SECONDARY TRAUMATIC STRESS
AND RELATED CONCEPTS

DR. ROD BALE
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Introduction

Figley (1995; 2002) has written extensively about the "cost of caring" and states 'professional work centred on the relief of emotional suffering includes absorbing information that is about suffering. Often it includes absorbing this suffering as well." Various names have been given to the problems that may arise in such activity. Thus the term Secondary Traumatic Stress is synonymous with Compassion Fatigue, Compassion Stress and Vicarious Traumatisation.

He uses the following definition of compassion "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster's Dictionary) and goes onto state the importance of empathy in clinical work. He states "systematic studies of the effectiveness of therapy point to the therapeutic alliance between client and clinician, the ability to empathise, to understand and help clients" (FIGLEY, E.R & NELSON T. 1989). He goes on to say 1f that is not present it is unlikely therapeutic change will take place. The most important ingredient in building a therapeutic alliance is the client liking and trusting his or her therapist. These feelings are directly related to the degree to which the therapist utilises and expresses empathy and compassion."

Whereas counter transference in psycho analytical terms was once viewed simply as the therapist's conscious and unconscious response to the patient's transference especially if the transference connected with the therapist's past experience. JOHANSEN, K.H. (1993) suggests a more contemporary perception of counter transference and views it as all of the emotional reactions of the therapist towards the patient/client regardless of their sources. These sources include life stressors, past and present experienced by the therapist. But they also include the trauma expressed by the client and absorbed by the therapist.
Figley, C.R. believes that Secondary Traumatic Stress is a natural consequence of caring between two people, one of whom has been initially traumatised and the other of whom is affected by the first traumatic experiences. These effects are not necessarily a problem but are the natural by product of caring for traumatised people. This paper examines the concept of Secondary Traumatic Stress particularly in relation to working with victims of torture.

Ideas concerning Secondary Traumatic Stress grew out of the concept of 'Bum Out' which can be defined as a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations. It is considered as a process that begins gradually and becomes progressively worse. There is an inability to achieve goals accompanied by frustration, a sense of loss of control and ineffectualness. Symptoms have been classified under the following headings physical, emotional, attitudinal and behavioural (fig. 1) and contrast with the features of Secondary Traumatic Stress (fig. 2.)

Figley (2002) has drawn up a table contrasting the symptom criteria for Post Traumatic Stress Disorder and Secondary Traumatic Stress (figs, 3, 4, 5, 6, 7 although the symptoms of Secondary Traumatic Stress are similar they are milder in degree.) Both GERSON (2000) and ALLDEN (2003) empathise the inadequacy of concentrating on P.T.S.D. as the only psychiatric sequelae to trauma and torture. Virtually the whole spectrum of psychiatric diagnosis can be seen in torture victims. The almost ubiquitous presence of depression in torture victims has been commented upon. GERSONS (2000) points out the symptoms listed under avoidance symptoms P.T.S.D criteria (4-7) overlap strongly with depression. A trauma spectrum of disorders has been advocated as a more appropriate way to assess the trauma victim and at the Medical Foundation we see the whole range of psychiatric symptomatology. Amusingly TYRER (2000) refers to P.T.S.D "as the US dollar in the money market; it trumps almost all other diagnoses and so people (both patients and their physicians) are keen to exchange their less attractive diagnostic occurancies for one that yields more, even if it sometimes means less" Interestingly Mol et al (2005) have recently produced a study showing that P.T.S.D symptomatology can occur following life events including chronic illness of a loved one and relational problems.
<table>
<thead>
<tr>
<th>SYMPTOMS OF BURN OUT</th>
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<tbody>
<tr>
<td><strong>PHYSICAL</strong></td>
</tr>
<tr>
<td>Fatigue</td>
</tr>
<tr>
<td>Exhaustion</td>
</tr>
<tr>
<td>Sleep difficulties</td>
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<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Gastro intestinal</td>
</tr>
<tr>
<td>disturbances</td>
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<tr>
<td>Frequent colds; flu</td>
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After MASLACH, C (1982)  
(Figure 1)
## CONTRASTING FEATURES

<table>
<thead>
<tr>
<th>BURN OUT</th>
<th>SECONDARY TRUMATIC STRESS</th>
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<tbody>
<tr>
<td>1. Emerges gradually</td>
<td>1. Can emerge suddenly</td>
</tr>
<tr>
<td>2. Symptoms have basis in personal and social situation</td>
<td>2. Symptoms often disconnected from real causes</td>
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<tr>
<td>3. Recovery can be problematic and slow</td>
<td>3. Faster recovery rate</td>
</tr>
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After F1GLEY C.R. (2002) (Figure 2)
CONTRAST BETWEEN SYMPTOM CRITERIA FOR P.T.S.D. AND S.T.S

A. STRESSORS

P.T.S.D (DSM - IV)
1. Person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2. The person's response involved intense fear and helplessness or horror.

S.T.S
1. Experienced indirectly the primary traumatic stressors through helping those who had experienced these traumas.

2. Emotional response to plight of Victim.

After F1GLEY C.R. (2002) (Figure 3)
CONTRAST BETWEEN SYMPTOM CRITERIA FOR P.T.S.D. AND S.T.S.

B. RE-EXPERIENCING SYMPTOMS

TRAUMATIC EVENT IS PERSISTENTLY RE-EXPERIENCED IN ONE (OR MORE)

OF FOLLOWING WAYS

P.T.S.D.                                                   S.T.S
1. Recurrent and intrusive distressing recollections of event including images, thoughts or perceptions
2. Recurrent dreams of the event.
3. Acting of feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes including those that occur on awakening or when intoxicated.
4. Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

After FIGLEY C.R. (2002) (Figure 4)
## CONTRAST BETWEEN SYMPTOM CRITERIA FOR P.T.S.D. AND S.T.S

### C. AVOIDANCE SYMPTOMS

**PERSISTENT AVOIDANCE OF STIMULI ASSOCIATED WITH THE TRAUMA AND NUMBING OF GENERAL RESPONSIVENESS (NOT PRESENT BEFORE THE TRAUMA) AS INDICATED BY THREE OR MORE OF THE FOLLOWING.**

<table>
<thead>
<tr>
<th><strong>P.T.S.D</strong></th>
<th><strong>S.T.S</strong></th>
</tr>
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<tbody>
<tr>
<td>1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.</td>
<td>1. Efforts to avoid thoughts, feelings or conversations associated with client's trauma.</td>
</tr>
<tr>
<td>2. Efforts to avoid activities, places or people that arouse recollections of the trauma.</td>
<td>2. Efforts to avoid activities, places or people that arouse recollection of the clients traumas.</td>
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<tr>
<td>3. Inability to recall an important aspect of the trauma.</td>
<td>3. Errors in judgment about conceptualizing and treating trauma case.</td>
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<td>4. Markedly diminished interest or participation in significant activities.</td>
<td>4. Markedly diminished interest or participation in significant activities.</td>
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<tr>
<td>5. Feeling of detachment or estrangement from others.</td>
<td>5. Feeling of detachment or estrangement from others.</td>
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<tr>
<td>6. Restricted range of affect (eg. unable to have loving feelings.)</td>
<td>6. Restricted range of affect (eg. Unable to know client personally or saviour orientated).</td>
</tr>
<tr>
<td>7. Sense of foreshortened future (eg. does not expect to have a career, marriage, children or a normal life span.)</td>
<td>7. Sense of foreshortened future (eg. Does not expect or want to have a long career).</td>
</tr>
</tbody>
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After FIGLEY C.R. (2002) (Figure 5)
D. AROUSAL SYMPTOMS

PERSISTENT SYMPTOMS OF INCREASED AROUSAL (NOT PRESENT BEFORE THE TRAUMA) AS INDICATED BY TWO OR MORE OF FOLLOWING

<table>
<thead>
<tr>
<th>P.T.S.D</th>
<th>S.T.S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty failing of staying asleep.</td>
<td>1. Difficulty failing or staying asleep.</td>
</tr>
<tr>
<td>2. Irritability or outbursts of anger.</td>
<td>2. Irritability or outbursts of anger.</td>
</tr>
<tr>
<td>3. Difficulty concentrating.</td>
<td>3. Difficulty concentrating.</td>
</tr>
<tr>
<td>5. Exaggerated startle response.</td>
<td>5. Exaggerated startle response.</td>
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After FIGLEY C.R. (2002) (Figure 6)
E. DURATION

P.T.S.D.

E. 30 days duration

F. Disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning evidenced by increased family conflict, sexual dysfunction, poor interpersonal communication, less loving, more dependent, reduced social support; poor stress-coping methods.

S.T.S

E. 30 days duration

F. Disturbing causes clinically significant distress or impairment in social, occupational or other important areas of functioning, evidenced by increased work conflict, missed work, insensitivity to client's lingering distress caused by trauma material reduced social support, poor stress coping methods.

After FIGLEY C.R. (2002) (Figure 7)
Evidence

Support for the psychological hazards of treating trauma patients can be found from GERSON (2000) who writes "after listening to the story of burning people jumping from balconies the therapist can begin dreaming about it. Treatment of a survivor of a plane crash can make the therapist fearful of flying. One feels saddened and helpless and the traumatic details can cause the interviewer to develop nightmares of such incidents.

ALLDEN (2002) writes, "when listening to individuals speak of their torture clinicians should expect to have personal reactions and responses themselves. Understanding these personal reactions is crucial because they can have an impact on one's ability to evaluate and address the physical and psychological consequences of torture. Reactions may include avoidance and defensive indifference in reaction to being exposed to disturbing material, disillusionment, helplessness and hopelessness that may lead to symptoms of depression or vicarious traumatisation, grandiosity or feeling that one is the last hope for the survivor's recovery and well-being, feelings of insecurity in one's professional skills in the face of extreme suffering, guilt over not sharing the torture sufferer's experience, or even 'anger when the clinician experiences doubt about the truth of the alleged torture history and the individual stands to benefit from an evaluation" (fig. 8)

Blackwell (2005) in his book "Counselling and Psychotherapy with Refugees" states "Given that work with refugees may focus on extreme acts of violence and destructiveness deliberately perpetrated in reality (rather than in fantasy where therapists in the West are more used to encounter it) it may resonate at a deep and frightening intrapsychic and interpersonal levels in a way the therapist has not previously experienced. Moreover, it is often the case that therapists, like people generally, deal with horrific experiences by repressing and dissociating. They can be quite unconscious of the effect the work is having on them, and can go on enacting these defensive manoeuvres in their work with clients in their relationships with colleagues and in their personal lives."
He later states that at a European Association for Traumatic Stress Research meeting he was interested to discover how many of the participants reported that this issue was not addressed in their workplaces, and in some cases it was at home where their changed behaviour and enactment of the effects of the work was noted.

Finally I would like to refer to the work of Caroline Davies (2003) at the Medical Foundation. Interestingly I have found that even those who took part in the study are unaware the results are available to see in the library. She describes the following affects of working with survivors of torture (eight in study) on counsellor/caseworkers (fig. 9) initially the worker felt unprepared for working with survivors of torture and were often shocked and disturbed. Emotional flooding was experienced by those who began their work with survivors of torture as interpreters before becoming counsellor/caseworkers. Inadequacy, self doubt; feelings of being overwhelmed and depressed were felt by most of the workers. Anger and shame were experienced at the system of processing asylum seekers. Depression and anxiety were constant elements in the work with survivors, who were also asylum seekers. Quoting one counsellor/caseworker "Sadness - and sadness and I pick it up from my clients - I know I'm very much aware of the fact that I am picking up their anger and I'm left with it and often I don't have anywhere to offload it." Guilt was often felt. They often described feeling deskilled and helpless and for some there was a strong sense of feeling isolated and apart from others. The realities of torture for some of the counsellors/caseworkers led them to question their assumptions about the world in which they live. There were positive affects of the work such as feeling a sense of awe at the resilience of the people with whom they were working. They spoke of feeling inspired, overwhelmed with respect and admiration for their clients and seeing their improvement and achievement bought great joy.

She then described the transforming of affects into effect (fig. 10) and all the counsellor/caseworkers noted that the impact on them changed over time and they learnt to protect and defend themselves, some by distancing themselves. One said I feel now compared with seven or eight years ago when I started working, that I am more able to protect myself. But at times, yes, I get affected by some of the issues that the clients bring with them."
Most of the counsellors/caseworkers found it difficult not to become enmeshed with their client work. A counsellor/caseworker said: "It is impossible to switch off after the session - if I'm busy back-to-back with clients, I switch off to switch on to the next person but in the evening I sit down and think of them." Some experienced disturbed sleep and one said: "I'm not talking about gross sleep disturbance - I'm talking about waking up say 3 o'clock in the morning - because I've started to think about a particular client."

For some, the work becomes a part of their life which made it difficult for them to assess its impact. One is quoted as saying, "maybe there are some effects I'm not aware of too. The possibility perhaps I'm not taking enough breaks. I'm having a lot of colds, too many." One counsellor said she was rarely overwhelmed by her client work, which concerned her: "the truth is I rarely feel overwhelmed actually, which sometimes worries me because] think do I not have empathy? Have I lost my sensibility? Was I ever sensitive? Is it psychological avoidance? Is it a defence? I don't know."

The impact of the work is that "it raises many questions for the counsellor/caseworker and in the process many assumptions both personal and professional are shattered. For some it requires they reassess and restructure their perceptions and understanding of what gives their work and their lives meaning.

A number of counsellors/caseworker felt they released tension at the expense of family, through letting off steam or by becoming increasingly short tempered and less patient. Some tried to restrain themselves knowing that their work is not a shared experience. Loved ones were the first to notice changes in behaviour.

Most counsellor/caseworkers were very aware of the profound affect that knowledge of their work can have on others. Some were very circumspect in what they said outside of the working environment.

At this point I think I can say there seems to be significant evidence for the concept of Secondary Traumatic Stress. All medical work is stressful but torture care because of sensitivity and empathy with the suffering of the torture survivor make it particularly
difficult to maintain the classical emotionally neutral stance of the clinician. So -how can we cope with such stresses? The following is the received knowledge as to how it can be approached. (Fig. 11.)
PERSONAL REACTIONS TO SURVIVORS HISTORY

1. Avoidance and defensive indifference
2. Disillusionment
3. Helplessness and hopelessness leading to depression
4. Grandiosity
5. Insecurity in one's professional skills
6. Guilt
7. Anger

Figure 8
AFFECTS UPON COUNSELLOR/CASEWORKERS OF WORKING WITH SURVIVORS OF TORTURE

1. Unprepared; often shocked and disturbed

2. Emotional flooding

3. Self doubt, inadequacy, feeling overwhelmed

4. Anger, shame

5. Depression and anxiety

6. Guilt

7. Feeling deskillled, helpless, isolated

8. Assumptions questioned

9. Positive reactions to clients

After DAVIES, C (2003)
Figure 9
EFFECTS UPON COUNSELLOR/CASEWORKER WORKING WITH SURVIVORS OF TORTURE

1. Impact changes over time
2. Carrying client work
3. Disturbed sleep
4. Work becomes part of life
5. Assumptions questioned
6. Impact on family and friends
7. Impact on others

After DAVIES, C (2003) Figure 10
PREVENTION AND CARE FOR SECONDARY TRAUMATIC STRESS

1. SELECTION OF WORKERS IN THE TRAUMA FIELD

   a History of previous trauma b Concept of hardiness

   (i) Emotional control
   (ii) Commitment
   (iii) Ability to cope with change

   c Compassion satisfaction
   d Professionalism

2. SUPERVISION

3. WORK LOAD

4. WORK GROUP ATTITUDES AND ACTION PLANS

   a 3:1 Ratio
   b Humour
   c Group activities; spiritual and meditative outlets
   d Adequate rest; avoidance alcohol and drug misuse
   e Leave office at the office
   f Facilitate health of our fellow colleagues

5. ENVIRONMENT

(Figure 11)
PREVENTION AND CARE FOR SECONDARY 
TRAUMATIC STRESS

1. SELECTION OF WORKERS IN THE TRAUMA FIELD

a. It is believed that workers who have suffered trauma in their lives and who have not adequately worked through it may be more at risk of developing secondary traumatic stress.

b. A concept of hardiness has been developed (KING 1998) et al which describes desirable characteristics in the clinician.

   (i) Emotional control; the possession of emotional stability that enables the worker to resist being overwhelmed by traumatic material
   (ii) A sense of commitment to this field of work and to one's patients
   (iii) An ability to cope with change and view it as a challenge

c. Compassion satisfaction has been described although one may have a degree of compassion fatigue (i.e. secondary traumatic stress) one still derives positive benefits from the work. It is felt that what one is doing is of help to this particular group of people and is even redemptive. In situations where one's belief system is being well maintained with positive material perhaps one's resilience is enhanced

d. Professionalism
If adequate standards of work performance are established then if setback occurs workers can view their work in a larger context than in a single incident. TURNER (2001) writes, "the best advice to clinicians is to stay true to their professional therapeutic relationship" He goes on to say they should "consider their personal supervision needs particularly carefully in this sort of work"
2. **SUPERVISION**

  Supervision is in the culture of the Medical Foundation but perhaps it has not been given the importance it deserves. Blackwell states that although the draft of his book had been completed for over a year he had not written anything about supervision. Obviously there can be a debate as to how this should be offered to the individual worker. I feel support comes into this category and non-specific informal support such as through the collegiate activity of the monthly doctors meeting can be seen as giving group support. However, the chance to discuss individual cases in an informal or formal manner is helpful to the clinician. It would be my opinion that secondary traumatic stress within a wide range of mild to severe is an inevitable occurrence in working in this field of torture care. It is not a weakness to acknowledge this but an important prerequisite to prevent it spilling over into one's private life.

3. **WORK LOAD**

  I am of the opinion that workload is an important matter to consider in this field. Gersons states, that P.T.S.D. can endanger the mental health of the interviewer. It is therefore advised to limit the number of trauma patients one has to interview or to treat. He also states supervision is highly recommended when working with trauma patients. Perhaps it is only a small number of additional cases that are taken on that increases work stress. There is always work pressure at the Medical Foundation and an unceasing demand on clinicians' time. It is important that it is recognised that there may be adverse effects of raising one's game to meet such demands.

4. Figley, C.R. mentions other work group attitudes and action plans to present secondary traumatic stress and amongst these are:

   a. A 3:1 ratio; for every three hours of working with clients there should be one hour for personal processing.

   b. Humour and other stress reduction methods.
He mentions "gallows humour" and the positive effects of such humour in tense situations amongst professional workers. In our work such humour is not applicable but humour particularly in the staff room is very evident. In fact my first impression of the Medical Foundation in the staff room at Grafton Rd was the amazing cheerful camaraderie that existed there. After listening to painful client/patient experiences it was a marked contrast to the feelings engendered by the interview. I felt that some mental defence such as denial was operating but the result was cheerful and supportive. Laughter therapy has been used as a treatment in its own right and the beneficial effects of laughter even on the immune system have been documented.

c He mentions team sports and other group activities can be beneficial in lowering stress levels. Spiritual and meditative outlets may be helpful to individual workers.

d Adequate rest and the importance of avoiding stress reduction through excessive alcohol or drug misuse is mentioned.

e He states it is important to let go of work "Leave the office at the office."

f As well as self care he advocates we try to facilitate the health of our fellow colleagues.

5. Finally Figley talks about the importance of the right environment to work within. He writes, "a bureaucratic impersonal, disempowering environment is in direct opposition to the empowerment principle. Institutions with such environments contribute to the individual's experience of being a victim, someone who is acted upon and has no control over his or her fate. Institutions that expose workers to secondary traumatisation need to foster an environment that empowers the individual regardless of their role in the institution. This means administrators must maintain a more personal management style and policies should remain flexible and leave latitude for employees to exercise their discretion. An institution that cannot be flexible and make allowances for the
personal needs and proclivities of individual workers is a poor environment for people working with trauma."

Bustos in his paper "Dealing with the Unbearable: Reactions of Therapists and Therapeutic Institutions to Survivors of Torture" describes the tensions that can develop within such institutions and is well worth reading. Therapeutic workers unconsciously project feelings engendered by their work onto the organisation. Conflicts can arise and the organisation responds by trying to deal with the anxiety involved by becoming more controlling. Staff dissatisfaction may become so great as to lead to a disruption of the organisation. It is important for the leadership of the organisation to exercise a degree of tolerance and understanding that conflicts within the organisation may have a degree of intrapsychic origin.
CONCLUSION

I have endeavoured to make a case for the phenomena of Secondary Traumatic Stress. Figley writes, "why are there so few reports of such traumatised people?" He answers by saying perhaps the psychotraumatological field is so young and that the field is in a pre paradigm state. Kuhn (1962,1970) argued that paradigms follow the evolution of knowledge. Knowledge about experiencing and reacting to traumatic material evolves in fits and starts. There is now a need to recognise that the process of attending to traumatic experiences and expressions may be traumatic itself. We work in a part of the spectrum of the trauma field which can be particularly stressful. If secondary Traumatic Stress is acknowledged to be an entity then it is important that all who work in this field need to have the knowledge it exists. It is necessary to be pro-active to its prevention by making use of the measures described.
REFERENCES


