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Preparing Students for Trauma Exposure in Field Education Settings

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Abstract

Over a two-year period, Master of Social Work (MSW) field education students were asked to complete measures on their trauma histories and trauma symptoms to assess their risk for secondary traumatic stress (STS) and vicarious trauma (VT) when in field placements. Results of the study found that a significant number of students had trauma histories, that they developed symptoms of STS while in their field experience, and that some developed symptoms of VT. Results indicate the necessity for trauma training, including self-care, for all faculty members, supervising field instructors, and student interns to support the field experience.

Keywords: field education; secondary traumatic stress; vicarious trauma; social work; master's students

Trauma exposure in the general population is prevalent (Simiola et al., 2018). A study by Benjet et al. (2015) of the general population in 24 countries around the world found that more than 70% of individuals reported being exposed to a traumatic event. Kessler et al. (1995) and Pietrzak et al. (2011) found that a significant number of these survivors will suffer from negative psychological and physical problems following the experience. Social work interns routinely work with clients who have survived traumatic events (Bride, 2007). Mueser et al. (2004) found that 90% of public mental health clients have a trauma history. Trauma-focused clinical work can lead to a variety of stress-specific reactions for the social worker, such as vicarious trauma (VT) and secondary traumatic stress (STS) (Salston & Figley, 2003). These can cause symptoms similar to those of posttraumatic stress disorder (PTSD) that intrude on the everyday life of the student intern and result in decreases in quality of life and professional functioning.

Literature Review

Trauma is defined as the results from an event, series of events, or circumstances experienced by an individual that are physically or emotionally harmful or threatening and have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Emotional reactions when working with trauma survivors are increasingly important in the practice of social work (Harrison & Westwood, 2009; Naturale, 2009), as client trauma histories are widely documented among those seeking mental health, public health, and social services (Ko et al., 2008; Pecora et al., 2009).

The term STS has been used to refer to the recognition that those who come into continued close contact with trauma survivors, including social work student interns, may experience significant emotional disruption and may become unintended victims of the trauma themselves (Figley, 1995). Consequently, STS is becoming viewed as an occupational hazard of providing direct services to traumatized populations (Figley, 1999; Hatcher et al., 2011). In fact, the newest revision of the Diagnostic Statistical Manual (DSM), version 5, reclassified PTSD to include "experiencing repeated or extreme exposure to aversive details of the traumatic event," such as "first responders collecting human remains; police officers repeatedly exposed to details of child abuse" (American Psychiatric Association, 2013, p. 271). This addition came in response to secondary victimization studies that showed first responders exhibited PTSD symptoms from witnessing firsthand traumatic experiences (Zoellner et al., 2013).

STS describes the sudden adverse reactions people can have to trauma survivors with whom they are working or seeking to help (Bride, 2007; Figley, 1995; Jenkins &

Baird, 2002). VT is more complex than STS as it is caused by disruptive and painful psychological effects that can persist for months or years if untreated (Pearlman, 2012; Pearlman & Saakvitne, 1995). VT is a negative alteration to the inner self of a trauma worker or helper that results from empathic interaction with traumatized clients and their reports of traumatic experiences.

While there is some literature that has examined STS and VT among clinical social workers (Bride, 2007; Devilly et al., 2009; Michalopoulos & Aparicio, 2012; Owens-King, 2019) few studies have examined these, or other stress reactions, in social work graduate student interns (Cunningham, 2004; Dane, 2002; Miller, 2001) who are likely to be treating trauma survivors. Social work student interns routinely work with clients who have survived interpersonal violence, child abuse and neglect, sexual abuse and assault, military combat, incarceration, man-made and natural disasters, and medical trauma, or who have cared for terminally ill family members for extended periods of time. Elliot and Guy (1993) found that women in mental health professions reported higher rates of trauma than women in other professions. Black et al. (1993) found that students in clinical fields reported more extensive trauma histories than students in nonclinical fields.

In more recent literature, racial trauma has shown to be important in understanding risk factors for people of color and indigenous communities. Related to vicarious trauma, racial trauma "is unique in that it involves ongoing individual and collective injuries due to exposure and re-exposure to race-based stress" (Comas-Díaz et al., 2019, p. 1). Further, the American Medical Association (AMA) in November 2020 acknowledged racism as a public health threat in the United States (O'Reilly, 2020). Current social work research has not investigated the link between racial trauma and vicarious trauma among social work students.

Butler et al. (2017) and Gilin and Kauffman (2015) reported evidence indicating that students in clinical training programs have higher Adverse Childhood Experience (ACE) scores than the general population. Crothers's (1995) study of staff members working with survivors of childhood sexual abuse identified several areas in which workers' lives were impacted, particularly early on in their employment. "According to most of the reviewed studies, higher levels of VT were associated with higher levels of exposure and lower levels of experience" (Chouliaria et al., p. 54). Michalopoulos and Aparicio (2012) found this to be true among social workers, thus making it imperative that we understand the impact of trauma on our novice student interns exposed to traumatic material presented by clients during their field education internship experience.

Methods

Procedure

The study was approved by the university Institutional Review Board. Students in the Master of Social Work (MSW) degree programs of two universities were asked to participate in a study of their experience with personal trauma and their exposure and response to traumatic material presented by clients in their field education internship. A total of 89 students participated in this study. Students in both the campus-based and online programs were asked to participate in data collection. Student respondents completed all study measures in an online, self-administered survey format sent electronically via a HIPAA- and FERPA-compliant secure encrypted hosting platform. The purpose and methods of the study were included in the informed consent along with information regarding voluntary participation, freedom to drop out of the study at any time without penalty, data security, and methods of insuring and maintaining respondent anonymity. The pretest was administered early in the fall semester and the posttest was administered late in the spring semester within the same academic year.

Participants

Participants consisted of MSW students in either their first (foundation)- or second (concentration)-year field education internship experience; the sample included advanced standing students who only complete the second (concentration)-year field education internship. Student respondents were enrolled in an MSW program in the United States within a northeastern, state-system, regional university or in a large, private, and research I–designated university on the west coast.

Measures

Students were asked to complete several instruments that have been shown to be valid, reliable, and widely used in other studies of STS and VT. In order to assess changes in stress/trauma responses related to field internship experiences, instruments were administered at pretest and posttest. Student respondents completed pretest instruments before they began field placement (within the first four weeks of the applicable semester) and posttest instruments after the completion of the field placement for both first (foundation)- and second (concentration)-year field education internship experiences. The rationale for conducting pretests and posttests was to determine if and how client interactions in field education sites effect STS and VT. Additionally, correlations between ACE scores and pretest and posttest outcomes of other instruments may indicate that student interns with varying ACE scores are at an increased risk for STS or VT. The instruments included in study were the: (1) ACE Questionnaire–Mini Version as described by Anda et.al. (2006); (2) Impact of

Event Scale (IES) as described by Weiss and Marmar (1997); (3) Trauma Screening Questionnaire (TSQ) as described by Brewin et al. (2002); and the (4) Secondary Traumatic Stress Scale (STSS) as described by Bride et al. (2004). The ACE was administered only at pretest as it measures experiences prior to age 19. All student respondents were beyond this age; therefore, there would be no change in their responses over time.

The ACE comes from a study conducted by Felitti and Anda at Kaiser Permanente in San Diego (Anda, 2006). This study indicates that childhood trauma exposure was commonly reported and categories of ACEs were highly correlated with one another (Felitti et al., 1998). Moreover, the ACE score, which is a total count of the number of ACE categories reported, can provide a measure of cumulative stress experienced during childhood. The 10 questions are in a "yes/no" format where a yes equals one point and no equals zero points. A total score of four or higher is considered to be a high ACE score while a score of 7 to 10 is extremely high. The ACE has been found to be a reliable, valid, efficient, and a cost-effective screening for the retrospective assessment of adverse childhood experiences. It has adequate internal consistency with a Cronbach's a = .88 (Murphy et al., 2014).

The IES is a short, self-reported questionnaire consisting of 22 Likert-scale items (Weiss & Marmar, 1997). It measures subjective response to a specific traumatic event and provides an overall subjective stress score. It is not diagnostic and there is no specific cutoff score identified by its authors. The IES addresses the three symptom clusters typical in PTSD: Avoidance, Intrusion, and Hyperarousal. A five-point scale ranges from 0 ('not at all') to 4 ('extremely'). High internal consistency has been demonstrated for the IES with a Cronbach's $\alpha = 0.96$ (Creamer et al., 2003). The subscales of Avoidance and Intrusion measure differences in the clinical response to traumatic events of varied severity, and show good internal consistency. The Hyperarousal subscale has good predictive validity regarding trauma (Brierre, 1997).

The TSQ is a 10-item symptom screen designed for use with survivors of all types of traumatic stress (Brewin et al., 2002). It uses a "yes/no" response format and assesses the presence of five Intrusion items (e.g., "Upsetting dreams about the event") and five Hyperarousal items (e.g., "Difficulty falling or staying asleep") experienced within the past week. At a cutoff of six symptoms in any combination, the TSQ showed a sensitivity/specificity of 0.86/0.93 in predicting PTSD in rail crash survivors at 6 to12 months post-trauma, and a sensitivity/specificity of 0.76/0.97 in crime victims within one-month post-trauma (Brewin et al., 2002). Walters et al. (2007) replicated this cutoff study in a sample of emergency unit patients with a sensitivity/specificity of 0.85/0.89 for future PTSD at one month and of 0.88/0.78 for six-month PTSD.

The STSS is a 17-item instrument that has been found to be reliable and demonstrates

convergent, discriminant, and factorial validity (Bride et al., 2004). The STSS instructs respondents to indicate how frequently they experienced each of 17 symptoms during the previous week using a five choice, Likert-type response format ranging from "never" (1)' to "very often (5)." Items are designed to be congruent with the 17 symptom criteria of PTSD as delineated in the DSM IV-TR. Higher scores on the STSS indicate higher levels of STS symptomatology. The scale addresses the three factors of Intrusion, Avoidance, and Arousal by measuring practitioner reactions to traumatic stress experienced through their work with clients. Alpha levels for the STSS and its subscales are as follows: full STSS a = 0.93; Intrusion a = 0.80; Avoidance a = 0.87); and Arousal a = 0.83 (Bride et al., 2004). Results of a study evaluating the STSS with the DSM-5 found that "Based on multiple fit indices, the results showed the 7-factor hybrid model, comprising intrusion, avoidance, negative affect, anhedonia, externalizing behavior, anxious arousal, and dysphoric arousal factors, has excellent fit to STS" (Mordeno et al., 2017, p. 1).

Results

Sample

The average respondent was 30 years old, white (63%), female (89%), in the first year of internship (77%), who also had previous experience in social service occupations (66%). Some ethnic diversity was represented among respondents with inclusion of students identifying as Hispanic (18%), Black (7%), other (7%), and Asian (5%). Slightly more than half of the students were in online programs (54%).

Results

The purpose of this study was to assess MSW students' experience with personal trauma and their exposure and response to traumatic material presented by clients in their field education internship. Results suggest that student trauma histories and symptoms need to be considered in order to assess their risk for STS and VT when in field placements. Presented in Table 1 are paired *t*-test results of pretest and posttest scores (N = 89) for the IES and subscale scores for intrusion, avoidance, and hyperarousal; the TSQ; and STSS with subscale scores for intrusion, avoidance, and arousal.

Table 1

Paired t-test Results of Pretest and Posttest Measures (N = 89)

Measure	Pretest Score	Posttest Score	Significance
IES Total Score	31.4	28.2	.16
IES Intrusion	9.3	8.8	.47
IES Avoidance	10.1	8.4	.05*
IES Hyperarousal	4.0	4.1	.86
TSQ Total	2.3	2.3	.80
STSS Total Scale	32.1	33.5	.14
STSS Intrusion	9.7	9.6	.76
STSS Avoidance	12.6	13.7	.01**
STSS Arousal	9.7	10.1	.27

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

While the IES scores were significantly less on any avoidance behaviors at the end of the field experience as compared to its start, the STSS revealed that self-reported experiences of avoidance symptoms associated with STS significantly increased. As per the DSM-5, these symptoms include avoiding difficult feelings of the traumatic event and avoiding external reminders that lead to distressing memories, thoughts, or feelings associated with the traumatic event (American Psychiatric Association, 2013).

Students often report that their reasons for selecting the social work profession are personal difficulties they had encountered and a desire to help others who experienced the same. Some of those difficulties may be reflected by items on the ACE questionnaire. In this convenience sample ($N = 89$), 47% of respondents reported the highest risk category of having experienced four or more ACEs. This is a concerning number of ACEs, and puts these students at risk for retraumatization. Table 2 illustrates respondents' ACE scores by percent.

Table 2

Adverse Childhood Experience (ACE) Questionnaire Scores (N = 89)

ACE Score	Percent	Cumulative Percent
0	10	10
1	14	24
2	19	43
3	10	53
4	19	72
5	7	79
6	9	88
7	10	98
10	2	100

No ACE score can be interpreted without also knowing about resilience, protective factors, or posttraumatic growth. However, most students were in their first internship in a traditional two-year program and easily could have been impacted by unanticipated client circumstances causing them secondary traumatic stress. In the case of this sample, there was a significant increase in secondary trauma avoidance symptoms as measured by the STSS (see Table 1). High ACE scores coupled with significantly increased secondary traumatic stress avoidance symptoms, seen in STSS scores, warranted closer examination of symptoms reported on the TSQ. Since the TSQ measures PTSD symptoms, this is particularly relevant given possible triggers that may have occurred during students' internships.

Results of the TSQ reveal that about one third of respondents in the sample experienced three PTSD symptoms, and 20% of the sample reported experiencing seven symptoms. Past trauma experiences, and exposure to secondary trauma in the field, may well have contributed to symptoms very similar to PTSD for about 20% of the student group. It remains unclear as to what extent those were recognized or addressed in supervision or in the courses that support the internship. These results are presented in Table 3, which illustrates the percentage of "yes" and "no" responses to trauma symptom items in the TSQ.

Table 3

Trauma Symptom Questionnaire (TSQ) Responses by Percent (N = 89)

Trauma Symptom Questionnaire Item	% Responses	
	Yes	No
Upsetting thoughts or memories that have come to your mind against your will	32	68
Upsetting dreams about the event	8	92
Acting or feeling as though the event were happening again	9	91
Feeling upset about reminders of the event	36	64
Bodily reactions when reminded of the event	23	77
Difficulty falling or staying asleep	28	72
Irritability or outbursts of anger	20	80
Difficulty concentrating	46	54
Heightened awareness of potential danger to self and others	28	72
Being jumpy or startled by something unexpected	16	84

Correlations between ACE scores and pretest and posttest outcomes of the IES, TSQ, and STSS were conducted. A significant correlation was found between IES avoidance symptom clusters at pretest typical in PTSD. Findings suggest that any childhood trauma associated with initial avoidance, as indicated by pretest IES avoidance scores, diminished by the end of the internship experience as evidenced by the ACE and posttest IES avoidance correlation. Perhaps being witness to success in treatment and client progress was personally therapeutic. No other pretest or posttest outcomes were associated with ACE scores. This is one other possible indicator that the high ACE scores among the sample were not associated with any significant trauma. Either protective factors may have helped, and/or posttraumatic growth had occurred for this group of students. These findings are detailed in Table 4.

Another possible explanation may be that students were quite anxious at the beginning of their field placement experience because they were lacking in confidence about their clinical skills and abilities to function proficiently in their placements, and thus rated themselves high on the anxiety scale. By the end of their placement, they probably were much more confident in their abilities to function well in the field and had decreased anxiety, which decreased their ratings on the anxiety scale.

Table 4

Correlations of ACE Scores and all Pretest and Posttest Measures

Measure	Correlation with ACE	Significance
Pretest IES Total Score	.22	.17
Posttest IES Total Score	–.07	.61
Pretest IES Intrusion	.17	.98
Posttest IES Intrusion	–.01	.96
Pretest IES Avoidance	.30	.03*
Posttest IES Avoidance	–.02	.90
Pretest IES Arousal	.09	.55
Posttest IES Arousal	–.17	.24
Pretest STSS Total	–.06	.98
Posttest STSS Total Score	–.07	.63
Pretest STSS Intrusion	–.14	.32
Posttest STSS Intrusion	–.05	.71
Pretest STSS Avoidance	.13	.36
Posttest STSS Avoidance	.01	.96
Pretest TSQ	.05	.75
Posttest TSQ	–.05	.75

Note. $*p < .05$

A closer examination of ACE items found that the most frequently reported trauma experiences were of growing up in a household with severe alcohol/drug and/or mental health problems. Mental health and addiction are common problems in every field of practice, and would have been readily encountered client problems in student internships. Therefore, it may have been these adverse child experiences and the internship experiences that most contributed to increase in the avoidance subscales of the STSS and IES. Further, despite the fact that 47% of the student sample reported four or more ACEs, there were no significant correlations between ACE scores and any outcome measures of secondary trauma, impact of events, or traumatic stress. The findings suggest that students have successfully dealt with childhood trauma directly, or in other ways that represented development of resilience, the existence of protective factors, or posttraumatic growth. We can only speculate with data collected. Future research should include investigation of those factors.

Table 5

Highest Frequency ACEs

ACE Item	Response	Frequency	Percent	Cumulative Percent
Lived with someone who had problems with drugs or alcohol	No	52	58.4	58.5
	Yes	37	41.5	100
	Total	89	100	
Household member depressed, mentally ill, or attempted suicide	No	45	50.5	50.5
	Yes	44	49.5	100
	Total	89	100	

Discussion

Since field education is considered the signature pedagogy in the profession and is required by the Council on Social Work Education (CSWE), the social work accrediting board, social work educators must recognize that working with clients with trauma histories can influence the potential for severe trauma response effects on students (Salston & Figley, 2003). Further, students who have already been exposed to racial trauma and/or prior traumatic events in their personal lives can encounter exacerbated trauma responses when working with clients. Combating the effects of traumatic stress responses is an important aspect of training social work students, and can be accomplished through the use of education, supervision, and other means of support to mitigate trauma reactions among graduate students (Adams & Riggs, 2008; Boscarino et al., 2004; Butler et al., 2017).

In order for students to receive adequate supports, faculty must be educated in the basics of trauma to provide didactic training. Faculty preparation includes instruction regarding various definitions and types of trauma, prevalence of trauma in particular areas of social work practice, consequences of working with trauma survivors, approaches to trauma assessment, principles of trauma-informed care, and available options for trauma-specific interventions for a variety of client populations. Faculty preparation and training can then be transferred to students via curricula in which they learn fundamental concepts and acquire skills to assess for a trauma history, appreciate the principles of trauma-informed care, and gain competence in utilizing these principles with all clients from the beginning of their earliest field education experiences. This would also enable student interns to enter internships with awareness of the options for trauma-specific treatment benefitting diverse clients. Further, student preparation and training can increase students' understanding of how

working with clients who have experienced trauma may affect them both personally and professionally. When considering this aspect of student education, it must be kept in mind that students report STS symptoms from the combination of exposure to trauma in the classroom along with exposure in field (Butler et al., 2017; Harr & Moore, 2011; Shannon et al., 2014).

In addition to the stress response to working with traumatized clients, social work education must also begin to explore how the lived experience of social work practitioners impacts their vicarious stress response in their professional careers. As the AMA publicly recognized systemic racism as a public health threat, it included a call to action for medical students (and presumptively all health and behavioral health professionals, such as social workers) to be trained to recognize systemic, cultural, and interpersonal forms of racism in public health and health administration. The AMA specifically mentioned the need for graduate-level education to include implementation and evaluation for preventing and ameliorating the health effects of racism (O'Reilly, 2020).

At minimum, trauma content and trauma-informed care should be included in all practice courses in the social work curriculum in order to prepare students for probable trauma exposure during their field experience (Wilson & Nochajski, 2016). Ideally, adding a specific trauma course to the curriculum should be a priority in MSW programs from both an ethical and practical perspective (Bussey, 2011; Newman, 2011). Likewise, in field education, when developing student learning contracts, attention must be given to including trauma competencies whereby students can demonstrate their understanding of trauma-informed practice and the use of trauma-informed care principles. This can be accomplished through written assignments provided by both field instructors and faculty, as well as through *in vivo* exposure (Grise-Owens et al., 2018).

It is not clear that all field instructors are versed in the issues of trauma (Knight, 2010). Therefore, all field instructors should be provided with basic information on trauma, practice issues for clients with trauma histories, and self-care for those working with trauma survivors (Strand et al., 2016). With the ubiquity of various telecommunication platforms, this can be achieved by developing and offering to field instructors an asynchronous seminar about these issues, augmented by reading materials, PowerPoint presentations, video recommendations, and/or having students provide in-service training to agency personnel based on what they have learned in their coursework. CSWE has created a resource, *Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice*, that would be very useful to field instructors and faculty alike (CSWE, 2018).

Finally, if social workers are to achieve the first ethical responsibility to clients noted

by the National Association of Social Workers, which states that "Social workers' primary responsibility is to promote the well-being of clients" (NASW, 2017), it is critical that students develop a self-care plan to help minimize their risk of developing STS or VT (Humphrey, 2013; Lewis & King, 2019; Owens-King, 2019). Students must manage many stressors during their field placements, such as employment, family obligations, and course assignments. It is also common for students to eat poorly, have less than adequate sleep, and refrain from exercise. Therefore, self-care should begin early in field placement settings and continue to be refined as needed throughout the students' tenure in social work degree programs. Butler et al. (2019) propose six life domains—physical, professional, relational, emotional, psychological, and spiritual—that may require attention in the practice of self-care. Physical self-care comes in many forms. The basics of sleep hygiene, healthy eating, and exercise should be part of a self-care plan. Bodywork such as massage, dance, or yoga are good options as well.

Certainly, on a professional level, students need to make effective use of supervision to address any issues or concerns around working with trauma survivors. Other options for professional concerns include conference attendance, in-service educational opportunities, reading of the relevant literature, and peer support. On a relational level, nurturing primary relationships is essential. The use of other social supports in addition to primary relationships is critical in helping to manage working with challenging client populations. The utilization of a social support system to create a work/life balance is a major path to increasing self-care behaviors while decreasing barriers to self-care (Xu et al., 2019).

Journaling is an effective method for addressing emotional issues, as are forms of artistic expression such as painting, music, and dance; identifying circumstances that lead to laughter is also very helpful. Stress management techniques that include activities such as progressive muscle relaxation and guided imagery can be useful, as is professional assistance. Psychological issues may be addressed effectively by using practices such as thought stopping or thought completion, limit setting and assertiveness, and through a professional relationship. Spiritual needs can be met by traditional religious organization attendance; other means such as prayer, mindfulness practice, meditation, and walking in the woods or going to the beach can also be helpful. Many of these behaviors are free and can be practiced anywhere and whenever needed. Clearly, social workers must take care of themselves in order to be fully accessible to clients (Lewis & King, 2019).

Limitations of the Study

An important limitation to the study was that the sample was a convenience sample where students self-selected into the study. It is unknown if this self-selection process involved students who were more aware of the importance of their own

trauma reactions as opposed to students who did not opt into the study. Further, this study was conducted in only two social work programs. The results could be unique to those programs or to the regional settings where the study was conducted. Another limitation of this study was the small number of students who responded to the questionnaires. Only master's-level social work students participated. It is not clear that these results would apply to BSW-level students or to students in other disciplines. Lastly, this study did not have a great deal of racial, cultural, or gender diversity, thus limiting its generalizability across all social work practitioners.

Future Research

Further study on how preparing social work students for working with trauma clients affects risk for the development of STS and VT is clearly indicated. A study with a larger number of students from a wider geographic region and varied cultural, racial, and gender identities should be planned. This could include a multisite, multiregional cohort of students to address the issues of generalizability. In addition, emphasis on obtaining qualitative responses from students about more specific details of their experiences working with trauma survivors would prove illuminating. In a recent study, Singer et al. (2019) published compelling evidence that social workers who have a meaning in life related to their work find this preventive for vicarious trauma reactions. It is suggested that social work career development programs aim to facilitate increasing a sense of purpose in life as a protective mechanism against the stressors associated with professional practice. Likewise, it is also recommended to advocate for including in the social work curriculum trauma instruction that continually evaluates its impact on students' response to working with trauma survivors. As the field empirically acknowledges the damaging effects trauma can have on those who choose a social work career, the call to action must include training social work students to manage their trauma exposure effectively and reinforcing protective barriers via continuing education throughout their social work careers.

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