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The Perception of Vicarious Trauma Among Master of Social Work Students

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THE PERCEPTION OF VICARIOUS TRAUMA AMONG MASTER OF SOCIAL WORK STUDENTS

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

Social workers are being sought out more often to treat traumatized individuals. In turn, social workers are at risk of vicarious traumatization. Vicarious trauma is a form of indirect trauma that may occur by working with traumatized clients. Master of Social Work (MSW) students should be educated on vicarious trauma as they will have many responsibilities; including treating traumatized individuals, when they begin practicing in the field. Education on vicarious trauma could lessen the risks of experiencing the pathology. The purpose of this study is to explore the perception of vicarious trauma among MSW students. Sixty-seven students from the MSW program at California State University, San Bernardino participated in this study and completed the Vicarious Trauma Questionnaire (VTQ). The study showed that on average the students scored moderate to low on each category of the questionnaire. Suggestions for future research and the social work curriculum are discussed in this project.

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CHAPTER ONE

INTRODUCTION

As the amount of traumatized individuals increase, the concern of the psychological well-being of the treating clinician is also increasing (Cunningham, 2003). Literature suggests that social workers and other helping professionals that interact with traumatized populations can be susceptible to symptoms of distress affecting their way of thinking and disturbing their existing cognitive schemas about self and general world view (McCann & Pearlman, 1990). Shackelford (2006) shared that the emotional, spiritual, physical and social aspects of a clinician's well-being can also be affected by working closely with traumatized populations. Helping professionals, namely social workers, for the purpose of this study, are taught to be compassionate and to respond with empathy. Although the client benefits from these set of skills, the costs for the therapist is rarely addressed (Figley, 2002). Having compassion and empathy makes helping professionals vulnerable as they show understanding and put themselves in the mind frame, thought process, and emotions of the client. In turn, when working with a traumatized client, the social worker may suffer from the trauma vicariously (Figley, 2002).

Purpose of the Study/Role of Education

This study builds on but does not copy Kimberly K. Shackelford's (2006) study regarding the *Preparation of Undergraduate Social Work*

Students to Cope with the Effects of Indirect Trauma. The purpose of this study is to understand the perception of Vicarious Trauma among Master of Social Work students. This study will identify the competence and overall understanding of vicarious trauma among MSW students. In this case study the importance of education will be explored.

Cunningham (2004) stated that social workers are aware of the effects of trauma work on a clinician. The researcher suggested that instructors should understand the fact that students will possibly be exposed to some trauma material in the field, and in the classroom as well, as students share their experiences with one another. The instructors should address the effects of being exposed to traumatic events, essentially alleviating the risk of secondary or vicarious trauma. The student will have some coping techniques of their own in case they begin a working relationship with a traumatized individual. Although there is an emerging amount of literature of the potential risk factors for vicarious trauma, literature shouldn't be the only avenue in which students are exposed to material about indirect trauma. As this writer is a current MSW student, it is from personal experience that students may not read extra material that is not assigned for class. Covering vicarious trauma material in the classroom should be a priority to instructors.

Napoli and Bonifas (2011) shared their idea that teaching practices in the classroom, such as mindfulness, would help students cope with vicarious trauma. The literature is an example of how being aware of vicarious trauma is

not enough. A student must know effective ways to deal with it. The researchers felt that incorporating such material in the classroom setting would make the social work student aware of their feelings and emotions, while being aware of the client's perspective. Mindful practice assures that the social worker will act with awareness. Nopoli and Bonifas' (2011) study serves as a paradigm of how coping mechanisms can be incorporated in class material to lessen the risk of vicarious trauma. Educating graduate students is an effective way to prevent risk factors of secondary trauma. Lessons on preventing vicarious trauma should be integrated or prioritized within the master level of social work education curriculum.

Vicarious Trauma

The term Vicarious Trauma was created in 1990 by McCann and Pearlman. Although anyone can suffer from vicarious trauma, McCann and Pearlman (1990) focused on the vicarious trauma experienced by therapists treating traumatized individuals. Vicarious trauma is an issue within the field of practice of social workers, as they are continuously exposed to the trauma of others. Vicarious trauma can be a disruptive factor in a social worker's career and life in general (Shackelford, 2006). Dunkley and Whelan (2006) stated, "Vicarious traumatization is specific in its recognition that counselors who are exposed to their clients' trauma material can also be traumatized" (p. 109). As vicarious trauma is getting more attention, research suggests that it comes with the duty of providing clinical work to traumatized individuals (Rasmussen,

2005). Words such as burnout, counter transference, and compassion fatigue have been used to explain emotional and psychological issues within the social work profession. Devilly, Wright, and Varker (2006) study suggested that vicarious trauma can be the cause of perceived burnout, compassion fatigue, and countertransference. Helping professionals need ways to cope and care for themselves as they continue to empower and assist traumatized populations.

Risks of Compassion and Empathy

Shackelford (2006) labeled empathy and compassion as the sources of vicarious trauma. Figley (2002) said, “Empathetic response is the extent to which the psychotherapist makes an effort to reduce the suffering through empathetic understanding” (p. 1437). The social worker or therapist builds a working relationship with clients as clients share their accounts and traumatic events, while the helping professional puts themselves in the client’s perspective. Empathetic understanding validates clients’ feelings. “Compassion stress is the residue of emotional energy from the empathetic response to the client and is ongoing demand for action to relieve the suffering of the client” (Figley, 2002, p. 1437). Figley suggested that compassion and empathy are inevitable and is the best resource for treatment in cases that deal with an individual that suffers from traumatic stress. Practicing these skills continuously puts the social worker at risk for vicarious trauma.

In the School of Social Work, social work students are taught different skills to meet the client where they are, and facilitate the client through their emotional state and perceptions. When working with traumatized individuals, literature suggests that social workers must be able to have compassion and empathy towards their clients. These skills are also proved to put social workers at risk for vicarious trauma. This issue illustrates that social workers should be educated to recognize signs of vicarious trauma, and also learn ways to prevent traumatic symptoms.

Vicarious Trauma in the Social Work Profession

Bride (2004) stated that social workers are continuously being contacted to work in crisis situations such as “survivors of childhood abuse, domestic violence, violent crime, disasters, and war and terrorism” (p. 63). Researchers are aware that social workers are interacting with traumatized populations at an extreme rate. In Bride’s (2004) study it was found that over 70% of social workers had encountered a symptom of secondary traumatic stress disorder before they participated in the secondary traumatic stress scale (STSS). In the study, over 40% of social workers reported intrusive thoughts, 19.1% and 12.4% of participants reported psychological distress, 5.8% reported disturbing dreams, and lastly 5% reported that they experienced an instance of reliving the traumatic event shared by the traumatized individual. The overall results showed that at least 15.2% of the social work participants reported some symptoms of secondary traumatic

stress that would meet criteria for Posttraumatic Stress Disorder. As social work continues to develop as a respected profession, the numbers of referrals will increase, and inevitably social workers will treat more clients with traumatic backgrounds.

Implications for Social Work

The social work profession needs to be more aware of the perception of vicarious trauma among Master's level social work students. These students will inevitably work with traumatized individuals and put their own psychological well-being at risk. It is the duty of the social work profession to make sure their professionals are aware of the costs of treating traumatic populations. Based on literature, if trainings and proper educational practices are implemented in the curriculum, it is likely that reported vicarious trauma will be lessened. The students will be aware of symptoms and their own feelings, which will assist them in self-care (Napoli & Bonifas, 2011).

Vicarious trauma will cause a high rate of burnout, compassion fatigue, and countertransference within the field of practice. These pathologies will affect social work professionals in the work place, and in turn, they will not be able to effectively treat their clients. This is not limited to clients with traumatic histories.

> Not surprisingly, when a counselor is suffering, the quality of work and the effectiveness of the organization may be compromised. That is, the counselor's empathic abilities, efforts to maintain a therapeutic stance,

> and establishment of boundaries with the client can be disrupted. (Dunkley & Whelan, 2006, p. 107)

Preventing an epidemic of vicarious trauma among practicing social workers and incoming social workers will keep the profession intact.

Figley (2002) shared the importance of helping professionals remaining compassionate and empathetic. Social workers will need the help of other professionals, including instructors, to address the issue of vicarious trauma.

> We cannot afford to not attend to the mistakes, misjudgments, and blatant clinical errors of psychotherapists who suffer from compassion fatigue. It is therefore, up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise we will lose clients and compassionate psychotherapists. (Figley, 2002)

Research Questions

This study seeks to answer the following four questions: How knowledgeable are MSW students about vicarious trauma? Do MSW students understand the risks of using skills such as empathy and compassion while treating a traumatized client? Are MSW students aware of the symptoms of vicarious trauma? Finally, are MSW students competent in coping practices? These questions will identify how much information on vicarious trauma is implemented within the Master of Social Work curriculum. Also, these questions will shed light on the preparedness of graduate students on encountering trauma victims and trauma material.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this study is to explore the perception of vicarious trauma among MSW students. The results will show the students' ability to recognize and cope with symptoms of vicarious trauma. This chapter will explore the history and effects of vicarious trauma and other similar pathologies such as burnout, secondary traumatic stress, and compassion fatigue. Additionally, this chapter will explore the connection of vicarious trauma to MSW students, interventions, underlining theories of vicarious trauma, and the need for educational awareness and training at the graduate level.

Understanding Trauma

Before vicarious trauma can be discussed, the basics of trauma need to be explored to understand the effects trauma can have on a client and possibly the helping professional. Herman (1992) stated that trauma requires for the victim to experience a horrifying and revolting event. In Herman's (1992) work the researcher revealed that there were periods in which psychological trauma received much attention, and times when there was a lack thereof. During World War II many soldiers began experiencing traumatic neurosis of war (Herman, 1992). Reportedly, soldiers experienced symptoms

of hysteria including: mutism, sensory loss, or motor paralysis. These soldiers were seen as cowards and liars, and received shock treatment in order to reduce symptoms (Herman, 1992). In that time, the only goal for treatment was to get the soldier back in battle. The “Talking Cure” made its way back into treatment from the initial efforts of curing hysteria, which made the victim experience the traumatic events by reliving them (Herman, 1992). By the end of the Vietnam War, the diagnosis and criterion for Post-Traumatic Stress Disorder was included in the DSM (Diagnostic and Statistical Manual of Mental Disorders) (Herman, 1992).

Herman (1992) revealed that during the 1970’s research began on sexual assaults on women and children, as it was a continuous occurrence within western society. The feminist movement used sexual assaults on women as its example of violence on women. Women feared being raped and reported symptoms of nausea, nightmares, lack of sleep, frighten responses, and disassociation. These symptoms were comparable to those of the soldiers that experience traumatic war neurosis (Herman, 1992). It seemed as though individuals of any traumatic event could suffer from posttraumatic stress.

McFarlane and Van Der Kolk (1996) discussed the challenges of traumatized individuals as they try to integrate back into society. People in society do not want to feel like they are unsafe in the world and the survivor of the traumatic event often reminds them of the horrendous event (McFarlane & Van Der Kolk, 1996). In some cases, society puts blame on the traumatized

individual, and do not give the desired support that the survivor expected or needed. It has been argued that traumatized individuals are more harmed by society after the traumatic event, than by the event itself (McFarlane & Van Der Kolk, 1996).

Shackelford (2006) acknowledged traumatized individuals' need for support and to tell their story. Survivors need someone to listen to them without judgment, but with understanding. Kaminer (2006) said, "The need for trauma survivors to re-tell or construct their trauma story in order to recover from post- trauma psychological sequelae is a principle that is common to most trauma intervention models" (p. 481). There have been several models that proposed stages for recovery among traumatized individuals. Herman (1992) introduced the three stages of recovery. The first stage seeks an establishment of safety for the trauma survivor; the second stage consists of recreating the trauma story, and the final stage involves reintegrating the survivor with the community. A social worker is equipped with the necessary skills to help the survivor succeed in recovery stages according to Herman (1992). However, the social worker will risk the chance of being affected by the description of the traumatic event experienced by the client. Salston and Figley (2003) stated that "stress incurred as a result of helping others" (p. 167). The researchers shared that there are numerous terms that that are related to vicarious trauma such as compassion fatigue, burnout, and secondary traumatic stress.

Vicarious Trauma

Vicarious trauma was introduced in 1990 by McCann and Pearlman. Since the term was officially introduced, researchers covered different areas of the negative outcomes and introduced ways to cope and deal with such trauma. Vicarious trauma can occur while clinicians treat traumatized individuals and provide empathetic and compassionate communication. “In the process providing services to survivors, the caregiver is exposed to traumatic material that begins to affect one’s worldview, emotional and psychological needs, the belief system, and cognitions, which develop overtime” (Salston& Figley, 2003, p. 169). Salston and Figley (2003) described vicarious trauma as a consequence of engaging with a traumatized individual empathetically. Many researchers argue that vicarious trauma is an inevitable factor that accompanies being exposed to traumatic information.

Way, VanDuesen, and Cottrell (2007) acknowledged that vicarious trauma has many negative effects, but focused on the cognition disruptions about self. This relates to the way that helping professionals feel about themselves and their competency after providing treatment to traumatized individuals. The researchers found that vicarious trauma can cause a clinician to have low self-esteem and also disruptions of how they may feel about self-intimacy. Vicarious trauma can have different effects on different individuals. The symptoms can be lessened if helping professionals are able to recognize the symptoms and use coping skills (Salston & Figley, 2003). Lerias

and Byrnes (2003) found seven key factors in literature that predicted susceptibility to vicarious trauma. “The key factors which are commonly found in the literature include, previous trauma history, psychological well-being, social support, age, gender, education and socio-economic status, and coping styles” (p. 132). For instance: An individual that has a history of trauma may run the risk of being retraumatized; an individual that has poor mental health may be weak when exposed to trauma. An individual that lacks social support may not cope well with trauma material, someone who is young and inexperienced may be easily traumatized, females reported anxiety due to vicarious trauma and lastly, those who do not possess a high level of education or live in a poor neighborhood may suffer from vicarious trauma as they have little to no access to support. This paper will explore some interventions and the importance of education.

Compassion Fatigue

Figley (2002) said,

> The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others. (p. 1434)

Compassion fatigue is lessening some of the suffering from the client, so the client can retell the story as part of treatment. Figley (2002) stated that the benefit of implementing compassion and empathy in treatment is observable by graduate students, but the risks are hardly ever addressed. Zeidner, Hadar, Matthews, and Roberts (2013) stated, “Compassion fatigue is a quite newly defined phenomenon, characterized by depressed mood, feelings of fatigue, disillusionment, and worthlessness, related to the provision of care to people who have experienced some form of trauma or severe stress” (p. 595). It is important to know that Compassion fatigue was first introduced in 1992, in regards to nurses that worked with traumatic work in hospitals. Later, compassion fatigue’s definition related to clinical practices as styles for treatment incorporated a compassion component (Salston &Figley, 2003). Newell and Macneil (2010) related compassion fatigue as a fusion of secondary traumatic stress and burnout symptoms.

Burnout

Shoji, Lesnierowska, Smoktunowicz, Bock, Luszczynska, Benight, and Cieslak (2015) stated, “Job burnout has been traditionally conceptualized as encompassing three dimensions, emotional exhaustion, depersonalization, and a lack of personal accomplishment” (p. 2). Burnout is not only related to being exposed to traumatic material.

Work-related Burnout can be caused by conflict between individual values and organizational goals and demands, an overload of

> responsibilities, a sense of having no control over the quality of services provided, awareness of little emotional or financial reward, a sense of a loss of community within the work setting, and the existence of inequity or lack of respect at the workplace. (Salston & Figley, 2003, p. 168)

Burnout is described as a process and not an event. Salston and Figley (2003) argued that burnout being a process indicates the difference of it being a form of secondary traumatic stress. However, burnout can be brought on by stressors, including stressors from continuously interacting with traumatized individuals (Salston & Figley, 2003)

Secondary Traumatic Stress

Newell and Macneil (2010) said that Secondary traumatic stress is the term most similar to vicarious trauma. “STS results from engaging in an empathic relationship with an individual suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that particular person’s trauma” (Newell & Macneil, 2010, p. 60). The researchers stated that an individual that experiences secondary traumatic stress present the symptoms of Posttraumatic Stress Disorder just as the individual who experienced the direct trauma (Newell & Macneil, 2010). Newell and Macneil (2010) suggested that the main difference between vicarious trauma and secondary traumatic stress disorder is that vicarious trauma results in cognitive disruptions due to direct interaction and practice with traumatized individuals. Secondary traumatic stress regards the “outward behavioral

symptoms rather than intrinsic cognitive changes" (Newell & Macneil, 2010, p. 60-61).

Importance of Understanding Vicarious Trauma for Master of Social Work Students

This study focuses on MSW students because of the responsibility that these individuals have while in the program and in the field as professionals. D'Aprix, Dunlap, Abel, and Edwards (2004) described why MSW graduates have more responsibility than their BSW associates. They stated,

> While MSW programs prepare students for more advanced and specialized practice. Social agencies typically pay graduates of MSW programs substantially more than graduates of BSW programs. Further, in contrast to their BSW colleagues, MSW graduates are allowed by laws regulating social work practice to engage in 'independent' or 'private' practice. In addition, MSW graduates with a minimum of two years of post-graduation supervised experience are permitted to provide psychotherapy services and to engage in private practice. (p. 266)

MSW graduates may take their careers further and become licensed Clinical Social Workers, and in turn, deal with more trauma material as clinical social workers are being sought out to help traumatized individuals more often (Bride, 2004). While the responsibilities of MSW students put them at risk of

vicarious traumatization, it seems their qualifications for their acceptance into the graduate program may also put them at risk.

There are many requirements that MSW applicants have to meet before they may be considered for the MSW graduate program (Han, Lee, & Lee, 2012). One of the requirements is to have prior work experience in the human service or social work related fields. Han et al. (2012) discussed that prior working experience and the personal attributes of being caring, sensitive, and compassionate may contribute to being at risk for burnout once in the field. Vicarious trauma has been linked to burnout, and may be the cause of some cases of burnout among clinical social workers (Devilly, Wright, & Varker, 2009). For these reasons, this study seeks to explore the perception of vicarious trauma among MSW students, as they put themselves at risk of the pathology.

Interventions

Vicarious trauma has gotten some attention in the area of research. There have been research studies on how the clinician can decrease the risk of being traumatized vicariously by using a variety of interventions. Sommer (2008) suggested that participating in trauma sensitive supervision among trauma clinicians and workers is an effective coping mechanism. There are four modules that makeup trauma sensitive supervision, they are “a strong theoretical grounding in trauma therapy, attention to the conscious and unconscious aspects of treatment, a mutual respectful interpersonal climate,

and educational components that directly address vicarious traumatization" (Sommer, 2008, p. 64). The supervisor's duties include being attentive to any changes a clinician may go through while treating traumatized individuals like burnout or lack of self-care as it may be related to onsets of vicarious trauma (Sommer, 2008). The individual will be able to communicate with the supervisor about traumatic exposure and their personal feelings associated with engaging in traumatic work (Sommer, 2008). Trauma sensitive supervision works as an outlet or type of support system for trauma workers to process their interactions and feelings. Sommer (2008) suggests that trauma sensitive supervision should be ongoing, even after the clinician attains their license.

Newell and Macneil (2010) identified self-care as an intervention to vicarious trauma. "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, p. 62). There are different ways in which a professional can engage in self-care. Newell and Macneil (2010) recommended that professionals should take advantage of scheduled breaks during the work day. Professionals should set realistic objectives for themselves regarding treatment for clients and workload in general. Also, professionals should get enough rest and spend time with family and friends

(Newell & Macneil, 2010). Gaining social support from colleagues is also a suggested intervention (Newell & Macneil, 2010).

Dass-Brailsford and Thomley (2012) conducted a study to distinguish if there were any signs of vicarious trauma among the helping professions of Hurricane Katrina. Although the studies show that there was no significant trend in vicarious trauma, the study shed light on the training that the volunteers had before they set off to help the victims of Hurricane Katrina. The training lasted two days, and covered topics like what to expect when helping those who have experienced a natural disaster. The trainings identified self-care as a form of immunization from vicarious trauma. The helping professionals spent a night away from the disaster to enjoy themselves and get the necessary rest that they needed. After each day, the professionals debriefed each other in a group, and gave support to each of their colleagues. Dass-Brailsford and Thomley (2012) acknowledged that the training and intervention strategies were the reason that the clinicians did not suffer from vicarious trauma. It is observable that the mandatory training helped the clinicians effectively do their job and care for themselves. The training proves that educating trauma workers is important. Helping professionals should be aware of the potential risk factors of traumatic events and how to handle them if presented to such a situation.

Importance of Social Work Education

Cunningham (2004) stated that educating students on theoretical frameworks assists them in helping clients as a professional. Education provides students with an understanding of traumatized clients' feelings, while still providing emotional distance and structure. Cunningham (2004) implied that there is a possibility that social work students may encounter symptoms of vicarious trauma before they are licensed professionals. The material that students encounter in the classroom and field can have a negative impact on their psychological well-being (Cunningham, 2004). Instructors need to be aware of the risks of presenting traumatic material in the classroom setting (Cunningham, 2004). Instructors need to address pathologies of vicarious traumatization, burnout, secondary traumatic stress, and compassion fatigue, and the negative effects associated with them. Addressing these terms will assist the students in the classroom and in the field of practice (Cunningham, 2004).

Napoli and Bonifas (2011) shared that educating students with the integrative health model teaches students interventions regarding vicarious trauma, and also effective social work skills. Mindfulness practice, which is a component of the integrative health model, will assist students with their social work skills (Napoli& Bonifas, 2011). Mindfulness is "Defined as the process of bringing awareness and attention to the present experience without internal or external filters" (Napoli & Bonifas, 2011, p. 636). Practicing mindfulness comes

with benefits. Napoli and Bonifas (2011) stated, “When students are mindful, they are aware and accepting of whatever is arising in the present moment without judgment, which strengthens their ability to understand clients’ perspectives and fosters the development of a therapeutic relationship” (p. 636-637). Maintaining a therapeutic relationship with clients while distancing from personal feelings has been a trend in literature. Graduate students need to be aware of potential risks and the interventions of vicarious trauma in order to be effective clinicians in the field of practice.

Theories Guiding Conceptualization

When McCann and Pearlman introduced vicarious trauma in 1990, they related the term to their previous work on Constructivist Self-Development Theory (CSDT). The theory encompasses psychological adaption, the relation of traumatic occurrences, and cognitive schemas about self and worldviews (McCann & Pearlman, 1990). CSDT focuses on the fact that individuals construct their own realities which determine how they interpret events. The theory suggested that when therapists experience vicarious trauma, their cognitive schemas are interrupted. The schemas in which individuals create develop overtime, as they interact with the environment around them. The theory suggested that vicarious trauma disrupts an individual’s cognitive schemas, and the perspective in which they see themselves and the world will be changed due to exposure of traumatic information.

The theory of Intersubjectivity is a framework concerning the relationship of psychological development and the process of therapy (Rasmussen, 2005). The researcher recognized that vicarious trauma alters therapists' perceptions of the world and sense of self. Intersubjectivity structures the therapeutic process in relational terms and psychological growth (Rasmussen, 2005). There are three realms in the unconscious which include: the prereflective unconscious (attains the makeup of experience outside of awareness to structure opinions), the dynamic unconscious (contains repressed memories), and the unvalidated unconscious (contains unacknowledged events, memories, and emotions once experienced) (Rasmussen, 2005). Intersubjectivity proposes that vicarious trauma lives in the "unvalidated unconscious", which holds unacknowledged memory and events. The theory supports McCann and Pearlman's (1990) claim that vicarious trauma interrupts the thought process, however the theory blames it on clinicians' relationships with their clients and their own personal psychological development (Rasmussen, 2005).

Methodological Limitations

The findings of the Dass-Brailsford and Thomley (2012) study showed that the clinicians that helped during Hurricane Katrina had no symptoms of secondary Traumatic stress. Although the study shared that the helping professionals received effective training the results were limited, the results of the study were not generalizable because of the population that participated in

the study. The study relied on a small convenient sample. The majority of the participants were Caucasian, so the study lacked ethnic diversity. The instrument of the study was a survey. It is possible that self-report and bias can affect the results of a survey instrument.

Summary

The literature and research regarding vicarious trauma and similar pathologies prove that clinicians can be affected by continuously being exposed to traumatic information. Vicarious trauma can resemble symptoms of PTSD, and can affect clinicians' work and personal life. Using the skills of compassion and empathetic responding can cause clinicians to be susceptible to vicarious trauma, as they are taking in the client's emotions and worldviews. It is important that social work graduate students receive the proper education and training to work with traumatized populations to avoid indirect trauma. Also students need to recognize symptoms of vicarious trauma and implement coping strategies to deal with the excessive exposure to traumatic material.

CHAPTER THREE

METHODS

Introduction

The review of literature supported the importance of educating Master of Social Work students on vicarious trauma, and the risks that comes with forming therapeutic relationships with traumatized individuals (Napoli & Bonifas, 2011). Studies have shown that clinicians need to be aware of the negative effects of vicarious trauma and be knowledgeable of coping skills that will alleviate the stressors of indirect trauma. Master of Social Work students are eligible to acquire licensure to practice clinical social work independently, and in turn will be exposed to a large amount of traumatic material (Bride, 2004). Master of Social Work students need to be introduced and educated on the topic of vicarious trauma before they practice in the field of social work (Cunningham, 2004). Also, training on vicarious trauma should be ongoing (Sommer, 2008). Vicarious trauma should be a topic that is covered more in depth in the school of social work. This study will explore the perception and overall knowledge of vicarious trauma among Master of Social Work students at California State University, San Bernardino.

Study Design

The purpose of this study was to explore the perception of vicarious trauma among Master of Social Work (MSW) students. This was a descriptive

study as it provides information about the perception and competence of vicarious trauma among the sample group of MSW students. The survey that was administered is cross-sectional and the information collected gives an overall understanding of the perception that master's level social work students have on vicarious trauma. This research method was chosen because a survey gives a general idea of the participating population as a whole, rather than the individual accounts of qualitative data collection. Surveys were given to MSW students to show if vicarious trauma is effectively implemented within the curriculum at the Master's level. Limitations of the study were that the data collected does not represent MSW students from different schools. Also, the data collected was from a small sample. Lastly, the survey was formatted like a test. Although the directions stated that the survey did not affect students' grade and did not judge the students individually, the students might have tried to answer the survey by thinking critically.

This research study sought to answer four questions: How knowledgeable are MSW students about vicarious trauma? Do MSW students understand the risks of using skills such as empathy and compassion while treating a traumatized client? Are MSW students aware of the symptoms of vicarious trauma? And finally, are MSW students competent in coping practices?

Sampling

The sample in this study included MSW students from all cohorts of the MSW program at California State University, San Bernardino, as training on vicarious should be ongoing (Sommer, 2008). The participants were from different agencies for field placement and might have had different experiences concerning vicarious trauma. Sixty-seven Master level social work students completed the proposed cross sectional survey. As students were busy with their studies, the sampling included a convenience sample. However, the sample was also purposive, as the population of MSW students shared the characteristics of educational level and affiliation with California State University, San Bernardino.

Data Collection and Instruments

The instrument that was used was a modified version of Shackelford's (2006) original 55 item "Knowledge of Indirect Trauma Questionnaire". The survey in this study included 30 questions and addressed four categories. The four categories of the survey were familiarity of coping skills, overall knowledge of vicarious trauma, understanding risk of using empathy and compassion in practice, and knowledge of symptoms of vicarious trauma. Also, demographic information about the sample population was collected. Shackelford (2006) verified face validity by sending her questionnaire to two specialists in the discipline of indirect trauma. Shackelford (2006) ensured reliability of the survey by running a trial test on a small sample before

conducting the actual study. The independent variables in this study were age and cohort of the participating sample. The dependent variable was the perception of vicarious trauma among MSW students. The dependent variable was measured by participants answering True or False questions regarding knowledge of vicarious trauma.

Procedures

This survey was placed on www.surveymonkey.com. The participants were solicited by the school's email system. Five-dollar gift cards to Starbucks and Juice It Up were offered to the first 40 participants that completed the survey. The researcher was in charge of collecting the data. Data Collection started on February 24, 2016 and ended on March 4, 2016.

The test consisted of true or false questions. There was also a category labeled "I don't know" so the participants were not forced to think critically about any answer if they did not know it.

Protection of Human Subjects

This researcher completed the Institutional Review Board's (IRB) course on Social Behavior Research and Key Personnel, and gained knowledge and understanding of the terms of research and how to protect human subjects that participate in the study from harm. The survey was accompanied by an informed consent and a debriefing statement. The

confidentiality of each participant was protected as the survey did not provide markers or asked for identifying information.

Data Analysis

The quantitative data collected was from a true or false questionnaire. The questionnaire's categories answered the four research questions including how knowledgeable are MSW students about vicarious trauma? Do MSW students understand the risks of using skills such as empathy and compassion while treating a traumatized client? Are MSW students aware of the symptoms of vicarious trauma? Lastly, are MSW students competent in coping practices?

The numbers of correct and wrong answers were calculated for each completed survey. Also, if a participant marked "I don't know" for any of the questions, it was considered an incorrect answer. The number of correct answers among the different age groups and cohorts were compared to determine if there was a correlation between specific age groups, cohorts, and the answers selected. The data was analyzed by observing the regularity of correct answers throughout the questionnaire by all participants, and the mean score of how many questions right in each category (Shackelford, 2006). The researcher utilized four independent samples t-test to distinguish if there was a relationship or significant difference between the mean scores of the before mentioned analyzed data and cohorts. A one-way between groups ANOVA was utilized to distinguish if there was a significant relationship between the

different age groups and the mean scores of correct answers on the questionnaire as a whole. A one-way between groups ANOVA was utilized to distinguish if there was a significant relationship between age groups and mean scores of questions pertaining to understanding using compassion and empathy in practice. A one-way between groups ANOVA was used to determine if age had an influence on knowledge of coping practices. A one-way between groups ANOVA was performed to determine if there was a significant difference between age and knowledge of symptoms of Vicarious Trauma.

Summary

This study explored the perception of vicarious trauma among MSW students through quantitative data collection. The participants were asked to complete a true or false survey. The survey was useful as it gave general information about the graduate student population. The target population was drawn from convenience and purposive sampling methods. The researcher offered an incentive to the first 40 participants of the study, to show gratitude for taking time to participate in the study. The confidentiality of the participants was protected as there were no identifying markers on the survey. This researcher distinguished patterns, significant differences, and correlating factors within the population of Master of Social Work graduate students.

CHAPTER FOUR

RESULTS

Introduction

This chapter will reveal the results and findings of the perception of Vicarious Trauma among MSW students. The data was collected using www.surveymonkey.com and analyzed using SPSS (Statistical Package for the Social Sciences) version 23. The descriptive characteristics of the participant sample will be discussed to give an illustration of who participated in the study, and the possible influence the descriptive characteristics may have on the findings. Next, the researcher will look at the findings of four independent samples t-tests. The independent samples t-tests will determine if there was a significant difference between the participant's cohort (full-time or part-time) in the MSW program and their scores on the over-all knowledge that they have of vicarious trauma, their understanding of risks for utilizing empathy and compassion in practice, their knowledge of symptoms of vicarious trauma, and their understanding of competent coping practices, according to the results of the true or false questionnaire. Finally, the researcher will present the results of four, one-way between groups ANOVA's for age of the study sample and the aforementioned areas of knowledge that participants demonstrated by taking the true or false questionnaire.

Descriptive Data

Table 1 represents the demographics of the participant sample. Sixty-seven students participated in the study. The modal age for the study sample was 31 and over (35.8%), while 34.3% of the samples were ages 21-25 and 29.9% were 26-30. The study sample was made up of 83.6% women and 14.9% men. Regarding ethnicity, 46.97% identified as Hispanic /Latino, 40.91% were Caucasian, 9.09% were African American/Black, 3.03 were Asian, and 7.58% identified as Other. Participants were given the option to select all of the ethnicities that they identified with. Full-time students made up 55.2% of the study sample, while 41.8% were part-time students. Lastly, in regards to field placement, 34.3% of the study sample are placed in internships that focused on children and families, 22.4% worked in a mental health agency, 17.9% worked in an educational setting, and 22.4% had other field placements. It is important to note that the participants were given the option to skip questions if they were not comfortable answering them.

Table 1. Demographic Data

	Frequency N	Percent %
Age		
21-25	23	34.3%
26-30	20	29.9%
31 or over	24	35.8%

	Frequency N	Percent %
Gender		
Female	56	83.6%
Male	10	14.9%
Unknown	1	1.5%
Ethnicity		
Asian	2	3.03%
Black/AA	6	9.09%
Hispanic/Latino	31	46.97%
White/Caucasian	27	40.91%
Other	5	7.58%
Unknown	1	1.52%
Cohort		
Full-time	37	55.2%
Part-time	28	41.8%
Unknown	2	3.0%
Field Placement		
Children/Families	23	34.3 %
Mental Health	15	22.4 %
Education	12	17.9%
Other	15	22.4%
Unknown	2	3.0%

Findings

An independent-samples t-test was conducted to compare the over-all knowledge of vicarious trauma scores for part-time and full-time student participants. There was no significant difference in scores for part-time

students (M = 20.40, SD = 8.32) and full-time students (M = 21.4, SD = 7.41); t (54) = -.454, p = .65, two-tailed). The magnitude of the differences in the means (mean difference = -.95, 95% CI: -5.17 to 3.26) was very small (eta-squared = .0038).

An independent samples t-test was performed to compare the empathy and compassion scores for both part-time and full-time student participants. There was no significant difference in scores for understanding risk of utilizing empathy and compassion in practice for part-time students (M = 2.46, SD = 1.42) and full-time students (M = 2.62, SD = 1.71); t (58) = -.38, p = .71, two-tailed). The magnitude of the differences in the means (mean difference = -.16, 95% CI: -.98 to .67) was very small (eta squared = .002).

An independent samples t-test was performed to compare the scores on knowledge of symptoms for vicarious trauma for both part-time and full-time cohorts. There was no significant difference in scores for awareness of symptoms of vicarious trauma for part-time students (M = 6.52, SD = 3.19) and full-time students (M = 6.90, SD = 3.18); t (54) = -.45, p = .66, two-tailed). The magnitude of the differences in the means (mean difference = -.38, 95% CI: -2.1 to 1.33) was very small (eta squared = .0037).

An independent samples t-test was conducted to compare the scores on competence of coping practices for part-time and full-time cohorts. There was no significant difference in scores for competence of coping practices for part-time students (M = 3.54, SD = 1.77) and full-time students (M = 3.73,

SD = 1.4); t (57) = -.458, p = .65, two-tailed). The magnitude of the differences in the means (mean difference = -.19, 95% CI: -1.01 to .64) was very small (eta squared = .0037).

A one-way between groups analysis of variance was performed to explore the influence of age on overall knowledge of vicarious trauma, as measured by the Vicarious Trauma Questionnaire (VTQ). The study sample were divided into three groups according to their age (Group 1: 21-25 yrs.; Group 2: 26 to 30 yrs.; Group 3: 31 yrs. and over). There was no significant difference at the $p < .05$ level in VTQ scores for the three age groups: $F (2, 53) = .74$, $p = .48$. Post-hoc comparisons using the Tukey HSD test determined that the mean score for all three groups (Group 1:M = 22.65, SD = 6.69, Group 2: M = 19.41, SD = 7.79, Group 3:M = 20.77, SD = 8.87) did not differ significantly.

A one-way between groups ANOVA was conducted to explore the impact of age on understanding risk of using empathy and compassion in practice, as measured by the VTQ. As aforementioned the study sample was divided into three groups. There was no significant difference at the $p < .05$ level in VTQ scores for understanding risk of using empathetic and compassionate skills in practice for the three groups: $F (2, 57) = .11$, $p = .90$. Post-hoc comparisons using the Tukey HSD test determined that the mean score for all three groups (Group 1: M = 2.68, SD = 1.34, Group 2: M = 2.44, SD = 1.82, Group 3: M = 2.52, SD = 1.62) did not differ significantly.

A one-way between groups ANOVA was conducted to explore the influence of age on knowledge of symptoms of vicarious trauma, as measured by the VTQ. There was no significant difference at the $p < .05$ level in VTQ scores for knowledge of vicarious trauma symptoms for the three groups: $F (2, 53) = .80$, $p = .46$. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups (Group 1: $M = 7.24$, $SD = 2.95$, Group 2: $M = 5.94$, $SD = 3.10$, Group 3: $M = 6.95$, $SD = 3.39$) did not differ significantly.

A one way between groups ANOVA was performed to explore the impact of age on competence of coping practices, as measured by the VTQ. There was no significant difference at the $p < .05$ level in VTQ scores for competence of coping practices among the three groups: $F (2, 57) = 1.74$, $p = .19$. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for all three groups (Group 1: $M = 4.21$, $SD = 1.23$, Group 2: $M = 3.42$, $SD = 1.68$, Group3: $M = 3.41$, $SD = 1.65$) did not differ significantly.

Summary

Results revealed that students more often recognized terms related to direct trauma such as compassion fatigue, burnout, countertransference, and posttraumatic stress disorder. The students were less likely to identify terms related to indirect trauma, such as vicarious trauma and secondary traumatic stress. Out of a possible score of 36 for the entire Vicarious Trauma Questionnaire, the highest score was 33 and the lowest score was zero.

For overall knowledge of vicarious trauma, the average score for part-time students was 20.40 while full-time students score was 21.4. The average correct answers for understanding using empathy and compassion skills in practice was 2.5 for part-time students and 2.6 for full-time students. The average score for knowledge of symptoms of vicarious trauma was 6.5 for part-time students and 6.9 for the full-time cohort. Lastly, competence of coping practices scores averaged 3.4 for the part-time students and 3.7 for full-time students. Although the full-time cohort's scores were slightly higher than the part-time cohort's score, there was no significant difference between the part-time and full-time cohorts knowledge of vicarious trauma.

For overall knowledge of vicarious trauma, the mean scores were 22.65 for Group 1 (ages 21-25), 19.42 for Group 2 (ages 26-30), 20.77 for Group 3 (ages 31 and over). The average scores for understanding the risk of using compassion and empathy in practice were 2.61 for Group 1, 2.44 for Group 2, and 2.52 for Group 3. The average scores for awareness of symptoms of vicarious trauma were 7.24 for Group 1, 5.94 for Group 2, and 6.95 for Group 3. The average scores for competence of coping practices were 4.21 for Group 1, 3.42 for Group 2, and 3.41 for Group 3. Ages 21 to 25 averaged the highest scores in all categories, while ages 31 and over scored second highest in average scores in all categories, except for on questions regarding competence in coping practices. Ages 26-30 scored slightly higher in competence in coping practices than ages 31 and over. Although there were

variations in average scores among the three groups there were no significant differences.

CHAPTER FIVE

DISCUSSION

Introduction

The purpose of this study was to explore the perception of vicarious trauma among Master of Social Work students. This study was set to answer four research questions: How knowledgeable are MSW students about vicarious trauma? Do MSW students understand the risks of using skills such as empathy and compassion while treating a traumatized client? Are MSW students aware of the symptoms of vicarious trauma? And finally, are MSW students competent in coping practices? The independent variables in the study were the participants' age and cohort.

Discussion

Research Question 1

The mean score on the Vicarious Trauma Questionnaire was 20.4 for part-time students and 21.4 for the full-time cohort. The average score on the questionnaire was 22.65 for ages 21-25, 19.42 for ages 26-30, and 20.77 for ages 31 and over. The total number of questions regarding overall knowledge of vicarious trauma was 36. Neither age nor cohort had a significant difference or influenced on the knowledge the study sample had on Vicarious Trauma.

Research Question 2

The mean scores on questions related to understanding using empathy and compassion in practice was 2.5 for part-time students and 2.6 for full-time

students. The average scores for this research question was 2.61 for ages 21 to 25, 2.44 for ages 26 to 30, and 2.52 for ages 31 and over. There were six questions regarding empathy and compassion. There were no significant differences in scores in regards to age or cohort of the study sample.

Research Question 3

Out of 12 questions related to knowledge of symptoms of vicarious trauma, part-time students scored an average of 6.5 and full-time students scored 6.9. In regards to age, the average score of knowledge of symptoms of vicarious trauma were 7.24 for ages 21 to 25, 5.94 for ages 26 to 30, and 6.95 for 31 and over. There were no significant differences in scores between these groups.

Research Question 4

Out of five questions regarding competence of coping practices, the average scores for part-time students was 3.4 and 3.7 for full-time students. The mean scores for competence of coping practices were 4.21 for ages 21 to 25, 3.42 for ages 26 to 30, and 3.41 for ages 31 and over. There were no significant differences between the scores of the three age groups and part-time and full-time cohorts.

Although there were no significant differences between the scores of the independent variables (age and cohort), the average scores revealed that the participating sample had some knowledge of vicarious trauma and aspects of the pathology. However, on average, the scores ranged from moderate to

low for each category. Question one of the survey asked the participants to identify the terms that they recognized. The participants were able to identify terms related to direct trauma like countertransference, burnout, compassion fatigue, and posttraumatic stress disorder. However, the participants were less likely to identify terms related to indirect trauma including secondary traumatic stress and vicarious trauma. Shackelford's (2006) study results revealed similar findings for recently graduated BSW's. The researcher suggested that students may not have received education on indirect trauma. The review of literature suggested that indirect trauma and direct trauma are interrelated. As indirect traumatic symptoms increase; the symptoms simulate those of direct trauma symptoms, such as posttraumatic stress disorder (Newell & Macneil, 2010). Newell and Macneil (2010) stated that secondary traumatic stress is the term that is most comparable to vicarious trauma. This disclosure can further explain why the participants were not able to identify the two terms concerning indirect trauma. Also, social work programs focus their curriculum on direct trauma (Shackelford, 2006).

Strengths and Limitations

This study's strength lies in the number of participants that participated in this study. The minimum number of participants required was 45. Offering an incentive for completing the survey assisted in soliciting participants. Also, the survey was only open for a week and a half, which limited the possible number of students that could have participated in the study if more time was

allotted. The research questions were appropriate for this study. The research questions reflected the questions asked on the distributed survey.

The Vicarious Trauma Questionnaire originally had face validity as it was based on Shackelford's (2006) study on indirect trauma. However, the survey was altered to fit the needs of this particular study and questions were added and eliminated from the original survey. This alteration possibly affected the survey's face validity and overall measurement of knowledge of vicarious trauma as there were more questions for certain categories and less for others. For example, there were 12 questions regarding symptoms of vicarious trauma and only five questions concerning competency of coping practices. After the data collection was complete, the researcher noticed that there were a couple of typos on the distributed survey. These misprints could have possibly affected the responses and results as the participants may have had difficulty comprehending the intended questions. The participants were able to use context clues to answer the questions. It is possible that some participants took educated guesses to answer the questions and may not have actually known the correct answers. Furthermore, there is no agreed upon standard by which we can consider what a high level of knowledge concerning vicarious trauma is. More analysis would have to be done on the instrument itself.

Directions for Future Research

More studies regarding vicarious trauma need to be conducted to determine if the findings in this study are accurate. Although MSW students

demonstrated some knowledge on vicarious trauma, it is evident from the average scores that MSW students need more education focused on vicarious trauma and other pathologies regarding indirect trauma. Studies on vicarious trauma should be conducted on different school campuses regarding MSW students' knowledge of vicarious trauma to determine if the findings are similar and what factors may influence the results.

Future research regarding vicarious trauma should make sure that questions are appropriate for measuring vicarious trauma and that their surveys are free from typographic mistakes. Researchers should be mindful of the time that they allow their study sample to participate in the study, as the current study revealed that more time was needed to have a larger study sample.

In regards to the gaps in literature, future research on vicarious and indirect trauma should address why aspects of direct trauma are heavily inputted in the school of social work's curriculum.

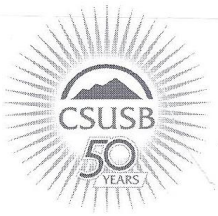
Implications for Practice

The study's findings are important to the field of practice as they reveal that Master of Social Work students on average have moderate to low knowledge of vicarious trauma and need more exposure to educational material on indirect trauma. Bride (2004) acknowledged that MSW's can further their professional careers by becoming licensed, and in turn be exposed to more traumatic material. Rasmussen (2005) stated that vicarious

trauma comes with the territory of being a clinician treating traumatized populations. It is reasonable that the social work profession educate their students and practicing professionals on vicarious trauma. Furthermore, students should be aware that helping traumatized clients may affect their lives and sense of self. Understanding vicarious trauma can promote mental well-being in the field.

APPENDIX A

INFORMED CONSENT



California State University, San Bernardino
Social Work Institutional Review Board Sub-Committee
APPROVED 12/2/2016 VOID AFTER 2/1/2017
IRB# SW1639 CHAIR

College of Social and Behavioral Sciences

Informed Consent

The study in which you are being asked to participate in is designed to explore the perception of vicarious trauma among MSW students. This is a graduate research project conducted by Breyana Jackson, under the supervision of Dr. Armando Barragan, Assistant Professor, at California State University, San Bernardino. This study has been approved by the School of Social Work's Sub-Committee of the California State University, San Bernardino Institutional Review Board.

PURPOSE: The purpose of this study is to understand the perception of vicarious trauma among Master of Social Work students. This study will identify overall understanding of vicarious trauma among MSW students.

DESCRIPTION: The participant will be asked to fill out a questionnaire that includes information related to vicarious trauma and its effects on Social Workers.

PARTICIPATION: Your participation is completely voluntary and you do not have to answer any questions you do not wish to answer. You may skip or not answer any questions and can freely withdraw from participation at any time.

CONFIDENTIALITY: The confidentiality of each participant will be protected as the survey will not provide markers or ask for identifying information. The participants in this study will remain anonymous.

DURATION: The survey should take no longer than 15-20 minutes.

RISKS: No anticipated harm will emerge as a consequence of participating in this study.

BENEFITS: Participants will be contributing to the field of knowledge in Social Work. Also, a five dollar gift card will be offered to each participant that completes the study.

CONTACT: If you have any questions about this survey, you can contact Dr. Armando Barragan at (909) 537-3501 or abarragan@csusb.edu

RESULTS: Results of the study can be obtained from CSUSB ScholarWorks database after June, 2016.

CONFIRMATION STATEMENT: I have read and understand the consent document and agree to participate in your study.

APPENDIX B

VICARIOUS TRAUMA QUESTIONNAIRE

Vicarious Trauma Questionnaire

Please answer the following demographic questions. When you complete these five questions please read the instructions for the next section carefully.

Demographic data:

Age:
- 21-25 _____
- 26-30 _____
- 31-35 _____
- 36-40 _____
- 41-46 _____
- Over 46 _____

Gender:
- Male____
- Female____

Cohort:
- 1st year part time _____
- 2nd year part time _____
- 3rd year part time _____
- 1st year full time _____
- 2nd year full time _____

Ethnicity:
- African American/ Black/ Caribbean_____
- Asian/ Pacific Islander _____
- Caucasian_____
- Hispanic Latino_____
- Native American ____
- Other _____

Field Placement:
- public child welfare_____
- Hospice_____
- health services_____
- family services other than public child welfare_____
- early childhood education_____
- education setting other than early childhood (schools)____
- residential child/youth service_____
- psychiatric or mental health service_____
- courts, criminal justice, prison, probation, parole, juvenile justice_____
- crisis center, emergency aid services_____
- domestic violence shelter_____
- developmental disabilities services_____
- substance abuse or addiction services_____
- other - please describe_____

Please answer the following questions. Do not guess or think critically. This is not a test. If you do not know the answer, please mark “no” or “DK” for “don’t know”.

1. Do you recognize these terms?
   Vicarious Trauma Y/N
   Secondary Traumatic Stress Y/N
   Compassion fatigue Y/N
   Burnout Y/N
   Countertransference Y/N
   Posttraumatic Stress Disorder Y/N

2. Secondary traumatic stress may be a result of listening to another person talk about his/her own trauma? T/F/Dk

3. Vicarious Traumatization is the transformation of the therapist’s inner experience as a result of empathetic engagement with survivor clients and their trauma material T/F/DK

4. Research suggests that the younger a counselor is the less likely the counselor will be affected by Secondary Traumatic Stress disorder. T/F/DK

5. The more a counselor is able to empathize with a client the more at risk the counselor is to be vicariously traumatized. T/F/DK

6. The ability to be empathetic is not related to a counselor’s likelihood of experiencing secondary traumatic stress when working with traumatized clients. T/F/DK

7. Countertransference is a result of vicarious trauma T/F/DK

8. Some symptoms involved in the diagnosis of posttraumatic stress disorder is persistent arousal such as difficulty going to sleep and hypervigilence. T/F/DK

9. A counselor’s self esteem would never be lowered as a result of vicarious traumatization. T/F/DK

10. Some symptoms involved in Secondary traumatic stress disorder is re-experiencing the event. T/F/DK

11. Self care does not mitigate the negative effects of secondary trauma T/F/DK

12. A counselor’s desire to be all and help all regarding his/her clients is not a risk factor for vicarious trauma. T/F/DK

13. Secondary traumatic stress responses may lead to symptoms that are similar to symptoms of posttraumatic Stress disorder. T/F/DK

14. Substance abuse and compulsive activities may be behaviors noticed in counselors who are being affected by secondary traumatic disorder. T/F/DK

15. Counselors may try to avoid certain clients or types of client situation as an effect of secondary traumatic stress.

16. Counselors may think that the world is not a safe place as a result of vicarious traumatization. T/F/DK

17. The counselor's world view may change if he/she is experiencing vicarious trauma. T/F/DK

18. Supportive supervision is important in lessening the negative effects of vicarious trauma T/F/DK

19. Knowledge of the effects of indirect trauma is important for counselors who work with traumatized individuals. T/F/DK

20. A counselor would not have nightmare regarding his/her traumatized client if he/she is working with the client in an appropriate and professional matter. T/F/DK

21. Indirect trauma may lead to Secondary traumatic stress responses that are maladaptive or adaptive. T/F/DK

22. Secondary Traumatic Stress Disorder and PTSD differ in that PTSD develops from direct trauma and secondary traumatic stress develops from indirect trauma. T/F/DK

23. Secondary Traumatic Stress is stress that results from helping or wanting to help a traumatized person. T/F/DK

24. A counselor may experience intrusive thoughts after working with a traumatized person. T/F/DK

25. Peer support in the workplace is not used to help the counselor lessen the negative effects of indirect trauma. T/F/DK

26. A counselor's personal trauma history will have no influence on risk for secondary traumatic stress disorder. T/F/DK

27. A counselor's ability to trust others is affected by vicarious traumatization. T/F/DK

28. A counselor's cognitive schemas might be affected by vicarious traumatization. T/F/DK

29. Counselor's understand the importance of connections with others and have the ability to be intimate with others so this is not affected by vicarious trauma. T/F/DK

30. Counselors would never need counseling from a professional counselor regarding the effects of indirect trauma. T/F/DK

Adapted from Shackelford, K. K. (2006). *Preparation of undergraduate social work students to cope with the effects of indirect trauma* (Order No. 3259420). Available from ProQuest Dissertations & Theses Full Text: The Humanities and Social Sciences Collection. (305305889).

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

This study explored the perception of vicarious Trauma among MSW students. The questionnaire's categories will answer the following research questions: how knowledgeable are MSW students about vicarious trauma? Do MSW students understand the risks of using skills such as empathy and compassion while treating a traumatized client? Are MSW students aware of the symptoms of vicarious trauma? Lastly, are MSW students competent in coping practices? The concepts to be used are the seven categories that are incorporated in the cross sectional survey which are familiarity of coping skills, identification of associated terms, definition of terms, understanding risk factors, understanding the effects of vicarious trauma, knowledge of the progression of vicarious, and lastly knowledge of disorders that may result from treating traumatized individuals. The questionnaire aims to help the researcher understand the competency of social work students at the graduate level regarding vicarious trauma. I was particularly interested in these research questions as they reveal the preparedness of MSW students to trauma work. Vicarious trauma is a serious and important issue in the field of social work. Your input will help analyze the topic and potentially improve the School of Social Work's curriculum.

If you have any question, comments, or concerns due to participating in this study, please feel free to contact Breyana Jackson at jackb316@coyote.csusb.edu or Dr. Armando Barragan at (909)537-3501 or abarragan@csusb.edu. If you would like to obtain a copy of the results of this study, please contact the CSUSB Pfau Library at the end of the Spring Quarter of 2016.

Thank you for your time and participation for completing this survey.

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