety. Even if they were of the same variety, or a very similar experience, I quite don't know how it would be clinically useful to share that with a client. In general, I am not totally against self-disclosure. I'll disclose things about myself like, I have a cat or I'm married. I'll occasionally tell a story about something I am, but it's usually not very personal, and it's always to sort of...either to develop the relationship with the client, or it could be small talk, or I'll disclose my reaction or opinion to something. I don't really talk about my history.

For Zazie, self-disclosure is only partially her decision. A physical disability has made it impossible for her clients not to know certain things about her, regardless of whether she might share these things with her client otherwise.

So, I have a trauma that is more obvious, and that is that I have a physical disability. So, that is a more obvious, unavoidable self-disclosure. I think because that already evokes so many different transference/countertransference issues, and there is a way that...on the one-hand it has been useful to use that, it's been an asset for the most part, I think there would be other ways that it would be difficult to disclose other aspects of my personal trauma because you don't want to make a tipping point where somehow the focus becomes what I've been through...

Because there is already going to be a lot of transference around it, it seems like a safer way to help people through more disclosure when it seems appropriate. If they ask me

questions or, without even making direct reference to it, talking about how we all have our own learning opportunities, and if they ask me about my disability I will elaborate a little bit more, but I do it judiciously.

In making the decision to disclose to clients about a shared trauma history, nine (69%) clinicians had spoken with a supervisor or therapist of their own about the decision. One clinician had never discussed her decision with a supervisor or therapist, and two clinicians either did not disclose, or declined to answer the question. For Molly, supervision played a role in how she handles disclosures in their own practice. Supervision has provided her a space to process and reflect upon her process.

I am still in supervision. I will never be in practice without being in supervision. It has nothing to do with the level of my skills and training. It's a question of managing the stress of the work and I also am a person who knows what I am thinking and feeling best by talking with someone else, so I find it critical. I am always talking about boundaries and I am always talking about what I have disclosed and why I have disclosed it, what I haven't disclosed, why I haven't disclosed it...it's always part of my consciousness...I am conscious of it every minute that I am in session with a patient. I am conscious of things that I wouldn't say slipped out, but things that I have permitted, on a sort of unconscious level to come out, and I think "ok, so why was that? Why did I choose to disclose that?" I am constantly processing that.

Seven (54%) of the participants felt as though having a shared trauma history made treating certain clients easier. Five (38%) participants felt as though it did not make treatment easier or more difficult, and one clinician did not answer the question. For Zazie, having a shared experience of trauma has helped her to understand clients.

I think it definitely makes it easier to relate to my clients, whether I disclose or not, I think I have a real understanding about how things happen. There are so many vectors in life, and some of them are sociocultural, and some of them are physical and some of them are situational and familial, and I think it has enriched my capacity to relate to people.

For Graeme, sharing an understanding of how a trauma history can affect someone has helped him connect to clients.

With specificity to trauma clients, I find myself able to identify with them because I understand the experiential quality of many of the symptoms. I do not believe that trauma has made me experience symptoms that other people do not experience because I believe that all people have experienced some form of trauma (little 't' trauma versus big 'T' trauma), and therefore have some experiential access to things such as hypervigilance, intrusive thoughts, and irritability... I believe that what makes me able to use my traumatic history to be able to connect with trauma clients is my awareness and acceptance of these symptoms and the subsequent understanding of the thought process of feeling unsafe.

For Gabrielle, her trauma marked a shift in her life that she has recognized when working with other survivors of trauma. She has been able to use that experience to relate to clients in practice.

I think that as probably any trauma survivor knows, there is sort of a before and after trauma experience, and in my case at least, there was my life before the trauma and after the trauma and they, and in some ways they are very distinct mindsets. Once you have experience the traumatic event, there is no way to go back to the way you saw the world before. I think that that is the biggest factor that I have this distinct knowledge that life is never again the same following the traumatic experience. I think I would have been a good therapist had I not had that, but I do feel like it informs my work a lot. Sometimes someone comes to see you, and they feel like no one in their lives understands just how different everything is due to the trauma, and I feel like I do understand how different their life is and I understand that nothing will ever be the same, or has been the same since the trauma experience. I think in offering that to my clients, they often feel like no one has understood that, and that they themselves haven't necessarily understood that, and then I think it's helpful for them to realize that that makes sense and that that is even, you know, a common experience given the trauma. So, I think that is one way that that informs the work.

For Bea, there is a belief that a shared history of childhood abuse has helped her be more empathic in her work.

I think initially it might have made it a little more difficult, but I think at this point, it's made it a lot easier. I will say that I think there are things that I get about what it's like to grow up in an abusive household that people who never experienced that wouldn't. I think that I understand that. I think it makes me more sympathetic towards people, especially kids, who are acting out...you know, how bad it can be, and why they kind of do all of these things, even adults, why they do these things that seem really hard to understand, and why they seem so dysregulated...I think that because I have felt those things at times in my life, I can be more sympathetic towards it because it seems a lot more understandable.

For other clinicians, the shared experience of trauma has not made it easier or more difficult to treat or relate to clients. Angela feels as though experiencing trauma of her own has been a neutral factor in her treatment of others, though her experience has in some ways, informed her outlook on treatment.

I think it's probably a neutral thing. There are some things that I *think* I know because of my own history, I'm not positive... One thing I do know, one thing that has helped a lot, is that I know you can get better, that has helped me. I don't have the symptoms of PTSD anymore, I have a very good life, and it didn't look like that when I was growing up, no one could have predicted that. So, when my client's ask if they can get better, I always say, with deep assurance inside of me, that yes, you can, you can get better...you know, you're coming every week, we are working on things...I think this is something that you can recover from. So, that is true, one of the side effects from growing up with a crappy childhood.

Neil feels as though his experience of trauma illuminated that people can have many different reactions to and about their trauma, something that has increased his awareness about aligning himself in the therapeutic encounter.

I think there is one important aspects of why I can understand trauma a little bit better...because if you experience a trauma, everyone in your life has preconceived expectations about your experience of it, and they make presumptions about how you should feel about something and that was often not the same as how you actually feel about something, and that can be confusing especially to young people because everyone around you is assuming that because you experience this, you must be feeling this and so, that's sort of an experience that kind of falsifies, or mystifies, the experience of the actual trauma...Being 16 years old, everyone is making assumptions about how I was coping with the trauma...I try to be very unassuming with my own clients. I try not to over-empathize. Since I'm into mentalization (a specific type of psychodynamically oriented therapy generally used to treat patients with Borderline Personality Disorder) I am into the idea of mismatching emotions a little bit. I am not trying to feel what my client's are feeling, but appreciate letting my clients feel what they are feeling. Help them feel like I appreciate it, but that I don't quite get it, and that I am curious about it and want to know more.

For Jesse, keeping boundaries around the disclosure of his own trauma has been an important thing to remember and focus on in treatment with clients.

I think it's easier when the person's own history of trauma is not directly similar, directly connected to my own, because I can maintain that professional distance from it. When I have a situation where I have a teenage coming in who has been bullied at school or has been assaulted or something like that, something that is very close to my own history, maintaining that professional boundary gets harder. In that situation, it's interesting because with the teenagers, the self-disclosure seems to be the most effective because their the ones who feel the most isolated in it, and in those situations it's very, very difficult to maintain that professional boundary, but again, the way I do it is to maintain the focus on what is best for the client and keep my own personal desire to heal for my own time.

In the following chapter, these findings will be discussed at length and themes will be noted and addressed.

CHAPTER V

DISCUSSION

This study set out to explore the perceived relationship between MSW's who have a personal history with trauma, and how that trauma impacted their decision to go into the field of social work, as well as the implications it has for clinical work with traumatized clients. The study focused on several facets of the clinician's personal experience such as how personal trauma impacted work with clients, how countertransference and self-disclosure were negotiated in session, and the benefits or limitations of working with particular populations. The study's purpose was to further explore the perceived relationship between personal trauma and social work, as there is still limited research on the topic, as well as to begin to dismantle the stigma and decrease the invisibility surrounding the prevalence of clinician's who have trauma histories of their own.

Demographics

The demographic sample of the participants in the study was interesting and worth noting. In a profession dominated by women, four (31%) of the individuals who responded to the call for participants identified themselves as male. This raises the question for future research of whether men who have experienced trauma are more likely to pursue social work as a career than men who have not experienced trauma.

Participants were between 35 and 61 years old, providing feedback and insight from several different stages of life and a social workers career. Additionally, participants came from multiple states around the country, further diversifying the pool of participants, and

resulting in a good cross-section of experiences from people in different geographical areas across the United States.

Career Choice

The findings of this study primarily confirmed findings from prior studies on similar subject matter (Csikai, Stephen, & Rozensky, 1997; Hayes, 2002; Pearlman & Saakvitne, 1995; Stone, 2008). Of the thirteen participants, only four (31%) cited the actual experience of the trauma as part of their initial reason for pursuing social work, noting that the trauma in some way gave perspective to the fact that certain work seemed more viable, valuable, sustainable, or worthwhile after the trauma.

Six (46%) participants said that working with a therapist (on issues surrounding their trauma or other issues) and seeing growth through that process was what prompted them to consider social work as a vocation. Similar to the ideas presented by Pearlman and Saakvitne (1995), three (31%) participants said their trauma was not necessarily part of their decision to become a clinician, or that they had been drawn to social work prior to their own trauma taking place, but that the trauma somehow played a role in how they imagined themselves in the field due to their perceptiveness, or ability to persevere or have perspective through difficult situations. Two (15%) participants mentioned feeling like they had come to the field initially with a desire to work through their own issues, so didn't cite the trauma as a direct reason, but that the link was present unconsciously which was discussed in articles by Stone (2008) and Hayes (2002).

Without looking into the personality types of the participants, it is hard to subscribe to Holland's (1966, 1973, 1985) theory that people choose careers "based on their personality type." Exploring further the values, ideologies, and beliefs of the participants might yield more

concrete results about how the trauma did or did not impact the decision to work with populations where trauma is present. However, considering the work that Pearlman and Saakvitne (1995) have done around investigating why certain people are well-suited to the field after experiencing trauma, we can draw connections about how experiencing trauma might make someone more able to empathize with another person who has also experienced trauma. Pearlman and Saakvitne (1995) explore why some trauma survivors become especially good clinicians due to their sensitivity, attunement, and ability to empathize, and that was surely found in how participants saw their ability to connect to clients of their own.

Countertransference

The study supported findings from other studies (Hayes, 2002; Heath, 1991; Stone, 2008), surrounding issues of countertransference in practice. Of the thirteen clinicians surveyed, every single one discussed how their trauma impacted their work with clients in some way, for the most part as a beneficial part of the therapeutic relationship.

All thirteen clients had engaged with a therapist at some point before or during obtaining their MSW, ostensibly to work through issues surrounding their own trauma, as well as other life issues. Most of the clinicians interviewed were either in therapy of their own during their practice as professional social workers, or saw a supervisor regularly. Herman (1992) and Heath (1991) mention the importance of supervision and/or therapy for clinicians to discuss issues surrounding countertransference with clients, to see how “one’s own personality reacts and interacts” in session with clients (Heath, p. 52).

Being able to “work through one’s own issues,” whatever that means for the individual clinician, seemed to be an integral part in working with clients of one’s own, and was mentioned by several of the clinicians interviewed.

Contrary to the study conducted by Nelson-Gardell and Harris (2003), only one (8%) of the thirteen participants in the study discussed having a heightened risk for re-traumatization or secondary traumatic stress due to working with traumatized clients. On the contrary, of all the clinicians surveyed, most said that their own trauma helped them to be “more empathetic, present, and understanding,” while acknowledging the importance of being cognizant of how the role as trauma survivor is present in the therapeutic encounter. Awareness of the issue seemed to be how clinicians could “keep things in check” during session with their own clients. In other words, most therapists did not see their trauma as a hindrance to working with clients who were also trauma survivors, but as something that helped them have a wider range of understanding and empathy, not only with traumatized clients, but also more generally. For a few participants who did think that their trauma history had proven to be difficult in their role as clinicians with certain clients, supervision was cited as an important part of managing the difficulty.

Self-Disclosure

Participant responses varied from disclosing when it seemed clinically appropriate to never disclosing about a shared trauma history. The main theme that emerged from all participants is that clinicians disclose sparingly, and only when it was in the best interest of the client and clinically appropriate. However, making the decision when something is going to be clinically appropriate, or when it might “feel right” is subjective, and no firm conclusions can be drawn about whether or not disclosure is indeed clinically appropriate, especially if the clinician is not discussing the decision with a supervisor or therapist of their own.

Of the clinicians who worked with clients who had a shared trauma history, five (38%) said that they had made a connection with the client about having also experienced trauma,

either explicitly (in two cases), or in a more vague way (“I know what it’s like to feel that way...”). For the clinicians that disclosed about a shared trauma history, disclosure was generally used to normalize the clients experience and gain an empathic connection.

Five (38%) clinicians said that they would disclose about certain parts of their lives, but that they had never disclosed the presence of trauma in their own lives to a client, which, given Well’s (1994) findings, is aligned with the notion that it is in the best interest of the client to not-disclose about certain things. Two (15%) participants were in the position of having their trauma history be either apparent (in the case of the clinician with the physical disability), or public knowledge (in the case of having the trauma history be linked to a news story readily found on the Internet). For one of these clinicians, she talked about using this disclosure as an opportunity to explore issues of transference with the client, but that she was wary of making other self-disclosures in an attempt not to overwhelm her clients with information that might make them feel in some way responsible for her well being. The other clinician said that he had had clients come into session after reading the news story online and say “I didn’t know that this happened to you,” and that he would discuss his trauma in that context, but that it also became an opportunity to discuss what it meant for the client to have that information about their therapist, and how it might effect or impact treatment. These findings are similar to the findings of Norris’(2006) study where participants felt as though disclosing about their own trauma history to clients might be perceived as “unprofessional” or “burdensome” to clients.

Several participants of this study cited the importance of being in therapy or supervision to help balance and manage issues in practice, including making the decision to self-disclose. The inclusion of a supervisory or therapeutic relationship when working with traumatized clients has been noted in the writings of Heath (1991) and Herman (1992).

Implications for Practice, Research, and Social Work Education

There are several areas where further study could be useful and beneficial for the population of social workers who have experienced trauma, as well as for the profession as a whole. In looking at how clinicians with trauma histories work with clients who also have trauma histories, it is important to investigate the threat and prevalence of potential re-traumatization, and how it can best be managed as to not interfere with the therapeutic alliance.

Additionally, looking at who comes to social work as a career more generally (people with trauma histories and people without trauma histories), will inform how trauma actually plays a part in the decision to do this work, as well as looking at the prevalence of trauma more generally within the population of those in the profession.

Due to the fact that 12 of the 13 participants (92%) identified as white or Caucasian, it would be important in future studies to gather a more diverse sample of clinicians throughout the field of social work.

Exploring more deeply gender differences and how gender may play a role for survivors of trauma who come to social work would be a worthwhile area for research. Additionally, the investigation of personality style when making generalizations about who comes to social work as a career might provide more clear categorizations when looking at the type of people who gravitate towards social work as a career.

Because the decision to self-disclose is a personal one and often made in session with client, it is difficult to ascertain whether it was indeed “in the best interest of the client” or “clinically appropriate.” Further study may be helpful in addressing client’s responses to clinicians who have disclosed elements of their personal trauma to clients, as well as looking at how and why the clinician feel as though the time was right in session. Being able to compare

responses from both clinicians and client will result in a greater understanding of the impact that self-disclosure can have on the therapeutic relationship.

Finally, including coursework about clinicians' personal experience with trauma in social work training programs would illuminate the prevalence of trauma history in individuals who come to social work as a career, decreasing stigma and the invisibility of those clinicians who have a personal trauma history before going into the field.

Encouraging social work students to engage in therapy of their own before graduating and practicing with clients would increase the likelihood that individuals explore their own feelings and narratives about the role that trauma has played in their lives, potentially decreasing negative or harmful countertransference and re-traumatization.

For clinicians who have trauma histories, being aware of the benefits and risks associated with working with traumatized clients in practice may impact how certain treatment plans are implemented. Increased understanding, empathy, and compassion may all be present for clinicians working with clients who have experienced similar traumas. However, acknowledging the potential risks for trauma survivor therapists in practice may increase the use of and necessity of supervision for clinicians in practice, thus improving the quality and level of care for both the client and clinician.

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Appendix A

Human Subject Committee Approval Letter



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

March 1, 2012

Mira Elwell

Dear Mira,

You did an exceptional job of making everything clearer for us. Your project is now officially 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.

Good luck with your project!

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee
CC: Pearl Soloff, Research Advisor

Appendix B

Recruitment Letter

Dear Friends and Colleagues,

I am writing to let you know about research I am doing as part of my Masters thesis for the Smith College School for Social Work. I am conducting interviews with licensed social work professionals to explore how one's personal experiences with trauma had an impact on their decision to go into the field of social work. Additionally, I am looking at how countertransference is experienced in working with client's who are also survivors of trauma, and how decisions surrounding self-disclosure are negotiated and influenced in a clinical setting as a result of a clinician's trauma history. I am looking for participants who meet the following criteria:

- are at least 18 years old
- are a licensed social work professional (LSW/LCSW)
- use English as their primary language
- identify a personal trauma history as a reason for pursuing a social work career

If you or anyone you know would be eligible and willing to participate, I would be so appreciative. The interview will last approximately an hour, and can be conducted in-person in San Francisco, CA, or over the phone.

I have included a message below that can be sent to friends, family, colleagues, or anyone else who you think might have an interest in this project.

I would be more than happy to discuss the project further and can be reached by e-mail at mlelwel@smith.edu or by phone at (---) --- - ----.

Thank you so much for your time and help!

Mira Levi Elwell
MSW Candidate, Smith College School for Social Work

Appendix C

Recruitment Flyer

CALLING MSW GRADUATE STUDENTS AND MSW CLINICIANS TO PARTICIPATE IN A RESEARCH STUDY

-Are you at least 18 years of age?

-Is English your primary language?

-Do you have a personal history with trauma that you believe impacted your decision to pursue social work as a career?

If you meet the above criteria, you may be able to participate in a study designed to look at the prevalence of trauma in social work professionals.

To participate, please call Mira Levi Elwell at (---) --- - ---- or e-mail mlelwel@smith.edu.



Appendix D

Letter of Informed Consent

Dear Research Participant,

My name is Mira Levi Elwell and I am a graduate student at Smith College School for Social Work. I am conducting a research project about professional social workers and trauma. This study will explore how personal trauma impacts one's decision to pursue social work as a career, as well as how countertransference can be influenced in a clinical setting as a result of trauma history. I am conducting this research for my MSW thesis, for professional presentation, and for possible future publication.

You have been asked to participate in this study because you are a licensed social worker who has indicated that trauma in your own life influenced your choice to go into social work as a career. As a participant in this study, you will be asked 10-15 open and closed-ended interview questions, as well as some basic demographic information such as your age, race, ethnicity, and gender. Participation is completely voluntary, and any identifying information gathered in the data collected will be changed to protect your confidentiality.

My research will be gathered through exploratory interviews using open and closed-ended questions with participants who are willing to share in-depth aspects of their experience surrounding trauma and career choice with me, as well as the impact on participant's clinical practice with clients, including how countertransference and self-disclosure are dealt with.

The interview will last approximately an hour. I will personally conduct the interview and I may take a few notes during the interview process. I will audio record the interview, transcribing your responses at a later point. In order to conduct the interview, we will either agree on a location in the San Francisco area that is both convenient to you and somewhat private, or set up a time to have a phone conversation if in-person contact is impossible.

There will be no monetary compensation for participating in this study, but you will be helping to understand why social workers with their own personal experiences with trauma, have chosen to work in this field. Your contributions will provide important information that may be helpful in educating current and future mental health professionals about the commonalities (or differences) of clinicians in the field, and how that may impact issues in practice. Additionally, you will have the chance to share your personal experiences about your career choice, which may be rewarding and enlightening.

Your identity will be protected in a number of ways. A pseudonym will be assigned to illustrate and discuss your responses in the interview. I will be the primary handler of all data collected. After all identifying information has been removed, my research advisor will have access to the data collected during the interview, including any transcripts or summaries created and may assist in the analysis of the data. Any person assisting in transcription will be required to sign a confidentiality agreement. I will keep the audio record, the transcripts,

consent forms and other data separately in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will remain locked and secured if still being used or destroyed if no longer needed.

Should this study be presented or published at any time, the data will be presented as a whole and when brief illustrative vignettes are used, any identifying information, such as schools attended or agencies worked for, will be disguised and a pseudonym will be used

This study is completely voluntary. You are free to refuse to answer specific questions and/or to withdraw from this study up until April 1, 2012. After that time, the interview will be integrated into the written report. If you decide to withdraw, all recordings and data describing you and your experiences will immediately be destroyed.

If you have any questions or would like to withdraw from the study, please contact Mira Levi Elwell at (---) --- - ---- or by e-mail at mlelwel@smith.edu. Please keep a copy of this consent form for your records. If you have any concerns about your rights or any aspect of the study, you may contact me, or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND 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 THE STUDY.

Signature of Participant

Date

Signature of Researcher

Date

Thank you for your participation in this study. Please keep a copy of this consent form for your files. If you should need to contact me for any reason, I can be reached by phone at (---) --- - ---- or by e-mail at mlelwel@smith.edu.

Appendix E

Thesis Interview Questions

Screening Questions to be asked via-e-mail or in the initial phone call before the interview is scheduled, in an attempt to guarantee participants are licensed clinical social workers, are at least 18 years old, speak and understand English fluently, and identify personal trauma as a reason for pursuing social work as a career.

1. Are you a licensed clinical social worker (LCSW)?
2. Are you at least 18 years of age?
3. Do you speak and understand English?
4. Do you have a trauma history?
5. If yes, do you feel as though it impacted your decision to pursue social work as a career?

Interview Questions

Demographic Information

1. What is your gender?
Male/Female/Trans/Gender Queer/Prefer not to answer.
2. What is your age?
3. How do you identify racially?
4. How do you identify ethnically?
5. What is the highest level of education you have completed?
6. Where did you obtain your MSW degree?

Career Choice

7. Was/is your MSW your first master's degree?
8. If you answered "no" to question 7 what field is your other degree in?
9. Why were you initially interested in pursuing social work as a career (ex. professional ideals, personal history, past experience with a therapist or helping professional, a personal loss etc.)?
10. Do you work primarily with client's who have experienced trauma?
11. If you are working in the field as a social worker, what type of setting do you work in (community mental health, residential, hospital, etc.)?

Trauma History

12. As someone who has identified a reason for choosing social work as a career due to a personal history with trauma, how do you feel as through the trauma impacted your decision?

Intersections of Trauma/Clinical Work

13. Have you ever been in treatment with a therapist yourself to talk about your trauma?
If yes, before, during, or after obtaining your MSW?
14. Have you ever worked with a client or clients who have had similar traumatic life experiences to you?
15. If yes, did you disclose this to your client during treatment?
16. Did you discuss the decision to disclose, or the event of disclosure with a supervisor or therapist?

17. What are some of the factors that went into your decision to disclose or not to disclose to your client?

18. Do you feel as though the shared experience made it easier to treat/relate to your client, or more difficult? Please explain.

19. Is there anything that I did not ask or address that you would like to add?