2017

Working with trauma : a qualitative and retrospective exploration of the experiences of clinicians who work with trauma

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Recommended Citation

WORKING WITH TRAUMA: A QUALITATIVE AND RETROSPECTIVE

EXPLORATION OF CLINICIANS WHO WORK WITH TRAUMA

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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2017

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ABSTRACT

The current study explored the gap in understanding the experiences of clinicians who work with trauma given the interesting intersection of high prevalence of trauma and demonstrated lack of training in working with trauma survivors. To this end, this qualitative and exploratory study sought to gain a retrospective understanding of clinicians' training and career experiences in an effort to glean what has worked well in preparing skilled clinicians to work with trauma. Findings confirmed that clinicians do not feel prepared to do trauma work upon graduating from their degree programs and that they must seek out training opportunities in order to gain competence in this area. Further findings (i.e. insights regarding supervision experiences and self-care) were discussed in an effort to elucidate the most salient takeaways for academic administrators, clinicians, and students training to work in trauma.

ACKNOWLEDGEMENTS

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CHAPTER 1

Introduction

Knowledge in the field of study related to trauma has been growing for many

decades. Symbolic to this growing interest and investment in research was the inclusion of the

diagnosis of post-traumatic stress disorder (PTSD) in the *DSM-III* in 1980 (American Psychiatric

Association, 1980), as well as the recent re-categorization of PTSD as an anxiety disorder to

being included under the newly formed category, "trauma and stress-related disorders"

(American Psychiatric Association, 2013). Yet, it appears that trauma studies continue the

struggle to gain a solid place of importance and understanding in the larger field of mental

health. As evidence of this point, complex post-traumatic stress disorder has been discussed for

over 30 years, first addressed by Judith Herman, and has become a conceptualized category of

trauma gaining influence amongst clinicians as well as in the literature (Herman, 1992, p. 120),

yet it has not been granted inclusion into the DSM as a formal diagnosis.

Further, we know that the number of people who have experienced trauma is remarkably

high. Several studies demonstrate this high prevalence of trauma in society. In fact, Courtois &

Gold noted that, "at present, the demand for services by professionals trained in this area far

outstrips the supply" (2009, p. 4). The authors further reported high comorbidity rates between

those with a history of trauma and several other mental and physical health struggles, which

suggest a high likelihood that services may be sought for a different disorder or set of symptoms,

but that trauma is likely to be present in the room (Courtois & Gold, 2009, p. 8). Given such a

high prevalence of trauma in the general population and the fact that rates of trauma are higher in clinical populations, many clinicians across the board (i.e. social workers, counselors, psychologists, etc.) are working with people who have experienced trauma.

However, though many clinicians are treating traumatized clients, many do not feel prepared, and report being interested in additional training (81%) (Cook et al., 2011, p. 255). Though there have been changes in recent years to include more specialized training (i.e. family violence, human trafficking, gender related issues, etc.), more inclusive and comprehensive curricular changes have yet to be made (Courtois & Gold, 2009, pp. 14-16). At this point, curricular changes have been shown to be necessary and have been demonstrably argued for in the various mental health disciplines. In one study, conducted by Cook et al. noted that psychologist's interest in more training is demonstrated; but they also pointed out that "therapists who work with trauma and who have little to no specialized training run the risk of practicing outside of their area of competence" (2011, p. 255).

The current study seeks to explore the gap in understanding the experiences of clinicians who work with trauma survivors given the interesting intersection of high prevalence of trauma in the general population and lack of training in working with trauma. The overarching questions for this study were: What does working with traumatized clients actually look like? What does it feel like to work with traumatized people? What is best in terms of preparation and training to do this work? This qualitative, exploratory study gathered in-depth, narrative responses from experienced (working in the field for more than at least 5 years) clinicians. The findings of this study may provide valuable information to clinicians and educators alike on the experience of doing trauma work. Administrators of training programs could use this data alongside previous studies to implement changes in their curriculum to include more extensive training in trauma

treatment. The findings may also be useful to students who wish to be as prepared as possible to work as effectively as they can when presented with trauma in the clinical encounter.

CHAPTER II

Literature Review

Ample data demonstrate a high prevalence of trauma in the general population, with an increased comorbidity rate of a history of trauma with other mental and physical health struggles. These data suggest a high likelihood that though services may be sought for a different disorder or symptomatology, trauma is likely to be present in the therapy room (Courtois & Gold, 2009, p. 8). This acknowledgment concludes that clinicians are doing trauma work, working with traumatized individuals, whether or not they sought to do so, and regardless of whether or not they feel prepared to do so. A high percentage (81%) of clinicians reported being interested in additional training in treating trauma (Cook, Rehman, Bufka, Dinnen, & Courtois, 2011, p. 255). Though there have been changes in recent years to include more specialized training (i.e. courses offered in family violence, human trafficking, gender related issues, etc.), more inclusive and comprehensive curricular changes have yet to be made (Courtois & Gold, 2009, p. 14-16). At this point, these changes have been shown to be necessary and have been demonstrably argued for in the various mental health disciplines.

As the current study seeks to explore the gap in understanding the experiences of clinicians who work with trauma as well as what helped clinicians to best prepare for trauma work, the following literature review will help to elucidate the unique place that psychological trauma has occupied for mental health professionals in the larger canon of psychological history. To this end, the first section will be comprised of a brief overview of the history of psychological trauma in order to understand where we are now and how we got here. The second section will

provide background information on the prevalence of exposure to trauma in our society as well as the prevalence of posttraumatic stress disorder; this section will help to highlight the importance of clinician's receiving appropriate and adequate training in the treatment of trauma. Finally, the last major section will review the literature that demonstrates the need for curricular changes in the training programs for mental health professionals.

History of Trauma

For millennia, human beings have been aware of the devastating effects of exposure to extreme terror as evidenced in literature from times dating back to Homer (Alford, C.F., 1992, p. 67; van der Kolk, 2007, p. 19). However, it was not until relatively recently that a formal study of trauma began. More confusing, however, is the curious path the study of psychological trauma has taken. Periods of fascination and rich study have alternated with periods of disbelief and amnesia (Herman, 1992, p. 7; van der Kolk, 2007, p. 19). Judith Herman, a noted researcher and clinician in the field of psychological trauma states that "this intermittent amnesia is not the result of ordinary changes in fashion that affect any intellectual pursuit" (1992, p. 7). Trauma does not suffer from a lack of interest, but rather, the "subject provokes such intense controversy that it periodically becomes anathema" (Herman, 1992, p. 7). Herman (1992) adds "to study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature" (p. 7). This confrontation has proven too powerful and too overwhelming at times for a field of study to remain continuously invested. Bessel van der Kolk (2007), another preeminent scholar of our time in the field of psychological trauma, points out that this amnesic pattern in the study of trauma in many ways mirrors the symptoms that people who have experienced trauma face on a daily basis with the field also experiencing "intrusions, confusion, and disbelief" (p. 19). Thus, though the field of trauma has a

rich history, it has suffered in terms of progress in our understanding of trauma by being forgotten time and again, only to have a new generation return to ask the same questions. Questions that might seem basic and that one would not be wrong to assume we should have answers to by now remain unanswered. For example, is the etiology of trauma organic or psychological? If one suffers from the effects of trauma, are they inherently weak? Can repressed memories be retrieved? Is dissociation always present? Van der Kolk (2007) states that even though these and other questions have been asked since the 1880s, none have been "definitively settled in the beginning of the 21st century" (p. 20). What will follow in this section is a brief overview of the rich history of the study of psychological trauma in an effort to greater understand the context of learning that current clinicians face.

Hysteria

In the late nineteenth century, a disorder called *hysteria* rose to become the subject of rigorous study and debate, and Jean-Martin Charcot, a French neurologist, was the lead investigator. Hysteria was a term so commonly used in society at that time that defining it seemed almost unnecessary, with one historian noting that "for twenty-five centuries, hysteria had been considered a strange disease with incoherent and incomprehensible symptoms. Most physicians believed it to be a disease proper to women and originating in the uterus." (Ellenburger, 1970, p. 142). Charcot was the first to describe hysterical attacks as being dissociative and "the result of having endured unbearable experiences" (van der Kolk, 2007, p. 21). As many of his patients were "beggars, prostitutes, and the insane," courage was ascribed to Charcot for bringing his reputation to bear on the credibility to the field and to these women (Herman, 1992, p. 10). Prior to Charcot's taxonomy-like investigations into hysteria, these women had been thought of as malingerers and largely ejected from society.

Charcot's followers wanted to carry this work further and identify the cause of hysteria. Sigmund Freud and Pierre Janet emerged as great rivals of this period. In their race to discovery, Freud and Janet realized that it would be necessary to talk to their patients, not merely observe them. Herman notes about this time that "for a brief decade men of science listened to women with a devotion and a respect unparalleled before or since" (1992, p. 12). After many years, their dedication to these pursuits led both Freud and Janet to the same conclusion that hysteria is the result of psychological trauma, with Freud stating that "hysterics suffer mainly from reminisces…the traumatic experience is constantly forcing itself upon the patient and this is proof of the strength of that experience: that patient is, as one might say, fixated on his trauma" (Breuer & Freud, 1955, p. 45). Janet and Freud adopted an empathic stance with their patients and their collaborations with patients "took on the quality of a quest" (Herman, 1992, p. 12).

Despite a history of skepticism regarding a connection hysteria and female sexuality, Freud's exploration led him into this arena, with his "case histories reveal[ing] a man possessed of such passionate curiosity that he was willing to overcome his own defensiveness, and willing to listen" (Herman, 1992, p. 13). Freud (1896) heard stories of rape, incest, assaults of all varieties, and believed that he had finally uncovered the root cause of hysteria:

> I therefore put forward the thesis that at the bottom of every case of hysteria there are *one or more occurrences of premature sexual experiences,* occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of a *caput Nili* in neuropathology. (p. 203)

It was clear that Freud believed he had discovered the "true origin." Yet, within a year Freud would discredit his own theory out of fear because he was "troubled by the radical social implications of his hypothesis" (Herman, 1992, p. 14). Herman (1992) explains that,

> Hysteria was so common among women that if his patients' stories were true, and if his theory were correct, he would be forced to conclude that what he called "perverted acts

against children" were endemic, not only among the proletariat of Paris, where he had first studied hysteria, but also among the respectable bourgeois families of Vienna, where he had established his practice. This idea was simply unacceptable. It was beyond credibility. (p. 14)

Freud did an about-face, nearly stopped listening to his patients, and created psychoanalytic theory. Psychoanalysis, "the dominant psychological theory of the next century was founded in the denial of women's reality," but it was more palatable to a patriarchal society that was comfortable with assigning women responsibility for the ills of the world (Herman, 1992, p. 14). Thus, with Freud, began the nineteenth century disappearing act of the study of psychological trauma. Freud, in "…ever greater convolutions of theory…insisted that women imagined and longed for the abusive sexual encounters of which they complained" (Herman, 1992, p. 19). Freud's contemporary, Janet, never abandoned his theory of the traumatic origins of hysteria, but lived to see his works forgotten and his ideas neglected" (Herman, 1992, p. 18). Charcot, the man who started it all, also lived to see his work be deemed worthless as a competing school of thought took power in rejecting his notion that hysteria has traumatic origins, and in its place held that hysteria was rooted in suggestibility and simulation.

War Trauma: A Soldier's Heart

The history of trauma changed slightly in the twentieth century when men were implicated, but not as much as one might imagine or hope. Following the first World War men broke down in astonishing numbers and these breakdowns began to resemble those of hysterical women. The term *shell-shock* was coined in 1915. Slowly, it "gradually became clear that often the cause [of shell-shock] was purely emotional" as it could be found in soldiers who were never directly involved in combat (van der Kolk, 2007, p. 20). However, just as in the debate on hysteria, discussions quickly turned to excoriating the moral character of those afflicted. A soldier who "developed a traumatic neurosis was at best a constitutionally inferior human being,

at worst a malingerer and coward" as "a normal solider should glory in war and betray no sign of emotion" thus perpetuating the paradigm of men being always in control and superior to women (Herman, 1992, p. 21). There was a progressive camp of psychiatric professionals arguing that "combat neurosis was a bona fide psychiatric condition that could occur in soldiers of high moral character" (Herman, 1992, p. 21). However, within a few years, hospitals filled with veterans who were an embarrassment and easy to forget.

In 1922, Abram Kardiner came on the scene excited and hopeful to be a "Columbus in the relatively new science of the mind" (Herman, 1992, p. 23). Kardiner worked with veterans and was devastated by both the severity of their symptoms and the apparent intractability of their distress. Kardiner had his own personal traumatic history (i.e. growing up in poverty, hunger, neglect, domestic violence, and early death of his mother), and acknowledged that this past influenced both the direction of his career and also made it possible for him to better understand his patients" (Herman, 1992, p. 24). Kardiner recognized that war trauma was akin to hysteria, but also recognized how pejorative that characterization had become:

> When the word "hysterical" is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such neurosis is, therefore, without sympathy in court, and…without sympathy from his physicians, who often take…'hysterical' to mean that the individual is suffering from some persistent form of wickedness, perversity, or weakness of will (Herman, 1992, p. 24).

The result of this condemnation was that doctors struggled to differentiate between shell-shock and cowardice and "during World War I, more than 2200 British soldiers were condemned to death for cowardice and desertion…" (van der Kolk, 2007, p. 21).

By the time the second World War began, there was a greater push to develop a quick and effective treatment and remove the stigma from soldiers who experience symptoms related to war stress. It became widely agreed that "*any* man could break down under fire" (Herman,

1992, p. 25). War also made mental health professionals aware that "under extreme conditions, the group, rather than the individual, is the basic unit of study and treatment" (van der Kolk, 2007, p. 28). Thus, Kardiner and his colleagues argued that the "strongest protection against overwhelming terror was the degree of relatedness between the soldier, his immediate fighting unit and their leader" (Herman, 1992, p. 25).

Following the Vietnam War, a large-scale investigation was undertaken in response to "disaffected soldiers" who organized for such an effort. The organization Vietnam Veterans against the War formed when it was inconceivable for veterans to organize against a war that was still being waged. The anti-war movement was growing and these veterans contributed a strong voice "raising questions about everyone's version of the socialized warrior and the war system, and exposed their country's counterfeit claim of a just war" (Herman, 1992, p. 26). 'Rap groups' formed and provided comfort to the veterans and raised awareness about the long-lasting effects of war. The antiwar movement added "moral legitimacy" and the "national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of war" (Herman, 1992, p. 27). In 1980, for the first time, psychological trauma was given a "real" diagnosis and obtained formal recognition in the American Psychological Association's Diagnostic and Statistics Manual – III (DSM).

Sex War

However, this formal recognition did not change things for women right away, and the progress made by the inclusion of posttraumatic stress disorder (PTSD) in the DSM did not readily translate into a deeper understanding of the plight of women. Women still had no name for what they struggled with in "the sphere of the personal, in private life" (Herman, 1992, p. 28). But the women's liberation movement that began in the 1970s sought to change that.

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Consciousness-raising efforts spread and shared many of the same characteristics as the rap groups that emerged during the Vietnam War. The realization that "violence is a routine part of women's sexual and domestic lives" caused Freud to "retreat in horror" (Herman, 1992, p. 28). Consciousness-raising groups offered another outcome. These groups "…creat[ed] a privileged space…for women to overcome the barriers of denial, secrecy, and shame that prevented them from naming their injuries." (Herman, 1992, p. 29). The American women's movement in the 1970s saw an increase in research on sexual assault, and a significant shift occurred as more and more women became principal investigators on studies exploring issues related to women's experiences (Herman, 1992, p. 30). Horrific statistics were uncovered. For example, one in four women had been raped, and one in three had experienced sexual assault as a child (Herman, 1992, p. 30). But as painful as it was to expose these truths, they were finally seeing the light of day. Women found themselves needing to establish that "rape is an atrocity…a crime of violence rather than a sexual act" (Herman, 1992, p. 30). This was their attempt to counter the claim begun by Freud nearly a century before that "rape fulfilled women's deepest desires" (Herman, 1992, p. 30). Feminists were redefining the cruel treatment of women, such as rape and assault—in all forms, as a method of control, and it provided these activists a fulcrum on which `to focus their efforts (Herman, 1992, p. 30).

Over time, societal changes were implemented as the first rape crisis center opened in 1971. Women pioneers were at the forefront of research that personally implicated them as well as forefront in a movement that honored their contributions. In 1980, when PTSD was included in the DSM, it became clear that the effects of rape and abuse were "essentially the same as the syndrome seen in survivors of war (Herman, 1992, p. 32). Herman (1992) notes at the end of her thoughtful review of the history of psychological trauma that 'recognizing the commonality of

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affliction may even make it possible at times to transcend the immense gulf that separates the public sphere of war and politics—the world of men—and the private sphere of domestic life—the world of women" (p. 32). May this be so.

Prevalence of Trauma

The history of trauma and its implications for individuals and society has a fraught past. As evident in the previous section, this history has impeded progress and development on our overall understanding of trauma in many ways. Despite periods of resurgence in scholarly activity related to uncovering knowledge about trauma, little is known today about the prevalence of trauma in our society or the prevalence of PTSD among people who have been exposed to traumatic events (Kessler, 2000, p. 4). However, several studies have emerged over the last two decades that present information which can help us understand the context in which mental health clinicians are being confronted by trauma in their practices. The information that follows in this section will shed light on the questions related to prevalence of trauma, as well as the implications this prevalence has for clinical practice.

Results have overwhelmingly shown that trauma is highly prevalent in the United States. For example, a study conducted utilizing a community survey of young adults found that more than a third of respondents had experienced at least one traumatic event by the beginning of their early adulthood (Kessler, 2000, p. 5). When the criteria for what qualified as trauma exposure was expanded in 1994 in the revised DSM-IV that number jumped to an astonishing 90% of respondents reporting exposure to at least one lifetime traumatic event (Breslau et al., 1998). Comparable findings were also obtained from another study completed in 1994 that surveyed a nonclinical population of college students and found that 84% reported experiencing at least one traumatic event (Vrana and Lauterback, 1994). Another study conducted by Resnick, Kilpatrick,

Dansky, Saunders, and Best found that nearly 70% of women respondents has experienced one or more "traumatic criminal victimization experiences" during their life (1993, p. 989).

While early studies (circa 1987) found PTSD to be quite rare with a prevalence between 1% and 2%, more recent studies have demonstrated a much higher prevalence of PTSD. A study performed by Breslau et al., (1991) using the earlier criteria from the DSM-III-R, found that 11.3% of women have a lifetime history of PTSD (p. 220). Resnick et al. (1993), also using criteria from the DSM-III-R, found a prevalence of 12.3% of women with a lifetime history of PTSD associated specifically with criminal victimization (p. 990). In both cases, researchers understood that several factors might contribute to these results which include DSM criteria as well as the assessment procedures. For example, in the first study conducted by Breslau et al. (1991), respondents had to simply say "yes" or "no" in response to questions read by their interviewer. Kessler (2000) suggests that this "procedure created greater emotional distance that may have contributed to the higher reports of trauma" (p. 6). Resnick et al. (1993) with regards to their findings, suggest that the "anonymity of telephone interviews may have contributed to the comparatively high rates of trauma reported in their study" (p. 988).

While there are invariably many factors that play an important part in obtaining accurate reports related to the experience of trauma, it seems clear that exposure to trauma is not rare at all. Further, while the prevalence of lifetime PTSD seems much lower, we must remember that 10-15% of a population is not an insignificant number.

Clinical Relevance of the Prevalence of Trauma and PTSD

As will be discussed further in the next section, it is not likely that clinicians who do not specialize in trauma will obtain adequate training in the treatment of trauma related symptoms. Thus, due to this lack of training, it is further unlikely that these clinicians will have a familiarity

with trauma in order to recognize its crucial significance. Therefore, the likelihood of a clinician practicing outside of their scope of competency increases. As the study of psychological trauma continues to grow, the results seem to confirm an underlying and "essential relevance" of understanding of the area of trauma even in a generalist clinical practice (Gold, 2008, p. 114).

Further rationale for increasing clinician's fluency with trauma can be appreciated by understanding that as highly prevalent as trauma is in the general population (as evidenced above), exposure to trauma and the prevalence of PTSD is higher yet in clinical populations. For example, Switzer et al. (1999) conducted a study that found that 94% of respondents from a community mental health center reported experiencing at least one lifetime traumatic event, with "…42% of these meeting criteria for PTSD over the previous year" (p. 29). In another sample from outpatient community mental health centers, it was found that 59% of women and 24% of men reported experiencing sexual assault at some time in their life (Hutchings and Dutton, 1993, p. 61). Finally, when compared to other clients in mental health agencies, people with PTSD report a higher utilization of mental health services (Gold, 2008, p. 115). Thus, clinicians working in general practice settings are likely to be faced with people who have experienced trauma. It is incumbent on these clinicians to receive adequate and appropriate training, lest they run the risk at best of being ill equipped to help these people, and at worst run the risk of doing more harm.

Need for Curricular Inclusion of Trauma-Informed Theory and Practice

Given the widespread prevalence of trauma in our society, it is clear that there is a great need for the inclusion of information and training regarding the treatment of trauma in mental health programs. In fact, given the growing body of literature on the prevalence of trauma as well as the severe and negative implications that trauma has for individuals and society, it is shocking

that integrated training in trauma is not the standard. Courtois and Gold (2009), noting especially

the gap in the training of psychologists, say, "indeed, the non-inclusion of information in

psychology about trauma as a major aspect of human experience and as a substantive contributor

to derailment of normative development and the development of psychopathology, defies logic"

(p. 12). Courtois and Gold (2009) further explain that this gap in training may partially be due to

the fact that it is difficult to add content into professional training programs in general (p. 12).

However, and much like Judith Herman and Bessel van der Kolk's incisive understanding about

the unique history of the study of trauma, Courtois and Gold (2009) offer that the "lack of

attention to trauma in the psychology curriculum (as well as the curricula of other professions)

has mirrored societal ambivalence and episodic attention and disregard" (p. 13).

This gap in training has serious ramifications in terms of preparing clinicians to have the

ability to provide trauma-informed services to clients and warrants greater attention. Cook et al.

(2011) help to shed light on why this is so important:

> This [gap] is especially problematic since the treatment of trauma survivors has been found to have relational, topical, and risk management challenges that are different from those found in other treatment populations and that can confound the therapist and interrupt the therapy. Moreover, if not managed knowledgably, these challenges can overwhelm and harm both the therapist (through vicarious traumatization) and client (through retraumatization). (p. 3)

Thus, the ramifications of this negligence can be significant, serious, and have deleterious effects

on both client and therapist.

Clinician Interest in Trauma Training

A study by Cook et al. (2011) offers data the show that experienced clinicians with an

average career length (at the time of study) of 26.7 years endorsed an interest in specialized

trauma training opportunities (p. 4). These researchers found a statistically significant correlation

between the approximate number of hours clinicians spent working with trauma survivors and

the level of interest in more training (81% of clinicians who work "some or often with trauma survivors expressed interest in additional training" (Cook et al, 2011, p. 5)). Further, Cook et al. (2011) found that clinicians who spent little to no time working with trauma survivors had very little interest in more training (p. 5). The researchers also discussed the limitations of their study, such as having a relatively small sample size (261 participants) which might not accurately represent the population (Cook et al., 2011, p. 5). For example, their sample reported spending an average of 14.3 hours per week working with trauma survivors (Cook et al., 2011, p. 5). Given the high prevalence of trauma, especially in clinical populations, this sample might not accurately represent the pervasiveness of the issue. However, despite this sampling struggle, the data is especially striking when it is taken into consideration that the survey was aimed at "practicing psychologists in general, not trauma practitioners in particular" (Cook et al., 2011, p. 6). Another noteworthy finding was that many clinicians in their study reported that they do not work with trauma survivors and that they have little to no interest in additional training. Again, given the prevalence, it is "quite surprising that these clinicians do not have trauma-exposed clients in their practices who are actually dealing with trauma-related emotional, social, or economic consequences" (Cook et al., 2011, p. 6). Therefore, it begs the question for future research to uncover "how the traumatic stress field reaches out to those clinicians who don't believe they have a stake in trauma education (Cook et al., 2011, p. 6).

Further, Cook et al. (2011) point to the need for more research, and in particular "in regard to which practitioners provide psychological survivors, what they are currently doing, and what kinds of training prepared them (e.g. graduate coursework, practicum placement, internship rotation, specialized internship, postdoctoral training, on-the-job training, and informal

experiences)" (p. 6). The current study seeks to specifically address the latter two areas of the above stated inquiry.

Dangers of the Lack of Trauma Training

Several dangers exist for therapists working with trauma who may be ill-equipped to do so. First of all, therapists who have little or no training always run the risk of "practicing outside of their area of competence" (Cook et al., 2011, p. 5). Therapists may also struggle to set and maintain appropriate boundaries as the "extreme circumstances in which some traumas occur…create conditions that increase [this] risk" (Cook et al., 2011, p. 5). Further specialized training can also help therapists know about the various "treatment traps" that tend to arise in the treatment of traumatized individuals (Chu, 1988, p. 24). Further, traumatic exposure, and specifically when the trauma took place through interpersonal relationship(s), can "create personal and relational difficulties in…the treatment process, including mistrust, problems of emotional regulation, and ambivalence about the possibility of recovery" (Cloitre et al., 2010, p. 919). Thus, mental health professionals must be trained to both expect these difficulties as well as receive training in how to best work with these issues (Cook et al., 2011, p. 5).

Vicarious traumatization. In addition to the usual dilemmas in treatment and the ones described above, working with trauma poses additional risks and challenges to the clinician directly. Recently, a growing body of literature discusses the "many adverse reactions that professional responders and caretakers (and even researchers) can develop as a result of stressors encountered in direct exposure to trauma on-site and/or indirect exposure working with traumatized clientele after the fact" (Courtois and Gold, 2009, p. 17). These particular reactions have variably been called "secondary traumatization," "compassion fatigue," and "vicarious trauma" (Figley, 1995, p. 4; McCann and Pearlman, 1990, p. 131; Stamm, 1995, p. 2). These

reactions can produce personal and professional costs to the therapist resulting from the "emotional pressure of working in a trauma setting" (Courtois and Gold, 2009, p. 17). Vicarious trauma can even lead to clinicians' decreased ability to be effective in their work with clients. Courtois and Gold (2009) say that "this aspect of trauma work necessitates that professional training include the development of finely tuned self-care and coping abilities to recognize and ameliorate the stressful impact of responding to this population" (p. 17). Thus, without proper training, we may lose able practitioners who care about the work and yet are rendered unable to continue in this line of work.

Existing Major Proposals for Trauma Training

Supervision and Consultation

Describing it as "fundamental to successful matriculation in work with traumatized populations," Cook et al. (2009) argue for the importance of adequate supervision and consultation (p. 6). Through an overview of the various stages in a clinicians' development, Cook et al. (2009) posit that "essential to mastery of competencies at each stage is the provision of support and feedback through supervision, consultation, and mentoring" (p. 7). Chard and Hansel (2006) extrapolate this need onto training programs in general when they argue for the importance of creating an "atmosphere of safety for trainees" (p. 195). In the absence of such an environment, Courtois and Gold (2009) argue that "students are unlikely to share the difficulties and self-questioning that inevitably arises in the course of the services they provide with their teachers and supervisors" (p. 17).

Likewise, paramount to the supervisor/supervisee relationship is for the supervisor to provide some normalizing as to the experience of training to be a clinician. Supervisors and faculty members must be called up to impart to trainees that reactions such as struggles in

treatment or self-doubt are expected and that "addressing them is a welcomed and responsible part of functioning in this arena" (Courtois and Gold, 2009, p. 17). Moreover, Giller, Vermilyea, and Steele (2006) assert that recognizing and acknowledging "one's own responses is an indispensable component of effect trauma work," and therapy in general (p. 67).

Overall, many researchers have noted the importance of and recommended that trauma training take place vis-à-vis a relational framework (Courtois and gold, 2009, p.17). Courtois and Gold (2009) petition that "the relational approach to training explicitly acknowledges that a great deal of trauma occurs in a relational context and is thus a relational experience, thus, its resolution best occurs in relational matrix" (Wells, Trad, & Alves, 2003, as cited in Courtois and Gold, 2009, p. 17). Dalenberg (2000) stresses that embodying this relational approach might include the supervisor risking vulnerability to acknowledge their own struggles with stressors related to trauma work as well as any countertransferential challenges that arise during the course of treatment with their supervisees (p. 136). Having supervisors that can model this level of openness and "humanness" gives students the context necessary to build a knowledge base and a level of clinical resilience to engage with trauma (Courtois and Gold, 2009, p. 17). Courtois and Gold (2009) further noted that through this relational matrix, the "apprentice professional" can undergo a personal transformation, and in order to cultivate and inspire this, it "is incumbent upon trainers to be attuned to and to foster this process" (p. 17).

Culturally-Competent Approach

Consistent with a relational understanding of training, many researchers and practitioners have also noted the importance of building clinicians' cultural competency and humility in relation to their trauma practice. Brown has articulated a compelling argument that expresses the importance of culturally-competent and informed trauma care (Brown, 2008). Factors that

include age, race, gender, sexual orientation, as well as other "social, political, and cross-cultural issues" are important insofar as they can exacerbate the effects of trauma and must be attended to in practice (Cook et al., 2011, p. 5). Additionally, trainees must be encouraged to explore cultural and social identities in order to create a strong, therapeutic, working alliance, as well as to use this alliance to develop a solid understanding of the framework through which the survivor ultimately "makes sense of and reacts to the trauma" (Courtois and Gold, 2009, p. 17).

Furthermore, some racial and ethnic groups have been found to be at a higher risk of experiencing PTSD (Alim, Charney, & Mellman, 2006; Norris & Alegria, 2005). Some minority groups are also "more likely to encounter risk factors that are linked to trauma exposure and adverse outcomes (Bernal & Santiago, 2006; Triffleman & Pole, 2010, as cited in Mattar, 2011, p. 258). Minority groups also tend to lack access to resources that may include quality mental health care or other health services. Some of the disparity factors include: "underutilization of psychiatric services by ethnic minorities, problems in engaging and retaining clients from diverse backgrounds, trends of apparent under and/or over diagnosis, lack of trained interpreters and poorly translated written material, tendencies toward a lack of trust of the health care system and ineffective communication with clients" (Atdjian & Vega, 2005; Smith, Rodriguez, and Bernal, 2011, as cited in Mattar, 2011, p. 258). Mattar (2011) concludes that "a more diverse, culturally and linguistically competent and well-trained workforce could help address many of these disparities by expanding our knowledge about effective ways to engage diverse populations" (p. 258). Yet, we have far to go.

Summary

As evidenced above, the study of psychological trauma has had a tumultuous history. In many ways then, it is unsurprising that the training of professionals to deal with the

consequences of psychological trauma has had a similar struggle. That trauma is highly prevalent in our society, that it often arises during the treatment of other concerns, and that this has not translated into a more thorough inclusion of trauma education in our training programs is an area of major negligence in our field. It is this researcher's hope that the current study will both further shed light on the problem and gather information on individual clinicians' efforts to overcome this dearth of training.

CHAPTER III

Methodology

The current study seeks to explore the gap in understanding the experiences of clinicians who work with trauma given this interesting intersection of high prevalence of trauma and demonstrated lack of training in working with trauma survivors. To this end, this study particularly seeks to gain a retrospective understanding of clinicians' training and career experiences in an effort to glean what has worked well in preparing clinicians to work with trauma.

A qualitative, exploratory, intensive interview-based study was conducted as this is a relatively new area of research, and specifically focused on the "lived" and "inside" perspective of skilled trauma clinicians (Padgett, 2017, p. 16). Furthermore, qualitative research affords the possibility to more deeply probe the subjective experience of participants which is particularly relevant when doing retrospective work. In order to understand how clinicians have been prepared and sustained through professional development in their trauma work, intensive interviews utilized semi-structured, open-ended questions in order to gather narrative data from participants. The overarching goal of these interviews was to "develop a comprehensive picture of the interviewee's background, attitudes, and actions in his or her own terms; to "listen to people as they describe how they understand the worlds in which they live and work" (Rubin & Rubin, 2012, p. 3). In undertaking an exploratory study, it is a hope that results may identify areas for further research, as well as offers further evidence to support curricula changes to include more and better training in trauma for clinicians. However, because changes to curricula

often take time, another goal of this study is to offer practical suggestions to clinicians and students who are preparing to work with trauma survivors.

Sample

Twelve clinicians who work with trauma survivors were interviewed. Participants were recruited from mental health disciplines that provide direct client care (i.e. clinical social work, clinical psychology, counseling psychology, mental health counselors, and marriage and family therapy—all of whom were licensed to practice in their state in order to increase the transferability of the study insofar as results might apply to all clinicians and not just a subset. However, all clinicians that participated in the study were licensed clinical social workers, with a few also having doctoral level degrees in social work as well. The researcher included a discussion on the transferability of the outcomes of the study in the results section. In order for inclusion in the study, all participants needed to have a minimum of at least five years of experience of direct clinical work with survivors of trauma.

Sample Recruitment

Convenient, purposive sampling and snowball techniques were used to recruit participants. Recruitment began through utilizing my network of contacts in the clinical fields in which I have been a part. In particular, my supervisor at my current internship, a former advisor, and my current thesis advisor initially served as liaisons to clinicians with which they have worked. I continued to use snowballing recruiting tactics from participants when my initial contacts were exhausted. All participants were recruited via email (see Appendix C for recruitment email).

The sample was purposive insofar as the researcher reached out to the most experienced trauma clinicians possible to attract the most suitable participants for the current study, and

convenient as all participants were recruited from the researcher's professional network or referred to the researcher by participants. Feasibility was increased through having flexibility around location and medium for interviews, with interviews taking place over the telephone when distance would have otherwise made it impossible. Furthermore, saturation of the sample was reached when new participants no longer contributed to new or more nuanced themes, which can be common feature amongst studies with "modest aims and a priori codes," such as the current study (Padgett, 2017, p. 186). The researcher sought to ensure saturation by asking participants to "say a little more when they claim to have said it all, and working on in the face of considerable repetition" (Drisko, 1997, p. 192), and confirmed saturation in data analysis.

This sampling method has several drawbacks in terms of recruiting a representative sample. Thus, it was difficult to ensure or actively seek out a diverse participant population with respect to race, gender, socioeconomic status, sexual orientation, etc.

Ethics and Safeguards

Risks and Benefits

No risks were identified for participants for participation in the study. However, several potential benefits to participants emerged. Clinicians had an opportunity to share part of the story of their development as clinicians, which is something that seems to be rare outside of an academic or training setting. Further, participants might have gained satisfaction in knowing that their contribution to the study may help to bolster an ongoing argument for better and more integrated trauma training across disciplines, degree programs, and training sites. Finally, and perhaps more immediately, and insofar as it is related to the dissemination of this research project, participants may be assured that their contribution will help to inform social work

students of what might help to best prepare them to work competently and thoughtfully with traumatized clients.

Informed Consent Procedures

I explained the informed consent and answered any questions from participants before obtaining a signature. Participants signed the informed consent in my presence before the interview if we met in person for the interview. I kept one copy and one copy was given to the participants for their records. For the interviews conducted over phone or Skype, participants returned their electronically signed consent form before the interview began. In that case, participants were encouraged to keep a copy of the consent form for their records. (See Appendix B for Informed Consent).

Precautions Taken to Safeguard Confidentiality and Identifiable Information

In order to safeguard identifiable information, and because all interviews were audio recorded, I removed names and other identifying information and assigned code numbers to each tape and transcript. Participants were informed that all research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. In addition, when reporting any findings, the researcher did not include any information that would make it possible to identify individual participants.

Participation in the study was voluntary, and clinicians could refuse to answer any question, or withdraw from the study at any time (up to April 1, 2017) without affecting their relationship to the researcher of this study or to Smith College. Further, approval from the

Human Subjects Review Committee was given on December 10, 2016, and no data was collected

prior to this date (See Appendix A for HSR approval letter).

Data Collection

Interviews were conducted via telephone for all twelve participants. In order to assure

confidentiality, the researcher was in a private space when conducting interviews; participants

were in a private space as well. During the course of the interview, I obtained demographic

information including, but not limited to, years of experience working with survivors of trauma,

types of populations served and in what setting, and amount of education and degree program

information.

Further, by signing the informed consent, participants agreed to be audio recorded, and

all interviews were recorded by a hand-held recording device. (Refer to previous section on

"Precautions Taken to Safeguard Confidentiality and Identifiable Information" for information

on how data was protected). Should this study be presented or published at any time, data will be

presented as a whole or in the form of a vignette with no identifying information attached.

Data was collected through a series of semi-structured, open-ended interview questions

pertaining to the clinician's feelings around the level of preparedness to work with trauma. The

questions were open-ended in order to elicit narrative, in-depth responses and the interview guide

served as a road map to "ensur[e] that key topics [were] covered, rather than a guide to the

ordering or language of specific questions" which encouraged participants' in-depth responses to

be guided ultimately by what they deemed most salient (Engel and Schutt, 2013, p. 289). All

interviews lasted approximately 45-60 minutes. Together, my advisor and I identified areas of

inquiry to focus on with regards to distinct areas of training that I would need to account for in

my interview questions. These sections include, but are not limited to: graduate training, post-

graduate training and professional development, supervision, and consultation experiences. We also wanted to be sure to include questions that would afford participants the possibility to offer suggestions of what could serve as improvements to the training of clinicians, from their personal perspectives. In order to enhance the validity and credibility of the interview guide, Katy Davis, Ph.D., Director of Trauma-Informed Care at the Women's HIV Program at the University of California, San Francisco, served as an expert reviewer (see Appendix D for Interview Guide).

Sample questions included:

- Did you feel prepared to do trauma work after completing your graduate degree?

- What drew you to trauma work?

- What (if any) other formal training programs have you participated in? (i.e. Dialectic Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), post-graduate training (fellowships), etc.).

- What did you find most helpful in your experiences with a supervisor? Least helpful?

- When you were unsure of how to proceed in treatment with a traumatized client, what did you do?

- What sustains you in this work?

The Interview Process

Insofar as much of the preexisting literature is etic in nature by maintaining an outsider's objectivity and abstraction at a theoretical level, I sought to further develop an emic perspective, encouraging and cultivating a rich "insider point of view," in order to obtain or work towards a deep understanding of the experiences of clinicians who work with trauma (Padgett, 2017, p. 16). While the researcher identified broad areas of inquiry (as evidenced be the headings of the

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interview guide), participants were afforded the freedom and flexibility to elaborate on their formative experiences in becoming skilled trauma clinicians. The researcher allowed the participants to answer questions by sharing whatever seemed to be the most salient to them, and supported this exploration by using thoughtful probes when necessary. The concept of theoretical sensitivity was also employed, which means attempting to achieve attunement to exiting theories, in this case trauma theories and the particular sensitivities clinicians who work with trauma must employ, while also ensuring that the theories do not dictate the course of analysis and interpretation and ultimate meaning-making from the results (Padgett, 2017, p. 188).

Data Analysis

Data was gathered via careful note-taking and through reviewing recorded interviews. Data from individual interviews were analyzed by utilizing a content-theme analysis, and the data were collectively examined through a constant comparative analysis that sought to describe the relationships among themes across interviews (Padgett, 2017, p. 177).

The following is the process I used to analyze and organize the data. First, interviews were transcribed verbatim and formatted to separate each question. Participants were assigned a number and all data was referenced throughout the coding process by that number. Individual audio and print files were encrypted and password protected on researcher's computer. Next, each transcript was read over carefully, several times, and salient contributions were initially highlighted and then organized into categories across participants. Categories were created using the actual phrasing of the participants when possible, or the researcher assigned a word or phrase when participants used a variety of words (i.e. researched used the word pacing to encapsulate participant responses including the word pacing itself, timing, attending to the client's needs and being attuned to what they can bear and when, etc.). Gradually, overlapping and similar codes

were combined, and outlier responses were given space as well. This coding process allowed major themes to emerge. Themes are defined as "fundamental concepts that characterize specific experiences of individual participants by the more general insights that are apparent from the whole of the data" (Bradley, Curry and Devers, 2007, p. 1760). Finally, the themes were revised to honed in as specifically as possible on what the participants shared, and direct quotations from participant data were used to help illustrate the findings. Again, all data was kept confidential and no names were used in the writing up of the findings. Thus, the results provided in the next chapter offer the fruit of this labor. Effort was taken to include as many salient, direct quotations from participants wherever possible to keep the results close to the actual interviews.

CHAPTER IV

Findings

This chapter documents the findings from 12 semi-structured interviews with licensed practicing clinical social workers who are considered to be, through both self-identification as well as by having met the minimum criteria for inclusion in the study; namely, being experts in working with individuals who have experienced trauma. Participants stated that they were grateful for the current study, and hoped that this topic of understanding what helps clinicians to be prepared to work with trauma continues to be investigated and integrated into clinicians' training. Several key themes arose throughout the course of conducting interviews. To begin, clinicians confirmed that they had not been trained specifically for trauma treatment and yet were confronted with it time and again in the clinical encounter. To that end, previous data that highlighted clinicians' feelings of ill-preparedness following graduation were confirmed unanimously. Further, most clinicians discussed the importance of being able to make good use of supervision as well as the importance of having what they considered to be a good supervisor, with those descriptions varying but with many similarities (to be discussed in more detail later). Finally, another key finding was that all clinicians believed that self-care was integral to being able to do the work well and to be able to do it for a career.

The interview consisted of seven general sections: 1) demographic data about the participants and their clinical experience, 2) categorical information about the participant's caseload and their clients 3) further professional and personal background information, 4) questions pertaining to formal trainings participants sought out, 5) an exploration of participants'

experiences with supervision and consultation, 6) questions related to clinician's wisdom gained over the years, challenges face, and what helps sustain them in this work, and finally, 7) questions about their hopes for the direction of the future of trauma work. Demographic questions and specific questions related to participants; experience in the field tended to yield quantitative data as they were the result of more close-ended questions. Conversely, responses to many of the later questions in the interview led to more qualitative responses, were coded as such, and will be discussed much more in terms of the themes that emerged through analysis.

Demographics Data about Participants and Professional Experience

Of the 12 total clinicians who were interviewed, ten were female (83%), 2 were male (17%), with a mean age of 56.33 (age range: 32-71). Eleven participants identified as Caucasian, and one participant identified as Latino. Participants were recruited from all over the country, with most living in urban or suburban areas in Massachusetts, North Carolina, and California. All participants were licensed, practicing clinical social workers with a Master's in Social Work degree. In addition, 3 participants had obtained a Ph.D. in Social Work, with one other participant currently in process of completing her Ph.D. in Social Work. The total number of years of experience combined by all participants was 328 years, with a range spreading from 7 years to 43 years. The mean of years of experience per clinician was 27.33 years of experience in the field of social work. Further, the total number of years of experience of specifically with trauma combined from all participants was 288, with a range spreading from 7 years to 41 years. The mean of years of trauma experience per clinician was 24 years. Finally, participants reported that on average they spent a total of 19.75 hours per week working with survivors, with a range of 5 hours to 30 hours per week.

Participants Caseload and Clients

All participants reported that if not all, the majority of their work was comprised of doing individual therapy. However, many participants reported having done some case management in the early years of their career, and then transitioned to spending most of their time practicing individual and/or group therapy. Many participants spoke of the importance and necessity of doing clinical case management alongside trauma work. One participant mentioned that they consider the work they do to include "industrial strength" case management that is necessary because it is "impossible to do this [trauma] work if someone doesn't have food and shelter as a minimum." Another participant mentioned that she sees her role as to be an advocate for clients who need assistance and advocacy in accessing other supportive resources alongside the trauma work.

Client Caseload

Four clinicians reported that they have worked with children and adults, with the remaining eight participants working only with adults. Participants have worked in outpatient as well as inpatient settings, in private practice, on college campuses, hospitals, residential programs, women's clinics, as well as in trauma-specific outpatient NGOs. Further, most (9) participants reported that they followed a fairly traditional or straightforward career path in terms of going right from their early college education into a graduate program and then directly out into the field. One participant reported that she went to school after raising her children, and two participants reported that they had volunteer experiences early on that inspired their choice to pursue education in social work.

This researcher was able to gain some information regarding the breakdown of the demographics of the populations worked with, but has since realized that a different format,

perhaps a survey, could have lent itself to better obtaining this information. Thus, this researcher will present basic information here, but would like to note that her biggest take away from these questions was that most of the clinicians have seen a broad range of clients, and that this confirms previous research that trauma is widespread and affects people from all walks of life. Participants shared that they have worked primarily with people from a low socioeconomic background, but have also seen clients from more affluent communities, students in college and folks struggling with co-occurring substance use, as well as women and men diagnosed with HIV. Racial descriptions shared were African-American, Korean, Haitian, Caucasian, Muslim, Arab, Portuguese, African (Eritrean), Brazilian, though most participants spontaneously shared that their lists were not comprehensive because of limitations of memory.

Types of Traumas

Participants also work with clients who experienced various traumas. Many of the types of traumas participants reported were: childhood abuse (physical, sexual, emotional), neglect, sexual assaults of many varieties, medical trauma, war trauma, terrorism, political trauma, refugee displacement, bullying, traumatic loss related to HIV, domestic/ intimate partner violence, survivors of a suicide attempts, being the loved one of someone who has been murdered/ committed suicide, internalized and externalized homophobia, harassment of all sorts, religious persecution, muggings, LGBTQ discrimination, Diagnostic and Statistics Manual (DSM) violence (meaning the violence imposed through the act of diagnosing), torture, gender-based violence, racism, clergy sexual abuse, elder abuse. Again, this list is not exhaustive of all traumas reported. There were some repeated traumas reported across participants, but by and large, the list grew longer and more varied with each additional interview conducted.

Professional and Personal Background

Preparation for Working with Trauma Clients

To the question as to whether or not participants felt prepared to do trauma work upon graduation from their degree program, all unanimously declared: "No." Several participants followed up their declaration with the additional: "no way, definitely not," or even "I didn't feel prepared to do much of anything." Others shared that because they were trained 40+ years ago that they had no content in trauma at all in their program, with one person sharing that they had never "even heard the word trauma before I graduated." Two participants that had since gone on to pursue doctoral-level education shared that they did not feel prepared following their MSW degree, but that they felt their doctoral training provided a much better foundation with regard to trauma work.

Motivation

Several themes arose when participants were asked about what drew them to trauma work. The most frequent response (given by eight participants) was that their personal experience with trauma or their own family struggles guided their career trajectory. One participant remarked, "I was so grateful for the help I received and as I worked through my own trauma, I wanted to be able to help other people do it as well." Another participant commented that their own history not only drew them to the work, but that "there are definitely parts of my own history that contributed to both my capacity to bear witness to a lot of trauma, and also strengthened my interest in understanding trauma." Significantly, a total of nine participants reported a personal trauma history, with three reporting no trauma history. Other frequently (7 participants) reported reasons for wanting to work with trauma was that they (clinicians) were "confronted by it [trauma] time and again" "on a regular and painful basis," and so this

confrontation demanded that the need be met. One participant expanded on that thought and said "the fact that it was all over the place, made it necessary to learn how to negotiate—especially as someone committed to working with oppressed populations." Four participants reported that they had experiences in their internships or post-graduate fellowships that offered them more training in trauma, and that this fostered a greater interest in the area.

Formal Trainings and Continuing Education

All participants reported that formal trainings and/or continuing education programs have been instrumental in their continued development as skilled trauma clinicians. Several participants noted that learning directly from major figures who shaped the field of trauma treatment, such as Judith Herman, Bessel van der Kolk, Christine Courtois, were invaluable in their development as clinicians as well as their understanding of the implications of trauma across the lifespan. Respondents stated that the following trainings were helpful (with the number of participants reporting attendance in parenthesis following the treatment name or theoretical stance): Eye Movement Desensitization and Reprocessing (EMDR) (5), Dialectical Behavior Therapy (DBT) (4), Trauma-Focused Cognitive Behavior Therapy (TF-CBT) (4), Internal Family Systems (IFS) (3), sensorimotor/somatic processing (2), mentalizing (1), Victims of Violence Fellowship (1), Program for Psychotherapy Fellowship (1), gestalt therapy (1), Skills Training in Affect and Interpersonal Regulation (STAIR) (1), Acceptance and Commitment Therapy (ACT) (1), Motivational Interviewing (1), Seeking Safety (1), Cognitive Processing Therapy (1), psychoanalytic training courses (1), writing/teaching (2).

In particular, one respondent noted that mentalizing was particularly helpful in helping her "manage [her] own countertransference—especially in times when perspective and communication is challenged," whereas IFS was useful in terms of "decentralizing" the role of

the clinician and maintaining the focus on the client. This respondent stated, "our healing is not going to come from another person, it's going to come from within," and added that IFS cuts through "charged interpersonal dynamics" as well as the countertransferential pull to become the omnipotent helper/rescuer—and that this has made a significant contribution to her work with clients. She reported that it "makes [her] day easier," and that she "works hard, but not in the same way" as before when her role was more central.

Also, noting the gaps in their education in relation to understanding trauma, several participants stated that these additional trainings helped to fill in the gaps in their understanding. One participant shared that trainings that approach trauma from a psychodynamic feminist orientation helped her to "look at trauma from a relational perspective, which in turn encouraged [her] to explore her countertransference more as she became of how easy to could collude in re-traumatizing simply by not taking a critical point of view."

Another significant takeaway from further trainings for one participant was simply the knowledge of the incidence of trauma in the general population. As this clinician began to be aware of how common it was for clients to have trauma in their backgrounds, he began to worry that perhaps he was "focusing on it so much that [he] might have been creating it." Through attending conferences and talking to other professionals, the high incidence of trauma was confirmed. For him, this knowledge was "both depressing and reassuring…to know that I wasn't creating this out of my experiences.

Supervision and Consultation

Supervision

Several themes emerged from participants in their responses to the questions pertaining to their supervision and consultation experiences. First, just over half of respondents noted that they

would characterize a supervisor(s) they have had as a skilled trauma clinician themselves. In other words, over half of respondents felt they were learning about trauma directly from someone who was an authority on the subject; whereas less than half of respondents did not make this same acknowledgment. However, these responses do not appear to correlate with respondents' further comments on supervision in terms of how effective and helpful their supervision(s) may have been. For example, only two respondents specifically reported that having a trauma-informed, "clinically-savvy and smart" supervisor was essential to their becoming a skilled trauma clinician themselves. Furthermore, only one participant noted that teaching specific skills (i.e. deep breathing, distraction techniques, etc.) in supervision was helpful.

These answers led me to consider what other elements of the supervisory relationship are most important insofar as the process of becoming a skilled clinician is concerned. Several key themes arose from this inquiry. All respondents reported to some extent that relational aspects were incredibly important to a good supervisory relationship. First and foremost, six respondents spoke to the importance of having a trusting relationship, and two participants bolstered this finding by adding how helpful (though difficult) it is to be able to be vulnerable with your supervisor. One particular participant's comment stood out to me when she said:

> Supervisors who could in some way, in some kind way, meet my vulnerability—whether it had to do with a reaction to a client or something more personally related to countertransference—taught me the most. In those cases, the supervisor was able to hold that with me, and allowed me to modulate the level of vulnerability and disclosure in supervision and that deepened the trust between us. Supervisors who attended in that way where I could go deeper were the ones who taught me the lesson in a lived way.

Several participants spoke to this same experience of being able to "bring the fullness of [their] experience" into supervision, "without worry of judgment," so that they had a partner in dealing with and exploring some of their most difficult countertransferential responses in a "safe, yet

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constructive" manner. To this end, four participants also noted that having a supervision space where it was encouraged to share not only successes, but also failures or mistakes, was crucial, with one person describing this particular aspect as "invaluable." One participant even reported that she wishes that more of her supervisors would have brought up more areas/things she could have improved on. She felt that they "too often focused on what I was doing well and it left me wondering what I wasn't doing well." While she reports these experiences as "affirming," it seemed that it did not create a supervisory relationship that could hold mistakes.

Consultation Groups

Next, in seeking greater understanding about participants' experiences in consultation groups, the responses were much more varied. Three participants are not currently in groups at all, and reported that they did not find these groups helpful, but experienced them to be mediocre in terms of learning achieved in them and burdensome in their time commitment. One participant said that it takes "a lot of time and effort to keep the groups going, and it ended up being good self-care to decide to not regularly attend these groups when it felt more taxing than worthwhile." One participant does not have ready access to a consultation group at their place of employment, but mentioned wishing that there were more opportunities for group consultation.

The other participants are all currently in a consultation group at their places of employment, have sought out groups externally, or have been a part of groups that have been helpful in the past. The following responses come from this subset of participants. Similar to the responses regarding what makes supervision effective, several participants spoke to the relational aspects of a group as playing a significant role in its effectiveness. Themes here included: establishing trusting relationships, mutual respect, and the understanding of a shared interest (trauma work). One participant specifically noted that "learning in a group context is an

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important part of therapy learning—just as group work is important to trauma recovery."

Another shared that the groups were "helpful insofar as they helped me to understand myself as well as how I worked with my clients. The groups demanded the need to be vulnerable." Many respondents shared that they learned a lot about themselves in the process of being part of a thoughtful consultation group. Furthermore, several interviewees spoke to the deep learning that comes along with the vulnerability of sharing in groups—that sharing successes and mistakes can be incredibly normalizing and help clinicians work through a particularly difficult impasse with a client. One respondent shared that a long-running consultation group she attends has been a "huge source of support" in her work. This group has worked "over many years to build trust and all members have an incredible and inspiring commitment to the work—we learn so much from each other because we're not afraid to be honest because the commitment to taking care of each other is there."

Wisdom Gained, Challenges Faced, and What Sustains

Top Three Factors

Next, I asked participants to share the top three things that try to keep in mind when working with trauma, and several areas of focus readily emerged from their responses. Half of the participants reported that pacing in trauma treatment is of the utmost importance, with one participant articulating this point as having "a lot of reverence for the client's process and really allowing the client to dictate the pace of the work." Another respondent added, "You can't jump into the trauma or even the stabilizations for that matter. You need a good sense of the person and what they can bear before you can do anything." Accenting this finding, 5 participants spoke to the importance of creating safety in treatment in general. Participants further expanded what they meant by safety to include: being aware of the possibilities for "enactments,"

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"communicating to the client that they have control throughout the process," "having a good sense of the client's strengths and vulnerabilities, and not jumping into trauma too soon," "creating a room [literally] that is contained and can serve as a container for the process." Three participants discussed the importance of self-care—with mentions of how trauma work in particular "will evoke a whole host of difficult reactions" that will need attending. Finally, another participant reported that in trauma treatment, "it is not a question of if you're going to experience vicarious trauma, but when…" and spoke to the importance of preparing for it, dealing with it when it comes up, but most importantly, how it is necessary to "be on the lookout" for the ways in which a clinician might get triggered.

Vicarious Trauma

To that end, five respondents specifically mentioned vicarious trauma as one of the greatest challenges to their work. Also, while not specifically naming it as vicarious trauma, another four participants spoke to the difficulty of doing trauma work with clients that is particularly difficult or triggering for the clinician. One participant reported that for her, some trauma histories "have an incredible staying power…that can be an incredible honor [to hear], and it can be painful." She went on to say that, "sometimes hearing these stories can be excruciating, and in some ways I want it to be…I hope to never develop a callous where it doesn't impact me because I think our being impacted helps us think about ways we can be helpful. But we also need to figure out ways to not let it break us, because we can't provide help if we are broken."

Two participants spoke to the need of working to identify what clients they might not be best suited to work with. One respondent said that she knows that she is "not a good therapist for trauma survivors who then become perpetrators themselves." She went on to say that that "would

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be hard for anyone, but it is impossible for me, and I just draw a line there." Another respondent said that he finds it triggering to "work with people who have experienced traumatic loss that echo the ways in which [he] has experienced traumatic loss as well"—noting that it is just too difficult to maintain a therapeutic distance in those instances.

Resource Availability vs Client Needs

Balancing what is often an overwhelming lack of resources with clinical need was another commonly shared challenge with three participants sharing it as a response. Two participants said that this problem is not one that is permanently solved, with one saying that she has "not so much worked through this challenge, but rather, have learned ways to live with it." For one participant, this has meant that she does what he can, when she can: "I vote and am vocal in the political sphere, and I am vocal in advocating for clients as needed along the way," but "I've also been really disappointed over the years when there has been a greater need and a greater response can't be worked out."

In response to the question about what they would do if they were ever unsure of how to proceed in treatment, eleven out of twelve respondents said that that would seek consultation. One participant specified that she would especially seek consultation if there were ever a "heightened level of risk," but most respondents simply and succinctly said that they would "consult" and that they have when they have been unsure of how to proceed. The one participant who did not report this said that she would bring up the conflict or difficulty with the client directly, seeking to elicit the client's expertise into their situation, but also "being honest when they [the clinician] might be feeling as if the client is stalling in treatment or maybe point out that they've noticed missed sessions if that's the case."

Sustaining Factors

Self-care and relationships. Overwhelmingly, in response to what helps to sustain clinicians in their work, respondents talked about self-care practices and the importance of meaningful relationships in their personal lives. Eleven participants reported that their families and primary relationships are most sustaining to them. One participant expounded that she just "care[s] about people [in general], and that is sustaining in and of itself." Another shared that her most intimate and close relationships helps her to prioritize a "healthy work/life balance—because I don't want to be so exhausted from work that I lose out on meaningful time with my family." Four participants noted that having colleagues to connect with around these issues is also crucial to feeling supported and therefore, able to sustain doing this difficult and draining work: "having colleagues and even supervisees who I have the privilege of working alongside gives the stress an outlet and a source for energy to continue doing the work." Ten participants also discussed their various self-care practices which include, but are not limited to: body work (exercising, yoga, etc.), ensuring basic needs are consistently met, creative practices (art, music, dance, etc.), and spiritual and meditative practices.

Client resiliency. Participants (seven) also reported that witnessing clients' resiliency as well as seeing them make positive changes and get some relief from their symptoms also plays a significant sustaining role in their work. One participant put it this way: "it is always gratifying to see someone make progress in their therapy. Over the many years I have been practicing, I have come to recognize that most people I've been able to work with seem to get some sort of relief from their symptoms and end up leading happier and more productive lives." Another participant said poignantly, "there is this whole process of destruction and healing in the world, and they are just always going on and we're always participating in them; and I guess I have

developed, over time, a great faith in the process." Yet another respondent said, "I am just so impressed by people's resiliency—those moments of awe translate into passion for the work."

      Political action and advocacy. Finally, another notable finding on this topic of sustenance is that several respondents (four) found that being politically active, having a passion for social justice, and fighting and advocating for justice in the ways clients are treated and working against what brings them to treatment in the first place has been an outlet that has provided nourishment for clinicians. One participant stated that she takes it to be a responsibility of "accountable social work to do the kind of justice work of fighting for change in society and not just within an individual," while another respondent described her drive for being politically active as grounded in her belief that "trauma is not a mental disorder—it is not about biology, it's about an environmental failure. So being organized in fighting on that level [political sphere] and advocating there is really important."

Directions for the Future

      In an effort to better understand what participants think is most important to know while in training to work with trauma, as well as what would be/have been most helpful in their training, I asked them the final two questions on the interview guide: 1) From your experience, what is the most important for students to know in preparing for this work? 2) If you could change one thing about how clinicians are trained, what would it be?

      The first question was somewhat similar to asking them for the top three things to keep in mind when working with trauma. As a result, there were some similar responses. However, this question did not as readily yield themes. Because I thought the answers to this question were particularly poignant, I will share quotes from all participants in Appendix E. Here, I will simply highlight a few that display the variety of responses as to what clinicians thought most important

for students to know as they prepare to work with trauma. One respondent shared that she

believes that "we all need to know that we share humanity and that we're not better than

anybody else…this sort of egalitarian communication goes a long way in establishing rapport

with people." A second participant echoed a previous sentiment about pacing being of the utmost

importance:

> …the whole pacing thing. You actually don't want a client to disclose more than they're
> ready to disclose and you don't want them to be flooded with emotion. That's not the key
> to therapy; the key to therapy is helping them to be able to talk about and process what
> they've been through in a way where they end up feeling like they've released something
> as opposed to feeling like they've been torn apart.

Finally, one participant simply and powerfully offered: "People get hurt in the context of

relationships, but they can also heal in the context of relationships. That's where the hope is;

that's where the power is in the work."

As responses to the final question pertaining to what participants would want to change

about the ways in which clinicians are trained were equally as varied as the previous questions, I

will once again share quotes from all participants in Appendix E and will only highlight a few

here. A couple of participants discussed wanting to make sure that students and new

professionals receive better and more effective supervision. To this point, one respondent shared:

> I would want to ensure that each clinician received at least one hour of supervision each
> week in an environment where they are respected, challenged, heard, and listened to in a
> non-judgmental way, and where they would be encouraged to take risks and be the best
> clinician they can be. Too many young clinicians are not being well supervised and I
> think our field is suffering because of that.

A second specifically added an emphasis on bringing in-person implications into supervision

when she said,

> I would want to prioritize students' learning that they are going to be affected
> emotionally by this work, and that's part of the process. Also, that the supervision that
> students get requires the same amount of emotional availability that seeing clients does. I

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want supervisors to talk to students about their countertransference and I hear all the time that that is not really happening.

Another participant offered that "there is not enough emphasis on the development and use of the therapeutic relationship as a forum for healing. Skills can be learned through protocols, but healing happens in relationship and there isn't much space for that anymore." Finally, one participant succinctly stated: "I would make sure everyone was in their own therapy."

Summary

Major findings from twelve semi-structured interviews with practicing licensed clinical social workers who are experienced in working with individuals who have experienced trauma have been presented in this chapter. Significant findings were derived throughout the interview, though perhaps most relevant to the professional development of aspiring clinicians would be the responses in relation to what the experienced clinicians deemed most noteworthy. The following chapter will explore interpretations of these findings as well as glean significance from the most salient findings. Additionally, strengths and limitations of the study will be discussed. Finally, suggestions for future research will be presented.

CHAPTER V

Discussion

The objective of this qualitative study was to explore the gap in the literature of understanding the experiences of clinicians who work with trauma as well as to gain an understanding of what helped clinicians to prepare for trauma work. While the need for integrated trauma training and a basic understanding of important components to a clinician's preparation to effectively treat trauma exists in the literature, additional concerns and areas of importance, as well as profound experiences were described throughout the interview process in the current study. Furthermore, while many themes arose throughout data analysis across participants, it also became clear that in some areas individual preferences for salience in learning style and therapeutic approach were as unique as the individual participants themselves. Thus, in this chapter I will discuss key findings as well as any particularly striking contributions shared by participants. The major sections presented in the chapter are: 1) key findings, which includes a comparison of study results to previous literature; 2) implications for social work practice; and 3) recommendations for future research in the area of understanding how clinicians work with trauma.

Key Findings

The complexity and difficulty of working with people who have experienced trauma were explored through narratives of seasoned professionals in the field of psychological trauma. Though the study was open to clinicians across all mental health disciplines, all the respondents were social workers (at the master's or doctoral level). This restricted sample had to do with the

network from which the researcher has the greatest number of contacts. While this narrow sample may skew the data in unknown ways, this researcher believes that of greater importance is the significant years of experience and expertise in the field that participants brought to bear in their responses to interview questions. This section explores the results of the study in comparison to previous literature that emerged in the literature review, and is divided into the following subsections: 1) clinician caseload; 2) types of trauma; 3) professional and personal background information; 4) formal trainings and continuing education; 5) supervision and consultation; 6) wisdom gained; 7) vicarious trauma; 8) self-care; and 9) political action and advocacy.

Clinician Caseload

As described in the literature on the prevalence of trauma, participants reported a high incidence of working with clients with historical traumatic experiences. Participants also reported working with clients from diverse socioeconomic backgrounds which challenges the commonly held notion that trauma primarily impacts poorer communities. Furthermore, in challenging this notion, these results give further credence in terms of what was too "unacceptable" to Freud; namely, that trauma is endemic, and "not only among the proletariat...," but also among the bourgeois of society (Herman, 1992, p. 14). However, more research specifically looking into incidence of trauma across diverse socioeconomic backgrounds is needed.

Types of Trauma

As I asked participants to describe the types of traumas with which they have worked with their clients, I became aware of a growing personal sense of despondency as the list continued to grow longer and longer with every additional interview. I think I approached this

question with an assumption that the list of types of trauma would eventually not yield distinct and different types of trauma. Therefore, I felt despondent in the face of confronting the realization that humans are always capable of finding new ways of hurting other humans. The despondency I felt is consistent with the belief that has often led the field of study of psychological trauma to be too powerful and overwhelming to remain in the forefront of consciousness of many scholars in the field. As Herman (1992) states, "to study psychological trauma is to come face to face with human vulnerability in the natural world and with the capacity for evil in human nature" (p. 7). This is not easy and yet, this is the work to be done.

Personal and Professional Background

Unanimously, respondents confirmed findings in previous research that clinicians do not feel adequately prepared to work with trauma following graduation from their degree programs (Cook et al., 2011). This is an important finding as programs have often been rigid and slow to change, which might be partially explained again by the "societal ambivalence" and amnesic effect that trauma has had in the field throughout its study (Courtois & Gold, 2009, p. 13). However, as the field of psychological trauma does seem to be gaining a stronghold in the realm of larger areas of psychological study, it will be interesting to continue to monitor how responses to this question may change in years to come.

The time frame for completing this study was eight months. At the time of conducting the literature review, no substantial research was found that explored the relationship of exposure to personal trauma in motivating clinicians to work with trauma. However, it is noteworthy that three-quarters of respondents reported some exposure to personal trauma. Some participants also noted a belief that their own trauma history not only "strengthened [an] interest in understanding trauma," but that this history also contributed to their capacity to "bear witness to a lot of

trauma." Thus, it seems incumbent on future researchers to study this relationship in the hopes of a) confirming or refuting this belief, and b) to better understand the mechanisms by which greater capacity is created in survivors of trauma.

Formal Trainings and Continuing Education

Cook et al. (2011) called for more research "in regard to which practitioners provide psychological services to trauma survivors, what they are currently doing, and what kinds of training prepared them" to be able to do this work (p. 6). The major objective of the current study sought to understand and explore exactly these questions. As there is no previous literature on the subject, it is impossible to know compare the results of this study. As the responses were quite varied in terms of types of additional formal trainings (from continuing education courses to two-year fellowships) as well as ad hoc trainings that clinicians may have received in the agencies in which they worked, no trend readily appeared in data analysis. However, insofar as every participant listed several trainings of varying intensities, one conclusion seems to be that it is imperative to seek outside educational opportunities to fill in the gaps of understanding trauma following graduation. The influence of these outside continuing education opportunities appears to be incredibly vital. For example, one participant's greatest takeaway was to simply understand the high incidence of trauma in the population which helped to allay his fears that he might "focusing on it so much that he might have been creating it." Another takeaway is the fact that these trauma clinicians have taken such a variety of supplemental trainings shows that these clinicians are devoted to furthering their proficiency with a variety of modalities and interventions in order to best meet the needs of their clients.

Supervision and Consultation

Supervision. Aligning with the literature on the importance of the supervisory relationship on the development of clinicians, the majority of respondents spoke strongly about the importance of having a trusting relationship with a supervisor. Further bolstering previous literature was the fullness with which participants spoke about the importance of relational elements in the supervisory relationship. Courtois and Gold (2009) state that supervisors who have the ability to model openness and "humanness" give students the clearest example of how to build the skills necessary to do the work (p. 136). This statement supports the data from the current study in which respondents describe their hopes of a supervisory relationship in which they can bring their vulnerability, relinquish worries of judgment, and rely on their supervisors to be grounded in a safe, yet constructive stance. Furthermore, Courtois and Gold (2009) emphasize the "relational matrix" in the training of clinicians in terms of the relational context in which many traumas occur. Thus, it was particularly poignant for one respondent in the current study to reflect this belief in saying "people get hurt in the context of relationships, but they can also heal in the context of relationships. That's where the hope is; that's where to power is in the work."

Consultation. A smaller amount of literature exists on the importance and the understanding of variety of consultation groups. Consultation groups served an integral function for some clinicians' development and sustenance in practice. For others, a consultation group was at best a good place to check in for peer feedback. Consultation groups held at agencies was perceived by some respondents as a nuisance and distraction from their work. However, I also wish I had asked more specific questions about the makeup of these groups in order to gain a clearer understanding of why consultation groups work well or what gets in the way when they do not work well. Respondents who appreciated and attended consultation groups shared a

similar emphasis on the relational (i.e. trust and shared interest in a topic area) components that were shared regarding the supervisory relationship. Thus, I might consider that this discrepancy between clinicians' varied responses to consultations groups might have more to do with personal differences and preferences as well as good "fit" of the group.

Wisdom Gained

It was interesting to note that in reporting what wisdom these clinicians have gained over the years, nearly all of the respondents referred to the stage model of trauma treatment. The notion of pacing, and following the client's needs, and creating safety in the therapeutic relationship were highlighted by all clinicians. Given that these clinicians have taken a variety of trainings and educational opportunities that have helped to shape them into experts in the field, it was both interesting and reassuring to see that, by and large, trauma theory is continually developing, being refined. Yet, theoretical positions regarding the etiology and treatment of trauma are taking hold and generally being regarded as foundational to the work, and particularly a stage model understanding of the treatment of trauma.

Vicarious Trauma

In hindsight, I wish I had included a search on vicarious traumatization in the literature review as it was such a common concern mentioned throughout the interviews. Respondents were in general agreement that vicarious trauma was important to be mindful of; and that part of the work in paying attention to themselves was having colleagues or mentors with whom they could discuss issues related to vicarious trauma. Participants noted that a balance needs to be maintained between taking care of one's self throughout the work while allowing themselves to remain affected and touched by their work with clients, and not wanting to "develop a callous response" to the stories and experiences of their clients. However, vicarious trauma, in and of

itself, is such a rich topic that it could also be better suited to a separate research inquiry that could explore the themes that arose in more depth.

That clinicians bore witness to a great amount of trauma, but also noted a tremendous amount of resiliency within their clients was a key finding in terms of what helps to sustain clinicians in their work. It seems very poignant that by remaining present to bearing witness to trauma in the work we expose ourselves not only to the trauma, but also to the store of resiliency and strength that our clients draw on and work to triumph in their lives. Alongside a further study of vicarious trauma in clinicians who work with a great deal of trauma, a study exploring the intricacies and implications of vicarious resiliency would be worthwhile in further cultivating preparedness in clinicians to work effectively with trauma.

Self-Care

Overwhelmingly, respondents reported how important their family and primary relationships are to them in sustaining them through this work and in maintaining a healthy work/life balance. It is also not surprising that other self-care strategies employed by participants were as varied as the participants themselves. Again, it seems that the majority of clinicians place caring for the body as integral to alongside caring for the mind. As this was an exploratory study seeking to gain a broad, yet rich picture of what training entails for clinicians who work with trauma, more research would be needed to specifically explore the function and efficacy of various self-care practices that clinicians employ, yet this is outside the scope of the current study.

Political Action and Advocacy

Finally, and importantly, one third of participants felt that it was important to remain politically active and advocate for justice. As this study sample was comprised of social workers,

it is not surprising that several clinicians mentioned a passion and "responsibility" to do justice work as ascribed in the National Association of Social Workers Code of Ethics: "Social workers challenge social injustice: Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" (National Association of Social Workers, 2008). Furthermore, throughout the larger history of the study of psychological trauma, periods of time when the study of trauma has flourished have coincided with support and legitimacy offered by coinciding political movements of the time (Herman, 1992, p. 9). Thus, it is prescient and of vital importance that clinicians continue to remain ever ardent in their pursuit of justice and healing for all of their clients.

Implications for Social Work Practice

Previous literature makes a compelling case for the need of skilled trauma clinicians given the high prevalence of trauma in our society and around the world. It is thus imperative that as clinicians we familiarize ourselves with how to work with trauma, recognize its effects and responses in our clients in order to provide competent care—especially to the most vulnerable among our clients. The findings of this study provided valuable information to clinicians, educators, and students alike on the experience of doing trauma work. Administrators of training programs could draw on this data and results from previous studies to implement changes in their curriculum to include more extensive training in trauma treatment and theory. The findings may also be useful to students who wish to be as prepared as possible to be work as effectively as they can when presented with trauma in the clinical encounter. While waiting for academic programs to make changes to curricula, students may draw from the wisdom of the experienced clinicians interviewed in this study to gain ideas and devise a plan to seek out the

training opportunities necessary to best prepare them for trauma work or to further their professional development.

Strengths and Limitations

There are several limitations to the data presented and the interpretations offered. First, the study sample size and representativeness was limited. Due to time constraints of the overall study as well as the time allotted for participant recruitment, a more representative sample of clinicians from across mental health disciplines could not be attained. However, while generalizability to all mental health professionals might be weak with this current study, generalizability to social workers in particular, as well as to the field of social work, may be a strength of this study. Further, a great strength of the sample was their combined 328 years of clinical experience working with trauma.

The interview questions were self-developed and received feedback from a known expert in the field, but there is likely to be a certain amount of bias involved. The researcher followed the interview guide as closely as possible, but at times needed to clarify a question and probe for more depth throughout the interviews, and thus, potentially unaware of introducing researcher bias into the process. Furthermore, as all of the interviews took place over the phone and in direct conversation (which some might perceive as intrusive), and this method may not have been the most ideal format to elicit the most reflective responses. However, despite trauma being a charged topic to discuss over the phone for some, all respondents could be considered experts in the field, and thus, have an understanding of their own limitations and comfort level, and likely self-adjusted along the way.

Recommendations for Future Research

As already stated time was perhaps the greatest limiting factor in terms of participant

recruitment as well as completing the most robust and complete literature review possible. Further research could be conducted to include a larger sample, which might include clinicians from a variety of mental health disciplines. Further research is also warranted to follow up on threads discovered through data analysis of this study. For example, how might the results from this study compare to a study with a sample of clinicians from a younger generation? As trauma theory is becoming more widely known across psychological research disciplines, might a younger generation's responses reflect this in terms of training and competence?

As previous literature found that clinicians who do not identify as working with trauma have relatively little interest in further trauma training, more research is needed to understand more of what is behind this lack of motivation (Cook et al., 2011, p. 6). Further, given the prevalence of trauma, it is surprising that clinicians would report not working with trauma at all (Cook et al., 2011, p. 6). Thus, further research is also warranted in order to understand how these clinicians operationally understand trauma.

Conclusion

Overall, the present study provides useful information on what helps clinicians to become skilled and expert clinicians in the field of trauma. The narratives of the clinicians interviewed offered rich experiential descriptions of what trauma work looks like, as well as shared many meaningful takeaways from clinicians who have managed to stay in the field for many decades. The purpose of the study was to begin to fill in the gap in existing literature between the high prevalence of trauma, the fact that most clinicians do not feel prepared from their degree programs to do trauma work, and what clinicians are then doing to seek out appropriate training in order to do the work they feel most called to do. It is a hope of this researcher that while we wait for programs to do the work of integrating trauma theory and training into curricula in a

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more robust way, students and clinicians might use the findings from this study to help guide

them in their formation to be a skilled trauma-informed clinician.

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Appendix A: 1

Human Subjects Review Committee Approval Letters

SMITH COLLEGE

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

December 10, 2016

Allyson Lent

Dear Ally,

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

Please note the following requirements:

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

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

In addition, these requirements may also be applicable:

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

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

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

Congratulations and our best wishes on your interesting study.

Sincerely,

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

CC: Jean LaTerz, Research Advisor

SMITH COLLEGE

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

January 19, 2017

Ally Lent

Dear Ally:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

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

CC: Jean LaTerz, Research Advisor

School for Social Work
Smith College
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February 21, 2017

Ally Lent

Dear Ally:

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

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

CC: Jean LaTerz, Research Advisor

SMITH COLLEGE

2016-2017
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
……………………………………………………………………………..

Title of Study: Working with Trauma: A Qualitative and Retrospective Exploration of the Experiences of Clinicians Who Work with Trauma

Investigator(s):
Allyson Lent, alent@smith.edu

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Introduction
- You are being asked to be in a research study seeking to understand the experiences of clinicians who work with trauma.
- You were selected as a possible participant because you are a mental health professional (for at least 5 years) who has worked with people who have experienced trauma.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to gain a retrospective understanding of clinicians' training and career experiences in an effort to glean how clinicians are being prepared for their work and what has worked well in preparing clinicians to work with trauma.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
If you agree to be in this study, you will be asked to do the following things: meet with the researcher, sign the consent form, and be interviewed for approximately 45 minutes to an hour. The interview will be audio recorded.

In a rare and for some unforeseen reason, the researcher may need to reach out for further clarification or follow-up, but this is not likely.

Risks/Discomforts of Being in this Study
- There are no reasonable foreseeable (or expected) risks.

Benefits of Being in the Study
- The benefits of participation include having an opportunity to share part of your story of how your career has developed and how you've grown into the clinician you are today. Further, you may also gain satisfaction in knowing that your contribution may help bolster an argument for better and more integrated trauma training in degree programs.
- The benefits to social work/society are include providing further evidence about what training methods are most beneficial in cultivating skilled trauma clinicians which has the added effect of better serving and meeting the needs of our clients.

Confidentiality
- Your participation will be kept confidential.
- Consent letters with participant names will be kept separate from notes, recordings, and transcripts. If the interview is conducted in person, the researcher will work to find a mutually agreeable location that is secure and private.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2017. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Allyson Lent, at xxxxxxxxxxxxxx or by telephone at (XXX)XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

I agree to be audio **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix C:

Recruitment Email

Dear potential participant,

I am clinical social work intern at the UCSF Alliance Health Project. I am also a student at Smith College School for Social Work and am conducting a study for my degree requirements. I am looking for participants. Even if you do not meet criteria to participate, it would be very helpful if you know of someone who might be eligible if you would be willing to pass along their contact information or put the two of us in contact.

In short, here is a summary of my study:

I am planning to interview 12-15 people who are skilled trauma clinicians. Data show that across disciplines (counseling psychology, clinical psychology, social work, etc.) there is an alarming lack of deep and integrated training in working with people who have experienced trauma. This study seeks to gain a retrospective understanding of clinicians' training and career experiences in an effort to glean what has worked well in preparing clinicians to work with trauma. In particular, the interview will explore a clinician's degree program, post-grad training, experiences with supervisors and/or consultation groups. This is an opportunity to reflect on one's career, what got you to where you are today, and this study will hopefully gain insight into areas of strength as well as weakness in how trauma clinicians are trained and what sustains them in their work.

Participants must be:
- o Trauma clinician (licensed to practice in their state), with at least 5 years of experience.

Participation in this study is estimated to take approximately one hour of the clinician's time. Interviews will be audio recorded, but kept private and confidential.

No compensation is available for participation as I am student with limited resources.

If you or someone you know may be interested in participating, please let me know. Likewise, if you know of another professional who may know where to contact other potential participants, please let me know.

Thank you for your time and consideration!

Allyson Lent

Appendix D:

Interview Guide

Demographic Information
- Personal Demographics: Age/Race/Gender/Geographic Location?
- How many years of professional experience do you have, specifically working with people who have experienced trauma?
- How many hours per week do you spend working with survivors?
- What does your client caseload look like? And has this changed over time? (i.e. time spent in case management, individual versus group therapy, administrative work, etc.).
- Describe your clients. (i.e. types of trauma, populations served, etc.).
- What degree program(s) did you graduate from? When did you graduate?
- Did you feel prepared to do trauma work after completing your graduate degree?

Brief Background
- What has your career path looked like to get to where you are now?
- What drew you to trauma work?
    o Do you have personal experience with trauma?

Training Experiences
- What (if any) other formal training programs have you participated in? (i.e. Dialectic Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), post-graduate training (fellowships), etc.).
- How have supplemental trainings been helpful? Which ones in particular? (i.e. CEs).
- What other experiences do you feel were helpful/formative in your development as a skilled trauma clinician?

Supervisory and Consultation Experiences
- What did you find most helpful in your experiences with a supervisor? Least helpful?
- Were any of your supervisors skilled trauma clinicians themselves?
- Did you make use of any consultation groups post-grad?
    o Were they helpful? How were they structured? Trauma specific?
- When you were unsure of how to proceed in treatment with a traumatized client, what did you do?

Wisdom Gained and Challenges Faced
- What are the top three things to keep in mind when working with traumatized clients?
- What challenges have you experienced?
    o How did you overcome them?

- What sustains you in this work?
  - Broadly and specifically.

Directions for the Future
- From your experience, what is the most important for students to know in preparing for this work?
- If you could change one thing about how clinicians are trained, what would it be?

Appendix E:

Supplemental Data

Question: From your experience, what is the most important for students to know in preparing for this work?

1. "Students always need fantastic support and supervision and someone to turn to. This is not work to be done alone."

2. "Read your Judith Herman, Bessel van der Kolk, Tony Morrison—really become acquainted with all of the faces of trauma in literature and in our field. Know what you can and cannot work with, and work with the process, gently untangling threads, and don't hurry. Rupture will occur at times, and then the work is to repair and resume the attachment."

3. "The whole pacing thing… You actually don't want a client to disclose more than they're ready to disclose and you don't want them to be flooded with emotion. That's not the key to therapy; the key to therapy is helping them to be able to talk about and process what they've been through in a way where they end up feeling like they've released something as opposed to feeling like they've been torn apart."

4. "Find a way to establish safety in yourself and in the dyad. There is nothing else to think about or to do until that is there, and that is done by being attune to yourself and to the other person."

5. "We all need to know that we share humanity and that we're not better than anybody else. We're just as capable as having a trauma happen; we may have been luckier than them, but we're not better than anyone. And if you have a quality about you that says this, then this sort of egalitarian communication goes a long way in establishing rapport with people."

6. 'We are in a position to become more reflective and thoughtful, and that would be my hope for the future—more thoughtfulness."

7. "It is not a matter of IF, but of WHEN with regards to experiencing vicarious traumatization, and you must be aware of that."

8. "Self-care is super important. Know your boundaries, be true to them and respect your boundaries. Also, know when to call in sick. We don't have mental health days in the mental health field, so you need to know for yourself when you need a mental health day, and take care of yourself."

9. "You are going to encounter trauma, regardless of the field you go into. Be aware of the high incidence of trauma, unfortunately, in our society. Do not be discouraged by it, but do seek out training that will help you become a better clinician along the way."

10. "Remember that the agenda has to be set by the client and not by the clinician. Clinician has to follow the client's need and take responsibility for maintaining a non-traumatizing format and pace."

11. "People get hurt in the context of relationships, but they can also heal in the context of relationships. That's where the hope is; that's where the power is in the work."

Question: If you could change one thing about how clinicians are trained, what would it be?

1. "I would want to ensure that each clinician received at least one hour of supervision each week in an environment where they are respected, challenged, heard, and listened to in a non-judgmental way, and where they would be encouraged to take risks and be the best clinician they can be. Too many young clinicians are not being well supervised and I think our field is suffering because of that."

2. "In general, clinicians need to be trained to do less, to no be doers...but to really be present and understand the power and the value of the relationship."

3. "I would want to bring psychoanalytic thought back and put it in the foreground, and bring back the concept of the unconscious. We're going to lose all the things that are really healing if we don't understand that the mind is so much more than what we're aware of."

4. "I would want to prioritize students learning that they are going to be affected emotionally by this work, and that's part of the process. Also, that the supervision that students get requires the same amount of emotional availability that seeing clients does. I want supervisors to talk to students about their countertransference and I hear all the time that that is not really happening."

5. "Highlight that trauma must always be put in context, and to teach students that before they get into any particulars relating to the trauma, that the trauma has been put into context and that the environmental failure in which it occurred is understood."

6. "I think clinicians need a lot more watching of other sessions during training. Perhaps using video tapes of their own sessions in place of process recordings. And role plays are also beneficial because you can see and try things in action."

7. "I want students to engage more in supportive and reflective supervision where they have freedom and support for understanding mistakes and celebrating successes and can be open to learning without fear or blame or any kind of negative reaction. Also, video-recorded sessions are a great and underutilized tool to use in supervision."

8. "In general, programs need to include more clinical training. So many programs have plenty of policy and research components and they don't include enough hands-on clinical training in the classroom."

9. "I want more training exercises in the classroom, and perhaps one-way mirror training exercises. So much of our work is hidden and it need not be. If we make ourselves vulnerable and take risks and welcome other people into our sessions (always with consent and confidentiality of course) we open ourselves up to deeper and far more valuable feedback."

10. "I want there to be a much stronger emphasis on phase-oriented model of trauma treatment. Too often I see students wanting to jump in too quickly, and unfortunately, I've also seen many clients who have been damaged by therapists who did not follow a stage model of treatment. Students need to know that the timing of uncovering work is really essential and often it means slowing down the treatment."

11. "I would make sure everyone was in their own therapy."

12. "There is not enough emphasis on the development and use of the therapeutic relationship as a forum for healing. Skills can be learned through protocols, but healing happens in relationship and there isn't much space for that anymore."