RE-EXAMINING THE COST OF CARING: A MIXED METHODS EXPLORATION OF SECONDARY TRAUMATIC STRESS IN MARRIAGE AND FAMILY THERAPISTS

by

STEPHANIE E. ARMES

(Under the Direction of Desiree M. Seponski)

ABSTRACT

Secondary traumatic stress (STS) is potentially harmful for clinicians working with trauma populations, yet literature is inconclusive about *how* it may harm clinicians. This study explored the effects of STS on Marriage and Family Therapists (MFTs). Using mixed methods research with a critical realist stance, this study employed a sequential explanatory design with quantitative data collected in the first phase and qualitative data in the second phase. This study explored facets of therapists' STS experiences and is detailed in two manuscripts. First, the measurement of STS was explored using the Secondary Traumatic Stress Scale (STSS) in a national sample of MFTs (N = 197). Based on STSS responses, 30.5% of the sample endorsed clinical levels of PTSD. Validity of the STSS for use with MFTs was further examined through dyadic interviews with a subset of MFTs from the larger quantitative survey and their partners (n = 10). Results indicate that the STSS should be conceptualized as a unidimensional construct when surveying MFTs. Not all MFTs endorsed clinical levels of PTSD. However, qualitative interviews highlighted that most therapists experienced symptoms of STS, and

even their partners recognized those symptoms they were experiencing. The first manuscript extends mixed methods research by mixing quantitative and qualitative data together and contextualizing how the STSS detects secondary trauma. In the second study, exposure to trauma via trauma clients was examined alongside therapists' STS, perceptions of social support, compassion satisfaction, organizational factors, and their reports of intention to leave their work. Secondary trauma partially mediated the association between trauma exposure and therapists' intention to leave. Organizational factors and compassion satisfaction were negatively and significantly associated with therapists' intention to leave. Implications for training programs and agencies are discussed. Both studies highlight the nuanced experience of STS in a national sample of MFTs. As this study is the first focusing on STS in MFTs, the findings can be used to aid training programs and agencies, and disseminated to MFTs within private practice. Implications for prevention can be applied to agencies seeing an influx of trauma clients and organizations with high turnover rates.

INDEX WORDS: Secondary trauma, mixed methods research, Marriage and Family Therapists

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DEDICATION

To those who have experienced trauma, violence, and injustice: we must do better.

As a society, we must break the cycle.

For the therapists working with trauma: this work is dedicated to your tenacity, creativity, courage, and strength.

ACKNOWLEDGEMENTS

As a Marriage and Family Therapist and systemic thinker, I could write an entire dissertation of gratitude acknowledging the many people who have supported me along this journey. As the reader came to this dissertation expecting to learn about secondary trauma, I must digress and attempt to convey my thanks in a few short pages.

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CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

This study adds to gaps in the literature regarding the prevalence and severity of Secondary Traumatic Stress (STS) in Marriage and Family Therapists (MFTs). MFTs working with clients experiencing trauma may experience symptoms of STS as they are exposed to trauma through listening to and empathizing with clients' traumatic experiences (Figley, 1995; Figley, 1999). STS is described as having a quick onset and by symptoms mirroring those of Post Traumatic Stress Disorder (PTSD). The key difference between PTSD and STS is the *type* of exposure; rather than being primarily exposed to trauma, therapists experiencing STS are exposed through listening to their clients' narratives of trauma and victimization (Figley, 1995). STS can also have a sudden onset, leaving therapists vulnerable to the effects of the trauma work they do. Therapists experiencing STS may feel powerless to enact change in the lives of their clients (Figley & Kleber, 1995). STS has been studied across many helping professions, such as in nurses, social workers, teachers, and first responders. However, fewer studies have empirically highlighted the prevalence and risks of STS for MFTs. This study extends present literature by further exploring the construct of STS in MFTs using mixed methods. Below, an introduction of risk and protective factors identified in the STS literature are presented, with an explanation of why it is important to continue further elucidation of the construct of STS for MFTs.

Statement of the problem

Much literature has explored the impact of secondary trauma on mental health clinicians. Several factors increase the risk of developing secondary trauma, such as type of clinical work (Kassam-Adams, 1999), exposure to trauma in childhood and adulthood (Kassam-Adams, 1999), percentage of clients with Post Traumatic Stress Disorder (PTSD) on a clinicians' caseload (Craig & Sprang, 2010), and hours spent weekly with trauma clients (Brady et al., 1999). Preventative factors which buffer the development of secondary trauma have been explored, such as empathy (Brockhouse, Msetfi, Cohen, & Joseph, 2011), compassion satisfaction, or satisfaction with one's work (Stamm, 2009), and evidence-based trauma training (Craig & Sprang, 2010). Despite advances in the study of secondary trauma, findings presented across the literature leave many questions regarding the construct and measurement of secondary trauma and its impact on clinicians' professional and personal lives. Specifically, the lack of uniform measurement of STS across studies has yielded a wide range of prevalence in helping professionals. When prevalence has been identified using representative sampling, it is still unclear how STS impacts MFTs in their personal and professional lives.

Significance of the Study

It is important to continue further exploration of secondary trauma for three reasons. First, due to increased trauma, violence, war, and poverty, there is an increased need for mental health services addressing trauma. It is estimated that across 24 countries internationally, the prevalence of experiencing or witnessing *one* traumatic event is 70%, with just over 30% of the populations in these countries experiencing *four* or more traumas (Benjet et al., 2016). As such, mental health professionals are likely to see an

increase in the number of trauma cases on their caseloads. With this increased exposure to trauma clients and situations, mental health professionals need to prepare for the potential of developing secondary trauma. Secondly, there is a need to explore how therapists can be better supported within agencies, organizations, and training programs that see an increase in trauma populations. Often, community mental health agencies see a high level of trauma (Cusack, Frueh, & Brady, 2004) leading to a drain on an agency's training and financial resources.

Finally, the measurement of secondary trauma is diverse across the literature. While the *prevalence* of secondary trauma seems to be high, some studies have used measures with weak psychometric properties (Hemsworth, Baregheh, Aoun, & Kazanjian, 2018), and others have yielded inconclusive results about whether a high prevalence of secondary trauma leads to clinically significant impairment or distress in clinicians (Elwood, Mott, Lohr, & Galovski, 2011). This variance in measurement, severity, and outcomes has presented inconclusive findings about the potential harm of secondary trauma on clinicians, the impact of trauma work on their close intimate relationships, and their ability to practice therapy in an ethical manner (Hensel, Ruiz, Finney, & Dewa, 2015). This study explored secondary trauma in a national sample of MFTs using the following research question: "How do MFTs experience STS, and what are personal, relational, and organizational factors that may aid in preventing their development of STS?" The use of mixed methods guided this study in further contextualizing therapist experiences of secondary trauma.

Literature Review

STS, or Compassion Fatigue (CF), has been described across many professions as a, "cost of caring," (Figley, 1995; 1999). STS has been identified in nurses (Beck& Gable, 2012), emergency responders (Roden-Foreman et al., 2017), social workers (Bride, 2007), child welfare workers (Dagan, Ben-Poat, &Itzhaky, 2016; Sprang, Craig, & Clark, 2011), substance abuse counselors (Bride & Kintzle, 2011), attorneys (Levin, Besser, Albert, & Smith, 2012), therapists (Chrestman, 1999; Craig & Sprang, 2010; Killian, 2008; Mendenhall & Berge, 2010; Negash & Sahin, 2011), and even social science researchers (Whitt-Woolsey & Sprang, 2017). As this study focused on MFTs, the following literature review provides a brief overview primarily focusing on experiences of therapists. Across this literature, there is a convergence and divergence of documented risk and protective factors, buffering effects, and measurement of the construct. This may, in part, be due to the relative novelty of STS in the field of traumatology; Figley (1999) noted that the study of STS was in a pre-paradigmatic state with no uniform definition or agreement on the construct across the literature. As such, this study seeks to re-examine the "cost of caring" in a broader, more coherent picture of how STS may impact therapists, their personal and professional lives, and their couple and social relationships.

As the demand for mental health services increases, therapists are likely to see an increase in clients who have experienced trauma. Estimates of trauma nationally range from 5% (for men; Solomon & Davidson, 1997) to 10-12% (for women; Solomon & Davidson, 1997). However, 91% of one sample of mental health consumers reported being exposed to at least one traumatic event throughout the course of mental health

treatment at a community mental health center (Cusack et al., 2004). It is likely that this increase in trauma may lead to an increase in therapists' experiences of STS, which could lead to higher turnover rates and potential for clinician distress. For example, substance abuse counselors' higher scores in STS were associated with lower job commitment and satisfaction (Bride & Kintzle, 2011). Given the increase in potential for an influx of trauma cases and development of STS, further research is needed to understand how to decrease turnover and aid clinicians experiencing STS.

One challenge to the study of STS is the diversity of terminology used to describe similar constructs, which may reflect the "pre-paradigmatic" state of the field referenced earlier (Figley, 1995). Related constructs of *Compassion Fatigue (CF;* Figley, 1995) and *Vicarious Traumatization (VT;* McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) were developed around the same time and conflated with *Burnout (BO*; Maslach & Jackson, 1981) while each are distinctive, yet interrelated, constructs. CF was originally conceptualized as a combination of STS and BO, with BO described as emotional exhaustion, depersonalization, and lacking a sense of achievement due to tiring work over time (Figley, 1995; 1999; Maslach & Jackson, 1981).

VT was theorized as a more extreme part of STS, in which clinicians working with trauma change their cognitive views of the world due to interacting with their clients' trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). VT was also conceptualized within the theoretical model of Constructivist Self-Development Theory (CSDT; Saakvitne, Tennen, & Affleck, 1998), which integrates constructivism and psychoanalytic theory while considering how social context affects individual personality, trauma experiences, and development over time. CSDT provided a useful

conceptualization of how VT occurs and is maintained in therapists working with trauma but did not encompass STS or CF into an overarching framework. Across the literature, STS, CF, and VT are sometimes referred to simultaneously. This study will focus on STS due to its presentation of symptoms mirroring PTSD for clinicians.

Prevalence

The reported prevalence of STS has varied; Bride (2007) identified 15.2% of a national sample of social workers as meeting criteria for PTSD. Caringi et al. (2017) estimated the prevalence of PTSD among licensed clinical social workers in Montana at around 35.7%, and a survey of child protective service workers yielded a similar prevalence of 37% (Cornille & Meyers, 1999). While the prevalence of STS has been estimated in many fields of the helping professions, there is no known study focused on investigating STS in MFTs, and the prevalence of STS in MFTs is unknown. As trained family systems thinkers, MFTs have an awareness of joining with the family and being part of the family's system (if only temporarily), which should promote a consciousness of needing to care for oneself during the course of therapy with trauma clients (Mendenhall & Berge, 2010). MFTs may be well-equipped to promote resilience in the face of STS for other mental health disciplines.

Risk Factors

Initial studies of STS focused on client factors leading to the development of STS. In a sample of trauma therapists, younger therapists and those with a higher caseload of clients with PTSD were more likely to have CF (Craig & Sprang, 2010). Therapists who reported exposure to trauma through their clients also reported PTSD symptoms of intrusion, avoidance, dissociation, and sleep disruptions (Chrestman, 1999). Therapists

with these symptoms also attempted to isolate their disturbing thoughts and symptoms away from family and fields, potentially isolating them from needed social support (Chrestman, 1999). Participating in the healing of others may impact the overall neurobiology of therapists. Although not empirically tested, Rasmussen & Bliss (2014) posited that therapists' mirror neurons may be the mechanism of STS transmission, placing therapists with excellent empathic abilities at further risk.

Protective Factors

While risk factors have been heavily reported, protective factors have also been identified. Within therapy practice, the use of evidence-based practice and having specific training in trauma were preventative factors for a sample of trauma therapists (Craig & Sprang, 2010). Satisfaction with one's work, or *Compassion Satisfaction (CS)* has been identified as a protective factor (Stamm, 2009). Job satisfaction in substance abuse counselors mediated the association between their STS and commitment to their jobs (Bride & Kintzle, 2011). An emphasis has been placed on the importance of both personal and professional self-care practices in helping prevent STS in social workers (Lee & Miller, 2013). Miller et al (2017) found that social workers with higher ratings of self-care also rated their physical health as higher.

STS and Couple Relationships

Previous research has investigated negative impacts of trauma symptoms on couple relationships, identifying trauma symptoms in one partner as a risk factor for decreased relationship quality and development of secondary trauma symptoms in the other partner (Goff, Crow, Reisbig, & Hamilton, 2007). A meta-analysis of studies investigating PTSD in military couples revealed that spouses of military service members

with PTSD were likely to also experience PTSD symptoms and have lower relationship quality (Lambert, Engh, Hasbun, & Holzer, 2012). Research investigating the impact of trauma on spouses and partners has also been extended to the study of secondary trauma in therapists and helping professionals, although not fully explored in the literature.

Social support is a protective factor preventing the development of STS (Killian, 2008), of which a committed couple relationship may provide. Yet, experiences of STS at work may in turn negatively impact therapists in their couple relationships. Finzi-Dottan & Berckovitch Kromosh (2017) found that STS affected marital quality of clinical social workers indirectly through stress spillover from the stressful nature of their work. Therapists have also reported that their trauma work has negatively affected their sexual desire in their relationships with their partners (Killian, 2008). Therapists have recalled clients' trauma while with their partners instead of being fully present (Killian, 2008). Partners of emergency medical service personnel identified *both* positive and negative effects of traumatic work on spouses and partners, indicating couple relationships may provide a protective factor in helping emergency service personnel cope with their stressful work (Wheater and Erasmus, 2017). As findings of the effects of STS on partners and the couple relationship have been mixed, it is important to continue investigating specifically how partners are uniquely affected by secondary trauma.

STS Over Time

Recently, the impact of helping has been investigated longitudinally. In a study of mental health professionals in the United States and Poland, Shoji et al. (2015) investigated whether STS would predict burnout at a second timepoint, or if burnout would predict STS. Using a cross-lagged model, they found that burnout predicted STS

six months later, but STS at the first timepoint did not predict later burnout. Shoji et al. (2015) suggested burnout as a potential mechanism for later development of STS. A longitudinal study of public defense attorneys found exposure to client trauma was associated with depression, PTSD, and functional impairment 10 months later (Levin et al., 2012). Exposure to client trauma in these attorneys was directly related to fewer hours reported on the job 10 months later, which may be an indicator of decreased professional effectiveness following experiences with client trauma (Levin et al, 2012).

Burnout mediated the pathway between work stress and desire to exit employment over time in a survey of work-related stress in social workers (Travis, Lizano, & Mor Barak, 2016). Qualitative interviews of mental health professionals working with trauma and torture survivors revealed that their STS symptoms were relatively stable over one year (Barrington & Shakespeare-Finch, 2014). However, alongside themes of vicarious trauma, therapists reported vicarious post-traumatic growth and meaning from their work (Barrington & Shakespeare-Finch, 2014). These results suggest that there are positive and negative affects of trauma work, and that future studies should consider both aspects when investigating effects of STS (Barrington & Shakespeare-Finch, 2014).

Critiques of STS

Initial theories of CF/STS were anecdotal in nature and based on clinical observations (Figley, 1995). Empirical data has followed these observations; however, Elwood et al. (2011) noted that although there seems to be a high *prevalence* rate of STS, the literature has shown less support for the presence of a *clinically significant* level of STS across the helping professions. What is the outcome of the "cost of caring," and how

can agencies, training programs, and clinicians identify these outcomes in order to prevent them? This question of outcome needs additional consideration in the literature.

Mixed methods and STS

Few studies of STS have incorporated the use of mixed methods research. Killian's (2008) study of therapists used a multimethod approach, reporting on qualitative and quantitative findings in the same paper but failing to mix these data together to form a more cohesive picture of STS. Beck and Gable (2012) used mixed methods to further explain self-reports of STS in labor and delivery nurses. Collecting both qualitative and quantitative data concurrently, the mixing of methods was used for the specific purpose of *complementarity* or measuring different facets of the same construct (Beck & Gable, 2012). Lim, Stock, Oo, and Jutte (2013) used mixed methods to explore trauma in mental health professionals in Myanmar. The divergent evidence of low STS prevalence from quantitative measures and reports of high exposure to stressors in qualitative interviews led Lim et al. (2013) to speculate about the ability of standardized measures to detect STS in their study. Caringi et al. (2017) conducted a study of licensed clinical social workers using quantitative surveys and used qualitative interviews with a subset of those who had taken the surveys, but the data were not integrated in their final analysis. Given that the present literature does not agree on the definition, measurement, clinical meaning, and significance of STS, investigation of STS mixing both quantitative and qualitative methods together should be considered. The use and mixing of quantitative and qualitative research methods is one way this study uniquely contributes to present literature examining STS.

Conceptual Framework

This study used an existing theory of trauma development and maintenance to lend conceptual clarity to how STS affects clinicians. The conceptual framework of this study uniquely extended conceptualizations of STS by using an empirically driven ecological trauma theory, the socio-interpersonal model of PTSD (Maercker & Horn, 2013; Maercker & Hecker, 2016). A brief review of the initial models of STS are reviewed for clarity. Then, the socio-interpersonal model of PTSD is presented.

Compassion Fatigue Resilience

Two perspectives of STS have informed empirical research of the construct. The CF model (Figley, 1995) initially conceptualized STS as a combination of STS and burnout. A second conceptualization considers STS separately from symptoms of burnout (Bride et al., 2004). This conceptualization approaches the measurement of STS by measuring PTSD symptoms of hyperarousal, avoidance, and intrusion symptoms of clinicians exposed to trauma. These three symptoms are listed in the *DSM-IV* (American Psychiatric Association, 2000) as symptoms of PTSD. This conceptualizes STS symptomology as being identical to PTSD, with the difference being secondary exposure to trauma through work with trauma clients. Figley's initial (1995) model of compassion fatigue was later revised (Ludick & Figley, 2017) to include *Compassion Fatigue Resilience* (CFR) as an outcome to be tested in future models. However, while this updated model of CFR gave suggestions for improving how STS is conceptualized, to date, no empirical studies have addressed measuring the model empirically. The model of CFR was incorporated into the overarching conceptual framework of this study by exploring potential negative outcomes of therapists experiencing STS.

Socio-Interpersonal Perspective of PTSD

Only recently did models of CF/STS include an *ecological* conceptualization of how therapist STS may influence couple and family relationships and how therapists' agencies buffer against the effects of STS. The socio-interpersonal perspective of PTSD (Maercker & Horn, 2013; Maercker & Hecker, 2016) was used to consider multiple levels of individual clinicians, their close relationships, and their organizations that may be affected by STS. The socio-interpersonal perspective of PTSD views the maintenance of trauma through theorizing how trauma is maintained across individual, relational, and community levels.

As individuals disclose personal trauma experience or for therapists, their experiences of trauma in their work, to the people they are close to, their close relationships can provide a supportive environment. A close relationship could also be a place where the trauma is misunderstood, or the person experiencing that trauma is blamed for the trauma experience. The culture and society in which a person lives can acknowledge trauma and injustice or continue a culture of blame for the trauma. These three pieces of PTSD maintenance (individual, close relationship, culture/society) have not been explicitly considered in the maintenance of STS. Adding an ecological picture of how STS occurs is important to further our understanding of this construct.

Philosophical Framework

Paradigm/mental model: Dialectic Stance

This study uses an overarching mental model, which Green (2007) defines as a "…set of assumptions, understandings, predispositions, and values and beliefs with which all social inquirers approach their work," (p.12). The mental model encompasses a

paradigmatic stance into research inquiry and creates more opportunity for dialogue across paradigms by including values, beliefs, and assumptions of the inquirer. This study used a *dialectic stance* (Greene, 2007; Shannon-Baker, 2015), valuing the use of multiple paradigms within the same study to encourage a dialogue across methods. As the quantitative and qualitative portions of this study employed differing epistemologies, the use of a dialectic stance allowed both methods to be equally valued. This stance also values difference, such that if the quantitative and qualitative results did not converge, the multiple perspectives from both research methods and paradigms would be valued. Further, a dialectic stance encourages reflexivity of the researcher, allowing the researcher to attend to whether quantitative or qualitative methods are being prioritized over the other (Shannon-Baker, 2015).

Epistemology: Critical Realism

An additional epistemology of critical realism was used to focus on how quantitative and qualitative methods supported each other despite the diverging focus of both methods (Shannon-Baker, 2015). Critical realism honors multiple perspectives of different paradigms by employing ontological realism, or the knowledge that, "reality exists and is independent from existing theories," (Maxwell & Mittapalli, 2010). Through a constructivist epistemology, critical realism considers that there is one reality, but that multiple perspectives, theories, and stances, may view that one reality differently. Thus, "Critical realism treats both individuals' perspectives and their situations as real phenomena that causally interact with one another. In this, realism supports the emphasis that critical theory places on the influence that social and economic conditions have on beliefs and ideologies," (Maxwell & Mittapalli, 2010; pp.157). In this study, critical

realism allowed inclusion of multiple perspectives (i.e., the socio-interpersonal perspective of PTSD, a dialectic stance, qualitative and quantitative research methodologies). Critical realism aided in viewing the causal, process-oriented (Maxwell & Mittapalli, 2010) relationships that were in place when therapists develop STS. Figure 1.1 depicts how the study ontology, mental model, epistemologies, and theory work together to form the overarching research methodology.

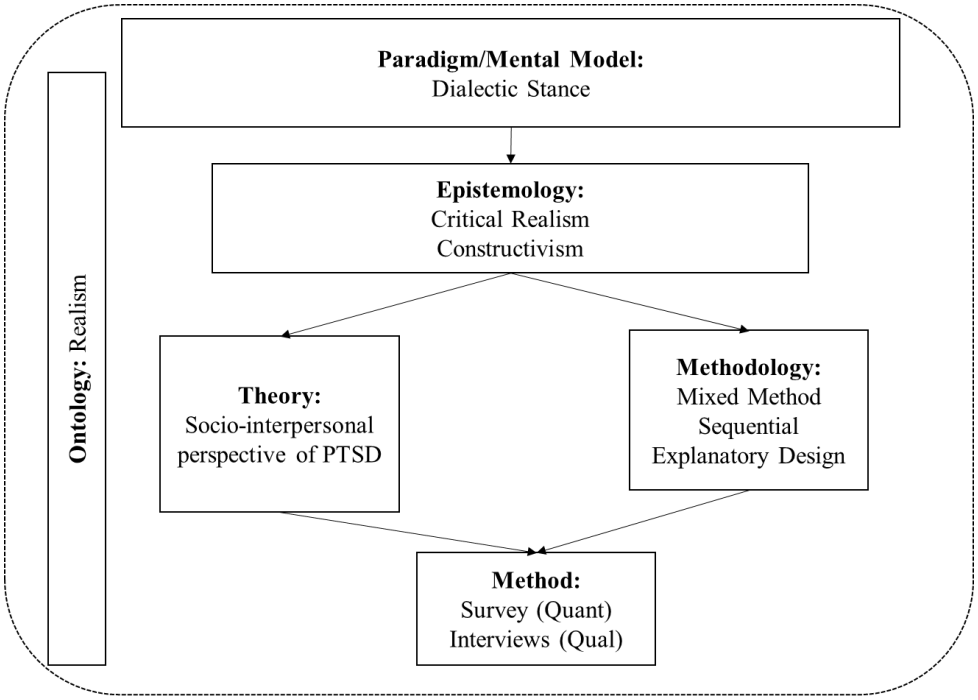


Figure 1.1. *Philosophical and Conceptual Frameworks*

Statement of Subjectivity

I consider myself an insider and outsider in this research. Before becoming a graduate student, I worked on a strategic outreach team to chronically homeless populations for five years. During that time, I experienced exposure to trauma secondarily through the traumatic experiences relayed to me by my clients. I also experienced increased stressors in attempting to help my clients navigate multiple social

systems to obtain housing. I worked with many organizations and mental health agencies and saw some adopt policies that helped their employees deal with the stressors of working in such an environment, while other agencies were known for their high clinician stress and turnover. A few years into my tenure at my agency, I got married and experienced increased support during difficult periods of helping others. However, after days when I worked with more difficult client situations, I also experienced decreased energy to put into my new marriage, which was one negative effect of my helping work. In this sense, I am an insider as I have experienced the rigorous demands of working as a helping professional in a community agency.

I am also an outsider, as I have been privileged in being able to return to graduate school. As an intern therapist during my graduate school education, most of my clinical work has been in university clinics, which have not had the same level of intensity as working in a community mental health center. I have not yet had to navigate billing medical insurance or practice without being under the license of a supervisor. While I have previously experienced extreme stressors and trauma related to difficult helping work, my current role as an intern therapist and graduate student has given me some insulation from a more intense agency position. In this sense, I am both an insider and outsider. A guiding and deep personal belief of mine is that all people, especially those who seek therapy during a potentially stressful or traumatic time in their life, deserve respect no matter their race, religion, sexual orientation, or ability. I believe that further understanding of how STS impacts clinicians will help therapists to provide more respectful, ethical therapy practice to those who have experienced trauma.

Research Questions

This study explored the overarching research question, “How do MFTs experience STS, and what are personal, relational, and organizational factors that may aid in preventing their development of STS?” As this study used mixed methods, two research sub-questions also guided this investigation. The first research sub-question was, “What is the prevalence of STS in MFTs, and how do they and their partners describe the experience of STS?” The second sub-question was: “What resources impact negative outcomes of STS at individual, couple, and organizational levels?”

A figure of the research questions is pictured below, using the socio-interpersonal perspective of PTSD (Maercker & Horn, 2013) to illustrate how individual, relational, and culture (agency setting) are incorporated into the research questions and study design. The inclusion of “Quan” and “Qual” also denote which method (quantitative and/or qualitative) was used in the exploration of each level. When one method had priority over the other, that method is noted in all caps.

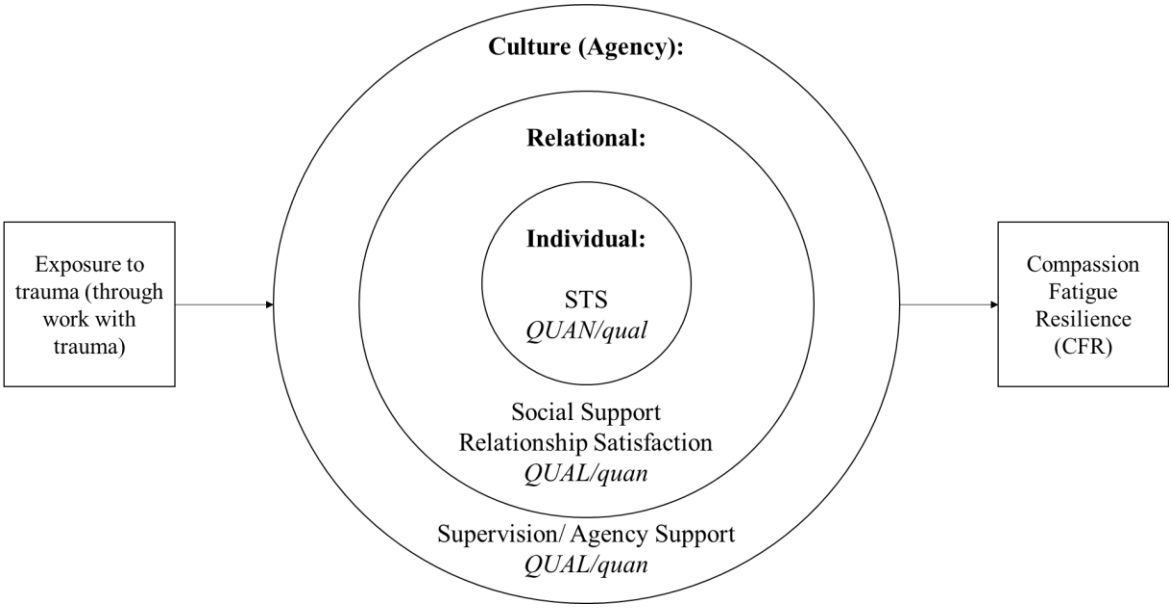


Figure 1.2. *Research Questions and method priority, using the socio-interpersonal model of PTSD as a guiding conceptual framework*

Note: QUAL = qualitative; QUAN = quantitative

Rationale for Mixed Methods Research

Suitability of Mixed Methods Research

Mixed methods research considers different types of knowledge gathered quantitatively and qualitatively and accomplishes this by using the mental models described above. Greene (2007) notes that the use of mental models (rather than paradigms) allows researchers to "set a large table" for multiple mental models and methods to merge together, producing a richer dialogue (p.14). This richness is produced through examining convergence and divergence of the data within the dialectical stance (some stances do not support the divergence of findings in the data; Greene, 2007). Not

all research questions are appropriate for mixed methods research and many questions can be answered by using either quantitative or qualitative methods. It is important to highlight the suitability of mixed methods design for this study.

Mixed methods research designs are particularly applicable for trauma research (Creswell & Zhang, 2009). Quantitative measures are often used to diagnose and measure the prevalence of a traumatic experience, but therapists also employ qualitative interviews to further highlight their clients' experiences of trauma (Creswell & Zhang, 2009). Studies using mixed methods should be driven by research purposes and questions (Onwuegbuzie & Leech, 2006). As STS has been studied throughout the field, it has been explored quantitatively and qualitatively, with little overlap between the two methods (Killian's 2008 study is one exception but did not mix the methods together). This study further conceptualized STS through a more explicit mixing and combination of methods than have been previously employed. The research questions of this study were also explicit in their use of specific methods for research sub-questions as is appropriate for a mixed methods design (Onwuegbuzie & Leech, 2006). The specific mixed methods purposes for conducting this study are described next.

Purpose of Mixed Methods Research

Employing mixed methods allowed this study to deepen understanding of STS, how it is measured, how MFTs and their partners recognize their symptoms of STS, and how organizations where MFTs practice are equipped to help MFTs with STS concerns. Greene (2007) noted that, "Methodology is ever the servant of purpose, never the master," (p.97). There were two specific mixed methods purposes in conducting this study. First, the mixed methods purpose of *complementarity* supports measuring different

facets of the same construct to more fully understand the phenomena (Greene, 2007). The quantitative methods used only told part of how participants in this study experienced STS. The qualitative methods in this study complemented quantitative methods by identifying how therapists' experiences of STS impacted their daily lives and their partners, as well as their own efficacy to be able to deal with symptoms of STS.

The second mixed methods purpose used in this study is that of *development*, or one research method being used first to develop the second research method (Greene, 2007). In this study, results from the quantitative surveys were used to *develop* questions for the qualitative semi-structured interviews and recruit participants for those interviews. This study is suitable to mixed methods research based on the overarching goals and research questions (Onwuegbuzie & Leech, 2006) as well as the purposes for mixed methods research (Greene, 2007). Having established the suitability and purposes, I will next describe the specific research design, with a description of sampling strategies, proposed measures, and analytic plan.

Mixed Methods Research Design

This study used a sequential explanatory mixed methods design (Creswell, 2015; Ivankova, Creswell, & Stick, 2006). Within this design, quantitative data was collected in a first phase and analyzed, with qualitative data collected in a later, second phase aiding in explanation of the quantitative findings (Creswell, 2015; Greene, 2007). Creswell's (2015) initial conceptualization of this research design was that the results of the quantitative portion of the design drive the collection of qualitative data, which further explain quantitative results. Using a dialectic stance with overarching epistemologies of constructivism and critical realism furthered this research design by aiding integration of

the data from quantitative and qualitative results in a third and final phase (Greene, 2007). A sequential explanatory design was used for the mixed methods research purposes of development and complementarity (Greene, 2007), as discussed above. The initial quantitative methods used in the first phase of this study drove the *development* of the qualitative questions asked in the semi-structured interviews. The use of quantitative and qualitative methods to measure different facets of STS experiences is also an example of *complementarity* (Greene, 2007). Figure 1.3 depicts each research phase, detailing the research procedure and product (adapted from Ivankova et al., 2006).

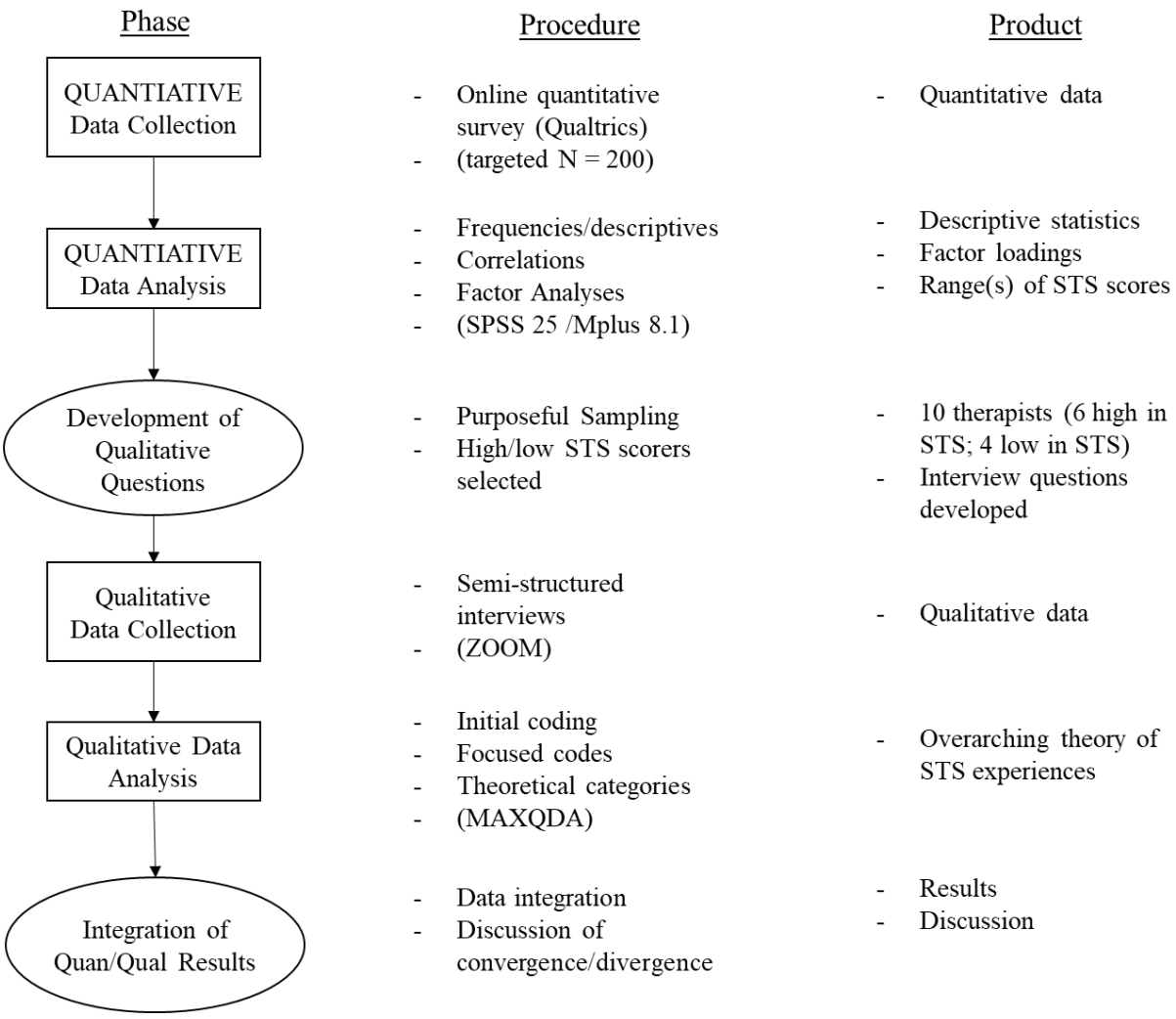


Figure 1.3. *Overarching research design and phases* (Adapted from Ivankova et al., 2006)

Sampling strategies

Quantitative phase. As is appropriate for a sequential research design, the present study was conducted in two phases. During Phase 1, a snowball sample of 197 MFTs was recruited for the study. To be eligible, participants needed to be at least age 21, have active MFT licensure in their state, and be actively practicing therapy with

individuals, couples, and/or families. Participants at all phases of licensure were eligible; for example, intern and associate licensed therapists who are actively practicing therapy could take part in the study, as could fully licensed MFTs.

Participants were recruited for the study in a few ways. Using a tailored design method (Dillman, Smyth, & Christian, 2014), an introductory email (Appendix B) was sent to directors of COAMFTE- and non-COAMFTE-accredited MFT programs with information about the study. The directors were asked to forward the introductory email to MFT graduates from the last 1-30 years (or as long as the program had been in existence). The email introduced the survey and informed recipients that the survey link would be made available in one weeks' time. One week after the introductory email, an email with the survey link (Appendix C) was sent to the MFT program directors. Finally, a message was sent two weeks after the email with the survey link reminding potential participants that the survey link was open and asking them to complete the survey (Appendix E). Participants were directed to the consent form as the first window of the online survey (Appendix D).

Next, an email invitation was sent to presidents of all AAMFT regional affiliates, with a request that the survey link be forwarded to members of that regional division. The same invitation was posted on discussion boards for family therapy through the National Council on Family Relations (NCFR), the American Family Therapy Academy (AFTA), and the AAMFT research discussion board.

Surveys took approximately 20 minutes to complete using Qualtrics, and participants were entered into a drawing for a $25 gift card (10 gift cards were distributed) as an incentive for their participation. At the end of each survey, participants

completing the online survey in its entirety were recruited for Phase 2 of the study by indicating their interest in completing an online interview with their partner.

Qualitative phase. Phase 2 of the study included qualitative interviews with a purposive sample (n = 10; Teddlie & Yu, 2007) of those who completed the online survey and indicated interest in completing an online interview with their partner. Participants were selected for the interviews based on their STS scores from the STSS completed in Phase 1 and on their indication that they would be willing to be contacted for the later phase of the study. Four participants who scored as having clinical ranges of PTSD and their partners, and six participants who scored low in PTSD and their partners were invited to complete the interview. Participants were contacted over email (Appendix F) asking for the best contact information for them and their partner. After receiving their contact information and confirmation they were still interested in completing the interviews, a consent form was emailed to them and their partner, with a time and date listed for their interview. Both participants were emailed a consent form separately describing the purpose of the interview, with an informed consent document for the interview attached in the email.

The purpose of the first few minutes of the interview was to discuss informed consent with the partners. Both partners were interviewed together and responded to questions about how trauma work of one partner impacted their couple relationship. The semi-structured interviews were conducted via ZOOM, a confidential online video conferencing service that is HIPAA compliant. Interviews were recorded using Zoom and kept locked in the researchers' office. Interviews lasted 60-90 minutes, and each partner

received a $20 gift card for their time. Interview questions for the semi-structured interview are listed in Appendix G.

Ethical considerations. Scholars have raised concerns about the ethics of conducting trauma research with those who have previous trauma experiences. While some participants with PTSD diagnoses have shown distress after completing trauma research surveys (Brown et al., 2014), this distress has been reported in only a small subset of overall samples within trauma research. In a systematic review of 46 studies, Jorm, Kelly, and Morgan (2007) found that across studies, participants in studies explicitly discussing trauma did not report negative effects over time. While some negative effects are reported by a small subset of sample participants, people often report positive perceptions of their participation in the trauma research (Jaffe, DiLillo, Haikalis, & Dykstra, 2015). It was expected that some participants in this study may be experiencing heightened symptoms of STS and may recall working with a challenging client situation as they respond to the survey questions. Potential discomfort was addressed by informing participants at the beginning of the interviews that they could skip over questions reminding them of previous clients or challenging client stories. During the online survey, participants could skip any questions they did not wish to answer that could be triggering of previous trauma experiences. Questions directly related to secondary trauma were asked first, with the final questions of the survey addressing agency experience and turnover.

Quantitative Measures

A brief description of each of the measures used for the first phase of the survey is listed below. Measures used in the survey are included in Appendix A.

Trauma exposure questionnaire. Trauma exposure from professional experiences was measured with items related to the type and amount of trauma work that MFTs are engaged in. Questions include, *What percentage of your caseload is seeing clients who have a diagnosis of PTSD?* and *How many hours per week do you spend working with populations experiencing trauma?* Two categorical (1 = no, 2 = yes) questions asked whether participants experienced trauma in childhood and as adults.

Secondary Traumatic Stress Scale (STSS). The STSS (Bride et al., 2004) is an instrument measuring intrusion, avoidance, and arousal symptoms resulting from indirect exposure to trauma and following criteria of 17 PTSD symptom criteria as is outlined in the *Diagnostic and Statistical Manual IV*. The instrument has 17 items and is scaled on a 5-Point Likert scale (1 = *Never*, 5 = *Very Often*). Each symptom subscale of STSS can be used independently, and scores on all items can also be summed for a total STSS score. Higher scores reflect higher levels of STSS; the STSS has demonstrated excellent internal consistency ($\alpha = .93$ for total scale score; Bride et al., 2004) and convergent and discriminant validity (Bride et al., 2004). Respondents rate each of the 17 items based on their experiences in the last 7 days. Sample items include, for example, "I wanted to avoid working with some clients."

Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) is a scale measuring perceptions of social support in three domains: family, friends, and significant other, with items rated on a 7-point Likert scale (1 = *very strongly disagree*, 7= *very strongly agree*). The MSPSS has demonstrated adequate internal consistency for the friends ($\alpha = .85$), family ($\alpha = .87$),

significant other (α = .91) and total scale (α = .88) scale scores (Zimet et al., 1988) and has demonstrated good construct validity.

Secondary Traumatic Stress-Informed Organizational Assessment (STSI-OA). The STSI-OA (Sprang et al., 2016) is a 40-item instrument measuring how equipped mental health organizations are in aiding employees experiencing STS. Responses are scaled on a 5-point Likert scale (1= *not at all*, 5 = *completely*). Scores range from 0-200, and higher scores reflect higher competency of organization to address STS in its employees. Findings from a study indicated good test-retest reliability, criterion validity, and good internal consistency (α = .98; Sprang et al., 2016). An example item includes: "The organization assesses the level of STS in the workplace." Only the first seven questions, which ask about the organization or agency's resilience-building activities to prevent STS, were used.

Intention to Leave. Four questions regarding therapists' intention to leave the field were used, adapted from Middleton and Potter (2015). The items measure whether respondents are thinking about leaving their work in the future. For example, one item states, "I have often thought about leaving this organization." Good internal reliability has been demonstrated for previous samples (α = .87; Middleton & Potter, 2015).

Qualitative Interviews

One purpose of the sequential explanatory design was development of the second, qualitative, research protocol (Creswell, 2015; Greene, 2007; Ivankova et al., 2006). The development of the interview protocol was guided by responses on the quantitative surveys. During analysis of the quantitative data, specific attention to scores on the measures of STS and protective factors of social support, relationship satisfaction,

organizational support, and therapist STS efficacy were given. The purposive sample recruited those who scored high and low in STS. Then, questions were developed based on the protective factors already measured.

Data Analytic Plan

Quantitative Analysis

Data analysis occurred in different phases, as is appropriate for an explanatory sequential mixed methods design. Phase 1 of the analysis was conducted first, before analysis of qualitative interview results. Using quantitative results from the online survey, Classical test theory within the test-score measurement tradition (Engelhard, 2013) was used to compare a standardized measure of STS from the research literature. Initial analyses was conducted using SPSS 25 (SPSS, 2018).

Internal consistency and descriptive statistics of the STSS was computed, with inter-item correlations from each of the three scales computed and assessed. Next, an exploratory factor analysis was conducted to identify if the factor structures for the present sample were similar as to previous literature. Then, data was imported into Mplus 8 (Muthén & Muthén, 2010), and a confirmatory factor analysis was conducted for each separate subscale to confirm the factor structures. The variables assessing therapists' exposure to trauma through their work and their reports of distress and impairment were correlated with the two STS instruments to assess their criterion validity. Finally, a path analysis was conducted using Mplus 8, using trauma exposure as an endogenous variable, and measures of STS and reports of intention to leave the field as exogenous variables.

Qualitative Analysis

The qualitative analysis included data from the semi-structured qualitative interviews conducted with MFTs and their partners/spouses. The interviews were transcribed and coded using MaxQDA (MaxQDA, 2017). Coding analysis used the constant comparative method (CCA; Charmaz, 2011; 2014). Using social constructivism as its epistemology, CCA focuses on how the researcher may affect interview outcomes through interacting with the research participant. Data analysis consisted of line-by-line coding using a priori codes from the STSS. Open coding was also used, employing gerunds and collapsing these initial codes into groups through analytic memoing (Charmaz, 2011; 2014). After considering these groups, focused coding was applied to the remaining transcripts.

Data management. All data was kept electronically on a password protected computer. For the quantitative phase of the study, the anonymity of research participants was ensured in the following ways. First, participants provided a unique and confidential identifier at the end of the quantitative survey so that those who were high and low in STS and interested in participating in the qualitative interviews could be located during the later research phase. Participants provided their unique identifier in order to be contacted in the second phase. Participants were re-directed to a second survey where they could enter the drawing for the incentive. For the qualitative phase, transcription of qualitative interviews excluded names and any other unique identifiers. As in the quantitative phase, audio recordings and transcriptions of interviews were kept on the researcher's password protected computer.

Assessing data quality. Identification of data quality is often different for quantitative and qualitative research methods. For example, quantitative methods employ the use of psychometrics when assessing validity and reliability of responses. Qualitative methods use member checking to consider the rigor of the data and to ensure data quality. In mixed methods studies, data quality can be assessed by how the different methods are integrated together. Data quality was assessed by attending to how the data converged together and the richness of therapists' STS descriptions.

Chapter Sequence and Conclusion

The overarching rationale and methods for this dissertation have been described above. The manuscript presented in Chapter 2, titled, *Measuring secondary traumatic stress in a national sample of marriage and family therapists* presents a mixed method paper exploring how MFTs are experiencing STS. The measurement of STS is examined using the STSS, and a priori codes from the STSS were developed for use in the analysis of the qualitative interviews. Then, Chapter 3, titled, *It takes a village: Marriage and family therapists' exposure to trauma, access to support, and intention to leave* presents a quantitative study of MFT's intention to leave due to their experiences of secondary trauma. Finally, in Chapter 4, I conclude with thoughts about how the findings from both manuscripts forward the study of secondary trauma in MFTs.

CHAPTER 2

MEASURING SECONDARY TRAUMATIC STRESS IN A NATIONAL SAMPLE OF MARRIAGE AND FAMILY THERAPISTS[1]

[1]Armes, S.E. To be submitted to *Traumatology*

ABSTRACT

Secondary traumatic stress (STS) has been measured various ways throughout the literature, leading to confusion about the construct and a lack of continuity across studies. The measurement of STS is explored in this sequential explanatory mixed methods study using a national sample of Marriage and Family Therapists (MFTs). A sample of 197 MFTs completed an online survey using the Secondary Traumatic Stress Scale (STSS) to assess their levels of STS. Then, a small sample (n = 10) of therapists and their partners was recruited from the larger survey to complete an interview about how the therapists' trauma work affected the couple relationship. Findings from the quantitative analysis indicated a 1-factor model was the best fitting model of the STSS for the present sample. A priori codes using items from the STSS were applied to transcripts from the qualitative interviews. Qualitative responses to each item were counted, evaluating the number of times therapists reported symptoms corresponding to the STSS during their interviews. Therapists who scored as likely having PTSD (n= 4) reported symptoms 50 times in the qualitative interviews, and therapists who did not have PTSD (n= 6) reported symptoms 45 times during their interviews. Implications for further measurement of secondary trauma and for marriage and family therapists are discussed.

Keywords: Measurement, mixed methods research, secondary traumatic stress, marriage and family therapists.

Introduction

The study of secondary trauma is continually developing. Varied definitions, measurement, and interventions to aid professionals experiencing trauma due to their helping work have emerged from the literature. Risk and protective factors of helping stress have been examined to further aid in preventing secondary trauma from occurring. Yet initial scholarly exploration poses a challenge to forwarding the scientific knowledge surrounding secondary trauma. As scholars have called the field pre-paradigmatic (Figley, 1999), there is not one agreed upon term or conceptualization for helping distress in the face of trauma. Terms of compassion fatigue (CF), vicarious traumatization (VT), and secondary traumatic stress (STS) are used at times synonymously even though these constructs present and are experienced differently. These differences in measurement have led to conceptually murky waters (e.g., Elwood Mott, Lohr, & Galovski, 2011) leading to differences in how interventions are conceptualized, used, and measured. The purpose of this paper is to validate the measurement of secondary traumatic stress (STS) in a national sample of marriage and family therapists (MFTs) using mixed methods research. A review of conceptualization and measurement challenges is first explored.

Conceptualizations of Secondary Trauma

There are distinct differences in how secondary trauma has been conceptualized, leading to the use of multiple measures across hundreds of studies (Elwood et al., 2011; Hensel, Ruiz, Finney, & Dewa, 2015). *Secondary Traumatic Stress* (STS) was initially proposed by Figley (1995) and referred to as a "cost of caring." STS results in symptoms similar to posttraumatic stress disorder (PTSD), as therapists are exposed to trauma secondarily by interacting with and listening to their clients' trauma stories. Figley and

Kleber (1995) proposed referring to STS as *Compassion Fatigue* (CF) was a less stigmatizing term for clinicians and emphasized the role of empathy in developing CF. CF is considered a form of empathy fatigue, wherein the therapist's empathic responses to the client's trauma is exhausted and CF symptoms present themselves (Figley, 1999; Figley & Figley, 2017; Ludick & Figley, 2016). While effects or symptoms of CF mirror symptoms of PTSD, CF adds to its conceptualization therapists' empathy fatigue. With empathy exhaustion being a prime factor for developing CF, symptoms of burnout and PTSD can potentially co-occur (Figley & Kleber, 1995; Stamm, 2009, 2010).

Despite STS and CF being used synonymously in some studies, other scholars conceptualized STS as distinct from CF (Bride, Robinson, Yegidis, & Figley, 2004; Sprang, Ford, Kerig, & Bride, 2018). The main difference in STS and CF definitions is how empathy is conceptualized. References of CF have noted empathy as a risk factor to later developing CF (Figley, 1995; Figley & Figley, 2017; Ludick & Figley, 2016). Conversely, STS has symptoms mirroring PTSD. STS is a trauma response with the same symptoms as included in a PTSD diagnosis in the *Diagnostic and Statistical Manual-5* (*DSM-5*; American Psychiatric Association, 2013; Bride et al., 2004; Sprang et al., 2018). The key difference between STS and PTSD is how the therapist is exposed to trauma. A primary trauma diagnosis in the *DSM-IV* noted that for a PTSD diagnosis to be made, an individual needed to have been exposed to a traumatic event (Criterion A). Using the *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for PTSD as an initial guide, Bride et al. (2004) created the Secondary Traumatic Stress Scale (STSS), with items mapping onto Criterion B (intrusion), C (avoidance), and D (arousal) symptoms. The *DSM-5* modified Criterion A to include being exposed to traumatic events through

"extreme exposure to details of the trauma" (including first responders and other helping professionals). As such, it is possible that STS is an extension of PTSD experiences. However, Sprang et al. (2018) noted that exposure to trauma experiences of clients may not always be extreme or repeated, as Criterion A in the *DSM-5* specifies. Thus, there may be aspects of STS not encompassed in the PTSD criteria, or the STSS measure that mirrors those items.

Vicarious traumatization (VT) is one facet of helping stress not captured in PTSD criteria recorded in the *DSM-5* or previous diagnostic criteria. VT occurs when clinicians modify their worldviews due to exposure to client's trauma experiences (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Essentially, the cognitive views of a therapist are altered due to the traumatic material they are exposed to in session (Saakvitne, Tennen, Affleck, 1998).

As the secondary trauma literature advances, VT, STS, and CF are interchangeably used, yet the symptoms and etiologies of how each construct occurs are unique, posing a threat to validity of measurement in many secondary trauma studies. This challenge is noted in recent literature as hindering further development of scholarship examining secondary trauma and hindering the development of preventative interventions (Molnar et al., 2017; Sprang et al., 2018). It is difficult to determine how clinically significant secondary trauma is within existing samples (Elwood et al., 2011), and effect sizes across studies have varied widely based on measures used and publication year (Hensel et al., 2015). It is impossible to discern which intervention and prevention efforts are helpful to clinicians, and which could do more harm than good (Elwood et al., 2011). Likewise, organizations may not accept intervention efforts if there

has not been a systematic way to validate both the measurement of and prevention efforts for secondary trauma.

Aims and Research Questions

This paper addresses the measurement of STS by examining STS in a national sample of marriage and family therapists (MFTs). Data from a national quantitative survey of MFTs are used alongside qualitative reports of secondary trauma in a smaller sample to contextualize and validate the measure of STS used in the survey. As is appropriate in mixed methods research papers, this study used one research question relating to the quantitative data, and one research question applying to the qualitative findings. The first (quantitatively focused) research question was: What are factors of STS in a sample of MFTs, and do these factors align with what has been reported in previous literature? The second (mixed methods) question was: How do qualitative reports of STS and helping work differ in therapists who have scored positively or negatively for PTSD? A descriptions of research methods is presented next, before describing the analyses and results of the study.

Methods

Mixed Methods Research

Mixed methods research combines qualitative and quantitative data for several purposes, holding an openness to findings emerging from the different types of data interacting together (Green, 2007). This study used mixed method research for the purpose of *complementarity*, or using multiple methods to inform the same overarching construct (Green, 2007). The research paradigm of a dialectic stance (Green, 2007; Shannon-Baker, 2015) and a critical realist epistemology (Maxwell & Mittapalli, 2010)

were used throughout study conceptualization, data collection, and analyses. A *dialectic stance* values multiple perspectives, allowing researchers to value dialogue between methods, views of study participants, and views of the researcher (Green, 2007). This dialectic stance allowed dialogue between quantitative (e.g., positivist) and qualitative (e.g., constructivist) data with differing underlying epistemologies. A dialectic stance created room for the potential of converging and diverging research findings.

Critical realism posits that reality can be ultimately knowable, but there are many ways of knowing and constructing reality (Maxwell & Mittapalli, 2010). An ontological realism that there is one reality existing "independently from knowledge and theory" is combined with epistemological constructivism, the co-construction of the researcher, participants, and data from the study (Maxwell & Mittapalli, 2010). A critical realist epistemology allows researchers to identify processes in place surrounding a specific construct, which prompts the examination of process-oriented causal inferences (Maxwell & Mittapalli, 2010). Causal inferences are made not in identifying variable-oriented causality, but rather, through a focus on the mechanisms in place within specific contexts in which a phenomenon occurs (Shannon-Baker, 2015).

Procedures

This study used a sequential explanatory mixed methods research design (Creswell, 2015; Creswell & Zhang, 2009; Ivankova, Creswell, & Stick, 2006). This design employed multiple phases of data collection and analyses, starting with quantitative data collection. After quantitative data were collected and analyzed, the results of the quantitative data informed qualitative data collection, further explaining the quantitative results (Creswell, 2015).

During Phase 1 of the study, a national sample of 197 MFTs was recruited to complete an online survey about their experiences of working with trauma and their family, organizational, and trauma work dynamics. Inclusion criteria to complete the survey was that the participants were currently licensed (either intern/associate or full licensure status) and actively practicing as an MFT. The study received IRB approval from the University of Georgia (IRB STUDY00006030) and data collection for the survey began in May 2018. Participants were recruited through letters of invitation to directors of MFT training programs (masters, doctoral, and post-graduate certificate programs) throughout the United States. MFT program directors were asked to forward the survey link to graduates of their programs. Additionally, invitations to participate in the study were included in online message boards through the American Association of Marriage and Family Therapy (AAMFT), the National Council on Family Relations (NCFR), and the American Family Therapy Academy (AFTA). Upon completion of the survey, participants were asked if they would be interested in participating in an interview about their trauma work with themselves and their partner. If interested, participants provided their contact information for the researcher to contact them later during the second phase of the study. All participants had the opportunity to enter into a random drawing for a $25 Amazon gift card.

Phase 2 of the study was implemented in September 2018 and completed in January 2019. The goal was to interview 10-12 couples where one partner was a therapist working with trauma. The inclusion criteria included being in a committed partnered relationship (couples did not need to be married to be interviewed), having one partner who was an actively practicing therapist, and being available at the same time to

complete a research interview over Zoom. Inclusion criteria included the therapists' partners to triangulate the therapists' reports of their STS symptoms and work experiences.

Upon completion of the interview, both partners received a $20 gift card incentive for their time. A total of 60 participants volunteered to be interviewed by the researcher; of those, only 53 were in committed couple relationships. To recruit a qualitative sample of couples with a wide array of experiences, the quantitative data from phase 1 was used to determine which participants would be recruited for phase 2. Quantitative data analysis from phase 1 indicated a wide range of scores in STS, and participants with low, mid, and high ranges of STS were recruited based on their scores.

The final sample yielded 10 couples, 6 with therapists who had low and medium ranges of STS and who did not endorse criteria for PTSD, and 4 with therapists who had high STS and endorsed PTSD based on the way they responded to the quantitative surveys. The researcher contacted participants for the second phase of the study and invited them to participate with their spouses or partners. After a mutually agreed upon interview time was set, the researcher sent informed consent forms to both the therapist and partners' email addresses. An invitation to complete the interviews over Zoom was sent to participants after receiving their informed consent forms. Interviews lasted from 60-100 minutes, and a semi-structured interview guide was developed by the researcher throughout the process of analyzing the quantitative data. Sample questions from the semi-structured interview guide include, *What is it like to have one of you be a therapist?* And *Could you give me an example of ways that your trauma work may affect your relationship negatively?* Interview questions were focused on the impact of the trauma

work on the therapist and how the therapists' relationship with their partner was affected. After completing the interview, the researcher wrote initial reflections, questions, and reactions to the participant's responses in a research journal (Charmaz, 2011).

Measures

Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). The STSS consists of 17 items mapping onto each diagnostic criterion for PTSD in the *DSM-IV-TR* (American Psychiatric Association, 1994). The STSS has demonstrated good internal consistency and validity (Bride et al., 2004). Bride (2013) added four additional questions to the STSS to incorporate changes made to the PTSD diagnosis in the *DSM-5* (APA, 2012). While the STSS has shown excellent reliability and construct validity, the factor structure of the STSS 21-item scale has not been consistent with the *DSM-5* PTSD criteria in some statistical models conducted (Mordeno, Go, & Yangson-Serondo, 2018).

Trauma exposure. Three questions assessing current exposure to trauma through the therapists' work were used. Participants provided information on the number of trauma clients (volume) seen weekly, the hours weekly (frequency) spent with trauma clients, and the percentage of PTSD clients on the therapist's caseloads. Additionally, participants completed a brief questionnaire about their age, gender, and years spent working in the field.

Participants

A total of 197 participants completed the quantitative survey. Initially, 241 participants responded to the online survey. Ten participants were not actively practicing and were screened out. A remaining 30 respondents did not complete the survey in its

entirety. The average age of participants was 38.31 (SD = 11.8), with 60 (30.5%) endorsing PTSD diagnosis (based on the *DSM-IV* criteria). Participants reported an average of 8.56 years spent working in the field (SD = 8.43; range = 1-44). The ten participants recruited for the qualitative interviews averaged roughly the same age (M = 38.11, SD = 11.48), with an average amount of time spent in the field being 5.5 years (SD= 3.5). Four out of the 10 therapists interviewed with their partners scored positively for endorsing a PTSD diagnosis. See Table 2.1 for additional demographic details for the quantitative survey participants and the 10 participants included in the qualitative interviews. Figure 2.1 depicts each therapist interviewed with their partner and the range of their STSS scores. Before presenting the analysis and results, a brief statement considering the researcher's subjectivity is presented.

Subjectivity Statement

I was both an insider and outsider throughout the course of this study. As a doctoral student holding multiple roles, I am not practicing as a full-time therapist. My experiences in a university training clinic and the lower number of clients I see in my clinical internship mean that I cannot fully understand the experience of full- time therapy practice. I am not eligible to see certain types of clients; since I am not fully licensed, I am unable to work with clients who have private insurance. I am not trained in a specific modality of trauma treatment; while I am starting the process to become certified in a few trauma treatments, I do not practice those treatments.

My status as an insider changed a few months into this study as I started my clinical internship at a local community agency. This agency saw clients who were funded mostly through Medicaid or were receiving services through the Division of

Family and Children's Services (DFCS). As I practiced more with clients in this environment, I worked with an increased amount of clients who experienced varied amounts of developmental trauma. Some clients had been removed from their homes and only recently reunited with their biological parents, while others were cut off from their families of origin. All of my clients were children and adolescents, meaning I was working with people who, at very young ages, had experiences that they should have never been exposed to. The poverty, discrimination, and barriers to care that many clients experienced confronted me while continuing to interview therapists for this study. As I continued to process the interviews I was conducting, I began to write clinical reflections in my research journal with the goal of reflecting on how this clinical work was affecting my interactions with both my research participants and data.

In November 2018, I learned that I had passed the national licensure exam for MFTs, granting me associate licensure status in the state of Georgia. I now felt more of an insider as a licensed associate MFT who was interviewing other licensed MFTs and their partners. I felt privileged to listen to the stories of what it was like to practice as full time therapists. However, I noticed myself making assumptions about their experiences, which I documented in my research journal and in memos as I proceeded to analyze the interviews. In an entry from January 29, 2019, I wrote:

> There may be an isomorphic process going on as the last two participants described working with private Medicaid clients, and having problems with the larger system. This is exactly what I am experiencing myself as a therapist in my current agency. At what point does this limit my ability to ask these participants questions? I find I may be making a lot of assumptions about how intense their jobs are, due to my own work being just as intense in the agency where I serve. The problems of poverty and neighborhood violence are so intense, that it seems the work may never be healed. That can definitely be said for some of the client systems and patterns I have seen over time in my agency.

In spite of this concern, parts of my outsider status allowed me to question what participants were experiencing. When I felt myself make assumptions about their work experiences, I allowed my outsider parts to further explore the dynamics they were experiencing in their agency. Keeping the research journal and infusing it with my clinical experiences allowed me to examine overlaps between my personal therapeutic experiences versus those of the research participants. I will next describe how the quantitative, qualitative, and mixed methods analyses were conducted.

Analysis

Quantitative Analysis

Exploratory and confirmatory quantitative analysis employed classical test theory (Crocker & Algina, 1986). Initial descriptive statistics were conducted with SPSS 24 (IBM, 2018). Means, standard deviations (Table 2.2), and correlations (Table 2.3) of all 21 items in the STSS were computed. Next, exploratory factor analyses (EFA) were conducted for the 17-item version of the STSS (using the *DSM-IV-TR* criteria) and the 21-item version of the STSS (using the *DSM-5* criteria). A 3-factor solution was expected for the 17-item scale, mirroring items from criteria B (intrusion), C (avoidance), and D (arousal) in the *DSM-IV-TR.* The EFA for the 17-item version of the STSS revealed a 3-factor solution. However, specific items did not load onto the three factors with the same pattern as previous studies have demonstrated. Instead, items from intrusion, avoidance, and arousal criteria loaded together onto three factors. The expectations for the EFA with the 21-item version of the STSS was similar to the 17-item scale. It was hypothesized that an EFA with 21 items would reveal a 4-factor solution, mirroring PTSD criteria in the

DSM-5 of intrusion (Criteria B), avoidance (Criteria C), negative alterations in cognition and mood (Criteria D), and hyperarousal (Criteria E). Results yielded a 3-factor solution, with items from different criteria loading onto the same factor, indicating the proposed 4-factor solution may not be a good fit for the present data.

To confirm a 3-factor solution for the STSS 17-item version and a 4-factor solution for the STSS 21-item version, confirmatory factor analyses (CFA) were conducted in Mplus 8.1 (Muthén & Muthén, 2010). First, a CFA for a single factor was conducted for the 17-item STSS, with modification indices used to improve overall model fit, covarying item errors where it made theoretical sense. The final model for the single factor STSS yielded appropriate model fit ($\chi^2(115) = 212.72$; RMSEA = .07; CFI = .94; TLI= .93; SRMR = .05). Then, a 3-factor solution was conducted with the STSS from the 17-item scale, testing model fit for factors of intrusion, avoidance, and arousal. The model results were not definitive, as correlations between arousal and avoidance factors were greater than 1 (see Table 2.4).

To test the factor structure of the 21-item STSS scale with 4 additional items from the *DSM-5* PTSD diagnosis, an initial CFA was computed with all items loading onto a single factor. As with the 17-item scale, the errors for some items were covaried to improve model fit. Model fit for the one factor solution was adequate ($\chi^2(184) = 335.30$; RMSEA = .07; CFI = .93; SRMR = .05). Then, a 4-factor CFA was computed using criteria from the *DSM-5*. Results indicated that all factors were highly correlated, with the covariance of negative alterations in cognition and mood and hyperarousal being 1.00. The covariance of avoidance and intrusion was also 1.00 (see Table 2.5).

Finally, variables of trauma exposure (number of trauma clients weekly, hours spent per week with trauma clients, and percentage of PTSD clients on the therapists' current caseload) were included in two structural equation models (SEM). The trauma exposure variables were included separately with the 17-item single factor construct and the 21-item single factor construct.

Qualitative Analysis

Qualitative interviews were transcribed and imported into MaxQDA for analysis (MaxQDA, 2018). Qualitative analysis was conducted using constant comparative analysis (CCA; Charmaz, 2011, 2014). CCA encourages dialogue between the researcher and the data, allowing the researcher to examine how they interacted with research participants. Initial open coding using gerunds (Charmaz, 2014) was employed. In addition, each symptom listed in the STSS was used as an a priori code, exploring how many times STS symptoms were mentioned in the interviews. Following initial open coding, focused coding and consolidation of initial codes was applied to the analysis while the researcher employed analytic memoing to reflect on how the codes and researcher's experience were interacting together. These focused codes were placed into theoretical categories based on their interrelatedness, the analytic memos, and the researcher's reflection from previous STS literature. Theoretical categories of intrusion, avoidance, arousal, and blame/numbing were maintained throughout the coding process, mirroring the diagnostic criteria for PTSD from the *DSM-5* and items on the STSS.

Mixed Methods Analysis

The theoretical categories related to secondary trauma for the therapists were counted, with numerical values assigned to each time participants mentioned an a priori

code during their interviews (Sandelowski, Voils, & Knafl, 2009). Once the a priori codes were counted, they were compared across the group of therapists that endorsed PTSD symptoms versus the group that did not endorse PTSD symptoms. These groups of therapists did not have the same number of participants. The group of therapists without probable PTSD (n = 6) was larger than the group with PTSD (n = 4). As such, the purpose in evaluating the amount of times each group endorsed the code was not to statistically compare participant groups. Instead, evaluating potential qualitative differences in the number of times a symptom was mentioned by either group served to further contextualize their experiences of STS.

Results

Quantitative Results

Initial correlations indicated that all STSS items were positively and significantly associated (see Table 2.3), with the highest correlations between items 10 (I thought about my work with clients when I didn't intend to) and 6 (Reminders of my work with clients upset me; $r = .62$, $p < .01$), and items 15 (I was easily annoyed) and 16 (I expected something bad to happen; $r = .62$; $p < .01$). The lowest correlation was between items 9 (I was less active than usual) and 20 (I unrealistically blamed others for the cause or consequences of the traumas experienced by my clients; $r = .17$; $p < .05$). Item 10, I thought about my work with clients when I didn't intend to, had the highest score for participants (M = 2.47; SD = 1.10). Item 20 (I unrealistically blamed others for the cause or consequences of the traumas experienced by my clients) was the lowest-scoring item out of all 21 items (M = 1.32; SD = .64).

Results from the CFA for the 17-item STSS are presented in Table 2.4. Results indicated the 1-factor model to be the best-fitting model (see Table 6 for model fit indices of all CFA models). All factors loaded onto one factor of secondary trauma at the $p < .001$ level, and there were no loadings less then $\beta = .5$. The 3-factor model of the 17-item STSS made conceptual and theoretical sense, as the CFA modeled the factors after the *DSM-IV-TR* criteria. However, this model, while showing similar model fit to the 1-factor model, had factors that were too highly covaried (e.g., arousal and avoidance; $\beta = 1.02$, $p < .001$). The internal consistency of a 17-item scale was $\alpha = .93$, suggesting that the single factor solution also has high reliability.

The 21-item STSS scale results are depicted in Table 2.5. Similar to the 17-item version, the single factor solution for 21 items was the best solution. There were no factor loadings under .5, all items loaded onto the single factor at a significance level of $p < .001$, and internal consistency for these items was high ($\alpha = .95$). While model fit indices were appropriate for the four-factor model, high covariance between factors indicated that a single factor of STS was a better fitting model for the present sample.

Findings from the SEM 17-item model (see Figure 2.2) indicated that trauma exposure via hours spent weekly with clients ($\beta = .23$, $p < .001$) and percentage of PTSD clients on the caseload ($\beta = .22$, $p < .001$) were positively and significantly associated with STS ($\chi^2(163) = 253.59$, $p < .001$, RMSEA = .05, CFI = .95, SRMR = .05). Interestingly, number of trauma clients was negative and not significantly associated with STS ($\beta = -.09$, $p = .42$), even though number of trauma clients was positively and significantly associated with hours spent with trauma clients ($\beta = .76$, $p < .001$). The trauma exposure variables accounted for 11.7% of the variance in secondary trauma scores ($R^2 = .12$, $p < .01$). The

21-item SEM model yielded similar results; number of trauma clients was not significantly associated with secondary trauma ($\beta = -.10$, $p = .36$). Both hours of trauma clients weekly ($\beta = .24$, $p < .05$) and percentage of PTSD clients on caseload ($\beta = .22$, $p < .01$) were positively and significantly associated with secondary trauma ($\chi^2(244) = 390.69$, $p < .001$, RMSEA = .05, CFI = .94, SRMR = .05). Trauma exposure variables accounted for 12.1% of the variance in secondary trauma scores ($R^2 = .12$, $p < .01$). Figure 1 depicts both SEM models.

Qualitative and mixed methods results

Intrusion symptoms. Five a priori codes from the STSS were included to explore therapists' intrusion symptoms in the qualitative interviews. The a priori codes included reliving client trauma, disturbing dreams about clients, thinking about work when not intending to, reminders of work being upsetting, and heart pounding. Many therapists described intrusive physical symptoms affecting them during sessions with their clients that were not associated with their hearts pounding. To further explore these physical symptoms, the sixth code (physical symptoms) was created during the open coding process. Table 2.7 includes frequencies for how many symptoms were endorsed and shows that the six participants who did not endorse probable PTSD from their STSS responses reported intrusion symptoms 19 times during their interviews. The four participants endorsing PTSD qualitatively reported intrusion symptoms 9 times. Below, each item code is discussed with quotes from participants.

Reliving trauma experienced by clients. The therapists described reliving trauma experienced and described by their clients to them in session. Deb described physically reliving the feeling her clients discussed related to their trauma: "I do find myself- and the

longer I've been in my career, the more I realize that it does- I feel it very physically. And so there are quite a few times I will- I almost- I feel like I'm feeling what my client was feeling." Deb's physical feelings refer to physically reliving the trauma in session. This reliving also presented itself when therapists were with their partners outside of session, as described by Sarah:

> One client in particular I remember hearing this story and just coming home and it was a really really violent abuse story. We were also watching Game of Thrones…Within a very short period of time I had heard this story from this child, and was watching an episode of the show where two children are murdered and I remember that scene going across, and I just, like I just burst into tears, because it was all, like it was this huge, like boom, right there, it was much more real than a TV show, because it went all straight back to my clients.

Sarah's reliving occurred while she was with her partner and was prompted by the violence in a show she was watching on TV. Both quotes illustrate that reliving a client's trauma could occur in session, as the client is describing their trauma, or outside of session, as therapists are with their family or friends.

Disturbing dreams about client work. Therapists described having bad dreams as a common occurrence and an indication that their therapy work was intruding into their personal life. This was a clue that they needed to practice additional self-care or seek out supervision. Interestingly, none of the therapists who endorsed PTSD based on their STSS scores reported disturbing dreams during the qualitative interview. However, four out of six therapists who did not endorse PTSD reported disturbing dreams about their work with clients. Rhonda described: "It is always a one hundred percent sure sign that if I have a dream about a client, I have a dream where I'm in session with them, that for me is like, as soon as I wake up I'm like, okay, you need to be doing something different."

Stuart described vivid nightmares that he had been having for a long time. He

later disclosed that due to a medical condition he addressed with a doctor, some (but not all) of his nightmares dissipated. In this quote, he describes how he associates some of his nightmares with what his clients told him in session, even if he did not dream about the details of their specific trauma: “I'll be fine and sometimes, I guess, I have just a very vivid dream and once I wake up from it, I am able to connect it to what it was like it might not even involve the person, but well you know, this week I was talking to so and so about this.”

Think about work when not intend to. This a priori code was difficult to identify throughout the coding process. It was unclear from interviews if therapists were thinking about clients when they did not intend to, or if thinking about their clients was occurring through some other process. For example, a current supervisor could ask them about their previous clients to determine if the therapist had previously encountered a block with a similar client. Joe described one client he worked with in his graduate school years that came up in his thoughts: “When I think back to graduate school at times, in some of those situations, I’ll think back to the clients I saw, and she usually pops up as, as one that …was kind of memorable.” Sarah more clearly described a client she would think about from time to time: “I mean it was years ago, and it is a story that I think will stay with me for a very long time.”

Reminders of my work upset me. Therapists described being upset by their work as being more or less overwhelmed. When thinking back to a time she had to make a report due to abuse, Joy stated: “And I sort of started to recognize at the end of it that I wasn't doing well, and that I was feeling overwhelmed.” Joy did not think about being upset in the moment she was making the report. Rather, she *later* did not like to be

reminded of the trauma experience of her client. She then described how she did not want to get out of bed and go to work, a potential symptom of avoidance, because she was overwhelmed by the reminders of making the report.

Sarah likewise described being upset by the stories of her clients, and the overwhelming nature of what it was like to work with them on their trauma: “Hearing these stories from these abused children and ninety percent of my caseload was traumatized kids was overwhelming.” Sarah described being so burdened by her client’s trauma narratives at her agency that she told her supervisor she wanted to jump off a bridge. Sarah explained that her supervisor helped her to reduce her caseload and take a break from seeing clients so she could pursue better mental health before returning to therapy. Still, Sarah reported that she chose not to remain as a therapist at that agency due to the difficult nature of being reminded of her client’s trauma experiences.

Heart Pounding. This was the final a priori code used from the STSS for the intrusion category. Therapists reporting this symptom in their qualitative interviews did not directly name that their heart was pounding. Instead, they mentioned physical symptoms that would be related to an increased heart rate. For example, Jessica shared, “I feel kind of like that adrenaline rush feeling.” Deb extended that experience by describing a heaviness in her chest, not necessarily that her heart was pounding: “A lot of heaviness in my chest or tension. A sickness in my stomach.” Deb’s response combined symptoms of her heart and alluded to additional, intrusive physical symptoms, leading to the creation of the physical symptoms code.

Physical symptoms. Aside from Deb’s admission to additional intrusive physical symptoms differing from a pounding heart, therapists also described how their physical

experiences in session could lead to additional intrusion of the trauma. Jessica shared:

> You know, to hold a space for someone requires a lot. I know a lot of times, I mean, sitting there, I feel how tense my body gets, and I get sweaty during sessions sometimes because I'm, so emotionally invested and just trying to analyze and there's so much emotional mental energy going on right there. I start having more of a physical reaction in the moment, right away. Meaning I get a lot more tense, I feel kind of like that adrenaline rush feeling. And also when the adrenaline escapes your body, that feeling. I get a little fuzzy in my head.

These experiences Jessica reported were specifically when clients disclosed trauma mirroring her own personal trauma history. Jessica reported that she pursued individual therapy in order to practice ethically in light of how her trauma experiences influenced her response to her clients. She also described pursuing therapy work with trauma that is dissimilar to her personal trauma history.

Avoidance symptoms. Seven a priori codes from the STSS were used in coding for themes of avoidance in the therapists' qualitative interviews. A priori codes included: discouraged about future, little interest in being around others, avoided things reminding of clients, wanted to avoid some clients, emotionally numb, less active than usual, and gaps in memory. Avoidance items were endorsed a total of 21 times by the therapists; the therapists who did not endorse PTSD symptoms reported avoidance symptoms five times throughout all interviews. Therapists endorsing PTSD reported avoidance symptoms 16 times during the interviews (see Table 2.8). Two STSS items (emotionally numb and less active) were not mentioned by any participants. Therapists discussed how difficult it was to stay active and exercise with their schedules but did not attribute it being due to trauma symptoms, acknowledging the challenges of balancing their work with other life demands. Responses about being emotionally numb were not identified from the qualitative interviews. Below, quotes from each of the STSS avoidance items are described.

Discouraged about the future. Therapists described their discouragement about the future in relation to whether they were actually helping their clients to function well. Roxy described:

> Am I making that much of a positive impact? Like, am I making enough of a positive impact that it's worth any of the consequences that go along with that? I mean, I'm not saving the world. You know I'm not ending…violence and trauma. I'm not doing that… I think certainly that sentiment kind of dwindled the longer and longer I've practiced, is it felt like, what impact am I really making?

Interestingly, the discouragement discussed was mentioned about only the *client's* futures. During their interviews, the therapists did not talk about any discouragement related to their *own* futures. Perhaps being discouraged about futures, specifically for these MFTs, is related to their perceived ability to help. Sarah shared:

> Definitely a big challenge is…feeling like what my clients most need is not what I can give them and honestly sometimes not what is available. So in that setting I often felt like I was sort of a band aid and I'm like I can help you tolerate living in this terrible situation. And as best as we can but your much greater needs are to fix this and what I'm doing is not changing that. So, it can feel very powerless in that way.

Ria's husband Dan was also able to identify this as a struggle that she was experiencing: "Am I being effective with them? You know, and that kind of question, because... for as analytical as she is, it can...it really bugs her."

Little interest in being around others. At times, therapists described an extreme need to decompress alone, feeling uninterested in engaging with their families, friends, and partners or spouses. This significantly affected their partners' feelings of efficacy in being able to support the therapists. Ria noted "That I am rolling over in here and I need people to just leave me alone, while I am processing it." Janet described how she would

come home some days and state to her husband, “I’m worn out and I just can’t do anything else tonight.”

Sarah described difficulty in balancing the need to take time for herself and being uninterested in being around her husband after being at her job and encountering her client’s trauma. She noted that while her husband gave her time and space alone when arriving home from work, this did not necessarily benefit their couple relationship:

> I don’t think we do necessarily a great job at balancing that because I think what happens is, I’m like, I can’t do this, I need some space. I just need to let my brain settle down. And he says okay, and we sort of go and do our separate things. Which like it works but it doesn’t help us reconnect and it doesn’t, I don’t know that would there be other ways for us to be together and have together time that would also give me what I need. I don’t know, we’ve never explored it.

The decreased interest in being around others when they arrive home from work could negatively impact couple and family relationships of the therapists.

Avoided things reminding of clients. Being reminded of clients occurred in several ways. In some cases, trying to avoid reminders of their clients led therapists to want to avoid their work altogether. Joy stated “I didn't want to get out of bed in the mornings. It was really clear, of like, oh I don't want to go to work. And most of the time I love going to work.” Additionally, avoiding reminders of clients came out in the way therapists interacted with popular media. Ria stated:

> I can't watch the news anymore. I can't watch TV. I have to shield that stuff, and I have to be very cautious about the things that I do watch, and I know that I come from a place of privilege and being able to say that, because a lot of other people can't turn off trauma. I feel like I have an obligation to find that happy medium of how [much] trauma do I expose myself to, in order to stay present and relevant and effective in therapy.

Wanted to avoid some clients. Some therapists noted they had difficulties working with certain types of clients, such as those with borderline personality disorder or

narcissistic personality disorder, or that these clients were not their favorite clients to work with. However, only one therapist described wanting to avoid a certain type of client. Janet described struggling to work with children and preferring to work with middle to older-aged adults due to symptoms of STS she experienced: "It makes me not want to work with that kind of clientele so much."

Gaps in memory about client sessions. There was only one report of not remembering a client session. Joe reported, "I don't remember being in the session, but I remember what I felt afterwards." He was discussing a particularly difficult case he remembered from graduate school. What was most important to him in remembering what happened afterwards was the presence of extreme emotions.

Arousal symptoms. A priori codes for arousal symptoms included five symptoms from the STSS scale: trouble sleeping, easily annoyed, I felt jumpy, expected something bad to happen, and trouble concentrating. No participants endorsed trouble concentrating during the interviews. Overall, arousal symptoms were described 19 times, with participants who endorsed PTSD describing arousal symptoms seven times throughout all interviews. Interestingly, participants who did not endorse PTSD mentioned arousal symptoms 12 times throughout the interviews (see Table 2.9). This discrepancy between those who did and did not endorse PTSD symptoms is largely due to Stuart and Penelope describing much difficulty in Stuart's sleeping. Interestingly, Stuart had the lowest STSS score out of all the therapists interviewed.

Trouble sleeping. Having trouble sleeping was reported by two therapists, one endorsing PTSD and the other not. Janet discussed working with child and adolescent abuse and neglect, which is the client demographic she ultimately decided to stop

working with because of how difficult it was for her: “I would have some sleepless nights.” Due to how vulnerable his client population was, which consisted mostly of those who were experiencing homelessness, Stuart noted: “It's frustrating to see, and sometimes, that makes sleeping hard. I can see how that would happen and you know, if somebody disappears on me that is particularly vulnerable, [it] keeps me up...up at night.” Additionally, this symptom affected Stuart’s wife, Penelope, who is not a therapist or helping professional: “When you wake up crying, I end up crying and holding you, but I mean, [it] does add a little bit of stress, because you are hurt and I can't fix you. You can tell. Like the sleep patterns. If it's been... a long rough week. His sleep patterns get really bad.”

Easily annoyed. Therapists discussed their increased likelihood to be annoyed with their partner or spouse. Rhonda described working with a high number of trauma clients, including nearly 40% of her clients being victims of sexual abuse. She expressed how difficult it was for her to work with her clients during the time of the Brett Kavanaugh hearings, and being unable to watch the news without becoming easily annoyed. Rhonda and her husband described having different political views, and she expressed that it was difficult for her as she became annoyed with her husband during the time of the hearings:

> And, I would just get … cranky, I was like, turn off the news, I don’t want to listen to this. I’d rather do another activity. I can’t handle hearing this anymore, and I expected you to listen to that stuff. And, not necessarily agree, but…I was going off about all the things and how upsetting it was. There was no fixing it. It would be a loop, over and over again in my brain, so I feel like that is an instance of things where work has impacted our relationship.

Although Rhonda worked with a high number of trauma clients, she did not endorse PTSD and expressed an awareness that she was easily annoyed in that moment. Ria also

expressed awareness of how she could become annoyed easily: “I know I get irritable. I know that's one of my biggest things. I get.... snarky and irritable and impatient.” Sarah noted that she was more likely to feel annoyed when she was working with trauma clients: “There’s definitely the, the sort of isolating, the irritability, and especially when I’m working with clients with a lot of trauma.”

I felt jumpy. Two therapists described feelings of panic or jumpiness during their trauma work. Yet these therapists also described their need to be aware, mindful, and practice being in the present to counteract those feelings. Deb noted: “And I'm not a very anxious person to begin with, but to be in this work and to experience their reactions, I find myself being more nervous or feeling more on-edge. And recognizing that it's kind of the overflow from them.” Ria expressed her feelings of panic, and described how she was trying to actively deal with them:

> I am moving in that direction. I recognize that it is a panic and I have been doing more focused mindful meditations on addressing that panic, making sure that I am not. I'm....I have a tendency to go, you know, jump in feet first, and it's either zero to sixty or not at all. Don't half-ass it. I am trying to find balance.

Expected something bad to happen. Ria was the only therapist who endorsed this item. She described a fear of the same bad things which were happening to her clients, some of who were elderly and immobile, as happening to her. For Ria, the specific challenge was related to her clients being helpless in their nursing care facilities. She stated: “It just really triggered for me, [became] almost an obsession of ‘Oh my god. I can't be that. I have to do everything in my power to live my life in a way where I will not be in an assisted living facility.’ I will always have the use of my body, so last year, I was on a crash course.” Due to the fear of ending up like some of her clients, Ria

described her efforts to be more physically active and lose weight so that she would have an easier time aging.

Numbing/blame symptoms. This category of symptoms has been referred to more recently as negative alterations in cognition and mood and was added to the *DSM-5* as a new diagnostic criteria for PTSD. Four a priori items were included from the 21-item STSS for these symptoms: Negative expectations about self, others, or the world, intense negative emotions, engaged in reckless or self-destructive behavior, and unrealistically blamed others for the trauma. During the coding process, one additional code, blaming self, was added: in the *DSM-5*, blaming self is included as a criterion alongside blaming others for the trauma. The STSS only includes blaming others for the trauma, not blaming self, so this additional code was added to include all of the criteria for PTSD that are included in this diagnostic category within the *DSM-5* (see Table 2.10).

Therapists endorsed symptoms from the numbing/blame category 27 times throughout their interviews. Therapists without PTSD reported numbing or blame half (9 times) the number of times in their interviews as therapists with PTSD (18 times). No therapists described reckless or self-destructive behavior or unrealistically blaming others for the trauma.

Negative expectations about self, others, or the world. Therapists described a more negative, pessimistic, or cynical view of the world. Ria mentioned “My world view has been jaded by the things that I see, and then I get very tunnel visioned.” Roxy described how her work with trauma has caused her to be more pessimistic with how she views the world. She expressed discomfort in that she and her partner, a social worker,

would discuss the world's problems at great lengths. There was an uncertainty in whether Roxy felt that this was a benefit for the relationship, or detrimental to her and her partner.

> I also feel like so much of what I see in my work is suffering, and the negative things about life and about humanity and that has turned me into kind of a more pessimistic person than I was before I entered the helping profession. And so, while I hear what he's saying about we might not be having these discussions, I don't know, part of me is like, well maybe that would be better, so that I wouldn't … when I look out my eyes at the world, the bad really stands out.

Sarah described a hardness that she experienced through her work with trauma: "I've had to learn to be a little bit thick skinned, a little bit less compassionate…in some ways, so that I can keep doing it. Which I feel like has sometimes made me a little harder, a little more cynical. Sometimes I appreciate that, sometimes less so." Sarah and Roxy both described ambivalence surrounding whether the negative expectations and way of viewing the world was appreciated or undesired by them.

Intense negative emotions. Many therapists described experiencing negative emotions as part of their work with trauma clients. Joe mentioned being able to compartmentalize his feelings normally within therapy, but being affected by a client who had experienced horrific trauma in early childhood: "I just remember you know like getting back to, uh, getting back to kind of our office space and just you know I was, I was kind of choked up and tearful." Rhonda described difficulties when trying to hold her intense negative emotions in, so that her clients were not affected by how emotional she is: 'Here I am saying, well, what you are saying really resonates with me, and I feel for you and I...it's making me teary, you know, I don't want you to feel like you have to emotionally take care of me. Because I feel so strongly and so much, how do I dial it

down." Rhonda recognized the need to not show her intense negative emotions to her clients, even if she was having a difficult time with what her clients were saying.

Some therapists were actively seeing clients who were nearing the end of their life, which caused them to experience intense negative emotions as they contemplated the loss of their clients. Janet noted one example from her work as a hospital chaplain, which was her second job over and above her work as a therapist:

> I remember I had a really tough loss I was really emotional about at the hospital. And it was just so emotional to be, like, to make that connection of like, that real compassion and that person that I knew as a person that had really touched my heart. And then, this person that didn't look like that at all, and all these people gathered.

Roxy described her negative emotions as the reason or cause of more serious personal struggles:

> I can remember multiple times where I've been upset because of something at work, and then that combined with something that's going on you know with me personally and that's led to me kind of you know breaking down emotionally. But I often wonder had it not been compounded by the work stress, I might not have been so upset by it, I might not have broken down.

Blaming self. This added code, which is not in the 21 STSS items, reflects that therapists, and sometimes the partners of the therapists, felt personal responsibility for the difficulties of their clients or their partners. Joy's husband Trey, a police officer, described how he initially felt when arresting someone for a crime:

> I was letting that affect me, cause I was going, man, I guess I'm causing this person to lose their job, or this or that, and in some ways felt bad, and it took me a while to finally realize that I'm not the one who did it to them, they did it to themselves, they chose to do whatever it was that caused me to make contact with them, and you know place them under arrest.

Jessica expressed a specific blame or judgment of herself for not being able to hold

enough mental and emotional energy for her partner: “Right after I’ve seen five people in a day can actually be very challenging and like, almost like, judging of myself, like, how can I not want to be there for my partner right now?”

A table of the STSS item codes is presented in Table 2.11. Participants endorsed STSS items 95 times throughout the interviews. Participants who screened positively for PTSD based on the STSS 17-item scale described STSS items 50 times during their interviews, compared to 45 times for those who did not screen positively for PTSD. The criteria with the highest number of items endorsed was intrusion (28 codes corresponding to these symptoms for all participants) and negative alterations in cognitions and mood (27 codes corresponding to these symptoms for all participants). Avoidance criteria were around the same, with 21 codes corresponding to avoidance criteria and 19 codes corresponding to arousal symptoms.

Discussion

This paper makes three unique contributions to existing literature. First, methodological advances in the measurement of STS are presented by using mixed methods. This paper describes the measurement of STS using mixed methods and is the first of its kind to validate the STSS using both quantitative and qualitative data. The quantitative and qualitative results from this study complemented each other in unique ways. Second, this is the first study to validate the STSS for specific use with MFTs. The prevalence rate of clinical PTSD (30.5%) are similar to rates found in licensed clinical social workers in Montana (35.7%; Caringi et al., 2017) and child protective service workers nationally (37%). Finally, results from this paper provide the first exploration of

how MFTs may experience STS, as measured by the STSS and their and their partner's qualitative reports.

Quantitative results from the confirmatory factor analyses yield several points for consideration surrounding the measurement of STS. As other studies have identified a 3-facor model for the STSS, it is surprising that the 3- and 4-factors models of the STSS were not the best fitting models for the present sample. However, Ting, Jacobson, Sanders, and Bride (2005) found similarly high correlations in a sample of mental health social workers. They proposed that the STSS is really a unidimensional scale, rather than having the three dimensions of intrusion, avoidance, and arousal factors. Conversely, model fit for a 1-and 3- factor model was found to be equal for both models in a recent sample of victim advocates (Benuto, Yang, Ahrendt, & Cummings, 2018).

Recently, scholars have identified models with more than 4 factors for the 21-item version of the STSS, pointing to increased complexity from 5-7 factors (Moreno et al., 2017). While these models demonstrated the best model fit for the samples where they were measured, a 7-factor model of the STSS would have many factors with only two indicators, leaving questions about the validity of the factors and statistical measurement error (Rasmussen et al., 2018). The results from this study point to Ting et al.'s (2005) recommendation that the STSS be considered a unidimensional scale. These results also demonstrate the need to begin demonstrating measurement invariance of the STSS across samples, as there may be specific items MFTs would be less likely to endorse than other samples of helping professionals for whom the STSS has been previously validated.

The STSS may be a good measure for MFTs to use to assess if they are experiencing PTSD symptoms or are being affected by their trauma work. While

therapists in the sample who endorsed PTSD mentioned more symptoms during their qualitative interviews, the participants who did not endorse PTSD still mentioned a high number of PTSD symptoms during the interviews. This points to the question of context, and how the therapists' inner resources, organizational resources, and couple relationship may help or hinder them from being able to recover from secondary trauma. Additional research is needed determining how therapists, who may be experiencing varying degrees of STS, are able to prevent or recover from its occurrence.

Qualitatively, therapists who did not endorse PTSD based on their STSS scores discussed more instances of intrusion and arousal symptoms, while therapists endorsing PTSD discussed more avoidance and symptoms of numbing and blame. For the therapists who did not endorse PTSD, intrusion symptoms could be a clue that their work is affecting them more than they would like. As they noticed these symptoms, some the therapists reported an awareness that the symptoms were occurring. For example, Stuart mentioned recurrent nightmares but also described alleviating some of them after discovering his sleep difficulties could be due to an untreated medical condition, for which he sought help.

Therapists who do not endorse PTSD but report symptoms of intrusion may be better prepared when the symptoms occur, compared to therapists with probable PTSD. For example, Jessica reported physical symptoms in session due to her personal trauma history, but noted that she was not pursing work with clients who have similar trauma history to her. This points to her awareness of how her trauma history could bring up symptoms of intrusion that she may not be able to deal with while in session with a client.

Deb reported reliving symptoms of her clients in session and described her need to be aware of her physical reactions during the session as a way for her to practice self-care.

One potential recommendation emerging from reports of arousal and intrusion is for therapists to be mindful of the media they are exposed to, and how they are using media to relax. Therapists reported reliving trauma of their clients through interacting with popular TV shows with similar content. Likewise, therapists reported becoming annoyed due to witnessing news mirroring their client's trauma. Encouraging therapists to have increased awareness of when they may be unable to watch a more violent show or interact with news outlets that could trigger their memories of client trauma could be a way to prevent some symptoms of arousal and intrusion.

Being discouraged about the future was mentioned by three of the therapists who endorsed PTSD symptoms. Therapists who did not have probable PTSD did not mention any discouragement about the future during their interviews. Additional exploration is needed to explore whether discouragement about the future could point to heightened symptoms over and above secondary trauma, such as vicarious traumatization. Assessing the level of discouragement therapists report could be one way for supervisors and agencies to determine a need to intervene with therapists and aid in preventing their STS symptoms from worsening. Symptoms of avoidance could be harder to personally recognize than the more obvious symptoms of intrusion and arousal, such as a pounding heart, becoming irritated, or having trouble sleeping. Encouraging therapists to practice mindful self-awareness may aid them in recognizing symptoms of avoidance.

Similarly, in the blame and numbing category, only therapists with probable PTSD endorsed negative expectations about the world. That three out of the four of these

therapists mentioned their negative expectations could also reflect that these therapists could have been experiencing a more serious form of vicarious traumatization. Future measurement studies should include measures of both STS and VT to determine the prevalence of STS and VT co-occurring for MFTs.

There have been no previous studies focused on how to measure STS within MFTs. The therapist's partners identified some of their symptoms and recognized when the therapists were affected by their trauma work. This was most noticeable for partners when therapists had trouble sleeping, nightmares about their client's trauma, and when the therapists had little interest in being around others. The partners' reports could indicate that therapist's trauma symptoms may negatively affect their intimate couple relationships. While beyond the scope of the present study, the partner's recognition of the therapist's problems point to a need to focus on how STS may affect the couple relationship. If not a current practice, agencies could consider supporting couples therapy as part of their employee assistance programs. Agencies could also consider providing no or low-cost healthy relationship psychoeducation to their employees and their partners.

Limitations

There were fewer therapists reporting probable PTSD that participated in the interview as those who were not experiencing PTSD. While this could have been a limitation if statistically comparing couples with each other, the purpose of including a range of STSS scores was to contextualize experiences of therapists with and without probable PTSD. Couples who were interviewed were all in heterosexual partnerships, therefore this study is unable to infer whether experiences of STS and observations by the therapists' partners would be different for LGBTQ populations. The data for the

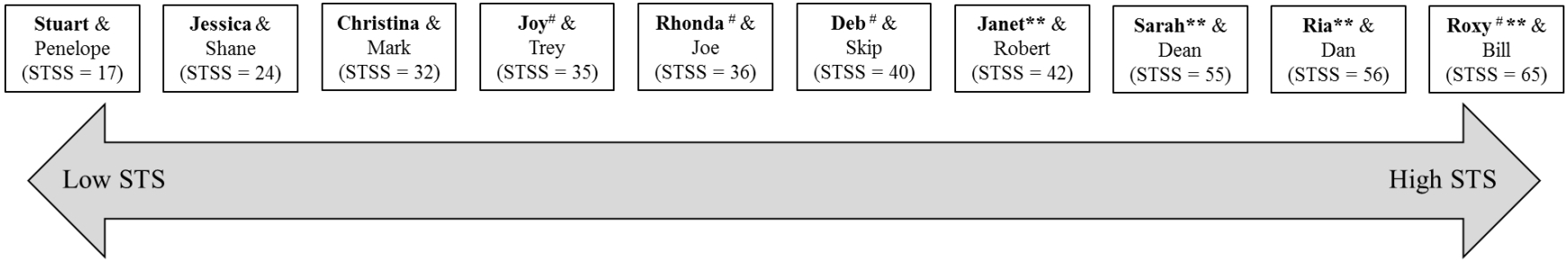
quantitative survey was cross-sectional, making it difficult to ascertain the stability of STS symptoms over time. Despite this limitation, all qualitative interviews were completed at least 3-4 months following the quantitative survey was complete. Therapists reporting STS symptoms in the quantitative survey a few months before still described symptoms of secondary trauma a few months later in their interviews.

Conclusion

This study is the first to explore secondary traumatic stress using mixed methods in a national sample of Marriage and Family Therapists. The results suggest that MFTs do experience STS, and at similar rates as other mental health professionals in the United States. This a concern for programs training MFT supervisees and for agencies who employ MFTs, as well as for MFTs in private practice. Quantitative and qualitative data suggest that the STSS did a good job in discriminating therapists who were experiencing probable PTSD versus those who were not. Further exploration is needed to contextualize the experience of secondary trauma beyond PTSD symptoms. Further assessments should consider exploring how isolated the therapists are, how much support they have access to, and the specific services they need in order to feel more successful as trauma therapists who are systemically focused. The results from this paper can be used to inform the assessment of MFTs who work with trauma. Future interventions should consider the findings from this paper indicating that therapist's partners were also aware of the therapists' trauma symptoms.

Table 2.1: *Demographic information, entire sample and qualitative participants*

	Entire Sample (N = 197)					Qualitative Participants (n = 10)				
	n	%	M	SD	Range	n	%	M	SD	Range
Age			38.31	11.8	23-73			38.11	11.48	28-60
Gender										
Male	36	16.1				1	10			
Female	183	81.7				9	90			
Other	5	2.2				0	0			
Number trauma clients			9.94	7.41	0-40			14.7	8.77	5-34
Hours with truama clients			12.5	9.8	0-41			15	7.07	5-26
Percentage PTSD clients (current)			36.45	30.33				37.7	26.53	9-100
Years worked in field			8.56	8.43	1-44			5.5	3.5	14-Feb
STSS, 17 items			34.32	11.92	16-75			40.2	14.91	17-65
STSS, 21 items			41.01	14.11	20-91			48.3	18.46	21-80
PTSD Caseness	60	30.5				4	40			



Note: # = dual helper couples; ** = Endorsed PTSD symptoms based on STSS scores, participant in bold is the therapist

Figure 2.1. *Qualitative participant STSS scores*

Table 2.2: *STSS scale item descriptives* (N = 197)

	M	SD
STSS1	2.21	0.99
STSS2	1.81	0.96
STSS3	1.42	0.75
STSS4	2.21	1.19
STSS5	2.22	1.06
STSS6	1.83	0.83
STSS7	2.32	1.15
STSS8	1.87	1.11
STSS9	2.31	1.14
STSS10	2.47	1.1
STSS11	2.31	1.02
STSS12	1.69	1
STSS13	1.52	0.86
STSS14	2.26	1
STSS15	2.38	0.97
STSS16	1.89	0.98
STSS17	1.66	0.86
STSS18	1.85	0.89
STSS19	1.43	0.75
STSS20	1.32	0.64
STSS21	2.09	1
17 item α	0.93	
21 item α	0.95	

Table 2.3: *STSS scale item correlations* (N = 197)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
STSS1	1																				
STSS2	.42**	1																			
STSS3	.33**	.55**	1																		
STSS4	.47**	.36**	.39**	1																	
STSS5	.53**	.47**	.33**	.53**	1																
STSS6	.35**	.56**	.41**	.42**	.55**	1															
STSS7	.53**	.47**	.36**	.54**	.54**	.41**	1														
STSS8	.47**	.43*	.45**	.50**	.43**	.31**	.60**	1													
STSS9	.45**	.43**	.26**	.48**	.46**	.41**	.54**	.38**	1												
STSS10	.43**	.56**	.37**	.51**	.58**	.62**	.58**	.46**	.53**	1											
STSS11	.53**	.41**	.32**	.57**	.60**	.43**	.60**	.47**	.54**	.60**	1										
STSS12	.40*	.59**	.44**	.46**	.52**	.50**	.52**	.49**	.51**	.60**	.56**	1									
STSS13	.29**	.44**	.38**	.47**	.40**	.49**	.40**	.41**	.33**	.49**	.45**	.55**	1								
STSS14	.39**	.49**	.26**	.24**	.48**	.47**	.37**	.16*	.38**	.51**	.42**	.48**	.38**	1							
STSS15	.39**	.41**	.28**	.37**	.49**	.43**	.52**	.39**	.45**	.50**	.54**	.54**	.45**	.54**	1						
STSS16	.41**	.50**	.44**	.47**	.59**	.57**	.53**	.47**	.44**	.56**	.58**	.61**	.55**	.53**	.62**	1					
STSS17	.34**	.39**	.26**	.35**	.42**	.39**	.36**	.27**	.41**	.46**	.52**	.42**	.39**	.46**	.43**	.46**	1				
STSS18	.51**	.48**	.39**	.54**	.58**	.48**	.48**	.43**	.44**	.53**	.61**	.48**	.51**	.49**	.59**	.58**	.52**	1			
STSS19	.38**	.37**	.36**	.36**	.46**	.38**	.40**	.37**	.36**	.44**	.52**	.45**	.47**	.29**	.38**	.45**	.37**	.52**	1		
STSS20	.31*	.45**	.47**	.39**	.37**	.44**	.30**	.32**	.17*	.46**	.34**	.46**	.43**	.37**	.31**	.38**	.34**	.45**	.41**	1	
STSS21	.50**	.45**	.31**	.49**	.70**	.58**	.52**	.41**	.49**	.58**	.58**	.54**	.40**	.49**	.48**	.60**	.41**	.63**	.42**	.35**	1

**$p < .01$
*$p < .05$

Table 2.4. *Confirmatory factor analysis, STSS 17 item scale* (N = 197)

	STSS 1 Factor Model (17 items)	STSS 3 Factor Model (17 items)		
		Intrusion	Avoidance	Arousal
STSS1	0.63***		0.62***	
STSS2	0.67***	0.71***		
STSS3	0.51***	0.53***		
STSS4	0.67***			0.66***
STSS5	0.74***		0.74***	
STSS6	0.66***	0.73***		
STSS7	0.74***		0.74***	
STSS8	0.64***			0.64***
STSS9	0.65***		0.65***	
STSS10	0.77***	0.82***		
STSS11	0.76***			0.77***
STSS12	0.76***		0.75***	
STSS13	0.63***	0.64***		
STSS14	0.64***		0.62***	
STSS15	0.69***			0.70***
STSS16	0.77***			0.77***
STSS17	0.59***		0.59***	
Avoid with Int		.94***		
Arousal with Int		.91***		
Arousal with Avoid		1.02***		
STSS3 with STSS2	0.32***	0.29***		
STSS14 with STSS8	-0.383***	-0.4***		
STSS14 with STSS4	-0.29***			
STSS10 with STSS6	0.24**			

Table 2.5. *Confirmatory factor analysis, STSS 21 item scale* (N = 197)

	STSS 1 Factor Model (21 items)	STSS 4 Factor Model (21 items)			
		Intrusion	Avoidance	NACM	Hyperarousal
STSS1	0.63***			0.64***	
STSS2	0.67***	0.73***			
STSS3	0.52***	0.60***			
STSS4	0.68***				0.67***
STSS5	0.74***			0.77***	
STSS6	0.68***	0.73***			
STSS7	0.72***			0.72***	
STSS8	0.62***				0.61***
STSS9	0.65***			0.64***	
STSS10	0.77***	0.80***			
STSS11	0.77***				0.79***
STSS12	0.75***		0.77***		
STSS13	0.64***	0.65***			
STSS14	0.64***		0.62***		
STSS15	0.69***				0.69***
STSS16	0.77***				0.77***
STSS17	0.60***			0.60***	
STSS18	0.76***			0.77***	
STSS19	0.59***				0.60***
STSS20	0.55***			0.52***	
STSS21	0.74***			0.76***	
STSS3 with STSS2	0.31***	.28***			
STSS14 with STSS8	-0.30***				
STSS14 with STSS4	-0.29***				
STSS20 with STSS9	-0.29***				
STSS21 with STSS5	0.34***	.33***			
Avoid with Int		1.00***			
NACM with Intr		.90***			
NACM with Avoid		.93***			
NACM with Hyp		1.00***			
Hyp with Int		.90***			
Hyp with Avoid		.95***			

Note: ***$p < .001$; Avoid = Avoidance, Int = Intrusion, NACM = Negative alterations in cognitions and mood, Hyp= Hyperarousal; all factor loadings had a significance level of $p < .001$

Table 2.6. *Model fit indices of confirmatory factor analysis, 17 and 21 item STSS scales* (N = 197)

	χ^2	df	RMSEA	CFI	SRMR	Adjusted BIC
Model 1 (1 factor 17-item scale)	212.72	115	.07	.94	.05	7872.85
Model 2 (3 factor 17-item scale)	220.14	114	.07	.94	.05	7882.39
Model 3 (1 factor 21-item scale)	335.30	184	.07	.93	.05	9323.62
Model 4 (4 factor 21-item scale)	363.47	181	.07	.92	.05	9358.13

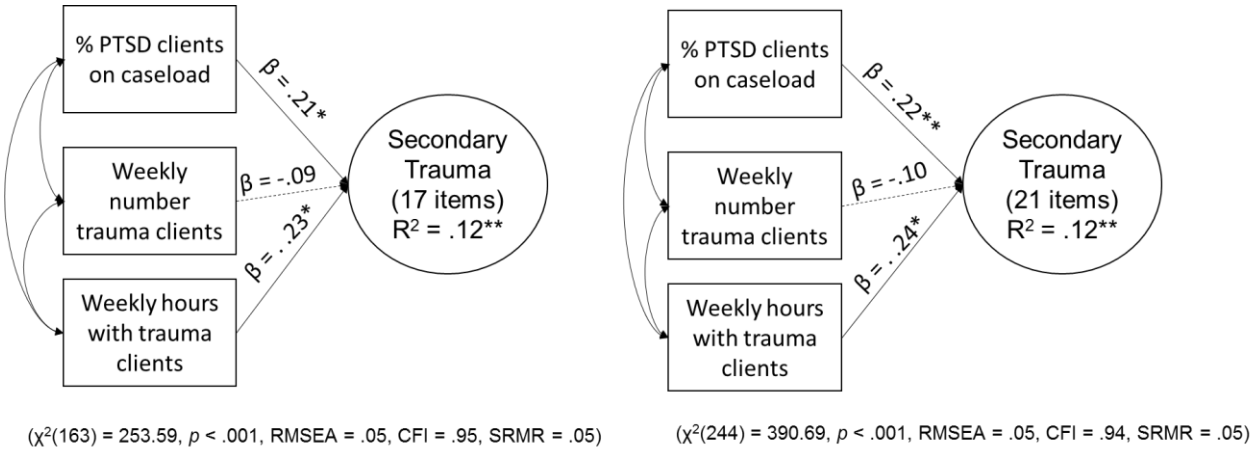


Figure 2.2. *Structural equation models, STSS and trauma exposure variables*

Table 2.7. *Intrusion codes endorsed by participants*

Participant	Reliving Client trauma	Disturbing dreams about client	Think about work when not intended	Reminders of work upset me	Heart Pounding	Physical Symptoms	Total
No PTSD Endorsed							
Jessica	0	1	0	0	1	2	4
Rhonda	0	2	1	2	0	0	5
Christina	0	0	1	0	0	0	1
Deb	1	0	0	0	1	3	5
Stuart	0	2	0	0	0	0	2
Joy	1	0	0	1	0	0	2
Total	2	5	2	3	2	5	19
PTSD Endorsed							
Ria	0	0	0	0	0	0	0
Janet	0	0	0	0	0	3	3
Sarah	3	0	1	1	0	1	6
Roxy	0	0	0	0	0	0	0
Total	3	0	1	1	0	4	9

Table 2.8. *Avoidance codes endorsed by participants*

Participant	Discouraged about future	Little interest being around others	Avoided things reminding of clients	Wanted to avoid some clients	Emotionally Numb	Less active	Gaps in memory	Total
No PTSD Endorsed								
Jessica	0	0	0	0	0	0	0	0
Rhonda	0	0	0	0	0	0	1	1
Christina	0	0	0	0	0	0	0	0
Deb	0	0	0	0	0	0	0	0
Stuart	0	1	0	0	0	0	0	1
Joy	0	0	3	0	0	0	0	3
Total	0	1	3	0	0	0	1	5
PTSD Endorsed								
Ria	1	2	1	0	0	0	0	4
Janet	0	1	0	1	0	0	0	2
Sarah	3	3	0	0	0	0	0	6
Roxy	4	0	0	0	0	0	0	4
Total	8	6	1	1	0	0	0	16

Table 2.9. *Arousal codes endorsed by participants*

Participant	Trouble sleeping	Easily annoyed	I felt jumpy	Expected something bad to happen	Trouble concentrating	Totals
No PTSD Endorsed						
Jessica	0	0	0	0	0	0
Rhonda	0	4	0	0	0	4
Christina	0	0	0	0	0	0
Deb	0	0	1	0	0	1
Stuart	7	0	0	0	0	7
Joy	0	0	0	0	0	0
Totals	7	4	1	0	0	12
Endorsed PTSD						
Ria	0	3	1	1	0	5
Janet	1	0	0	0	0	1
Sarah	0	1	0	0	0	1
Roxy	0	0	0	0	0	0
Totals	1	4	1	1	0	7

Table 2.10. *Blame/Numbing codes endorsed by participants*

Participant	Negative expectations	Intense negative emotions	Reckless or self-desctructive behavior	Unrealistically blamed others for trauma	Blaming self	Totals
No PTSD Endorsed						
Jessica	0	0	0	0	1	1
Rhonda	0	3	0	0	0	3
Christina	0	0	0	0	0	0
Deb	0	3	0	0	0	3
Stuart	0	0	0	0	0	0
Joy	0	1	0	0	1	2
Total	0	7	0	0	2	9
PTSD Endorsed						
Ria	4	4	0	0	0	8
Janet	0	2	0	0	0	2
Sarah	2	0	0	0	0	2
Roxy	4	2	0	0	0	6
Total	10	8	0	0	0	18

Table 2.11. *Total item codes endorsed by participants*

Intrusion	Reliving Client trauma	Disturbing dreams about client	Think about work when not intended	Reminders of work upset me	Heart Pounding	Physical Symptoms		Total Intrusion
No PTSD Endorsed	2	5	2	3	2	5		19
PTSD Endorsed	3	0	1	1	0	4		9
Total	5	5	3	4	2	9		28
Avoidance	**Discouraged about future**	**Little interest being around others**	**Avoided things reminding of clients**	**Wanted to avoid some clients**	**Emotionally Numb**	**Less active**	**Gaps in memory**	**Total Avoidance**
No PTSD Endorsed	0	1	3	0	0	0	1	5
PTSD Endorsed	8	6	1	1	0	0	0	16
Total	8	7	4	1	0	0	1	21
Arousal	**Trouble sleeping**	**Easily annoyed**	**I felt jumpy**	**Expected something bad to happen**	**Trouble concentrating**			**Total arousal**
No PTSD Endorsed	7	4	1	0	0			12
PTSD Endorsed	1	4	1	1	0			7
Total	8	8	2	1	0			19
NACM	**Negative expectations**	**Intense negative emotions**	**Reckless/self-desctructive behavior**	**Unrealistically blamed others for trauma**	**Blamed self**			**Total NACM**
No PTSD Endorsed	0	7	0	0	2			9
PTSD Endorsed	10	8	0	0	0			18
Total	10	15	0	0	2			27
Total No PTSD Endorsed								45
Total PTSD Endorsed								50
Total Symptoms Endorsed								95

CHAPTER 3

IT TAKES A VILLAGE: MARRIAGE AND FAMILY THERAPISTS' EXPOSURE TO TRAUMA, ACCESS TO SUPPORT, AND INTENTION TO LEAVE[1]

[1]Armes, S.E. To be submitted to *Journal of Marital and Family Therapy*

Abstract

Secondary traumatic stress (STS), or experiencing trauma through exposure to clients' traumatic stories, has been identified in many helping professions. However, there has not been one study uniquely focused on STS in Marriage and Family Therapists (MFTs). The present study explored STS in a national sample of MFTs (N = 201), hypothesizing that exposure to trauma through work with trauma populations would be associated with STS and intention to leave the field. Findings indicated that trauma exposure was significantly and positively associated with STS ($\beta = .33$, $p < .001$) and intention to leave ($\beta = .18$, $p < .001$), with STS partially mediating the association between MFTs' exposure to trauma and their reported intention to leave the field ($\beta = .06$, $p < .05$). Compassion satisfaction ($\beta = -.49$, $p < .001$) and organizational commitment to resilience building where MFTs were employed ($\beta = -.26$, $p < .001$) were negatively and significantly associated with intention to leave. The variables in the final model accounted for 58% of the variance ($R^2 = .58$, $p < .001$) in therapists' reports of intention to leave. Implications for prevention in MFT training programs and in mental health agencies are discussed.

Keywords: Marriage and family therapists, secondary traumatic stress, support, intention to leave

Introduction

Due to increased globalization, exposure to trauma is increasing. There is an increase in atrocities committed against humankind, such as civil wars, forced migration, natural disasters, intimate partner violence, and child abuse and neglect. Amid these traumas, Marriage and Family Therapists (MFTs) are uniquely situated to work with clients experiencing trauma due to their training in family systems and systemic thinking (Mendenhall & Berge, 2010). Yet, there is much the field of family therapy does not know about how exposure to client trauma could negatively impact family therapists' clinical effectiveness.

MFTs may be at risk of developing *secondary traumatic stress* (STS Figley, 1995; Bride, 2004), which is similar to posttraumatic stress disorder (PTSD) in that therapists experience distress due to the trauma experiences they hear from their clients. The prevalence of clinically significant STS has ranged from 15.2% in a national sample of social workers (Bride, 2007) to 37% in a sample of child protective social workers (Cornille & Meyers, 1999). The current prevalence of STS in MFTs is unknown. Bride (2004) compared several studies of STS in different mental health clinician populations and reported a *potential* for lower prevalence rates of STS in MFTs and clinical psychologists. However, it is currently unknown whether MFTs have similar amounts of exposure to secondary trauma through their work.

Years of experience working in the field are thought to have an inverse relationship with STS, such that more years of experience are protective against developing secondary trauma (Craig & Sprang, 2010; Kagan & Itzick, 2019; Macchi, Johnson, & Durtschi, 2014; Robinson-Keilig, 2013). In some studies, age has functioned

similarly, such that being younger places a person more at-risk of developing secondary traumatic stress (Craig & Sprang, 2010). However, Bride (2004) noted that those who are younger with fewer years of experience in the field may not have had time to develop coping skills when working in the trauma field. Additionally, therapists' previous personal trauma history is an identified risk factor across several studies (Hensel, Ruiz, Finney, & Dewa, 2015; Ivicic & Motta, 2017; Kassam-Adams, 1999). Finally, *volume* (the number of trauma clients), *frequency* (hours spent weekly with those clients), and *ratio* of trauma clients on the therapists' caseload were significantly and positively associated with STS across 38 articles studying STS (Hensel et al., 2015).

Factors preventing STS have focused on individual therapist characteristics, such as compassion satisfaction and increased self-care behaviors. *Compassion satisfaction* or deriving meaning and satisfaction from the work one does is a protective factor in preventing or ameliorating the effects of STS (Barrington & Shakespeare-Finch, 2014; Killian, 2008; Ludick & Figley, 2016). Compassion satisfaction has been a protective factor in preventing turnover in the field (Bride & Kintzle, 2011). Multiple levels of the therapists' system inform protective factors. Social support (Figley & Figley, 2017; Hensel et al., 2015; Killian, 2008; Ludick & Figley, 2016) and organizational support where therapists are working (Ben-Porat, 2017; Hensel et al., 2015; Ludick & Figley, 2016) decrease the effects of STS in therapists.

While previous research has identified factors associated with developing STS, few studies have identified potential negative outcomes due to experiencing STS. Hesse (2002) suggested that secondary trauma can negatively affect the therapeutic relationship as STS erodes the clinical judgement of the therapist, leading to a therapy practice that is

(potentially) ethically compromised. Secondary traumatic stress mediated the association between social workers' exposure to trauma and their perceptions of poorer physical health (Lee, Gottfried, & Bride, 2018). Likewise, exposure to client trauma was associated with PTSD and functional impairment 10 months later in a longitudinal sample of attorneys (Levin, Besser, Albert, & Smith, 2012). Higher amounts of traumatic exposure led to fewer hours they later spent on the job (Levin et al, 2012), pointing to a high risk for turnover when exposure to trauma is part of a professional helping role. High reports of compassion fatigue were associated with higher levels of psychological distress in a sample of social workers (Kagan & Itzcik, 2019).

Studies point to the risk of STS leading to turnover intention and eventual turnover in the helping fields. Also of interest is how protective factors at multiple levels of the therapists' system (e.g., personal, relational support, and organizational) can buffer against the negative effects of STS. Increased levels of STS were linked to decreased job commitment and turnover intention in a sample of substance abuse counselors (Bride & Kintzle, 2011). Work/family conflict and stress predicted later emotional exhaustion and turnover in a sample of child welfare social workers (Travis, Lizano, & Mor Barak, 2016), stressing the importance of organizational factors at decreasing worker distress in the workplace. Finally, vicarious traumatization has been shown to be significantly associated with child welfare professional's reports of their intention to leave the field (Middleton & Potter, 2015).

Aims and Goals

The goal of this paper is to explore the negative effect of secondary trauma on MFTs, contributing to further understanding of how to improve retention in the field of

MFT. This paper will identify potential risk and supportive factors affecting MFTs' intention to leave their work as therapists. This paper was guided by two interrelated research questions: (1) How does work-related trauma exposure and secondary trauma affect MFTs intention to leave their therapy work? (2) What are supportive factors that aid in preventing MFT's intention to leave?

Hypotheses

The following hypotheses guided this paper:

1. Trauma exposure and secondary trauma will be positively associated with marriage and family therapists' intention to leave their work.
2. Secondary trauma will mediate exposure to trauma and intention to leave.
3. Social support and being part of an STS informed organization will be negatively associated with therapists' intention to leave.
4. Compassion satisfaction will be negatively associated with trauma exposure and intention to leave.

Method

Procedure

Participants were recruited to complete an online survey. To be eligible for the study, participants needed to be actively practicing as a pre- or current-intern/associate level Marriage and Family Therapist (e.g., LAMFT, MFT-I, etc.) or fully licensed Marriage and Family Therapist (LMFT). Participants were invited to the study through multiple online platforms and completed a series of questionnaires online through Qualtrics. An invitation and study link was first emailed to program directors of all Marriage and Family Therapy programs accredited through the Commission on

Accreditation for Marriage and Family Therapy Education (COAMFTE). The email requested that program directors forward the study invitation and link to program graduates from the last 1-25 years, or however long the program had been operating. A total of 110 program directors of COAMFTE training programs were contacted.

Many additional MFT training programs are not COAMFTE accredited. An additional 130 MFT training programs at either the masters' or doctoral levels within the United States were identified, and an email invitation and survey link were sent to program directors of the non-COAMFTE accredited programs, requesting they also forward to program graduates who may be interested in completing the survey. A total of 240 MFT program directors (COAMFTE and non-COAMFTE accredited) was contacted throughout the course of the study.

Research with MFTs has been somewhat difficult, as there is not one representative list that has been approved for research purposes to use through the American Association of Marriage and Family Therapy (AAMFT). After contacting MFT program directors, recruitment was expanded to online forums, where the survey invitation, link, and study IRB information was included. The following online discussion forums were included during the recruitment phase: the AAMFT research discussion board, regional AAMFT affiliate group discussion boards and Facebook pages, the AAMFT Emerging Professionals Network, the National Council on Family Relations (NCFR) Family Therapy section, the American Family Therapy Academy (AFTA) therapist listserv, and two professional LinkedIn groups for Couples and Family Therapists that were not affiliated with AAMFT. Permission to conduct the study was

obtained through the University of Georgia Internal Review Board (IRB STUDY00006030). Data collection began in May 2018 and concluded in January 2019.

Participants

A total of 241 participants responded to the online survey. Of those who responded, 231 (97.9%) reported that they were conducting therapy with clients directly. Respondents who reported they were not actively seeing clients in therapy were screened out of the present study. Several participants (n = 30) dropped out before the online survey was completed. Partial data for those therapists was collected and used for the study. In total, 197 participants completed all survey items. Over half (51.9%, n= 125) of the sample reported being fully Licensed Marriage and Family Therapists (LMFT), with 29% being licensed MFT associates or interns who had received their masters degree and were working toward full licensure. In total, 195 participants (80%) reported being licensed as either full or associate level MFTs. Of those who reported "other" licensure type (n= 16, 6.6%), many noted they were awaiting permission to take the MFT licensure exam and were working as a therapist to accrue hours toward licensure as a LMFT. Additionally, some participants contacted the researcher to explain that they did not have MFT licensure in their state. A few participants from Canada also participated in the study, and reported that they did not have an official MFT license, but had been trained in an MFT training program.

The average number of trauma clients seen weekly was around 10 (SD = 7.41) with hours spent with those clients averaging 12.5 hours (SD= 9.8) weekly. Participants reported an average of 36.45 percent (SD= 30.33) of clients on their current caseload as having a PTSD diagnosis, and an average of 50.38 percent (SD = 32.59) of their current

caseload as consisting of trauma clients (but not necessarily a PTSD diagnosis). See table 1 for additional information about practice experiences. Average age was 38.31 years (SD = 11.8), with age range of participants being 23-73. Most of the sample (n = 183, 81.7%) was female and Caucasian (n = 186, 82.3%). Many participants reported personally experiencing childhood trauma (n = 143, 67.5%) and trauma in adulthood (n = 145, 69.0%). See table 2 for personal demographic information of the sample.

Measures

Trauma exposure. Participants responded to four items about their exposure to trauma through their work. Participants identified the *volume* of trauma clients by reporting the number of trauma clients seen weekly and hours spent with trauma clients weekly. The *frequency* of trauma exposure was identified by asking participants to report the hours per week of contact with trauma clients. Finally, the *ratio* of trauma clients on the therapists' caseload in relation to other clients not experiencing trauma was reported through two items. Participants first reported the percentage of clients with a PTSD diagnosis on their current caseload. As not all clients who have experienced trauma have been diagnosed with PTSD, participants then reported the total percentage of trauma clients on their current caseload. Measuring the volume, frequency, and ratio of trauma clients are commonly identified risk factors documented in a meta-analysis across 38 studies of Secondary Trauma (Hensel et al., 2015).

Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). The STSS is a measure of secondary trauma mirroring symptoms listed in the *Diagnostic and Statistical Manual-IV* (*DSM-IV*; American Psychiatric Association, 1994). The scale has 17 items which map onto the three symptom criteria in the DSM-IV.

The STSS was designed to be used as a total sum score or as three separate subscales of intrusion (*DSM-IV* Criteria B), avoidance (*DSM-IV* Criteria C), and arousal (*DSM-IV* Criteria D). A key difference between the STSS and *DSM-IV* diagnosis of PTSD is that the STSS wording has been changed to note that therapists are exposed to trauma through listening to their clients' trauma experiences. The STSS has demonstrated good validity and reliability in previous studies. Internal consistency for the intrusion (α=.82), avoidance (α=.85), arousal (α= .83), and total STSS score (α= .93) were excellent for the present sample. The STSS has been previously used to determine whether therapist meet diagnostic criteria for PTSD based on the *DSM-IV* diagnostic criteria of re-experiencing, avoidance, and hyperarousal (Bride, 2007). Endorsing one re-experiencing item, three avoidance items, and two hyperarousal items will meet criteria for a PTSD diagnosis. Sixty participants (30.5%) in the present sample met diagnostic criteria for PTSD, while 87 participants (44.2%) met criteria for a subclinical diagnosis of PTSD (meaning, they endorsed at least one item each diagnostic criteria category).

Secondary Traumatic Stress-Informed Organizational Assessment (STSI-OA; Sprang, Ross, Miller, Blackshear, & Ascienzo, 2016). The STSI-OA is a 200-item scale intended for use within organizations and to identify how prepared an organization is in being able to address secondary trauma in its employees. The STSI-OA evaluates 5 different factors of an organization measuring different aspects of organizational support, such as safety measures, leadership practices, and organizational policies. Participants completed 7 items from the subscale titled, "The organization promotes resilience-building activities that enhance the following:" Participants then rated each item on a 5-point Likert scale (1=*not at all,* 5 = *completely*). The questionnaire had a place for

participants in private practice or not affiliated with an organization to mark N/A. Sample items included, for example, “Basic knowledge about Secondary Traumatic Stress,” and “Strong peer support among staff, supervisors, and staff and/or outside consultants.” Internal consistency for the present sample was excellent (α=.85).

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS measures perceptions of social support across 3 domains: Family, Significant Other, and Friends. A total mean score of MSPSS can also be used. Participants responded to the prompt, *thinking about your social relationships, please respond to each question* for 12 items, rating each item on a 7-point Likert scale (1 = *very strongly disagree*, 7 = *very strongly agree*). Sample items included, “There is a special person who is around when I am in need,” and “I have friends with whom I can share my joys and sorrows.” The Family (α=.94), Significant Other (α=.91), and Friends (α=.93) subscales as well as the total scale (α=.90) all had excellent internal consistency for the present sample.

Compassion Satisfaction (CS; Stamm, 2009, 2010). The Compassion Satisfaction subscale from the Professional Quality of Life Scale version 5 (ProQOL-5; Stamm, 2009) measures the satisfaction people derive from their helping work. The CS subscale has 10 items in which participants responded to what they experienced in the last 30 days on a 5-point Likert scale (1 = *never*, 5= *very often*). Sample items include, “I feel invigorated after working with those I help,” and “I get satisfaction from being able to help people.” Previous psychometric studies of the ProQOL-5 have yielded mixed results, however, the CS subscale has demonstrated reliable and valid psychometric

measurement across many samples in the literature (Hemsworth, Baregheh, Aoun, & Kazanijian, 2018). Internal consistency for the present sample was excellent (α=.90).

Intention to leave (Middleton & Potter, 2015). Four items were included measuring therapists' intention to leave their work, based on a 6-point Likert scale (1= *strongly disagree,* 6 = *strongly agree*). Sample items included, "I am actively seeking other employment," and "I plan to leave this organization in the next 12 months." A previous study noted good internal consistency (α=.87; Middleton & Potter, 2015) in a sample of child welfare workers, and internal consistency for the present sample was excellent (α=.93).

Analysis

Initial exploratory analyses were conducted using SPSS 25 (IBM, 2018). Correlations of study variables indicated associations in the expected (positive) direction between the trauma exposure variables, secondary traumatic stress, and intention to leave. Correlations also indicated associations in the expected (negative) direction between trauma exposure, intention to leave, and social support, informed organization, and compassion satisfaction variables (see table 3).

Next, a confirmatory factor analysis (CFA) of intention to leave, secondary traumatic stress, and trauma exposure was conducted using Mplus 8.1 (Muthén, & Muthén, 2010). A latent construct for trauma exposure through clients included the number of trauma clients and hours with those trauma clients per week, as well as the percentage of overall trauma clients and percentage of clients with a PTSD diagnosis on the therapists' current caseloads. Modification Indices indicated allowing number of trauma clients per week and hours spent with trauma clients per week to covary, and as

that also made theoretical sense within the model, those items were covaried in the final model. While the covariance of those items was positive and significant (β = .63; *p* = .001), it was not high enough to consider both items as measuring the same construct.

The latent construct for Intention to Leave included all four items of the scale. Modification indices indicated allowing items 3 (*I plan to leave this organization in the next 12 months*) and 4 (*I am actively seeking other employment*) to covary. Both items were significantly and positively covaried (β = .50; *p* = .001). As previous studies have indicated that the STSS may be a unidimensional factor, a continuous factor of the STSS 17-item scale was included in the CFA with trauma exposure and intention to leave.

The latent construct of trauma exposure was positively and significantly associated with the latent construct of intention to leave (β = .29; *p* = .001) and the continuous factor of secondary trauma(β = .34; *p* = .001). Likewise, the latent constructs of secondary trauma and intention to leave were positively and significantly associated (β = .48; *p* = .001). Model fit indices for the CFA measurement model indicated excellent model fit (χ^2 (39) = 49.46; *p* = .12; RMSEA = .04; CFI = .99; SRMR = .04). All factor loadings significantly loaded onto the model with loadings higher than .50 (see figure 1).

Next, a structural equation model (SEM) was conducted in Mplus 8.1 using intention to leave as an exogenous variable, with the STSS, MSPSS, STSI-OA, and CS scales as exogenous mediating variables, and trauma exposure as the endogenous variable. Control variables of childhood trauma experience, experience of trauma in adulthood, and age were added into the model. The model showed excellent model fit (χ^2 (102) = 132.91; *p* = .02; RMSEA = .04; CFI = .98; SRMR = .06). A test of secondary

traumatic stress mediating trauma exposure and intention to leave was conducted using bootstrapping in Mplus, with the number of randomized samples drawn from set at 2,000.

Theoretically, different variables have been previously associated with secondary trauma and negative outcomes for helping professionals. Receiving specific trauma training, receiving specific secondary trauma training, the number of employees per participants' agencies or organizations, years spent working in the field, and whether they were in a partnered relationship were added into the model as controls. None of these variables were significantly associated with intention to leave the field or STS. To maintain statistical parsimony, these variables were removed from the final model.

To ensure quality of the statistical models, the following guidelines were used and met. First, the development of a statistical model should have a sound theoretical base (Kline, 2011). Hypotheses generated before developing these models were based in findings from the past few decades of research in secondary traumatic stress. The measures used in this paper were previously used across many studies and demonstrated a history of good internal consistency for all measures, and construct validity for the STSS measure. The sample size (N = 201) meets recommended minimum criteria for running SEM models (Kline, 2011). Finally, model fit indices indicated good model fit for both the CFA and SEM models (Brown, 2006; Kline, 2011).

Results

Results from correlations of study variables (Table 3.3) indicated that secondary traumatic stress was positively and significantly associated with weekly number of trauma clients ($r = .19$, $p < .01$), weekly hours spent per week with trauma clients ($r = .28$, $p < .01$), percentage of PTSD clients on caseload ($r = .27$, $p < .01$), percentage of

trauma clients on caseload (r = .30, p < .01), and intention to leave (r = .42, p < .01). Secondary traumatic stress scores were also negatively and significantly associated with social support (r = -.33, p < .01) and compassion satisfaction (r = -.47, p < .01).

Results from the structural equation model indicated that trauma exposure through clients' trauma was positively and significantly associated with intention to leave (β = .18, p < .001), secondary trauma (β = .33, p <.001), and negatively and significantly associated with social support (β = -.21, p < .01). Secondary trauma was also significantly and positively associated with intention to leave (β = .18, p < .05). Resilience building activities through being part of a secondary traumatic stress-informed organization (β = -.26, p < .001) and the therapist's reports of compassion satisfaction (β = -.49, p < .001) were negatively and significantly associated with intention to leave. The mediation analysis indicated a significant indirect effect from trauma exposure to intention to leave via therapists' STS scores (β = .06, p < .05).

While age, personal experience of childhood trauma, and personal experience of trauma in adulthood were added to the model as controls, only personal experience of childhood trauma was associated with intention to leave (β = -.10, p = .08). This finding approached significance, but was not significant at the p < .05 level. The variables in the final model accounted for 58% of the variance in participant's intention to leave, and 11% of the variance in participants' secondary traumatic stress scores (see Figure 3.2).

Discussion

The results suggest that secondary trauma partially mediated therapist's trauma exposure through their work and intention to leave their work. For MFTs, secondary trauma may be one mechanism determining whether they stay in their current work,

decide to move to a different agency, or leave the field altogether. It is unclear from the present results whether reports of intention to leave would be associated with intention to stop practicing as a therapist. However, one participant contacted the researcher via email (personal correspondence, November 29, 2018) to explain that secondary trauma had been a reason they decided to take earlier retirement.

That secondary trauma plays a role in MFTs trauma exposure and their intention to leave their current work setting leaves aa important question for mental health agencies and organizations employing MFTs; namely, what are ways to improve therapist retention? This question could also be important for MFT training programs, which often contract with internship and practicum agencies where their trainees may be exposed to high levels of trauma. From these results, at least some interventions should address therapists' potential to develop secondary trauma through their exposure to trauma clients. Likewise, a nuanced approach focused on multiple levels of MFTs' lives can aid prevention efforts.

Individually, compassion satisfaction, or satisfaction with one's work, was not significantly associated with trauma exposure in the SEM model. However, compassion satisfaction was negatively associated with therapists' intention to leave their work. This suggests that an appreciation of one's work and deriving satisfaction from helping may buffer against therapists' intention to leave, despite experiences of secondary trauma. This finding is consistent with the literature that notes compassion satisfaction is a protective factor against developing negative outcomes (Barrington & Shakespeare-Finch, 2014; Killian, 2008; Ludick & Figley, 2016). Job satisfaction mediated the relationship between secondary traumatic stress and turnover intention in a sample of

substance abuse counselors (Bride & Kintzle, 2011) pointing to the need for therapists to be satisfied with their work for them to stay in their profession. Compassion satisfaction and secondary trauma were negatively and significantly associated in the present model, lending additional support for satisfaction with ones' helping role as being protective against secondary trauma.

Therapists have relationships at multiple levels of their ecological system. This study hypothesized that perceived support of friends, family, and significant others would be a protective factor against the desire to leave potentially stressful work environments. Trauma exposure at work was negatively and significantly associated with perceived social support. Trauma exposure may modify therapists' perceptions of their available social support systems, rendering them less likely to seek support after experiencing a stressful workday. It is worth noting that secondary trauma and social support were negatively and significantly associated in the model ($\beta = -.33$, $p < .001$). Despite the negative association of trauma exposure on perception of social support, increased perceptions in social support may be a protective or buffering factor against developing secondary trauma for the present sample.

Although trauma exposure at work could negatively affect perceptions of social support, perceived social support could still be a protective factor aiding in therapists' resilience. Conversely, a therapist with a supportive significant other, family, or friends could be more encouraged to leave a stressful job, which could affect their overarching intention to leave. To test whether an interaction between social support and secondary trauma would be associated with intention to leave, an interaction term of the two variables was computed into Mplus and added to the model (the covariance between

social support and secondary trauma was removed for this test). The interaction of perceived social support and secondary trauma was not significantly associated with intention to leave. It could be that the therapists' social support networks were meaningful to them, but that different levels of support were more helpful in preventing their secondary trauma and intention to leave.

At the larger, organizational level, being part of an organization promoting resilience and prevention of secondary trauma aided in preventing therapists' intention to leave. Being part of a secondary trauma-informed organization that promoted resilience building activities was negatively associated with secondary trauma in the model (β = -.19, p <.05). As such, secondary trauma prevention and intervention efforts at the organizational level may aid in not only decreasing secondary trauma, but also limit turnover in therapists' intention to leave. This result points to increased need for organizations to be part of resilience building activities for their workforce. These activities could be part of a larger definition of professional self-care (Lee & Miller, 2013; Macchi, Johnson, & Durtschi, 2014), where therapists are encouraged to seek more frequent clinical supervision, take adequate lunch breaks, and make their work space a more inviting, peaceful place. Additional suggestions from previous scholars include organizations tracking secondary trauma of their therapists over time (Molnar et al., 2017), acknowledge as an organization the effect of trauma work on therapists employed there (Rosenbloom, Pratt, & Pearlman, 1999), supporting needed vacation time (Bell, Kulkarni, & Dalton, 2003), and aiding therapists in creating and implementing self-care plans (Bell et al., 2003). Encouraging therapists to consider the different aspects of their

professional self-care, such as seeking professional development or developing peer support (Lee & Miller, 2013) can also aid in developing a more cohesive self-care plan.

Work setting may play a role in trauma exposure, secondary trauma, and intention to leave. Welfare social workers reported lower compassion satisfaction and higher burnout and secondary trauma compared to a similar sample of social workers in health care settings (Itzick & Kagan, 2017). Participants in the present sample worked in a variety of settings, with some reporting work across multiple work environments. Comparing therapists who work in private practice with those working in agency settings was not possible for the present paper. To determine whether varying job factors could be affecting therapists' intention to leave, receiving trauma and secondary trauma training, number of years working in the field, and number of employees at the therapists' places of employment were added into the model as controls. None of these factors were significantly associated with intention to leave. Receiving trauma training, utilizing evidence-based practice (Craig & Sprang, 2010) and having more years of experience (Chrestman, 1999) have been identified in previous studies as protective factors buffering against the development of secondary trauma. These were not necessarily significantly associated with secondary trauma or intention to leave for the present sample, pointing to continued need to evaluate protective factors that may be specific to MFTs.

Final controls added and maintained in the model accounted for therapists' age, childhood trauma experience, and experiencing trauma during adulthood. Childhood trauma (Kassam-Adams, 1999) and years of experience working in the field were associated with secondary traumatic stress in previous studies (Craig & Sprang, 2010; Hensel et al., 2015; Ivicic & Motta, 2017). For the present sample, however, experiencing

trauma in adulthood and age were not significantly associated with either secondary trauma or intention to leave the field. Childhood trauma experience was not significantly associated with secondary trauma but was negatively associated with intention to leave their work ($\beta = -.10$, $p = .09$). While this finding is only marginally significant, it warrants a question about how childhood trauma experience may function for the MFTs in this sample. Potentially, experiencing trauma as a child could increase MFTs' desire to help others which would decrease the likelihood they would intend to leave their work. More research is warranted to determine how personal trauma experience functions for MFTs in their reports of secondary trauma.

Trauma exposure, secondary traumatic stress, social support, organizational resilience, and compassion satisfaction contributed to 58% of the variance in therapists' reports of their intention to leave. Yet trauma exposure accounted for only 11% of the variance in secondary trauma scores in the model. Although personal trauma history and age were added as controls, the variance in secondary trauma remained around 11%. This indicates that there are additional factors contributing to secondary trauma scores for the present sample, and potentially, MFT as a profession.

Limitations

The data for this study were cross-sectional in nature. This paper is unable to identify a potential causal pathway between trauma exposure through therapists' work, secondary trauma, and MFTs' intention to leave the field. Across the literature, only a handful of longitudinal studies have been conducted examining secondary trauma in helping professionals (e.g., Barrington & Shakespeare-Finch, 2014; Levin et al., 2012; Shoji et al., 2015) and none of these studies was focused solely on MFTs. Future research

should extend this study by surveying MFTs at multiple timepoints to assess the effect of working with trauma over time. Self-reports of trauma exposure, secondary trauma, and intention to leave may have been either lower or higher than therapists' actual experiences, depending on their memory of their work and events.

This study focused on recruiting MFTs practicing at associate/intern or full levels of licensure. It is difficult to determine how representative this sample is of MFTs practicing in the United States as a whole. There were 201 participants included in the final model. One previous study using randomization across all 50 states yielded similar sample sizes of MFTs (e.g., N = 174, Jordan & Seponski, 2018a, 2018b). This limitation points to challenges in conducting research with MFTs. For continued expansion of research conducted with MFTs, there must be new approaches to research recruitment and increased commitment of the American Association of Marriage and Family Therapy to ease access of contacting MFTs for research purposes. Despite these limitations, this is the first study focusing solely on the effects of trauma work on MFTs and provides information that can impact unique points of intervention and prevention.

Implications

Previous literature placed importance in secondary trauma prevention solely on the shoulders of the helping professional, exploring increased practices of self-care as being one prevention and intervention tool (Killian, 2008; Lee & Miller, 2013; Salloum et al., 2015). Additional studies have identified increased support, in the form of clinical supervision frequency, as a way to increase therapists' professional quality of life (Macchi et al., 2014). The results from the present study would suggest that, "It takes a village," in training new therapists and preventing and/or retaining therapists in their

current work. Therapists' exposure to trauma through their work affected their development of secondary trauma, their perceptions of decreased amounts of social support, and their intention to leave.

Being part of an organization promoting resilience building activities was negatively associated with therapists' intention to leave, pointing to the increased need for institutional accountability. Trauma exposure and secondary traumatic stress affected therapists' intention to leave. The findings would suggest that MFT training programs have a responsibility to equip trainees to work with intense trauma. One example of how trauma can be acknowledged within training programs is to create a trauma ritual for faculty and trainees (e.g., Grauf-Grounds & Edwards, 2007). Likewise, mental health agencies can support their staff who are experiencing secondary trauma due to their work. Previous suggestions of support and intervention at the agency level include acknowledging the impact of trauma work on agency staff (Rosenbloom et al., 1999), helping therapists implement self-care plans (Bell et al., 2003), and varying the caseload of therapists so that they are not working with the same type of trauma across all their clients (Bell et al., 2003). An additional question requiring further research is how secondary trauma affects the quality of therapeutic interventions and relationship over time. Measuring STS alongside studies of therapeutic process research could be one way to explore this question.

Conclusion

This paper advances the study of secondary trauma in unique ways. This is the first study (to the author's knowledge) to focus solely on trauma exposure and secondary trauma in Marriage and Family Therapists. Secondary trauma literature has focused on

child welfare workers, social workers, and mental health clinicians, and these studies have captured a small number of MFTs, compared to the rest of their samples. Thirty percent of participants in the present sample endorsed PTSD for all diagnostic criteria, and 44.2% of the sample endorsed subclinical levels of PTSD, suggesting a high prevalence of secondary trauma in the sample, and the potential for high prevalence in MFTs throughout the field. Previous knowledge of secondary trauma is extended by including therapists' intention to leave, pointing to secondary trauma being a potential mechanism for negative outcomes in MFTs working with trauma. Finally, multiple layers of therapists' lives were considered, including their compassion satisfaction, social support, and their agency organizational climate. Given the multiple layers affecting therapists' secondary trauma and intention to leave the field, this paper provides a systemic conceptualization of how secondary trauma could be prevented or maintained.

Table 3.1. *Professional demographic information*, N= 224

	n	%	M	SD	Range
Number weekly trauma clients			9.94	7.41	0-40
Hours weekly with trauma clients			12.5	9.8	0-41
Percentage PTSD clients, current caseload			36.45	30.33	
Percentage trauma clients, current caseload			50.38	32.59	
Percentage PTSD clients, cumulative caseload			40.64	29.38	
Percentage trauma clients, cumulative caseload			51.75	32.04	
Years worked in field			8.56	8.43	1-44
Licensure Type					
Licensed Professional Counselor	8	3.3			
Licensed Professional Counselor Associate	1	0.4			
Licensed Clinical Social Worker	3	1.2			
Licensed Marriage and Family Therapist	125	51.9			
Licensed MFT Associate/Intern	70	29			
Clinical Psychologist	3	1.2			
Other	16	6.6			
Practice Setting					
University training clinic	13	5.8			
Community mental health agency	42	18.6			
Nonprofit agency	31	13.7			
Private practice	103	45.6			
Other	37	16.4			
Specific Trauma Training Received					
Yes	146	64.6			
No	80	35.4			
Specific Secondary Trauma Training Received					

Yes	54	24.1
No	170	75.9

Table 3.2. *Personal demographic information*, N= 224

	n	%	M	SD	Range
Age			38.31	11.8	23-73
Gender					
Male	36	16.1			
Female	183	81.7			
Other	5	2.2			
Race					
White/Caucasian	186	82.3			
Black/African American	15	6.6			
Asian	7	3.1			
Native Hawaiian /Pacific Islander	2	0.9			
Other	16	7.1			
Ethnicity					
Hispanic	13	5.9			
Non-Hispanic	192	87.7			
Other	14	6.4			
Relationship status					
Single	47	20.8			
Committed relationship, dating	14	6.2			
Committed relationship, cohabiting	18	8			
Engaged	9	4			
Married	127	56.2			
Divorced	9	4			
Widowed	2	0.9			
Experienced child trauma	143	67.5			
Experienced trauma in adulthood	145	69			

Endorsed PTSD	60	30.5
Endorsed Subclinical PTSD	87	44.2

Table 3.3. *Correlations of all study variables* (N = 207)

		1	2	3	4	5	6	7	8	9
1	Number of Clients	1								
2	Hours per week	.76**	1							
3	Percentage PTSD	.48**	.58**	1						
4	Percentage trauma	.49**	.55**	.77**	1					
5	Secondary Traumatic Stress	.19**	.28**	.30**	.27**	1				
6	Social Support	-0.14	-.22**	-.18*	-.17*	-.33**	1			
7	Informed Organization	-0.06	-0.05	0.08	0.09	-0.11	.20*	1		
8	Compassion Satisfaction	-0.14	-.22**	-0.08	-0.13	-.47**	.35**	.35**	1	
9	Intention to Leave	.17*	.27**	.23**	.25**	.42**	-.26**	-.40**	-.60**	1

Note: *p <.05; ** p < .01

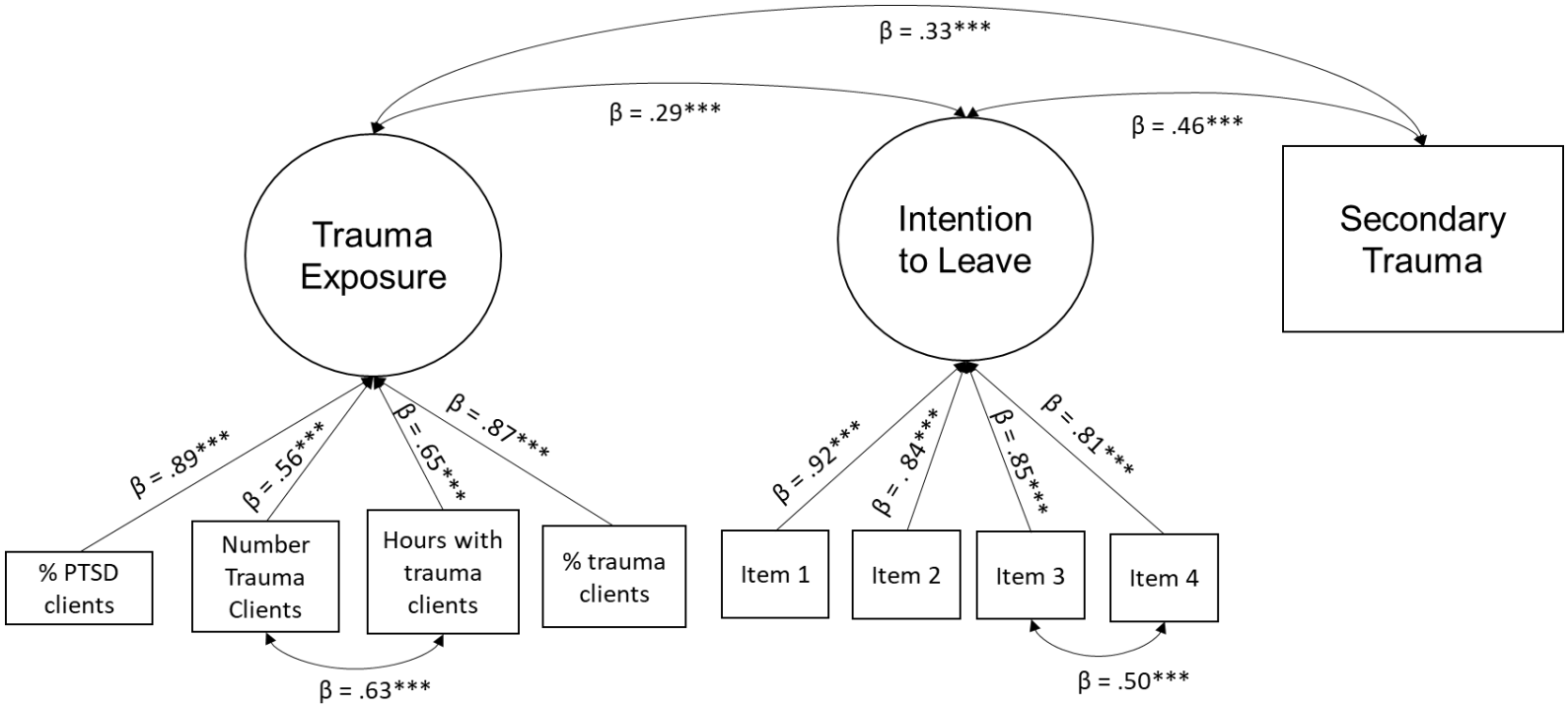


Figure 3.1. *Confirmatory Factor Analysis*, N= 210

Note: χ^2 (23) = 33.67, p = .07; RMSEA = .05 CFI = .99; SRMR = .03; p < .001

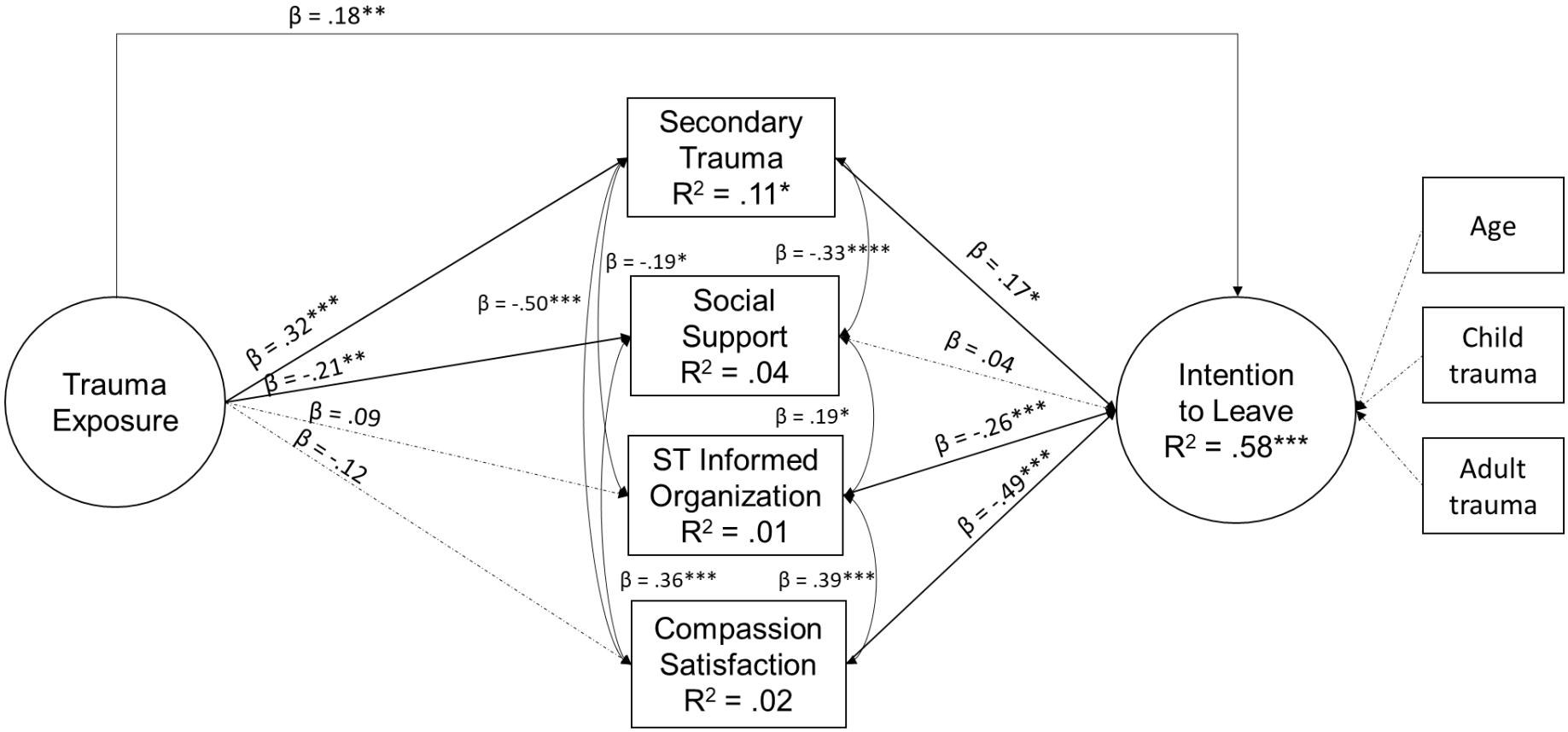


Figure 3.2. *Structural equation model, factors associated with intention to leave*, N = 201

Note: χ^2 (74) =110.06, p = .004; RMSEA = .05; CFI = .97; SRMR = .06; N = 201

CHAPTER FOUR

CONCLUSION

A definition of trauma across the literature has been difficult to clarify. Movement from the *DSM-IV-TR* to the *DSM-5* diagnoses of PTSD did not yield scholarly or conceptual agreement about the definition of trauma (PTSD; Greene, 2018; Rasmussen, et al., 2018). In turn, there are increased challenges to measuring secondary trauma. This lack of conceptual clarity in operational definition has resulted in numerous studies examining secondary trauma with measures that have not been validated or proven reliable, with little known about how secondary trauma can negatively affect clinicians. The use of several different constructs and terms interchangeably has led to increased confusion across the literature about the definition of secondary trauma. Direct trauma can leave an individual confused and disorganized in their thoughts. It is as if an isomorphic process also leaves the study of secondary trauma as similarly jumbled and messy. The purpose of this study was to further clarify how secondary trauma is experienced in a sample of marriage and family therapists. Below, specific contributions, strengths and limitations, and clinical considerations are elucidated.

Contributions

Prevalence

This study contributes to overarching literature on STS and explores how MFTs experience STS. Previous findings report estimated prevalence rates of STS in various mental health professions. However, the prevalence of STS in MFTs has remained

unknown until now. In this sample of MFTs, the prevalence of therapists meeting criteria for PTSD was just over 30%. This prevalence rate is higher than the 15.2% found in a national sample of social workers (Bride, 2007), and is similar to prevalence rates previously reported in clinical social workers in Montana (35.7%; Caringi et al., 2017) and child protective service workers nationally (37%; Cornille & Meyers, 1999). A less conservative estimate of prevalence could be to focus on therapists reporting subclinical PTSD. Subclinical levels of PTSD are computed by calculating whether therapists endorsed only one item each in the PTSD criteria of arousal, avoidance, and intrusion symptoms from the *DSM-IV*. When the criteria for probable subclinical PTSD was computed, 44.2% of the sample reported probable subclinical PTSD. These prevalence rates suggest that MFTs are experiencing STS at similar rates to other mental health professionals in the field, and may be experiencing STS at a higher rate, depending on the sample and nature of their work.

Theoretical Contributions

Previous literature advocates for studies to conceptualize trauma (Armes et al., 2019; Maercker & Horn, 2013) and secondary trauma (Figley& Figley, 2017; Ludick & Figley, 2016) ecologically. By including questions about therapists' perceptions of their social support and agency resilience-building activities, the quantitative survey in this study employed a socio-interpersonal perspective of posttraumatic stress (Maercker & Horn, 2013). Individual-level factors of trauma exposure were included using quantitative therapist reports of trauma client characteristics and STS. Relationally, therapists reported their perceived social support of their family, friends, and significant others in the quantitative survey. Complementary data about therapists' close relationships was

elicited through the qualitative interviews conducted with therapists and their partners. The community level of the socio-interpersonal model was examined through therapists' reports of their organization's resilience building activities. Reports of therapist's organizational support and challenges emerged from the qualitative interviews.

This study provides an extension of the *Compassion Fatigue Resilience* (CFR) model (Figley & Figley, 2017). The CFR model includes many intra and interpersonal factors alongside a multifaceted outcome: being resilient in the face of secondary trauma experiences through trauma work. Resilience could occur through many pathways. This study examined resilience by investigating whether therapists intended to leave or stay at their places of work. An intention to leave a stressful working environment could be a form of self-care indicating resilience as therapists look for work that may be less traumatizing. Therapists could be aware of their personal limitations to function well in their current clinical practice and make the decision to leave their place of employment. Yet intention to leave could also be a negative indicator of resilience in therapists with secondary trauma. If secondary trauma is the impetus for therapists to leave the field completely, intention to leave could be an indicator of decreased CFR. Recent scholars have identified the need to extend literature in order determine risk factors, protective factors, and negative outcomes within secondary trauma research (Molnar et al., 2017; Sprang et al., 2018). This study addresses an extension of the CFR model by examining intention to leave as a negative outcome that could also be a marker of resilience in therapists, depending on each therapists' unique context and experiences.

Methodological Contributions

This is the first known study to explore the measurement of STS using mixed methods in MFTs. The study extends STS measurement literature by using different data points (e.g., quantitative and qualitative reports) to *complement* therapist's reports of secondary trauma (Greene, 2007) and as a form of triangulation across methods (Ruark & Fielding-Miller, 2016). In measurement literature, quantitative validation studies are considered a gold standard (Burton-Jones & Lee, 2017), with minimal inclusion of qualitative data at times to contextualize overarching findings (Ruark & Fielding-Miller, 2016). Mixed methods scholars have advocated for increased measurement studies to be conducted using an integration of quantitative and qualitative data (Daigneault & Jacob, 2014; Onweugbuzie, Bustamante, & Nelson, 2010). The integration of qualitative data was not included in this study to modify the STSS or provide further instrument development, as is recommended by Onweugbuzie et al. (2010) when conducting mixed methods measurement studies. Yet the qualitative responses mentioned by therapists during their interviews provides initial support for the presence of STS in MFTs.

As initial validation of the STSS used mainly quantitative methods (Bride et al., 2004), this study lends support to the validity of using the STSS with MFTs by including complementary information from both quantitative and qualitative data (Greene, 2007). In the present study, validation is achieved by integrating qualitative and quantitative data to show how the STSS functions for therapists with probable PTSD and those without PTSD symptoms. Additionally, qualitative interviews with the purposive sample reflected that therapists' partners were witnesses to their symptoms of secondary trauma. The partners confirmed therapists' reports of difficulty sleeping, being easily irritated or

annoyed, and loss of interest in being around other people. Five items in the STSS (21-item version) were not endorsed by participants in the qualitative interviews. These items are: emotionally numb, being less active than usual, trouble concentrating, reckless or self-destructive behavior, and unrealistically blamed others for the trauma. There are potential methodological considerations for future studies using the STSS with MFTs. Removing these items from the STSS could make a shorter screening scale for therapists or agencies to use. It is also likely that future qualitative interview questions could be modified to directly ask MFTs if those five symptoms are part of their lived experiences. Future studies with MFTs should continue using mixed methods to further explore therapist's experiences of STSS. Below, study strengths and limitations are described.

Strengths and Limitations

Strengths

This is the first study to focus on secondary trauma specifically in a sample of MFTs. The exploratory sequential mixed methods design provides a rigorous exploration into multiple levels of therapist's experiences of STS by examining social support, agency characteristics, and negative outcomes. Additionally, this study explores multiple perspectives of therapists' STS by including dyadic interviewing with their partners is a purposive sample. Previously, the STSS was validated for use with several mental health professionals (Bride et al., 2004; Caringi et al., 2017; Cornille & Meyers, 1999). This study provides support for applicability of the STSS to MFTs as a population. Additionally, this study highlights the importance of considering multiple ecological layers for therapists experiencing secondary trauma. The association of STS with exposure to trauma through client trauma experiences is only part of the ecological

picture of STS for therapists in this study. Exposure to client trauma also affected their perceptions of their access to social support and their intentions to leave. This study is the first to explore intention to leave work as a potential negative outcome of secondary trauma in MFTs. A final strength of this study is that it provides initial evidence of larger structural factors among the therapists' organizations or agencies where they work.

Limitations

This study has many strengths furthering the field of research regarding STS in MFTs. Amidst these strengths, there are also a few limitations. It is difficult to determine whether the present sample is truly representative of all MFTs practicing in the United States. While the response rate is difficult to determine due to the recruitment and sampling strategy used, the final quantitative sample recruited (N = 197) is similar to a nationally representative random sample of MFTs conducted through the mail (N = 174; Jordan& Seponski, 2018a, 2018b). Recruiting participants for the qualitative interviews who had scored positively for PTSD was more challenging than recruiting those who did not endorse PTSD based on their STSS scores. It is unclear if therapists with PTSD symptoms preferred not to be interviewed due to higher levels of distress, or if this was an artifact of the fall and winter holiday seasons during which they were being recruited. There could have been a selection bias for the online survey in that therapists experiencing high levels of secondary trauma or those with heightened feelings of compassion satisfaction were more likely to participate. However, not all therapists interviewed in the qualitative phase of the study worked with trauma as part of their clinical practice due to purposive sampling based on a range of STSS scores. Results from the quantitative survey also detail that while many therapists worked with trauma,

there was a wide range of volume, frequency, and ratio of trauma clients on the therapists' caseloads, accounting for only half (on average) of their total caseloads. All data was self-reported. Future research should extend secondary trauma literature to consider client's reports of their therapists' efficacy. Potentially, therapists with STS may not be as clinically effective and this is an area needing further exploration. Despite these limitations, the strengths of this study are in the integration of ecological theoretical perspectives with mixed methods in national sample of MFTs. These strengths provide several clinical considerations, discussed next, which pertain to MFTs.

Clinical Considerations

Marriage and Family Therapists should consider using the STSS alongside other screening tools to assess whether they are presently experiencing symptoms of secondary trauma. Learning to identify when STS symptoms arise for therapists could be an important tool aiding in therapist resilience over time. Additionally, assessing their own levels of trauma could help therapists develop self-awareness in recognizing when symptoms of STS arise in the future.

Previous literature highlights the importance of self-care practices for therapists working with trauma (Killian, 2008; Lee & Miller, 2013; Miller et al., 2017). Yet the definition of self-care and how therapists pursue self-care lacks clarity. There is some debate in the literature about self-care being an individual practice versus an evolving process (Barrington & Shakespeare-Finch, 2014; Killian, 2008). Previous studies and theoretical models describe self-care as a protective factor indicating therapist resilience (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017; Figley & Figley, 2017; Ludick & Figley, 2016). Likewise, self-care was a preventative factor in increasing home-based

family therapists' perceptions of their quality of life (Macchi, Johnson, & Durtschi, 2014). Lee and Miller (2013) presented a framework of both *personal* and *professional* self-care. Marriage and Family Therapists need to develop personal self-care practices to help them maintain their trauma work. Developing a meditation practice, exercising, and being with friends and family were all mentioned during the qualitative interviews as effective personal self-care techniques. Attending trainings, actively pursuing supervision, and developing peer support with other therapists are methods of *professional* self-care that therapists can practice to increase their resilience in their places of work.

Many recommendations of self-care do not consider the multi-layered systems in which therapists are nested. Therapists in committed couple relationships may be challenged to provide support to their partner while concurrently needing support from their partners. One philosophy of trauma, using germ theory, posits that a person can become "infected" by trauma by simply being exposed to it (Bloom, 1999). A consideration for therapists and their partners is how be in their couple relationships without further transferring their secondary trauma to their partners (Regeher, 2005). Therapists in committed couple relationships need to develop methods of personal and professional self-care, while also determining alongside their partners the best way to care for their couple relationship. As such, *relational self-care* could be a third type of self-care for therapists in committed couple relationships to pursue.

At the larger systemic level, MFT training programs and agencies working with a high number of trauma clients need to consider how they are equipping their trainees and/or staff. MFT educational programs can help prepare trainees to work with trauma by

offering coursework covering best practices for trauma work. These programs could also consider measuring STS over time in their student trainees as a way to evaluate if STS occur during graduate study in the process of learning to become a therapist.

Agencies working with a high volume of client trauma need to give critical thought to how they will support their therapists. Examples that therapists found helpful, as detailed in qualitative interviews, were supporting educational trainings by giving therapists time off and paying for the training, instead of requiring therapists to pay out of pocket. The ratio of PTSD clients in clinician's caseloads and their hours spent with trauma clients weekly were positively and significantly associated with PTSD. Agencies could consider helping therapists with high levels of STS balance their caseloads with fewer trauma clients.

At a larger systemic level, agencies may experience systemic constraints in being unable to support their therapists as there is a pressure to increase client loads to increase insurance payments brought into the agency. One potential intervention is for policymakers to increase the amount of money therapists are compensated for their time and to include funding for non-clinical activities that are therapeutic, such as case management and coordination of services. Sarah described the need for better mental health funding, which could positively affect therapist's working environments:

> I think we see a lot of people who talk like they value their therapist on the individual level and we see individuals talk about how great therapy is for me, and we don't see that at the systemic level, we don't see therapists getting paid in a way that shows that it's valued to that degree. We don't get therapists getting the support in terms of staff or funding that would make that seem, that's carried through. And like if I compare it to like the medical field, which, certainly has its own set of stressors, but if I think, okay could I deal with that if I got paid like a doctor got paid, you know if I go to my doctor's office, she's got somebody who follows her around to take notes on every session for her.

The salary constraints described by Sarah could also constrain an agencies' ability to provide funding for extra educational and training opportunities. Agencies may want to support an increase in salary for their staff and evidence-based trainings in trauma treatment but be unable to afford this. If constrained by a lack of resources, agencies could support more flexible time off when their therapists report symptoms of secondary trauma. Agencies can also develop more informal peer consultation networks to help therapists feel less professionally isolated.

Future Research

Future research can extend this study by evaluating the stability of STS over time using longitudinal methods. Additional research into agency contexts, supports, and challenges can add to increasing research that contextualizes secondary trauma as occurring within nested systemic layers. Research aimed at targeting agency-level interventions should investigate the processes of professional self-care within agencies, such as increasing therapists' access to supervision. Further research is also needed regarding the efficacy of secondary trauma interventions, as has been previously recommended (Sprang et al., 2018). Additionally, if therapists' committed couple relationships are a supportive factor for them, research should also explore whether therapist's partners are negatively affected by their trauma work.

Conclusion

This study explored secondary traumatic stress in marriage and family therapists using an innovative combination of mixed methods research. The question remains of

what a resilient therapist is. To sit with clients who have experienced trauma and, at times, relive that trauma with them is a difficult task for any therapist. This study examined therapists' trauma exposure, secondary trauma, intention to leave their work, and their organizational and family support networks. Findings indicate that personal, professional, and relational factors all play a role in affecting therapists' negative outcomes in the wake of their trauma work. Continued systemic support is needed, with research interventions focused on therapists recognizing and preventing the recurrence of secondary trauma symptoms.

REFERENCES

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Armes, S. E., Seponski, D. M., Koa, S., Khann, S., Lahar, C. J., Bryant, C. M., Bride, B. E., Wickrama, K. S., Bunnak, P., & Schunert, T. (2019). Exploring contextual trauma in Cambodia: A socio-interpersonal perspective of PTSD. *Journal of Traumatic Stress.* https://doi.org/10.1002/jts.22365

Barrington, A. J., & Shakespeare-Finch, J. (2014). Giving voice to service providers who work with survivors of torture and trauma. *Qualitative Health Research, 24,* 1689-1699.

Beck, C. T., & Gable, R. K. (2012). A mixed methods study of secondary traumatic stress in labor and delivery nurses. *JOGNN, 41,* 747-760.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Human Services, 84,* 463-470.

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M….&Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the world mental health survey consortium. *Psychological Medicine, 46,* 327-343.

Ben-Porat, A. (2017). Competence of trauma social workers: The relationship between field of practice and secondary traumatization, personal and environmental

variables. *Journal of Interpersonal Violence, 32,* 1291-1309. doi: 10.1177/0886260515588536

Benuto, L. T., Yang, Y., Ahrendt, A., & Cummings, C. (2018). The secondary traumatic stress scale: Confirmatory factor analyses with a national sample of victim advocates. *Journal of Interpersonal Violence,* 1-20.

Bloom, S. L. (1999). The germ theory of trauma: the impossibility of ethical neutrality. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 257 – 276). Baltimore, MD: Sidran Press.

Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis, 7,* 29-46.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52,* 63-70.

Bride, B.E. (2013). *The Secondary Traumatic Stress Scale, DSM 5 Revision*. Unpublished Manuscript.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004) Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 14*, 27-35. doi: 10.1177/1049731503254106

Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology, 17,* 22-28.

Bride, B.E., Lee, J., & Miller, S. (2016, January). *Examining self-care as a moderator of secondary traumatic stress and functional impairment in clinical social workers*.

Presented at the 2016 Annual Conference of The Society for Social Work and Research, Washington, DC.

Brown, T. A. (2006). *Confirmatory factor analysis for applied research*. New York, NY: The Guildford Press.

Brown, V. M., Strauss, J. L., LaBar, K. S., Gold, A., McCarthy, G., & Morey, R. A. (2014). Acute effects of trauma-focused research procedures on participant safety and distress. *Psychiatry Research, 215*, 154-158.

Burton-Jones, A., & Lee, A. S. (2017). Thinking about measures and measurement in positivist research: A proposal for refocusing on fundamentals. *Information Systems Research, 28*, 451-467.

Caringi, J. C., Hardiman, E. R., Wledon, P., Fletcher, S., Devlin, M., & Stanick, C. (2017). Secondary traumatic stress and licensed clinical social workers. *Traumatology, 23*, 186-195.

Charmaz, K. (2011). A constructivist grounded theory analysis of losing and regaining a valued self. In F. J. Wertz, K. Charmaz, L. M. McMullen, R. Josselson, R. Anderson, & E. McPadden (Eds.), *Five ways of doing qualitative analysis* (pp.165-204). New York, NY: The Guildford Press.

Charmaz, K. (2014). *Constructing Grounded Theory, 2nd ed.* Los Angeles, CA: Sage Publications.

Chrestman, K.R. (1999). Secondary exposure to trauma and self reported distress among therapists. In B.H. Stamm (Ed.). *Secondary traumatic stress, second edition: Self-care issues for clinicians, researchers, and educators.* Baltimore, MD: Sidran Press, pp. 29-36.

Cieslak, R., Shoji, K., Lusczynska, A., Taylor, S., Rogala, A., & Benight, C. C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment, 25,* 917-928.

Cornille, T. A., & Meyers, T. W. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity, and predictive factors. *Traumatology, 5*, 15-31.

Craig, C.D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma therapists. *Anxiety, Stress, & Coping, 23*(3), 319-339.

Creswell, J. W. (2015). *A concise introduction to mixed methods research.* Los Angeles, CA: Sage.

Creswell, J. W., & Zhang, W. (2009). The application of mixed methods designs to trauma research. *Journal of Traumatic Stress, 22*, 612-621.

Crocker, L., & Algina, J. (1986). *Introduction to classical and modern test theory.* New York, NY: Holt, Rinehart, and Winston.

Daigneault, P-M., & Jacob, S. (2014). Unexpected but most welcome: Mixed methods for the validation and revision of the participatory evaluation measurement instrument. *Journal of Mixed Methods Research, 8*, 6-24.

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). *Internet, phone, mail, and mixed-mode surveys: The tailored design method*. Hoboken, NJ: John Wiley & Sons, Inc.

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and

implications for trauma-focused treatment. *Clinical Psychology Review, 31,* 25-36. doi:10.1016/j.cpr.2010.09.004

Engelhard, G. (2013). *Invariant measurement: Using Rasch models in the social, behavioral, and health sciences.* New York, NY: Routledge.

Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized,* pp.1-20.

Figley, C. R. (1999). Compassion fatigue: Towards a new understanding of the costs of caring. In B. H. Stamm (Ed.) *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators,* (pp. 3-28). Baltimore, MD: Sidran Press.

Figley, C.R., & Kleber, R.J. (1995). Beyond the "victim": Secondary traumatic stress. In R.J. Kleber, C.R. Figley, & B.P.R. Gersons (Eds.). *Beyond trauma: Cultural and societal dynamics*. New York, NY: Plenum Press, pp.75-98.

Figley, C. R., & Figley, K. R. (2017). Compassion fatigue resilience. In E. M. Seppala, E. Simon-Thomas, S. L. Brown, M. C. Worline, C. D. Cameron, & J. R. Doty (Eds). *The Oxford Handbook of Compassion Science*. New York, NY: Oxford University Press, pp. 387-397.

Finzi-Dottan, R., & Berckovitch Kormosh, M. (2017). The spillover of compassion fatigue into marital quality: A mediation model. *Traumatology.* Advance online publication.

Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the couples satisfaction index. *Journal of Family Psychology, 21,* 572-583.

Grauf-Grounds, C., & Edwards, C. (2007). A ritual to honor trauma: A training community's witness. *Journal of Systemic Therapies, 26,* 38-50.

Greene, J. C. (2007). *Mixed methods in social inquiry*. San Francisco, CA: Wiley.

Greene, T. (2018). Blame, PTSD, and DSM-5: An urgent need for clarification. *European Journal of Psychotraumatology, 9,* 1-4.

Goff, B. S. N., Crow, J. R., Reisbig, A. M., & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology, 21*(3), 344-353.

Hemsworth, D., Baregheh, A., Aoun, S., & Kazanjian, A. (2018). A critical enquiry into the psychometric properties of the professional quality of life scale (ProQol-5) instrument. *Applied Nursing Research, 39,* 81-88.

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28,* 83-91.

Hesse, A. R. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal, 30,* 293-309.

Itzick, M. & Kagan, M. (2017). Intention to leave the profession: Welfare social workers compared to health care and community social workers in Israel. *Journal of Social Service Research, 42,* 346-357. https://doi.org/10.1080/01488376.2016.1246402

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods, 18,* 3-20.

Ivicic, R., & Motta, R. (2017). Variables associated with secondary traumatic stress among mental health professionals. *Traumatology, 23*(2), 196-204.

Jaffe, A. E., DiLillo, D., Hoffman, L., Haikalis, M., & Dykstra, R. E. (2015). Does it hurt to ask? A meta-analysis of participant reactions to trauma research. *Clinical Psychology Review, 40,* 40-56.

Jorm, A. F., Kelly, C. M., & Morgan, A. J. (2007). Participant distress in psychiatric research: A systematic review. *Psychological Medicine, 37,* 917-926.

Jordan, L. S., & Seponski, D. M. (2018a). Public participation: Moving beyond the four walls of therapy. *Journal of Marital and Family Therapy, 44*(1), 5-18.

Jordan, L. S., & Seponski, D. M. (2018b). "Being a therapist doesn't exclude you from real life": Family therapists' beliefs and barriers to political action. *Journal of Marital and Family Therapy, 44*(1), 19-31.

Kagan, M., & Itzick, M. (2019). Work-related factors associated with psychological distress among social workers. *European Journal of Social Work, 22,* 30-42. doi: 10.1080/13691457.2017.1357021

Kaplowitz, M. D., Hadlock, T. D., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly, 68,* 98-101.

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B.H. Stamm (Ed.). *Secondary traumatic stress, second edition: Self-care issues for clinicians, researchers, and educators.* Baltimore, MD: Sidran Press, pp. 37-48.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14(2),* 32-44.

Killian, K., Hernandez-Wolfe, Pl, Engstrom, D., & Gangsei, D. (2017). Development of the vicarious resilience scale (VRS): A measure of positive effects of working with trauma survivors. *Psychological trauma: Theory, Research, Practice, and Policy, 9,* 23 -32.

Kline, R. B. (2011). *Principles and practice of structural equation modeling, 3rd ed*. New York, NY: The Guilford press.

Lee, J. J., Gottfried, R., & Bride, B. E. (2018). Exposure to client trauma, secondary traumatic stress, and the health of clinical social workers A mediation analysis. *Clinical Social Work Journal, 46,* 228-235. doi:10.1007/s10615-017-0638-1

Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society: The Journal of Contemporary Social Services, 94,* 96-103.

Levin, A., Besser, A., Albert, L., & Smith, D. (2012). The effect of attorney's work with trauma-exposed clients on PTSD symptoms, depression, and functional impairment: A cross-lagged longitudinal study. *Law and Human Behavior, 36,* 538-547.

Lim, A. G., Stock, L., Oo, E. K. S., & Jutte, D. P. (2013). Trauma and mental health of medics in eastern Myanmar's conflict zones: A cross-sectional and mixed methods investigation. *Conflict and Health, 7,* 1-13.

Ludick, M., & Figley, C. R. (2016). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology,* Advance online publication. http://dx.doi.org/10.1037/trm0000096

Macchi, C. R., Johnson, M. D., & Durtschi, J. A. (2014). Predictors and processes associated with home-based family therapists' professional quality of life. *Journal of Marital and Family Therapy, 40,* 380-390.

Maercker, A., & Hecker, T. (2016). Broadening perspectives on trauma and recovery: A socio-interpersonal view of PTSD. *European Journal of Psychotraumatology, 7,* 1-9.

Maercker, A., & Horn, A. B. (2012). A socio-interpersonal perspective on PTSD: The case for environments and interpersonal processes. *Clinical Psychology and Psychotherapy, 20,* 465-481.

MAXQDA, software for qualitative data analysis, 1989-2017, VERBI Software – Consult – Sozialforschung GmbH, Berlin, Germany.

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (2nd ed., pp.145-167).

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131-149.

Mendenhall, T. J., & Berge, J. M. (2010). Family therapists in trauma-response teams: Bringing systems thinking into interdisciplinary fieldwork. *Journal of Family Therapy, 32,* 43-57.

Middleton, J. S., & Potter, C. C. (2015). Relationship between vicarious traumatization and turnover among child welfare professionals. *Journal of Public Child Welfare, 9*, 195-216.

Miller, J. J., Lianekhammy, J., Pope, N., Lee, J., & Grise-Owens, E. (2017). Self-care among healthcare social workers: An exploratory study. *Social Work in Health Care, 56,* 865-883.

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology, 23*, 129-142.

Moreno, I. G., Go, G. P., & Yangson-Serondo, A. (2017). Examining the dimensional structure models of secondary traumatic stress based on DSM-5 symptoms. *Asian Journal of Psychiatry, 25*, 154-160.

Muthén, L. K., & Muthén, B. (2010). *Mplus*. Muthén & Muthén.

Negash, S., & Sahin, S. (2011). Compassion fatigue in marriage and family therapy: Implications for therapists and clients. *Journal of Marital and Family Therapy, 37*, 1-13.

Onwuegbuzie, A. J., & Leech, N. L. (2006). Linking research questions to mixed methods data analysis procedures. *The Qualitative Report, 11*, 474-498.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558.

Rasmussen, B., & Bliss, S. (2014). Beneath the surface: An exploration of neurobiological alterations in therapists working with trauma. *Smith College Studies in Social Work, 84*, 332-349.

Rasmussen, A., Verkuilen, J., Jayawickreme, N., Wu, Z., & McCluskey, S. T. (2018). When did posttraumatic stress disorder get so many factors? Confirmatory factor models since *DSM-5*. *Clinical Psychological Science,* 1-15.

Regehr, C. (2005). Bringing the trauma home: Spouses of paramedics. *Journal of Loss and Trauma, 10,* 97-114.

Robinson-Keilig, R. A. (2013). Secondary traumatic stress and disruptions to interpersonal functioning among mental health therapists. *Journal of Interpersonal Violence, 29*, 1477-1496.

Ruark, A., & Fielding-Miller, R. (2016). Using qualitative methods to validate and contextualize quantitative findings: A case study of research on sexual behavior and gender-based violence among young Swazi women. *Global Health: Science and Practice, 4*, 373-383.

Saakvitne, K. W., Tennen, H., & Affleck, G. L.. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self development theory. *Journal of Social Issues, 54*, 279-299.

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, 54-61.

Shannon-Baker, P. (2015). Making paradigms meaningful in mixed methods research. *Journal of Mixed Methods Research, 10*, 319-334.

Shoji, K., Lesneirowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & Cieslak, R. (2015). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the U.S. and Poland. *PlosOne, 10*, 1-15.

Solomon, S. D., & Davidson, J. R. T. (1997). Trauma: Prevalence, impairment, service use, and cost. *The Journal of Clinical Psychiatry, 58*(Suppl 9), 5-11.

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare, 90*, 149- 168.

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2018). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research and leading experts. *Traumatology,* 1-10.

Sprang, G., Ross, L., Miller, B. C., Blackshear, K., & Ascienzo, S. (2016). Psychometric properties of the secondary traumatic stress-informed organizational assessment. *Traumatology, 23*(2), 153-164.

Spss, I. (2018). IBM SPSS statistics version 25. *Boston, Mass: International Business Machines Corp*.

Stamm, B. H. (2009). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL).*

Stamm, B. H. (2010). The Concise ProQOL Manual. Pocatello, ID: ProQOL.org.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*, 77-100.

Ting, L., Jacobson, J. M., Sanders, S., & Bride, B. E. (2005). The secondary traumatic stress scale (STSS). *Journal of Human Behavior in the Social Environment, 11,* 177-194.

Travis, D. J., Lizano, E. L., & Mor Barak, M. E. (2016). "I'm so stressed!": A longitudinal model of stress, burnout, and engagement among social workers in child welfare settings. *British Journal of Social Work, 46,* 1076-1095.

Wheater, K., & Erasmus, C. (2017). Experiences of secondary trauma amongst spouses of emergency service personnel. *Social Work*, *53*(4), 470-478.

Whitt-Woosley, A., & Sprang, G. (2017). Secondary traumatic stress in social science researchers of trauma-exposed populations. *Journal of Agression, Maltreatment & Trauma,* doi: 10.1080/10926771.2017.1342109. Accessed August 29, 2017.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52,* 30-41.

APPENDIX A

Survey Questionnaire

Thank you for agreeing to take part in this study. All the answers you provide on this survey will help to further understand how working with trauma during therapy impacts the lives of marriage and family therapists.

The following questions ask about your work experiences and demographics:

1. Are you currently licensed to practice as a helping professional?
    a. Yes
    b. No
2. Are you currently seeing clients directly in an agency, organization, private practice, training facility, or additional setting?
    a. Yes
    b. No

If 1&2 = NO, transition to page where they can enter for random drawing.

3. What is your current licensure status? (choose all that apply)
    a. LPC
    b. LPC intern/associate
    c. LCSW
    d. LCSW intern/associate
    e. MFT
    f. MFT intern/associate
    g. Clinical psychologist
    h. Other _____
4. What is your gender?
    a. Female
    b. Male
    c. Other
5. What is your age (in years)? _____
6. What is your current relationship status?
    a. Single
    b. Dating in a committed couple relationship
    c. Cohabiting in a committed relationship
    d. Engaged
    e. Married
    f. Divorced
    g. Widowed

7. (If married, dating in a committed relationship, or other): How many years have you been with your current partner or spouse? (Numeric response by number of years)
8. What is your race?
    a. White/Caucasian
    b. Black/African American
    c. American Indian or Alaska Native
    d. Asian
    e. Native Hawaiian or Other Pacific Islander
    f. Other_____
9. What is your ethnicity?
    a. Hispanic
    b. Non-Hispanic
    c. Other _____
10. What best describes the current facility where you practice as a therapist?
    a. University training clinic
    b. Community mental health agency
    c. Nonprofit agency
    d. Private practice
    e. Other_____
11. Roughly how many full-time employees currently work for your organization?
    a. 1-10
    b. 11-50
    c. 51-200
    d. 201-500
    e. 501-1,000
    f. 1,001-5,000
    g. 5,001-10,000
    h. 10,000+
    i. I am currently not employed in an agency/organization
12. How many years have you worked as a therapist/professional helper?
    a. 0-2 years
    b. 3-5 years
    c. 6-10 years
    d. 11-20 years
    e. 21+ years
13. Do you receive specific trauma training as part of your work?
    a. Yes
    b. No
14. (If 12= yes): Please specify the type of trauma training you have received
    _____
15. Do you receive specific *secondary* trauma training as part of your work?
    a. Yes
    b. No

16. (If 15= yes): Please specify the type of secondary trauma training you have received _____
17. Within which of the following service systems do you do the majority of your work with traumatized clients?
    a. Child welfare
    b. Community mental health
    c. Juvenile justice
    d. Educational or school setting
    e. Healthcare
    f. First responder groups (e.g., police, fire, paramedics)
    g. Tribal settings
    h. Other _____
18. What is your job role?
    a. Volunteer
    b. Intern
    c. Front line worker
    d. Clinician
    e. Supervisor
    f. Manager
    g. Senior manager
    h. C-level: CEO, Executive director, COO, etc.
    i. Other_____
19. How many trauma clients do you see on a weekly basis?
    a. 0
    b. 1-5
    c. 6-10
    d. 11-15
    e. 16-20
    f. 21-25
    g. 26-30
    h. 31+
20. On average, how many hours per week do you spend with traumatized clients?
    a. 0
    b. 1-5
    c. 6-10
    d. 11-15
    e. 16-20
    f. 21-25
    g. 26-30
    h. 31-35
    i. 36-40
    j. 40+
21. What percentage of your current caseload is working with clients who have PTSD?

    a. (0-100%, dropdown menus will be used in Qualtrics)
22. What percentage of your current caseload is working with trauma survivors?
    a. (0-100%, dropdown menus will be used in Qualtrics)
23. Did you experience a traumatic event(s) as a child?
    a. Yes
    b. No
24. (If yes) How many traumatic events did you experience as a child?
25. To what extent did the event negatively impact you **at the time it occurred?**
    a. 0 = Not at all
    b. 1 = A little
    c. 2 = Some
    d. 3 = A lot
    e. 4 = A great deal
26. Does the event negatively impact you **currently**?
    a. 0 = Not at all
    b. 1 = A little
    c. 2 = Some
    d. 3 = A lot
    e. 4 = A great deal
27. Have you been exposed to a traumatic event(s) as an adult?
    a. Yes
    b. No
28. (If yes) How many traumatic events have you experienced as an adult?
29. To what extent did the event negatively impact you **at the time it occurred?**
    a. 0 = Not at all
    b. 1 = A little
    c. 2 = Some
    d. 3 = A lot
    e. 4 = A great deal
30. Does the event negatively impact you **currently**?
    a. 0 = Not at all
    b. 1 = A little
    c. 2 = Some
    d. 3 = A lot
    e. 4 = A great deal

Professional Quality of Life Scale version 5

When you help people, you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation.

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

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

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a helper.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
9. I think that I might have been affected by the traumatic stress of those I help.
10. I feel trapped by my job as a helper.
11. Because of my helping, I have felt “on edge” about various things.
12. I like my work as a helper.
13. I feel depressed because of the traumatic experiences of the people I help.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with helping techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a helper.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed because my caseload seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
24. I am proud of what I can do to help.
25. As a result of my helping, I have intrusive, frightening thoughts.
26. I feel “bogged down” by the system.
27. I have thoughts that I am a “success” as a helper.
28. I can’t recall important parts of my work with trauma victims.

29. I am a very caring person.
30. I am happy that I chose to do this work.

Secondary Traumatic Stress Scale

(Bride, 2013)

The following is a list of statements made by persons impacted in their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past 7 days.

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

1. I felt emotionally numb.
2. My heart started pounding when I thought about my work with clients.
3. It seemed as if I was reliving the trauma(s) experienced by my clients.
4. I had trouble sleeping.
5. I felt discouraged about the future.
6. Reminders of my work with clients upset me.
7. I had little interest in being around others.
8. I felt jumpy.
9. I was less active than usual.
10. I thought about my work with clients when I didn't intend to.
11. I had trouble concentrating.
12. I avoided people, places, or things that reminded me of my work with clients.
13. I had disturbing dreams about my work with clients.
14. I wanted to avoid working with some clients.
15. I was easily annoyed.
16. I expected something bad to happen.
17. I noticed gaps in my memory about client sessions.
18. I experienced intense negative emotions.
19. I engaged in reckless or self-destructive behavior.
20. I unrealistically blamed others for the cause or consequences of the traumas experienced by my client(s).
21. I had negative expectations about myself, others, or the world.

Secondary Trauma Self-Efficacy

For each situation described below, please rate how capable you are to deal with thoughts or feelings that occur (or may occur) as the result of your work with people experiencing extreme or traumatic events.

Please rate each situation as you CURRENTLY believe how capable you are.

1=Very Incapable	2=Incapable	3=Somewhat Incapable	4=Neither incapable or capable	5 = Somewhat capable	6 = Capable	7 = Very Capable

"How capable am I to…"

1. Deal with my emotions (anger, sadness, depression, anxiety) about working with these people.
2. Find some meaning in what had happened to these people.
3. Control recurring distressing thoughts or images about these people.
4. Deal with thoughts that similar things may happen to me.
5. Be supportive to others after my experiences with these people.
6. Cope with thoughts that I can't handle working with these people anymore.
7. Get help from others to better handle working with these people.

Secondary traumatic stress informed-organizational assessment

Secondary Traumatic Stress (STS) affects our personnel, organizational structure, policies, and procedures in both subtle and overt ways. Although many organizations working with individuals exposed to trauma acknowledge that STS is present in their workforce, they may need guidance on how to reduce risk and promote staff wellness and resilience. This assessment tool will give organizations an opportunity to engage in self-assessment to determine the impact of STS in their organization, and, combined with an overall trauma-informed organizational change framework, support strategic planning in specific areas of need.

After reading each item, place a check mark under the appropriate choice as to how your organization (or place of work) performs on that indicator. These indicators can provide you with a map or framework to guide organizational change.

1=Not at all 2=Rarely 3=Somewhat 4=Mostly 5=Completely 6= N/A

The organization promotes resilience-building activities that enhance the following:

1. Basic knowledge about STS
2. Monitoring the impact of STS on professional well-being
3. Maintaining positive focus on the core mission for which the organization stands
4. A sense of hope (e.g., a belief in a clients' potential for trauma recovery, healing, and growth)
5. Specific skills that enhance a worker's sense of professional competency
6. Strong peer support among staff and/or outside consultants
7. Healthy coping strategies to deal with the psychological demands of the job.

Social Support

These next questions focus on your current resources of social support. Thinking about your social relationships, please respond to each question.

1=Very Strongly Disagree	2=Strongly Disagree	3=Mildly Disagree	4=Neutral	5 = Mildly Agree	6 = Strongly Agree	7 = Very Strongly Agree

1. There is a special person who is around when I am in need.
2. There is a special person with whom I can share my joys and sorrows.
3. My family really tries to help me.
4. I get the emotional help and support I need from my family.
5. I have a special person who is a real source of comfort to me.
6. My friends really try to help me.
7. I can count on my friends when things go wrong.
8. I can talk about my problems with my family.
9. I have friends with whom I can share my joys and sorrows.
10. There is a special person in my life who cares about my feelings.
11. My family is willing to help me make decisions.
12. I can talk about my problems with my friends.

Relationship satisfaction

1. Please rate the degree of happiness, all things considered, of your relationship.

0=Extremely unhappy	**1=Fairly unhappy**	**2=A little unhappy**	**3 = Happy**	**4 = Very Happy**	**5 = Extremely Happy**	**6 = Perfect**

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

2. I have a warm and comfortable relationship with my partner.

0=Not at all true	**1=A little true**	**2=Somewhat true**	**3= Mostly true**	**4 = Almost completely true**	**5 = Perfect**

3. How rewarding is your relationship with your partner?

0=Not at all	**1=A little**	**2=Somewhat**	**3= Mostly**	**4 = Almost completely**	**5 = Completely**

4. In general, how satisfied are you with your relationship?

0=Not at all	**1=A little**	**2=Somewhat**	**3= Mostly**	**4 = Almost completely**	**5 = Completely**

Distress and Impairment

(Bride, Lee, Miller, 2016)

In the following areas of functioning, how much significant distress and impairment has resulted from your trauma work with clients:

0=None	1=A little	2=Some	3= A Lot	4 = A Great Deal

1. Social functioning
2. Occupational functioning
3. Familial functioning
4. Sexual functioning
5. Psychological functioning
6. Emotional functioning
7. Physical functioning

Intention to leave

(Middleton & Potter, 2015)

1=Strongly Disagree	2=Disagree	2=Somewhat Disagree	2= Somewhat Agree	5 = Agree	6 = Strongly Agree

1. I have often thought about leaving this organization.
2. I would leave this job tomorrow if I was offered a job for the same salary but with less stress.
3. I plan to leave this organization in the next 12 months.
4. I am actively seeking other employment.

Vicarious Resilience Scale

(Killian, Hernandez- Wolfe, Engstrom, & Gengsei, 2017)

0 = Did not experience this	1= Experienced this to a *very small* degree	2= Experienced this to a *small* degree	3= experienced this to a *moderate* degree	4 = Experienced this to a *great* degree	5 = Experienced this to a *very great* degree

Please reflect on your experience working with persons who have survived severe traumas. Since you began this work, you may have undergone changes in how you view your clients, your approach to this work, and/or your own experience or worldview. Please read each of the following statements about your attitudes, experiences, and how your view of your life *since you began this work*, and indicate the degree to which you disagree or agree.

1. Better able to reassess dimensions of the problems
2. Better able to keep perspective
3. See life as more manageable
4. Better able to cope with uncertainties
5. More resourceful
6. Learned how to deal with difficult situations
7. More connected to people in life
8. Life goals and priorities have evolved
9. More compassion for people
10. More time and energy into relaitonships
11. Iddeas about what is important changed
12. More mindful and reflective
13. In tune with body
14. More time for meditative, mindful, or spiritual practices
15. Better able to assess level of stress
16. Better at self-care
17. Inspired by peoples' capacity to persevere
18. Hopeful about peoples capacity to heal and recover from traumas
19. More hopeful and engaged when focusing on strengths
20. Clients' spiritual practices source of inspiration
21. Recognize spirituality as component of clients' survival
22. Highlight clients' spiritual/religious beliefs to promote resilience
23. Ethnicity, gender, class, sexual orientation and privilege, access, resources
24. When experience distressing throughs am able to just notice them

25. Better able to remain present when hearing trauma narratives
26. Notices client trauma narratives without getting lost in them

Future Research

1. Would you be interested in completing an interview with the researcher and your partner regarding your work experiences, and how these experiences impact your couple and social relationships? This interview would take between 45-60 minutes in the next 2-4 months, and would be completed with your spouse or partner. If you are not currently partnered, you would complete the interview independently. The incentive for completing these interviews is a $20 VISA gift card for all who participate in the study.

   Yes: Move to page collecting unique (but confidential identifiers). After completing this page, you will be taken to a separate survey to enter into the drawing for the incentive.

   No: You will be taken to a separate survey to enter into the drawing for the incentive.

PAGE FOR COLLECTING UNIQUE IDENTIFIER

Please enter an email address where you can be contacted to

PAGE FOR INCENTIVE DRAWING (HAPPENS AFTER SURVEY IS COMPLETE *OR* 1ST 2 QUESTIONS ARE ANSWERED NO)

1. Would you like to be entered into a drawing for a $25 Amazon gift card in appreciation for your time completing this survey?
   a. Yes
   b. No
2. Please enter your email address where you can be contacted if your name is drawn to receive the gift card:

   _____

FINAL SCREEN:

Many of the questions you have responded to today may bring up memories of trauma reported to you by the people you help. If you would like to talk with someone more

about your experiences or are experiencing heightened symptoms of PTSD, please consider contacting one of these resources:

1. **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline:** 1-800-662-HELP (4357). This phone number can help you locate services within your area.
2. **Crisis Text Line:** Text HOME to 741741 for free, 24/7 crisis support anywhere within the US. This service is available if you do not feel like talking to someone, you will be able to text with a supportive crisis counselor 24/7.

APPENDIX B

E-mail introduction and invitation

Hello,

My name is Stephanie Armes, and I am contacting you to invite you to participate in a research study titled, "*An exploration of secondary trauma in marriage and family therapists*." This study seeks to understand how working with clients who have experienced trauma impacts both the personal and professional lives of Marriage and Family Therapists.
In one weeks' time, I will be sending you the link to a survey to complete. After completing this survey, you will have the opportunity to be entered into a drawing for a $25 VISA gift card.
Please let me know if you have questions about this research. I can be reached at stephanie.armes25@uga.edu. I am guided by my major professor, Dr. Desiree Seposnki, in this research. She can be reached at seponski@uga.edu if there are additional questions.

Appreciatively,

Stephanie Armes
PhD Candidate and Graduate Research Assistant
Department of Human Development and Family Science
Emphasis in Marriage and Family Therapy
University of Georgia
Stephanie.armes25@uga.edu

APPENDIX C

Email with survey link

Are you a currently licensed (Full, Associate, and/or Intern status), actively practicing Marriage and Family Therapist (MFT)?

I am studying secondary trauma in MFTs and invite you to participate in the study here: [www.linktosurvey.com].

By completing the survey, you can enter into a drawing for a **$25 Amazon gift card**. If you do not want to participate in this study but want to enter the drawing, send an email to stephanie.armes25@uga.edu. **The survey is scheduled to close in the next week. If you would like to participate, please consider taking the survey soon.**

Questions? Contact Stephanie Armes at stephanie.armes25@uga.edu.

Study information: IRB #: 000000006030 (Status: Approved, The University of Georgia) UGA IRB chairperson: (706) 542-3199 Principal Investigator: Stephanie Armes, M.S., Doctoral Candidate Major Professor and Advisor: Dr. Desiree Seponski, PhD;seponski@uga.edu

Appreciatively,

Stephanie

Stephanie Armes, M.S., LAMFT

PhD Candidate & Graduate Research Assistant

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http://www.fcs.uga.edu/people/bio/sea85831

APPENDIX D

University of Georgia Consent Form (for internet survey)

My name is Stephanie Armes, and I am a Doctoral Candidate in the Marriage and Family Therapy emphasis, Human Development and Family Science PhD program at the University of Georgia. One week ago, I sent you an email inviting you to participate in a research study titled "*An exploration of secondary trauma in Marriage and Family Therapists*", and today I am sending you the link to participate in this study, if you choose to. The purpose of this study is to understand how working with clients who have experienced trauma impacts both the personal and professional lives of Marriage and Family Therapists. Whether you work in a small nonprofit agency, a large community mental health organization, or in private practice, your responses on this survey will help us to further understand secondary trauma and continue developing knowledge and interventions that will help prevent secondary trauma.

To take this study, participants must be:

- 21 years of age or older
- A licensed Marriage and Family Therapist at the Associate or Full levels
- Be actively practicing with individuals, couples, and/or families

If you agree to participate, you will be asked to complete an online survey about your experiences of working with trauma, which should only take about 20-25 minutes. Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. You will have the opportunity to enter a drawing for a $25 Amazon gift card in appreciation for your time in completing the survey. If you do not wish to participate in this research but would still like to be entered into the drawing, send an email to stephanie.armes25@uga.edu. You will also be offered the opportunity to participate in an additional part of the study that will be conducted in 2-3 months' time. This part of the study will include online interviews with therapists and their partners. You can sign up for the interview at the end of the survey by submitting your email address and contact information, however we will only contact you if you are willing to be interviewed with your partner. Your contact information will be detached from your answers and kept separately from the information you give on the survey. If you decide to stop or withdraw from the study, the information/data collected from or about you up to the point of your withdrawal will be kept as part of the study and may continue to be analyzed.

All information you disclose on the survey will be confidential (meaning it is private). Because you are taking the survey online, your confidentiality is limited, and you may want to take the survey on your home computer if you would feel more comfortable on a computer not networked to your work computer or to a public internet source. Your personal contact information (name and email address) will be collected from you for the purposes of (1) entering you into the drawing for the gift card incentive and (2) to communicate your interest in participating in the second phase of this study. Your contact information will be separated from the survey and a unique code will be assigned to you.

A list of your name and the code assigned to you will be kept securely locked in the research office at University of Georgia and will not be disclosed to anyone. Upon completion of the study in June 2019, the list linking your name and identifying code together will be destroyed. Researchers will not release identifiable results of the study to anyone other than individuals working on the project without your written consent unless required by law. The results of the research study may be published, but your name or any identifying information will not be used. In fact, the published results will be presented in summary form only.

The findings from this project may provide information on how to best prevent the development of secondary trauma in Marriage and Family Therapists. There are no known risks or discomforts associated with this research. As you complete the survey, you may feel discomfort related to memories of clients you have previously helped in therapy. (If there is financial or other compensation/incentives, include this.) By agreeing to participate in the research and completing the survey, you will be entered into a drawing for a $25 Amazon gift card. Your name and contact information will be collected at the end of the survey and will be separated from your survey responses.

If you have any questions about this research project, please feel free to call at (706) 542-2131 or send an e-mail to stephanie.armes25@uga.edu. Questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board, 609 Boyd GSRC, Athens, Georgia 30602; telephone (706) 542-3199; email address irb@uga.edu.

Sincerely,

Stephanie Armes

APPENDIX E

Final survey reminder

Hello,

My name is Stephanie Armes, and last week I sent you a link to an online survey inviting you to participate in a study titled, "*An exploration of secondary trauma in marriage and family therapists*." This study seeks to understand how working with clients who have experienced trauma impacts both the personal and professional lives of Marriage and Family Therapists.

I am contacting you today to remind you of the survey being available to take online. You can access the survey here: [www.linktosurvey.com]. After completing this survey, you will have the opportunity to be entered into a drawing for a $25 VISA gift card. Thank you for your time and attention in completing this important research. Please let me know if you have questions about this research. I can be reached at stephanie.armes25@uga.edu. I am guided by my major professor, Dr. Desiree Seponski in this study. She can be reached at seponski@uga.edu if there are additional questions.

Appreciatively,

Stephanie Armes

PhD Candidate and Graduate Research Assistant

Department of Human Development and Family Science

Emphasis in Marriage and Family Therapy

University of Georgia

Stephanie.armes25@uga.edu

APPENDIX F

Recruitment email for qualitative interviews

Hello,

Thank you so much for completing the survey portion for the study titled, *An exploration of secondary trauma in marriage and family therapists*." I am contacting you today because you expressed interest in participating in further interviews about your experiences with trauma work. For these interviews, I am recruiting therapists who are in a committed relationship and am inviting their spouse or partner to complete the interview with them. In order to complete this interview with you, I would like to set up a time to call you and your partner using ZOOM, a free software that is HIPAA-compliant and is encrypted. Before setting up a time to call you, I would like to mail you and your partner a consent form with information about the interview.

Please respond at your earliest convenience with:

1. An email address where the consent form can be mailed to you and your partner.
2. The best day(s) and times in the next 3-4 weeks for us to speak. The conversation will last between 45-60 minutes.
    a. (A series of times and days in which partners can choose interview day/time will be listed)

Once I receive a response from you, I will email you and your partner a consent form and schedule your interview, honoring the times that are best for you both.

Thank you for your time, and I look forward to speaking with you soon.

Appreciatively,

Stephanie Armes

PhD Candidate and Graduate Research Assistant

Department of Human Development and Family Science

Emphasis in Marriage and Family Therapy

University of Georgia

Stephanie.armes25@uga.edu

APPENDIX G

Semi-structured interview guide

Initial interview script: Thank you for speaking with me today, I appreciate you taking the time to discuss your experiences in working with the people you help. Today, I would like to ask you some questions about how having one (or both) people involved in helping others impacts you individually, as well as how this may impact your relationship.

Before we begin the interview, I need to speak with you both about informed consent and the process of sending you your gift card incentive. Did you receive the informed consent form in your email? Do you have any questions about the process of our interview today? [Go over informed consent with couple]

Where would you like me to send the gift card incentive? [Note where each partner would like to get the gift card].

Part of this research process is making sure I have gotten a clear picture of what you are experiencing by having one (or both) of you involved in work as a helping professional. Would it be okay with you both if I contact you after I have completed my analysis of the qualitative interviews, to check over what I have found? [Discuss member checking further, if there are questions. Then, proceed to interview questions]

I will go ahead and start with some questions I would like to discuss today. Because I have questions about your work with trauma, and how that may impact one (or both) of you as well as affect your relationship, please let me know if there are any questions you need to skip. I will check in with you both throughout the course of the interview to make sure you would like to continue with the interview, or if you need to take a break before continuing with the questions.

1. How does having one partner who works with trauma impact your relationship?
2. Do you ever notice that having one (or both) of you involved in helping work negatively impacts the relationship? How does it negatively impact the relationship?
3. Do you ever notice that having one (or both) of you involved in helping work positively impacts the relationship? How does it positively impact the relationship?
4. How would your relationship and life together be different if one (or both) of you was not involved in helping with trauma populations?
5. Is there anything I have not asked you both yet that you would like me to know about how trauma work impacts your relationship?

I would like to briefly check in with you both to see how you are doing, since we have been discussing trauma and its impact for a few minutes. Are you both okay to continue with the interview?

6. How have your experiences working with trauma shaped you as a therapist? [For partner/spouse] How do you think trauma work has shaped your partner or spouse?
7. How has your trauma work impacted you? How has having your (spouse/partner) involved in trauma work impacted you?
8. [for therapists] Have you had any negative experiences from working with trauma in therapy?
    a. How have these impacted your professional life?
    b. How did they impact your personal life?
    c. How did you move on from these experiences, or ask for help?
9. [for therapists] Have you had any positive experiences from working with trauma in therapy?
    a. How have these impacted your professional life?
    b. How did they impact your personal life?
    c. How did you maintain this positive experience in the midst of your challenging work?
10. Do you think your professional work with trauma has changed you? If so, how?
11. What professional resources do you have access to at your agency, organization, or in your private practice, that help you to maintain this work?
    d. How could your place of work be better at providing you support to maintain this work?
12. What personal resources help you to maintain this work?
13. Have you ever experienced secondary trauma? How did you move forward in your work and personal life?

Thank you so much for your time today. I appreciate the ability to speak with you about trauma and how your (or your partner's) work with trauma may be impacting your relationship. As we have been talking about your, you may remember some particularly traumatic experiences disclosed by your clients. If you would like to talk with someone more about your symptoms, here are two national hotline resources you can use:

3. **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline:** 1-800-662-HELP (4357). This phone number can help you locate services within your area.
4. **Crisis Text Line:** Text HOME to 741741 for free, 24/7 crisis support anywhere within the US. This service is available if you do not feel like talking to someone, you will be able to text with a supportive crisis counselor 24/7.

APPENDIX H

Interview Informed Consent Form

Dear [Participant Name],

Researcher's Statement
I am inviting you to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. This form is designed to give you the information about the study so you can decide whether to be in the study or not. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, you can decide if you want to be in the study or not.

Principal investigators
I am a doctoral candidate under the direction Dr. Desiree Seponski in the department of Human Development and Family Science at The University of Georgia. I am inviting you to participate in a research study entitled *An exploration of secondary trauma in marriage and family therapists*. This is the second phase of a two-phased research study; you are eligible to participate in this part of the study because you either (1) completed the first phase of the study and indicated in the survey you completed that you and your partner would be interested in completing interviews with the researcher, or (2) your spouse or partner completed a survey and indicated that they would be interested in completing an interview with you and the researcher at a later time.

Interview purpose
This overall study seeks to understand how working with clients who have experienced trauma impacts both the personal and professional lives of Marriage and Family Therapists (MFTs). The interview portion of this study is focused on how working with trauma impacts MFTs and their partners in committed romantic relationships. The question guiding this study is: How does secondary traumatic stress affect therapists' committed romantic relationships?

Inclusion criteria
In order to participate in this phase of the study, you must meet the following criteria:
1. You must be either (a) a full or associate licensed MFT and actively practicing or (b) be the spouse or partner of a full or associate licensed MFT who is actively practicing.
2. Be willing to set aside 45-60 minutes for an online telephone interview.

Study Procedures
If you agree to participate in this study, you will be asked to:
1. Read and sign this consent letter and return it to the researcher.
2. Confirm an appointment time via email with the researcher. Each appointment will last between 45-60 minutes.

3. Provide the researcher with your contact details.
4. On the day and time of the interview, the researcher will contact you on the contact details you provided. The interview will begin with obtaining verbal informed consent.
5. After discussing consent verbally, digital audio recording of the interview will begin and the semi-structured interview will be conducted. Please note; the time slot indicated for your interview must be reserved with no expected interruptions.
6. You and your partner will each receive a $20 gift card in appreciation for your time. The researcher will ask you and your partner separately in a follow-up email where to send the gift card incentive.
7. After your interview is transcribed and the data is analyzed, you will be invited to review the interpretations and provide suggestions. This is optional.

Audio Recording

Your responses will be audio-recorded for transcribing purposes. Audio-recordings will be deleted five years from the date of completion of this study. **By initialing here _____ you give permission to be contacted to review your transcript and the researchers' interpretations of your interviews.** You will be contacted via your preferred method of contact.

Taking part is voluntary

Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw from the study, the information that can be identified as yours will be kept as part of the study and may continue to be analyzed, unless you make a written request to remove, return, or destroy the information.

Privacy/Confidentiality statement

No individually identifiable information about you, or provided by you or your partner during the research, will be shared with others without your written permission. You will be assigned an identifying number and a false name. This number and name will be used on all material collected about you. The researcher will not use your name or your family name in any report shown to anyone outside the research team. The transcriptions from audio recordings will be stored by paper copy in a locked container in a locked room with coded data in a different location or in a password protected computer file with the coded data on a separate computer. Only the research team will have access to the audio recordings and to the key to my information; the recordings will not be publicly disseminated. Researchers will not release identifiable results of the study to anyone other than individuals working on the project without your written consent unless required by law.

Risks and discomforts

We do not anticipate any risks from participating in this research. You may experience some discomfort as you remember difficult situations arising from your work with trauma, or your partners' reactions to their trauma work.

Benefits
To benefit the larger field of Marriage and Family Therapy, from this study, is expected that: 1) The experiences of MFTs and their partners will be explored in detail, therefore giving you the opportunity to share your experiences 2) It is expected that clinical practice of MFTs will improve through knowledge gained from the study 3) A theoretical framework of how trauma impacts both clinicians and their partners will be developed.

Incentives
In appreciation for your time, the research will mail you a $20 gift card after the interview has been completed. You will be asked to provide information at the bottom of this page for where you would like your incentive to be mailed. The gift card will not be sent to you until you have completed an interview with the researcher.

If you have questions
Please ask any questions you have now. If you have questions later, you may contact Stephanie Armes at stephanie.armes25@uga.ed or at 706-542-4905 or you can contact Dr. Desiree Seponski (PI) at Seponski@uga.edu or at 1-706-542-4821. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, you must initial in the space provided below and complete the form describing where you would like your incentive sent. By completing and returning this form and you are agreeing to participate in the above described research project and will subsequently be contacted by the researcher to set up an online interview appointment. Your initials below also indicate that you have read or had read to you this entire consent form, and have had all of your questions answered.

Name of Researcher: Stephanie Armes **Initials:** SEA **Date**

Name of Participant: _____ Initials:_____ Date:_____

Please continue to the next page to complete the incentive mailing form and possible times for an online interview of 45-60 minutes with your partner.

Thank you for your consideration! Please keep a copy of this letter for your records.

Sincerely,

Stephanie Armes
Department of Human Development and Family Science
Emphasis in Marriage and Family Therapy
The University of Georgia

Contact Information Form

Please use this form to identify the best days and times to complete the interview. Once you have completed the form, please save it and email it back to the researcher at: stephanie.armes25@uga.edu.

Best Day(s) to call you for the interview:	
Best Time(s) to call you for the interview:	
Please initial that you have access to a computer with the internet so that the interview can be completed:	
Please initial that you give permission for the researcher to contact you via email in order to set up the interview:	
Address of where you would like your incentive mailed: (*Note: the incentive will be mailed after completing the interview*)	
Would you like to review the initial findings of the researcher after the analysis has been completed?	