HHS Public Access

Author manuscript

Soc Work. Author manuscript; available in PMC 2018 July 12.

Published in final edited form as:

Soc Work. 2018 April 01; 63(2): 125–133. doi:10.1093/sw/swy012.

Wounded Healers: A Multistate Study of Licensed Social Workers' Behavioral Health Problems

Shulamith Lala Ashenberg Straussner,

Professor and director, Post-Master's Certificate Program in Clinical Approaches to the Addictions, Silver School of Social Work, New York University, 1 Washington Square North, New York, NY 10003

Evan Senreich, and

Associate professor of social work, Department of Social Work, Lehman College, City University of New York, Bronx, NY

Jeffrey T. Steen

Assistant professor, Bridgewater State University, Bridgewater, MA

Abstract

Studies indicate that helping professionals are disproportionately affected by behavioral health problems. Among social workers, the nature and scope of these problems are understudied. This article reports the findings of a 2015 survey of 6,112 licensed social workers in 13 states regarding their problems with mental health; alcohol, tobacco, and other drugs; and gambling. To ascertain whether these problems preceded or developed during their social work careers, the periods of time when these issues were experienced were identified. Results indicate that 40.2 percent of respondents reported mental health problems before becoming social workers, increasing to 51.8 percent during their social work career, with 28 percent currently experiencing such problems. Nearly 10 percent of the sample experienced substance use problems before becoming social workers, decreasing to 7.7 percent during their career. Analyses by race or ethnicity, sex, and age identified between-group differences in the prevalence of these problems. The article concludes with a discussion of the implications for the social work profession.

Keywords

alcohol; tobacco; and other drug use; gambling problems; mental health impairment; social work workforce

The Swiss psychoanalyst Carl Jung (1966) conceptualized the idea of “wounded healers” to refer to helping professionals who experience personal challenges that affect their work. This archetype is based on the Greek myth of the centaur Chiron, who was physically wounded, and by way of overcoming the pain of his own injuries became a master of the healing arts. Jung proposed that the physician who has experienced adversity is better equipped to understand the causes and amelioration of a patient's suffering, but may also experience limitations as a result of this personal history. In the literature, this concept has been applied to social workers and other helping professionals, describing the ways in which personal behavioral health challenges may present both assets and liabilities to professional

practice, with further research recommended regarding the wellness of the social work workforce (Barr, 2006; Newcomb, Burton, Edwards, & Hazelwood, 2015; Reamer, 1992, 2015).

With this in mind, this article presents findings from an online survey of 6,112 licensed social workers in 13 states who reported the extent of their own problems with mental health, alcohol and other drugs (AOD), tobacco, and gambling. Differences by sex, race or ethnicity, and age illuminate the nature of these problems in the social work workforce.

NATIONAL DATA ON BEHAVIORAL HEALTH PROBLEMS

In 2015, 17.9 percent of adults in the United States met the DSM-IV criteria for a mental disorder, 5.9 percent of individuals age 12 and older met the criteria for an alcohol use disorder, and 2.9 percent met the criteria for an illicit drug use disorder. In addition, 23.9 percent of the U.S. population age 12 and older used tobacco products (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). However, there were differences in these prevalence rates based on age, race or ethnicity, and sex (Grant et al., 2016). Moreover, Kessler et al. (2008) estimated that 0.6 percent to 2.3 percent of adults in the United States experienced gambling problems during their lifetime. While using a somewhat different methodology than the national studies and thus making direct comparison difficult, the current study surveyed licensed social workers in 13 states located in all four geographical regions of the United States (U.S. Department of Commerce, n.d.) and used self-report measures of their mental health, AOD problems, tobacco use, and gambling problems to describe the wellness of this large group of social workers.

BEHAVIORAL HEALTH PROBLEMS AMONG SOCIAL WORKERS

A review of the literature shows a lack of recent data regarding behavioral health impairment among social workers in the United States, although a few older studies suggested that social workers were significantly affected by problems with mental health and AOD use. In a 1987 survey of 198 members of the New York City chapter of the National Association of Social Workers, Fewell, King, and Weinstein (1993) found that 43 percent of respondents had known at least one colleague with AOD problems. Using the Social Worker Health Questionnaire, Strozier and Evans (1998) surveyed a random sample of 668 NASW members nationwide and found that 5.7 percent were problem drinkers, 13 percent used painkillers, and 6 percent used marijuana. Over a fifth of the sample reported having unpredictable moods, 10 percent disabling anxiety, and 9.4 percent depression. Siebert (2003) surveyed NASW members in North Carolina and found that 8 percent were at serious risk and 15 percent at moderate risk for alcohol problems. Of those at serious risk, 39 percent reported that they had worked when too impaired to be effective. In another publication, Siebert (2004) reported that 19 percent of the sample of social workers in North Carolina were depressed. In a study of social workers in Kentucky, 13 percent scored as having alcohol and other drug problems and 9 percent as depressed (Pooler, 2008). In England, studies that have examined the experiences of depression among social workers found that for the majority of the respondents, work stress was cited as a major cause of their

depression (Stanley, Manthorpe, & White, 2007). None of the studies examined tobacco use or problems with gambling among social workers.

In sum, past studies have indicated that social workers are at least as likely, if not more so, to experience mental health and AOD problems as the general population, issues that potentially affect their work with clients. However, these studies' small sample sizes make it difficult to generalize findings, and more important, it is unknown if these problems existed before or after their employment as social workers.

WOUNDED HEALERS: A THEORETICAL FRAMEWORK

Although there does not appear to be a comprehensive contemporary theoretical model in the social work literature expanding on Jung's concept of the wounded healer, Zerubavel and Wright (2012) created such a framework for psychologists practicing as psychotherapists. They discussed how therapists' own emotional wounds, if sufficiently worked through, can heighten therapeutic effectiveness by enhancing their empathy toward the painful experiences of their clients, increasing their patience and tolerance when a client's progress seems slow, and maintaining their faith in the therapeutic process. On the other hand, a therapist's psychological wounds, if not sufficiently addressed, can result in the clinician not being emotionally present, having poorly managed counter-transference reactions, engaging in the blurring of boundaries, as well as overidentifying with and projecting issues onto clients. These possible negative ramifications are emphasized by Newcomb et al. (2015) in their article regarding social work students' reactions to previous adverse experiences in their lives.

Zerubavel and Wright (2012) made a distinction between wounded healers who can use their wounds to help others and impaired professionals whose emotional problems adversely affect their clinical work. A major point made by these authors is that colleagues and supervisors tend to stigmatize therapists for being open about their psychological wounds, and thus discourage them from obtaining support that could strengthen their work with clients. As the authors noted, this is particularly important because many therapists choose their profession due to their own history of pain or suffering, and such backgrounds may result in being particularly vulnerable to vicarious trauma reactions in their work with clients.

The present descriptive study aims to address the lack of recent data regarding the scope of social workers' problems with mental health, AOD, gambling, and tobacco use by examining a large, multi-state sample of licensed social workers. Due to the exploratory nature of this study, the authors did not formulate a priori hypotheses. However, the authors were interested in exploring whether behavioral health problems experienced by social workers preceded their entry into the profession—in essence, did they begin practicing social work as wounded healers, or did they develop such problems subsequently to their becoming social workers?

METHOD

Participants

From September to December 2015, 6,112 licensed social workers in 13 U.S. states responded to this online survey. Before the survey took place, professional licensing boards of all 50 states were contacted regarding the availability of licensed social workers' e-mail addresses. At the time of inquiry, 13 states provided this information to the public: Arkansas, Connecticut, Florida, Minnesota, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, Washington, West Virginia, and Wyoming. These states represent all four regions of the country as designated by the U.S. Census Bureau. A total of 90,302 social workers were actively licensed in these states, with e-mail addresses available for 71,770 of them. After duplicate or clearly erroneous addresses were eliminated, the sampling frame was reduced to 69,661 social workers. Of these, one-half, or 34,831 licensed social workers, were randomly selected to participate in the study. As numerous respondents held licenses in more than one state, licensed social workers from all 50 states completed the survey.

Procedures

Qualtrics, an online survey platform, was used to develop the questionnaire and manage data collection. Feedback on earlier drafts of the questionnaire was provided by licensed social workers located around the country. Potential respondents were e-mailed three invitations to participate in the study over a period of six weeks. Respondents were randomly selected to receive an incentive, one of five \$200 gift cards from Amazon. Institutional review boards from the investigators' respective institutions approved the study. Of the 6,112 individuals who started the study, 5,711 (93 percent) finished the questionnaire, resulting in a larger response rate for items at the beginning of the survey than at the end. Because the number of cases deleted for reasons of missing data was consistently below 10 percent, listwise deletion was used for the analyses.

In regard to the response rate, a variety of approaches can be used to calculate such rates in online surveys (Tourangeau, Conrad, & Couper, 2013). One approach, which was used in this study, was to omit those e-mails that bounced back as "undeliverable" when calculating the overall sample size. Consequently, the response rate for this study was calculated to be 27.5 percent.

Measures

The questionnaire consisted of 75 closed- and open-ended items organized into eight sections: physical health, mental health, AOD problems and tobacco use; gambling and sleep problems; use of mental health and substance abuse treatment services; problems with wellness among family members; problems with wellness among social work colleagues; adverse childhood experiences; professional background and workplace experiences; and personal background. This article focuses only on the findings regarding respondents' histories of mental health issues, AOD problems, tobacco use, and gambling. These variables were measured as follows:

Mental Health Problems—Respondents were asked if they experienced mental health problems and when. Periods of time were “before becoming a social worker,” “over the course of my social work career,” and “at this point in my life.” In regard to whether mental health problems had been experienced, four response choices were provided: “strongly agree,” “agree,” “disagree,” and “strongly disagree.” If participants answered “strongly agree” or “agree” to any of the items regarding mental health problems, they were automatically directed to a page in which they indicated what specific categories of mental health problems they experienced during each of the three periods. Thirteen categories of mental health diagnoses were listed, with an option to add additional diagnoses.

AOD Problems—Respondents were asked if they ever had a problem with alcohol, and another question inquired if they ever had a problem with drugs. The response options were “yes,” “no,” and “not sure.” These two items are modifications of questions included in a previous large-scale study of AOD problems (Dube, Anda, Felitti, Edwards, & Croft, 2002; Dube et al., 2003). The participants were then asked if they ever had serious problems with alcohol or other drugs during the three periods of their lives indicated earlier, with four response choices: “strongly agree,” “agree,” “disagree,” and “strongly disagree.”

Tobacco Use—In one item, participants were asked how often they used tobacco over the course of their social work career. The four response choices were “I used tobacco throughout my social work career”; “I used tobacco off and on throughout my social work career”; “I used tobacco in the past, but have completely stopped using it”; and “I hardly ever or never used tobacco.”

Gambling Problems—In one item, participants were asked whether they had a problem with gambling over the course of their social work career. The response choices were “often,” “sometimes,” “rarely,” and “never.”

Demographic Information—In the final section of the survey, items with multiple-choice and fill-in response options asked participants to provide their sex, race or ethnicity, age, and other demographic information.

Analysis

Responses to the various items were first analyzed using univariate statistics. Subsequently, the responses to the items were compared by sex, race or ethnicity, and age using chi-square analyses with Bonferroni corrections for pairwise comparisons. In regard to race or ethnicity, self-identified white, black, and Latino groups were compared. Respondents from other self-identified ethnic and racial groups were not included in this analysis due to small sample size. To compare responses according to age, the sample was divided into three age groups: 21–39; 40–59; and 60 and older. For variables in which there were four response choices, such as “strongly agree,” “agree,” “disagree,” and “strongly disagree,” the results were collapsed into “yes/no” dichotomous variables to report a large amount of data in a succinct way for this article. “Strongly agree” and “agree” were considered a “yes” response, whereas “disagree” and “strongly disagree” were considered a “no” response. For the gambling item, “often” and “sometimes” were considered to be a positive response, and

“rarely” and “never” were considered to be a negative response. For the two items asking respondents about lifetime problems with AOD use, or both, only “yes” and “no” responses were compared, with “not sure” eliminated from the analysis (2.0 percent and 0.6 percent of respondents, respectively).

RESULTS

Demographics of Respondents

Demographic information about the participants is provided in Table 1. Respondents predominantly identified as female (88.8 percent) and heterosexual (90.7 percent), with over 95 percent reporting that they were born in the United States. In regard to race or ethnicity, 83.2 percent of study participants identified as white or European American, 6.2 percent as black or African American, and 3.9 percent as Latino or Hispanic. Due to the small number of respondents reporting other racial and ethnic backgrounds, the remaining participants (6.7 percent) were categorized as “mixed/other.” The mean age of respondents was 46.2 years. Slightly more than 80 percent of respondents held an MSW degree. The vast majority (77.2 percent) were currently engaged in direct practice or clinical social work. The two most common fields of practice in which respondents were employed were mental health (61.0 percent) and children and adolescents (50.6 percent). Those employed solely in private practice represented 12.1 percent of the sample. The mean length of time of employment in social work was 16.1 years. For more detailed findings, see Table 1.

Behavioral Health Problems

Over four out of 10 participants experienced mental health problems before becoming social workers, over half experienced these problems over the course of their social work careers, and over a quarter were currently experiencing such problems (see Table 2). Nearly one in 10 respondents reported a history of alcohol problems and almost 6 percent reported a history of drug problems. Although only 2.4 percent of participants reported AOD problems at the current time, nearly 10 percent reported having had AOD problems before becoming a social worker and 7.7 percent reported AOD problems during their social work career. Fewer than 1 percent reported ever having gambling problems. Tobacco was used by 29.8 percent of respondents in their lifetime, with 17.9 percent reporting that they had completely stopped using it. Therefore, only 11.9 percent of social workers were current users of tobacco.

By far, the two most common psychiatric diagnoses reported by participants were depression and anxiety (see Figure 1). Over a quarter of respondents reported a history of depression before becoming social workers, which increased slightly to 29.2 percent during their social work career. Over 14 percent of respondents stated that they were currently experiencing depression. Similarly, anxiety disorders increased during the careers of social workers and remained high, with over 17 percent of respondents stating they were currently experiencing such symptoms. Approximately 8 percent of participants reported experiencing posttraumatic stress disorder before their social work careers, which decreased by more than half at the current time, as did the level of eating disorders. Although the rates of bipolar disorder were not high, they remained relatively stable over time. The other three diagnoses reported by over 1 percent of respondents were attention-deficit/hyperactivity disorder,

obsessive–compulsive disorder, and learning disorders, all of which decreased slightly over time.

Differences by Sex

There were many statistically significant differences in reported mental health problems between male and female social workers during their social work careers (see Table 2), but no significant sex differences in mental health were found for individuals before entering the profession or currently. There were also no significant sex-based differences in the small number of social workers having gambling problems, but there were significant sex differences between men and women in their AOD use before and during their social work careers, as well as currently, with men much more likely than women to experience such problems. Finally, as many as 41.8 percent of the men reported lifetime tobacco use in comparison with 28.4 percent of the women.

Differences by Race or Ethnicity

Notable differences in reported behavioral health problems by race or ethnicity are seen in Table 2, with the greatest statistically significant differences occurring between white and black respondents. In comparison with white social workers, black participants were far less likely to report mental health problems before becoming a social worker, during their social work career, and at the current time. They were also far less likely to report alcohol problems over their lifetime and AOD problems during their social work career. Latino participants were significantly less likely to report mental health problems during their social work career than white participants, but were more likely than black respondents to report mental health problems before becoming a social worker.

Differences by Age

There were some statistically significant age-related differences among study participants. Younger social workers (those 21 to 39) reported higher rates of mental health problems in every time period; those age 60 and older had the lowest rates. Although there were no significant age differences for AOD problems during social work career or currently, the youngest group had fewer AOD problems before becoming social workers. This group also reported the lowest levels of lifetime tobacco use. However, the oldest age group was the least likely to be currently using tobacco (8.5 percent) in contrast to 12.9 percent for those ages 21 to 39, and 12.3 percent for those ages 40 to 59.

DISCUSSION

A major finding of this study is that for this sample of licensed social workers, mental health problems were very common. Over 40 percent of social workers reported experiencing mental health problems before their social work careers, and almost 52 percent indicated that they experienced mental health problems over the course of their social work careers, with 28 percent currently experiencing such problems. Although, as indicated previously, comparison with national data is problematic, these very high rates of mental health problems need to be studied further and addressed by the profession. Although much less common than mental health problems, the rates of AOD problems, affecting fewer than 10

percent of participants during any time period, seem to reflect the general population and other studies of social workers (Pooler, 2008). As noted previously, male social workers were far more likely to report AOD problems than female social workers, with over 19 percent reporting such issues before becoming a social worker and over 12 percent reporting such problems during their social work career. Although the current rates of AOD problems by men (4 percent) were relatively low, such problems still have an impact on the workforce.

In addition to gender-based differences, this study found variations among ethnocultural groups, with white participants far more likely to report mental health problems than black and Latino social workers. This conforms to other studies that found that individuals who identified as black or Latino reported lower lifetime levels of psychiatric disorders than white individuals (McGuire & Miranda, 2008). One explanation posited for such findings is a greater concern about stigma regarding mental health problems among already stigmatized minority groups (Gary, 2005). Regarding AOD problems, black respondents were also far less likely to report substance use problems before becoming a social worker than white or Latino respondents, mirroring national data (SAMHSA, 2016).

This study also indicates that the highest levels of mental health problems were found among those ages 21 to 39. This is consistent with national data, which indicate that the rates of mental health problems are highest among younger adults and drops off over time, particularly after age 50 (SAMHSA, 2016). However, this does not explain why the youngest cohort in this study reported the highest level of mental health problems before their social work career, and may indicate that newer social workers are increasingly entering the field as wounded healers. If so, studies need to be performed regarding the reasons for this trend. In contrast to mental health issues, the youngest cohort of respondents had the lowest level of AOD problems, contradicting national data indicating that younger individuals are more likely to have substance misuse problems (SAMHSA, 2016).

This study also found that this sample of social workers had a much lower rate (11.9 percent) of current use of tobacco, compared with 25.2 percent of the general population (SAMHSA, 2016), and that nearly 18 percent of respondents had stopped their previous use of tobacco. The percentage of respondents with a lifetime history of gambling problems (0.8 percent) is similar to rates found in the general population (Kessler et al., 2008).

A notable finding of this study is that the overall rates of reported mental health problems increased after the participants became social workers, but AOD problems decreased. This finding could possibly indicate that being a social worker increases the risks of mental health problems and may be reflective of the workplace stress experienced by social workers. This is in line with the data provided by Stanley et al. (2007), who found that social workers in England reported that work demands exacerbated their problems with depression. The results of the current study appear to indicate that working in the field of social work does not increase the risk of AOD problems, but may actually be protective in regard to substance misuse. It is also possible that some individuals who develop or continue to encounter AOD problems may not be able to maintain their positions over time and leave, or are forced out of, the social work workforce. Only further research can help us better understand these issues.

The results of this study indicate that the conceptual framework regarding the wounded healers in the profession of psychology, as formulated by Zerubavel and Wright (2012), appears to be relevant to the field of social work as well. Based on findings from our study, a large percentage of social workers could be described as wounded healers. Although it is not known how the participants' histories of mental health and AOD problems have affected their work with clients, the findings support Zerubavel and Wright's assertion that behavioral health problems among clinicians need to be destigmatized and additional mechanisms for support in the workplace need to be developed. As the frequency of mental health problems appears to accelerate during social workers' careers, there is an obvious need for more transparency about social workers' behavioral health issues, accompanied by the implementation of support systems to enhance wellness in the agencies and institutions where social workers are employed. Zerubavel and Wright (2012) noted that a history of behavioral health problems can either enhance or interfere with one's effectiveness as a clinician; therefore, studies need to be performed within the social work profession to explore the possible benefits and liabilities of having experienced these issues. Given the frequent employment of social workers with clients who have a history of trauma (Straussner & Calnan, 2014), it is critical that wounded healers in our field are supported to use their own wounds to help others and not become impaired professionals whose emotional problems adversely affect their clinical work.

Another implication of this study's findings is that schools of social work need to teach students how to exercise self-care to prevent and ameliorate mental health and AOD issues and how to use their histories of trauma to "develop the resilience useful for professional practice" (Newcomb et al., 2015, p. 55). Although social work programs often include course content about self-care related to secondary trauma when working with clients with painful life circumstances, additional efforts need to be made to destigmatize students' own behavioral health problems so that they can manage these issues more effectively during their field placements and while working in the profession.

Limitations of the Study

There are several important limitations to this study. First, licensed social workers in only 13 states were surveyed, so one should use caution in generalizing the results to all licensed social workers. However, it is important to note that the demographics of this study sample were very similar to those found in a 2004 random-sample study of licensed social workers in 48 states by Whitaker, Weismiller, and Clark (2006). Second, the response rate of 27.5 percent may have resulted in biased findings since we do not know whether those social workers who responded to this survey differ from those who chose not to do so. Third, this study explored stigmatized topics regarding respondents' personal problems, which participants may have been hesitant to honestly describe in spite of assurances of confidentiality.

CONCLUSION

The results of this online survey of 6,112 licensed social workers indicate that the social work profession needs to pay far more attention to the behavioral health of its workforce; to

encourage further research; and to create meaningful systems that promote discussion, prevention, and treatment of behavioral health issues. According to the NASW *Code of Ethics* (2017), social workers have an ethical responsibility to ensure that their personal problems, including behavioral health issues, do not interfere with their work. However, it is the profession's obligation to advocate for work environments that provide the necessary support to protect and maintain the well-being of social workers, efforts that would likely result in the provision of higher-quality services to clients and more effective programs.

References

- Barr A. An investigation into the extent to which psychological wounds inspire counsellors and psychotherapists to become wounded healers, the significance of these wounds on their career choice, the causes of these wounds and the overall significance of demographic factors. The Green Rooms 2006 <http://www.thegreenrooms.net/wounded-healer/>
- Dube SR, Anda RF, Felitti VJ, Edwards VJ, Croft JB. Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors*. 2002; 27:713–725. [PubMed: 12201379]
- Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study. *Pediatrics*. 2003; 111:564–572. [PubMed: 12612237]
- Fewell CH, King BL, Weinstein DL. Alcohol and other drug abuse among social work colleagues and their families: Impact on practice. *Social Work*. 1993; 38:565–570. [PubMed: 8211315]
- Gary FA. Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*. 2005; 26:979–999. [PubMed: 16283995]
- Grant BF, Saha TD, Ruan J, Goldstein RB, Chou SP, Jung J, et al. Epidemiology of DSM-5 drug use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *JAMA Psychiatry*. 2016; 73:39–47. [PubMed: 26580136]
- Jung CG. *The practice of psychotherapy 2*. New York: Bollingen Foundation; 1966
- Kessler RC, Hwang I, LaBrie R, Petukhova M, Sampson NA, Winters RC, Shaffer HJ. DSM-IV pathological gambling in the National Comorbidity Survey Replication. *Psychological Medicine*. 2008; 38:1351–1360. [PubMed: 18257941]
- McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs*. 2008; 27:393–403. [PubMed: 18332495]
- National Association of Social Workers. *Code of ethics of the National Association of Social Workers*. Washington, DC: Author; 2017
- Newcomb M, Burton J, Edwards N, Hazelwood Z. How Jung's concept of the wounded healer can guide learning and teaching in social work and human services. *Advances in Social Work and Welfare Education*. 2015; 17(2):55–69.
- Pooler DK. Social workers and distress: Implications for sustaining a healthy workforce. *Journal of Workplace Behavioral Health*. 2008; 23:445–466.
- Reamer FG. The impaired social worker. *Social Work*. 1992; 37:165–170.
- Reamer FG. The impaired social work professional. In: Corcoran K, , Roberts AR, editors *Social workers' desk reference 3*. Vol. 2. New York: Oxford University Press; 2015 170175
- Siebert DC. Denial of AOD use: An issue for social workers and the profession. *Health & Social Work*. 2003; 28:89–97. [PubMed: 12774530]
- Siebert DC. Depression in North Carolina social workers: Implications for practice and research. *Social Work Research*. 2004; 28:30–40.
- Stanley N, Manthorpe J, White M. Depression in the profession: Social workers' experiences and perceptions. *British Journal of Social Work*. 2007; 37:281–298.
- Straussner SLA, Calnan A. Trauma through the life cycle: A review of current literature. *Clinical Social Work Journal*. 2014; 4:323–335.
- Strozier AL, Evans DS. Health and distress in social workers: Results of a national survey. *Smith College Studies in Social Work*. 1998; 69:60–77.

- Substance Abuse and Mental Health Services Administration Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health Rockville, MD: Author; 2016 (HHS Publication No. SMA 16-4984)
- Tourangeau R, , Conrad FG, , Couper MP. The science of Web surveys New York: Oxford University Press; 2013
- U.S. Department of Commerce Census regions and divisions of the United States Washington, DC: U.S. Census Bureau; n.d Retrieved from http://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf
- Whitaker T, , Weismiller T, , Clark E. Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Executive summary Washington, DC: National Association of Social Workers; 2006
- Zerubavel N, Wright MO. The dilemma of the wounded healer. Psychotherapy. 2012; 49:482–491. [PubMed: 22962968]

Figure 1. Percentages of Respondents Reporting Specific Mental Health Problems Over Time

Notes: PTSD = posttraumatic stress disorder, ADHD = attention-deficit/hyperactivity disorder. The most frequently occurring mental health problems and their prevalence (%) during these specific time periods were anxiety (20.6, 28.7, 17.4), depression (25.4, 29.2, 14.2), PTSD (8.1, 7.7, 3.7), ADHD (4.7, 4.4, 3.9), and eating disorder (6.7, 4.3, 2.6). A small percentage of respondents reported other mental health problems (not listed on the chart), including obsessive-compulsive disorder (2.1, 2.2, 1.5), bipolar disorder (0.9, 1.1, 0.9), learning disorder (1.6, 0.8, 0.8), hoarding (0.1, 0.4, 0.5), personality disorder (0.4, 0.2, 0.2), autism (0.1, 0.1, 0.1), schizoaffective disorder (0, 0, 0.1), and schizophrenia (0, 0, 0).

Table 1

Characteristics of Sample

Characteristic	%	(SD)
Sex (<i>n</i> = 5,620)		
Male	10.9	
Female	88.8	
Other	0.3	
Age (<i>n</i> = 5,534)		
Mean	46.2	(13.3)
Median	46.0	
Race or ethnicity (<i>n</i> = 5,534)		
White/European American	83.2	
Black/African American	6.2	
Latino/Hispanic	3.9	
Mixed/other	6.7	
U.S. born (<i>n</i> = 5,632)	95.4	
Sexual orientation (<i>n</i> = 5,598)		
Heterosexual	90.7	
Gay/lesbian	5.1	
Bisexual	2.5	
Other	0.8	
Highest social work degree (<i>n</i> = 5,619)		
Bachelor's	18.3	
Master's	80.1	
Doctorate	1.7	
Years employed as social worker (<i>n</i> = 5,534)		
Mean	16.1	(11.3)
Median	15.0	
Private practice only (<i>n</i> = 5,080)	12.1	
Direct versus other types of practice (<i>n</i> = 5,007)		
Only direct practice	38.6	
Direct and other practice types	38.6	
Only non-direct practice	22.8	
Most common fields of practice ^a (<i>n</i> = 5,689)		
Mental health	61.0	
Children and adolescents	50.6	
Health and medical	33.3	
Older adults	31.6	
Families and couples	31.3	
Substance abuse	25.7	
Child welfare	23.6	
School social work	22.2	

^a Respondents could choose more than one field of practice from a list of 21 fields. This list includes fields of practice reported by at least 20 percent of participants.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2
Percentages of Respondents with Behavioral Health Problems, by Sex, Race or Ethnicity, and Age ($N = 5,995$)

	Gender (<i>n</i> = 5,597)					Race or Ethnicity ^a (<i>n</i> = 5,250)					Age ^b (<i>n</i> = 5,526)							
	% Total	Male (<i>n</i> = 615)	Female (<i>n</i> = 4,982)	χ^2	(<i>df</i>)	<i>p</i>	White (<i>n</i> = 4,680)	Black (<i>n</i> = 351)	Latino (<i>n</i> = 219)	χ^2	(<i>df</i>)	<i>p</i>	21–39 years (<i>n</i> = 2,025)	40–59 years (<i>n</i> = 2,410)	60+ years (<i>n</i> = 1,091)	χ^2	(<i>df</i>)	<i>p</i>
Behavioral Health Problem																		
MH problems before SW career	40.2	40.8	39.6	0.36	(1)	.56	41.0	24.5	35.2	38.99	(2)	.001*	49.0	35.9	32.0	115.08	(2)	.001*
MH problems during SW career	51.8	48.0	52.4	4.07	(1)	.04*	53.2	37.3	43.8	38.74	(2)	.001*	57.7	51.3	43.2	61.01	(2)	.001*
MH problems—current	28.0	25.6	28.2	1.81	(1)	.18	28.5	22.3	21.9	10.06	(2)	.007*	33.6	27.6	18.7	78.57	(2)	.001*
History of alcohol problems	9.5	17.5	8.4	52.70	(1)	.001*	9.7	4.9	7.4	9.71	(2)	.008*	7.4	11.0	9.3	16.29	(2)	.001*
History of drug problems	5.7	15.4	4.4	124.01	(1)	.001*	5.6	3.7	5.0	2.34	(2)	.31	4.7	6.5	5.3	6.78	(2)	.03*
AOD problems—before SW career	9.7	19.3	8.3	76.00	(1)	.001*	9.9	4.3	7.8	12.56	(2)	.002*	8.0	10.6	9.9	8.84	(2)	.01*
AOD problems—during SW career	7.7	12.1	6.9	21.32	(1)	.001*	7.5	5.5	5.5	3.16	(2)	.21	7.6	7.6	7.0	0.50	(2)	.78
AOD problems—current	2.4	3.9	2.0	8.91	(1)	.003*	2.1	2.9	1.4	1.50	(2)	.47	2.4	2.2	1.9	0.62	(2)	.73
Used tobacco	29.8	41.8	28.4	46.30	(1)	.001*	30.6	23.3	21.0	16.37	(2)	.001*	25.8	31.2	34.2	27.59	(2)	.001*
Gambling problems	0.8	1.3	0.7	2.39	(1)	.12	0.6	1.4	1.4	4.13	(2)	.13	0.5	1.1	0.7	4.84	(2)	.09

Notes: MH = mental health, SW = social work, AOD = alcohol and other drugs.

^aFor race, pairwise comparisons reveal that all statistically significant differences between the groups apply to white versus black respondents. For white versus Latino respondents, only differences in MH problems during SW career and used tobacco are statistically significant. For black versus Latino respondents, only differences in MH problems before SW career are statistically significant.

^bFor age, pairwise comparisons reveal that all statistically significant differences between the groups apply to ages 21–39 versus 40–59. For ages 21–39 versus 60+, only differences in MH problems before SW career, MH problems during SW career, MH problems—current, and used tobacco are statistically significant. For ages 40–59 versus 60+, only differences in MH problems during SW career and MH problems—current are statistically significant.

* $p < .05$.