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Trauma and Resiliency in Social Work Degree Candidates

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Abstract: Exposure to traumatic events sufficient to result in symptoms is a common phenomenon within the general public. Extrapolation of this observation to clinical social work students in training is reasonable, though unsubstantiated, at a time when this area of practice is expanding. Untreated trauma symptoms in students have the potential to harm both students and their clients, though little data exits on the prevalence of such events in students or on predicting symptom manifestation. Resiliency is a cluster of behavioral phenomena associated with recovery from trauma in the general population, but this assumption has lacked empirical investigation in degree candidates in the field of social work. Using the Ego-Resiliency Scale, the Trauma Recovery Scale, part of the Traumagram, and the Impact of Events Scale – Revised, exposure to trauma and the predictive value of resiliency for social work students from Florida State University was investigated. Findings show that resiliency and symptoms of posttraumatic stress were inversely related, but this relationship was not statistically significant. These findings provide evidence that resiliency may occur simultaneously with symptoms of trauma. They further suggest that students may be entering a specialty area of practice susceptible to unresolved trauma, risking their own health and potentially impairing optimal client outcomes.
Keywords: candidates, Posttraumatic stress disorder (PTSD), Protective factors, Resiliency, Social work, Trauma.

1. Introduction

There is a Japanese Proverb that states "Fall seven times, stand up eight" (Quoteland, 2005). This, broadly considered, is resiliency. More specifically, resiliency can be conceptualized as success despite exposure to risk (Jackson and Capella, 2012). Epidemiological studies, for example, have reported that the majority of Americans have been exposed to at least one traumatic event in their life (Bonanno, 2004). Though many psychosocial and environmental variables have been found to serve as risk factors that may impact individual outcome before and after exposure to traumatic events, this study exams resiliency factors and the prevalence of exposure to traumatic events in degree candidates entering the field of social work.

1.1. Resiliency in Children

Resiliency was originally observed, described, and then studied in children. Bissonnette (1998) stated that in children, resiliency "generally refers to the capacity for successful adaptation despite challenging or threatening circumstances and the development of competence under conditions of pervasive and/or severe adversity" (p.3). Resiliency, often referred to as ego-resiliency by early investigators, changes as the child develops and is enhanced when protective factors are in place. These protective factors include a variety of phenomena that have been empirically investigated by numerous researchers and associated with numerous positive outcomes.

Block and Block (1980) conducted an extensive longitudinal study of children and their families with children ages 3, 4, 5, 7, and 11, and reported that resilient children were more empathic, bright, self-accepting, novelty seeking, appropriate in expressions of emotions, better able to cope with stress, self-reliant, competent, creative, as well as less anxious, suspicious, sulky, imitative, and reassurance seeking. Huey and Weisz (1997) also conducted a longitudinal study of resiliency. They concluded that 'ego-resilient' children had secure attachments in infancy and delayed gratification as children and young adults, while 'ego-brittle' children were at risk of depression and using hard drugs in adolescence. After an extensive literature review, Moghadam (2006) identified several personal protective factors to include:

> Easy-going temperament, autonomous, optimism, hope, positive reframing skills, self-esteem, good self-concept, problem-solving skills, self-efficacy, locus of control, communication skills, secure attachment, and above average IQ, coping skills, tenacity, sense of humor, athleticism, physical attractiveness, body

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pride, decision making skills, racial identity, parental warmth and support, family cohesion and harmony, parental involvement, parental expectations, non-familial, non-familial adult support, positive peer relationships, friendships, academic achievement, special interests and hobbies, areas of high competence, and higher socio-economic status (p. 20-22).

1.2. Resiliency in Adults

Numerous adult protective factors have also been empirically described. Tugade and Frederickson (2004) concluded that resilient adults are optimistic, zestful, energetic, curious, and open. Such individuals were presumed to create positive emotions through positive thinking, relaxation, and humor. Resilient individuals responded to an anxiety promoting speech preparation task with a more positive mood, including more happiness and interest, even though the task created equal anxiety in both resilient and non-resilient participants. Higher resiliency was also associated with lower appraisals of threat and less duration of cardiovascular reactivity.

In a study of 133 adults with a disability, aged 20-63, Moghadam (2006) attempted to predict "resilient successful life outcomes" (p. vi) testing optimism, self-efficacy, internal locus of control, and tenacity. Optimism, internal locus of control, and self-efficacy were all found to be predictive of resiliency, which, in this study was operationalized not as invulnerability, but as healing power facilitating recovery from trauma, "an elasticity and flexibility, which allows one to return to homeostasis and wellness consequent to perceived injury" (p.15). This study referred to resiliency as an internal trait that develops from the need to overcome an upsetting event and succeed in life regardless of adversity. However, it was also stated that this trait is "amenable to modification" (p.17) through external interventions. Unfortunately, this study lacked a reliable and valid resiliency scale.

Using partial correlations, (Block and Kremen, 1996) found that the personality characteristics associated with resiliency in both men and women included social poise, gregariousness, cheerfulness, comfort with self, a rich but appropriate emotionality, and an absence of fearfulness and rumination. They found a significant correlation between male resiliency and intelligence quotient (IQ), also reporting that resilient males show a capacity for commitment, responsibility, ethical behavior, and sympathy in caring relationships. The resilient male appeared to be comfortable in the world, while the 'ego-brittle' male experienced friction in interpersonal relationships, irritability, hostility, rebelliousness, and moodiness.

1.3. Trauma

Researchers have reported that a range of events may be considered traumatic to an individual. According to Aguilera (1994), there are typical maturational crises that take place in infancy and early childhood, preschool, pre-puberty, adolescence, young adulthood, adulthood, late adulthood, and old age that are traumatic to some. Also, there are situational crises that include premature birth, child abuse, status and role change, abortion, rape, physical illness, Alzheimer's disease, elder abuse, chronic psychiatric conditions, spousal battering, divorce, substance abuse, suicide, the death process, and grief. According to Moghadam (2006), the stressfulness of an experience is dependent on the overall outlook on life as well as the unique appraisal of the immediate circumstance of the person who has experienced the trauma. Individual factors then, such as optimism or pessimism, play a role in individual outcomes.

Echterling *et al.* (2005) differentiated crises from traumatic events, and suggested that although all traumas are crises, not all crises are traumas. They define a trauma as "a serious physical or psychological injury that has resulted from a threatening, terrifying, or horrifying experience" (p.7) and evidence indicates that these experiences are, unfortunately, commonly borne in the general population.

For example, in a study of 1,000 men and women 40% of participants reported a traumatic event in the last three years (Levine, 1997). In another study involving a community sample of 1,007 21-30 year old members of a health maintenance organization, researchers found that 39% of participants had experienced a traumatic stressor, with 24% of those participants meeting the criteria for PTSD (Wolfe and Kimerling, 1997). In an epidemiological study of 1,000 Americans, Echterling *et al.* (2005) reported that 69% of participants had experienced at least one "extremely traumatic event" (p.11).

1.4. Exposure to Trauma in Social Work Students

Within popular culture is the periodic assertion that psychosocial helpers are more effective practitioners if they have personally overcome the psychosocial phenomena for which they are intervening with clients. Whether this misconception exists in social workers in training has received insufficient empirical inquiry to propose prevalence estimates. Of more practical and imminent concern is whether social work students have a personal history of trauma, if they possess resiliency factors, whether evidence of resiliency protects against symptomatology, and whether students with a history of trauma are symptomatic. If life experience of social work students can be inferred from population studies, many have personal histories that include exposure to traumatic events. Trauma is a professional practice area that is large and is growing, providing impetus for schools of social work to provide specialized training in trauma intervention (Breckridge and James, 2010). Numerous social work programs have curriculum emphases or subspecialties in this area, such as the Troy University Master of Social Work degree program, approved to matriculate students beginning fall 2014, with addressing needs of military families as one of two instructional tracks. It would be useful to know whether personal history of trauma influences students toward trauma intervention as a practice emphasis, perhaps encouraged by the popular misconception noted above. It is vital to know, however, whether social workers in training are potentially symptomatic as a result of trauma exposure,

whether they have resiliency, and if resiliency is a protective factor. Therefore, this study, investigates both the personal history of traumatic events for a large convenience sample of social work students and the prevalence of resiliency in this sample.

2. Research Hypotheses

In a large convenience sample of social work degree candidates:

1) There is an inverse relationship between resiliency and symptoms of posttraumatic stress.
2) There is linear relationship between resiliency and the severity of traumatic events.
3) There is a positive linear relationship between the severity of traumatic events and symptoms of posttraumatic stress.
4) Resiliency is a better predictor of symptoms of posttraumatic stress than the severity of traumatic events.
5) Resiliency mediates the severity of traumatic events in terms of symptoms of posttraumatic stress.

2.1. Delimitations

Participants for this study are a convenience sample of college students in the College of Social Work at Florida State University. Participation was voluntary. Results of this study are not intended to be generalizable to children, the general adult population, or to college students from other majors. All scales used in this study were self-report.

3. Methods

3.1. Design

This research project explores the concept of resiliency, is descriptive of lifetime occurrences of traumatic events, and begins inquiry regarding the coping abilities of social work degree candidates. This research was conducted using a survey design with the individual as the unit of analysis. The research is a non-experimental correlational study. Predictor variables include resiliency, the number of traumatic events experienced over the course of a lifetime, and the demographic characteristics of gender, age, and race. Outcome variables are the degree of stressfulness reported at the time of the traumatic event and at the time of the study, and protection from symptoms of posttraumatic stress. The survey was available to participants on-line through a link to Survey Monkey. Assurances of respondent confidentiality were included in the invitation to participate and were rigorously enforced.

Also disclosed *a priori* was detailed disclosure of the risk that participation might potentially pose to respondents. Consent was obtained independently from the survey in order to assure respondent anonymity. Participants were recruited by e-mail.

3.2. Measurement

The measures used for this study are presented in the order they appear in the survey. The first assessment included in the survey was the Ego-Resiliency Scale (Klohnen, 1996). The Ego-Resiliency Scale is a 14 question, Likert scale with four possible responses for each item (does not apply at all, applies slightly, applies somewhat, and applies strongly). This instrument measures identified components of resiliency (Windle *et al.*, 2011).

The second questionnaire in the survey was the Trauma Recovery Scale (Gentry, 2006). This assessment was placed in the survey to identify if the respondent had been exposed to traumatic event(s), and to obtain specific information related to these events. The Trauma Recovery Scale begins by identifying if the respondent has experienced any incident that meets the criteria for a traumatic event as specified in the Diagnostic and Statistical Manual-text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). There are 20 events serving as examples of events/experiences that may have been traumatic. The scale also includes an 11-item Likert scale that allows the respondent to enter a numerical percentage of agreement with a statement provided to indicate the level of coping with the traumatic events experienced. Respondents also had the option of spatially marking a line between 0% and 100% to represent that number.

The next questionnaire in the study was the Impact of Events Scale-Revised (Weiss and Marmar, 1997). This scale includes 22 items that assess functioning over the past week with regards to a previous disaster. For this study, the word "disaster" has been replaced with the words "past trauma" due to the scale's history of use with a variety of traumatic events and various populations including Vietnam War Veterans, Israeli combat soldiers, emergency service workers, firefighters, criminal victims, adults sexually abused as children, parents of children who have been sexually abused, victims of earthquakes, firestorms, floods, hurricanes, railway accidents, car accidents, rape, cancer, and other life-threatening medical conditions. The Impact of Events Scale is widely used in the trauma field of study (Figley, 1989) and is one of the most commonly used self-report assessments of posttraumatic stress (Joseph, 2000), who described it as the "gold standard self-report measure in trauma research" (p.108).

Finalizing the survey was Part C sections 8 and 9 from the Traumagram Questionnaire (Figley, 1989). The open-ended questions from these sections were sought to provide qualitative feedback of both the coping mechanisms and coping hindrances that respondents encountered.

4. Results

After receiving approval from the Institutional Review Board, email requests containing a link to the survey were disseminated. The population of interest was the body of degree candidates in the College of Social Work. There were 291 undergraduate students, of which 87% were female and 13% were male, between the ages of 18 and 55, with a mean age of 23, who identified themselves as having the following racial/cultural heritage: 63% white, 24% black, 10 % Hispanic, and 2% American Indian, with less than 1% Pacific Island or Asian. In addition to the undergraduate enrollees, there were 418 candidates pursuing a master's degree, 88% of whom were female, 12% male, between the ages of 20 and 63 with a mean age of 32.. They identified themselves as having the following racial/cultural heritage: 76% white, 16% black, 4% Hispanic, and 1% Asian, American Indian. 1% did not respond. As a whole, the 709 students were 87% female, 13% male, aged 18-63 with a mean age of 28.61. There were 253 responses: 71% white, 19% black, 6% Hispanic, and 1% Asian, American Indian, with less than 1% pacific, and 1% not reported. Eleven response sets were deleted due to insufficient information. One participant did not consent to the survey, 2 participants provided consent to participate but no other data, and 8 participants provided demographic data only.

Each of the research hypotheses are restated and answered independently.

1) There is an inverse relationship between resiliency and symptoms of posttraumatic stress. The relationship, though inversely related as hypothesized, was not statistically significant. Using Pearson Product Correlation, the relationship between the Ego-Resiliency Scale and the Impact of Events Scale – Revised was found not statistically significant at -.077. Only 7% of the change in symptoms of posttraumatic stress was attributable to changes in resiliency. The null hypothesis was accepted.
2) There is linear relationship between resiliency and the severity of traumatic events.
3) Pearson Product Correlation of .096 failed to attain the level of statistical significance, a result consistent with other research on this question in the broader population. In other words, those that manifest resiliency do so in spite of the level of subjective distress experienced from a traumatic event. This study provides supportive evidence expanding previous results to social work students in training.
4) 3: There is a positive linear relationship between the severity of traumatic events and symptoms of posttraumatic stress.
5) The Pearson Product Correlation of .495 was both significant at the .000 level and consistent with the stated hypothesis other reported empirical results..
6) 4: Resiliency is a better predictor of symptoms of posttraumatic stress than the severity of traumatic events.
7) Analysis of the qualitative responses resulted in accepting the null hypothesis. The data indicated that resiliency was not a useful predictor of symptoms in our student cohort. The data clearly indicated that the subjective severity of the trauma had utility as a predictor of symptoms.
8) 5: Resiliency mediates the severity of traumatic events in terms of symptoms of posttraumatic stress.
9) The qualitative data were consistent with the quantitative data in accepting the null hypothesis. Resiliency did not serve as a mediational factor for symptoms of traumatic stress in our student cohort.

5. Qualitative Findings

One section of the survey allowed respondents to enter any additional traumas experienced that were not listed on the Trauma Recovery Scale (Gentry, 2006). Participants were prompted to think of the worst thing that had ever happened to them (an indicator proposed by Turner & Avison, 2003, to elicit responses of trauma). Thirty-two individuals submitted responses, most of which were recapitulations of traumatic events on the instrument or involved a combination of those events. Table 1 contains the prompts from the Trauma Recovery Scale and the verbatim responses provided by participants.

Table-1. Trauma List and Qualitative response

Trauma	Response
1. Natural Disaster or Industrial Accident	"Stayed in my home during Hurricane Ivan"
	"My car stopped during a tornado and almost rolled down a hill into traffic."
	"flood in community"
	"An airplane I flew on had to turn around due to the maintenance personnel forgetting the air conditioning panel"
2. Physical Injury Resulting from an Accident	"I cracked my skull when I was 16 years old while playing baseball. I suffered a traumatic brain injury as well as a stroke. I was hospitalized for several months and had to learn how to walk, talk, and other basic abilities in life that are taken for granted"
	"experienced two major car accidents within six months"

	"Car accident in which physical injury did not result"
3. Witnessing Event that was Traumatic to Another	"Stress from parent losing job and having to move to another state"
	"11-Sep"
	"I did not include Domestic Violence on this list because it has not occurred directly to me. However, I work with DV victims and have experience 2nd hand trauma that affects me on occasion in my daily life"
	"I was witness to the Sept. 11th terrorist attack on the World Trade Center as I worked around the corner and saw terrible devastation, dismemberment, etc."
4. Parental Divorce or Abandonment as a Child	"Temporary separation from a parent and placed in foster care"
5. Childhood Physical Assault/Abuse	"parental neglect"
	"emotional abuse by a parent"
6. Adult Physical Assault/Abuse	
7. Domestic Violence	
8. Victim of Crime	"As a teenager, a man tried to abduct me while I was running in my neighborhood. He was later convicted of the death of 3 teenage girls"
9. Threat of Physical Violence	
10. Childhood Sexual Abuse	
11. Rape	
12. Other Unwanted Sexual Experience	
13. Combat Trauma	
14. Incarceration or Being Held in Captivity	"Boyfriend incarcerated"
15. Physical Torture	
16. Humiliation	"fallout with several friends, dealing with alienated family members of my husband"
	"Being yelled at and belittled by the clients at my internship"
	"I have experienced verbal abuse, emotional abuse, and abandonment by friends"
17. Property Loss	"House fire"
18. Traumatic Death of a Loved One	"My friend's father died right in front of me, while I was giving him CPR in Germany about 4 years ago. I've never cried about it..."
	"I am not sure if you want to know if we have experienced these traumatic experiences within the last month or ever. In this case, my mother passed of cancer last year and my husband was diagnosed with terminal brain cancer in September. Both are equally traumatic."
19. Loss of a child, Abortion, Miscarriage, Still Birth, or SIDS	"I authorized a permanent, irreversible surgery while pregnant and depressed that I deeply regret. I never should have been able to consent to this surgery in my condition. This surgery sterilized me and I am deeply traumatized by the experience. I think about it almost all of the time"
	"Custody of my child was lost for seven months"
	"children being caught doing illegal activities"
20. Suicide Attempt by Self or Other	"Successful suicide attempt by a loved one"
	"My brother shot himself in the head"
	"Client committing suicide"
21. Traumatizing Events of Discrimination	"Not being able to communicate with others because of a learning disability and not being able to understand information like other people. It can definitely affect a person in life just in general but on important issues such as a career. The individual with the learning disability can try extremely hard to try to

	be the best they can be. It is others who are the problem in the scenario due to them not being patient or due to them not understanding or due to the fact that they believe that the individual with the learning disability cannot do anything"
22. Life-threatening Medical Diagnosis of Self or Loved One	"I am not sure if you want to know if we have experienced these traumatic experiences within the last month or ever. In this case, my mother passed of cancer last year and my husband was diagnosed with terminal brain cancer in September. Both are equally traumatic"
	"My sister suffered from an eating disorder and almost died because of it"
	"Non-life threatening serious medical trauma"
	"parent's drug addiction/multiple recoveries and relapses"
	"Experiencing or Living With PTSD Episodes of Loved One"

Verbatim responses that resisted uninterpreted categorization on the Trauma Recovery Scale (Gentry, 2006) were as follows:

1) "loss of job"
2) "Divorce
3) "Homeless"
4) "Finals and end of semester papers due. Huge stress. immeasurable trauma. loss of sleep. Other than that, nothing terrible."
5) "A break up with a loved one that was very hard on you or the other "
6) "A fight with a best friend that ended in bad terms and ended their relationship"
7) "Moving to a new country... I would say it was moderately traumatizing."
8) "Being cheated on by my first spouse - I think being betrayed by a trusted intimate is a type of trauma you could add to the list. P.S. I'm a doctoral student and that wasn't one of the options on the first page!"

Some of the student responses, like the loss of relationships, affairs, and job loss, possibly indicate the need for further training on trauma. The literature often categorizes these experiences as stressful events instead of traumatic ones. The DSM-IV-TR (American Psychiatric Association, 2000) specifically excludes these examples from the definition of trauma, insofar as the diagnosis of PTSD is involved. However, clinical experience suggests that such events may indeed trigger symptoms of posttraumatic stress. Perhaps the identified area of need lies in the diagnostic criteria currently used rather than a training issue. Clinical manifestation of trauma depends on the individual's response to the event.

6. Discussion

This study empirically investigated traumatic occurrences in social work degree candidates and sought predictors of the presence of or amelioration of symptoms. The results showed that, as resiliency increased, symptoms of posttraumatic stress decreased. However, the relationship was not statistically significant. The presence of resiliency factors in current students did not correlate to an absence-or reduction of-symptoms. The students in our sample could be both resilient and symptomatic.

These findings are problematic. If supported by subsequent, confirmatory inquiry, our students and their clients having experienced personal trauma may be at risk if they pursue this practice area. After rudimentary training in evidence-based practices, social work students should be completely inoculated-if there were any who had succumbed-to another anecdotal misperception sometimes espoused within popular culture: the best interventionists are those who experienced and overcame. Social work candidates can be trained in best practices-and should be-and the outcome of these practices does not depend on sharing mutual symptoms. Evidence based practice and personal experience-based practice may not be mutually exclusive, but they are certainly uneasy bedfellows. In the case of trauma, a history should not preclude clinical training and specialization in this field of practice. Being symptomatic of trauma, however, should. By definition, a traumatic event is one causing such distress that many people will aggressively avoid any triggers of the event. However, the professional helper may quickly find himself unable to control his exposure to triggers from clients with a history of trauma. This is a level of suffering none of us would willingly impose on our candidates. It also forces questions of their ability to be competent in certain circumstances, which none of us would willingly impose on the clients we are training our candidates to serve. For residents of the United States, a decade of war, a series of natural disasters which have strained the community fabric of entire geographical regions, economic conditions that have seen lost jobs, lost security, and lost homes, and other circumstances that may adversely impact the functional capacity of members of any society suggest that trauma intervention is a practice specialty that will only increase in relevance in the coming years. Heretofore, this societal

relevance has failed to be reflected in the knowledge base of the profession. It is hoped that this study contributes to the limited data available, and serves as a starting point for further, more rigorous inquiry.

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