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Prevention of Vicarious Trauma: Are Coping Strategies Enough?

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STRATEGIES ENOUGH?

Prevention of Vicarious Trauma:

Are Coping Strategies Enough?

Submitted by Angie Gerding
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, publicly present their findings. This project is neither a master's thesis nor a dissertation.

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Abstract

Social workers are increasingly being called on to assist a greater proportion of clients who have experienced trauma. As a result clinicians are exposed to greater chances of developing vicarious trauma. The clinician may experience higher levels of stress, unwanted/distressing images of trauma material, sleep disturbance, and anxiety (Cunningham, 2004). Researchers have found that the signs and symptoms of vicarious trauma can decrease if the clinician uses commonly recommended coping strategies to help control the unwanted disturbances of working with traumatized clients (Bober, Regehr, 2005). These coping strategies include leisure, self-care, supervision, and spirituality activities. A quantitative survey was sent to 450 social workers in the metro area with a license level of LGSW or LICSW. The purpose of the survey was to investigate the effectiveness of commonly recommended coping strategies at reducing the signs and symptoms of vicarious trauma. A total of 62 surveys were returned and the data was carefully analyzed. The literature reviewed and the data obtained from the data analysis contained similar findings. The findings found that leisure, self-care, and spirituality activities all had a strong relationship for reducing a clinician's score on the quality of life scale. Supervision activities had a weak relationship between time spent engaging in supervision activities and a participant's score on the quality of life scale. To date, most research has focused on what individuals can do to address vicarious trauma. Further research should explore what can be done at the organizational level to help reduce the signs and symptoms of vicarious trauma.

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Vicarious trauma is a growing concern for clinicians who work with clients who have experienced trauma, yet it receives little clinical research attention. In 1990, McCann and Pearlman created the term vicarious trauma to describe the negative impact of trauma treatment on clinicians. Vicarious trauma is now defined as “the course through which the therapist’s inner experience is negatively transformed as a result of empathic engagement with client’s traumatic material” (Canfield, 2008, p. 88). Vicarious trauma characterized the cumulative effect of working with survivors of traumatic life events, such as disasters, childhood sexual abuse, physical or sexual assault, and domestic violence (Trippany, Kress, & Wilcoxon, 2004).

Given high prevalence rates of trauma exposure in the general population, social workers face a high rate of professional contact with traumatized clients. The general population reports a lifetime prevalence of exposure to traumatic events that ranges from 40 percent to 81 percent (Bride, 2007). Moreover, although the reporting of being exposed to traumatic events among the general public is high, reporting is higher amongst the subgroups of individuals with whom social workers are likely to work. Between 82 percent and 94 percent of outpatient mental health clients reported a history of exposure to traumatic events, with 31 percent to 42 percent meeting criteria for Post Traumatic Stress Disorder (PTSD) (Bride, 2007).

Many researchers have found that work with traumatized clients has negative consequences on the clinician (Baired & Jenkins, 2003; Cunningham, 1999). A clinician’s cognitive world is often altered by the verbal exposure to a client’s traumatic material (Baired & Jenkins, 2003). Hearing the traumatic material of the client’s trauma often leaves the clinician’s beliefs about self, others and the world distorted (Baired &

Jenkins, 2003; Cunningham, 1999). Many researchers have found that a disruption in the one's worldview is "perhaps the most distressing aspect of vicarious trauma and may affect one's sense of trust, raise concerns about personal safety, result in avoidance of stimuli reminiscent of the trauma, and diminish one's view of human nature" (Cunningham, 2004, p. 307).

Vicarious trauma is pervasive and when the clinician does not address these issues right away, trauma begins to affect all areas of the clinician's life. Vicarious trauma affects a clinician's feelings, relationships, and non-work life as well as work with clients (McCann & Pearlman, 1990). It can cause emotional, cognitive, behavioral, and physical symptoms. The clinician may experience higher levels of stress, unwanted and distressing images of traumatic material arising between client sessions, sleep disturbance, and anxiety (Cunningham, 2004).

The signs and symptoms of vicarious trauma will intensify over time and with multiple clients if not treated right away. The signs and symptoms of vicarious trauma can decrease if the clinician uses commonly recommended coping strategies to help control the unwanted disturbances of working with traumatized clients (Bober & Regehr, 2005). Commonly recommended coping strategies may include leisure activities, self-care activities, supervision activities and spirituality activities. The clinician should focus on maintaining a balance between work and personal life, peer consultation, supervision or professional training, vacation time, exercise, stress management, and self-care plans.

Social workers are increasingly being called on to assist a greater proportion of clients who have experienced trauma. A large amount of research focuses on the effects trauma has on clients, however, less research has been focused on the clinicians that treat

traumatized clients. The little available research has found that clinicians who work with traumatized clients may develop reactions specific to the traumatic nature of the client's material.

The purpose of this project is to further explore whether specific coping strategies are effective at improving clinicians' quality of life amongst clinicians who work with clients with a primary diagnosis of Post Traumatic Stress Disorder. The project will explore how often clinicians engage in commonly recommended coping strategies and whether those coping strategies are effective at reducing distress and vicarious trauma symptoms. The project will explore four areas that represent the commonly recommended coping strategies. These areas include leisure, self-care, supervision, and spirituality activities.

Literature Review

Vicarious Trauma

The term vicarious trauma is used to assist in understanding the experiential process of clinicians who work with those who have experienced trauma (Pearlman & Saakvitne, 1995). According to McCann and Pearlman, "clinicians who work with victims of trauma may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (1990).

Researchers have found that vicarious trauma symptoms are developed over time and are the result of being exposed to multiple clients and multiple stories of trauma (Cunningham, 1999). Vicarious trauma manifests differently in each individual.

Risk Indicators of Vicarious Trauma

Researchers have found six main reasons clinicians are at risk of developing vicarious trauma symptoms. These include age/lack of experience, exposure to traumatic client material, empathy with trauma survivors, insufficient recovery time, unresolved personal trauma and absence of coping skills (Bell, Kulkarni, & Dalton, 2003; Canfield, 2008; Jordan, 2010). Many people are drawn to this work because of a deep belief in social justice and a personal desire to foster social change. However, these beliefs, combined with being exposed to traumatic client material, empathy, insufficient recovery time, and unresolved personal trauma, increases one's vulnerability to vicarious trauma.

Age/Lack of Experience. Researchers have found that younger clinicians are more susceptible to symptoms of vicarious trauma because of lack of experience (Baird & Jenkins, 2003; Bell, Kulkarni, & Dalton, 2003; Cunningham, 1996). They have found that clinicians do not develop effective coping strategies for dealing with the effects of trauma (Bell et al., 2003). They haven't had proper time to integrate traumatic stories and experiences into their belief systems. Mclean and Wade (2003) found in a study on vicarious trauma symptoms in trainees that a greater disruption in cognitive schema is associated with age of the clinician. Researchers have found that novice workers, regardless of age, are at greater risk for developing vicarious trauma (Bell et al., 2003). Novice workers do not have as much experience working with traumatized clients. As a result, they experience vicarious trauma symptoms with greater intensity (Bell et al., 2003).

Exposure to traumatic client material. Exposure to a client's traumatic material has been found to be one of the most important predictors of the development of

vicarious trauma symptoms (Bell et al., 2003). In some cases, exposure to traumatic material will lead to disrupted beliefs about self and others. Painful images and emotions related to the client's traumatic memories might become incorporated into the therapist's mind causing the therapist to develop their own graphic memories of the traumatic event. (Baird and Jenkins, 2003).

Empathetic engagement. Empathetic engagement with clients is one of the main roles of a clinician working through the recovery process with a client who has experienced trauma (Canfield, 2008). However, empathetic engagement also makes clinicians vulnerable to the detrimental effects of vicarious trauma (Canfield, 2008), as many theorists have speculated that a clinician can develop vicarious trauma symptoms through this process (Bell et al., 2003; & Figley 1995). Vicarious trauma happens because a clinician cares about the client. When one identifies with the pain of people who have endured terrible things, one brings grief, fear, anger, and despair into his/her own awareness and experience.

Researchers have found that one of the main ways a clinician's cognitive schemas are altered is through empathic engagement with clients who have experience trauma (Canfield, 2008). Canfield (2008) states, "that a part of empathetic engagement involves bearing witness to graphic description of violent events from a victim's past, exposure to the realities of people's cruelty to one another, and involvement in past and/or present trauma-related reenactments" (p. 88).

Insufficient recovery time. Insufficient recovery time is a strong predictor of vicarious trauma symptoms in a clinician. Clinicians who work with trauma victims are often exposed to trauma stories multiple times a week. The client's powerful images may

stay with a clinician, who may at times re-experience them outside of therapy sessions. This re-experience of the client's powerful images can be in the form of flashback, dreams, painful emotions, or intrusive thoughts (Baird and Jenkins, 2003). Researchers have found that increased time spent with traumatized clients will increase the risk of stress reaction in clinicians (Bell et al., 2003). The stresses that are associated with hearing multiple stories of trauma on a daily basis will build. A clinician who fails to take time to heal or distance herself from her work is more likely to experience vicarious trauma symptoms (Baird and Jenkins, 2003).

Unresolved personal trauma. A final predictor of a clinician developing vicarious trauma symptoms is if she has unresolved personal trauma. Unresolved personal trauma can include trauma that happened in a clinician's childhood or family of origin while growing up or it can include serious injury or illness of self or a loved one (Jordan, 2010). Research indicates that a high proportion of mental health clinicians have a personal history of trauma (Cunningham, 2004; Elliot & Guy, 1993; and Pearlman & Mac Ian, 1995). Pearlman and Mac Ian (1995) found that 60 percent of clinicians who reported a personal history of trauma had significantly more vicarious trauma symptoms. A study completed by Cunningham (2003) to examine the impact of trauma on clinicians who work with survivors of sexual abuse, found that clinician's vicarious trauma is more likely to occur in clinician's who have unresolved personal trauma. A clinician who has not addressed their personal trauma histories may experience strong emotions while working with trauma victims (Jordan, 2010).

Absence of coping skills. Researchers have found that clinicians are more susceptible to vicarious trauma signs and symptoms when they do not actively engage in

coping strategies (Bober & Regehr, 2005). Researchers suggest that clinicians use a variety of coping skills to manage the signs and symptoms of vicarious trauma. These coping skills include self-care, leisure, supervision, and spirituality activities (Bober & Regehr, 2005). These skills help the clinician to maintain a balance between work and personal life.

Symptoms of Vicarious Trauma

Researchers have found that clinicians demonstrate an increased level of trauma symptomatology the more they are involved with trauma survivors. They have found that working with traumatized clients is stressful and that they are likely to be negatively affected by this work (Cunningham, 2003; Chrestman, 1999).

Clinicians may experience emotional, mental, physical, and spiritual symptoms. The emotional symptoms that a clinician may experience as a result of working with trauma victims include feelings of anxiety, helplessness, grief or loss, irritability and guilt (Cunningham, 2004; Sommer, 2008). The emotional symptoms may impact the way a clinician is able to manage their emotions. It may make it difficult for them to accept or feel okay about themselves. Clinicians may also experience mental symptoms of vicarious trauma. These symptoms include the clinician having memory lapses or forgetting things. Clinicians may have a difficult time making decisions. They may have flashbacks and may repeatedly visualize the traumatic event. They may also have physical symptoms of vicarious trauma, which may include sleep disturbances, nightmares, and a loss of appetite (Sommer, 2008). Clinicians may also experience feelings of nausea, sweating, and dizziness. Lastly, they may also experience spiritual

symptoms of vicarious trauma, which include loss of meaning in life and of the future (Trippany, 2004). They may lose a sense of connection to self and too significant others.

Change in Clinician's Frames of Reference

Researchers have found that these symptoms of vicarious trauma can have major implications on clinicians' frame of reference (Canfield, 2008). Frames of reference include worldview, identity, psychological issues and spirituality. Canfield (2008) states, "that as a result of chronic exposure to the realities of trauma, therapists are changed" (p. 87). As clinicians are exposed to more symptoms of vicarious trauma it is likely that they will experience disruptions in their basic sense of identify, world-view, and spirituality (Canfield, 2008). Canfield (2008) states that this will impact multiple aspects of their life. These include "self and others, interpersonal relationships, internal imagery, body experiences, and physical presence in the world" (Canfield, 2008, p. 88).

World-View. Cognitive schemas "refer to the cognitive structures used by individuals to organize experience and information to function effectively in a complex, changing environment" (Cunningham, 2003, p. 452). An individual's cognitive schemas or worldview can be altered as a result of vicarious trauma symptoms. These changes may affect the way clinicians view themselves, others, and the world, and may alter clinicians' assumptions and beliefs about the world (Canfield, 2008; Baird and Jenkins, 2003; Cunningham, 2003). An individual's cognitive schema is made up of cognitive content areas that can be altered by the impact of empathizing with a client who has experienced trauma. The cognitive content areas that experience loss or disruptions caused by empathizing with a client who has experienced trauma are the areas of safety,

trust, esteem, intimacy and control regarding both self and others (Cunningham, 2003; Baird and Jenkins, 2003).

Identity. A clinician may begin to experience changes in identity. Researchers have found that clinicians may see changes in the way they practice or think about their role in life (Canfield, 2008; Cunningham, 2003; Cunningham, 2004). They have found that changes in identity are linked to clinicians being unable to keep their professional life apart from their personal life (Canfield, 2008).

Psychological Issues. Clinicians who experience vicarious trauma symptoms may see changes in beliefs related to major psychological issues. They may experience changes in safety, trust, esteem, intimacy, and control as the result of opening up their heart and mind to the trauma material (Cunningham, 2003; Baird and Jenkins, 2003). According to Pearlman, “higher levels of fearfulness, vulnerability, and concern may be ways in which this disruption in safety needs is manifested” (1995, p. 558). As a result clinicians may become over protective of their children, may be fearful of new people, and may perceive every individual as a potential threat.

Spirituality. In terms of spirituality a clinician may begin to question the meaning and purpose of life (Canfield, 2008). As a result of listening to clients share their stories of traumatic events, researchers have found that clinicians may begin to question the intentions of people and may begin to see the world as unsafe. Clinicians may begin to lose hope and faith in people and may begin to see the world as hopeless.

Coping Strategies

There is general recognition in the literature on vicarious trauma that supports the notion that the intensity of working with traumatized individuals negatively impacts the

well-being of clinicians (Bober & Regehr, 2005). Although not all clinicians who work with victims of trauma will experience vicarious trauma symptoms, all are potentially at risk. All clinicians should have a professional awareness of preventive measures that can be used to address the symptoms of vicarious trauma (Newell, 2010). Theorists in the area of vicarious trauma recommend a variety of coping strategies for reducing the levels of vicarious trauma signs and symptoms that clinicians may experience. The commonly recommended coping strategies for reducing the signs and symptoms of vicarious trauma fall into four areas. These areas include leisure, self-care, supervision, and spirituality activities. These coping strategies should focus on helping the clinician escape, rest, and play (Bober & Regehr, 2005).

Researchers have found that when clinicians are able to identify strategies to prevent vicarious trauma from becoming severe and problematic they are less likely to experience vicarious trauma symptoms (Cunningham, 2003). Researchers also have found that, “addressing vicarious trauma would not only alleviate the negative impact on the clinician, but also would help ensure quality services for clients who seek their assistance” (Cunningham, 2003, p. 457). Researchers have also identified the significance of keeping a balance between work and personal life in helping to reduce the symptoms of vicarious trauma (Figley, 1995; & Hesse, 2002). Lastly, researchers have found that when appropriate coping strategies are in place, the negative cognitive changes associated with vicarious trauma occur less frequently (Canfield, 2008).

Leisure. Leisure activities are important for reducing the effects of vicarious trauma (Trippany et al., 2004). Leisure activities include spending time with family, vacation, hobbies, and exercise (Jordan, 2010). Researchers have found that leisure

activities are effective at reducing symptoms of vicarious trauma because of their restorative nature (Trippany, 2004).

Self-Care. Clinicians who work with trauma victims should make adequate time for self-care activities. Professional self-care is “the utilization of skills and strategies by workers to maintain their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients” (Newell & MacNeil, 2010).

Researchers have found that self-care activities reduce and minimize stress and therefore reduce vicarious trauma signs and symptoms (Jordan, 2010). Self-care activities include stress management, training, and self-care plans (Bell et al., 2003). Researchers state that self-care involves “appropriate management of vital functions and practicing a healthy lifestyle” (Jordan, 2010, p.231). General bio behavioral self-care strategies should also be utilized (Jordan, 2010). These include adequate sleep, a well balanced diet, and taking small breaks during the day.

Supervision. Supervision is strongly encouraged as a coping mechanism for clinicians who work with trauma victims. Many researchers have found that supervision that actively addresses vicarious trauma is essential to reducing the signs and symptoms of vicarious trauma (Bell et al., 2003). Rosenbloom, Pratt, and Pearlman (1995) state “supervision should foster an atmosphere of respect, safety, and control for the clinician who will be exploring the difficult issues evoked by trauma therapy” (p. 77). A clinician should feel safe expressing fears, concerns, and inadequacies they are experiencing during supervision (Bell et al., 2003). Supervision should also address the effects of trauma in a nonjudgmental manner (Cunningham, 2003).

Researchers have found that supervision is more effective at reducing symptoms of vicarious trauma if it is separate from evaluation (Bell et al., 2003). Supervision and evaluation should be kept separate because clinicians may be more disinclined to bring up issues in their work that might be signals of vicarious trauma out of fear of a poor evaluation. Bell et al., (2003) found that the “number of times a worker received non-evaluative supervision and the number of hours of non-evaluative supervision were positively related to low levels of vicarious trauma symptoms” (p.468).

The literature on vicarious trauma also emphasizes the need for group supervision or group support within the agency. Researchers state that this should be an informal time for staff to process traumatic material with supervisors and peers (Bell et al., 2003). Researchers have found that peer support groups “may help because peers can often clarify colleagues’ insights, listen for and correct cognitive distortions, offer perspective/reframing, and relate to the emotional state of the social worker” (Bell et al., 2003).

Spirituality. Researchers have found that clinicians with a larger sense of meaning and connections are less likely to experience vicarious trauma. Clinicians who experience vicarious trauma often have distorted worldviews and cognitive schemas. Without a sense of meaning researchers have found that clinicians may become cynical, nihilistic, withdrawn, and emotionally numb, hopeless and outraged (Trippany, 2004). In a survey of trauma counselors, 44 percent reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993).

Finding meaning can help trauma clinicians alleviate the impact of vicarious trauma. Clinicians can find meaning in numerous ways. These can include organized

religion, meditation, and volunteer work (Newell & MacNeil, 2010). These activities can facilitate a sense of spirituality. As a result researchers have found that “counselors with a sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities” (Trippany, 2004).

Time Devoted to Coping Strategies

The commonly recommended coping strategies for reducing the symptoms of vicarious trauma only work when the clinician devotes an adequate amount of time to engaging in these activities (Bober and Regehr, 2005). Bober and Regehr (2005) found in their study on coping strategies, “that participants generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities and supervision, however, these beliefs did not translate into time devoted to engaging in the activities” (p. 7).

The research presented provides understanding for the impact vicarious trauma can have on a clinician. The research demonstrates the magnitude of the emotional, mental, physical, and spiritual symptoms of vicarious trauma. It also demonstrates the changes in reference a clinician may experience, which include worldview, identity, psychological changes, and spiritual changes. The research highlights the importance of using commonly recommended coping strategies to reduce or manage the symptoms of vicarious trauma. The commonly recommended coping strategies include leisure, self-care, supervision, and spirituality.

Researchers in the area of vicarious trauma recommend many coping strategies for reducing the signs of vicarious trauma. However little research has been devoted to examining the effectiveness of these strategies. This study will explore how effective the

commonly recommended coping strategies are at reducing signs or symptoms of vicarious trauma. This study seeks to assess how often clinicians engage in the activities recommended and whether engaging in these activities results in lower levels of vicarious trauma symptomology.

This research is important to social work because clinicians are faced with a high prevalence rate of traumatized clients. Many researchers have found that work with traumatized clients has negative consequences on the clinician (Cunningham, 1999). The reality of working with victims of trauma has a major impact on a clinician's well being. It is important to explore how often clinicians engage in commonly recommended coping strategies and how a clinician's engagement in coping strategies affects a clinician's quality of life. This is important because social workers need to first take care of themselves before they can effectively treat others.

Conceptual Framework

Vicarious trauma is a term that is derived from the Constructivist Self-Development Theory (CSDT). "The premise of this theory is that individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences" (Trippany, Kress, Wilcoxon, 2004, p. 32). An individual understands their life experiences by the development of their cognitive schemas and perceptions of the world. The Constructivist Self-Development Theory can be applied to the experience of vicarious trauma. Specifically, through vicarious trauma, schemas and perceptions are developed that become maladaptive.

CDST describes how exposure to traumatic material affects the self of the therapist. According to CSDT there are “five components of self and how the self and one’s perceptions of reality are developed” (Trippany, 2004, p.32). These include frame of reference, self-capacities, ego resources, psychological needs, and cognitive schemas. Trippany proposed “that the interpersonal components of the Constructivist Self-Development Theory (i.e., frame of reference, self-capacities, ego resources, psychological needs, and memory system) are the most vulnerable to symptomatic adaptation (e.g. disruptions in previous belief systems as a result of clients’ trauma material) in the emergence of vicarious trauma in clinicians” (2004, p. 32).

The Constructivist Self-Development Theory states that a clinician’s vicarious trauma experiences or symptoms are normal reactions to a client’s stated trauma experiences (Trippany, Kress, Wilcoxon, 2004). The clinician develops “irrational perceptions of the self and the world as a way to protect against the emotionally traumatic experiences” (Trippany et al., 2004, p. 32). For an example a clinician who works with a client who experienced childhood abuse may begin to see the world as an unsafe place.

It is commonly recommended for clinicians who work with trauma victims to use coping strategies to help them reduce the signs and symptoms of vicarious trauma. According to Lazarus and Folkman’s (1994) transactional theory of stress, “coping strategies are thoughts or acts that an individual uses to manage the external and/or internal demands of a specific person-environment transaction that is appraised as stressful” (p. 34). It is important for a clinician to use coping strategies to deal with their stress.

The purpose of the transactional theory of stress is a framework for evaluating processes of coping with stressful events (Folkman & Lazarus, 1994). The transactional theory of stress has two appraisals, primary and secondary that are central to the theory. First, one evaluates the potential threat or relevance of the encounter (primary appraisal). Perrewe and Zellers (1999) state, “an individual can experience a stressful encounter, which is considered to be harmful, threatening, or challenging toward an individual’s well-being” (p.740). This stressful encounter for a clinician can be re-living a client’s traumatic story while working with the client. Perrewe and Zellers (1999) believe that, “if the individual determines they have a stake in the encounter, the theory proposes that they will engage in a secondary appraisal” (p. 741). If the clinician has been greatly impacted by the traumatic story of the client then they are likely to engage in a secondary appraisal.

In secondary appraisal, the clinician evaluates her interpretation of the event, how hearing the client’s traumatic story affected her (Perrewe & Zellers, 1999). The emotional and functional effects of primary and secondary appraisals are then mediated by actual coping strategies. A significant amount of research has supported the transactional model by demonstrating that, “the way people evaluate what is happening with respect to their well-being, and the way they cope with it, influences whether psychological stress will result, and its intensity (Perrewe & Zellers, 1999, p.740). For an example, a clinician who works with a child who experienced childhood abuse and who has listened to the client tell their story may begin to re-live that experience with their client and they may begin to view the world as an unsafe place. The clinician’s well-being may feel threatened by the encounter of re-living the client’s traumatic experience through the client telling their

story (primary appraisal). The clinician will then determine how empathically listening to the client share their experience of childhood abuse has affected their well-being (secondary appraisal). If the clinician has proper training in coping strategies and utilizes them appropriately then the clinician will be able to manage certain emotions and reactions to the stressful event of re-living the client's experience with them. They would be able to recognize that not all people are bad and that the world isn't completely unsafe, which ultimately would be expected to improve their quality of life.

Methods

This research employed a cross-sectional, quantitative approach to investigate the effectiveness of commonly recommended coping strategies at reducing the signs and symptoms of vicarious trauma for clinicians who work with traumatized clients. The survey examined whether clinicians believe and engage in commonly recommended coping strategies for vicarious trauma and whether engaging in these activities resulted in lower levels of distress on the Professional Quality of Life Scale-Secondary Traumatic Stress subsection. It sought to understand the effectiveness of leisure, self-care, supervision, and spirituality activities at reducing the signs and symptoms of vicarious trauma.

Research Design

A survey was designed by the researcher by utilizing pre-existing surveys to address the effectiveness of commonly recommended coping strategies at reducing the symptoms of vicarious trauma among clinicians who work with traumatized clients. The survey consisted of forty likert scale questions and three demographic questions. Nine of the likert scale questions are adapted from the Professional Quality of Life Scale-

Secondary Traumatic Stress Subscale (Hudnall, 2009). The questions measured the clinician's symptoms of vicarious trauma. Participants rated each of these likert scale questions on a scale ranging from one to five (1= never, 5= very often). Thirty-one of the likert scale questions were adapted from the Coping Strategies Inventory (Bober & Regehr, 2005). These questions measured the clinician's use of commonly recommended coping strategies including leisure, self-care, and supervision in reducing the signs and symptoms of vicarious trauma. Participants rated each of these likert scale questions on a scale ranging from one to five or one to four (1=Not at all helpful, 5= always helpful) or (1= not at all, 4= frequently). Four of the likert scale questions were created by the analyst to measure the clinician's use of spirituality as a coping strategy in reducing the signs and symptoms of vicarious trauma. Participants rated each of these likert scale questions on a scale ranging from one to five or one to four (1=Not at all helpful, 5= always helpful) or (1= not at all, 4= frequently).

The demographic questions asked the participant to record their degree of licensure by selecting LGSW or LICSW, self-reporting the number of hours per week providing services for traumatized clients and self-reporting their number of years of experience they have working traumatized clients. Answers to these questions were used in conjunction with the Likert scale responses during the data analysis.

Sample

The sample for this study was clinicians who currently or have previously worked with traumatized clients in the Twin Cities/Metro area. The study utilized a convenience sampling procedure in order to acquire a sample size of 62 participants. Online survey participants were recruited on a first-come first-serve basis until the sample size was

acquired and the survey length expired. Social workers with a LGSW or LICSW licensure were targeted. The participants for this survey were targeted by obtaining email addresses from the Minnesota Board of Social Work.

The data collection process required the survey administer to provide an online description of the study to participants before the completion of the questionnaire. This study description explained the risks associated with participation in the study.

Participants who have any questions could contact the School of Social Work at St.

Thomas University. This study received approval from the Institutional Review Board at the university before being administered to participants. Risks associated with the study were minimal.

Protection of Participants

Several measures were taken to protect the confidentiality and integrity of participants. Consent letters were provided for each participant detailing the purpose, rationale, benefits, risks, and voluntary nature of the study. The University of St. Thomas Institutional Review Board approved the consent form, which consisted of the appropriate information to ensure privacy and anonymity of the respondent. Participants were informed that their decision to participate in the survey was voluntary and would not affect their employment. Participants were informed that their responses were not associated with them or their facility. Surveys did not contain identifying information for any of the participants. The participants were provided with contact information for the researcher and research advisor in case of further inquiries.

Descriptive Statistics

The overall research question is “How effective are commonly recommended coping strategies at reducing the signs and symptoms of vicarious trauma?” The dependent variables are the symptoms of vicarious trauma (emotional, mental, physical, and spiritual symptoms) and the independent variables are commonly recommended coping mechanisms (self-care, leisure, supervision and spirituality activities). The larger research question was considered by examining six smaller research questions.

The first research question examined the social work degree the participant has. The variable (question #1) was operationalized by the participant self-reporting their degree by selecting either LGSW or LICSW. For descriptive analysis of this nominal data, a frequency distribution with a bar chart provided a count of how many participants identified with each response category as well as showed the overall frequency distribution for this variable.

The second research question examined the degree in which the participant believes that coping strategies will assist with dealing with the demands of trauma work. The variable was operationalized by the participant using a likert scale (1 being not at all helpful and 5 being always helpful) to measure their belief in the following strategies for dealing with the demands of trauma work: leisure (questions 1, 2, 3, 4, 5), self-care (questions 6, 7, 8, 9), supervision (questions 10, 11, 12, 13, 14), and spirituality activities (questions 15, 16). The scores for each subgroup were added together to get one score per respondent for leisure, self-care, supervision and spirituality activities. The lowest total score for leisure and self-care activities was 5, representing that the participant does not find the coping strategy helpful. The highest total score for leisure and self-care activities

was 25, representing that the participant does find the coping strategy helpful. The lowest total score for supervision activities was 4, representing that the participant does not find the coping strategy helpful. The highest total score for supervision activities was 20, representing that the participant does find the coping strategy helpful. Lastly, the lowest total score for spirituality activities was 2, representing that the participant does not find the coping strategy helpful. The highest total score for spirituality activities was 10, representing that the participant does find the coping strategy helpful. Higher scores indicate greater belief of the coping strategy, while lower scores represent lesser belief of the coping strategy. The specific research question states, “What is the belief among clinicians that each of the coping strategies are effective at reducing the signs and symptoms of vicarious trauma?” A separate analysis was conducted for each coping strategy. Measure of central tendency and dispersion, along with a histogram, were presented for leisure, self-care, supervision, and spirituality activities.

The third research question examined the time in which the participant engages in each of the commonly recommended coping strategies that assist in dealing with the demands of trauma work. The variable was operationalized by the participant using a likert scale (1= not at all, 4= frequently) to measure the time in which they engage in the following strategies for dealing with the demands of trauma work; leisure (questions 1, 2, 3, 4, 5), self-care (questions 6, 7, 8, 9, 10), supervision (questions 10, 11, 12, 13), and spirituality activities (questions 14, 15). The scores for each subgroup were added together to get one score per respondent for leisure, self-care, supervision and spirituality activities. The lowest total score for leisure activities was 5, representing that the participant does not engage in the coping strategy. The highest total score was 20,

representing that the participant frequently engages in the coping strategy. The lowest total score for self-care and supervision activities was 4, representing that the participant does not engage in the coping strategies. The highest total score for self-care and supervision activities was 16, representing that the participant frequently engages in the coping strategies. Lastly, the lowest total score for spirituality activities was 2, representing that the participant does not engage in the coping strategy. The highest total score was 8, representing that the participant frequently engages in the coping strategy. Higher scores indicate greater engagement in the coping strategy, while lower scores represent lesser engagement in the coping strategy. The specific research question states, “What is the time in which clinician’s engages in each of the coping strategies for reducing the signs and symptoms of vicarious trauma?” Each coping strategy was measured individually. Measures of central tendency and dispersion, along with a histogram, were presented for leisure, self-care, supervision and spirituality activities.

Inferential Statistics

T-Test. The fourth research question examined if there is a relationship between the participant’s license level and their vicarious trauma symptoms. The variables were operationalized in the following way, “place check you license level” and by answering nine questions about their trauma symptoms (their score on the Professional Quality of Life Scale (PQOL scale-Secondary Traumatic Stress subsection)). The specific research question is “Is there a relationship between a clinician’s age and their level of vicarious trauma symptoms?” The hypothesis is that there is an association between license level and vicarious trauma symptoms. The null hypothesis is that there is not an association

between age and vicarious trauma symptoms. A correlation and scatterplot will be used to measure the variables.

Correlation and scatter Plot. The fifth research question examined if there is a relationship between the participants' belief that each of the coping strategies will assist with dealing with the demands of trauma work and the time a clinician engages in each of the coping strategies. The variables were operationalized by taking the mean scores of each of the strategies for dealing with the demands of trauma work: leisure (questions 1, 2, 3, 4, 5), self-care (questions 6, 7, 8, 9), supervision (questions 10, 11, 12, 13, 14), and spirituality activities (questions 15, 16) and comparing them to the time a participant devotes to engaging in each of the strategies: leisure (questions 1, 2, 3, 4, 5), self-care (questions 6, 7, 8, 9, 10), supervision (questions 10, 11, 12, 13), and spirituality activities (questions 14, 15). Higher scores indicate a greater relationship between belief in coping strategies and time spent engaging in them. Lower score indicate a lesser relationship between belief in coping strategies and time spent engaging in them. The specific research question is "Is there a relationship between the participants' belief that coping strategies will assist with dealing with the demands of trauma work and the time a clinician devotes to each coping strategy?" The hypothesis is that there is a relationship between the belief of coping strategies for dealing with the demands of trauma and the time a clinician devotes to each of the coping strategies. The null hypothesis is that there is no relationship between the belief of coping strategies for dealing with the demands of trauma and the time a clinician devotes to each of the coping strategies. A correlation and scatterplot were used to measure the variables.

Correlation and Scatter Plot. The last research question examined the association between the participant's time allotted for engaging in coping strategies and the level of trauma symptoms the participant reports. The variables were operationalized by the participant answering fifteen questions about time allotted for engaging in coping strategies (their score on the Coping Strategy Inventory Scale (CSI scale)) and by answering nine questions about their trauma symptoms (their score on the Professional Quality of Life Scale (PQOL scale-Secondary Traumatic Stress subsection)). The participant's score on the CSI scale were added together for each subgroup (leisure, self-care, supervision and spirituality) to get a total score. The participant's score on the PQOL score was added together to get one score on the Secondary Traumatic Stress Scale, 22 or less (low secondary traumatic stress level), 23-41 (average secondary traumatic stress level), and 42 or more (high secondary traumatic stress level). The specific research questions states, "is there an association between time allotted for engaging in coping strategies and the level of trauma symptoms?" The hypothesis is that there is an association between the allotted time for engaging in coping strategies and the level of trauma symptoms. The null hypothesis is that there is not an association between the allotted time for engaging in coping strategies and the level of trauma symptoms. A correlation and scatterplot were used to measure the variables.

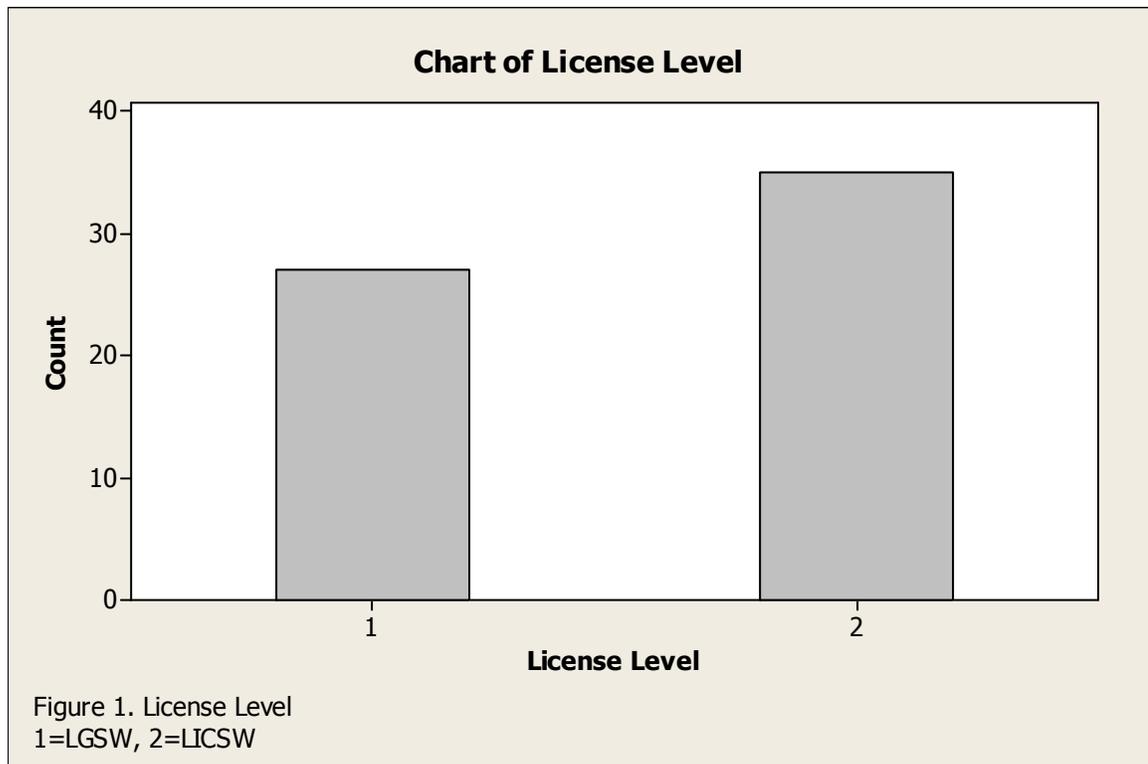
Findings

The first descriptive statistic examined the distribution of licensure level for this study sample through the use of a frequency distribution, tallying the count for each license level, along with a bar chart. A frequency distribution, shown below in Tale 1, depicts participant licensure level.

Table 1. Tally for Discrete Variables: License Level.

License Level	Count	Percent	CumCnt	CumPct
1	27	43.55	27	43.55
2	35	56.45	62	100.00
N=	62			

The bar chart shown above demonstrates that the largest group identified themselves as LICSW, representing 56.45% (n=35) of the sample. The remaining participants, 43.55% (n=27) identified with the category of LGSW. Figure 1 below depicts these results.



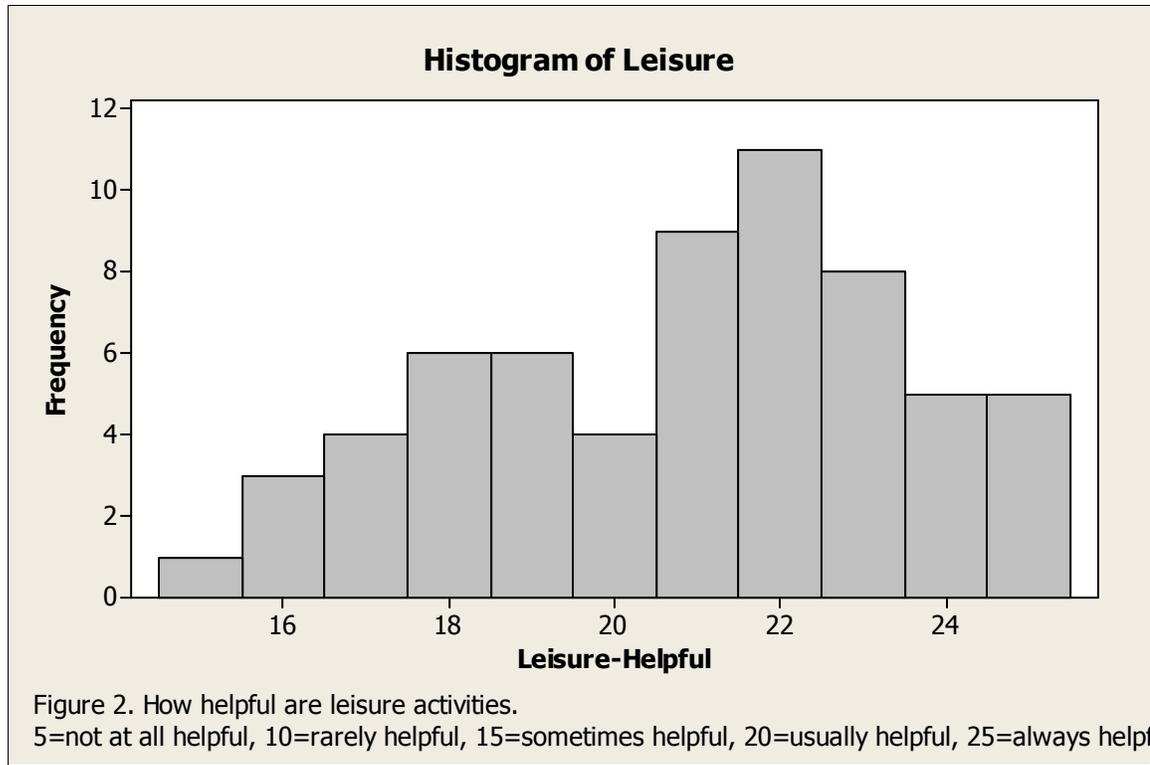
The second descriptive question looked at the degree in which the respondents believe that coping strategies will assist with dealing with the demands of trauma work. The question was evaluated through a measure of central tendency and dispersion, along with a histogram to graphically depict the distribution of the variable. The questions were separated into subgroups representing leisure, self-care, supervision, and spirituality

activities. A measure of central tendency and dispersion, shown below in Table 2, depicts the respondent's belief in Leisure activities.

Table 2. Descriptive Statistics: Leisure-Helpful

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Leisure-Helpful	62	0	20.855	0.335	2.635	15.000	19.000	21.000
Variable		Q3	Maximum					
Leisure-Helpful		23.000	25.000					

The variable leisure activities is measuring the respondent's view on how helpful leisure activities are at reducing the signs and symptoms of vicarious trauma. Of the 62 respondents, the mean percentage was 20.85, which depicts a higher than moderate belief in leisure activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 2.63. The median total score was 21, which means that half of the respondents report leisure activity scores less than 21 and the other half of the respondents report leisure activity scores of greater than 21. The minimum reported score was 15 whereas the maximum reported score was 25. The histogram in Figure 2 shows the distribution of scores.



The histogram in Figure 2 shows that the participant responses reach their highest frequency at the value of 22 for leisure activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW’s and LGSW’s view leisure activities as ‘usually helpful’ to ‘always helpful for dealing with the demands of trauma work.

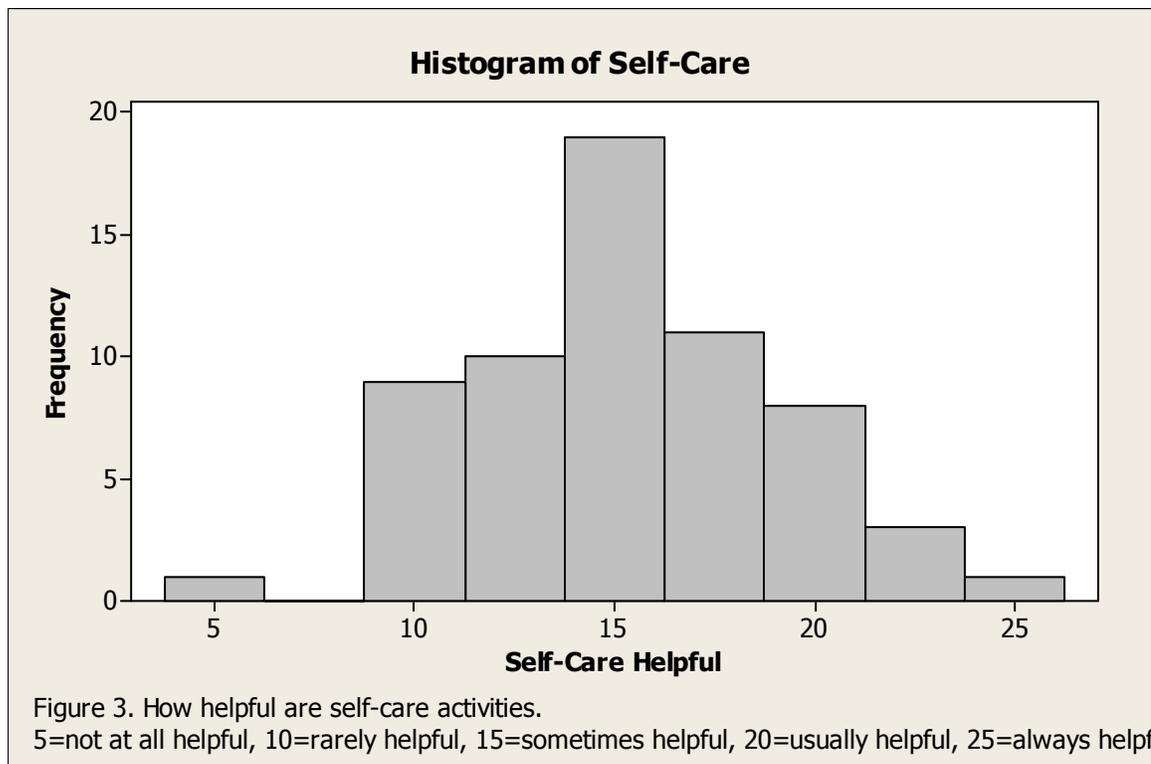
A measure of central tendency and dispersion, shown below in Table 3, depicts the respondent’s belief in self-care activities.

Table 3. Descriptive Statistics: Self-Care Helpful

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Self-Care Helpful	62	0	15.371	0.484	3.812	5.000	13.000	15.000
Variable		Q3	Maximum					
Self-Care Helpful		18.000	25.000					

The variable self-care activities is measuring the respondent’s view on how helpful self-care activities are at reducing the signs and symptoms of vicarious trauma. Of the 62

respondents, the mean percentage was 15.37, which depicts a moderate belief in self-care activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 3.81. The median total score was 15, which means that half of the respondents report self-care activity scores less than 15 and the other half of the respondents report self-care activity scores of greater than 15. The minimum reported score was 5 whereas the maximum reported score was 25. The histogram in Figure 3 shows the distribution of scores.



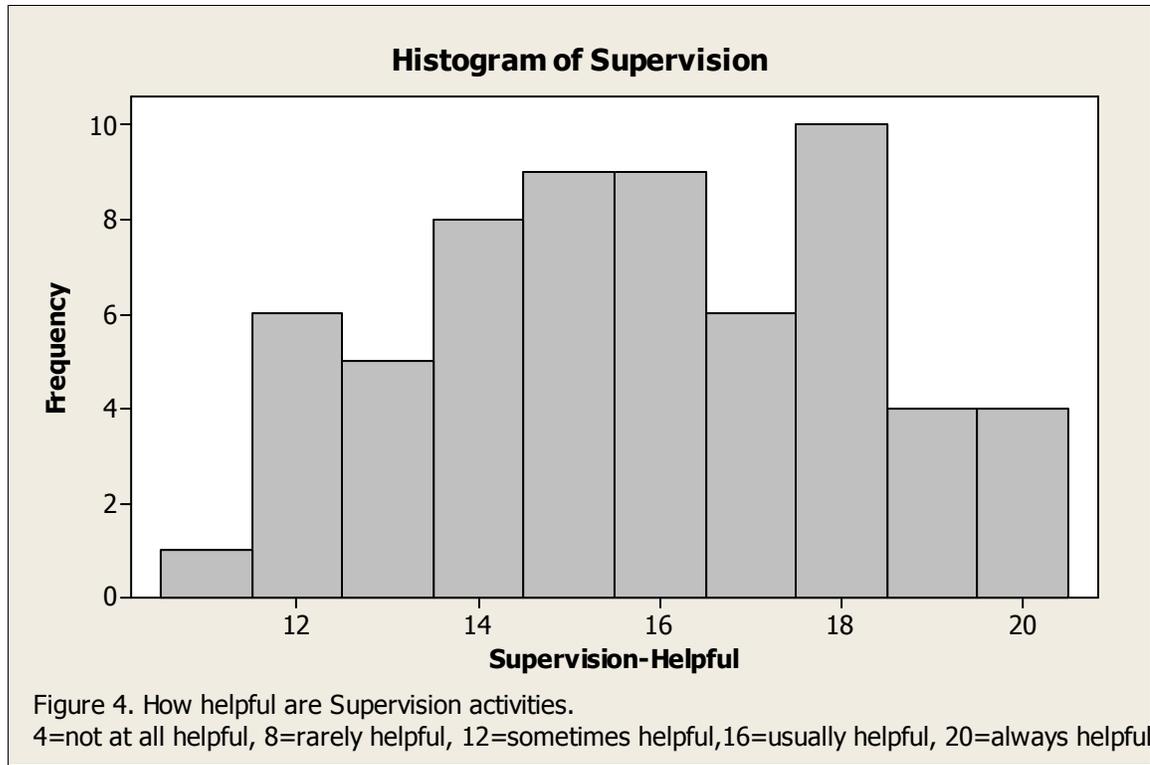
The histogram in Figure 3 shows that the participant responses reach their highest frequency at the value of 15 for leisure activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW's and LGSW's view self-care activities as 'sometimes helpful' for dealing with the demands of trauma work.

A measure of central tendency and dispersion, shown below in Table 4, depicts the respondent's belief in supervision activities.

Table 4 Descriptive Statistics: Supervision-Helpful

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Supervision-Helpful	62	0	15.758	0.304	2.393	11.000	14.000	16.000
Variable		Q3	Maximum					
Supervision-Helpful		18.000	20.000					

The variable supervision activities is measuring the respondent's view on how helpful supervision activities are at reducing the signs and symptoms of vicarious trauma. Of the 62 respondents, the mean percentage was 15.75, which depicts a moderate belief in supervision activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 2.39. The median total score was 16, which means that half of the respondents report supervision activity scores less than 16 and the other half of the respondents report supervision activity scores of greater than 16. The minimum reported score was 11 whereas the maximum reported score was 20. The histogram in Figure 2 shows the distribution of scores.



The histogram in Figure 4 shows that the participant responses reach their highest frequency at the value of 18 for supervision activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW’s and LGSW’s view supervision activities as ‘usually helpful’ to ‘always helpful for dealing with the demands of trauma work.

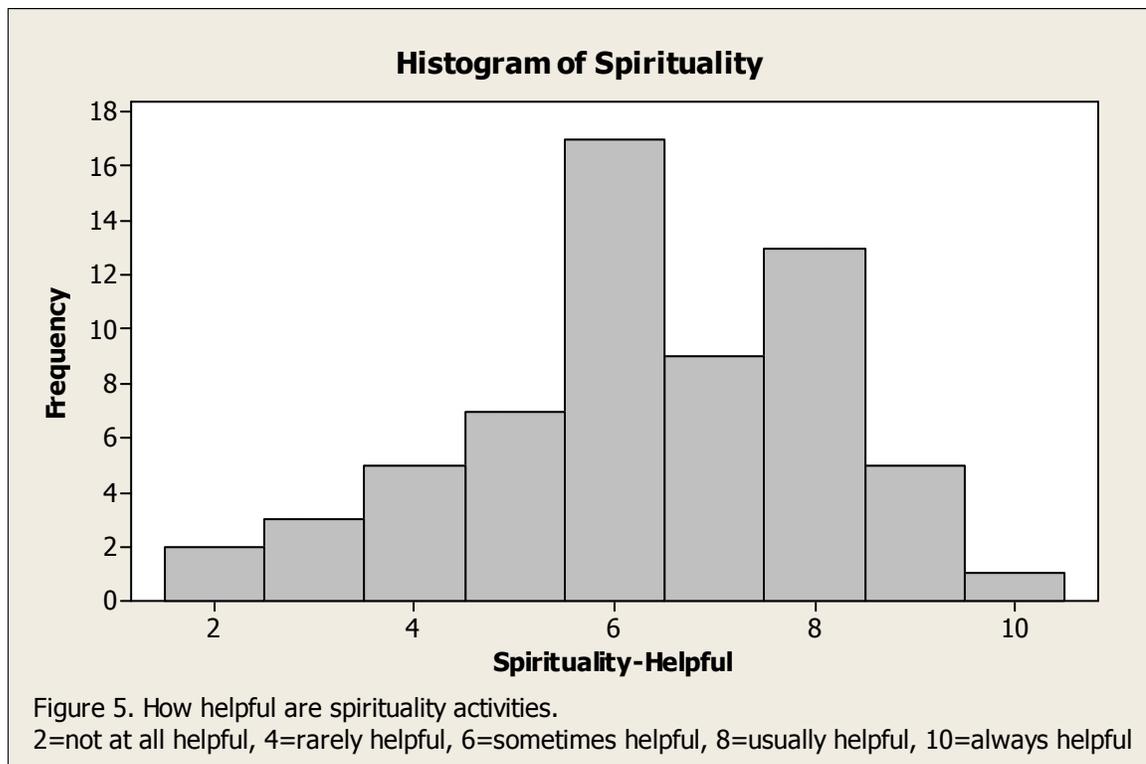
A measure of central tendency and dispersion, shown below in Table 5, depicts the respondent’s belief in spirituality activities.

Table 5. Descriptive Statistics: Spirituality-Helpful

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Spirituality-Helpful	62	0	6.323	0.231	1.818	2.000	5.000	6.000
Variable		Q3	Maximum					
Spirituality-Helpful		8.000	10.000					

The variable spirituality activities is measuring the respondent’s view on how helpful spirituality activities are at reducing the signs and symptoms of vicarious trauma. Of the

62 respondents, the mean percentage was 6.32, which depicts a moderate belief in spirituality activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 1.81. The median total score was 6, which means that half of the respondents report spirituality activity scores less than 6 and the other half of the respondents report spirituality activity scores of greater than 6. The minimum reported score was 2 whereas the maximum reported score was 10. The histogram in Figure 5 shows the distribution of scores.



The histogram in Figure 5 shows that the participant responses reach their highest frequency at the value of 6 for spirituality activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW's and LGSW's view spirituality activities as 'sometimes helpful' for dealing with the demands of trauma work.

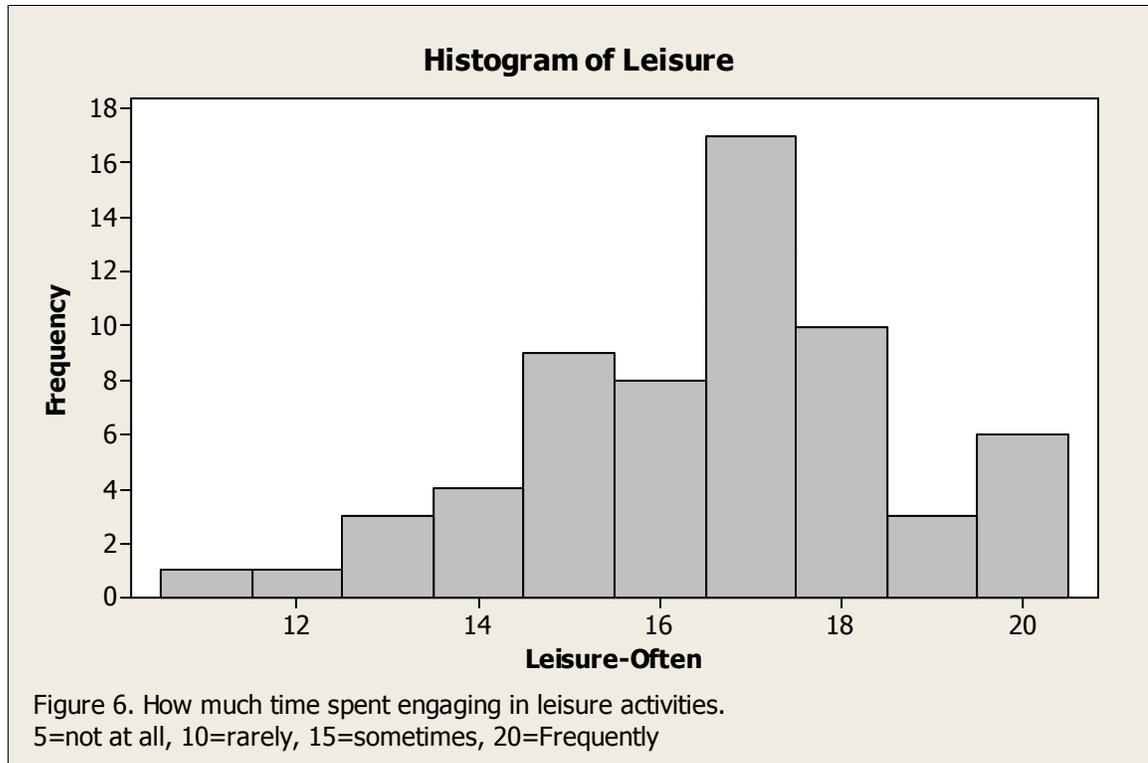
The third descriptive question looked at the time in which the participant engages in each of the coping strategies that assist with dealing with the demands of trauma work. The question was evaluated through a measure of central tendency and dispersion, along with a histogram to graphically depict the distribution of the variable. The questions were separated into subgroups representing leisure, self-care, supervision, and spirituality activities. A measure of central tendency and dispersion, shown below in Table 6, depicts the respondent's time spent engaging in leisure activities.

Table 6. Descriptive Statistics: Leisure-Often

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median	Q3
Leisure-Often	62	0	16.565	0.259	2.038	11.000	15.000	17.000	18.000

Variable	Maximum
Leisure-Often	20.000

The variable leisure activity is measuring the respondent's time spent engaging in leisure activities to assist with demands of trauma work. Of the 62 respondents, the mean percentage was 16.56, which depicts that a respondent reports a moderate score for engaging in leisure activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 2.03. The median total score was 17, which means that half of the respondents report leisure activity scores less than 17 and the other half of the respondents report leisure activity scores of greater than 17. The minimum reported score was 11 whereas the maximum reported score was 20. The histogram in Figure 6 shows the distribution of scores.



The histogram in Figure 6 shows that the participant responses reach their highest frequency at the value of 17 for leisure activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW’s and LGSW’s engage in leisure activities between ‘sometimes’ and ‘frequently’ for reducing the signs and symptoms of vicarious trauma.

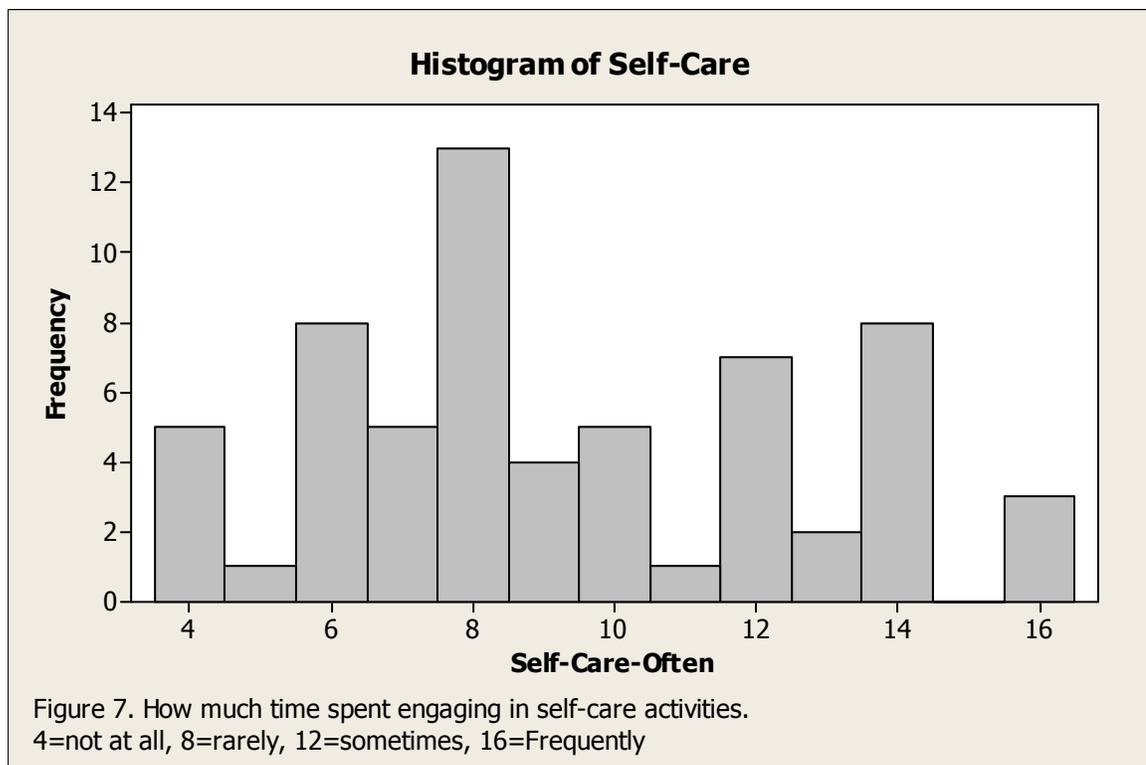
A measure of central tendency and dispersion, shown below in Table 7, depicts the respondent’s time spent engaging in self-care activities.

Table 7. Descriptive Statistics: Self-Care-Often

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median	Q3
Self-Care-Often	62	0	9.339	0.427	3.363	4.000	7.000	8.000	12.000

Variable	Maximum
Self-Care-Often	16.000

The variable self-care activity is measuring the respondent's time spent engaging in self-care activities to assist with demands of trauma work. Of the 62 respondents, the mean percentage was 9.33, which depicts that a respondent reports a lower than moderate score for engaging in self-care activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 3.36. The median total score was 8, which means that half of the respondents report self-care activity scores less than 8 and the other half of the respondents report self-care activity scores of greater than 8. The minimum reported score was 4 whereas the maximum reported score was 16. The histogram in Figure 7 shows the distribution of scores.



The histogram in Figure 7 shows that the participant responses reach their highest frequency at the value of 8 for self-care activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW's and LGSW's

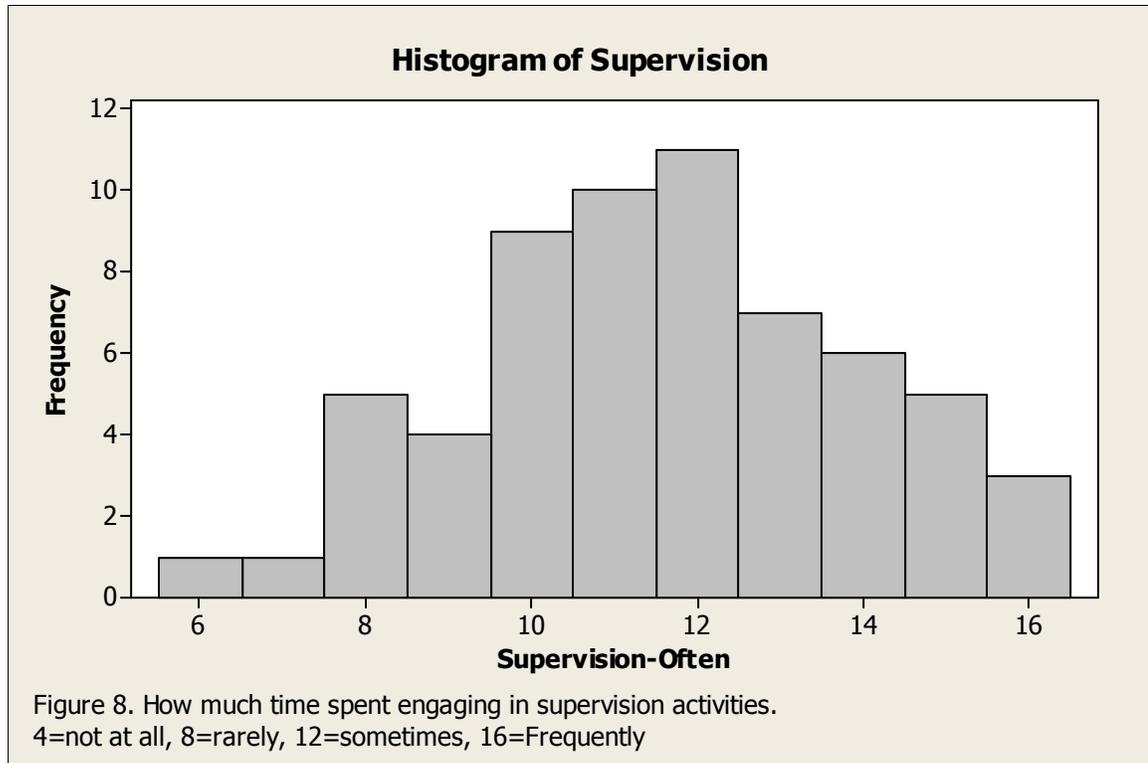
engage in self-care activities ‘rarely’ for reducing the signs and symptoms of vicarious trauma.

A measure of central tendency and dispersion, shown below in Table 8, depicts the respondent’s time spent engaging in supervision activities.

Table 8. Descriptive Statistics: Supervision-Often

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Supervision-Often	62	0	11.597	0.298	2.350	6.000	10.000	12.000
Variable		Q3	Maximum					
Supervision-Often		13.000	16.000					

The variable supervision activity is measuring the respondent’s time spent engaging in supervision activities to assist with demands of trauma work. Of the 62 respondents, the mean percentage was 11.59, which depicts that a respondent reports a lower than moderate score for engaging in supervision activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 2.35. The median total score was 12, which means that half of the respondents report supervision activity scores less than 12 and the other half of the respondents report supervision activity scores of greater than 12. The minimum reported score was 6 whereas the maximum reported score was 16. The histogram in Figure 8 shows the distribution of scores.



Participant responses reach their highest frequency at the value of 12 for supervision activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW’s and LGSW’s engage in supervision activities ‘sometimes’ for reducing the signs and symptoms of vicarious trauma.

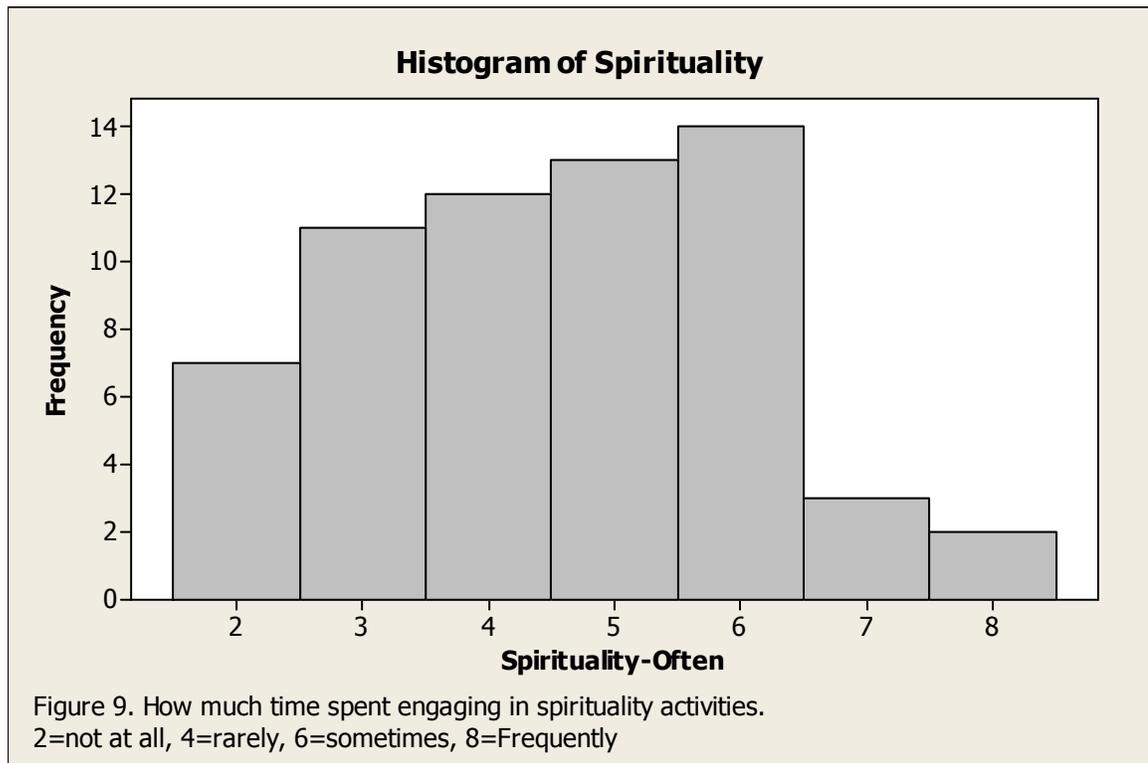
A measure of central tendency and dispersion, shown below in Table 9, depicts the respondent’s time spent engaging in spirituality activities.

Table 9. Descriptive Statistics: Spirituality-Often

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median
Spirituality-Often	62	0	4.532	0.199	1.565	2.000	3.000	5.000
Variable		Q3	Maximum					
Spirituality-Often		6.000	8.000					

The variable spirituality activity is measuring the respondent’s time spent engaging in spirituality activities to assist with demands of trauma work. Of the 62 respondents, the mean percentage was 4.53, which depicts that a respondent reports a lower than moderate

score for engaging in spirituality activities for reducing the signs and symptoms of vicarious trauma. The standard deviation was 1.56. The median total score was 5, which means that half of the respondents report spirituality activity scores less than 5 and the other half of the respondents report spirituality activity scores of greater than 5. The minimum reported score was 2 whereas the maximum reported score was 8. The histogram in Figure 9 shows the distribution of scores.



The histogram in Figure 9 shows that the participant responses reach their highest frequency at the value of 6 for spirituality activities. The measure of central tendency and dispersion along with the histogram depict that this sample of LICSW's and LGSW's engage in spirituality activities 'sometimes' for reducing the signs and symptoms of vicarious trauma.

Inferential Statistics

The following question was analyzed utilizing a t-test: What is the relationship between the participant's license level and their score on the quality of life scale? Table 10 below depicts the t-test.

Table 10. Two-Sample T-Test and CI: Quality of Life, License Level

Two-sample T for Quality of Life

License Level	N	Mean	StDev	SE Mean
1	27	30.3	11.2	2.2
2	35	31.5	12.1	2.0

Difference = mu (1) - mu (2)

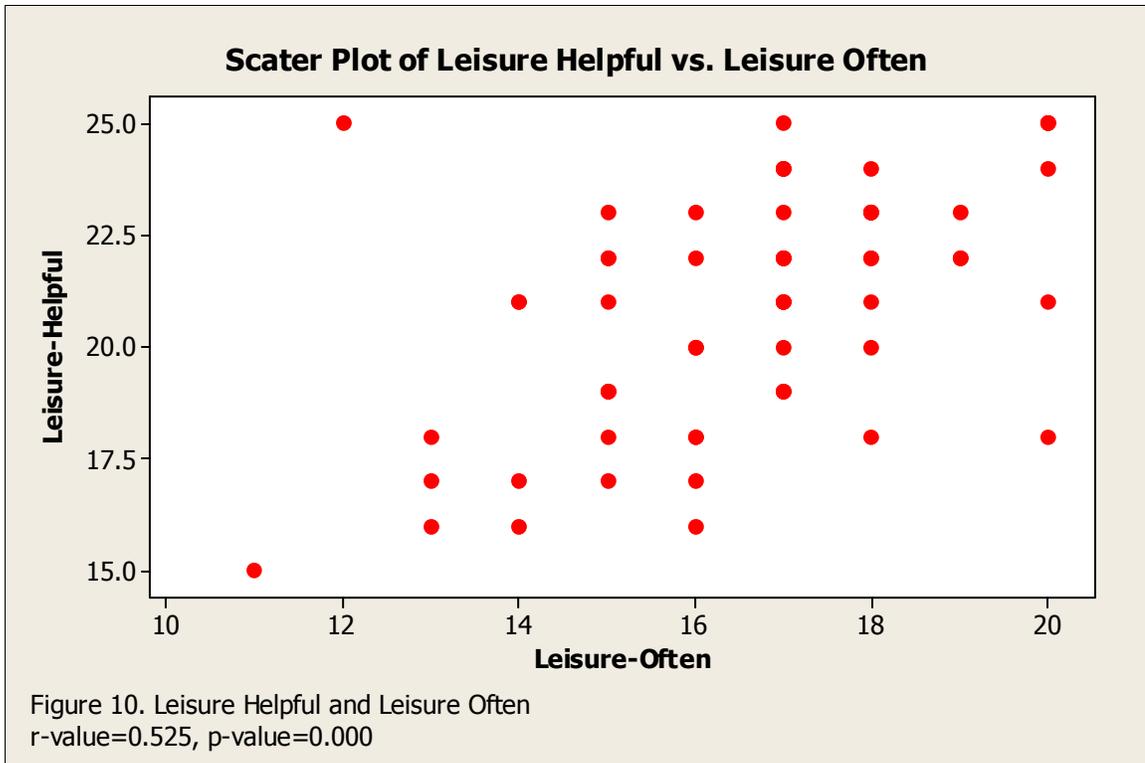
Estimate for difference: -1.28

95% CI for difference: (-7.23, 4.66)

T-Test of difference = 0 (vs not =): T-Value = -0.43 P-Value = 0.667 DF = 58

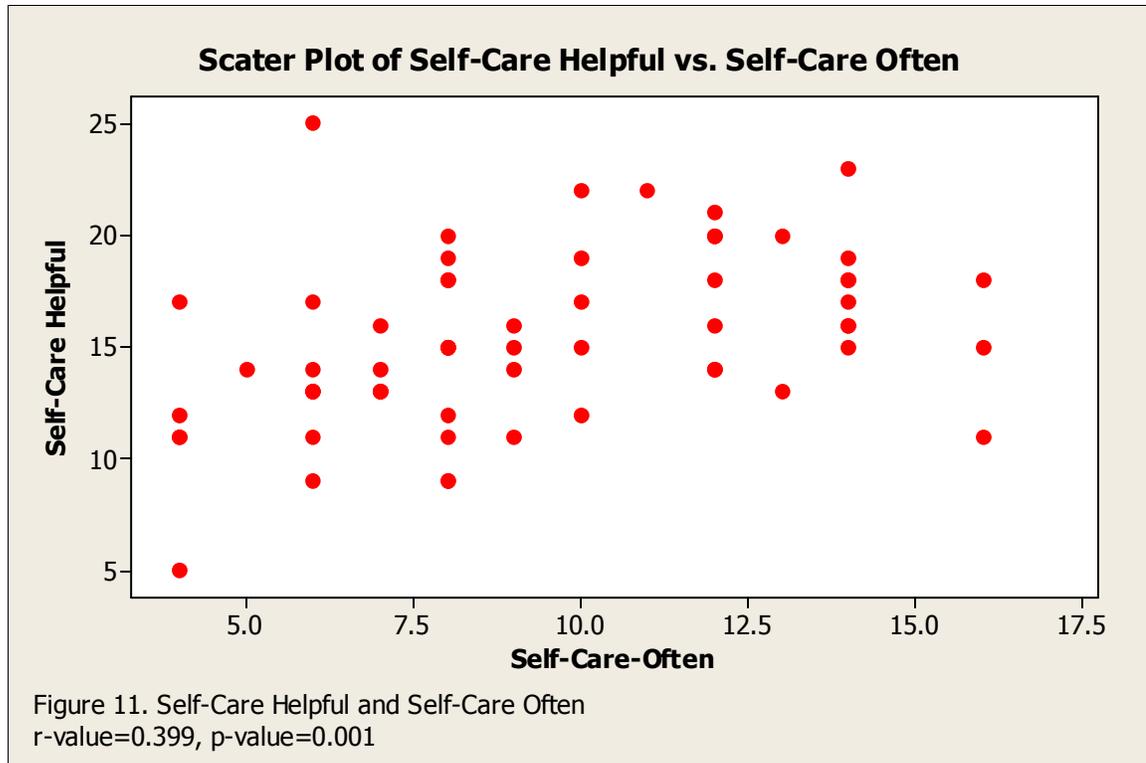
The p-value > 0.66 (greater than .05) indicates that there is not a statistically significant relationship between license level and quality of life score. Therefore, the results fail to reject the null hypothesis the statistic has failed to find a relationship between the participant's license level and their score on the quality of life scale.

The second inferential statistics question was analyzed using a correlation: What is the relationship between the participants' belief that each of the coping strategies will assist with dealing with the demands of trauma work and the time a clinician engages in each of the coping strategies (leisure, self-care, supervision, and spirituality activities)? Figure 10 below depicts the correlation between a participant's belief of leisure activities for dealing with the demands of trauma and the time they devote to leisure activities.



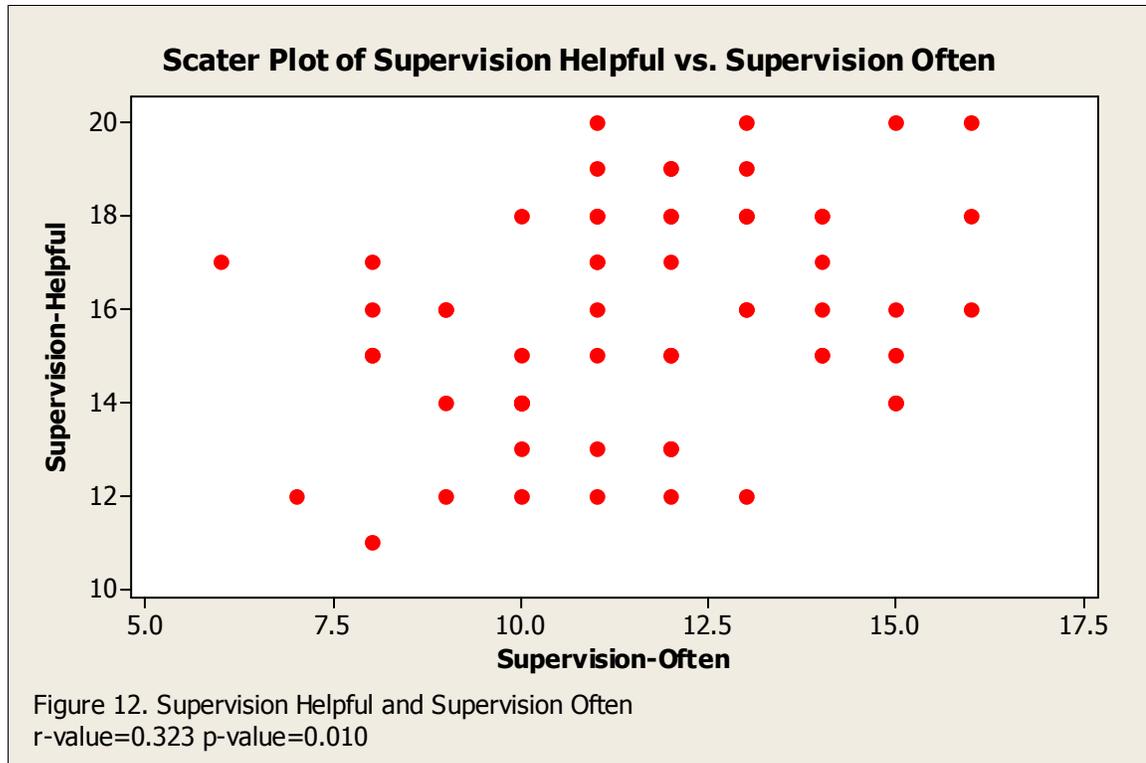
The Pearson correlation 0.53 indicates that there is a strong relationship between a participant’s belief of leisure activities and the time they devote to leisure activities. The p-value < 0.00 (less than .05) indicates a statistically significant relationship between a participant’s belief of leisure activities for dealing with the demands of trauma work and the time they devote to leisure activities. As the participant’s belief of leisure activities increases, so does the participant’s time they devote to leisure activities. Therefore, the results reject the null hypothesis that there is no relationship between a participant’s belief of leisure activities and the time they devote to leisure activities.

Figure 11 below depicts the correlation between a participant’s belief of self-care activities for dealing with the demands of trauma and the time they devote to self-care activities.



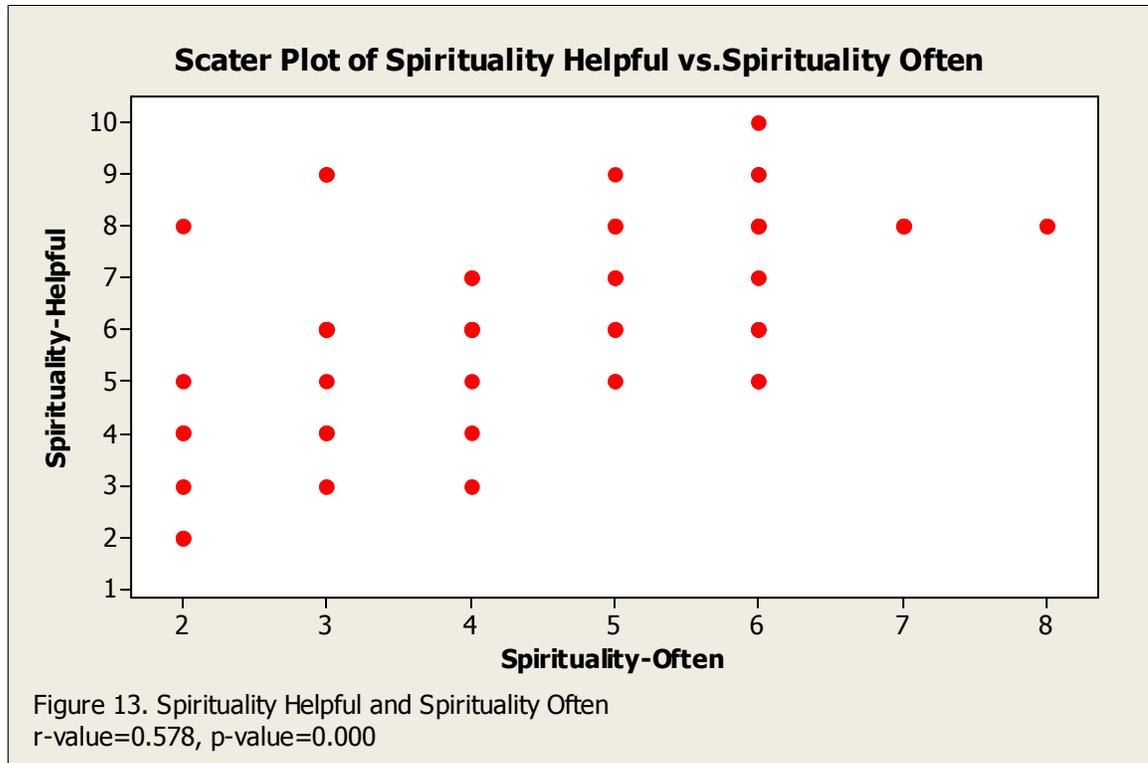
The Pearson correlation of 0.39 indicates that there is a moderate to strong relationship between a participant's belief of self-care activities and the time they devote to self-care activities. The p-value < 0.00 (less than .05) indicates a statistically significant relationship between a participant's belief of self-care activities for dealing with the demands of trauma work and the time they devote to self-care activities. As the participant's belief of self-care activities increase, so does the participant's time they devote to self-care activities. Therefore, the results reject the null hypothesis that there is no relationship between a participant's belief of self-care activities and the time they devote to self-care activities.

Figure 12 below depicts the correlation between a participant's belief of supervision activities for dealing with the demands of trauma and the time they devote to supervision activities.



The Pearson correlation of 0.32 indicates that there is a moderate relationship between a participant's belief in supervision activities and the time they devote to supervision activities. The p-value < 0.01 (less than .05) indicates a statistically significant relationship between a participant's belief of supervision activities for dealing with the demands of trauma and the time they devote to supervision activities. As the participant's belief of supervision activities increase, so does the participant's time they devote to supervision activities. Therefore, the results reject the null hypothesis that there is a no relationship between a participant's belief of supervision activities and the time they devote to supervision activities.

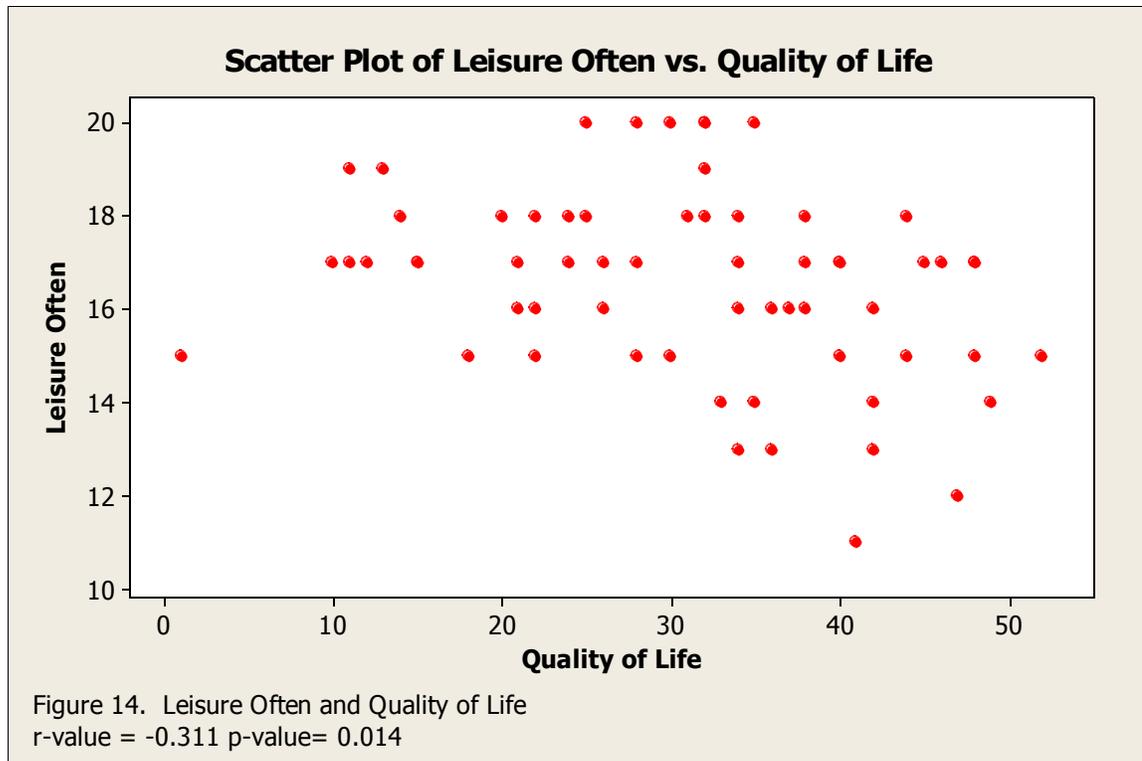
Figure 13 below depicts the correlation between a participant's belief of spirituality activities for dealing with the demands for trauma and the time they devote to spirituality activities.



The Pearson correlation of 0.57 indicates that there is a strong relationship between the variables. The p-value < 0.00 (less than .05) indicates a statistically significant relationship between a participant's belief of spirituality activities for dealing with the demands of trauma and the time they devote to spirituality activities. As the participant's belief of spirituality activities increase, so does the participant's time they devote to spirituality activities. Therefore, the results reject the null hypothesis that there is no relationship between a participant's belief of spirituality activities and the time they devote to spirituality activities.

The last inferential statistic question examines the relationship between the participant's time devoted to engaging in coping strategies (leisure, self-care, supervision, and spirituality activities) and their score on the quality of life scale. Figure 14 below

depicts the correlation between a participant's time devoted to leisure activities and their score on the quality of life scale.



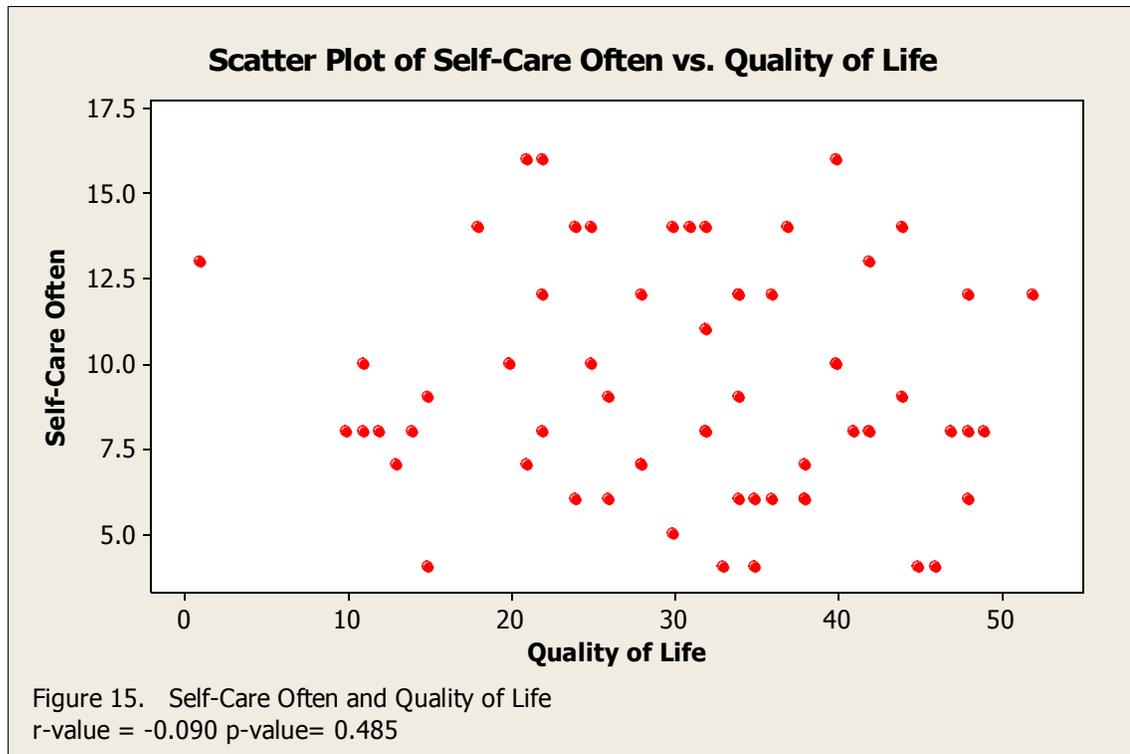
Note: Quality of life score is only based upon the secondary traumatic stress scale.

The Pearson correlation of -0.31 indicates that there is an inverse relationship between a participant's time devoted to leisure activities and their score on the quality of life scale.

This indicates that as time spent engaging in leisure activities increase, the participant's score on the quality of life scale decreases, as time spent engaging in leisure activities decreases, the participant's score on the quality of life scale increases. The p-value > 0.01 (greater than .05) indicates that there is a statistically significant relationship between the time a participant devotes to leisure activities and their score on the quality of life scale.

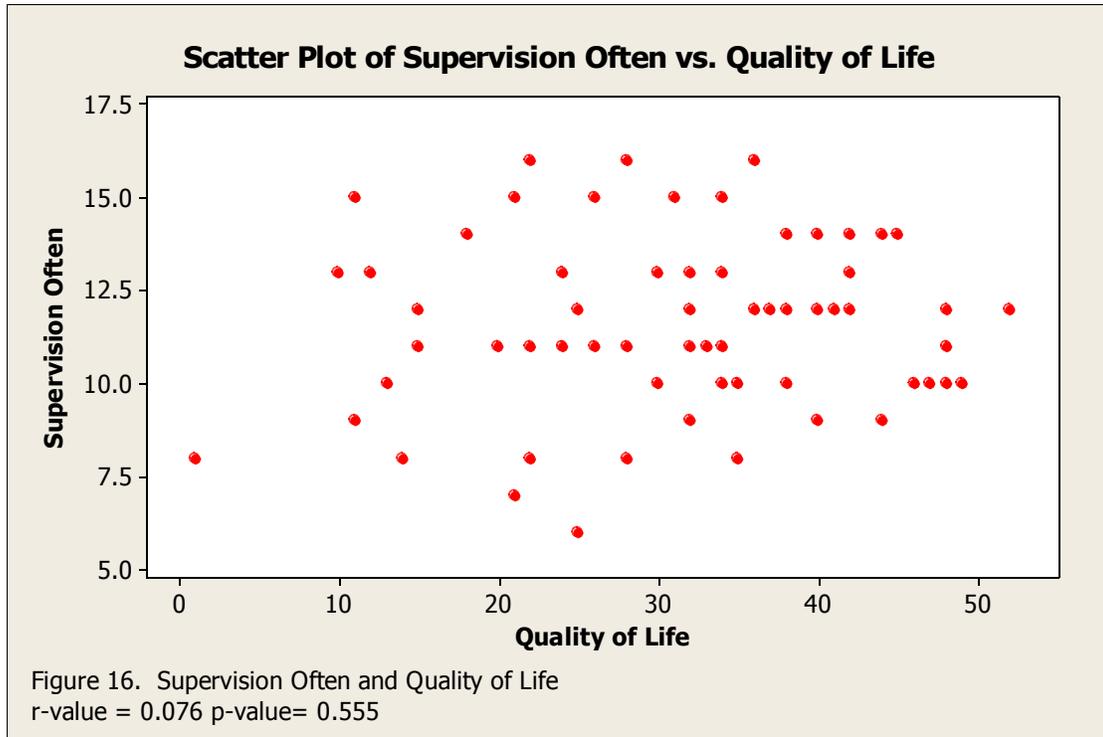
Therefore, the results reject the null hypothesis that there is not a relationship between a participant's time devoted to leisure activities for dealing with them demands of trauma work and their score on the quality of life scale.

Figure 15 below depicts the correlation between a participant's time devoted to self-care activities and their score on the quality of life scale.



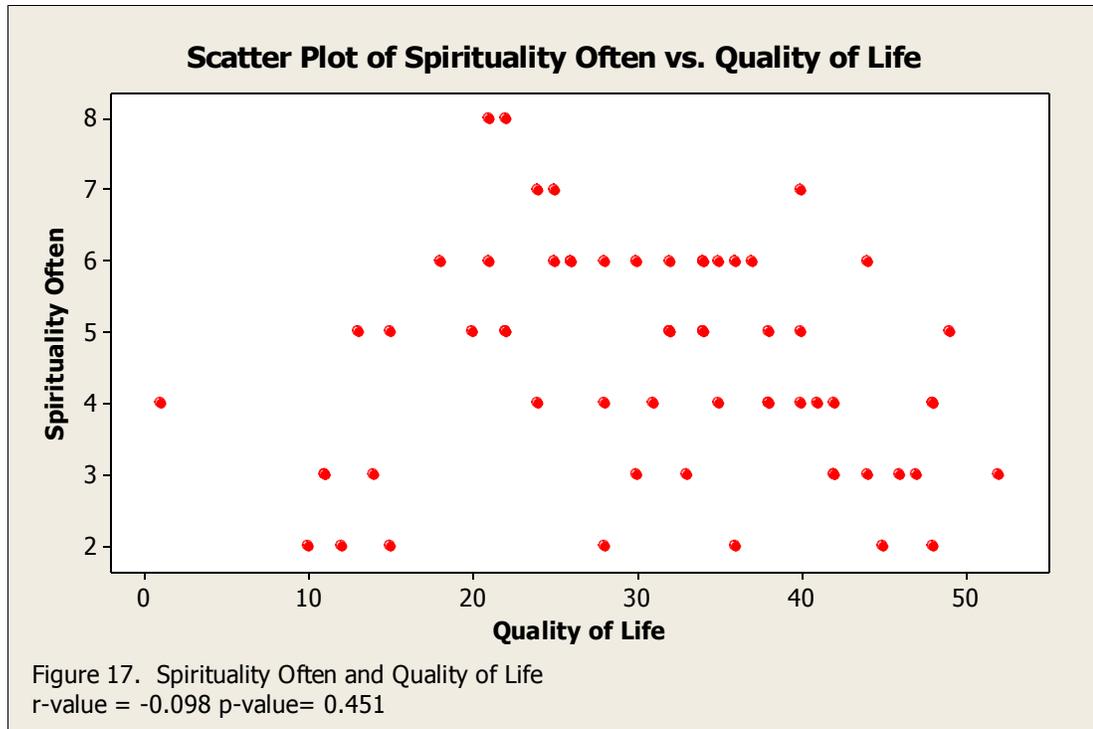
The Pearson correlation of -0.09 indicates that there is an inverse relationship between a participant's time devoted to self-care activities and their score on the quality of life scale. This indicates that as time spent engaging in self-care activities increase, the participant's score on the quality of life scale decreases, as time spent engaging in self-care activities decreases, the participant's score on the quality of life scale increases. The p-value > 0.48 (greater than $.05$) indicates that there is not a statistically significant relationship between the time a participant devotes to self-care activities and their score on the quality of life scale. Therefore, the results reject the hypothesis that there is a relationship between a participant's time devoted to self-care activities for dealing with the demands of trauma work and their score on the quality of life scale.

Figure 16 below depicts the correlation between a participant's time devoted to supervision activities and their score on the quality of life scale.



The Pearson correlation of 0.07 indicates a weak relationship between a participant's time devoted to supervision activities and their score on the quality of life scale. This indicates that as time spent engaging in supervision activities increases so does a participant's score on the quality of life scale. The p-value > 0.55 (greater than .05) indicates that there is not a statistically significant relationship between the time a participant devotes to supervision activities and their score of the quality of life scale. Therefore, the results reject the hypothesis that there is a relationship between a participant's time devoted to supervision activities for dealing with the demands of trauma work and their score on the quality of life scale.

Figure 17 below depicts the correlation between a participant's time devoted to spirituality activities and their score on the quality of life scale.



The Pearson correlation of -0.10 indicates an inverse relationship between a participant's time devoted to spirituality activities and their score on the quality of life scale. This indicates that as time spent engaging in spirituality activities increase, the participant's score on the quality of life scale decreases; and as time spent engaging in spirituality activities decreases, the participant's score on the quality of life scale increases. The p-value > 0.45 (greater than .05) indicates that there is not a statistically significant relationship between the time a participant devotes to spirituality activities and their score on the quality of life scale. Therefore, the results reject the hypothesis that there is no relationship between a participant's time devoted to spirituality activities for dealing with the demands of trauma work and their score on the quality of life scale.

Discussion

The purpose of this study was to examine the relationship between how helpful coping strategies are and time a clinician spends engaged in coping strategies and the

impact commonly recommended coping strategies have on a clinician's score on the quality of life scale. There is general recognition in the literature that working with traumatized clients has negative consequences on the clinician's well-being (Cunningham, 2003; Chrestman, 1999). Clinicians may experience emotional, mental, physical and spirituality symptoms and in severe cases vicarious trauma can change a clinician's frame of reference including a clinician's worldview, identity, psychological issues and spirituality (Canfield, 2008).

All clinicians are potentially at risk of developing vicarious trauma symptoms. As a result, all clinicians should have a professional awareness of preventive measures that can be used to address the symptoms of vicarious trauma (Newell, 2010). This study examined the effectiveness of the coping strategies that theorists in the area of vicarious trauma generally recommend for reducing the levels of vicarious trauma symptoms a clinician may experience. These coping strategies include leisure, self-care, supervision, and spirituality activities.

In this study, the findings suggest that the participants found leisure and supervision activities to be 'usually helpful' to 'always helpful' for dealing with the demands of trauma work. The participants found self-care and spirituality activities to be 'sometimes' helpful for dealing with the demands of trauma work. Overall, the participants found the commonly recommended coping strategies to be 'usually helpful' for dealing with the demands of trauma work. This is similar to the literature reviewed as researchers found that clinicians generally believed that commonly recommended coping strategies were helpful for reducing the signs and symptoms of vicarious trauma (Bober & Regehr, 2005).

The study found that the participants engaged in leisure activities ‘sometimes’ to ‘frequently’ for dealing with the demands of trauma work. The participants engaged in supervision and spirituality activities ‘sometimes’ for dealing with the demands of trauma work. Lastly, the participants engaged in self-care activities ‘rarely’ for dealing with the demands of trauma work. Overall, the participants ‘sometimes’ engaged in the commonly recommended coping strategies for dealing with the demands of trauma work.

In this study, the findings suggest that when participants believe in the usefulness of recommended coping strategies (leisure, self-care, supervision and spirituality activities) they generally are more likely to engage in those activities. Pearson’s correlations revealed significant relationships between beliefs in the benefits of leisure, self-care, supervision, and spirituality activities and time allotted for engaging in these activities. Leisure activities had a strong relationship between a participant’s belief of leisure activities and the time they devote to them. Self-care activities had a moderate to strong relationship between a participant’s belief of self-care activities and the time they devote to them. Supervision activities had a moderate relationship between a participant’s belief of supervision activities and the time they devote to them. Lastly, spirituality activities had a strong relationship between a participant’s belief of spirituality activities and the time they devote to them. This is similar to the findings in the literature review as researchers found that clinicians who generally believe in coping strategies spend more time engaging in them (Bober and Regehr, 2005).

Contrary to the literature reviewed, commonly recommended coping strategies are not all effective at reducing a clinician’s score on the quality of life scale. The research states that leisure, self-care, supervision, and spirituality activities were all effective at

reducing the signs and symptoms of vicarious trauma (Bober and Regehr, 2005). The findings suggest similar findings to those found in the literature review. Leisure, self-care, and spirituality activities all had a strong relationship for reducing a clinician's score on the quality of life scale. Participant's who reported engaging in leisure, self-care, and spirituality activities 'often' tended to score lower on the quality of life scale. A lower score on the quality of life scale indicated fewer secondary traumatic stress symptoms. Supervision activities had a weak relationship between time spent engaging in supervision activities and a participant's score on the quality of life scale. This indicates that a participant's time spent engaging in supervision activities is not as effective as leisure, self-care, and spirituality activities at improving a clinician's quality of life.

Implications for Further Research

It is recommended that future research should first examine more closely the risk factors associated with developing vicarious trauma symptoms. By exploring these main risk indicators researchers may be able to examine preventive measures that would help reduce a clinician's chances of developing vicarious trauma symptoms. For an example, researchers could examine whether professors should help students going into helping fields to develop concrete coping strategies that are effective for them while they are still in school. This would provide the students with an established set of tools to use before entering the field, hopefully helping to reduce vicarious trauma symptoms and improve quality of life.

Lastly, most research on vicarious trauma has focused on what individuals can do to address vicarious trauma symptoms. Further research should explore more in depth the changes that could be made at the organizational level for the prevention of vicarious

trauma. Researchers should focus on how organizations could implement programs throughout a clinician's workday to develop and spend time engaging in the commonly recommended coping strategies. Researchers should also focus more on the impact supervision has on a clinician's quality of life. As the findings demonstrate, the participants believed in supervision activities for improving quality of life but reported low numbers of engaging in supervision related activities. By researchers focusing on supervision they will be able to examine what aspects of supervision are most effective. Researchers could also examine what needs clinicians feel are not being met during supervision. For an example, researchers could explore whether clinicians view spirituality activities to be helpful and if so, a supervisor could help the clinician explore how spirituality impacts their work with clients and their overall quality of life.

Implications for Social Work Practice

The findings of this study have several implications for social work and other helping professions. Several strategies have been suggested to protect the clinician from the negative effects of the working with traumatized clients. These include leisure, self-care, supervision, and spirituality activities. According to the findings clinicians should spend time engaging in leisure, self-care and spirituality activities for enhancing quality of life.

The findings also demonstrate the need for effective supervision. The majority of the respondents believed in the effectiveness of supervision activities but reported only 'sometimes' engaging in them. This suggests that clinicians find supervision to be effective for dealing with the demands of trauma work. Supervisors should be aware of this even though time spent engaging in supervision activities had a weak relationship to

score on the quality of life scale. Organizations should continually be focused on finding ways to meet their clinicians' supervisory needs. Supervisors need to create a comfortable environment which encourages discussion on leisure, self-care, supervision, and spirituality activities as well as an environment that promotes time spent engaging in these activities.

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Appendix A

Please select your license level

1. LGSW
2. LICSW

Please state your counseling experience

1. How many hours a week do you spend working with traumatized clients (such as survivors of traumatic life events, such as disasters, childhood sexual abuse, physical or sexual assault, and domestic violence (Jordan, 2010)? _____
2. How many years of experience do you have working with trauma victims? _____

Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1= Never 2= Rarely 3= Sometimes 4= Often 5= Very Often

1. I am preoccupied with more than one person I (help). _____
2. I jump or am startled by unexpected sounds. _____
3. I find it difficult to separate my personal life from my life as a (helper). ____
4. I think that I might have been affected by the traumatic stress of those I (help). ____

5. Because of my (helping), I have felt “on edge” about various things. _____
6. I feel as though I am experiencing the trauma of someone I have (helped). .
7. I avoid certain activities or situations because they remind me of frightening experiences of the people I (help). _____
8. As a result of my (helping), I have intrusive, frightening thoughts. _____
9. I can't recall important parts of my work with trauma victims. _____

Adapted from: B. Hudnall Stamm, 2009-2011. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL).

Below is a list of activities in which counselors/therapists may participate. Please mark how helpful each activity is in dealing with the demands of trauma work.

0= Not at all helpful 1= Rarely helpful 2= Sometimes helpful 3= Usually helpful 4= Always helpful

1. Time with family _____
2. Vacation/Time off _____
3. Movies/TV _____
4. Hobbies _____
5. Exercise _____
6. Stress management training _____
7. Stress management training for the team _____
8. Planning trauma programs for clients _____

9. Developing self-care plans _____
10. Developing team-care plans _____
11. Case discussion with colleagues _____
12. Case discussion with management _____
13. Regular supervision _____
14. Supervision specifically related to trauma _____
15. Meditation _____
16. Volunteer work _____

Below is a list of activities in which counselors/therapists may participate. Please mark how often you engage in each activity.

0= Not at all 1= Rarely 2= Sometimes 3= Frequently

1. Time with family _____
2. Vacation/Time off _____
3. Movies/TV _____
4. Hobbies _____
5. Exercise _____
6. Stress management training on an individual basis _____
7. Stress management training for the team _____
8. Developing self-care plans _____
9. Developing team-care plans _____
10. Case discussion with management _____
11. Regular supervision _____
12. Supervision specifically related to trauma _____
13. Discussing cases in team meetings _____
14. Meditation _____
15. Volunteer work _____

Adapted from: Bober, T. & Regehr, C. (2006) Strategies for Reducing Secondary or Vicarious Trauma: Do They Work? Brief Treatment and Crisis Intervention.