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Secondary Traumatization in Mental Health Care Providers

by Rose Zimering, Ph.D., James Munroe, Ed.D., and Suzy Bird Gulliver, Ph.D.

April 2003, Vol. XX, Issue 4

Mental health care professionals specializing in the treatment of trauma hear and observe the emotions of fear, helplessness and extreme human suffering on a consistent basis. Recent research demonstrates these occupational duties may cause psychological symptoms in the practitioner. The practitioner bears witness to the survivors' account of trauma.

Primary posttraumatic stress disorder may be diagnosed in an individual who has experienced, witnessed or was confronted with a traumatic event and responds with intense fear, helplessness or horror. Intentional traumas (e.g., combat, sexual assault, terrorism and mass violence), as well as unintentional traumas (e.g., disasters, accidents), may cause this pervasive psychiatric condition.

Secondary trauma is defined as indirect exposure to trauma through a first account or narrative of a traumatic event. The vivid recounting of trauma to a survivor and the clinician's subsequent cognitive or emotional representation of the event may result in a set of symptoms and reactions that parallel PTSD (e.g., experiencing, avoidance and hyperarousal). Secondary traumatization is also known as *compassion fatigue* (Figley, 1995) and *vicarious traumatization* (Pearlman & Saakvitne, 1995).

Secondary trauma is an understudied and controversial clinical phenomenon. In this article we will explore the controversy, review the existing literature, describe personal and professional consequences, and address prevention of secondary traumatization.

The Controversy

Detractors of the secondary traumatization phenomenon in health care professionals claim that labeling clinicians with secondary PTSD is pathologizing and best viewed as a reaction, not a disorder. Just as most individuals directly exposed to a stressor exhibit some PTSD symptoms that abate quickly over time, many will have transitory reactions to survivor narratives. Yet in both primary and secondary trauma exposure, a small percentage of individuals will develop a psychiatric disorder.

Research findings of primary and secondary PTSD related to the World Trade Center terrorist attacks illustrate this point. Galea and colleagues (2002) showed that in the first five to six weeks following the Sept. 11, 2001, terrorist attacks in New York City, 20% of residents living close to the World Trade Center met criteria for primary

PTSD. Thus, the majority of individuals directly exposed to the terrorist attack in New York City did not meet criteria for PTSD.

Research on secondary traumatization shows a similar prevalence pattern in health care professionals who treated survivors of the World Trade Center (Gulliver et al., 2002). On standardized clinical interviews, many providers reported symptoms of PTSD linked to their exposure to survivor narratives, but most did not meet diagnostic criteria for PTSD. However, a minority of professionals met diagnostic criteria for PTSD in the months following their exposure to survivor narratives.

A second controversial point concerns whether the PTSD *DSM-IV* Criterion A includes indirect exposure to a trauma. However, the definition of a traumatic event can be ambiguous. In fact, PTSD can occur in individuals who have been exposed indirectly to a traumatic stressor. For example, Weisaeth (1989) found PTSD in workers who were not present at the time of an industrial explosion at their workplace. More recently, Schlenger et al. (2002) reported that indirect exposure to the Sept. 11 disaster via the number of hours of television coverage watched on and after Sept. 11 was significantly associated with probable PTSD in individuals living outside of the terrorist attack sites. These findings show that the parameters of the Criterion A event which can precipitate PTSD are still evolving.

Review of the Literature

The current state of empirical literature on secondary traumatization among health care professionals is in its infancy. Although theorists such as Figley (1995) and Pearlman (1990), and Stamm (1995) have written extensively on the topic of secondary traumatization, the level of corroborative data is not commensurate with the sophistication of existing theories. A recent review of *Psychiatry* journal articles found only 17 peer-reviewed articles on secondary traumatization. Of these, 10 contained data, and the majority of these were descriptive (qualitative) in nature.

The descriptive studies on secondary traumatization can be categorized as developmental (e.g., Jenkins and Baird, 2002; Motta et al., 2001), predictive studies (e.g., Adams et al., 2001; Schauben and Frazier, 1995; Wasco and Campbell, 2002) and one meta-analysis that indirectly evaluated techniques to prevent secondary trauma (Everly et al., 1999).

The second category of studies explores secondary traumatization as a function of occupational roles and examines the variables that correlate with the development of trauma symptoms. Eight studies describe the phenomena of secondary trauma among trauma counselors with diverse training, caseloads, degrees and socioeconomic status (Adams et al., 2001; Ghahramanlou and Brodbeck, 2000; Everly et al., 1999; and Steed, 2000; Jenkins and Baird, 2002; Schauben and Frazier, 1995; Schauben and Frazier, 2001; Bicknell, 2001; Wasco and Campbell, 2002). All eight studies describe a set of symptoms analogous to PTSD, yet a very low incidence of meeting clinical criteria for PTSD (range between studies: 0% to 4%) or impairment in occupational roles was reported. This result is difficult to interpret, as the current status of the psychometric utility of available instruments decreases confidence in any conclusion, and each study used a different set of assessments. In sum, trauma counselors are likely to report some negative consequences of their work that maps onto a PTSD symptom profile. What remains to be seen is how often this symptom profile is clinically significant and how symptoms affect patient care.

This same set of studies yields contradictory evidence about correlates of secondary trauma symptoms. The most frequently studied correlate is the therapist's personal trauma history. Jenkins and Baird (2002) found that personal trauma history correlated with secondary trauma symptoms, but Schauben and Frazier (1995) and Adams et al. (2001) did not. In addition, Schauben and Frazier found that the percentage of survivors in a provider's caseload, the greater the number of secondary trauma symptoms reported.

Other factors suggested by theorists as potentially predictive of secondary traumatization include insufficient training, identification with the victims, lack of support in the workplace, and insufficient social and familial support. Further research to assess these characteristics is recommended.

Assessment

There are three self-report inventories that can measure secondary trauma: the Compassion Fatigue Self-Test (CFST) for Psychotherapists (Figley, 1995), the Trauma Belief Scale (TSI-BLS) (Pearlman, 1996) and the Secondary Trauma Questionnaire (STQ) (Motta et al., 2001). These inventories vary by their domain of study and targeted population. While the CFST and STQ items more closely measure secondary trauma exposure and PTSD symptomatology, the TSI-BLS measures changes in core schemas (e.g., safety, trust, esteem, intimacy and control) consistent with the author's theoretical conceptualization of vicarious traumatization. The CFST, TSI-BLS and STQ were developed to assess secondary trauma in therapists whereas the STQ was designed for both therapists and the general population.

Standardized clinical interviews specific to secondary traumatization have not been developed. However, Gulliver et al. (2002) used the Clinician Administered Trauma Scale (CAPS) in their study of secondary trauma in disaster relief clinicians. Trade Center survivor narratives heard by the clinicians were coded as the event and the CAPS questions were administered as it would be for primary trauma.

A recent validation study of the CFST and TSI-BLS self-report measures found convergent validity between the CFST and TSI-BLS, moderate convergence with burnout, and strong convergence with general distress (Jenkins and Baird, 2007). The next level of measure development will likely provide norms and cutoffs for intensity, that will strengthen current assessment methodology.

Clinical Consequences

If trauma is contagious (Herman, 1992) and the effects of treating trauma may parallel those of primary trauma, a clinician's work with patients may be adversely affected. Herman (1992) suggested that the effects on therapists include disruptions in the therapeutic alliance, conflict with professional colleagues, attempts to rescue or control patients, and violations of therapeutic boundaries.

Therapists overwhelmed by traumatic material may begin to avoid or deny patients' experiences (Baranowsky, 2002). Alternatively, they might push patients quickly in an effort to master their own responses. The schematic disruptions associated with vicarious traumatization (Pearlman and Saakvitne, 1995) can impact clinical work. A clinician whose views of trust and safety have been undermined might be unable to respond effectively to traumatized patients. Researchers interviewing trauma survivors might also introduce bias into their efforts to control their own exposure to trauma material. The recognition of secondary effects requires that we further investigate the implications for practitioners because we cannot assume that the practitioners' responses will not impact the care they provide.

Prevention

The key components of secondary trauma prevention might be found within support systems (Herman, 1992). Echoing this sentiment, Pearlman and Saakvitne stated that four domains are important to the prevention of secondary trauma in mental health care providers: 1) professional strategies, such as balancing caseloads and accessible supervision; 2) organizational strategies, such as release time and safe physical space; 3) personal strategies, such as respecting own limits and maintaining time for self-care activities and 4) general coping strategies, such as self-nurturing and seeking connection. Thus far, no study has evaluated the effectiveness of these prevention strategies.

Training Implications

The empirical evidence indicating secondary effects in practitioners raises the immediate question of how this should be incorporated into clinician training. We have a duty to educate those entering the field to anticipate how the work will affect them and to prepare them to address these effects (Munroe, 1995).

Although secondary traumatization may adversely affect practitioners and the services they deliver, work with trauma survivors can also be immensely rewarding and has the potential to allow practitioners to grow personally and enhance their compassion, provided responses to this difficult work are used constructively.

Conclusions

Treatment of posttraumatic psychological reactions in civilians became a public health concern in the United States after Sept. 11. This public priority also extends to the emotional well-being of clinicians who are exposed to traumatic stimuli in their occupational duties. Just as ongoing national policy discussions explicitly recommend that health care professionals and other first responders be vaccinated in the event of bioterrorist attacks, similar consideration should be given to first-line trauma and disaster relief clinicians. If clinicians are to maintain the mental health care needs of U.S. citizens living in an increasingly violent world then their psychological well-being must also be recognized and protected.

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