Secondary traumatic stress among psychotherapists: determinants and consequences

Abstract

The aim of the paper is to present the phenomenon of secondary traumatic stress (STS), i.e. stress resulting from contact with trauma victims. The authors discuss conceptual issues related to STS (as well as terminological questions), characterize several methods of assessment of STS and data on its prevalence in samples from various populations. The main part of the article is devoted to considering STS among psychotherapists treating survivors of trauma. The problem is examined from the point of view of occurrence of STS among therapists, its predictive factors and consequences.

Keywords

secondary traumatic stress (STS), psychotherapists

Introduction

For the last 20 years there has been increased attention to people who experience trauma indirectly by working with trauma victims or by being in contact with them.
Various terms are used to describe this phenomenon, such as "secondary trauma", “vicarious trauma”, “compassion fatigue” and others\(^2\). Although many authors treat these concepts as roughly synonyms (Bride, 2012), in this paper we prefer the terms “secondary traumatic stress” (STS) and “secondary traumatic stress disorder” (STSD). They were first introduced by Charles R. Figley\(^3\) who used them in his seminal book (Figley, 1995a): *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. Figley defined STS as "the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995b, p. 7). Such a stress may lead to symptoms identical to posttraumatic stress disorder (PTSD) i.e.: intrusive images, hyperarousal, numbing and avoidance reactions. That is why Figley proposed for the these PTSD-like symptoms the analogical name “secondary traumatic stress disorder (STSD).

PTSD was first introduced as a diagnosis in 1980 (Friedman, 2014) in the third edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The diagnostic criteria for PTSD were modified in next revisions of the DSM (DSM-III-R, DSM-IV, DSM-IV-TR, and the 2013 update DSM-V).

Although STSD was never included in any former or contemporary official classification of diseases, one can find opinion that “recently [terms] secondary traumatic stress and secondary traumatic stress disorder (STS / STSD) have become increasingly commonly used” (Renshaw et al., 2011, p. 461).

### Assessment of secondary traumatic stress

One of the first tools used in diagnosis of secondary stress was *Compassion Satisfaction / Fatigue Self-Test for Helpers* developed by Charles Figley and Beth Hudnall Stamm\(^4\) (Figley & Stamm, 1996). The instrument underwent later further improvements and now is known as *Compassion Satisfaction*... 

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\(^2\) In the last paragraph of our paper we devote some space to the consideration of these terminological variants.

\(^3\) A pioneer in the field of traumatic stress, a renowned professor, the founder and director of the Traumatology Institute at Florida State University (1998–2008), the founder and the first editor of *Traumatology: An International Journal* (1995–2012).

\(^4\) B.H. Stamm was a professor and director of Institute of Rural Health at Idaho State University (according to personal communication by her to A. Gołąb in email received on 1 October 2014, she is now retired). She was an initiator and director of the research program Professional Quality of Life (ProQOL – see: http://www.proqol.org/ )
and Compassion Fatigue (PROQOL) version 5 (Stamm, 2010)\(^5\). Apart from a subscale for measuring Secondary Traumatic Stress (10 items, alpha scale reliability.81) it has a subscale for Burnout (10 items, alpha scale reliability.75) and for Compassion Satisfaction (10 items, alpha scale reliability.88).

There are also other diagnostic instruments to detect symptoms of secondary stress. In 1999 Robert W. Motta and coauthors elaborated a 20-item secondary trauma questionnaire (Motta et al. 1999, 2001). Original scale was later (Motta et al. 2004) reduced to 18 items measuring two factors: Intrusion and Avoidance (with alpha coefficient.89).

In 2004 Brian E. Bride with co-workers published a 17-item Secondary Traumatic Stress Scale (STSS, cf. Bride et al., 2004). It consisted from 3 subscales: Intrusion (5 items), Avoidance (7 items) and Arousal (5 items).

### Prevalence of secondary traumatic stress

Roman Cieślak and collaborators (Cieslak et al., 2013) report prevalence rates for PTSD-like diagnosis of STS in various groups. The data are based on studies using STSS as a diagnostic tool and DSM-IV-TR\(^6\) criteria B, C, and D (symptoms of re-experiencing, avoiding, and hyperarousal). These criteria were met by 15.2% of social workers, 16.3% of oncology staff, 19% of substance abuse counselors, 20.8% of providers treating family or sexual violence, 32.8% of emergency nurses, 34% of child protective services workers, and 39% of juvenile justice education workers. The quoted authors found that among mental health providers working with the military the prevalence of STS was 19.2%.

### Secondary trauma among psychotherapists

The occurrence of secondary stress symptoms has also been identified in psychotherapists, especially those, who deal with traumatic stress.

Laurie Pearlman and Paula Mac Ian asked 188 self-identified trauma therapists about their own psychological well-being. The authors noticed

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\(^5\) PROQOL version 5 has now 19 different language versions (see: http://www.proqol.org/ProQol_Test.html).

significant level of PTSD-like symptoms in 62 percent of examined trauma therapists (Pearlman & Mac Ian, 1995).

Shelah Adams and Shelley Riggs (2008) investigated 129 trauma therapy trainees and established that 31% of them exceeded the clinical cut-off score in the Trauma Symptom Inventory.

Toni Farrenkopf (1992) observed that 33% of therapists who treated sexual offenders reported high levels of secondary traumatic stress, especially hypervigilance, suspiciousness and fear for the safety of loved ones.

As an example may serve what said in an interview Helen Fitzgerald (2009), who worked for ten years in criminal justice social work: „I worked with sex offenders because I wanted to help them, but I began suspecting every man”. She continued: „I hated that it had seeped into my personal life. I couldn’t get to sleep at night. Images flashed – no, crashed – before me, of the things I had read or heard that day: X touching the nine-year-old girl; Y masturbating in front of his two boys”.

According to Laurie Pearlman and Karen Saakvitne who studied psychotherapists of adult incest survivors (Pearlman & Saakvitne, 1995), secondary trauma stems from psychotherapists’ empathic engagement with clients’ traumatic history. The result of this process, which may be viewed as kind of a countertransference, is a transformation in the inner experience of the therapist. The authors call this transformation vicarious traumatization. It undermines a therapist’s adaptive assumptions of personal security and a meaningful world, increasing the likelihood of feelings of pain and loss (Chrestman, 1999). In contrast to countertransference, which is specific to a given therapy, vicarious traumatization is “accumulative across many therapies” (Rasmussen, 2011, p.230).

Determinants of secondary trauma among psychotherapists

Research suggests that some of the psychotherapist characteristics are important for developing symptoms of secondary traumatic stress.

One of such characteristics, which are mentioned in literature, is a therapist’s prior history of trauma⁷.

Victoria Follette with her collaborators (Follette et al., 1994) assessed past trauma experiences in several hundred mental health professionals who

⁷ Marydale Salston and Charles Figley maintain that „(...) literature supports the belief that most trauma therapists have experienced some traumatic event” (Salston & Figley, 2003, p. 170).
worked with child sexual abuse survivors. They found that 29.8% of therapists reported experiencing some form of childhood trauma. Professionals with a history of child abuse exhibited significantly higher levels of PTSD-like symptoms.

Many authors are convinced that if a therapist has an increased capacity for empathy, it may contribute to an intense empathic engagement with the client’s traumatic issues. An old saying goes: “It is both a blessing and a curse to feel everything so deeply”.

An example of a study showing the statistically significant relationship between dispositional empathy (measured by the Interpersonal Reactivity Index) and STS is the dissertation of Victoria MacRitchie (2006) from Johannesburg.

Higher rates of secondary traumatic stress are noted among those mental health specialists, who have high number of traumatized patients in their caseload.

Laura Schauben and Patricia Frazier studied counselors working with sexual violence survivors (Schauben & Frazier, 1995). Counselors with a higher percentage of survivors in their caseload reported more symptoms of post-traumatic stress disorder independently from their own history of victimization.

Development of secondary stress symptoms is believed to be associated with deterioration of social support (Emery, Tracey and McLean, 2009).

Age, gender, and education level of the therapist have not shown clear relations with their susceptibility to STS.

Young age of the therapist was associated with greater level of STS in one study (Ghahramanlou and Brodbeck, 2000), but not in two others (Kassam-Adams, 1999; Meldrum et al., 2002). Lower level of therapist education was linked to higher STS in one study (Baird and Jenkins, 2003), but was not related in another (Ghahramanlou and Brodbeck, 2000). There is no consensus on the impact of therapist gender on the occurrence of STS (Meldrum et al., 2002).

Consequences of secondary trauma among psychotherapists

There are several long-term effects of secondary traumatic stress, which include constant feeling of being overwhelmed, drained, and exhausted in working with clients (Catherall, 1995; Figley, 2002). STS symptoms can also lead to therapist’s preoccupation with thoughts of clients outside of work and
overidentification with the clients’ material (Beaton and Murphy, 1995; Miller, 1998). In addition, STS symptoms may be visible in therapist’s behaviors, which the most frequent are distancing, numbing, detachment and cutting clients off (Figley, 1995a, 2002; Pearlman and Maclan, 1995).

Secondary trauma can also impact the therapist on a personal level. More specifically, the therapist might encounter relational problems (with spouse/partner, family, and friends). Some therapists may start abusing substances (Beaton and Murphy, 1995).

While the term „burnout” is often thrown around in discussions of stress it is risky to identify conceptually secondary stress with the syndrome of professional burnout (Newell & MacNeil, 2010). Burnout syndrome is described as an experience of a long-term emotional exhaustion and reduced sense of personal accomplishment. Of course it can be observed also among people who work with other people (Maslach, 1993, 2001; Rzeszutek and Schier, 2014). It can result from work stress and work constraints, as well as work pressure. Burnout differs from STS in that it does not impact the therapist’s inner experience of safety or intimacy (Benson and Magraith, 2005). Moreover, unlike burnout, STS is associated with a sudden onset of symptoms that are pervasive. Nevertheless, both STS and burnout can lead to decrease in concern and esteem for clients, as well as to a decline in the quality of work with clients (Raquepaw and Miller, 1989).

Working with traumatized clients, psychotherapists should take into consideration the risks which are associated with trauma work. Especially new trauma therapists should be aware that they are at great risk of being traumatized as a result of their work (Neumann and Gamble, 1995). Therefore, trauma therapists should consider participating in clinical supervision, consultation, or engaging in other forms of self-care. In particular, professionals in private practice settings may be more prone to the effects of STS due to the lessened daily interaction with other mental health professionals and greater isolation. Mental health professionals should also continue to engage in additional training and coursework to broaden their abilities in working with trauma clients. More specifically, professionals who work with trauma clients regularly may want to take into an account receiving supervision for techniques that can assist a client in determining and expressing their feelings. Clinical supervision and supervisory feedback have been said to increase levels of self-efficacy in working with patients (Harrison and Westwood, 2009; Meldrum et al., 2002).

Trauma therapist should keep in touch with new approaches and ideas in the realm of her or his work. A relatively new invention in the field of treating
trauma survivors are elaborated by David Berceli *Trauma Releasing Exercises* (TRE, cf. Berceli, 2005). Berceli’s approach is continuation of Alexander Lowen’s bioenergetics (Lowen, 1975). TRE consists in evoking muscle tremors in order to release muscular tension stemming from experienced traumas.

# Remarks on terminology

The extensive bibliography on secondary traumatic stress published by Beth Stamm (2010a) includes over 1000 references. It is a result of internet search. Among terms used in titles of searched documents the most frequent were: „secondary trauma / traumatization / traumatic stress (appeared 203 times), „vicarious trauma / traumatization (186 times) and „compassion fatigue” (123 times).

In the remarks which follow we are going to concentrate on two aspects of terminology: one is semantic point of view, another is historical one: the authorship of the terms and time of their first appearance.

A rationale for using composition of two words: „secondary” and „trauma” seems obvious: on the one hand a trauma defines the essence of the situation, on the other the trauma is not experienced first-hand. Instead one it is experienced indirectly and as if „secondarily” through reports of trauma victims.

The same could be said about „vicariousness” of trauma. The adjective „vicarious” comes from Latin word „vicarius” meaning „substituting”. So „to experience anything vicariously” means „undergo at second hand through sympathetic participation in another’s experiences”. A psychotherapist, a social worker or another person who works with the victim of trauma and learns in details her traumatic experience as if participates in her experience and this way may become a „vicarious” victim of it.

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10 The term „vicarious trauma” was coined in 1990 by Lisa McCann and Laurie Anne Pearlman. They give the following rationale: „Therapists who work with victims may find their cognitive schemas and imagery system (...) altered or disrupted by long-term exposure to the traumatic experiences of their victim clients” (McCann & Pearlman, 1990, p. 132).
The third term is “compassion fatigue”\textsuperscript{11}. The specificity of the phrase “compassion fatigue” consists in joining two aspects of helping professionals’ activity. One side of helper’s activity is compassion (uniting two positive motives: empathy and sympathy). Another side of helping may be negative feeling of exhaustion or tiredness. In this context one should mention another term which may be found in the literature on secondary traumatic stress, namely “burnout”\textsuperscript{12} (for instance: Craig & Sprang, 2010). In order to prevent the suggestion that helping has mainly negative consequences some authors insist that one should study not only “compassion fatigue” but also “compassion satisfaction” (Stamm, 2010b).

In the literature one may find attempts to make semantic clarifications and propose more precise definitions of the mentioned above four basic terms in order to elucidate the differences between their meanings (for example: Bush, 2009; Newell & MacNeil, 2010).

However our strong impression is that probably the most adequate description of the present status of discussed terminology give Katie Baird and Amanda Kracen (2006, p. 181) who so formulate their view: “there still exists a lack of conceptual clarity in the literature about VT [vicarious trauma], STS [secondary traumatic stress], and the related constructs of burnout and compassion fatigue”.

\section*{Prospects for the future}

Perhaps the future will bring some unification of meaning of concepts related to secondary stress.

\textsuperscript{11} First author who wrote about “compassion fatigue” was Carla Joinson (1992). Charles Figley (1995) has used the term in the title of his famous book (Figley, 1995a). In another book devoted to the problem Figley (2002, p. 2) expresses the following view: “Compassion fatigue is the latest in an evolving concept that is known in the field of traumatology as secondary traumatic stress. Most often this phenomenon is associated with the ‘cost of caring’ for others in emotional pain”. History of the concept “compassion fatigue” assessed Christopher Marchand (2007).

\textsuperscript{12} Stamm (2010a, Introduction) informs that she did not use “burnout” in her search terms “as it (...) can apply to any type of job” and “not unique to working with people who have experienced extreme suffering”. Nevertheless about 70 titles of texts in her bibliography contains word “burnout”. Some authors propose the psychoanalitical term “countertransference” to describe facts denoted by others as secondary stress. Similarly as in case of “burnout” it is evident that “countertransference” should be related to much broader range of situations then secondary stress. “Countertransference” is not restricted to psychotherapies helping victims of trauma.
For sure a further research is needed to increase the accuracy and scope of known facts and to systematize them.

In Poland the described topic seems relatively new: both in terms of lacking research studies and a paucity of literature dealing with applied questions. One may ask, whether there are chances to introduce the term „secondary traumatic stress disorder“ (or any of its equivalents) as a nosological term into official classifications of diseases. The late appearance of the term „postraumatic stress“ in taxonomies of diseases (DSM, ICD) makes us quite pessimistic in prognosing official recognition of secondary stress symptoms as a disease.\(^\text{13}\)

However in principle it should not hinder continuing accumulation of theoretical and practical knowledge about secondary traumatic stress.

### References


\(^{13}\) It is true that DSM-IV published in 1994 acknowledged the possibility of PTSD development among family members of trauma victims. But since 1994 the process of extending conceptual boundaries of PTSD is very slow.


