

**Risking Connection Trainee-Outcome Research: A Pilot Study**  
**August, 2003- June, 2004**

**Summary of Findings**

This study assessed the impact of a Risking Connection Training on the well-being of trainees. More specifically, we measured the construct of vicarious traumatization both before and after the training. Our results indicate that participants learned the material presented in the Risking Connection Training. As a group, participants' scores reflected an above average Personal Achievement score as measured by the Maslach Burnout Inventory (MBI) and intact spirituality as measured by the Life Orientation Inventory (i.e., less disrupted than the normative sample). We did not find a significant change in vicarious traumatization index after the training as compared to before the training. We noted the following trends on the Emotional Exhaustion subscale of the MBI: Emotional exhaustion scores were higher for younger and less experienced participants.

See below for the comprehensive, final report, including a discussion of the findings.

# **Risking Connection Trainee-Outcome Research: A Pilot Study**

**August, 2003- June, 2004**

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## ***Background and Purpose of Research Project***

### **Risking Connection Theory**

Risking Connection (RC) describes a theory-based practical approach to working with trauma survivors in a variety of settings (Saakvitne, Gamble, Pearlman, & Lev, 2000). The approach is grounded in constructivist self development theory (CSDT), a clinical theory that provides a framework for understanding and treating trauma survivors. CSDT posits that individuals develop psychologically in relationship with their worlds (i.e., personal history, sociocultural context, interpersonal relationships) and co-construct their own realities. With regard to traumatic experience, CSDT both describes those realms of experience that are impacted by traumatic events and asserts that the meaning of the trauma exists for and depends upon the individual. More specifically, CSDT understands individuals' responses to trauma as meaningful adaptations (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

The RC philosophy and the 20-hour training curriculum based on this philosophy both emphasize the role of the therapeutic relationship, empowerment of clients and treaters, collaboration, psychoeducation, an understanding of symptoms as adaptations, and meaning-making in the treatment of survivors of childhood abuse and neglect. In addition, the effects of the work on the treater are addressed within the RC framework and in the training. The training, which is most often conducted over a three-day period, combines didactic presentations and experiential exercises.

Mental health practitioners who use the Risking Connection (RC) model report that it is an extremely effective treatment approach, helping clients to feel more in control of their lives, less symptomatic, more self-aware, and more engaged with life. On the basis of CSDT, our clinical experience, and the clinical experience reported by others using this treatment approach, we hypothesize that adoption of the RC approach leads to better client outcomes as well as higher staff morale and less turnover. It is important to note that whereas many of the concepts that form the foundation of RC do have theoretical and empirical support<sup>1</sup>, the current study is the first to conduct outcome research using the RC approach.

**Department of Mental Health and Addiction Services in Connecticut**

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<sup>1</sup> See Saakvitne (2002), research appendix.

The Department of Mental Health and Addiction Services (DMHAS) in Connecticut consists of many divisions, one of which is the Young Adult Services Division (YAS). The goal of YAS is "to provide specialized, age and developmentally appropriate supports for young people ... who are diagnosed with a major mental illness" (State of Connecticut Department of Mental Health and Addiction Services Web Site). Programs have been developed at 8 state-operated and private non-profit Local Mental Health Authorities throughout Connecticut.

In 2001, the leadership of YAS began to believe that a new treatment model for YAS clients was necessary. As DMHAS-YAS began examining their recipient population, they discovered that "...the entire group had virtually nothing in common except histories of significant early trauma of one form or another" (DMHAS-YAS White Paper Highlights). And as they began to question their theoretical assumptions, they came to believe that the traumatic events suffered by their clientele seemed to "traumatize the entire developmental process for [them]" as opposed to being isolated incidents (DMHAS-YAS White Paper Highlights). Viewing their clients through a trauma lens became an important goal for DMHAS-YAS, and they hired the Trauma Research, Education, and Training Institute, Inc. (TREATI) to conduct five RC trainings for their staff as part of their new approach to treatment.

Five different 3-day RC trainings were offered within a three-month period of one another, and trainees had the choice of which training to attend. Trainees were approximately 250 employees from Connecticut's DMHAS-YAS teams. Trainers consisted of both TREATI and YAS staff, and the format of the curriculum was adapted for the DMHAS-YAS population. Both the training and the research project have been true collaborations between TREATI and DMHAS-YAS.

### *Research Questions*

The purpose of our study has been to assess the effects of a three-day RC training on the trainees. We hypothesized that as a result of the training: (1) Treators would gain knowledge in the field of trauma, (2) Treators' levels of collaboration with clients would increase, (3) Treators would perceive themselves to be more effective in their work with trauma survivors, and (4) Treators would experience an enhanced sense of well-being.

We also anticipated that the data from this research would provide empirical support for the value of the *Risking Connection* approach to trauma treatment, information to the curriculum developers about potential modifications to the curriculum, information to DMHAS about the benefits of the training for their staff, and feedback to participants regarding the effects of participating in the training.

In order to test our hypotheses, we operationalized the four, aforementioned outcomes and measured them both prior to and after the RC trainings utilizing various qualitative and quantitative instruments. We only received 34 completed pre-training questionnaire packets and 20 completed post-training questionnaire packets. Given the relatively small number of completed data sets, analyzing all of the variables we initially set out to would have been ill advised due to lack of statistical power. Therefore, we decided to narrow the focus of our

research study by looking at the effects of the training on the well-being of the trainees. More specifically, we wanted to know whether the training impacted the trainees' experiences of vicarious traumatization.

### Vicarious Traumatization

Vicarious traumatization (VT) is defined as the negative transformation of the inner experience of the helper as a result of empathic engagement with trauma survivors and their traumatic material and a felt sense of responsibility for trauma survivors (Pearlman & Saakvitne, 1995; Saakvitne, Pearlman, et al, 1996). It is a construct that has been measured in various ways in the extant literature, and no one instrument currently exists to measure this concept as it is defined within CSDT. In the present study, we based our measure of VT in a theoretical understanding of the construct as multifaceted. Like the effects of trauma, VT is manifested in one's beliefs, ego resources, self capacities, emotions, trauma symptoms, and sense of spirituality. Using a three-pronged approach to VT, we measured aspects of the construct through a composite score of three questionnaires, each corresponding to one of the following facets of experience: spirituality, beliefs about self and others, and feelings of emotional exhaustion.

## *Research Design*

### Procedures and Participants

A member of the research team distributed information about the pilot study to supervisors from each of the YAS sites at one of their regularly scheduled meetings prior to the beginning of the series of RC trainings. Supervisors were given information about what participation would entail; they were told that participation was strictly voluntary; and they were given flyers describing the study to distribute to their staff. Potential participants (the staff of the DHMAS-YAS programs) were then issued an invitation to participate in the study through their supervisors. Interested individuals signed up for the study by either mailing a pre-distributed postcard to the research team, or by signing up directly with their supervisors.

Although we initially planned to administer pre-training (and post-training) questionnaires to participants in person, the logistics of doing so became too complicated given the number of sites as well as the number of different work-shifts at many of these sites. We instead mailed a pre-training packet to all interested individuals. The packet included a consent form, the six questionnaires described below, instructions for completing these questionnaires, a request-for-findings postcard, and a pre-stamped return envelope. Potential participants were given an opportunity to request a copy of the research findings by returning the enclosed postcard. Although members of the research team were available by phone to answer any questions participants may have had, none of the participants utilized this service. Approximately 100 packets were distributed by mail prior to the trainings and 34 were returned.

Four to six weeks after each of the six trainings, the research team mailed a post-training packet to individuals who had participated in the respective training and who had returned a pre-training packet. Of the 34 individuals who returned pre-training packets, 20 returned post-training packets as well, yielding a total of 20 participants (59%) with complete data sets. The participants held various job descriptions, each with a range of experience in the mental health

field, and worked in one of five different sites. Each participant attended one of the five three-day RC trainings.

### Confidentiality

Responses to all questionnaires were kept confidential via a coding system. Questionnaires were encoded with a number and names did not appear on the questionnaires or in the database in which the results were entered. Two members of the research team (Christine H. Farber and Katie Pollak) had access to individual responses. Results and reports are based on aggregate responses only.

### Questionnaires

In addition to completing a brief demographic survey, participants were administered the following five questionnaires:

- *The Risking Connection Curriculum Assessment* (Traumatic Stress Institute, 2003): Assesses knowledge gained from participation in the Risking Connection Training within the dimensions of Respect, Information, Connection, and Hope.
- *Collaboration in Mental Health Treatment Questionnaire* (Traumatic Stress Institute, 2003): Assesses extent to which participants report collaborating with clients in a variety of clinical and community scenarios.
- *Maslach Burnout Inventory- Human Services Survey* (Maslach & Jackson, 1986): Assesses the construct of burnout as it manifested in human service professionals. The Human Services Survey yields the following three subscales: Emotional exhaustion (EE- measures feelings of being emotionally exhausted and overextended by one's work); Depersonalization (DP- measures an unfeeling and impersonal response toward one's clients); and Personal Accomplishment (PA- measures feelings of competence and success in one's work). Higher scores on EE and DP reflect higher levels of burnout, and lower scores on PA reflect higher burnout.
- *Trauma Work Questionnaire* (Gamble, 1995/2003): A two-part questionnaire, Part I assesses frequency of potentially stressful clinical situations for the mental health worker as well as perceived stressfulness of such situations. Part II assesses types of coping and self-care activities engaged in and perceived helpfulness of such activities.
- *Trauma and Attachment Belief Scale* (Pearlman, 2003): Assesses disrupted beliefs about oneself and others in five central need areas (safety, trust, esteem, intimacy, and control) thought to be particularly sensitive to the effects of trauma. This questionnaire yields a total score and 10 subscale scores reflecting each of the need areas above with respect to beliefs about relationships with self and others. A higher score reflects more disrupted schemas.
- *Life Orientation Inventory* (Neumann & Pearlman, 1995/2000): Assesses disrupted spirituality which is defined according to the following four dimensions: Meaning, ontological relatedness, awareness, and non-material aspects of being. A lower score reflects more disrupted spirituality.

The demographic questionnaire assessed the following: Gender, age, job title, length of time in current position, length of time in mental health field, place of employment/DMHAS agency, and whether the participant had heard about and/or read the RC curriculum.

## *Findings*

### Participant demographics

Of the 34 total participants, 9 (26.5%) were men and 25 (73.5%) were women. Age of participants ranged from 23-57 years with mean age of 38.71 years. Length of time in current position ranged from .5-19 years with a mean of 5.72 years, and length of time in mental health field ranged from 1-25 years with a mean of 8.42 years. Twenty-two (64.7%) participants reported working as a case manager or mental health assistant, 3 (8.8%) were therapists, 3 (8.8%) worked in rehabilitation, 2 (5.9%) were administrators, and 4 (11.8%) reported working in "other" positions.

The following six YAS agencies were represented: North Central Counseling Services (8.8%), Southeastern Mental Health Authority (8.8%), Greater Bridgeport Community Mental Health Center (14.7%), Birmingham Group Health Services (26.5%), North West Mental Health Authority (5.9%), and Capitol Region Mental Health Center (17.6%). 17.6% of the respondents did not indicate for which agency they worked.

The majority of respondents (67.6%) had not heard of the Risking Connection approach to trauma treatment and a larger majority (82.4%) had not read the curriculum prior to the pre-training assessment.

### Knowledge gained from the training

Participants did gain knowledge about the RC approach to treatment after participation in the training, as indicated by the Risking Connection Curriculum Assessment ( $p < .001$ ).

### Scores reflecting well-being

The following table lists the mean scores received on each of the measures of well-being as compared to a normative sample. Both pre- and post-training scores are represented. As shown in the table, average, aggregate scores of the YAS group for the TABS, Emotional Exhaustion subscale (EE), and Depersonalization subscale (DP) all fall within the average range when compared to the respective normative samples of mental health workers. The average, aggregate Personal Accomplishment score (PA) is slightly higher than that of the normative sample's average, indicating higher levels of personal accomplishment. The average, aggregate Life Orientation Inventory scores are also higher than the outpatient sample we compared them with, indicating that the DMHAS-YAS group reported less disrupted spirituality.

## Well-being Scores

Questionnaire	Total N	Pre/Post	Mean/ SD	Range	Normative Values
TABS-total	34	Pre	48	115-271	44 (SD=9) <sup>2</sup>
TABS-total	20	Post	48	118-208	
LOI-total	34	Pre	176.12/ 29.23	86-224	140.9 (SD=34.71) <sup>3</sup>
LOI-total	20	Post	169.18/ 32.93	93-217	
EE	34	Pre	19.88/ 10.34	5-48	14-20 <sup>4</sup>
EE	20	Post	19.75/ 9.72	8-42	
DP	34	Pre	6.85/ 5.23	0-22	5-7
DP	20	Post	8.40/ 5.43	1-23	
PA	34	Pre	35.15/ 8.79	8-47	33-29
PA	20	Post	35.9/ 7.11	19-46	

The scores represented above are aggregate, mean scores. The range of scores among participants is also represented. With regard to burnout scores, 20.6% of participants experienced high EE, 8.8% experienced high DP, and 41.2% experienced low PA prior to the training. After the training 14.7% experienced high EE, 5.9% experienced high DP, and 23.5% experienced low PA.

### Vicarious Traumatization Index

As mentioned above, given the relatively small number of completed questionnaire packets, analyzing all of the variables we initially set out to analyze was impossible, and we narrowed our research focus to our fourth original question, that of the trainees' experiences of well-being, and more specifically, vicarious traumatization.

Based on the data from the Emotional Exhaustion subscale of the Human Services Survey (measuring the impact of VT on one's feelings of emotional exhaustion), the Trauma and Attachment Belief Scale (measuring the impact of VT on one's beliefs about self and others), and the Life Orientation Index (measuring the spiritual impact of VT), we created a VT index. We first ran reliability analyses on each of these measures and found that the Awareness subscale of the LOI was unreliable in this sample (Chronbach's alpha= .36). For this reason, we recreated a total LOI score taking out those items that made up the Awareness subscale. This yielded an overall Chronbach's alpha of .90 for the remaining items as a whole. We then correlated each of the scales and found a significant negative correlation between the TABS and LOI (-.39;  $p < .005$ )<sup>5</sup> and a non-significant negative correlation between the EE and the LOI as well as a non-significant positive correlation between the EE and the TABS. A VT index was created by

<sup>2</sup> Based on sample of 266 trauma therapists

<sup>3</sup> Based on sample of approximately 220 outpatients

<sup>4</sup> Norms for burnout subscales are based on sample of 730 mental health workers

<sup>5</sup> This was a two-tailed test

combining z scores of each of these measures, taking into account the correlations among the variables.

A comparison of the pre- and post-training VT indexes was not significant as we had predicted. The small sample size may account for this and for this reason we cannot assume that the training did not impact VT.

### Emotional Exhaustion

Given the nature of this study as a pilot, we also ran some exploratory analyses with the EE subscale of the MBI Human Services Survey. Participants fell into one of three groupings on the EE: low (48.5%), moderate (29.4%), or high (20.6%). Although not significant, trends were discovered in terms of age and number of years in the mental health field, both of which negatively correlated with EE. These findings are supported in the extant literature (Ghahramanlou & Brodbeck, 2000; Creamer, 2002).

We did not note trends related to EE and gender, agency, or job description. Neither were there significant trends related to EE and number of coping strategies endorsed. However, it is interesting to note that those in the moderate EE category endorsed the most coping strategies and they were the only group for whom coping strategies increased post-training. One possible explanation for this trend is that those individuals in the low EE group did not feel the need to use coping strategies, while those in the high EE group were too overwhelmed to do so.

## *Discussion*

Participants learned the material presented in the RC trainings. We hypothesized that learning this material would positively impact vicarious traumatization; our data did not confirm this hypothesis. Given the very small number of participants within this study, however, it is not entirely surprising that our hypothesis was not confirmed. A larger sample may have yielded different results. On the other hand, it may be unrealistic to think that one three-day training is adequate to affect participants' emotional exhaustion, spirituality, or core beliefs about self and others, or that such effects would be measurable shortly after such a training. These deeper changes may require a more prolonged intervention, such as monthly workplace discussion or support groups that reinforce the learning from the training program.

As a group, participants fell into the normal range on several measures of aspects of well-being (TABS, EE, and DP), and they scored slightly higher than average on PA, indicating that the group is not experiencing burnout and is experiencing feelings of competence and successful achievement in their work with clients. Again, this is based on aggregate scores, and it is important to note that approximately 20% of the sample did fall in the high range of EE, 9% in the high range of DP, and 41% in the low range of PA. Interestingly, the percentage of individuals in each of these high burnout groups decreased post-training. This trend might indicate that individuals who were experiencing the most disruption to their well-being benefited most from the training in terms of well-being. Alternatively, it may simply reflect regression to the mean, a natural phenomenon in which outliers' scores are often closer to the mean at a



second measurement. These competing hypotheses could be tested with both a larger sample and repeated intervention and measurement with a second group of participants.

Given the voluntary nature of this study and small sample size, we cannot assume that the various outcomes identified above are representative of all DMHAS-YAS staff. It could be that those individuals who agreed to participate and took time to complete the questionnaires are the highest functioning of the YAS staff, those with the most free time, and/or those who are currently experiencing well-being and that those individuals experiencing diminished well-being may have self-selected out of the study due to, for example, time limitations or an overwhelming work load.

It is also important to consider the nature of vicarious traumatization when interpreting these results. Vicarious traumatization is a process that evolves over time and across interactions with clients. It is also transformed over time. Moreover, its transformation is affected by various factors, including one's current work environment, life stressors, and ongoing social support. Suggestions for future research include measuring aspects of vicarious traumatization over time as well as assessing factors other than a one-time training intervention that might impact vicarious traumatization.

Although statistical analyses related to the transformation of vicarious traumatization were not significant, we believe that the development of a VT-index is an important contribution to existing research. No one instrument currently exists to measure vicarious traumatization. The ProQual (Stamm, 2003) appears promising for assessing "compassion fatigue" and "compassion satisfaction." It does not, however, sample the wide range of realms that are encompassed by the vicarious traumatization construct. An index of various measures offers one option for addressing this issue. Further research utilizing such an index is required to test the viability of this approach.

Finally, implications for DMHAS-YAS might include further investigation of diminished well-being and vicarious traumatization levels of the entire staff. Attending to younger staff members as well as those who have less experience in the field might be particularly useful given trends noticed in our data indicating higher risk for vicarious traumatization among these populations as well as literature supporting these observations more generally.

DMHAS-YAS staff whom we surveyed did learn the material. This might partially reflect a willingness and desire on the part of staff to increase their knowledge of the RC approach to trauma treatment. Continued opportunities for learning might enhance the sense of personal accomplishment that this sample already reported.

Reflecting on the concept of vicarious traumatization and how it both develops and is transformed leads us to recommend continued attention to how the work environment at DMHAS-YAS acknowledges the effects of the work on the treater, supports its staff, and provides opportunities for addressing and transforming vicarious traumatization. Again, the higher than average personal accomplishment scores may indicate that this is already happening to some extent within DMHAS-YAS.

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