

Secondary Traumatic Stress Effects of Working With Survivors of Criminal Victimization

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This paper focuses on the consequences for providers of working with survivors of traumatic events, particularly criminal victimization. The paper reviews the relevant research and treatment literature associated with secondary traumatic stress (STS) and related variables (burnout, compassion fatigue, vicarious trauma, and countertransference). The latter part of the paper identifies the most important mitigating factors in the development of STS. These include good training specific to trauma work, a personal history of trauma, and the interpersonal resources of the worker. Implications for treatment, prevention, and research are discussed.

KEY WORDS: secondary traumatic stress; stress reactions; stress management; vicarious trauma; crime victim counselors; trauma workers.

Professionals and volunteers who work with crime victims deserve a lot of credit. Although rewarding, they must listen to some very disturbing stories, become familiar with injustices, and attend to the emotional needs of those often overlooked (Alexander, 1990; Bard & Sangrey, 1986; Neiderbach, 1986; Ogawa, 1989; Roberts, 1990; Salston, 1995). There has been a significant amount of literature focusing on crime victims and other survivors of traumatic events in the last two decades. Yet comparatively little research has focused on those who work with the traumatized. This paper focuses on the secondary traumatic stress (STS) reactions experienced by these workers.

The emotional, cognitive, and physical consequences of providing professional services to survivors have been addressed in the literature over the past decade (Carbonell & Figley, 1996; Danieli, 1996; Figley, 1995; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). These consequences can produce STS for helping professionals providing direct services to survivors. There

have been numerous conceptual views developed in attempt to explain the experience of the stress incurred as a result of helping others. The research and practice literature reflects the use of various terms that are or are nearly synonymous with STS. These include burnout, compassion fatigue, vicarious traumatization (VT), and traumatic countertransference (Figley, 1995, 2002).

STS Generally

Schauben and Frazier (1995) assessed the effects on female mental health professionals of working with sexual assault survivors and identified coping strategies used by counselors to cope with job-related stress. The participants were asked to indicate the most difficult and most positive aspects of working with survivors and the specific coping strategies used to alleviate stress. The results of the study revealed that the most difficult aspects of working with adult survivors of sexual assault included therapy management, client emotions, issues with larger systems, and personal emotions. Also reported by these professionals were changes in their own cognitive schemas related to beliefs about the world (e.g., a just and safe world for good people), hearing violent details from their clients,

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continued client victimization over the course of therapy, and extreme client behaviors (e.g., emotional outburst, trembling).

Over 45% reported enjoyable aspects of working with this population. The most frequently cited positive aspects included witnessing client resilience and personal growth, collegial support, and a sense of the importance of the services provided. Over 35% reported that they had found at least one effective coping strategy for handling the difficult trauma material. Among the most frequently cited were adopting an effective routine of diet and exercise, engaging in spiritually oriented activities, and seeking emotional and instrumental support from others.

In determining aspects of STS, Sloan, Rozensky, Kaplan, and Saunders (1994) proposed to explore the stressors of traumatic stimuli, work environment, time pressure, and qualitative and quantitative workload medical, mental health, and public safety professionals following a shooting at an elementary school. The results indicated public safety personnel reported less intrusive thoughts than the other two groups immediately following the shooting, which the authors stated may or may not be due to some form of denial. Qualitative workload was the only significant predictor of intrusion scores at both time periods and significantly predicted current avoidance scores. Three of the five stressors significantly predicted avoidance scores immediately following the traumatic incident.

In regard to exploring factors that explain STS from a perspective explained by compassion fatigue and VT, Folette, Polusny, and Milbeck (1994) proposed to determine if a relationship between trauma history and psychological symptoms existed for those mental health and law enforcement professionals working with child sexual abuse survivors. The results indicated professionals with trauma histories from both mental health and law enforcement showed significantly higher trauma symptoms than did professionals with no trauma histories. However, in regard to predicting VT, a trauma history was significant only for law enforcement professionals. For mental health, a total of 71% of the variance for STS was explained by negative coping, level of personal stress, and negative clinical response to sexual abuse cases.

Marmar et al. (1996) purposed to better understand the impact of mass casualty on rescue workers. The results indicated greater exposure, greater threat, and less training were the best predictors of moderate-to-high distress.

Work-Related Burnout

This concept was coined by Freudenberg (1974) but the major development emerged with the work of

Maslach (1982). Work-related burnout is not limited to persons working with the traumatized. Burnout can be caused by conflict between individual values and organizational goals and demands, an overload of responsibilities, a sense of having no control over the quality of services provided, awareness of little emotional or financial reward, a sense of a loss of community within the work setting, and the existence of inequity or lack of respect at the workplace (Maslach & Leiter, 1997). Often times, the individuals who experience burnout are highly idealistic about the way in which they can help others (Pines & Aronson, 1988). Burnout also can be related to consistent exposure to traumatic material (Aguilera, 1995).

Similar to STS, burnout is a "process, not an event" (Farber, 1983b, p. 3) "marked by physical, emotional, and behavioral indicators that can be easily recognized" (Aguilera, 1995, p. 269), allowing for self-initiated intervention if the caregiver is trained and aware of the manifestations. The physiological responses include physical exhaustion, headaches, and hypertension. Not unlike STS, reactions to burnout include emotional responses, such as emotional exhaustion (Prosser et al. 1996), depression, and anxiety. Behavioral responses include boredom, decline in performance, insomnia, increased addictions or dependencies, interpersonal difficulties, and cognitive response such as self-doubt, blame, and general disillusionment (Farber, 1983a; Prosser et al., 1996). There can be a sense of reduced personal accomplishment and purpose, feelings of helplessness and hopelessness (Maslach, 1982), impairment of family relationships (Farber, 1983a; Pines, 1983), and the development of a negative self-concept and negative attitudes toward work, life, other people, and nightmares (Pines & Aronson, 1988).

Etzion (1984) explored the relationship between burnout and social support because social support has been proposed as a major resource in reducing harmful consequences of stress. Burnout was found to be significantly and positively correlated with stressors, whereas support was significantly and negatively correlated with burnout. Life support was more effective in moderating work stress for women, but work support was a more effective moderator for men. Women had significantly higher burnout and life stress than did men but higher life support.

Prosser et al. (1996) found higher rates of burnout in community mental health workers than in hospital-based staff. Practice implications addressed the need to develop measures of prevention of burnout, especially for community mental health workers, and the need for a greater understanding of the impact of long-term involvement on professionals and clientele. In Stav, Florian, and Shurka's study, frequency of and satisfaction with supervision were identified as potential moderators of burnout in

social workers in various settings (Stav, Florian, & Shurka, 1987).

Unfortunately, the concept of burnout is far too vague to be useful in understanding and helping those who work with people traumatized by crime. Other concepts synonymous with STS emerged in the last 10 years: compassion fatigue, vicarious trauma, and the reconceptualization of countertransference

Compassion Fatigue

The name *compassion fatigue* was first printed in regard to discussions related to burnout in nurses exposed to traumatic work-related experiences (Joinson, 1992). According to Koerner (1995), compassion is more than empathy, more than being able to fully appreciate what someone is experiencing. It is “based on a passionate connection . . . passion moves one beyond feeling and emoting toward social action aimed at relieving the pain of others” (p. 317). Koerner further addressed the fact that having a compassionate style of practicing “demands risk coupled with a recognition of our own limitations” (p. 317). The terms *compassion stress* and *compassion fatigue* began to be used as synonymous terms for STS and STSD. Compassion fatigue, or STSD, parallels the diagnosis of PTSD (APA, 1994), except the traumatic event is the client’s traumatic experience that has been shared in the process of therapy or interaction with the survivor.

Hollingsworth (1993) investigated the responses of therapists working with female survivors of incest to build a theory of the effects of such work. All of the research participants experienced lasting negative change in at least one the following cognitive schema: trust of others, safety of children, intimacy, connectedness, esteem for others, and independence of power. General themes indicated feelings of anger, disgust, sadness, and distress, difficulty in maintaining relationships and boundaries, somatic responses, and intrusion symptoms. Hollingsworth (1993) found that effective strategies evolved for these female therapists that enable them to work with this population of clients. The most frequently found strategies included the use of peer support, supervision and consultation, training, personal therapy, maintaining balance in one’s life, and setting clear limits and boundaries with clients. In addition, the study determined the existence of lasting positive changes, which had not been addressed in the literature at that time.

Many competent caregivers are “most vulnerable to this mirroring or contagion effect. Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress . . . resulting from

helping or wanting to help a traumatized or suffering person” (Figley, 1993, p. 1). If the signs of STS are ignored, STSD may develop. Caregivers with compassion fatigue begin to dream the clients dreams, experience intrusive thoughts or images (Cerney, 1995), and experience distress or physiological reactivity to reminders of that client’s traumatic experience. Avoidance symptoms may be exhibited as an active effort to avoid thoughts, feelings, activities, and situations that remind one of the traumatic events of the client. There could be a decrease in interest in activities that once brought pleasure or relief of stress; affect can be diminished as well. Compassion fatigue will bring about the experience of hyperarousal symptoms, such as sleep disturbances, difficulty concentrating, high startle response, feelings of agitation or irritability, or hypervigilance (Figley, 1995).

Compassion fatigue can affect not only the caregivers, but also their family and closest friends, because they are a system of support (Cerney, 1995). Therefore the same “contagion effect” (Figley, 1993) can be transmitted to the support system. Caregivers “may traumatize their families by their chronic unavailability and emotional withdrawal, perhaps in the same way that trauma victims sometimes traumatize those around them” (Cerney, 1995, p. 140). This distancing may occur when caregivers do not believe anyone would be able to understand the distress they are experiencing as a result of such intense and difficult work (Dutton & Rubinstein, 1995).

Vicarious Traumatization

In the process providing services to survivors, the caregiver is exposed to traumatic material that begins to affect one’s worldview, emotional and psychological needs, the belief system, and cognitions, which develop over time. VT is a result of empathic engagement with survivors’ trauma material (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). It is recognized as normal, predictable, and inevitable, yet, if the caregiver does not work with the transformation that is taking place, it can have a serious effect on the caregiver as an individual, as a professional, as well as with interpersonal relationships (McCann & Pearlman, 1990a, 1990b; Pearlman & Saakvitne, 1995).

The ways in which VT can be addressed is through acceptance and recognition of the changes that occur, through giving oneself permission to limit exposure, and to continue in education in the field of traumatology, but also in the general field to maintain contact with theory and to develop new interests. For therapists it is also important to name the reenactments that occur during therapy for the

benefit of the client as well as the benefit of the therapist, and to set limits with clients.

Lee (1995) explored the development of STS from the perspective of compassion fatigue and VT and assessed the degree of STS among marriage and family therapists. The results were compared to samples from two validity studies with patients with PTSD and medical students. The therapists reported to have a mean of 63% of clients with a diagnosis of clients with PTSD scored higher on the IES intrusion than the medical students. The TSI Belief Scale (measuring VT) indicated the lowest cognitive disruption for the therapists; cognitive schemas were significantly correlated with STS and the therapist's level of satisfaction with one's total caseload; and it was found that the more hours listening to client traumatic material, the greater the intrusion score.

Pearlman and Mac Ian (1995) attempted to develop dependent variables as indicators of VT and independent variables that might predict VT in trauma therapists and clinical graduate students. These variables included relations among aspects of trauma therapy, aspects of the therapist, and therapist's current psychological functioning. The results indicated that, overall, those with a trauma history showed more cognitive disruption. Those participants with more time devoted to trauma work had fewer disruptions in self-trust. The more inexperienced had the highest scores, which were exacerbated when the participants had no supervision.

Traumatic Countertransference

Although countertransference is linked to psychoanalytic theory and has been in the literature for many years (Neumann & Gamble, 1995), it had limited use for understanding STS of trauma workers. The more contemporary perspective on countertransference involves the spontaneous or evoked responses of the therapist in regard to information provided, behaviors exhibited, emotions displayed by the traumatized client. According to Danieli (1996), countertransference reactions "inhibit professionals from studying, correctly diagnosing, and treating the effects of trauma. They also tend to perpetuate traditional training, which ignores the need for professionals to cope with massive real trauma and its long-term effects" (p. 196).

Hayes et al. (1991) identified attributes that potentially manage countertransference in therapy. Self-insight and self-integration of the therapist played the largest role in managing countertransference. Therefore, management of countertransference appears to be a function of personality composition, rather than skills, a conclusion that is

supported by the previous theory of unresolved conflict within the therapist.

Therapists working with survivors will often experience reactions to hearing extremely violent and graphic stories, which keep the therapist from remaining present with the client. As a way of defending oneself from hearing the traumatic material of the survivor, therapists may dissociate to some degree, distance themselves, question the viability of the story being told, experience somatic responses, and be overwhelmed with feelings of grief or helplessness. If the traumatic experiences "touch" on any personal traumatic history, the therapist may become somewhat numb, and not hear the client (Danieli, 1996).

Whether confronting classical or traumatic countertransference, a therapist must possess a healthy character structure, be able to control anxiety, actively employ conceptual skills, be able to maintain empathy while disengaged from the process of identification, and work on bringing unconscious material into conscious awareness in order to effectively manage countertransference (Hayes, Gelso, Van Wagoner, & Diemer, 1991). The management of countertransference is essential due to the possibility of developing STS. Therefore, it is of "paramount necessity of carefully nurturing and regulating the self and ensuring the development of a self-protective, self-healing, and self-soothing way of being as a professional and as a full human being" (Danieli, 1996, p. 200).

Other Important Issues

Personal Trauma History

Most of the empirical research in regard to STS includes "personal trauma history" as an independent variable. The conceptual literature supports the belief that most trauma therapists have experienced some traumatic event (Figley, 1995; Pearlman & Saakvitne, 1995). However, the results of empirical studies have varied in regard to the relationship between STS and personal trauma history. Figley (1995) addressed some potential dangers for trauma therapists with a trauma history to overgeneralize personal experiences and "overpromote" specific coping strategies found to be useful to the survivor/therapist. Other areas of concern included the potential for unresolved trauma to be triggered by client's traumatic material that is similar in nature to that of the therapist. Death of a loved one is an example (Figley, 1996; Rando, 1984). This is obviously a factor that needs further study, as well as incorporation into supervision or consultation. Pearlman and Saakvitne (1995) also suggested that a therapist seek personal therapy if there is any awareness of unresolved trauma.

Institutional Interpersonal Resources

Another critical issue in working with the traumatized is help and support from the employer. Dershimer (1990) notes that

Staff support is not a luxury but a necessity. Without it clinicians . . . can become dehumanized, causing them to distance themselves in relationships, experience fewer feelings, and become more mechanical and less caring in both their personal and professional lives (p. 119).

Cerney (1995) discussed the balance in one's life as imperative because the needs of the professional life can intrude on the personal life, which damages interpersonal relationships. Therefore, "maintaining a satisfactory personal life enables therapists to have fun, to enjoy themselves alone and in the company of others, to laugh, and to renew their faith in the goodness of most humans" (p. 141). Cerney also noted the importance of maintaining appropriate boundaries, and prioritizing commitments in order to develop that balance. Aguilera (1995) built upon that thought by addressing the way one enlarges one's world is through development of close personal and family relationships. This requires time commitments and emotional commitments that can build mutual support within loving relationships. When someone strengthens other systems in life, one gains strength in coping.

Assessment of STS

Therapists with unacknowledged STS can cause harm to clients, as well as distance themselves from family and friends (Pearlman & Saakvitne, 1995), by not being able to be focused and attentive to the needs of others. With clients, this can lead to difficulties with boundaries, missed appointments, or abandonment of clients (Pearlman & Saakvitne, 1995). There can be feelings of helplessness (Cerney, 1995) and withdrawal from support systems, and cynicism (Pearlman & Saakvitne, 1995).

For effective treatment, a formal assessment needs to be completed. Three measures designed to assess for STS include the Compassion Fatigue Scale (Figley, 1995; Stamm, 1998), TSI to measure changes in cognitive schemas (Pearlman & Saakvitne, 1995), and the Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis, & Figley, in press). The latter is the least known and most recently published. STSS, a 17-item instrument, is designed to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events via one's professional relationships with traumatized clients. A total of 287 licensed social workers who were randomly selected from those listed by the Georgia

licensing board completed a mailed survey containing the STSS and other relevant survey items. The results indicated strong reliability, convergent and discriminant validity, and factorial validity for the measure.

Treatment of STS

There are several models that could be used in the treatment of STS. These include critical incident stress debriefing (CISD; Harris, 1995; McCammon & Allison, 1995), the multiple stressor debriefing model (Armstrong, O'Callahan, & Marmar, 1991), a sensory-based therapy (Harris, 1995; Ogden & Minton, 2001), vicarious trauma treatment approach (Pearlman & Saakvitne, 1995), and Accelerated Recovery Program for Compassion Fatigue (Gentry, Baranowsky, & Dunning, 1997). A recent compendium (Figley, 2002) included a larger list and description of treatments for compassion fatigue and a strategy for matching which worker/client with which treatment approach at what point in time.

Decisions on appropriate intervention would be based on personal preference of the therapist being treated, the opportunity for an immediate intervention following a critical incident, or whether the awareness of STS is readily embraced. The therapist may need to have the opportunity to talk about what he or she is experiencing, feeling, and thinking. In this instance, a peer group intervention would be appropriate. These experiences need to be processed in treatment teams, in consultations with colleagues, and in debriefing meetings in order to integrate them effectively (Valent, 1995), and mitigate STS. There is no one way to treat STS, and all options are viable. An appropriate intervention can be decided in conjunction with a trauma specialist.

Prevention of STS

"Much secondary trauma can be avoided or its effects ameliorated if therapists seek regular supervision or consultation" (Cerney, 1995, p. 139). Pearlman and McCann (1990) stressed the importance of regular supervision or consultation when working with crime victims or survivors of other traumas. The purpose of this is to process the painful client material, as well as any personal emotions or cognitions (Cerney, 1995) that may be experienced as overwhelming. This is a vital process in preventing STS.

Personally, a therapist must strive to have balance within life (Cerney, 1995; Wilder & Plutchik, 1982). There needs to be a balance between home, work, self, and others. There needs to be a balance between the physical self, the emotional self, and the spiritual self in order to

continually work with those who are struggling through the impact of the traumatic experience. The importance of social support cannot be overemphasized (Harris, 1995). The work one can do with oneself can include journaling any dreams, process the intrusions and integrate the memories, progressive relaxation, imagery, physical activity, appropriate diet, drawing upon spiritual strengths, and seek involvement in an activity of interest, that brings pleasure. It is important for the therapist to incorporate those skills taught to clients in order to provide effective self-care.

If there is a critical incident that evokes STS in therapists, crisis intervention should be available on a voluntary basis for workers who need it (Everstine & Everstine, 1983). Any intervention should not only be voluntary and tailored to the individual needs of the worker (e.g., peer, group, or individual sessions), but these services should be offered continuously not just once. Although CISD is important (Pickett, Walsh Brennan, Greenberg, Licht, & Worrell, 1994), it is critical that it should not be forced on anyone (Figley, 2002). No matter the method, the worker needs to eventually address his or her experiences, acquire the lessons that will be useful to them in the future, and let any unwanted emotional arousal evaporate. The lessons should lead to human growth and increased worker competence.

Yassen (1995) included an ecological model for prevention of compassion fatigue that included specific suggestions in two areas of the personal life and three areas related to environment. The model provides way to evaluate the worker's current life and ways to reduce stress and increase joy.

There were other ways reported in the literature to prevent or recover from compassion fatigue and related challenges. Figley (1989) encouraged the therapist to avoid and eliminate having a "savior" syndrome, to make time for pleasure, to remain involved in professional activities to gain further support, and to set realistic goals and boundaries. Dershimer (1990) pointed to the need for support from an authority, such as God, a learned scholar, a political figure, or a respected person in one's family, social, or work group. It is also important to continue to clarify why one is engaged in working with those who are traumatized and to maintain a good diet, exercise, and healthy way of life.

Conclusion

Professionals are at risk of being traumatized by their work with those traumatized by criminal victimization. Understanding the potential effects of this impact is an important step in activating appropriate self-care. A de-

sire to help survivors of traumatic events, exposure to the traumatic material of survivors, and empathy are foundational factors in the development of STS (Figley, 1995; Valent, 1995). STS, Compassion fatigue, and VT are directly related to the exposure to traumatic material (Figley, 1995; Pearlman & Mac Ian, 1995). STS can affect not only those who provide direct services to survivors, but also the family and closest friends of the caregiver, because they are a system of support (Cerney, 1995; Figley, 1993; Pearlman & Mac Ian, 1995). It is clear from this review that it is important to develop and utilize effective coping mechanisms and systems of support in order to ameliorate the effects of exposure to the traumatic material of survivors and STS (Cerney, 1995; Dershimer, 1990; Figley, 1989; Pearlman & McCann, 1990; Schauben & Frazier, 1995). It is also obvious to us that there is a vital need for professionals to receive increased training, education, consultation, and supervision related to trauma and STS (Folette et al., 1994; Lee, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Stav et al., 1987).

Research Implications

To gain further knowledge and understanding of STS, it is essential that effective research be continued. Quality reporting of the research findings must also be encouraged to allow for replication of the studies to support or challenge findings, to provide information in regard to more diverse populations, and to be able to have a greater understanding of the factors that contribute to STS. As noted earlier, much more research is needed in this area. In particular, we need to gain a broader understanding of the factors contributing to STS (Folette et al., 1994; Lee, 1995). If drugs and alcohol use increases with the symptoms of STS, much more research is needed to both document this pattern and identify the biophysiological pathways and theoretical foundations that account for their use.

Just as we need to know more about how trauma affects diverse populations (e.g., in terms of race, region, nationality, disability, class), we need to know about the differential effects of STS among these groups (Schauben & Frazier, 1995). We need much more information on and theories to predict the STS effects longitudinally, across the life course and career of service providers.

A theoretical model of compassion fatigue (Figley, 1995) cited nine major variables predicting compassion fatigue. Among the most important and least studied, we find, are a sense of satisfaction for working with the traumatized and the ability (or competence) in creating distance between the worker and the work (including the clients with whom they work)—both physically and mentally. We believe that this model deserves testing.

There have been conflicting results in the studies conducted in regard to whether or not personal trauma history of the professional is a contributing factor to the development of STS. It is obvious further research is indicated. However, it may be of value to gather information from the professionals with regard to professional treatment received, as well as perceived effectiveness of the treatment. Established measures could be utilized to gather data in regard to current traumatic stress reactions specific to past trauma. There would be obvious limitations in regard to isolating the effects of only the past trauma. However, useful information could be obtained.

Practice Implications

In regard to treatment of STS, treatment studies are also indicated. There are numerous viable treatment options. It would be of interest to the professional community to learn more about the effectiveness of these treatment modalities specific to STS.

The conceptual literature in regard to compassion fatigue and VT indicate some basic differences. VT is a process that occurs over time (Pearlman & Saakvitne, 1995), whereas compassion fatigue involves a faster onset of the symptoms, as well as a faster recovery than experienced in VT (Figley, 1995). The focus on the role of symptoms in compassion fatigue, as compared to the focus on the change in cognitions as emphasized in VT, is another difference noted. The variety of research conducted has indicated both the existence of symptom patterns and changes in cognitive schemata. Further research could potentially help create more understanding in regard to the rate of onset as well as determine if compassion fatigue and VT are mutually exclusive.

Educating Future Traumatologists

Finally, we know enough to realize that secondary traumatic stress, particularly compassion fatigue, is an occupational hazard of caring service providers—be they family, friends, or family counselors. Recognizing this, we have a special obligation to our students and trainees to prepare them for these hazards. We must do all that we can to insure that those who work with traumatized people—including but not limited to those exposed to crime victimization—are prepared. We have a “duty to inform” them about the hazards of this work. A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision. But, at the same time, we have a duty to talk about the rewards; that the rewards of working with the trauma-

tized far outweigh the costs. And this happens when we balance caring for others with caring for ourselves.

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