



## Understanding Secondary Traumatic Stress

### Introduction

Each year, millions of children are exposed to some type of traumatic event including physical, sexual or emotional abuse, neglect, witnessing domestic violence, community violence, car accidents or some form of natural disaster. These experiences may be single events or chronic occurrences but both may have devastating effects on the developing child. These experiences can result in “serious and chronic emotional and behavioral problems that are very difficult to treat” (Perry, 2003, p. 2). The emotional scars and behavioral difficulties stemming from these events often spill into every part of the child’s life. Each day teachers, social workers, therapists, counselors, caseworkers, child advocates, legal and law enforcement professionals, health and mental health providers, and caregivers (either foster or biological) work to help them. Often without knowing it, these individuals are secondarily exposed to trauma and may themselves begin to feel the pain of the event.

***Trauma is contagious***

*Judith Herman (1992)*

### What is Secondary Trauma?

Secondary trauma, also known as compassion fatigue (Figley, 1995) and vicarious trauma (Pearlman and Saakvitne, 1995; Stamm, 2002) refers to the indirect exposure to trauma through either a close personal relationship with a victim or through a working or therapeutic relationship with a victim. Figley (1995) describes secondary traumatic stress as the “natural consequent behaviors and emotions” that often result from having close contact with a victim of a traumatic event or through the experience of helping a traumatized individual (p. 7). For many working in helping fields the concept of secondary trauma is not one of which they received training on as they entered the field,



although the idea may seem somewhat intuitive (i.e., it may be difficult at times to hear about another's trauma). Many enter their chosen profession excited about the ability to

provide help during difficult times. They may also feel positive effects from their work with traumatized children and families. However, a caseworker listening to story after story of childhood victimization or a school counselor working closely with a child who has lost a family member in a traumatic accident can also experience a negative side to their work.

The study of secondary traumatic stress has grown dramatically over the last decade. Events such as the terrorist attacks in Oklahoma City, New York, Washington, DC, and Pennsylvania as well as attacks in Spain and elsewhere around the world have only increased our secondary exposure to trauma. In a recent publication, Stamm, et. al. (2002) sites scientific studies that suggest nearly 50% of women and 60% of men working on the front lines as "first responders" in the United States are exposed to events that are potentially traumatizing. This does not, however, take into account the countless professionals and caregivers whose work begins after the event and who relive the events with those have experienced them first-hand.

### **What we know about Secondary Trauma**

There is an understanding that exposure to the trauma of another, whether through a close personal relationship or family tie, or through a professional or working relationship, may have a negative affect on the "helping" individual. There is also a common belief that secondary trauma can occur through viewing or hearing about a traumatic event via the news, as in the case of the terrorist attacks on September 11, 2001. The underlying premise of secondary traumatic stress is that through "hearing the story told with such intensity" or hearing "similar stories so often" or having the "gift and curse of extreme empathy" the helper suffers. In other words, the actual act of



caring for or helping someone through a traumatic event can have a negative effect on the helper.

The signs and symptoms of secondary trauma are similar to those of post-traumatic stress disorder. According to Figley (1995) secondary traumatic stress disorder (STSD) is a “syndrome of symptoms nearly identical to PTSD” except that STSD is associated with the *knowledge of the event* rather than the actual experience of the event (p. 8) (italics added).

According to the DSM-IV, the main feature of PTSD is the

“development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (American Psychiatric Association, 1994).

The second criterion is that the individual’s response to the traumatic event must involve intense horror, fear and a sense of helplessness. The specific symptoms of PTSD fall into three (3) main categories: re-experiencing the traumatic event, avoidance or numbing related to stimuli associated with the event, and a persistent state of arousal. Specific symptoms within each of these three (3) categories are discussed below.

#### Re-experiencing the Traumatic Event

- Recurrent intrusive imagery related to the event (including thoughts, images and perceptions)
  - Children’s play may center on the traumatic event



- Recurrent dreams about the event
  - In children this may include nightmares not directly tied to the event
- Re-experiencing the event (i.e., a sense that the event is recurring). This may include a reliving of the experience, flashbacks or hallucinations of the event.
  - Young children may reenact the traumatic event
- Psychological distress and physiological reactions to cues or reminders of the traumatic event

#### Avoidance and Numbing

- Efforts to avoid thoughts and feelings related to the traumatic event
- Efforts to avoid places, people and activities that are reminders of the trauma
- Difficulties recalling specific aspects of the event
- Significant decrease of interest in activities that were previously participated in
- Detachment from others
- Restricted range of affect
- Sense of foreshortened future

#### Persistent Arousal (that did not exist prior to the trauma)

- Sleep disturbances (difficulty falling or staying asleep)
- Irritability
- Problems concentrating
- Hypervigilance
- Exaggerated startle response

(American Psychiatric Association, 1994)

For individuals experiencing secondary traumatic stress many of these symptoms are present. The main difference is that they are experiencing these symptoms based on second hand information described to them by the trauma victim or by experiencing a



trauma that occurred in the life of another individual. For example, a caseworker who experienced the death of a child on her caseload may have intrusive thoughts about the child, imagery of autopsy photos which make falling asleep difficult, dreams of the last time she saw the child and difficulty concentrating on other cases.

### **What makes an individual susceptible to Secondary Traumatic Stress?**

There are several factors that make a person more susceptible to secondary traumatic stress. Figley (1995) states that underlying these factors are the concepts of empathy and exposure. The idea that one's ability to be empathetic and an increased exposure to the trauma of others contributes to secondary trauma seems intuitive. However, a closer examination is helpful.

Empathy is an all important trait when working with clients, especially with those who have experienced a trauma. It allows the caseworker, therapist or mental health provider the ability to understand the traumatized individual's experience and thereby formulate methods for treating or helping them. However, empathy is also the modality through which a helping professional begins to feel the pain of the victim and ultimately may begin to experience similar symptomatology.

Exposure to trauma is another area for concern for those working with trauma victims. Many times those helping traumatized individuals have either experienced a trauma themselves (e.g., been in a serious car accident or experienced a robbery or rape) or have unresolved trauma issues. These unresolved issues may include undisclosed childhood physical or sexual abuse. It is not uncommon to find child protective services caseworkers who themselves were abused children. Secondarily experiencing the trauma of others may reopen childhood wounds that have yet to be dealt with, thus increasing the individual's susceptibility to secondary trauma symptoms.



Working with children who have been traumatized is yet another area of vulnerability. Many professionals who deal with violence and physical trauma on a regular basis (i.e., first responders) find working with traumatized children especially trying. Emergency medical service technicians, fire fighters and police officers report they feel the most vulnerable to secondary trauma when encountering the pain of children (Beaton and Murphy, 1995).

Other factors associated with increased vulnerability to secondary trauma include: insufficient training, insufficient support in the workplace and lack of social or family support (Zimering, Munroe and Gulliver, 2003; Friedman, 2002). One might posit that individuals with multiple areas of vulnerability have a greater the likelihood of absorbing the trauma of those with whom they come into contact. Those working in the child welfare field are particularly at risk for feeling the effects of secondary traumatic stress. According to Friedman (2002), child welfare agencies have long been seen as rewarding but difficult places to work due to the lack of resources, high number of clients who have difficult problems, high demands for productivity and below average salary/benefits. These factors combined with the fact that many individuals who enter into the child welfare field were themselves child victims, many possess a great capacity for empathy and a desire to help others, topped off with the fact that they are dealing with children who have experienced every sort of injury and abuse, make these professionals highly susceptible to secondary traumatic stress.

### **What can be done to combat Secondary Traumatic Stress?**

Understanding what secondary trauma is and how you may be vulnerable to it are the first steps to dealing with it. Below are just a few ways to combat secondary traumatic stress.

- Take care of yourself (basic self-care is vital)
  - Take breaks



- Eat healthy foods and be mindful of caffeine levels
- Get enough sleep
- Exercise
  
- Do not isolate yourself – stay connected to co-workers, family and friends
- Take a day off when you need it – Working through the trauma won't make it go away it will only lead to exhaustion and an increase in symptoms
- Debrief
  - Talk to supervisors and co-workers
  - Attend a formal Stress Debriefing
  - Talking about the traumatic event will allow for healing – stuffing emotions or hiding feelings will only compound the reaction to future stressful events
- Other
  - Set good boundaries – with coworkers, clients and work
  - Develop hobbies and relationships that are unrelated to work
  - Laugh – humor is great medicine



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