Secondary Traumatization in Mental Health Care Providers

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

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

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

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

Secondary trauma is an understudied and controversial clinical phenomenon. In this article we will explore the controversy, review the existing literature, describe the 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 described as a reaction, not a disorder. Just as most individuals directly exposed to a traumatic stressor exhibit some PTSD symptoms that abate quickly over time, many clinicians who experience, witness or are confronted with traumatic events exhibit symptoms that parallel PTSD (e.g., re-experiencing, avoidance and hyperarousal).

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

Secondary traumatization shows a similar prevalence pattern in mental health care professionals who treated survivors of the World Trade Center collapse (Gulliver et al., 2002). On standardized clinical interviews, many providers endorsed 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 full diagnostic criteria for PTSD in the months following their exposure to survivor narratives.

A second controversy points concern whether the PTSD DSM-IV Criterion A can include indirect exposure to a trauma. However, the definition of a traumatic stressor 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, Schlenker et al. (2002) reported that indirect exposure to the Sept. 11 disaster via the number of hours of television coverage watched per day 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), McCann and Pearlman (1990), and Stamm (1995) have written extensively on the
phenomena of secondary traumatization, the level of corroborative data is not
cummensurate with the sophistication of existing theories. A recent review of Psychlit
journal articles found only 17 peer-reviewed articles on secondary traumatization. Of
these, only 12 contained data, and the majority of these were descriptive
(qualitative) in nature.

The descriptive studies on secondary traumatization can be categorized as measure
development (e.g., Jenkins and Baird, 2002; Motta et al., 2001), predictive variable
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 or treat
secondary trauma (Every 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
symptoms. Eight studies describe the phenomena of secondary trauma among
counselors with diverse training, caseloads, degrees and socioeconomic status
(Adams et al., 2001; Ghahramanlou and Brodbeck, 2000; Every et al., 1999; Iliffe
and Steed, 2000; Jenkins and Baird, 2002; Schauben and Frazier, 1995; Steed and
Bicknell, 2001; Wasco and Campbell, 2002). All eight studies describe a stable set of
symptoms analogous to PTSD, yet a very low incidence of meeting clinical criteria
(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 typology.
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 greater
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, insufficient
support in the workplace, and insufficient social and familial support. Future research
to further 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 TSI
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
the target population. While the CFST and STQ items more closely measure trauma
exposure and PTSD symptomatology, the TSI-BLS measures changes in cognitive
schemas (e.g., safety, trust, esteem, intimacy and control) consistent with the
author's theoretical conceptualization of vicarious traumatization. The CFST and TSI-
BLS 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 PTSD
Scale (CAPS) in their study of secondary trauma in disaster relief clinicians. World
Trade Center survivor narratives heard by the clinicians were coded as the Criterion A
event and the CAPS questions were administered as if it would be for primary PTSD.

A recent validational study of the CFST and TSI-BLS self-report mea-sures showed
convergent validity between the CFST and TSI-BLS, moderate convergent validity
between the CFST and STQ, and strong convergence with general distress (Jenkins and
Baird, 2002). The next level of measure development will likely provide norms and cutoffs for symptom
intensity, that will strengthen current assessment methodology.

**Clinical Consequences**

If trauma is contagious (Herman, 1992) and the effects of treating trauma survivors
can parallel those of primary trauma, a clinician's work with patients may be
adversely affected. Herman (1992) suggested that the effects on therapists may
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 their
patient's experiences (Baranowsky, 2002). Alternatively, they might push patients too
quickly in an effort to master their own responses. The schematic disruptions
associated with vicarious traumatization (Pearlman and Saakvitne, 1995) could also
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 studies in
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 practice
systems (Herman, 1992). Echoing this sentiment, Pearlman and Saakvitne (1995)
stated that four domains are important to the prevention of secondary traumatization
in mental health care providers: 1) professional strategies, such as balancing
caseloads and accessible supervision; 2) organizational strategies, such as sufficient
release time and safe physical space; 3) personal strategies, such as respecting one's

own limits and maintaining time for self-care activities and 4) general coping strategies, such as self-nurturing and seeking connection. Thus far, no studies have 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 significant public health concern in the United States after Sept. 11. This public priority should also extend 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 made with first-line trauma and disaster relief clinicians. If clinicians are to maintain pace with the mental health care needs of U.S. citizens living in an increasingly dangerous world then their psychological well-being must also be recognized and protected.

Dr. Zimering is associate professor at Boston University School of Medicine and assistant chief of psychology and director of the PTSD Clinic at the Veterans Affairs Boston Healthcare System Outpatient Clinic.

Dr. Munroe is deputy director of the VA Boston Outpatient PTSD Clinic. He has worked and written extensively in the area of secondary trauma in therapists and disaster mental health care professionals.

Dr. Gulliver is assistant professor of psychiatry and psychology at Boston University School of Medicine and director of health psychology at the VA Boston Healthcare System Outpatient Clinic.

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