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Secondary Traumatic Stress Among Mental Health Professionals: Implications for Graduate Training Programs

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Secondary traumatic stress (STS), which involves symptoms that mimic post-traumatic stress disorder, results from indirect exposure to trauma through caring for or working with traumatized individuals. Not surprisingly, given their frequent provision of services to trauma survivors, mental health professionals are among those at highest risk of developing STS. Accordingly, the present review sought to fill a gap in the literature by addressing the implications of STS for psychology graduate programs responsible for training mental health professionals. It is suggested that training programs can make three types of changes—curricular, environmental, and direct service related—to reduce student risk for, and enhance resiliency in the face of, STS.

Indirect exposure to trauma, such as caring for or working with traumatized individuals, can lead to secondary traumatic stress (STS; Shoji et al., 2014). Given that provision of services to trauma survivors is a common element of the work performed by mental health professionals, it is not surprising these professionals are among those at highest risk of developing STS (Cieslak et al., 2014). With up to 14% of mental health professionals experiencing STS, the following review seeks to fill a gap in the literature by addressing the implications of STS for psychology graduate programs responsible for training mental health professionals (Buchanan, Anderson, Uhlemann, & Horwitz, 2006). To this end, STS will first be clearly defined and distinguished from similar terms. The symptoms of STS and resulting consequences, along with both risk and protective factors, will then be discussed. Finally, the implications of STS for graduate training programs in applied forms of psychology will be assessed. Specifically, it is suggested that training programs can make three types of changes—curricular, environmental, and direct service related—to reduce student risk for, and enhance resiliency in the face of, STS.

STS: An Overview

Definitions and Characteristics

The terms STS, compassion fatigue, burn out, and vicarious traumatization have often been used interchangeably (Bell, 2003; Ben-Porat & Itzhaky, 2009; Salston & Figley, 2003). Nevertheless, while there is considerable overlap in terminology, there are subtle differences that distinguish these terms from one another. STS specifically refers to symptoms that mimic Post-Traumatic Stress Disorder (PTSD) in those professionals who work with victims of trauma (Baird & Kracen, 2006; Bell, 2003), while compassion fatigue focuses on the depletion of emotional, physical, and spiritual strength of human service workers due to their great expense of empathy for their client (Merriman, 2015). Essentially, the term STS focuses on specific symptoms, while compassion fatigue uses a broader definition to include the counselor's overextension of empathy as a source of later symptoms. Alternatively, burn out is generally the term used to refer to emotional exhaustion, accompanied by reduced feelings of personal accomplishment, and feelings of cynicism that interfere with an individual's ability to adequately perform their job (Green, Albanese, Shapiro, & Aarons, 2014). Lastly, vicarious traumatization refers to broad and overarching negative changes in professionals' views of themselves, their work, and the world as a result of being exposed to their clients' traumatic experiences (Bell, 2003; Ben-Porat & Itzhaky, 2009; Buchanan et al., 2006). In essence, burn out focuses on the end result of emotional exhaustion—not being able to perform one's job—while vicarious traumatization refers to significant cognitive changes in professionals' world views.

As STS, compassion fatigue, burn out, and vicarious traumatization all refer to emotional distress and traumatization in some way, there is understandably some overlap. For instance, symptoms of STS include

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intrusive memories of a client's trauma, hypervigilance, irritability, feelings of grief and sadness, difficulty sleeping, difficulty concentrating, avoidance of traumatized clients and traumatic material, and reductions in compassion or empathy for traumatized clients (Collins & Long, 2003; Figley, 2002). Not surprisingly, mental health professionals who experience STS suffer from high rates of burnout and dissatisfaction in their work (Collins & Long, 2003). Because of these symptoms of STS, they may also experience compassion fatigue (Figley, 1995).

It is not surprising that as a result of these STS symptoms, mental health professionals may attempt to cope in destructive ways. For instance, they may detach from their clients in attempts to avoid further traumatization, or they may overly identify with clients, attempting to exert control over overwhelming material and taking responsibility for their clients' well-being (Collins & Long, 2003). Overly identifying with clients is particularly troublesome as it can lead to clients censoring what they share in attempts to protect their therapists from the pain of their traumas.

Risk Factors

Several studies have indicated that a significant portion of human service workers, mental health professionals in particular, experience STS (Birck, 2001; Cieslak et al., 2013). Cornille and Meyers (1999) found that 37% of their sample of 183 child protective workers showed clinical levels of STS (Birck, 2001). Among 126 master's level outpatient and inpatient social work professionals, Alenkin (2011) found that 60% experienced symptoms of STS (Kintzle, 2013). Kintzle, Yarvis, and Bride (2013) found that 59% of their sample (n = 70) endorsed at least one symptom of STS, with 33% of their sample endorsing 5 or more symptoms and 8% endorsing symptoms at a moderate to severe level.

Because STS appears to be occurring at such an alarming rate and not only affects the mental health professional, but also can lead to residual effects on clients, it is important to note the risk factors involved. These risk factors include extreme empathy for clients (Baum, Rahav, & Sharon, 2014; Bell, 2003), emotional contagion (Baum et al., 2014), gender (Kassam-Adams, 1995), a history of trauma (Bell, 2003), a lack of experience in working with trauma (Morrison, 2007), a large caseload of traumatized clients (Buchanan et al., 2006), and a lack of workplace support (Schauben & Frazier, 1995).

Extreme empathy for clients can lead to STS, as the pain of the client is deeply felt by the practitioner (Baum et al., 2014). While empathy for a client is generally thought to be a positive characteristic of practitioners, it can become a problem when practitioners begin to place themselves in their traumatized client's shoes and in so doing begin to exhibit PTSD-like symptoms (Bell, 2003). As it stands, "Educators have not been as effective in teaching students about the potential personal hazards in using empathy with clients who have experienced trauma" (Nelson-Gardell & Harris, 2003, p. 6). Teaching students and trainees about this potential hazard would conceivably allow trainees to become aware of the risk and the symptoms should they begin to experience them.

Along with empathy, emotional contagion may also play a factor in increasing vulnerability to STS (Baum et al., 2014). Emotional contagion refers to the degree to which being around individuals with certain emotions causes one to begin feeling those same emotions. Thus, when a client experiences deep emotions after a trauma, the practitioner may begin to internalize some of those emotions, developing STS.

Gender is another risk factor for the development of STS. Just as research has shown the female gender to be a risk factor for PTSD (Brewin, Andrews, & Valentine, 2000), researchers have also found that women are especially vulnerable to STS (Baum, 2014). It is theorized that in regards to STS, it is by virtue of women consistently scoring higher on measures of empathy and emotional contagion than men that they are more vulnerable to developing STS (Baum, 2014; Kassam-Adams, 1995). Another reason women may be at higher risk of developing STS is that many women have a personal history of interpersonal trauma (Tang & Freyd, 2012).

Those with a history of trauma, such as childhood abuse, may be at greater risk for experiencing symptoms of STS (Bell, 2003; Cunningham, 2003). This is an important factor to consider given that it has been estimated more than one-third of mental health professionals have experienced childhood abuse (Buchanan et al., 2006). The current literature on STS for those with a history of trauma is somewhat limited, however (Zerubavel & Wright, 2012). Because the symptoms of STS are the same as PTSD, with the difference being the

origin of the trauma, future research should take care to distinguish between STS and PTSD in providers with a history of trauma. If clinicians exhibit re-experiencing symptoms, such as nightmares or flashbacks, it is important to assess if these symptoms are related to a personal trauma or the trauma of their client. If the symptoms are related to the client's trauma, this would be considered STS, and not PTSD (Collins & Long, 2003).

It is important to note that a history of trauma does not necessarily lead to STS. In fact, Follette, Polusny, and Milbeck (1994) determined that mental health professionals who had dealt with personal trauma evidenced a higher degree of positive coping skills when faced with client trauma than did those without a personal history of trauma. The authors concluded that personal trauma experiences force people to develop the coping skills necessary to deal adaptively with traumatic material.

Not having developed coping skills to deal with trauma may be one reason that inexperience in working with traumatized individuals is a risk factor for STS. Accordingly, trainees and beginning mental health professionals are at heightened risk for STS (Schauben & Frazier, 1995). This is also why a lack of support is a risk factor for STS. Without proper guidance and support, individuals who have never experienced working with traumatized clients may quickly become overwhelmed. Workplace support, in general, is very important in preventing STS and decreasing the feelings of isolation that often develop as a consequence (Schauben & Frazier, 1995). A workplace environment that discourages open communication about therapist emotions, distress, and need for self-care greatly increases the odds of STS (Schauben & Frazier, 1995).

The number of traumatized individuals on any given mental health professional's caseload is also related to the likelihood of developing STS (Buchanan et al., 2006; Meyers & Cornille, 2002). Similarly, the severity of the trauma clients have experienced may be related to the likelihood of therapists developing symptoms. Indeed, as Buchanan and colleagues (2006) found, repeated exposure to the graphic details of clients' trauma stories, particularly those involving interpersonal violence, increases the likelihood of mental health professionals developing STS (Bober & Regehr, 2005). Working with traumatized children may also put therapists at an even greater risk for STS symptoms than working with traumatized adults (Beaton & Murphy, 1995).

Because STS is defined by symptoms of PTSD, it is reasonable to hypothesize that risk factors for PTSD may play a part in the development in STS. Future research is needed to fully assess this hypothesis; however, it may be wise for clinicians and those in charge of training clinicians to bear in mind the risk factors for developing PTSD. These risk factors include socioeconomic status, age, type of trauma experienced, exposure to general life stressors, tendency towards avoidance coping, level of education, psychiatric history, and race (Brewin, Andrews, & Valentine, 2000; Sareen, 2014).

In sum, the research on STS indicates that extreme empathy (Baum et al., 2014; Bell, 2003), emotional contagion (Baum et al., 2014), gender (Kassam-Adams, 1995), a personal history of trauma (Bell, 2003), a lack of experience in working with trauma (Morrison, 2007), a lack of workplace support (Schauben & Frazier, 1995), and a large caseload of traumatized clients (Buchanan et al., 2006) are all risk factors for developing STS.

Protective Factors

Though there are many risk factors for STS, there are also protective factors that may prevent STS (Baum et al., 2014; Bell, 2003; Buchanan et al., 2006; Schauben & Frazier, 1995). These factors include training and education, experience in working with traumatized clients, and good supervision (Boscarino, Figley, & Adams, 2004; Collins & Long, 2003; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995).

Training mental health professionals regarding trauma work can prepare them for the difficulties they may not have expected. Specifically, training and education regarding the importance of self-care when working with traumatized clients, as well as the coping skills that can be employed to handle graphic and disturbing materials, can protect practitioners from becoming overwhelmed in the face of client trauma and developing STS (Eidelson, D'Allesio, & Eidelson, 2003).

In the same way that education and training can prepare mental health professionals to hear traumatic material, experience working with traumatized clients can serve as a protective factor against STS (Collins & Long, 2003). Clinicians who have already worked with traumatized clients may be aware of what to expect and, consequently, may not become as overwhelmed as those who have not previously served traumatized clients (Pearlman & Mac Ian, 1995). Longer working

hours and larger caseloads, however, have shown to increase STS, as described previously (Birck, 2011). As such, having worked with a smaller caseload of traumatized clients consistently over a longer period of time may be largely advantageous over a larger caseload of traumatized clients in a shorter period of time.

Along with education and training for STS, supervision can play a protective role by normalizing STS for the supervisee (Morrison, 2007). After all, it has been argued that STS is almost inevitable for trauma workers (Collins & Long, 2003). Researchers have shown that normalizing STS in the context of supervision in such a way as to de-stigmatize those that struggle with STS symptoms can aid in their recovery (Morrison, 2007). In addition, Salston and Figley (2013) suggest that having regularly scheduled supervision and the ability to consult with a supervisor as needed can prevent STS or even ameliorate its effects. Thus, quality supervision that would serve as protection against STS would include supervisor normalization of STS symptoms, consistency of regularly scheduled supervision, and supervision being used for consultation purposes.

Apart from training and education, experience in working with traumatized clients, and good supervision, there may be further protective factors against STS that research has yet to fully explore. Namely, as stated above in the discussion of the risk factors for STS, the same protective factors against PTSD may play a role in protecting against STS. While future research should be conducted to support this notion, the protective factors related to PTSD can still be kept in mind. These factors include positive self-esteem, optimism, and social support (Frazier et al., 2011; Maercker & Horn, 2013).

Implications for Graduate Training Programs

Therefore, as is apparent, STS is a workplace risk for the mental health professional (Figley, 1995). Accordingly, considering that one of the fundamental goals of graduate training programs in applied forms of psychology is to provide students with the knowledge and skills necessary to excel as providers of mental health services (American Psychological Association [APA], 2013), one might assume that consideration of STS has long been a standard element of such graduate programs. However, even a quick perusal of the relevant literature (Figley, 1995; Figley, 2002; Maslach & Goldberg, 1998) and training program standards (APA, 2004, 2013) reveals this is not the case. Indeed, despite recognition over the years by leaders in the STS field of the critical role training programs could play in educating about and preventing STS (Figley, 1995, 2002), at present STS remains largely overlooked at the graduate training level. The remainder of this paper will explore how this oversight might be remedied by examining three categories of implications of STS for the graduate programs in psychology responsible for training mental health professionals—curriculum implications, program environment implications, and departmental direct service experience implications.

Curriculum Implications

According to the APA's (2010) Ethical Principles of Psychologists and Code of Conduct—the foremost ethics code in the mental health professions and the code to which all psychologists are held—it is the responsibility of graduate training programs in psychology to "take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge" (p. 9). There is little question that knowledge of STS is appropriate knowledge for any graduate student planning to pursue work in the clinical arena. Estimates indicate that among those most likely to seek mental health services, rates of trauma exposure are high (Craine, Henson, Colliver, & MacLean, 1988; Hanson, Hesselbrock, Tworkowski, & Swan, 2002; Mauritz, Goossens, Draijer, & van Achterberg, 2013), and, as demonstrated above, routine provision of mental health services to traumatized individuals results in the development of STS for a significant minority of mental health professionals (Cieslak et al., 2014).

Consequently, one of the foremost implications of STS for graduate training programs in psychology is the necessity of incorporating teaching on STS into the curriculum (Figley, 1995). In regards to the form this teaching might take, several topic areas seem particularly relevant. For one, students should be informed of the symptoms of STS (Figley, 2002), as well as the risk and protective factors. Provision of such information has the potential to markedly diminish the impact of STS on mental health professionals, for clinicians equipped with knowledge of STS during their graduate training would be better able to quickly recognize and address

the symptoms of STS should they develop the condition. Moreover, knowledge of the risk and protective factors would enable students to begin remediating any risk factors they might possess and enhancing their protective factors while still in training, in turn, lessening their chances of developing STS upon their entrance into the field as licensed clinicians.

Another relevant topic area graduate training programs in psychology should consider incorporating into their teaching on STS involves the client factors associated with heightened risk of mental health professionals developing STS. As mentioned previously, research suggests that client age matters, such that those mental health professionals who work with traumatized children are more likely to develop STS than are those who work with traumatized adults (Beaton & Murphy, 1995). Further, there is evidence to suggest that risk of STS varies by the etiology of clients' trauma. For example, a number of studies have demonstrated that engagement with clients who are victims of interpersonal violence (e.g., intimate partner violence, child abuse, rape, torture) is particularly likely to incite STS in mental health professionals (Bober & Regehr, 2005). Equipping students with this knowledge while in graduate school would permit them to make judicious choices as to the various types and combinations of trauma survivors they elect to treat once operating in the field as licensed clinicians.

A final topic area graduate training programs in psychology would be remiss not to integrate into their teaching on STS concerns cultural considerations. There is a substantial body of literature indicating that PTSD manifests differently in different cultural groups. Avoidance and numbing symptoms, for instance, have been found to be a relatively uncommon manifestation of PTSD in non-Western settings (Hinton & Lewis-Fernandez, 2011). Conversely, both Palinkas, Petterson, Russell, and Downs (2004) and Hinton, Hinton, Pich, Loeum, and Pollack (2009) determined that manifestation of PTSD in the form of frightening nightmares occurs far more frequently in non-Western settings. Somatic symptomology also appears to be considerably more common in certain cultural groups than in others (Hinton & Lewis-Fernandez, 2011). Although study of cultural variation in symptomology has not yet been extended explicitly from PTSD to STS, given the marked parallels between the two conditions there is every reason to believe that manifestation of STS varies by cultural background as well (Baird & Kracen, 2006; Bell, 2003). Accordingly, graduate training programs in psychology would be wise to include information on these cultural variations as part of their teaching on STS so as to ensure that trainees of divergent cultural backgrounds are informed regarding how STS may influence them differentially due to their distinctive heritage.

A second curricular implication of STS for graduate training programs in applied forms of psychology concerns the inclusion of at least some specialized trauma training as a standard element of the curriculum. As mentioned previously, the rates of trauma exposure and trauma-related disorders among those who seek mental health treatment are high (Craine et al., 1988; Hanson et al., 2002; Mauritz et al., 2013). Subsequently, it is safe to assume that the preponderance of mental health professionals will be exposed to client trauma at some point in their careers. Therefore, given the evidence that suggests specialized trauma training protects mental health professionals against STS development when faced with client trauma (Eidelson et al., 2003; Ortlepp & Friedman, 2002), it seems that inclusion of this training into graduate training programs as a fixed curricular element would prove beneficial for the vast majority of students.

Environment Implications

The existence of STS as a work-related hazard for mental health professionals also has compelling implications for the departmental environment cultivated by graduate training programs in psychology. For many students, departmental practicum experiences constitute their first real and sustained exposure as clinicians to the world of direct service provision. Consequently, it is probable that for a sizable portion of students, this experience is largely responsible for shaping their perception of the features that comprise an appropriate work environment for mental health professionals. While this is a heavy responsibility for training programs, it can also be regarded as a prime opportunity to model for students the type of work environment research has shown functions as a protective factor against STS (Boscarino et al., 2004; Orltepp & Friedman, 2002). For example, Morrison (2007) determined that a supportive, open workplace environment in which workers are encouraged to dialogue with their colleagues about

the feelings and fears that arise in response to work with traumatized clients protects against STS. Likewise, Coster and Schwebel (1997) highlighted the importance of workplace environments that purposefully endeavor to normalize, and thus to destigmatize, STS. Similarly, Moran (2002) emphasized the value of workplace environments in which humor is embraced. Consistent, widespread efforts by graduate training programs in psychology to cultivate a workplace environment in their own training clinics that exudes these protective factors would undoubtedly produce great dividends, as it would equip students with first-hand awareness of what a healthy workplace looks like. This, in turn, would enhance students' ability following graduation to identify and avoid STS facilitative workplace environments.

A starting point for programs aiming to institute the aforementioned environmental changes might be to execute a confidential survey of students for purposes of ascertaining student perceptions of the department climate. That is, do students perceive that open discussion of the feelings and fears they experience in response to their work with traumatized clients is welcomed and will not reflect poorly on their clinical evaluations? Likewise, do students report that appropriate humor is embraced and cultivated by clinical faculty or do they regard stoicism as the norm? Programs could then use the information gleaned from these surveys to structure their approach to instituting necessary environmental changes. The specific form these changes take will depend on the distinctive environmental weaknesses that are identified, as well as on the available resources and skill set possessed by department personnel.

Departmental Direct Service Implications

The final category of implications of STS for graduate training programs in psychology concerns the direct service experience students accrue through required participation in departmental training clinics (APA, 2013). There is no reason to assume that students working with clients in such clinics are immune to STS. Rather, quite to the contrary, it is probable that students working in these settings are actually more susceptible to STS than is the average licensed professional working in the field. Research has repeatedly demonstrated that lack of experience working with traumatized individuals is a risk factor for STS development (Abu-Bader, 2000; Cunningham, 2003; Pearlman & Mac Ian, 1995), and graduate students—as a consequence of their status as students in training—inherently possess minimal hands-on experience providing mental health services to all types of clients, traumatized clients included.

The fact that students working in departmental training clinics may be at heightened risk of developing STS due to their limited clinical experience implies that the graduate programs that house these clinics need to make special efforts to operate the clinics in such a way that risk of student development of STS is minimized. Fortunately, there are a number of steps graduate programs can take to decrease the likelihood that their students will develop STS as a consequence of providing services in the departmental clinic. For example, both Boscarino and colleagues (2004) and Ortlepp and Friedman (2002) established that quality supervision is a major STS preventative factor. This indicates that graduate training programs should ensure all students engaged in departmental clinic work are provided with regular, quality supervision in which discussion of the personal effects of exposure to client trauma is encouraged. Correspondingly, careful client screening is crucial in order to prevent students from being assigned clients whose trauma level warrants treatment by a professional with more experience than is possessed by most beginning clinicians. Lastly, in light of the strong relationship between high caseloads and STS (Kadambi & Truscott, 2004), it seems prudent for training clinic leadership to carefully monitor student caseloads in an attempt to protect students from becoming so overwhelmed that STS ensues.

A related concern involves whether graduate training programs should routinely assess students for STS during their tenure in departmental training clinics. On one hand, such assessment seems warranted. After all, the licensed professionals who administrate departmental training clinics have a responsibility to protect the clients served within those clinics from harm (APA, 2010) and, as has previously been established, STS has great potential to impair the quality of the services that a mental health professional provides (Collins & Long, 2003; Figley, 1995, 2002). On the other hand, institution of department-wide screening procedures for STS—particularly if certain screening results are associated with student remediation—could cultivate a department climate in which students conceal their symptoms, thereby diminishing the likelihood that those students

suffering from STS will receive the assistance of which they are in need. Therefore, due to the ethical complexities involved, graduate training programs in psychology should approach the implementation of routine STS screening in departmental clinics with much foresight and deliberation, taking special pains to consider and balance the needs of both clients and trainees.

Conclusion

In closing, the experience of STS and its very troubling symptoms, is a distinct possibility for all individuals who devote their professional efforts to providing mental health services to hurting people (Cieslak et al., 2014). Accordingly, it only makes sense that education about and prevention of STS should become a standard element of every psychology graduate program responsible for training mental health professionals. As detailed above, three types of changes training programs could begin to make immediately to better equip students concerning STS involve curricular changes, department environment changes, and direct service experience changes.

Given that these proposed forms of change have received limited attention in the research literature, future research efforts should be aimed at evaluating their effectiveness and practicality from an empirical standpoint. Additionally, if and when training programs adopt the proposed changes described herein, objective and quantitative evaluation of the impact of the changes on the clinical efficacy of the students enrolled in these training programs should follow. Moreover, research aimed at ascertaining rates of STS among graduate psychology students is called for to provide a clearer picture of the extent of the impact of STS on the graduate trainee population, as is research that explores what distinguishes graduate training programs with high rates of STS among students from those with low rates.

Ultimately, the hope is that STS education and prevention will become a widespread focus of all graduate training programs in applied forms of psychology. The more students who are sent into the field of mental health work are adequately equipped to identify and successfully manage the STS, the more traumatized clients will be able to receive the services of which they are desperately in need.

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