NCTSN

The National Child
Traumatic Stress Network

Secondary Traumatic Stress
A Fact Sheet for Child-Serving Professionals

"…We are stewards not just of those who allow us into their lives but of our own capacity to be helpful…"[1]

Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events.[2] These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children's lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as **secondary traumatic stress**—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of secondary traumatic stress and its potential impact on child-serving professionals. We also outline options for assessment, prevention, and interventions relevant to secondary stress, and describe the elements necessary for transforming child-serving organizations and agencies into systems that also support worker resiliency.

How Individuals Experience Secondary Traumatic Stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal

resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes[3]

- Hypervigilance

- Hopelessness

- Inability to embrace complexity

- Inability to listen, avoidance of clients

- Anger and cynicism

- Sleeplessness

- Fear

- Chronic exhaustion

- Physical ailments

- Minimizing

- Guilt

Clearly, client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some trauma-tized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.[4,5]

Understanding Who is at Risk

The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary traumatic stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

- *Compassion fatigue*, a label proposed by Figley[4] as a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with that term.

- *Vicarious trauma* refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client.[13] It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material. The primary symptoms of vicarious trauma are disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

- *Burnout* is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

- *Compassion satisfaction* refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training.[6-8] Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.[7]

Identifying Secondary Traumatic Stress

Supervisors and organizational leaders in child-serving systems may utilize a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members.

The most widely used approaches are *informal self-assessment* strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterize the individual's trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress.[4,9]

Supervisors might also assess secondary stress as part of a *reflective supervision model*. This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional's responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise.

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL).[7,8,10,11] This questionnaire has been adapted to measure symptoms and behaviors reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried.

Strategies for Prevention

A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress. The most important strategy for preventing the development of secondary traumatic stress is the triad of psychoeducation, skills training, and supervision. As workers gain knowledge and awareness of the hazards of indirect trauma exposure, they become empowered to explore and utilize prevention strategies to both reduce their risk and increase their resiliency to secondary stress. Preventive strategies may include self-report assessments, participation in self-care groups in the workplace, caseload balancing, use of flextime scheduling, and use of the self-care accountability buddy system. Proper rest, nutrition, exercise, and stress reduction activities are also important in preventing secondary traumatic stress.

Prevention

- Psychoeducation
- Clinical supervision
- Ongoing skills training
- Informal/formal self-report screening
- Workplace self-care groups (for example, yoga or meditation)
- Creation of a balanced caseload
- Flextime scheduling
- Self-care accountability buddy system
- Use of evidence-based practices
- Exercise and good nutrition

Strategies for Intervention

Although evidence regarding the effectiveness of interventions in secondary traumatic stress is limited, cognitive-behavioral strategies and mindfulness-based methods are emerging as best practices. In addition, caseload management, training, reflective supervision, and peer supervision or external group processing have been shown to reduce the impact of secondary traumatic stress. Many organizations make referrals for formal intervention from outside providers such as individual therapists or Employee Assistance Programs. External group supervision services may be especially important in cases of disasters or community violence where a large number of staff have been affected.

Intervention

- Strategies to evaluate secondary stress
- Cognitive behavioral interventions
- Mindfulness training
- Reflective supervision
- Caseload adjustment
- Informal gatherings following crisis events (to allow for voluntary, spontaneous discussions)
- Change in job assignment or work group
- Referrals to Employee Assistance Programs or outside agencies

The following books, workbooks, articles, and self-assessment tests are valuable resources for further information on self-care and the management of secondary traumatic stress:

- Volk, K.T., Guarino, K., Edson Grandin, M., & Clervil, R. (2008). *What about You? A Workbook for Those Who Work with Others.* The National Center on Family Homelessness. http://508.center4si.com/SelfCareforCareGivers.pdf

- *Self-Care Assessment Worksheet*
  http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf

- Hopkins, K. M., Cohen-Callow, A., Kim, H. J., Hwang, J. (2010). Beyond intent to leave: Using multiple outcome measures for assessing turnover in child welfare. *Children and Youth Services Review*, 32,1380-1387.

- Saakvitne, K. W., Pearlman, L. A., & Staff of TSI/CAAP. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton.

- Van Dernoot Lipsky, L. (2009). *Trauma Stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler Publishers.

- Compassion Fatigue Self Test
  http://www.ptsdsupport.net/compassion_fatugue-selftest.html

- *ProQOL 5* http://proqol.org/ProQol_Test.html

- Rothschild, B. (2006). *Help for the helper. The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton.

Worker Resiliency in Trauma-informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The Secondary Traumatic Stress Committee of the National Child Traumatic Stress Network has identified the following concepts as essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must

- Recognize the impact of secondary trauma on the workforce.

- Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.

- Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals.

- Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma.

- Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices.

These elements should be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress.

> *"We have an obligation to our clients, as well as to ourselves, our colleagues and our loved ones, not to be damaged by the work we do."[12]*

References

1. Conte, JR. (2009). Foreword. In L. Van Dernoot Lipsky, *Trauma stewardship. An everyday guide to caring for self while caring for others* (p. xi). San Francisco: Berrett-Koehler Publishers, Inc. Available at: http://traumastewardship.com/foreword.html Accessed June 12, 2011.

2. National Center for Children Exposed to Violence (NCCEV). (2003). Available at: http://www.nccev.org/violence/index.html Accessed June 5, 2011.

3. Van Dernoot Lipsky, L. (2009). *Trauma Stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler Publishers.

4. Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY: Brunner/Mazel.

5. Pryce, J.G., Shackelford, K.K., Price, D.H. (2007). *Secondary traumatic stress and the child welfare professional.* Chicago: Lyceum Books, Inc.

6. Bride, B.E., Hatcher, S.S., & Humble, M.N. (2009). Trauma training, trauma practices, and secondary traumatic stress among substance abuse counselors. *Traumatology*, 15, 96-105.

7. Craig, C.D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping*, 23(3), 319-339.

8. Sprang, G., Whitt-Woosley, A., & Clark, J. (2007). Compassion fatigue, burnout and compassion satisfaction: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259-280.

9. Figley, C.R. (2004, October). *Compassion Fatigue Therapist Course Workbook. A Weekend Training Course.* Green Cross Foundation. Black Mountain, NC. Available at: http://www.gbgm-umc.org/shdis/CFEWorkbook_V2.pdf

10. Stamm, B.H. (2010). The concise ProQOL manual, 2nd Ed. Pocatello, ID: ProQOL.org. Available at: http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf

11. Stamm, B.H., Figley, C.R., & Figley, K.R. (2010, November). *Provider Resiliency: A Train-the-Trainer Mini Course on Compassion Satisfaction and Compassion Fatigue.* International Society for Traumatic Stress Studies. Montreal, Quebec, Canada.

12. Saakvitne, K. W., & Pearlman, L. A., & Staff of TSI/CAAP. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton.

13. Pearlman, L. A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). New York, NY: Brunner/Mazel.

About the National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.