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Rural social work practice: Trauma-focused interventions social workers use

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RURAL SOCIAL WORK PRACTICE

Abstract

This research study examines rural social workers' level of trauma knowledge and trauma treatment self-efficacy and the use of evidence-based interventions (CBT, TF-CBT, CPT, EMDR and PE). A retrospective design was used to examine Texas rural social workers' use of evidence-based interventions. The Texas rural social worker sample (N=19) was extrapolated from a larger study (N=1007) conducted in 2014 examining Texas social workers' trauma treatment and their use of evidence-based interventions. Descriptive and correlation statistical procedures were implemented to analyze the data for the current study. The results show social workers' knowledge of trauma and treatment self-efficacy scores are above average. Furthermore, continuing education and training are associated with evidence-based intervention use. However, not all interventions used are associated with continuing education and training (e.g., CBT). Therefore, the trauma-focused intervention social workers use could determine whether it is cost-effective to train social workers in a certain intervention or not.

Keywords: trauma, trauma-focused, evidence-based intervention, rural social workers, trauma-treatment, CBT, TF-CBT, CPT, EMDR, PE

RURAL SOCIAL WORK PRACTICE

Rural Social Work Practice: Trauma-Focused Interventions Social Workers Use

Research suggests practitioners' knowledge of trauma treatment is related to their training in evidence-based interventions (EBI). Those who are trained in EBIs have higher trauma knowledge base than those who are not trained in EBIs (Sprang, Craig, & Clark, 2008). Furthermore, the lack of EBI training leads to eclecticism, which has been found to be ineffective with trauma treatment (Becker et al., 2004; Sprang, Craig, & Clark, 2008). Thus, practitioners' knowledge of trauma influences their choice of intervention in the treatment of trauma. For example, therapists who claim to use an eclectic approach are less likely to be well informed about trauma treatment. Becker et al. (2004) found psychologists were more likely to choose an eclectic approach (37%) whereas practitioners trained in trauma chose cognitive-behavioral therapy (CBT, 76%) as their treatment of choice (Cook et al., 2010; McClure et al., 2005). Sprang et al. (2008) found trauma trained-therapists (33%) compared to non-trauma trained-therapists (65%) were significantly more likely to report using eye movement desensitization and reprocessing (EMDR, 4.7%) and identifying a treatment approach of choice (e.g., CBT, 29%) as opposed to reporting an eclectic approach (5.2%). Van Minnen et al. (2010) found increased training in imaginal exposure (IE) was associated with higher preference in EMDR use and lower preference for supportive counseling.

Research findings indicate trauma treatment requires a phase-oriented approach (Cloitre et al., 2011) and those trained in evidence-based practice (EBP) know how to proceed with trauma cases. Thus, evidence-based training (e.g., CBT or EMDR) is critical to trauma treatment effectiveness. Allen et al. (2012) found clinicians who trained in trauma-focused cognitive-behavioral therapy (TF-CBT) correctly identified empirically supported interventions, whereas those without TF-CBT training incorrectly identified non-EBT as empirically supported

RURAL SOCIAL WORK PRACTICE

interventions (Spencer et al., 2010). Similarly, Craig and Sprang (2010) found clinicians who had specialized training in trauma treatment were significantly more likely to use EBP and social workers were significantly more likely to use non-EBP than psychologists (Gray et al., 2007; Hamblen et al., 2010; Katz et al., 2006; Najavits et al., 2011). Rosen et al.'s (2004) study showed trauma specialists compared to generalist mental health providers used more validated questionnaires and were more likely to discuss traumatic events directly. This is important because according to Back et al.'s (2009) findings, trauma in clients must be addressed precisely to prevent trauma avoidance. Therefore, better treatment outcomes are related to the intervention practitioners use (Malik et al., 2021; Powell et al., 2020; Steward et al., 2021).

The studies reported on practitioners' knowledge of trauma treatment support the findings training on trauma-focused interventions increase social workers' trauma knowledge and skill set. For example, Couineau and Forbes (2011) found the most significant barrier to using a trauma-focused intervention was lack of confidence and skills (lower self-efficacy); however, training increased confidence and skills (higher self-efficacy; Weine et al., 2001). In addition, Laska et al. (2013) found 12% of therapists' skills were attributed to the best outcome in clients. Therefore, to increase social workers' trauma knowledge and trauma treatment efficacy, training is necessary.

Trauma Treatment

The most accepted therapies (trauma-focused interventions) for treating psychological trauma are CBT, cognitive processing therapy (CPT), prolonged exposure therapy (PE), and EMDR (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015; Foa et al., 2007; Friedman et al., 2007; Graca, Palmer, & Occhietti, 2014; Lopes, Macedo, Coutinho, Figueira, & Ventura, 2014; Resick & Schnicke, 1992; Shapiro, 2018; Taylor, 2004). All the interventions follow a similar

RURAL SOCIAL WORK PRACTICE

format: psychoeducation, symptom stabilization, treatment, and symptom reduction reevaluation. Furthermore, all the interventions require training to a certain degree. The level of training ranges from graduate school introduction to the intervention to full training that includes protocols and manuals. Full training is usually at least forty hours along with consultation during and after the training.

These therapies aim at restructuring the maladapted cognition, emotion, and behavior along with reducing those symptoms associated to the traumatic experience at the physiological level. Some interventions focus more on cognitive restructuring while others focus on avoidance and affect regulation. Nevertheless, the goal of trauma treatment is to reduce symptoms and improve overall functioning (Carbajal, 2018; Carbajal & Aguirre, 2013; Foa, Hembree, & Rothbaum, 2007). For a client to process a traumatic experience successfully, the client must maintain a healthy level of affect tolerance as he or she processes the traumatic experience (Van der Kolk, 1994). A person with low affect tolerance is prone to dissociate because of hyper-arousal or because of hypo-arousal, the person is not able to access the traumatic system enough to process the information effectively (Brewin, 2003; Van der Kolk, 1994). Therefore, trauma treatment requires delicacy and adeptness to help a client maintain a healthy level of tolerance and thereby help the client process the traumatic experience.

Trauma intervention training is necessary for social workers to help clients with traumatic symptoms (Carbajal, 2018; Clark et al., 2012). With trauma training (trauma-focused intervention training), a social worker learns about the required phases for trauma treatment and the strategies (techniques) to use to reduce traumatic symptoms (Cloitre et al., 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). However, little research exists on clinical practice in rural communities. Therefore, research is needed to determine the

RURAL SOCIAL WORK PRACTICE

degree to which rural social workers are trained in trauma treatment. This is more important because many rural communities often have gaps that limit their ability to access resources. For example, they have limited access to care, limited public transportation infrastructure, geographical barriers to nearest hospitals, lack of mental health and substance use disorder providers, and they lack necessary workforce with matching competencies (Carbajal & Cooper, 2021). This study specifically examines Texas rural social workers' use of trauma-focused interventions in working with clients who experience trauma (posttraumatic stress) and their knowledge and trauma treatment efficacy. The study will provide information about rural social workers' training on interventions that focus on trauma. This information can guide the profession and social work education to better prepare its practitioners and students to work with clients experiencing trauma.

Method

The data for this study is part of a larger study (N=1007) conducted in 2014 to determine Texas social workers' odds ratio on using trauma-focused interventions based on their level of knowledge on trauma and their perceived self-efficacy (Author). The parent study was approved by the university Institutional Review Board (IRB).

The author for the parent study administered a background questionnaire. It included questions on social workers' level of education, licensure type, clinical experience, practice setting, and client trauma treatment. In addition, it included questions regarding social workers' use of trauma-focused interventions (CBT, TF-CBT, PE, CPT, and EMDR). Furthermore, the background questionnaire included demographic questions (e.g., years of experience, continuing education, and formal training, etc.).

RURAL SOCIAL WORK PRACTICE

The author for the parent study also administered two scales, the Trauma Treatment Self-Efficacy scale, a revised version of Bussey's (2008) scale, and revised PTSD Knowledge Questionnaire. The Trauma Treatment Self-Efficacy scale is 8-items, scored on a 11-point Likert scale from 0 (cannot do at all) to 10 (highly certain can do), higher scores indicate higher self-efficacy in trauma treatment and skills. A reliability test was performed resulting in a .94 alpha (N=283). McKenzie and Smith (2006) developed the PTSD Knowledge Questionnaire, 54-items. The questionnaire is scored on a 5-point Likert scale, part 1 is rated from 0 (very poorly informed) to 4 (very well informed), and part 2 is rated from 0 (strongly disagree) to 4 (strongly agree), higher scores indicate higher knowledge about PTSD (trauma). McKenzie and Smith established content and face validity by having staff at the Australian Centre for Posttraumatic Mental Health review the questionnaire. The test-retest reliability was .89 and the Cronbach's alpha was .73 (McKenzie & Smith 2006). A Cronbach's alpha reliability test was performed on the Revised PTSD Knowledge 18-item scale resulting in a .81 alpha (N=253).

Most participants were females (78.7%) and Caucasian (72.4%). Hispanic/Latino and African American respondents comprised of 13.3% and 4% of the sample, respectively. The average age of respondents was between 35 and 44 (14.6%) with the 55 to 64 age group having highest participation (32.2%). Many social workers reported having an LCSW license (58.8%); 37.9% of social workers had a LMSW license and 93% of the social workers were master level.

The purpose of this study was to determine rural social workers' trauma-focused treatment use and to assess their level of trauma knowledge and trauma treatment efficacy. From the parent study, 22 participants were from a rural setting (rural areas were defined based on population density and city sizes, for example, Nacogdoches, Tyler, and Odessa); however, three

RURAL SOCIAL WORK PRACTICE

participants were removed due to reporting they did not treat clients with traumatic experiences, resulting in 19 participants.

A Cronbach's alpha reliability test was performed to determine the Trauma Treatment Self-Efficacy scale's (8-items) reliability with this sample. However, the test indicated high multicollinearity (high correlations among items) including inter-item correlation. Therefore, the items' MSA (measure of sampling adequacy) was used to evaluate and to improve the scale's reliability (Hair, Black, Babin, & Anderson, 2010). The anti-image correlation matrix was used to determine which items to drop. Those items with an MSA correlation coefficient below .8 were dropped. The inter-item correlation was examined to determine which items had correlation coefficients above .8. Those items with above .8 coefficients were dropped, resulting in a 6-item scale. A reliability test was performed on these 6-items (N=18) resulting in a .92 alpha.

A Cronbach's alpha reliability test and an exploratory factory analysis were conducted to evaluate the Revised PTSD Knowledge scale with this sample. A reliability test was performed with all the 18-items (N=14) resulting in a .60 alpha. An exploratory factory analysis on the 18-item Revised PTSD Knowledge scale was conducted. The purpose was to evaluate the items' MSA and to improve the scale's reliability (Hair, Black, Babin, & Anderson, 2010). The anti-image correlation matrix was used to determine which items to drop. Those items with an MSA correlation coefficient below .8 were dropped, resulting in 10-items. A reliability test was performed on these 10-items (N=16) resulting in a .82 alpha.

Analysis Plan

SPSS 26 statistical software was used to analyze the data. Descriptive analyses (e.g., frequencies, means) were used to describe the study's sample and variables. This analysis provided information about participants (e.g., practice location, demographic information,

RURAL SOCIAL WORK PRACTICE

clinical experience, etc.). Correlation analyses included type of licensure; years of clinical experience; years of working with clients who experienced trauma; percentage use of intervention; continuing education in CBT, TF-CBT, CPT, and EMDR; and training in CBT, TF-CBT, CPT, and EMDR; PE was not included in the analysis because Texas rural social workers did not report using it.

Results

Descriptive Statistics

Table 1 presents practitioners' demographic information (N=19). Most participants were females (78.9%) and Caucasian (73.7%). Hispanic/Latino and African American respondents comprised of 10.5% and 10.5% of the sample, respectively. The highest age group was 34 or younger (36.8%).

Table 1 Social Workers' Demographic Information

	n	(%)
Gender		
Male	4	(21.1)
Female	15	(78.9)
Age		
34 or younger	7	(36.8)
35-44	4	(21.1)
45-54	4	(21.1)
55-64	2	(10.5)
65 or older	2	(10.5)
Ethnicity		
Caucasian	14	(73.7)
African American	2	(10.5)
Hispanic/Latino	2	(10.5)
Native American	1	(5.3)
Licensure type		
LMSW	10	(52.6)
LCSW	9	(47.4)
Highest degree		
Masters	18	(94.7)
Doctoral	1	(5.3)

RURAL SOCIAL WORK PRACTICE

Many social workers reported having an LMSW license (52.6%), while 47.4% of social workers had a LCSW license, and 94.7% of the social workers were master level.

Participants' Practice Characteristics

Table 2 presents social workers' practice characteristics. Many practitioners were in private practice (31.6%); others worked in community settings (21.1%). Fewer practitioners reported working in outpatient/treatment center (10.5%), inpatient facilities (15.8%), and VA/vet center/medical center (10.5%). Over 50% of practitioners reported treating a client with trauma, and over 50% reported they had less than 10 years of experience treating clients with posttraumatic stress. Furthermore, 63% reported treating military members.

Practitioners reported using CBT (73.7%) as the primary intervention for trauma treatment followed by TF-CBT (31.6%). Practitioners reported they used EMDR (5.3%) and CPT (5.3%) equally, and none of the practitioners reported using PE. Moreover, rural social workers' knowledge of trauma mean score was 3.46 (SD=.42, range from 0-4) and their trauma treatment self-efficacy mean score was 6.25, (SD=2.25, range from 0-10).

Table 2 Social Workers' Practice Characteristics

	n (%)
Clinical setting (Yes response only)	
Counseling/Community agency	4 (21.1)
Private Practice	6 (31.6)
Outpatient/treatment center	2 (10.5)
Inpatient	3 (15.8)
VA/Vet center/medical center	2 (10.5)
Other settings	4 (21.1)
Years of trauma treatment	
0-9	12 (63.1)
10-19	3 (15.8)
20+	4 (21.1)
Intervention use (Yes response only)	
CBT	14 (73.7)
TF-CBT	6 (31.6)
CPT	1 (5.3)
PE	0 (0.0)

RURAL SOCIAL WORK PRACTICE

EMDR	1 (5.3)
Other	3 (15.8)

Correlation Statistics

A multivariate analysis was conducted to assess social workers' use of evidence-based interventions with licensure type, age, years of clinical experience, years of treating clients with trauma, continuing education, and training on trauma-focused intervention variables. There were no significant correlations ($p > .05$) among the tested variables with knowledge of trauma, treatment self-efficacy, continuing education on CBT and TF-CBT, training on CBT, and years of treating clients with trauma.

Table 3 Evidence-Based Intervention Correlations

	Intervention Use				
	N=19	CBT	TF-CBT	CPT	EMDR
Licensure level		-.46*	-.03	.31	.24
Age		-.24	-.08	.29	.46*
Years of exp.		-.11	-.13	.19	.63**
Years of trauma exp.		-.08	-.22	.45	.45
CEU					
CBT		-.14	-.13	-.28	-.12
TF-CBT		-.45	.39	-.25	-.19
CPT		.46*	-.18	.94**	-.10
EMDR		.33	-.21	-.09	.96**
Training					
CBT		-.02	-.33	-.29	-.18
TF-CBT		-.45	.48*	-.19	-.20
CPT		.25	-.22	.84**	-.10
EMDR		.25	-.20	-.09	.88**

* $p < .05$. ** $p < .01$. *** $p < .001$.

RURAL SOCIAL WORK PRACTICE

Rural social workers' licensure type was negatively associated with using CBT $r(19) = -.46$, $p < .05$, while age and years of experience were positively associated with using EMDR, $r(19) = .46$, $p < .05$ and $r(19) = -.63$, $p < .01$, respectively. Continuing education on CPT was positively associated with using CBT $r(19) = .46$, $p < .05$; and CPT, $r(19) = .94$, $p < .01$. Continuing education on EMDR was positively associated with using EMDR, $r(19) = .96$, $p < .01$. Training on TF-CBT was positively associated with using TF-CBT, $r(19) = .48$, $p < .05$. Training on CPT was positively associated with using CPT, $r(19) = .84$, $p < .01$, while training on EMDR was positively associated with using EMDR, $r(19) = .88$, $p < .01$.

Discussion

This study specifically investigated Texas rural social workers' knowledge of trauma and trauma treatment self-efficacy. In addition, this study assessed social workers' trauma-focused intervention use and training. The findings indicate social workers' knowledge of trauma and treatment self-efficacy is above average. Furthermore, rural social workers' use of TF-CBT, CPT, and EMDR training in TF-CBT, CPT, and EMDR resonates with the findings from Sprang, Craig, and Clark's (2008) study, which training predicted practitioners' use of EBPs. Moreover, this study's findings indicate social workers' continuing education had the least associated variables with intervention use. Therefore, treatment training might determine whether a social worker will use the intervention and whether they will obtain the best treatment outcomes (Allen, Gharagozloo, & Johnson, 2012). Moreover, social workers' age and years of experience indicate they are more likely to use EMDR therapy than any other intervention.

Trauma-focused training provides a higher knowledge base on that intervention and a general knowledge base about trauma since it is a trauma-focused intervention (Clark et al., 2012; Courtois & Gold, 2009; SAMHSA, 2014). Therefore, knowledge of trauma and training

RURAL SOCIAL WORK PRACTICE

go hand in hand. The finding of the influence training has on intervention use is crucial to social work practice since knowledge can increase self-efficacy and thus, increase social workers actual use of trauma-focused interventions (Couineau & Forbes, 2011; Hamblen, Norris, Gibson, & Lee, 2010). This is similar to van Minnen, Hendriks, and Olf's (2010) findings that increased training in a trauma-focused intervention was associated with lower preference for supportive counseling (a non-EBT), providing more evidence for efficacy in trauma treatment. More importantly, as Steward et al.'s (2020) found in their feasibility study, psychologists who were trained in TF-CBT in El Salvador resulted in large effect sizes in symptom reduction for youth who had trauma. Therefore, training and applying a trauma-focused intervention determines treatment efficacy and outcome (Carbajal, 2018, Malik et al., 2020; Powell et al., 2020).

Social workers' use of CBT had no association with any of the tested variables except for with licensure type, negatively associated. It might be that social workers trained in CBT are not trauma-focused trained. Finally, continuing education also indicates that it might have the least effect on trauma-intervention use.

Limitations of Study

This study was a retrospective study based on a larger study. The data used to analyze this sample was from 2014, and the population might have changed since then. The tested variables and low number of participants (N=19) should be considered with this limitation. Furthermore, the correlations in some variables are weak, which constitutes a need for further exploration to determine if there is a relationship between variables such as knowledge of trauma and treatment self-efficacy, as a low N prevents from determining association strength in correlation statistics. In addition, generalization can only be applied to master level licensed (LMSW or LCSW) social workers who have experience in treating clients with trauma and were

RURAL SOCIAL WORK PRACTICE

members of the NASW/TX in Texas but not to the general population of social workers in Texas. Therefore, the interpretation of these findings should consider the homogeneity of the population. Thus, future research should consider increasing the sample and widening the geography of participants.

Conclusion

It is likely social workers provide services to clients who have experienced trauma (SAMHSA, 2014; Simmons & DeCoster, 2007). Social workers work with those experiencing trauma in numerous settings including mental health facilities, hospitals, prisons, private practices, and shelters for battered women. Hence, social workers' knowledge of trauma and treatment self-efficacy needs further exploration, as many settings were not associated with knowledge of trauma and treatment efficacy, except for private practice and self-efficacy, $r(18) = .70, p < .01$; social workers in private practice reported having higher treatment self-efficacy. A study should focus on the population social workers serve in these settings to determine if trauma treatment is applicable to their settings; although, this sample reported currently treating clients with trauma. In this study, the VA setting was not correlated with knowledge of trauma and treatment efficacy, which needs further exploration as trauma treatment is applicable at the VA and at a rural setting (Getz, 2017; Yarvis, 2011).

This study findings suggest the content and effectiveness of continuing education and training needs further exploration (Williams, 2007). This study found there is a correlational difference in continuing education and training in relation to the intervention social workers use; the correlational difference is training (knowledge retention and application), as more trauma-focused interventions were associated with training compared to continuing education. This

RURAL SOCIAL WORK PRACTICE

difference could be explained by the fact trainings require participants to demonstrate competency (knowledge retention and application) whereas continuing education does not.

Finally, trauma treatment requires specialized training (Bussey, 2008; Courtois, 2002; Courtois, & Gold, 2009). Clark et al. (2012) states, “Persons afflicted with post-traumatic stress disorder (PTSD) and co-occurring disorders require specialized assessment, treatment planning, and interventions to increase the probability of positive outcomes” (p. 353). Sprang et al., (2008) investigated practitioners’ interventions with trauma and found 65% of practitioners had no specific trauma treatment training. They also found training predicted practitioners’ use of evidence-based practices, and social workers were more likely to use non-evidence based practice to treat trauma than psychologists. Clark et al. (2012) investigated attitude toward EBP patterns and found most practitioners prefer “...relational support techniques and peer consultation rather than EBPs...” and most of them “did not use EBPs for trauma assessment and treatment approaches, but instead, utilized generalist approaches” (p. 356). Therefore, clients with trauma may not receive treatment from the most competent practitioners if they are not trained or use trauma-focused interventions.

RURAL SOCIAL WORK PRACTICE

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RURAL SOCIAL WORK PRACTICE

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