The mission of the Springfield College School of Social Work is to teach social work practice and knowledge to prepare its students to meet universal human needs, and to engender mutually beneficial interaction between individuals and societal systems at all levels based on principles of economic and social justice, dignity, and human rights. The School offers the only master of social work program in New England that can be completed part time in three years with weekend classes. It also offers a full-time weekday program that can be completed in two years. An advanced standing master of social work program is available to qualified graduates of bachelor of social work programs that are accredited by the Council on Social Work Education. The School also offers a combined master of social work/juris doctorate four-year program in conjunction with Western New England University School of Law. The School of Social Work is part of Springfield College’s long history of service to others. The School of Social Work is located in new quarters at the College’s Brennan Center.

2013

The Journal of Advanced Generalist Social Work Practice is an annual publication. Copies are available by contacting Springfield College School of Social Work, 263 Alden Street, Springfield, MA 01109.

Mailing Address:

263 Alden Street
Springfield, MA 01109
Phone: (413) 748-3065, 748-3060
Fax: (413) 748-3069
springfieldcollege.edu/ssw

Location:

Springfield College
School of Social Work
Brennan Center
45 Island Pond Road
Springfield, MA 01109
Introduction
Walter J. Mullin, Ph.D., Editor

Articles

1Single-System Study of a Terminally Ill Client with Depression
Amy A. Grossman

14Lesbian and Gay Clinicians Consider Self-Disclosure to Heterosexual Clients
A. Brooks Gleason

28Helping Children with Attachments
Deidre Jones

37Clinicians’ Perspectives of Working with Mandated Clients
Kristin Anderson

48Group Work with Youth with Sexual Behavior Problems
Michelle Michaelian

56Effects of Secondary Trauma on Social Workers
Nelson Colon
Although not easily apparent to all social workers employed at agency settings, their direct social work practice is legitimized by the community in which they work. Social work settings take their charge from the community and establish missions aimed at helping to resolve social problems affecting more than one member of the community. What does a community do when its members are homeless, poor, without accessible jobs, experiencing family problems, have mental illness, involved in gun violence, or are generally dissatisfied with their lives? Agencies are created to work on these problems with individuals, improving one life at a time and, as they do this, they are making the community a better place to live.

One of the best examples of community based practice can be found in the social work approach to child welfare. Clearly, the larger community has a goal to ensure that its children are safe. The community does not tolerate the abuse and neglect of its children. Legal authorities and child welfare experts set standards for child safety, while also acknowledging the multitude of factors that might lead to abuse or neglect. Why not simply enforce a law that criminalizes child abuse or neglect? Would a law such as this send a clear message that there are consequences when a child is abused or neglected? Why do we need an agency to work on this? Historically, it is clear that legal action alone does not solve social problems. Incarcerating people with mental illness does not eliminate the problem for either the community or the individual. Likewise, in the example of child abuse and neglect, removing children from their biological parents or sending parents to jail ultimately leads to a multitude of other problems that can be more complicated than the original problem. The answers are not simple. Social workers have the job of utilizing balanced approaches based on an understanding of social system operations to solve individual and societal problems.
The community charge to work on social problems can be found in an agency’s mission statement, value statements, and objectives. For example, in Massachusetts, the Department of Children and Families (DCF) is the agency with the mission to protect children from abuse and neglect (Commonwealth of Massachusetts, 2013). Items on the DCF website (http://www.mass.gov/eohhs/gov/departments/dcf/) emphasize that the objective of the agency is “safely stabilizing and preserving families, safely reunifying families and safely creating new families (through kinship, guardianship and adoption).” The interplay of community, family, and individuals is embedded within this DCF mission statement and reflects the essence of advanced generalist social work practice.

Advanced generalist social work practice, as taught at Springfield College School of Social Work (SCSSW), incorporates this dynamic between the community and the individual into all of its approaches. The mission of the SCSSW is to engender mutually beneficial interactions between individuals and societal systems at all levels. Direct practice begins with an acknowledgement that a problem exists in the community, as well as with the individual and demands that social workers pay attention to the goodness-of-fit between the two. This is powerful. When a person and a community fit well, the resources to solve the problem are more readily available and problem resolution becomes more possible.

This is the 11th volume of the *Journal of Advanced Generalist Social Work Practice*. The journal is comprised of the original writing of students at the Springfield College School of Social Work. In the spring of each year, students submit articles for review by faculty members who teach in the content areas of the article. For fair and impartial review, the name of the author is removed from the submission. Once a paper is accepted, the student and the editor review and make revisions to it. The goals of the journal are to demonstrate the breadth of practice approaches and theories that the advanced generalist social worker employs, and to give students the opportunity to publish their writing.

In addition to this introduction, there are six articles. In the first article, the author writes about a terminally ill client who is exhibiting symptoms of a major depressive disorder. The author evaluates the effectiveness of her therapeutic approaches by utilizing a single system research design. In the second article, the author explores varying opinions surrounding professional self-disclosure of sexual orientation to clients. The author uses a qualitative research approach and offers specific thoughts from the
professionals she interviewed. The third article focuses primarily on children in the foster care system and examines attachment theory in relation to foster parenting and associated trainings for foster parents. The author explores the effects of disrupted attachments on children who experience multiple foster placements. The paper encourages increased focus surrounding nurturing healthy attachment in children who have experienced trauma and neglect.

In the fourth article, the author seeks to understand the challenges of clinicians who work with mandated clients. The author identifies common issues, as expressed by a group of clinicians familiar with treating mandated clients. She discusses client resistance, lack of engagement, distrust, and outright hostility and makes suggestions about best practices with this population of clients. The fifth article tackles the subject of group work with sexually offending youth. The author emphasizes the importance of group process and dynamics amongst participants. The final article discusses the effects of secondary trauma on professionals who work directly with people who have experienced abuse, trauma, and neglect. The article serves as a call to self-care for all social workers, citing benefits to both personal emotional wellbeing and job performance. The article identifies signs of burnout and describes experiences of social workers who have gone through significant on-the-job stress as a result of working with their clients.

Walter J. Mullin, Ph.D.
Editor
Major depression is one of the most common psychiatric disorders affecting terminally ill people, with prevalence rates reported from 3 percent to 45 percent (McDaniel, Mussleman, Porter, Reed & Nemeroff, 1995; Minagawa, Uchitomi, Yamawaki & Ishitani, 1997; Plumb & Holland, 1997; Hotopf, Chidgey, Addington-Hall & Ly, 2002). These rates are four times greater than the rate of depression in the general population (Irwin et al., 2008). An individual is considered terminally ill if the prognosis of life expectancy is six months or less (Medicare Benefit Policy Manual, 2004). Untreated major depression in terminally ill people can be devastating on many levels. It can significantly impact quality of life by eroding hope and impairing interactions with loved-ones, just as the person most needs to prepare for death. Terminally ill people with major depression are more likely to desire and request a hastened death (Breitbart, Rosenfeld, Pessin, Kaim, Funesti-Esch, Galietta & Brescia, 2000, p. 2909). Chochinov, Wilson, and Enns (1995) reported that untreated depression represents a major risk factor for suicide in the terminally ill population. Importantly, however, major depression is not always an inevitable part of the dying process (Brugha, 1993; Rabkin, McElhiney, Moran, Acree & Folkman, 2009) and for those terminally ill people who do suffer from depression, there are a variety of effective interventions available. These include a combination of psychotherapy and psychotropic medication.
LITERATURE REVIEW

Research indicates that although it is well known that major depression and terminal illness frequently co-occur, (McDaniel, Mussleman, Porter, Reed & Nemeroff, 1995; Minagawa, Uchitomi, Yamawaki & Ishitani, 1997; Plumb & Holland, 1997; Hotopf, 2002), major depression is often unrecognized and untreated (Kessler et al., 2003; Maguire, 1985; Rodin & Voshart, 1986; Pirl & Roth, 1999). The literature suggests several issues that limit the recognition of major depression in dying people. First, there is a common misconception that terminal illness routinely causes depression (Brugha, 1993). The general public and mental health clinicians often believe that depression is a normal feature of the dying process and, as a result, they often fail to distinguish between preparatory grief (Lindemann, 1944), an appropriate response to the realization that one has a terminal illness, and the appearance of significant symptoms of major depression. Second, the structured clinical interview using the Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), while widely accepted as the gold standard of diagnostic tools for depression, lacks specificity in people with terminal illnesses (Noorani and Montagnini, 2007; Block, 2000). In fact, many of the survey instruments used to detect depression, have not been well studied in people with terminal illness (Periyakoil & Hallenbeck, 2002). Researchers have moved forward in their efforts to clarify guidelines for applying the standard diagnostic approaches and in creating new screening measures that are specific to the needs of terminally ill people. The need for improved diagnostic methods was documented by a study (Irwin, Rao, Bower, Palica, S. S. Rao, Maglione, Soskins, Betterton, & Frank, 2008) in which a retrospective chart review of 2716 terminally ill patients receiving hospice care was conducted. Researchers evaluated the baseline rate of recognition of depression in patients by frontline hospice workers. During this review, they found that depression of any kind was under-recognized in this population and that it fell on the low end of prevalence estimates.

Currier, Holland, and Neimeyer (2008) interviewed 119 end of life (EOL) professionals from a range of disciplines about their therapeutic approaches and analyzed the content of their interviews, specifically attending to how they assisted their clients in making sense of loss. The researchers also examined the therapeutic approaches used by practitioners as they fostered their clients’ capacity to develop a subjective understanding of loss at the end of life (Davis, Nolen-Hoeksema & Larsen, 1998; Gillies & Neimeyer, 2006; Janoff-Bulman & Frantz, 1997). This study was based on research that has
demonstrated that the process of making sense of loss has the positive effect of restructuring and improving on the impact of pain that follows a loss (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Davis et al., 1998; McIntosh, Silver & Wortman, 1993; Silver, Boon & Stones, 1983) and that the capacity to develop an understanding of the loss experience can serve as a critical part of the healing process (Davis et al., 1998).

In their content analysis, Currier, Holland, and Neimeyer (2008) collected information in an EOL questionnaire. The researchers were also specifically interested in knowing if practitioners used narrative techniques such as Breitbart’s Life Review (Breitbart & Heller, 2003; Breitbart et al., 2004; Greenstein & Breitbart, 2000) or Chochinov’s Dignity Therapy (Chochinov et al., 2005). The study participants had a mean number of 12.7 years of experience in the end of life occupation. More than one quarter of the EOL practitioners report implementing narrative techniques such as Breitbart’s Life Review (Breitbart & Heller, 2003; Breitbart et al., 2004; Greenstein & Breitbart, 2000) and Chochinov’s Dignity Therapy (Chochinov, Hack, Hassard, Kristjanson, McClement & Harlos, 2005). These emerging psychotherapeutic interventions, which are grounded in existential psychotherapy (Frankl, 1988; May, 1961; Van Kaam, 1967; Van Deurzen, 2002; Yalom, 1980), have gained increased attention among professionals working with terminally ill clients in various end of life contexts. This study represents the first effort to systematically describe the meaning-making approaches most used in actual therapeutic contexts with the dying and bereaved (p. 138).

Research on the best approach with terminally ill depressed people suggests the need for new psychotherapeutic models and the evaluation of their effectiveness. For example, a recently developed intervention called Dignity Therapy (Chochinov, Hack, Hassard, Kristjanson, McClement & Harlos, 2005) was “designed to address psychosocial and existential distress among terminally ill clients” (p. 1). Built upon their extensive previous research, Hack, Chochinov, Hassard, Kristjanson, McClement, and Harlos, (2004) developed a brief, psychotherapeutic intervention for use in terminally ill clients. Unlike many interventions discussed in the literature, which are complex and longitudinal in nature, Dignity Therapy is a relatively simple and easily completed protocol that invites clients to discuss issues that matter most to them. The sessions are recorded, transcribed and edited, and a final version is then returned to the client that they can bequeath to a loved one.

A study of Dignity Therapy was completed during a two-year period with 100 terminally ill patients in Canada and Australia. Participants were
asked to complete pre- and post-intervention measures that documented their sense of dignity, depression, suffering, hopelessness, sense of purpose and meaning, desire for death, will to live, and suicidality, as well as a post-intervention satisfaction survey (Chochinov, Hack, Hassard, Kristjanson, McClement & Harlos, 2005). Of the 100 patients who completed the study, 91 percent reported feeling either satisfied or highly satisfied with the intervention, 68 percent indicated that it increased their sense of purpose, and 47 percent reported that dignity therapy increased their will to live. “Post-intervention measures of suffering showed significant improvement (z= -2.00; p= 0.023*), are clinically significant, not just statistically significant, as did self reports of depressed mood (z= -1.64; p= 0.05); the post intervention improvement in dignity approached significance (z= -1.37; p= 0.085*)” (p. 8).

It is interesting to note that the patients who reported more initial despair appeared to benefit the most from Dignity Therapy, and 81 percent of participants reported that Dignity Therapy had already helped, or would help their family. Given some limitations to the study, Dignity Therapy needs to be evaluated using a randomized control design. According to the authors, such a randomized controlled trial of Dignity Therapy has recently been funded by the National Institute of Health and will be conducted in Canada, Australia, and the United States.

INTERVENTION HYPOTHESIS

This single-system study draws from recent empirical data and hypothesizes that the use of Dignity Therapy combined with continued use of antidepressants will improve symptoms of major depression in a terminally ill client.

PRESENTATION OF THE CASE

JE is a divorced, 46-year-old Caucasian male who lives at the home of his ex-girlfriend and their 12-year-old daughter in a small house in suburban Massachusetts. JE’s adoptive parents are no longer living. His only other living relatives are four children, only one of whom he sees on a regular basis. He has no contact with his remaining three children, all of whom live with his ex-wife, with whom he has a highly conflicted relationship. JE worked two jobs throughout most of his adult life, spending 24 years as the groundskeeper for a large hospital. Currently, JE has been unemployed for three to four years due to health problems. He was referred to hospice nine months ago following a period of significantly declining health and after the terminal diagnoses
of congestive heart failure and chronic obstructive pulmonary disease (COPD). JE is currently bedridden and on long-term oxygen therapy. He also has a history of bone fractures to his hips and ribs (secondary to osteoporosis), lymphedema, and major depression. He is prescribed approximately 15 different daily medications, among those are extremely high daily doses of morphine for pain control, Ativan for anxiety, and an antidepressant, which he has been taking for the past two years.

During the initial clinical interview, which took place in the client’s bedroom at his ex-girlfriend’s home, JE appeared well groomed and well oriented with good insight. His memory appeared fully intact and his behavior was cooperative but somnolent at times. JE’s mood appeared dysphoric and he reported that he felt “really depressed and lonely.” He stated he had no reason to live, although he also stated that he did not want to die either. JE expressed that he had thought about suicide on several occasions in the past nine months but that he knows he would “never go through with it.” JE met criteria for major depressive disorder. He shared that he is very much afraid of dying and that he feels that he must have “done something terrible in my past life to deserve this.” JE expressed that he often feels that his life has “been a waste, starting from the very beginning” when his birth mother abandoned him in the hospital after delivering him six weeks prematurely. JE’s support system consists of his ex-girlfriend, his 12-year-old daughter, his 24-year-old son, and the hospice team.

INTERVENTION OBJECTIVES AND PRACTICE ACTIVITIES

The primary objective of this intervention was to reduce JE’s symptoms of depression. The secondary objectives were to bolster his sense of purpose, meaning, overall dignity, and quality of life in his remaining days. The intervention activities included weekly sessions of the Dignity Therapy protocol (Chochinov et al., 2005), a brief psychotherapeutic intervention developed for terminally ill clients, along with the client’s continued use of an antidepressant. Following the completion of the Dignity Therapy protocol, weekly supportive counseling sessions began (phase III), utilizing a client-centered approach.

COMMITMENT TO COOPERATE

Upon his admission to hospice, JE signed the agency’s HIPAA documentation and consent to treatment form. JE was informed that a social
work intern would be making weekly home visits and conducting this study. JE was further informed of the purpose and timeline of the study, the potential risks and benefits to participating, as well as issues of confidentiality and his right to withdraw from the study at any time. JE verbally agreed to participate in the study and to be audio-taped during sessions for the purpose of completing his generativity document.

**METHODS**

**RESEARCH DESIGN**

An ABC single-system design (see Table 1.0) was utilized in this study to record consecutive, weekly measurements on the Beck Depression Inventory-II (Beck, 1996), beginning with baseline measurements (phase I), followed by the Dignity Therapy (Chochinov et al., 2005) intervention period (phase II), and finally, a brief second intervention period (phase III).

**Table 1.0 Summary of single-system research design**

<table>
<thead>
<tr>
<th>Baseline (phase I)</th>
<th>Intervention (phase II)</th>
<th>Counseling (phase III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>60 minute sessions (as tolerated)</td>
<td>60 minute sessions</td>
</tr>
<tr>
<td>(weeks 1 &amp; 2)</td>
<td>DTP (weeks 3-6)</td>
<td>CCT (week 7)</td>
</tr>
</tbody>
</table>

*Note: DTP = Dignity Therapy Protocol; CCT = Client-Centered Counseling.*

Ethical concerns necessitated both an abbreviated baseline period as well as a second intervention period (phase III), after the completion of the Dignity Therapy protocol. Strengths of this research design are that it enables a significant amount of design flexibility, it allows the researcher to modify the protocol in response to the results of the intervention and data collection, and it provides a baseline level of performance to compare to the treatment phase(s).

**THREATS TO VALIDITY**

Threats to validity in this single-system study include the lack of specificity of the outcome measure (BDI-II) (Beck, 1996) in the population studied, diffusion or treatment contamination, and the effects of repeated testing. There were several threats to validity related to using this particular outcome measure in this study. The first and most significant threat is that the BDI-II is not designed to measure depression in terminally ill subjects,
or to be completed on a weekly basis. A related threat to validity could result from asking the subject to answer repetitive questions, as this could have caused the subject to become bored or frustrated at answering the same questions every week, leading to inaccurate results. Another limitation is that of a social desirability bias; the subject may have wanted to appear as though he were improving in the eyes of the researcher.

Other threats include history, instrumentation, attrition, and selection bias. The subject of this study was very ill and prescribed many daily medications throughout the treatment phase. The effects of these drugs and the interactions between these drugs, which included many different classes of psychoactive medication, can be expected to have affected the results of this study. In addition, the internal physical experience of the subject, given his highly debilitating and painful illness, is likely to have directly and indirectly influenced the individual items this measure of depression purports to evaluate, as well as the subject’s participation in this study.

Diffusion is also a significant limitation of this design because the first intervention phase could influence the second intervention phase, as well as shape any conclusions that might be drawn about the effectiveness of either. The intervention was conducted by a social work intern who was a beginner in the Dignity Therapy protocol (Chochinov et al., 2005).

INTERVENTION

The initial clinical interview was conducted by this social work intern in the second year of her social work master’s program. Although this intern had no formal experience administering the BDI-II (Beck, 1996), she has 22 years of experience as an occupational therapist and in this role, has administered many standardized measures, including psychosocial assessments. The subject had been diagnosed and treated for major depression by a psychiatrist one year prior to his admission to hospice and he continued the same medication regime throughout his nine months at hospice and for the duration of this study.

In the two-week baseline period (phase I), which consisted of two administrations of the BDI-II (Beck, 1996) at the start of each session, the subject’s total score was 40 or above, placing him in the “severe” range for depressive symptomatology on this instrument. This score confirmed the presence of depression, despite ongoing and current antidepressant medication treatment. The treatment series (phase II), which occurred in sessions three through six, consisted of the manualized Dignity Therapy protocol (Chochinov et al., 2005). The Dignity Therapy protocol outlines
the procedure for tape recording the subjects’ responses to a series of specific interview questions. This data gathering was followed by the interviewer compiling the recordings into a written narrative, reading the narrative to the subject to correct any errors or omissions, editing the transcript, and finally, presenting the finished narrative to the subject, to be kept or gifted to a family member. The second treatment (phase III) session occurred after the narrative was complete; this was a 60 minute supportive counseling session utilizing a client-centered approach.

**MEASUREMENT**

This study used the Beck Depression Inventory-II (BDI-II) (Beck, 1996), which is a 21-item, self-report measure that is intended to assess the existence and severity of depressive symptomatology. Each of the 21 items corresponds to a symptom of depression and these scores are totaled to give a single score that indicates the level of depressive symptoms. Level of depression is rated as follows: a total score in the range of 0-13 is minimal, 14-19 is mild, 20-28 is moderate, and 29-63 is severe. The BDI has been used for more than 35 years and is reported to be highly reliable, regardless of population. The subject completed the BDI-II in approximately three minutes at the beginning of each session.

**FINDINGS**

Figure 1 graphs the plotted total scores from the BDI-II (Beck, 1996). In phase I, (Figure 2) the level was 40.50 (mean of weeks 1-2), with a standard deviation of .50, and in phase II, the level was 23.25 (mean of weeks 3-6), with a standard deviation of 7.50. A comparison of the mean scores from baseline (phase I) to intervention (phase II) shows an 18 percent reduction in scores, as measured on the BDI-II, during that six week period. The aggregate values are as follows: the range was 13 to 41, the median was 27.0, the mean was 27.14, and the standard deviation was 10.47.
The results of this study suggest that in this 46-year-old man with a terminal illness the combination of Dignity Therapy (Chochinov et al., 2005) and antidepressant treatment were associated with decreased scores on the BDI-II (Beck, 1996), which correspond to a reduction in symptoms of major depression from a baseline (phase I) level of “severe” to “mild” (phase II) at the completion of the intervention. To date, this writer knows of no other studies evaluating the use of Dignity Therapy in the reduction of depressive symptomatology in
terminally ill subjects. These results appear to be relatively consistent with those of other studies cited in the literature that suggest an improvement in overall quality of life when meaning-centered psychotherapies are used in terminally ill clients.

While this study appears to suggest that Dignity Therapy (Chochinov et al., 2005) and antidepressant use were associated with reduced depressive symptomatology in this subject, rival hypotheses to be considered are that the subject responded favorably to the introduction of weekly counseling sessions, or, since the intervention took place when the weather was becoming much warmer, and allowed the client to leave his home for the first time in months, this could account for the reduction of the subject’s symptoms of depression. In the future, it might be useful to consider which items on the BDI-II (Beck, 1996) were most associated with a reduction in depressive symptoms. Regardless, it is clear that depression is a significant issue for those with terminal illnesses and further research into the efficacy of psychotherapeutic interventions in this population is greatly needed.

References


Lesbian and Gay Clinicians Consider Self-Disclosure to Heterosexual Clients

A. Brooks Gleason

When is it useful for a clinical social worker or therapist to disclose personal information to a client? This question has been raised consistently since the inception of psychotherapy, leading to numerous and differing perspectives about the usefulness of therapist self-disclosure (TSD). There is a large literature that offers insight into TSD (Anderson & Anderson, 1985; Hanson, 2005; Knox & Hill, 2003, Mahalik, VanOrmer, & Simi, 2000) but there are only a few articles that address the unique issues faced by lesbian, gay, bisexual and transgender (LGBT) therapists working with heterosexual clients (Coolhart, 2005). When appropriately executed, TSD has been shown to contribute to a positive therapeutic alliance (Hanson, 2005), and helps clients make informed decisions about working with a clinician (Mahalik, VanOrmer, & Simi, 2000).

Literature about therapist self-disclosure is often muddled by inconsistent definitions (Thomas, 2008). Weiner (1983) described TSD as any occurrence when the therapist offers more than professional expertise or when the therapist is intentionally more open and genuine with the client. Mathews (1989) defined TSD as occurring when the therapist reveals factual information about his or her own life or reveals feelings he or she has about the client. Additionally, TSD has been defined as including verbal statements that reveal something personal about the therapist (Hill & Knox, 2002). For the purpose of this study, TSD will be defined as the therapist’s verbal or nonverbal expression of personal information or feelings, both deliberate and unintentional.
As a person who identifies as lesbian, and as a social work graduate student, I was struck by the lack of instruction and support resources available to LGBTQ therapists. As I sought guidance for disclosing my sexual orientation, specifically after being asked if I was married to a man, it became clear to me that there is a need for better awareness of how sexual orientation impacts the therapeutic relationship. Therefore, I decided to examine the experiences of practicing lesbian and gay therapists. Due to time limitations, the sample did not include therapists identifying as bisexual, transgendered, or questioning. This paper will identify themes they addressed.

I was interested in the factors that contribute to general therapist self-disclosure and those that pertain specifically to the disclosure of sexual orientation. I investigated therapists’ perceptions of how “coming out” to heterosexual clients affected the therapeutic alliance. Finally, I also explored the effects of disclosure or nondisclosure on the personal and professional development of each therapist.

**PRACTICE MODELS AND THERAPIST SELF-DISCLOSURE**

Different practice models based on psychological theories each define the workings of the therapist-client relationship differently. Psychoanalysis is based upon the premise that the client develops transference to the therapist connected to unresolved client conflicts from the past. The therapist remains neutral to allow the conflicts to become understood and resolved. A psychoanalytic therapist’s self-disclosure has the potential to hamper the client’s work. Some psychoanalytically oriented therapists accept the idea that complete anonymity is impossible because personal information is always revealed in such ways as clothing styles and office décor (Lane & Hull, 1990).

Cognitive-behavioral practice models view self-disclosure as a potentially beneficial intervention when it can be used to challenge a client’s maladaptive thinking (Goldfried, Burckell, & Eubank-Carter, 2003, Knox & Hill, 2003). Therapists promote change using themselves to demonstrate ways to examine faulty beliefs. Similarly, those of the humanistic orientation rely upon appropriate self-disclosure to advance the therapeutic process. With an emphasis on equality and mutual respect, humanistic therapists speculate that self-disclosure portrays transparency and genuineness of the therapist. In humanistic approaches, TSD demystifies treatment; promotes openness, trust, self-understanding; and client change. (Lane & Hull, 1990; Robitscheck & McCarthy, 1991; Kaslow, Cooper, & Lisenberg, 1979).
In feminist-informed models, self-disclosure is encouraged as a way to empower clients. Self-disclosure is believed to decrease the power differential between therapist and client, as well as to promote a more egalitarian relationship (Simi & Mahalik, 1997). Offering details about therapists’ training, values, lifestyle, religion, social class, sexual orientation, and feelings toward the client offers clients the ability to make an informed decision about working with a particular therapist (Simi & Mahalik, 1997; Mahalik, VanOrmer, & Simi, 2000). This can be seen as an important aspect in choosing a therapist, given the personal nature of the client-therapist relationship and specific issues for which the client may be seeking treatment.

While a theoretical orientation might guide the therapist in approaches to self-disclosure, clients can easily observe personal aspects of a therapist’s life based on ways of interacting, personal clothing style or office decorations. In this way, TSD is unavoidable and non-deliberate. Abundant studies about direct verbal disclosure exist, but there are few studies about non-deliberate and nonverbal TSD (Farber, 2006; Thomas, 2008) including common, everyday disclosures revealed by the manner of dress, hairstyle, jewelry (e.g., wedding ring), and use of aftershave or perfume (Bloomgarden & Mennuti, 2009, p.32). In small communities, by virtue of close proximity between the therapist and the client, the therapist’s religion, political views, family situation, economic status, and sexual orientation may be obvious (Farber, 2006; Schank & Skovholt, 2006).

**LGBT THERAPISTS AND SELF-DISCLOSURE**

Within the current heterosexist society, the lesbian, gay, bisexual, or transgendered (LGBT) therapist is frequently forced to make decisions about self-disclosure. The LGBT therapist will be faced with omitting personal information, allowing clients to continue with incorrect assumptions, or to deliberately self-disclose. For example, Thomas (2008) noted that a wedding ring is a form of self-disclosure. In the heterosexist environment, the wedding ring indirectly infers the assumption of heterosexuality. Although same-sex marriage is legal in some states, it is likely that many clients still might associate a wedding ring with being heterosexual. The therapist knows that the client is making an assumption that is incorrect and the therapist is then faced left to make a decision about self-disclosing (Thomas, 2008).

For the LGBT therapist, anxiety about how to react if questioned about marital status is a challenge. For example, Roberts (2005) describes the struggle presented by a lesbian supervisee. Rather than reveal that she was
married to a woman, the supervisee removed her wedding ring prior to sessions. As the supervisor and supervisee worked together, it became apparent that the therapist felt unable to “join” with her clients as easily as her heterosexual colleagues.

In general, there seems to be a lack of guidance on how LGBT therapists’ should disclose or not disclose. Coolhart (2005) writes that this decision often relates to the therapist’s own sexual identity development and level of comfort. Therapists who are more comfortable with this identity are more willing to openly disclose to their clients.

METHOD

RESEARCH DESIGN

For this heuristic, qualitative study I captured the experience of six therapists, five lesbian females, and one gay male, who self-disclosed sexual orientation to heterosexual clients. The heuristic model allows for the researcher to be fully submerged in the process of understanding participants’ experiences and to vividly portray their perspectives. The exhaustive self-searching characteristics of heuristic research (Moustakas, 1990) also provide motivation for research that is pertinent to social work practice in any setting.

Participants in this study were obtained via convenience sampling. I recruited participants by posting a request on Facebook, sending emails to professionals who might know of a potential participant, and by telephone contact. Due to imposed time limitations, I chose to interview the first six therapists who responded to the requests and completed the informed consent. I informed participants of the research topic and offered the opportunity to cease participation at any time during the research process. All participants were informed of methods for maintaining confidentiality and each expressed full understanding of the consent before signing an informed consent form and participating in an interview. Each participant received a $5 gift card in appreciation for his/her time.

Participants completed a demographic survey prior to the interview, providing information about age, personal sexual orientation, practice setting, years of experience, and populations served (see Appendix B). Each participant acknowledged they had self-disclosed sexual orientation to a heterosexual identified client at least once in their career.

After the recruitment phase, I conducted individual, semi-structured,
30-40 minute, interviews in various locations including the therapists’ homes, offices, and a college library. All questions were open-ended with liberties taken to add supplemental questions, encouraging participants to speak freely. To ensure validity, a pilot study was conducted with one participant; those responses are not included in the current study. Interviews were digitally recorded. Questions addressed general perspectives about the factors that led to the psychotherapists’ decisions to self-disclose sexual orientation, and the effects of this disclosure on the therapists’ self-development. Interviews were then transcribed and coded for recurrent themes among responses.

PARTICIPANTS

One male and five females, ranging in age from 38-63, participated in the study. All females identified as Caucasian and the male participant responded “human” to inquiry about racial/ethnic identity. Respondents identified as gay or lesbian. Four reported a relationship status of “married,” or “partnered,” and one “single.” All participants reported being 100 percent “out” to all friends and family. One was “out” only to selected colleagues while five respondents reported being 100% “out” to all colleagues.

The participants had 3.25 to 35 years of clinical experience. Two of the participants had doctorate degrees and four had master’s degrees. Four participants practiced psychotherapy in Massachusetts and two in Connecticut. Collectively, they identified theoretical orientations that included humanistic, family systems, psychodynamic, harm-reduction, strength-based, and cognitive behavioral. All six participants had clients that ranged in age from childhood to adulthood and who came from varying socioeconomic backgrounds. The participants reported that their caseload was predominantly heterosexual. Respondents worked with 3 percent to 50 percent LGBT-identifying clients throughout their careers and currently, LGBT-identifying clients make up 5 percent to 50 percent of caseloads.

FINDINGS

In the interviews with the six participants, they identified the most important issues connected to sharing details of their own sexual identifies with clients. They presented the following themes.

DISCLOSURE IS CLIENT SPECIFIC

Though participants used a mixture of practice approaches, there was
unanimous agreement that therapist self-disclosure is sometimes beneficial to the client but that this disclosure was always dependent upon the client’s needs. Two participants offered examples of telling their clients about the loss of their parent. They thought that sharing this information benefitted clients. Two others felt admission of their role as a parent had strengthened the therapeutic alliance. In terms of self-disclosure of therapists’ sexual identity, all participants spoke about the importance of assessing a client’s individual needs first. None of the participants considered self-disclosure of sexual orientation a necessity with all clients. Disclosure of sexual identity to heterosexual-identified clients was perceived by therapists to be helpful in some cases with several motivations and influential factors for such disclosure being identified.

**AUTHENTICITY AND INTEGRITY**

The participants described primary themes of honesty and authenticity were established as therapists described motivations for disclosing sexual identity to heterosexual and homosexual clients. The participants expressed beliefs that failure to be forthcoming with disclosure of their sexual orientation could lead to the client questioning the therapist’s integrity. One participant, a clinical social worker who also supervised master of social work interns, believed omission or dishonesty about one’s sexual identity could lead to the therapist feeling less authentic and therefore, could negatively affect the therapist’s confidence in his/her ability to be effective. Maintaining personal integrity was identified as a benefit of the therapist disclosure of sexual orientation to heterosexual clients by all participants. One participant believed that a therapist’s honesty about sexual orientation conveys a message of safety for heterosexual clients in the therapeutic dynamic.

The therapist self-disclosure of sexual orientation creates more of a safe environment. By that disclosure, they get to sit with it. You know, there is a just as much of a possibility that [the disclosure] is a positive as much as a negative. And they get to see how they feel about that. By saying I am a gay man or a gay therapist, a heterosexual client is going to be more likely to share their closeted experiences or thoughts or proclivities, of which there are many.
Another participant further emphasized the importance of authenticity by stating,

That is part of who I am and that’s part of my whole person. So, if I’m bringing my whole person into the room, that’s part of it. And also not wanting to be, not wanting to lie. Especially because I am married, I have a ring. So [not disclosing] would just be weird, I think.

THE ELEPHANT IN THE ROOM

Among the six participants, there was a general agreement that based upon appearance, dress, and demeanor, many clients likely assumed that the therapist was gay or lesbian. Female participants indicated that having short hair, wearing androgynous or men’s clothing, having a dominant presence in the room, an athletic physique and/or interest in sports, signified to many clients that the therapist identified as lesbian. One participant believed her gait combined with her dress and short hair most definitely allowed clients to assume she identified as homosexual. A male participant, responded to inquiry about whether clients perceived him as gay without verbal disclosure by saying, “Oh, I’m sure. I’m sure. I’m certainly not Mr. Macho Man.”

Based upon the therapists’ perceptions that clients assumed they identified as gay or lesbian, they believed that the failure to openly acknowledge their sexual identity led to awkwardness like having an “elephant in the room.” Half of the participants assessed if their sexual orientation could be negatively affecting the client/therapist dynamic during initial sessions. If it seemed that there was tension in the relationship, they decided it was important to disclose sexual identity to avoid future disruption of the therapeutic alliance.

BENEFITTING THE CLIENT

Participants’ expressed that their decision to disclose their sexual identity to clients was always weighted with consideration of how it would benefit the client. Perceived client benefits included: establishment of mutual trust, creation of a safe therapeutic environment, normalizing different sexual orientations, encouragement for the client to disclose personal information/struggles, and offering an opportunity for the client to address a topic that might later affect the therapeutic relationship. One participant said
that being open with some clients about sexual orientation, even if the therapist is unaware of the client’s orientation, could be empowering.

I had one kid who came back and told me she ended up coming out as a lesbian some years later. She came back and she said the other kids would say, ‘Oh, we saw the therapist. We think she is gay. We saw her out holding hands with a woman.’ I wanted to cheer. You were the only person I knew was out.” And she was totally not out and that helped her. And we never talked about her orientation, but it helped her knowing I was out.

THERAPIST IDENTITY DEVELOPMENT

Four participants described an increased comfort with their sexual identities as they became more experienced, both personally and professionally. Ultimately, this comfort led them to be more open with this type of self-disclosure.

One participant illustrated the point, saying,

Disclosure of my sexual identity was definitely much more anxiety provoking when I was younger. Well, you know the whole thinking about it. My sexual identity is more integrated into me in general. So, therefore, I don’t think about it as much because I am walking around the world openly gay most of the time now, whereas I wasn’t before. So, I think the whole struggle around it was so exhausting and I felt so crummy that I knew it couldn’t go on forever. I couldn’t just keep living like that. It just didn’t seem healthy.

Another participant affirmed this point as she described the development of one’s self as imperative to effectively practicing psychotherapy. She stated, “Know yourself, know the world, and you’ll know when it’s important to share or not.”

COMMUNITY AFFECTS DISCLOSURE

Participants reported the degree of support from colleagues as an influential factor to disclosure. One participant reflected upon the importance of the work environment in saying,

The work is a major factor. The decision to disclose personal information of any nature, but especially something that for some people, can be so emotionally charged, should not be decided
without having supportive coworkers. It is important that they, your coworkers, are comfortable and accepting of that part of you. I have never had a bad experience, but it’s like you’re taking a risk anytime you “come out” to someone. And to do that in the professional environment without the support of your colleagues could backfire.

Four participants acknowledged that the surrounding community influenced their decisions regarding TSD of sexual orientation. Same-sex marriage is legally recognized in the states where all the participants practice. Two therapists practice and live in a community with a reputation for LGBT tolerance and advocacy. One participant commented,

“I think of who I am; I am a wife, a mother, a therapist ... I go down this list and it’s like ‘Oh, yea, I’m married to a woman.’ And so, it’s such a part of me that I probably don’t think enough about it when I’m in the clinical situation because it is so comfortable living in [my town]. I forget that there are a lot of people out there that don’t like us until I visit home.

This participant described her hometown as less tolerant of LGBT individuals.

**DISCUSSION**

Several aspects of therapist self-disclosure are addressed in the literature with minor attention to therapist self-disclosure of homosexual identity to heterosexual clients. Findings from the current study suggest therapist sexual identity is of significance in psychotherapeutic relationships. During the initial recruitment of participants, I was surprised by some clinicians’ reactions to the topic. Many individuals questioned the reasons a therapist would ever disclose information regarding sexual orientation. One lesbian-identifying individual, who chose not to participate in the current study, expressed TSD of her sexual orientation would never be pertinent to the therapeutic process of a heterosexual client.

The heuristic method of study allowed me to continually monitor internal responses to the research process. I was not prepared for the defensiveness and denial about TSD of sexual orientation some lesbian/gay identifying therapists, who were not part of this sample. The perspectives of those who, due to time constraints or lack of willingness, did not participate in the study were as informative as those who graciously took the time to talk about their experiences. Challenges to motivations for TSD of sexual identity forced me to evaluate the significance of the topic, both personally and
as a clinical intern. This researcher, by integrating the stories of six participants and the experience of being repeatedly challenged for investigating the topic, came to the realization that by allowing those in my professional sector of life continue with incorrect assumptions, I felt dishonest. In therapeutic relationships where my goal is to solicit trust, it seems disingenuous to allow clients to make incorrect assumptions about my sexual orientation.

Given direct questions, one is afforded an opportunity to confirm, deny, or omit information. When, in the context of conversation, an incorrect statement about the therapist is made, correcting the client or exploring the reasons for the assumptions could easily shift the focus from the client. I felt torn between TSD for the benefit of the client and personal integrity, two themes identified in the study. As a client divulged aspects of her tumultuous marriage of three years, she glanced at my wedding ring and commented, “I’m sure you and your husband fight too.” As a therapist, I was presented with an opportunity to join with the client and offer feedback regarding healthy disagreement and to normalize some aspects of her marriage, such as, “Arguments occur within many relationships, including marriage.” By continuing with the line of conversation assumed to be most pertinent and beneficial for the client, she is left with an incorrect assumption. To correct her statements would divert attention from her point and would make the conversation about the therapist. Given this situation, this researcher became concerned that as someone who works and resides in the same community, the possibility of indirect disclosure in public could negatively affect relationships with clients whom have been allowed to remain under the impression that their therapist is heterosexual. A discovery of nondisclosure may create feelings of embarrassment or mistrust of the therapist.

Several factors must be weighed prior to all TSD, including disclosure of sexual orientation. All TSD should be client-specific. When deemed appropriate, therapists perceived self-disclosure of their sexual identity as beneficial to the client, in part, because the TSD allowed the therapist to be comfortable and therefore, present as an authentic, honest being in the therapy room. Despite theoretical perspective, the need to be accurately represented was considered a priority by all participants. Furthermore, participants in the current study revealed clients are prone to correctly assume the therapist is gay/lesbian. Other LGBTQ therapists stated that they may appear to fit gender stereotypes, and thus, are often assumed to be heterosexual. To assume these therapists are less concerned with presenting their authentic self is inaccurate. By failing to acknowledge the conundrum faced by therapists coping with
incorrect client assumptions, the psychotherapeutic community may be allowing misrepresentation that could negatively affect the therapeutic alliance.

Therapists who identify as gay/lesbian and challenge gender norms, with respect to appearance, are more likely to find themselves confirming client perceptions. While those who more closely portray gender norms often contradict client assumptions of homosexuality. Such confrontation of perceived sexual orientation, if not impeccably executed, may negatively affect client self-esteem, mutual trust, and most importantly, may divert focus from the client. Therefore, training for clinical social workers should include effective and safe techniques for confronting clients’ assumptions about the therapist and potential risks of self-disclosure. For instance, clients are not held accountable for confidentiality and therefore, when in possession of information about a therapist, are free to disclose that information as they please including information the therapist may prefer for them to keep private. To prepare for the potential consequences to the therapeutic relationship as well as to their personal lives, therapists must receive explicit guidance in regards to TSD.

There were several limitations to this study. Convenience sampling yielded only six participants, living and practicing in states that have legalized same-sex marriage. Findings were limited to the perspectives of Caucasian therapists. Two therapists were familiar with this research prior to interviewing and another participant was an acquaintance of the supervising faculty for the project. Personal knowledge of the research and faculty may have influenced responses. Two interviews were conducted via email, prohibiting this researcher from integrating nonverbal and verbal responses. Time constraints barred this researcher from further investigation of common themes not directly related to factors that contribute to TSD of sexual orientation, such as the effect of nondisclosure on the therapist and how that plays out in the therapy room. Findings were also restricted to perspectives of therapists who believed many, if not most, clients correctly assumed the therapist identified as gay/lesbian. Future inquiries about TSD of sexual orientation should address the experience of lesbian/gay therapists who tend to portray more classical societal gender norms. Sampling inclusive of diverse therapist populations from differing geographical, political, and religious regions is critical to research about LGBTQ issues. Though the current study addressed an array of ages and professional experience, a comparative study of perspectives among younger and older therapists regarding TSD of sexual identity may be beneficial.
Self-disclosure has been inconsistently defined in the literature and research implications for practice have been complicated (Thomas, 2008). TSD is further convoluted by insufficient research to address LGBTQ therapists’ practice with heterosexual clients. As the cultural zeitgeist progresses from oppression and avoidance of LGBTQ individuals to a more accepting society, the psychotherapeutic community must also evolve. Theo articulated the magnitude of the issue,

On the one hand, I can see the argument that [my sexual orientation] doesn’t necessarily and shouldn’t necessarily be anyone else’s business. On the other hand, people often want to know what my degrees and experience are. And you know who I love, or who I live with, or what has happened to me, that I can all see as private. But my experience in life as a man, and as a therapist, and as a human being has been as a gay man. And to me, that overrides the statement of ‘It’s personal and not information that is needed in the therapeutic dynamic.’ I think it is [needed] because it is a part of what has made me who I am, a big part, as much as my degree.

To recognize therapists as individuals capable of utilizing their experience and education to encourage emotional growth, is to understand that therapist identifying as LGBT have unique strengths and perspectives that when acknowledged in the therapy room, may benefit the therapeutic alliance.

References


At the end of the fiscal year 2009, it was estimated that there were 421,350 children placed in foster care in the United States. The mean age was 9.6 years and the median age was 9.7 years. The mean length of stay was 26.7 months and the median stay was 15.4 months (U.S. Department of Health and Human Services Children's Bureau, 2011). In Massachusetts, there were 8,097 children under the age 18 years who were in foster care at the close of the 2010 fiscal year. The highest number of children under the age of 18 in foster care in Massachusetts was recorded in 1995 (13,302 children). Of those children who entered foster care during the 4th Quarter of FY’2010, 62% were first time entrants and 38% were re-entrants (Department of Children & Families, 2010a).

For foster children, the hope is that parenting provided by foster parents will reverse developmental damage and enable them to achieve good outcomes in adult life. Research suggests that there are foster caregivers who are able to offer sensitive caregiving to even the most damaged and vulnerable children (Schofield & Beek, 2005).

A child who has developed a safe base from which to explore his or her social world is commonly described as having a secure attachment to their primary caretaker. Positive attachment relationships between caregiver and infant serve as a solid basis for prevention of a number of social problems that may develop later in the infant’s life. Most children in foster care have experienced abuse or neglect from their caregivers, making insecure or
disorganized attachments a common occurrence. Some researchers estimate that insecure or disorganized attachment styles occur in as many as 80 percent of maltreated children (Avery, Matthews, Hoffman, Powell, & Cooper, 2008). Research studies have long demonstrated the benefits of training for foster parents. Training produces key changes within the family unit, such as improved parent attitudes, better parent-child interaction, and a reduction of child problem behavior. It also increases the likelihood that a placement might remain stable. Parental training programs vary from state to state. Some programs, such as Parent’s Resource for Information, Development, and Education (PRIDE), Model Approach to Partnership in Parenting (MAPP), and Parents as Tender Healers (PATH), are nationally known and widely used. Training about attachment is of special importance to foster parents as it helps foster parents to understand that a child’s behavior is frequently based on an attachment need (Avery et al., 2008).

REVIEW OF LITERATURE

John Bowlby (1988) studied attachment behavior in infants and toddlers and determined that the quality of early experiences in relationships with caregivers, and the separation and loss of those relationships, shape the self and the quality of later relationships in distinctive ways. Bowlby’s attachment theory states that grief, anger, and distress are the results of temporary or permanent loss of access to existing attachment figures but these can be resolved when children are able to develop new secure attachment relationships with alternative caregivers. There are four patterns of attachment: secure, insecure-avoidant, insecure-ambivalent, and disorganized/disoriented. Secure attachment relationships develop through interaction, in which children learn to seek support and comfort in the caregiver at the same time that an adult responds positively to the child’s needs. Children in secure attachment relationships differ from children in insecure attachment relationships with respect to their ability to use the caregiver as a “haven of safety” and as “secure base” while exploring their environment. Insecurity in attachment relationships is manifested by anxiety about the availability of caregivers. Disorganized and controlling attachments are a special case of insecurity, engendered by frightening or other atypical parental behaviors (Oosterman & Schuengel, 2008).

Attachment serves a necessary role in the survival of individuals. It is the way that infants learn to connect and interact with others, allowing them to begin learning social norms. Attachment behavior is most evident when the infant feels “threatened, endangered, or stressed” and needs to rely on the
The caregiver to provide a secure base to which they can return. There are some important concepts when assessing an attachment relationship or when evaluating possible treatment interventions. Social cues may include body language, verbalizations, and facial expressions that indicate a child’s level of engagement with a caregiver. Reciprocity is the natural give and take interaction of healthy relationships and is based on accurate cue-reading. Internal representations begin at birth as an infant conceptualizes how the world works and continues to be altered by new experiences. Inadequate caretaking on the part of the parent may be related to the parent’s inability to read the child’s cues or provide reciprocity (Cornell & Hamrin, 2008).

The infant’s confidence in the secure base determines the extent to which he or she feels free to explore, play, and learn. Attachment between a child and primary caregiver is a biological function based on proximity that helps protect children from predators and other dangers. It is the caregiver’s contribution that will be significant in determining the infant’s secure or insecure attachment pattern. The caregiver is often the mother, but can be any consistent figure that provides for the needs of the infant. Foster parents can provide this secure base. Positive attachment behavior is observed when an infant uses smiling, crying, and other behavior to engage the caregiver, and when a caregiver reacts to the child’s wants and needs. Infants in foster care bring adaptations from their past which impact on the new attachment relationship. The expectation is that the new caregivers will understand this and will be able to offer secure relationships in spite of the previous adverse care (Schofield & Beek, 2005). Problems with attachment early on can continue throughout the person’s life span (Cornell & Hamrin, 2008).

There are two common approaches in helping foster families with attachment problems (Cornell & Hamrin, 2008). The psycho-educational model involves both parent and the child. This method teaches basic caregiving skills and orients the parent to appropriate developmental expectations. The psycho-therapeutic model provides a “corrective emotional experience” for the mother through her relationship with the therapist. The therapist role is to observe the dyad and intervene to improve the mother-child relationship at both the interactional and relational levels. Given the severity of foster children’s trauma histories and resulting difficulties, it seems apparent that individuals who are becoming foster parents should receive solid training in ways to successfully ‘parent’ these children during the time they reside in foster care. Foster parenting is a complex, demanding, and important process. To help prepare for this service, most foster parents undergo
pre-service training. The benefits of foster parent training are well-established. Training can provide knowledge, support, connection with others, and can match potential parents with child placements that are a good fit. Also, training can reduce disruption in child placements, help prevent foster parent burnout, and improve relationships between foster parents and their foster children (Whiting, Huber, & Koech, 2007).

PRIDE is a 30 hour training for prospective foster parents. The competencies focus almost exclusively on skills that foster parents require to meet the needs of foster children who are placed with them. PRIDE training provides broad coverage of many areas to be central to the welfare of children in care (Dorsey et al, 2008). The PRIDE model of practice has three major components and fourteen activities within those components. There are five essential competencies which include “protecting and nurturing children,” “meeting children’s developmental needs, and addressing developmental delays,” “supporting children’s relationship with their birth families,” “connecting children to safe, nurturing relationships intended to last a lifetime,” and “working as a member of a professional team” (Child Welfare League of America, 2012).

MAPP is a 24 to 30 hour training for prospective foster parents. It is heavily infused with material to prepare foster parents for the challenges that they and their family will encounter by becoming foster parents. It strives to create well-informed foster parents who know what they are getting into and who know how to work within the child-serving system. When foster families have the needed resources, support, training, and skills to care for children in the foster care system, the results is a positive child welfare outcome. The PRIDE and MAPP models are designed so that upon completion of the training, parents have realistic expectations of the rewards and challenges of parenting a child or youth through the foster care or adoption. Both are comparable and each state chooses the model that feel best fits their agency.

In Massachusetts, the Department of Children and Families uses the MAPP training program for prospective foster parents. It is referred to as Massachusetts Approach in Partnership Parenting. MAPP is a 10-week, mandatory pre-service education program for people interested in fostering or adopting children and youths living in the custody of the state. MAPP provides parents with information and skill-building that will effectively prepare them to parent children who are in care. This information is learned through activities, speaking points, discussion questions, reflective questions, role play/pair shares, and resources (Department of Children and Families, 2012a).
One of the modules presented in MAPP training is aimed specifically at helping children and youth with attachments. The goal is to guide participants in understanding the nature of attachment and issues related to the children who enter foster care. The objective is to be able to answer the questions: What is attachment and why attachment is important? This is accomplished with a participatory activity entitled the Yarn Activity. It starts with four volunteers (birth parent, child, foster parent, and adoptive parent). The birth parent and the child face each other and yarn is placed around their backs. The ends of the yarn are tied. The narrator describes the importance of the yarn as being a strong attachment between the parent and child. Due to unfortunate losses within the family, the child is removed for the home. The foster parent is asked to stand between the birth parent and child. A piece of yarn is tied around the back of the foster parent with both ends tied to the attachment yarn between birth parent and child. The narrator continues to explain how grateful the foster parent is for the attachment between the birth parent and child. This attachment has allowed for the child to form an attachment with the foster parent. The narrator continues with the story. As time pass, the birth parents are unable to work things out for the child to return home. The child will need to have a permanent family. The adoptive parent stands on the other side between the birth parent and child facing the foster parent. A piece of yarn is tied to the end of the adoptive parents “attachment” to the child/birth parent’s “attachment” and the other end to the foster parent’s “attachment.” The narrator continues to explain how grateful the adoptive parent is to see that the child arrives with strong attachments. The adoptive parent knows that because of the exiting attachment, it is possible to build a relationship with the child more quickly. The narrator asks the group to imagine if the adoptive parent has not had the opportunity to go through MAPP class. Sometimes, the adoptive parent might be jealous of the child’s attachment to the foster parent. The question is asked, “What would the adoptive parent like to do?” A pair of scissors is given to the adoptive parent. If the adoptive parent cuts the attachment between the child and the foster parent, the adoptive parent’s attachment is also cut. If the adoptive parent cuts the attachment between the child and his/her birth parents, the adoptive parent’s attachment is also cut (Department of Children and Families, 2012a).

The Yarn Activity helps foster parents understand that when they try to sever ties that children have with previous attachments, the outcome is always destructive. It is understandable that foster/adoptive parents may feel threatened by previous attachments. These valuable attachments are the
cornerstone of all relationships for children in care. Good attachment has many possible outcomes in the present and in the future. Attachments helps children develop trust in others and become self-reliant. Attachment is the first and most essential building block in a child’s development.

**CASE EXAMPLES**

MAPP’s definition of attachment consists of affectionate and emotional ties between people that continue indefinitely over time and last even when people are geographically apart (MAPP, 2010). The following two examples were drawn from my sessions as a co-leader of MAPP training for prospective foster parents. Mary was a 10-month old baby who had been neglected and under stimulated. Her mother left her in her crib wet and crying, and seldom held or cuddled her. Mary’s mother fed her watered down formula and no solid food even though she was at an age when she should have been eating it. Mary had no toys, not even a crib mobile to entertain her. In order for foster parents to help develop an attachment to Mary, it was important to help Mary become attached and feel secure. The foster parents decided that their response to her was important. They were interested in making sure they attuned to her needs by trying to respond quickly to her when she needed attention and they tried to do this in a soothing and patient manner. It was also important for them to hold her and “talk” to her (Department of Children and Families, 2010a).

David was a 15-year-old boy who has been in multiple placements during the past 11 years. He tended to isolate himself in the home, interact little with family members, and make statements that he hated everyone and should be left alone. In order for his foster parents to develop an attachment with David, they had to first understand it might take a long time to earn David’s trust. The foster parents decided they would begin by finding ways to encourage David to interact with the family. They believed this would help him know they were committed to helping him feel secure. (Department of Children and Families, 2010a).

**DISCUSSION**

Children who are placed out of their family homes experience many losses and many of their basic emotional needs are threatened. As a result, they can easily develop negative coping skills. It is the role of the foster parent to help children feel secure and learn positive coping skills. Attachment is the first and most essential building block in a child’s development. Children grow and
develop within the context of nurturing relationships with their attachment figures. These relationships with attachment figures serve as the foundation for a basic sense of well-being, security, and trust in oneself and others. There is also an important source of connection to others that is vitally important to a child’s sense of identity and belongingness in the world.

When foster parents are consistently able to respond to a child’s needs and discomfort in helpful and empathic ways, children experience relief from uncomfortable needs states, while feelings of trust and security are developed between the child and the foster parent that lead to a sense of attachment and connection. While meeting needs is important to fostering attachment, a child’s relationship with their foster parents should go beyond need satisfaction. They should include other enjoyable experiences as well. The positive interaction cycle is where foster parents find ways to interact with children in positive ways and give children positive messages about themselves (MAPP, 2010). The positive interaction cycle also helps children develop a sense of attachment to their foster parents. The child’s sense of self-worth and self-esteem grows and so does the attachment between the child and foster parents.

Foster parents also need to give children consistent messages that they are wanted and they belong. When foster parents tell children they are wanted, spend time with them, and include them in their family activities, they are telling them that their relationship with each other is special. This closeness helps to form important attachments with children in their care. Foster parent trainings are a wide mix of programs that vary from state to state. PRIDE and MAPP are nationally known and widely used. Foster parents who attend some type of training feel that they are prepared for the reality of and the ability to care for children who has been exposed to abuse and/or neglect. By understanding the concepts of attachment, prospective foster parents will be able to provide a secure base to those who come from a place where their base might have been cracked or destroyed.

SUMMARY AND CONCLUSIONS

The purpose of this paper was to show the need to provide prospective foster parents information on Bowlby’s theory about attachment. In her book, Another Place at the Table, foster parent Kathy Harris (2003) writes, “When children come, they are shattered. In the course of a few short hours, they have lost everything that anchored them to their sense of self. My job is to paste them together until they can start to make some sense of it all. I offer
a small island of safety in an unstable and terrifying world.” Research shows problems in attachments are very common for children who have been exposed to abuse and/or neglect. Helping children address attachment problems is one of the most important things a foster parent can do. Foster parents who have attended training are correlated positively with placement stability. Foster parent training reduces the incidence of failed placements, increases desirable placement outcomes, and enriches the safety and well-being of a child placed in their care.

References


New York

The Home for Little Wanderers (2012 MAPP Training
http://www.thehome.org/site/PageServer?pagename=
adoption_waiting_mapp#.UGjJbq44LRQ.


U.S. Department of Health and Human Services Children’s Bureau (2011)
*FY 2003-FY 2011 Foster care: entries, exits and in care on the last
day of each federal fiscal year.* http://www.acf.hhs.gov/sites/
default/files/cb/entryexit2011.pdf

theory*. Retrieved October 28, 2009 from

programs: A content analysis of four common curricula. *Relational Child & Youth Care Practice, 20*(3), 64-2.
The purpose of this study was to understand the challenges of clinicians working with individuals mandated to participate in mental health treatment at an outpatient clinic. I became curious about this topic while working at a mental health agency where clinicians expressed frustration about counseling clients who were mandated to participate in services. The clients missed appointments and many times did not seem to be mentally present during sessions. The clinicians raised questions about the effectiveness of these services. Their observations sparked an interest to investigate the multiple facets of working with mandated clients.

Mandated mental health treatment is controversial. By mandating clients to obtain mental health help, the element of free choice is lost. Autonomy and self-determination are important elements of mental health assistance. Among clinical professionals, there is an array of opinions, from those who claim mandated treatment is successful and moral in all situations to those who assert it is always unethical and ineffective.

Mandated care has been used in the treatment of the mentally disabled for centuries. With the creation of the Elizabethan Poor Law in 1601, individuals with mental disabilities were placed into almshouses (Ambrosino, Heffernan, Shuttlesworth, & Ambrosino, 2005). While this was an attempt to care for the mentally ill, this trend ultimately led to their institutionalization in mental hospitals. Beginning in the 1960s the state hospitals in the United States began to close, releasing thousands of mentally disabled individuals into the
community (Engel, 2008). Discharged patients were offered community-based treatment without being confined or segregated. During the past few decades, individuals have been mandated to receive mental health treatment only when there is a danger of harm to themselves or others. Currently, courts order people to get treatment for anger management, substance abuse, and parenting when it appears there is a risk to self or others. Some educational institutions can require treatment as a condition of being a student. Similarly, work sites might require treatment for an employee to keep a job. Inpatient hospitalization, when mandated, is most often due to a person being unsafe to themselves or others and discharge depends on the person committing to a safety plan and other services.

One example of mandated treatment occurs in child welfare agencies. A common example is that the social worker meets with a mother who is experiencing high levels of stress. The worker may add to the family’s service plan that the mother needs to see a therapist to help her deal with the stress. The mother knows that, in order to get the Department of Children and Families (DCF) to close her case, she must comply with the service plan, even if she does not have the time, money, or desire to receive this service. As a result, the mother begins to attend therapy. There is a power dynamic at play within this relationship that affects the individual’s decision to seek services.

Another example of a mandated service occurs through the court system. As an alternative to jail or probation, judges have the option to mandate an individual to seek therapeutic treatment. In some cases, the judge may be concerned that, due to the severity of the individual’s mental health diagnosis, he or she may be unsafe without treatment. In other situations, the treatment is used as a form of punishment. For example, a man who abused his partner may be required to attend a batterer’s class to learn more appropriate coping strategies.

This paper has two goals. The first is to identify the challenges experienced by mental health clinicians in working with mandated clients. The second is to address the question, “Do mental health clinicians see mandating people to clinical services as helpful, even though it may stand in opposition to the value of client self-determination?”

**REVIEW OF THE LITERATURE**

There was an abundance of articles about mandated treatment and studies concerning the effectiveness of the treatment. However, there were
limited resources regarding the experiences of clinicians doing this work. One common theme in the research was related to the ethical dilemma that clinicians encounter when working with involuntary clients because it goes against the *Code of Ethics of the National Association of Social Workers* (NASW) (1996) emphasis on self-determination.

Scheyette, Kim, Swanson, Swartz, Elbogen, Van Dorn, and Ferron, (2009) conducted a quantitative survey of 193 NASW social workers in North Carolina to investigate clinicians’ perspectives regarding autonomy and directive interventions. These authors found that “over 70% of the sample endorsed the belief that involuntary treatment would rarely be necessary if there were good services accessible to clients with [serious mental illness]” (p.291). They also showed that voluntary treatment was preferable to clinicians. However, more than 70 percent of clinicians believed that involuntary treatment was realistic for individuals with serious mental illness (SMI) and 64.8 percent believed that involuntary treatment could be effective for individuals with SMI (p. 293). Only 35.6 percent of clinicians believed that involuntary treatment was necessary to prevent violence (p. 292).

Taylor (2006) conducted a survey using a random sampling of 750 members of the *Register of Clinical Social Workers, 11th Edition*. Out of the 750 surveys, 320 were returned in usable condition. The survey consisted of questions relating to ordering involuntary treatment and providing mandated services. Ninety percent of participants had worked with involuntary clients. In the results, 82.9 percent either “agreed” or “totally agreed” that involuntary treatment for individuals with mental illness was beneficial (Taylor, 2006, p. 26). Social workers, however, were divided in their level of comfort in most areas connected to mandated treatment including forcing involuntary medication, emergency hospitalization, outpatient commitment, to testifying, inpatient services, substance services, and outpatient services. The sample of social workers, however, was generally uncomfortable in seeking or facilitating an involuntary medication order as well as testifying for commitment at a hearing” (Taylor, 2006, p. 27). In this study, participants were given the opportunity to add anything else they thought was missing in an open-ended format. The results fell into four common categories. Thirty-six percent wrote about prevention of danger to the client or other people. Twenty-five percent wrote that treatment could be mandated for those with less severe mental illness due to the positive results the clinicians had seen from their own experience. Twenty-two percent of respondents were concerned about systemic problems of short-term care rather than long-term treatment.
Lastly, 20 percent of respondents wrote about their conflicting feelings regarding a client’s right to self-determination as written in the *Code of Ethics of the National Association of Social Workers*. (Taylor, 2006, p. 29) In conclusion, Taylor (2006) wrote of the “overwhelming support” for mandated treatment that was found in this research and the increase in comfort over time with involuntary treatment (p. 30).

O’Hare (1996) wrote about mandated treatment and the stages of change. He examined a broad range of clients, considering those mandated through the court system due to domestic violence, substance abuse, child abuse, or mental illness. He studied 376 adult outpatient clients, 20.7 percent of whom were court-ordered (p. 418). O’Hare (1996) found that although a majority of the court-ordered clients were in the pre-contemplative stage, 28.3 percent of the mandated clients were “either thinking about changing (contemplating), actively engaged in doing something about the problem (participating), or trying to maintain previous gains in dealing with the problem (maintaining)” (p. 420). He cautioned the reader to refrain from stereotyping and underestimating involuntary clients because many are ready for change.

In spite of the support for mandated treatment, O’Hare argued that social work treatment models require a voluntary client. He claimed that the client must possess a readiness for change. In addition, he argued that “oppressed groups are disproportionately represented among court-ordered clients, a fact that threatens to carry social power imbalances into the helping relationship” (O’Hare, 1996, p. 418). O’Hare concluded that mandated treatment, “may undermine the effectiveness and morale of social workers, do little to improve the lot of the offender, and promise unachievable benefits to the general public” (O’Hare, 1996, p. 418).

**METHOD**

The sample for this study was drawn from clinicians who worked in an outpatient mental health agency in an urban city in western Massachusetts. A convenient sampling of five clinicians was selected from the agency where I worked as an intern. I contacted a number of clinicians with whom I worked who had a range of experiences in the agency. Five of the clinicians were willing to participate in this research project.

The term “co-researchers” was used in reference to the five clinicians who participated in this study. Of the five clinicians, all were Caucasian females. This was not intentional, but was due to the nature of my sample. The average
age was 38, with the youngest being 25 and the oldest being 57. Two of the clinicians had their master’s in social work, one had a master’s degree in psychology, another clinician had a master’s in marriage and family therapy, and the fifth had her Ph.D. in psychology. Four of the five were licensed, none independently. Their average length of experience was eight years, with the least experience being three and a half years, and the longest experience being 15 years. Three of the clinicians reported working with involuntary clients “a little” while two reported working with them “a lot.” The interviews were conducted in the office and lasted from 30 minutes to one hour. The standard introduction was read and the co-researchers were given the Ethics Consent Form to review and sign.

Throughout the process of my research, I was influenced by Clark Moustakas’ book Heuristic Research. Moustakas (1990) defined heuristic research as “a process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis” (p. 9). He advocated for an inclusion of the self in the research and wrote that this type of research “involves self-search, self-dialogue, and self-discovery; the research question and methodology flow out of inner awareness, meaning, and inspiration” (Moustakas, 1990, p. 11). While much of the present day’s research removes the scholar from the subject, Moustakas argued that the best research personally involved the researcher. I found this inspiring and strove to immerse myself into it, to “live the question in waking, sleeping, and even dream states” (Moustakas, 1990, p. 11). I felt truly passionate about gaining knowledge about the experience of working with mandated clients and I reflected this passion during my research. In the end I felt that it caused me to care more about the topic.

In my collection of the data, I utilized other qualitative approaches mentioned by Marshall and Rossman (2011). I prepared a “standardized, open-ended interview method” but attempted to take a more “topical approach,” being willing to stray from my scripted questions if the conversation flowed that way (Marshall & Rossman, 2011, p. 144). It was my goal to allow the interview to go in the direction my co-researchers decided. As Marshall and Rossman (2011) discussed, “the participant’s perspective on the phenomenon of interest should unfold as the participant views it (the emic perspective) and not as the researcher views it (the etic perspective)” (p. 144).

In my analysis of the data, I also utilized Marshall and Rossman’s (2011) qualitative analytic procedures. The seven phases of this method included
“organizing the data, immersion in the data, generating categories and themes, coding the data, offering interpretations through analytic memos, searching for alternative understandings, and writing a report or other format for presenting the study” (Marshall & Rossman, 2011, p. 209). In the immersion phase I also utilized Moustakas’ (1990) skills to help me effectively “enter into the material in a timeless immersion until it is understood” (p. 51).

RESULTS

Several themes emerged during the analysis of the data. The most common theme was how effectively clinicians worked with the mandating entity. All of the co-researchers identified that their clients were mandated by either the legal system (e.g., a probation officer), or through the Department of Children and Families. The identified challenge was how to maintain a client’s confidentiality and build trust with him or her while having to report back to the mandating party. Four of the five co-researchers identified this as a major challenge in their work with mandated clients.

One co-researcher, a 30-year-old female with a Ph.D. in psychology, identified the multiple challenges that she experienced in her work with involuntary clients and the mandating entity. She said,

Then the question becomes, “Who is the actual client?” The main thing that DCF and probation officers want to know is what the clients are doing in session. That’s what is difficult for me. I’ve got the client who is in the room with me. I’ve got the agency that is saying this person has to attend. I’ve got my employer saying I need to see a certain number of people per week. Finally, I’ve got the insurance company for whom I need to justify why it is medically necessary for the client to receive services … Even though I only see the client face-to-face, there are four total entities that are invested in treatment.

Another co-researcher, who echoed her frustration, said, “Therapy doesn’t fix everything. DCF and the courts don’t understand that.”

A sub-theme that emerged under the theme of mandating entities was connected to the Department of Children and Families. Four out of the five clinicians expressed major frustration with the fact that DCF workers want their clients to be in therapy and as a result add it to the family’s service plan. The term “pseudo-mandate” may be more appropriate for this situation because, while the client is under no obligation to comply with the service plan, there may be negative consequences if the individual does not comply.
The individual may have her children removed or may be delayed in reunification with her children if she does not follow the contents of her service plan. Additionally, a family’s case with DCF will remain open longer if they do not follow the service plan. One co-researcher said, “[DCF has] so much power and how they use it is inconsistent. It depends from worker to worker to worker [as to] what they do.”

When asked what she would like to see done with this research, another co-researcher said,

Well, I think that there needs to be more research on whether or not it is effective for DCF to mandate treatment in order to accomplish the goals that are established for the family to function at an optimal level. It may be more effective to ask the families how they can meet the identified service plan goals instead of mandating specific treatment because even if they make every scheduled appointment because DCF is telling them to doesn’t mean the family is getting anything out of it.

Still another co-researcher said, “I’m finding a lot of the therapy session is taken up by the client complaining about DCF. It’s good they have a place to vent and a sympathetic ear but I wonder if DCF knows they’re mandating client to go and bitch about them for 45 minutes a week?”

There was one clinician that seemed to have a positive perception of DCF. She implied that her experiences were not the same as the four others clinicians. She said, “I have found with DCF if you meet with a client and they don’t meet the need for services and that is your clinical judgment then DCF will be fine with that as long as the person was compliant.”

Another theme that emerged from the research was that mandated clients tend to be “reluctant,” “resistant,” “and lacking in motivation.” Because of this lack of motivation, the clinicians described their attendance as “inconsistent.” They also noted that it takes much longer to develop a positive and trusting relationship with clients that are mandated. In regards to the challenges of engaging involuntary clients, one co-researcher said,

I found that if families are being referred particularly by DCF ... and the family is resistant ... that it takes a much longer time to build a relationship with the family as a whole and with individual members. You know, it’s hard to get them to trust you and it’s hard to get them to open up and really give you a clear sense of what the issues are that they’re struggling with or that they want help with.
Similarly, one co-researcher noted that the rapport and trust developed “over a period of months as opposed to weeks.”

Still another theme that emerged through the research was the different skills that the clinicians utilized when working with involuntary clients. The co-researchers identified “patience” and “flexibility in style” as being necessary. Three co-researchers advised clinicians not to “take on” client’s frustrations of being mandated. One said, “Empowerment is the most effective skill. If you empower, you have a better chance of success. Give them the power back. Therapy has to give back to them to make them feel capable of moving their life forward.”

Three clinicians stressed the necessity of remaining a neutral party between DCF and the client. One co-researcher said, “You can’t side too much with anybody. You don’t want to give parents the impression that you are just on their side … or give DCF the impression that you’re on their side. Walking a thin line.” Another co-researcher cautioned against this as well, saying it was “easy to get sucked into the vicious cycle.”

All five co-researchers spoke about the ethics of mandating treatment. Within this theme there were several different opinions. One co-researcher felt strongly that mandated therapy was unethical. She said, Mandating a client who is otherwise free to go about their business doesn’t really respect their autonomy. The population we work with is so disenfranchised and so disempowered... They’re not saying you have to go to your PCP or your dentist, but you have to go to therapy and work on your issues. This takes the power away and intensifies the power differential between the therapist and the client. Inadvertently, I have a lot more power over them.

One co-researcher discussed feeling conflicted about the idea. While she felt “frustrated” and wished clients did not need to be mandated, she recognized some positive outcomes that have occurred. She said, “I’ve never really thought about it in terms of agreeing or disagreeing. Do I wish it was mandated? Absolutely not, but sometimes people aren’t willing to go unless it is mandated and then once people come they do benefit.” Similarly, one co-researcher said, “Mandating is uncomfortable for me. At the same time mandating sometimes is beneficial. There is no clean answer, but I would rather have the opportunity available to them.”

One co-researcher saw the benefits of mandated therapy. She had been working with a client for two and a half years who was mandated for therapy by DCF. While the client was initially reluctant, the clinician was able to form
a relationship and build trust. Because of this she said that she had found it to be “effective.”

**DISCUSSION**

The major similarity between the available literature and the findings of this research is the acknowledgement that, despite ethical concerns, mandated treatment can be effective for people. Four out of the five clinicians interviewed in this study acknowledged the positive benefits they had personally witnessed with clients mandated for treatment. However, they also noted that this positive outcome does not occur for the majority of involuntary clients. Taylor (2006) found in his research that clinicians also saw the benefit from mandated treatment with clients who were not considered “dangerous” (p. 29).

There were many differences between the available literature and this research. In the literature there was no mention of DCF mandating individuals for treatment. However, in this research it was mentioned by all five clinicians and was identified as a source of stress. It was even recommended by one clinician that this research should be used to reexamine the effectiveness of this practice.

A second major difference was the lack of research on clinicians’ experience with mandated individuals who did not have a serious mental illness (SMI), such as schizophrenia and bipolar disorder. An overwhelming majority of the literature involved a client being mandated due to a SMI that could result in dangerous behavior to the client or others. Clinicians interviewed in the literature discussed inpatient hospitalizations, required medication adherence, and mandated therapy. The major argument found was that clients with a SMI did not have the ability to make a rational decision regarding their treatment due to their diagnosis. In contrast, individuals mandated for treatment not due to an SMI were never mentioned in this research. The five clinicians interviewed separately identified DCF and the legal system as mandating the treatment for individuals and there was no mention of medication adherence or dangerousness of clients.

**CONCLUSION**

Continued research on this topic is essential to advanced generalist practice because it considers the individual’s interaction with mezzo and macro systems and is a social justice issue. Because the nature of the data suggested
an overwhelming negative view of DCF’s method of mandating clients, this data could be used to encourage a reexamination of this issue. The hope of this reexamination would be to increase the self-determination and autonomy of all individuals mandated for treatment on a macro level and to improve the work experience of clinicians who are often caught between the clients and the mandating entities. The data could also be used to show the need for a concrete guideline concerning clinician’s interactions with mandating entities. On a micro level, this would benefit both clinician and client, allowing for trust to develop more quickly between the two. Ultimately, this data could be used to influence policies, hopefully being a “meta-macro intervention” (Wronka, 2008, p.111). As one co-researcher stated, “Effective policy is going to make it possible for the people we serve to live.”

There were several limitations to this study that need to be acknowledged. The study itself was time-limited, occurring during the course of three months. A convenient sample of co-researchers was used that included coworkers and friends that worked in the same geographic location. The similar demographic nature of the co-researchers could have affected the data, as well as the small number of participants.

In order for this research to be influential, further studies should be conducted to ascertain if this is a universal experience. The study should include a larger sample size with more varied demographics throughout a larger geographic area. It would also be interesting to interview clients that have had the experience of being mandated for treatment. Their voices and their experiences with involuntary treatment could be influential to studies and policies.

This study has been very influential to both me as a researcher and me as a person. I thoroughly enjoyed the research process and grew in my understanding of effective research through this experience. I learned how important it is to hear people, to listen to their experiences, and to support them in their challenges. That is why this process impacted me personally. It was empowering to hear that other clinicians were passionate about this issue and the process of joining their voices together showed me the power of qualitative research.

This research has opened my eyes to a real problem that exists within our mental health system, a problem I was unaware of and a problem that can only be altered by increased recognition. The mostly ineffective method of DCF mandating client’s needs to be reexamined. It is my hope that this research can be used to bring this issue to light, to increase curiosity, and to inspire change.
As one co-researcher said, “How do we lobby together to change policies to empower people? It’s about the big picture. That’s the only way you make real change. Effective policy is going to make it possible for the people we serve to live.”

References


Group Work with Youth with Sexual Behavior Problems
Michelle Michaelian

Sexual violence committed by youth accounts for a significant proportion of sexual crimes. Records indicate that youth account for 17 to 20 percent of all sexual crimes (U. S. Department of Justice, 2009, Letourneau & Borduin, 2008). Historically, group work approaches have been used in helping change sexual offending behavior. There is a noted lack of empirical investigation, however, into the effectiveness of group therapy for youth with sexual behavior problems. Recent research has suggested that a solely cognitive behavioral-relapse prevention approach is not adequate for this population (Letourneau & Borduin, 2008). Researchers assert that current treatment protocols fail to address the multiple determinants of sexual offending (Letourneau & Borduin, 2008), and that group approaches pay too little attention to social and cultural determinants of youth’s behavior (Hunter, Gilbertson, Vedros & Morton, 2004). Hunter, Gilbertson, Vedros, and Morton (2004) contend that the use of cognitive behavioral therapy, with a focus on relapse prevention, is based on the “empirically unfounded assumption” that treatment should focus primarily on the sexual offending behavior. Juveniles with sexual behavior problems are, however, a heterogeneous group and present with multiple treatment needs. The notion of a “one size fits all” (p. 179) treatment approach for this population is not the best strategy (Hunter, Gilbertson, Vedros & Morton, 2004).

The goal of this paper is to present a review of the general research on group work with sexual offending youth. In this paper, I will describe the contrasting evidence regarding the efficacy of group work with this population.
I will also present a case example of a group I led where the awareness of group dynamics and relationship factors rather than cognitive-behavioral analysis offered an opportunity for the growth of six group members.

**REVIEW OF LITERATURE**

Individual, group, and family therapies are all used in clinical interventions with juvenile sexual offenders (Hunter, Gilbertson, Vedros & Morton, 2004). Group treatment emphasizes improving social skills, strengthening impulse control, and managing anger. Cognitive-behavioral groups focus on the correction of cognitive distortions and thinking errors in relation to sexual offending and developing victim empathy. As part of their treatment plans, members are given sex education and they work on formulating a relapse prevention plan (Hunter, Gilbertson, Vedros and Morton, 2004). One main premise of group work in the past has been that strong confrontation of the youth is essential to invoke change, including full disclosures to the group of one’s past sexual offenses.

There are several differing views on the topic of group work with youth who sexually offend. Some suggest that there are potential negative long- and short-term effects of this type of work with this population. Hunter, Gilbertson, Vedros, and Morton contend that current group work with these youth is grounded in “empirically unfounded assumptions” (2004, p. 179). They point to the incorrect assumptions that the treatment needs of all juvenile sexual offenders are universal and that individual offenders are most effectively treated when placed in groups with other juvenile sexual offenders. They also point to other faulty assumptions including the ideas that treatment should focus primarily on the sexual offending behavior and that sexual offending is largely a function of deviant sexual arousal. Hunter, Gilbertson, Vedros, and Morton (2004) contend that “limited attention is typically given to social and cultural determinants of the youth’s behavior, in spite of growing evidence that these influences are important in understanding both the origin and maintenance of sexually aggressive and delinquent behavior” (2004, p.178).

Letourneau, Henggeler, Bordin, Schewe, McCart, Chapman, and Saldana (2009) support the social and cultural theories by noting that the risk factors for juvenile sexual offending are very similar to those observed for other types of antisocial behavior (2009). Empirical evidence has suggested that juvenile sexual offenders suffer from higher rates of emotional and behavioral problems than do non-delinquent youth, although they are similar to those of violent nonsexual offenders or nonviolent nonsexual offenders (Letourneau & Borduin,
Data has shown that families of both sexual offending youth and nonsexual juvenile offenders have low rates of parental monitoring and high rates of parent-child and inter-parental violence (Letourneau, 2008). Also, studies have shown that juvenile sexual offenders are more likely to have had social difficulties and are isolated from same age peers (Letourneau & Borduin, 2008). These youth, similar to other delinquent youth, are also known to associate more with deviant peers than do non-delinquent youth.

A frequently cited study by Dishion, McCord, and Poulin offered evidence of “powerful iatrogenic effects” (p.755) when high risk adolescents are placed in cohort groups (1999). It has been argued that there may be more modeling and reinforcement of antisocial behavior than pro-social behavior within groups made up of deviant youth (Dishion, McCord & Poulin, 1999). A study conducted by Mager, Milich, Harris, and Howard did lend some support for Dishion McCord, and Poulin’s deviancy training hypothesis, but found that more deviancy training occurred when adolescents were placed in mixed groups of low and high risk youth (2005). Mager, Milich, Harris, and Howard’s study “supports the continued use of the standard group treatment model for young adolescents with conduct problems,” but stated this should be “conducted in groups that consist entirely of at-risk members” (2005, p. 361).

In a 2005 study, Weiss examined the hypothesis that deviancy training is an outcome of group interventions with this population. His study “found little strong evidence for either hypothesis” (2005, p.1043). They did, however, find that negative outcomes are more likely to occur in youth who have “experienced rejection by mainstream peers, but are not yet associated with deviant peers or with youth who live in the same neighborhood as delinquent youth with whom they are not yet acquainted” (Weiss, et al., 2005, p.1043). There is, however, persuasive data that group work still remains a viable option for treatment of juvenile offenders. Several recent studies have offered evidence that these effects may be overstated. This research has found that these iatrogenic effects are more likely to occur when lower risk youth are placed with high risk youth (Weiss, 2005).

Burton, despite the potential for these negative outcomes, asserts that group work does seem to be an effective intervention with this population, although it may not be appropriate for all youth (2008). He states that certain types of youth should receive individual treatment only, when considering the possible iatrogenic effects that can occur. Marshall and Burton (2009) further discuss the impact of group processes in offender treatment on the attainment of treatment goals. They found that “confrontation reduces the likelihood of
beneficial effects” (p. 40). They also stated that when therapists were genuine, there was a greater likelihood of a successful outcome. They also found that researchers reported that “a stronger alliance between therapists and juvenile sexual offenders is positively correlated with both greater engagement and improved outcomes” (Marshall and Burton, 2009 p.144), and they go on to note that therapist qualities, such as affect-behavior integration, warmth and humor, are also related to positive results (Marshall and Burton, 2009). Marshall and Burton concluded that “it is the therapist’s characteristics that are most important with the contribution of specific techniques being less influential” (2009, p.146), and that the “characteristics of therapists and the therapeutic alliance both appear to be importantly related to the effectiveness of treatment both with juvenile offenders in general and with juvenile sexual offenders” (2009, p. 6).

CASE EXAMPLE

The following example was drawn from multiple sessions of a group, where I served as co-leader, for youth who were placed in a specialized foster care setting. The focus of the group was on sexual behavior problems. This group consisted of six adolescent males between the ages of 15-17, all of whom had anti-social behavior problems and had committed sexual offenses. The goals of the group were to complete a sexual assault curriculum, develop a relapse prevention plan, and improve social skills. In addition, a major focus of the group was to support the growth of positive facets of the youth’s life.

The group had been meeting for several months when I joined, after the initial clinician left the group. The six boys were initially resistant to my leadership and had a difficult time staying on task or trusting in the group process. The group members spoke over one another, complained about having to come to group, and each member’s body language was indicative that they were uncomfortable and angry about being in the group. As a group leader, I suggested after three weeks of similar sessions, that we “take a break” from the curriculum and begin as if we were a new group. The group members were subsequently asked what each one expected to gain from attending the sessions. Several members expressed dissatisfaction with treatment and made statements such as “I am sick of doing cycles, I have done this so many times”; “can’t we discuss real life stuff?”; and “I am so tired of feeling like I am just a sex offender, when will I get to just be normal again?” I explained to the group that while we needed to address the cycle and relapse prevention, that we will also be discussing their “real lives” and how to navigate themselves in the commu-
nity. We then, over the next several weeks, did trust and team building activities, some of which we, as leaders, also completed.

As the weeks passed, group members became visibly more comfortable and made statements such as “I like that you did this, too” and “really, you’re not afraid to do it?” The group progressed through these activities, and the members began to see the group as a place of support and comfort. When new members entered, as this was an open group, the veteran members explained the group expectations to the new boys. They made statements such as “we talk about some serious stuff in here,” and “we’re like family, so you have to respect that.” They discussed the role of the group leaders to the new members as well, making statements such as “they will call you out if they have to, but they respect us.”

As time progressed, the group began to play out different dynamics that were reflective of their life difficulties. A primary example of this was one young man who became somewhat of the scapegoat in the group. He, at first glance, seemed to be unduly targeted by other members. Upon further observation, it became clear that he was enacting the role of the “victim,” creating scenarios that drew attention from others in the group and taking up much of check in time. His body language would drastically change when the focus was not on him so that others were compelled to ask “what is wrong?” This behavior was characteristic of this young man in other areas of his life and played a part in his past sexual offending. The group members began to become frustrated and confronted him quite aggressively. With guidance from group leaders, the group was eventually able to assist him in identifying what need this meets for him, resulting in the response, “I just don’t know how to just say what I’m feeling” and “I just get upset when I all of a sudden think about certain stuff.” The group became a venue to play out circumstances that occur in their daily lives. The “scapegoat” started to see his behavior in a different light and the group members discovered a way to not victimize a vulnerable member but rather they could help him navigate this process. The members were able to apply these skills in understanding their maladaptive behavior cycle and felt less intimidated and angry toward the process. They felt their needs were being met while understanding themselves through one another.

**DISCUSSION**

Group work with adolescents who have sexual behavior problems should not focus solely on the sexual behavior, rather group leaders need to view each member as a whole person with multiple needs. Although it has been
shown that there is a low probability that these youth will commit another sexual offense, it is also shown that they are at a much higher risk to become involved in other delinquent activities (Letourneau & Bourdin, 2008). The reality that this population is heterogeneous should inform treatment protocols and caution practitioners to carefully evaluate each youth individually before making decisions. Every person presents with different needs, and treatment goals should reflect the individual, not solely the offending behavior. There is compelling evidence that group work is a viable option in working with youth with sexual behavior problems, despite the possible iatrogenic effects it may cause. A thorough evaluation of each youth’s treatment needs enables clinicians to make careful and informed decisions about the most appropriate approach for the individual. In the case example, the group was important because it helped the members move from their own individual needs to discover their common purpose. Treating each adolescent as if they are the same as the other would be negligent and irresponsible.

Evidence of the importance of process in group therapy with this population must be emphasized. Marshall and Burton (2009) found that therapist qualities and characteristics are, in fact, more important than the specific techniques used, such as a strong focus on completing the cycle and developing a relapse prevention plan (2009). The therapeutic alliance has been proven to heavily contribute to the attainment of treatment goals and equal attention should be given to the process as it is to the technique. The previous case example demonstrates this clearly. The group, although cognitively capable of completing the cycle, was unable to attend to the task until they felt the group was safe. They needed to see one another, as well as the group leaders, as genuine and willing to participate in the group process. As the group became more cohesive, they were able to express fears of failure and feelings of inadequacy. The boys needed to understand that the group’s purpose was not punitive, rather that it could be used to give and receive feedback and support one another’s growth. Each member became less of an individual and more a part of the group, understanding they entered into treatment with a common purpose. This was accomplished through the team and trust building activities where they were able to become more vulnerable in front of each other, allowing them to see the others as equal. The members’ comments regarding the group leaders illustrate the importance of genuineness and the treatment alliance. The group was unable to progress until they felt connected to each member, as well as the leaders.
SUMMARY AND CONCLUSIONS

Group work with adolescents with sexual behavior problems is a viable and pertinent element of the treatment process. Components of the traditional cognitive behavioral and relapse prevention model set a good foundation for work with this population, but alone it may not be appropriate to address their multiple needs. Emerging research calls our attention to the numerous similarities between youth with sexual behavior problems and adolescents with other types of antisocial behavior. Evidence supporting group work with youth with other antisocial traits is compelling. Practitioners cannot continue to solely treat each youth with sexual behavior problems with the same cognitive behavioral and relapse prevention treatment model. They need to assess each youth carefully and ascertain, based on clear clinical judgment, what the treatment needs are for each client. This is not to say, however, that clinicians and programs should not consider the possible negative effects that group work may have on a client. Group work may not be appropriate for every youth with sexual behavior problems, and sound clinical judgment must prevail. In light of the recent evidence for group work with this population, practitioners have a responsibility to consider the positive outcomes this treatment option can offer. Further research on this topic would be beneficial, as it may provide support for the use of group in treating this population, as well as illustrate the need to consider other treatment models for these youth.

References


What is the impact of a client’s trauma on social workers? Regardless of the type of setting, social workers help clients who have had terrible life experiences, including such things as the tragic death of a family member, physical abuse, sexual abuse, medical illnesses or life-threatening natural disasters. Listening to clients talk about their trauma can profoundly effect any social worker. “Working with traumatized clients or patients not only threatens the emotional balance of helping professionals, it may also cause these caregivers to suffer overwhelming negative feelings” (Kanno, 2010, p. 2). Since social workers are trained to be empathetic to their clients, and they work hard to accomplish this, the client’s trauma can cause the social worker to experience symptoms of trauma himself and undermine the intervention goals.

A 2007 study conducted by Brian Bride, entitled “Prevalence of Secondary Traumatic Stress Among Social Workers,” revealed that 70.2 percent of social workers had exhibited at least one secondary trauma symptom (STS) in the previous week, and 55 percent met criteria for at least one of the core STS symptoms. A similar study conducted by Ting, Jacobson, Sanders, Bride, and Harrington in 2005, involved 515 mental health workers who acknowledged the effects of secondary trauma on their personal and professional lives (Kanno, 2010).

This research was conducted while I was a graduate student in a master of social work (M.S.W.) program and working as a child protective social worker. At the child protection agency, I worked with children who had witnessed severe domestic violence, and children who had been physically and sexually abused and severely neglected. To me, it was obvious that a social
worker could easily experience emotional numbing, intense anxiety, and difficulties in daily functioning (Brady, Guy, Poelstra & Fletcher-Brokaw, 1999) attributable to occurrences in the client’s lives. My interest in conducting this research was to increase awareness of this topic and to assist my fellow social workers in recognizing this phenomenon. Ultimately, I wanted to emphasize the importance of self-care as a way for social workers to manage the impact of client’s trauma on them.

LITERATURE REVIEW

Many studies on secondary trauma emphasize the importance of accepting the reality that a client’s trauma can impact a social worker. Authors of these studies emphasize the importance of knowing the types of reactions social workers with secondary trauma experience. The possibility of secondary trauma occurring to a social worker is one of the risks that come with the job. Much of the research conducted on secondary trauma is written by the author(s) first identifying the type of trauma the client has experienced, and then examining the social worker’s reactions. In this review of literature, I will discuss articles that deal with traumatic sexual abuse and coping with a diagnosis of cancer.

In the article, “Impact of Trauma Work on Social Work Clinicians: Empirical Findings” (2003), Maddy Cunningham develops three hypotheses about the effects of secondary trauma on social workers who are working with the human-induced trauma of sexual abuse and the naturally caused trauma of cancer. In her research, she hypothesized that: (1) there is a positive relationship between the social worker experiencing secondary trauma symptoms and the percentage of sexually abused clients in caseload, (2) there will be a positive relationship between percentage of clients with cancer in a caseload and a negative worldview in the area of safety, and (3) clinicians working with clients who were sexually abused will report more disruptions in the schemas of other-trust and other-esteem than clinicians working with clients who have cancer. In her second theme, Cunningham mentions “negative worldview” in the areas of safety, which can refer to the belief that a terminal illness can happen to anyone. Furthermore, in her third theme, she discussed disruptions in schemas of trusting others as well as low self-esteem, which could be explained by a child being sexually abused by a parent and the therapist forming a biased negative opinion of the support system that raised the child.

Cunningham used the Traumatic Stress Institute Belief Scale as a measuring instrument. The Trauma Stress Institute Belief Scale is a useful
instrument for clinicians to utilize to determine the long lasting effects of trauma on patients. Cunningham found significant, but negative, correlation between working with concerned patients and the two subscales of self-safety and other-safety. For hypothesis number three, a t test revealed, “clinicians working primarily with sexually abused clients reported more disruptions on the subscales of other-trust and other-esteem than clinicians working primarily with cancer patients, this hypothesis was supported” (Cunningham, 2003). One can conclude that clinicians working with clients who have been traumatized, versus those that are terminally ill, are more likely to have symptoms of secondary trauma; with the argument that the terminally ill patient has not be traumatized by their illness as they have not yet passed away, which raises some ethical dilemmas.

In a study entitled “Hospital Social Workers and Indirect Trauma Exposure: An Exploratory Study of Contributing Factors” (Badger, Royse, and Craig, 2008), the authors explore the nature of secondary trauma on hospital-based social workers. The authors surveyed social workers and examined variables that included years of social work experience, full-time or part-time status, area of practice (inpatient, emergency, or outpatient), and percentage of time spent with patients. They examined the correlation of the above mentioned independent variables with dependent variables including empathy, emotional separation or lack of empathy, occupational stress, and secondary trauma symptoms to determine if there were any positive correlations. The researchers found that emotional separation and occupational stress were strongly correlated with an increased likelihood of secondary trauma symptoms in hospital social workers. The number of years employed as a social worker by itself did not correlate with secondary stress symptoms.

Naturale looked specifically at secondary trauma for social workers who responded to disasters (2007). Her research was based on three case studies where social workers either volunteered shortly after natural disasters or were contacted to help with the impact of traumatic events in the community. In the first case study, a 23-year-old, bachelor-level social worker volunteered in New York shortly after the Sept. 11 attacks. After six months, the social worker began to experience symptoms every morning before work that included feeling very stressed, experiencing panic, having a “pounding heart, rapid breathing, excessive sweating and then exhaustion” (Naturale, 2007 p. 3). In the second case study, a 32-year-old, licensed, master-level clinical social worker, who volunteered shortly after hurricanes in the Gulf Coast, oversaw eight mental health professionals assigned to various regions of the disaster
area. Shortly after touring the disaster stricken area, the social worker began to experience intense anxiety that got worse as time passed. The social worker developed appetite and sleep problems, and began to worry constantly about the people she had seen. As time continued to pass, she developed symptoms of mania. The final case study revolved around a school shooting in the Midwest. Social workers in the school were called to work with students who had witnessed the shooting and who were feeling isolated from many classmates and becoming hostile toward peers. As the social workers tried to help the students, they also began to experience symptoms that were similar to those of the clients. In all of the three case studies, each social worker was provided direct supervision and ultimately was able to recognize that their reactions were directly related to the trauma work they had done.

**METHODOLOGY**

A heuristic approach was used to understand the lived experience of the individuals interviewed for this research. The study was guided by the work of Carl Moustakas (1990) who emphasizes the importance of discovering essential elements of a phenomenon by drawing from first person accounts of individuals who have directly encountered the phenomenon in experience. The emphasis is clearly placed on the recreation of the lived experience; full and complete depictions of the person’s life experiences. Moustakas (1990) named six phases of heuristic research: initial engagement, immersion, incubation, illumination, explication, and creative synthesis. In the initial engagement phase, the researcher begins by identifying an interest or passion. In the immersion phase, the researcher dedicates his full focus to the research, allowing everything around him or her to be drawn toward the meaning behind the research question. In the incubation phase, the researcher takes a step back and thinks more quietly about the topic. Moustakas (1990) writes that even though the researcher withdraws from the research, the research itself will still find the researcher. Moustakas (1990) gives a metaphor of when one loses his keys, he will continue to escape them until he stops looking for them and then they appear. In the illumination phase, the researcher explores established knowledge and follows his own intuition based on this knowledge. Moustakas (1990) further explains this as a breakthrough into themes of the question and how they will be formed. This phase is needed in order to bring a conscious awareness to the research and bring a deeper meaning for each question being formed. In the explication phase, the researcher develops awareness of his own biases, thoughts, feelings, and what that may bring to his research. The sixth
and final phase is creative synthesis. In this phase the researcher is familiar with the major constituents, qualities, and themes of the research. Further, the researcher has developed significant knowledge of the material that is integral to the exploration. Moustakas (1990) states that, in order to fulfill this phase, there must be a time of solitude and meditation to focus on the topic and question in order to enable creative synthesis.

As a student in a master of social work program, the term secondary/vicarious trauma was something that was familiar to me, however, I did not understand the full meaning of it. I set a goal to find a deeper meaning and understanding of the phenomenon. I wanted to know about the ways that client’s trauma effects social workers. This became the driving force behind this research, and my initial engagement and immersion phases. As I continued with my graduate education, I wondered about how prepared M.S.W. students might be to understand the toll a client’s trauma might take on them. How would we be affected by secondary trauma? Would this only affect our work life or would it affect our personal lives, as well?

The participants in this research will be described as co-researchers, as they are the individuals who have lived the experience that is being explored. The co-researchers were all employed at an agency in Springfield, Mass. The research proposal was reviewed and approved by senior management at the agency where the research was conducted and by the college where I was studying for an M.S.W. All co-researchers were given the opportunity to elope from the research at any time if the questions or topic of the research caused any negative effects. A convenient sample was used in recruiting the co-researchers.

All five co-researchers had a master’s degree in social work and their work experience ranged from six months to 23 years. This provided a wide range in perspective on the field of social work and their lived experiences. The co-researchers were composed of four women, with one man.

The interviews were conducted in private rooms/space normally used for crisis assessments. I decided not to record the interviews to avoid alarm or extra stress for the co-researchers, and to facilitate a deeper dialogue to unfold. The interviews all lasted between 30-45 minutes in length. Standardized open-ended interview questions were used.

**PRESENTATION OF DATA**

In analyzing the data, I identified six themes from the research. These themes included
1. having a positive experience in the field of social work,
2. being familiar with the term secondary trauma,
3. having experienced secondary trauma through their professional work,
4. personal life being affected by secondary trauma,
5. the use of self-care, and
6. avoidance of secondary trauma.

What has been your experience thus far?
All of the co-researchers emphasized the benefit of having had positive experiences in conducting their work as social workers. All co-researchers said they found the work to be rewarding even though it was always challenging, as well. One of the co-researchers really showed a love for the field of social work and described her experience as follows: “The work is great! Another co-researcher, who had been in the field for 23 years, stated: “My experience has gotten better with the more experience I have obtained.”

Are you familiar with secondary trauma?
Every co-researcher knew or had a notion of secondary trauma. All were asked to elaborate on their definition of secondary trauma in their own words. One co-researcher stated: “It happens to a lot of people in this field [social work].” Another co-researcher also stated: “Yes, for example, a parent on my case load died yesterday. I had just removed her kids on the day before she died.” He used this example to emphasize the emotional difficulty in losing a client and having to find a home for the children.

Have you experienced secondary trauma?
Every one of the co-researchers said she or he had experienced secondary trauma. One co-researcher, who has been in the field since May 2010, said she sees a therapist herself to address her secondary trauma and anxiety that began after entering the field. She stated: “I didn’t think so, but have started seeing a therapist to help process things. I wasn’t processing, I was anxious; I couldn’t relax at home and started binge eating.” Another co-researcher stated that she began to experience some of the symptoms associated with secondary trauma: “lack of sleep, can’t turn mind off, what could I have done different.” Four out of the five co-researchers experienced emotions varying from sadness to crying about traumas their clients had endured. The same co-researcher who recently lost a client shortly after removing her children, explained that he had worked with the family for such a long time and had built such a great trusting and honest relationship with the family, that
he was brought up to the hospital room to view the deceased body and cried with the family.

**How has secondary trauma affected your personal life?**

Four out of the five co-researchers stated secondary trauma had affected their personal lives. One co-researcher explained that the awareness of the difficult traumas in her client’s lives made her appreciate things: I feel grateful for the life I have, for having family support, [a] job, and [an] education.” Other co-researchers had negative effects: “Withdrawn, I eventually left my job,” “tired quickly, more anxious toward the end of the weekend when the work week begins.”

**Do you use self-care?**

All of the co-researchers stated they use self-care in one form or another. They described doing things like going to the gym to volunteering at local shelters. Each one had found this to be helpful in managing and addressing the effects of secondary trauma. One of the five co-researchers said she engages in “self-indulgence pleasures.” She said, “I get my hair and nails done, that’s my time.”

**Could secondary trauma be avoided?**

All five of the co-researchers answered with a strong and decisive no. One co-researcher stated, “If you avoid it you are not a good social worker. If you can’t be empathetic to their issues, you will be seen as adversary.” Another co-researchers stated, “Not in this field, unless you’re a robot.” It was apparent that in order to be effective in the role of a social worker, one must put emotions on the line in order to show true empathy about other’s trauma.

**SUMMARY, IMPLICATIONS, AND OUTCOMES**

After synthesizing the data and comparing it to previous research cited, I discovered many similarities. The co-researchers had all experienced symptomology associated with secondary trauma. They described items that are considered symptoms for a diagnosis of post-traumatic stress disorder.

In this research there were clear themes which outlined the impact of a client’s trauma on social workers. In spite of their own experiences of having experienced secondary trauma, all of the co-researchers affirmed that the work with clients and the goal of being a helping agent was the work they were meant to do. Even though all five co-researchers experienced secondary trauma, they didn’t hesitate to continue in the field. The one co-researcher, who left her job
due to secondary trauma, ultimately returned to the same agency to continue her work there.

All of the co-researchers used self-care as one form of managing the effects of secondary trauma. Importantly, however, none of them stated that supervision was used to help process and address their trauma. This is a crucial part of addressing this phenomenon as supervision seems to only focus on the individual that is being served by the social worker and not on the social worker’s feelings and reactions about the work he is providing.

An important factor to consider in regard to secondary trauma is the role of agency administration. As previous studies have reported, “administrators are removed from the social worker’s day-to-day experiences and may not realize the impact of the work stress,” therefore, policy should be introduced in the human service field to encourage social workers to access therapeutic resources through their employer. (Badger, Royse, & Craig, 2008 p.8) This could be a wise decision by the employer as it would help ensure that the social worker is able to be effective in delivering necessary services to the identified population served. Also, peer supervision and consultation should be encouraged and explored between colleagues to provide moral support to one another.

There were limitations to this research. First, by interviewing only people with a master’s degree in social work, questions about the ways that other disciplines manage secondary trauma could not be addressed. There are multiple professionals with other educational backgrounds who perform therapeutic services to individuals besides the social worker. Second, the small sample size of co-researchers meant that the themes could not be generalized in the way that a larger sample would have permitted.

It was my hope in conducting this research that my knowledge about secondary trauma might also help others, especially those who were just graduating from an M.S.W. program and entering the field of social work with newly acquired knowledge. All social workers would benefit from knowing about secondary trauma and the ways to process its impact in order to be effective and consistent with their work. As social workers embark on new careers, it is important to advocate not only for the clients, but also for themselves.
References


SPRINGFIELD COLLEGE

Mailing Address:
263 Alden Street
Springfield, MA 01109-3797

Location:
School of Social Work
Brennan Center
45 Island Pond Road
Springfield, MA

www.springfieldcollege.edu/ssw