2

Secondary Exposure to Trauma and Self Reported Distress Among Therapists

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This chapter is one of two brief reports of research on therapists who treat traumatic stress clients. Kelly Chrestman discusses the implications of her research in which she found that therapists who had higher caseloads of trauma clients reported more trauma-related symptoms and less interactions with family and friends. This is a sobering finding that challenges those of us who work with trauma. However, Chrestman also found that experience and quality of life variables were mediators for increased symptom reporting. Moreover, the increased symptoms were not necessarily representative of phobic avoidance but representative of increased awareness of true danger. If this is the case, it seems particularly important for us to identify the potential dangers to clinicians and ways of positively mediating unwanted affects.

Vicarious traumatization (McCann & Pearlman, 1990), contact victimization (Courtois, 1988), or secondary post traumatic stress reaction (Dutton & Rubenstein, 1995; Figley, 1995) are terms which have been used to describe disruptive and painful psychological effects which may develop

in mental health professionals who work with survivors of traumatic events. These effects have been distinguished from more general concepts, such as countertransference and burnout, in that the secondary post-traumatic stress reaction is a response to characteristics of disclosed traumatic events which the therapist has not experienced directly (Danieli, 1985). Secondary traumatization in therapists has been hypothesized to include symptoms which have been observed in trauma survivors themselves including intrusive imagery related to the client's traumatic disclosures (Courtois, 1988; Danieli, 1988; Herman, 1992; McCann & Pearlman, 1990), avoidant responses (Blank, 1985; Courtois, 1988; Dutton, 1992; Haley, 1974), physiological arousal (McCann & Pearlman, 1990; Dutton & Rubenstein, 1995; Figley, 1995), other somatic complaints (Herman 1992a, 1992b), distressing emotions (Blank, 1985; Courtois, 1988; Herman, 1992a, 1992b; Margolin in Herman 1992b; Scurfield, 1985), addictive or compulsive behaviors (Crews, Polusny, Milstein, Arkowitz & Follette, 1992; Dutton & Rubenstein, 1995; Figley, 1995; Herman, 1992b; McCann & Pearlman, 1990), and functional impairment (Dutton & Rubenstein, 1995; Figley, 1995; Herman, 1992b; McCann & Pearlman, 1990). Overall distress is hypothesized to be mediated by risk and resiliency factors which include the therapist's personal characteristics, characteristics of the client and the trauma, the therapist's attempts to cope, and the environment in which the therapy takes place (Dutton & Rubenstein, 1995; Figley, 1995).

To test this model a survey methodology was employed and questionnaires were mailed to therapists belonging to the International Society for Traumatic Stress Studies (ISTSS), the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D), and the American Association of Marital and Family Therapists (AAMFT). Response packets consisted of a variety of questionnaires designed or selected to assess personal and professional history, psychological symptoms, cog-

nitive schemata, coping behaviors, and behavior changes. In short, it was predicted that therapists reporting secondary exposure to trauma would endorse more distress/symptoms on measures of trauma specific responses, and more negatively valenced cognitions on measures of cognitive schemata than therapists who do not report secondary exposure. It was also expected that relevant personal and contextual variables would mediate the relationship between secondary exposure and negative outcome.

EMPIRICAL EVIDENCE

Results supported these expectations for the most part. First, a predictable relationship between secondary exposure and psychological distress change was demonstrated. Specifically, secondary exposure to trauma was associated with increased symptoms of intrusion and avoidance on the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979) and increased symptoms of dissociation and sleep disturbance on the Trauma Symptom Checklist (Elliot & Briere, 1991). While scores did not reflect symptomatology in the clinical range, they indicated a level of distress which was significantly different from therapists who did not experience secondary exposure.

Second, several variables appeared to have a mediational relationship between secondary exposure and therapist distress. Specifically, increased professional experience was associated with decreased avoidance, dissociation, anxiety, and sexual abuse trauma symptoms; increased income was associated with decreases in all symptom measures; utilization of additional training, as assessed by number of CEUs obtained, was associated with decreased avoidance; increased percentages of trauma clients in the caseload was associated with increased levels of dissociation, anxiety, sexual abuse trauma symptoms, and intrusion; higher percentages of time spent in general clinical activities relative to other activities was associated with increased

avoidance; and higher percentages of time spent in research activities was associated with decreased avoidance.

Third, there were no significant differences in cognitive schemata when assessed directly through the World Assumptions Scale (Janoff-Bulman, 1989). However, therapist behaviors related to safety schemata endorsed on a modified form of the Behavior Change Checklist (Mac Ian & Pearlman, 1992) changed relative to the amount of time spent with trauma clients. In this sample, as the percent of clients in the caseload increased, therapists decreased their children's activities away from home, decreased so-called "risky" behavior, felt less comfortable when seeing clients in the office alone, increased checking of doors, and increased listening for noises. These behaviors are clearly related to safety of self and significant others and can be construed as representative of the impact of secondary exposure on safety-related cognitions of therapists.

Other behaviors which varied with the percent of trauma clients in the caseload included talking to family or friends about work and attending professional activities. Those with higher ratios of trauma clients talked less to family and friends about work and attended more professional conferences and activities. These behaviors may represent an attempt to protect significant others from exposure to secondary trauma by restricting disclosure and by seeking other forums for discussion of trauma therapy. They also reflect a therapist's sense of isolation or alienation related to the extreme nature of his or her work. Seeking out other trauma therapists through conferences and professional activities may represent an attempt to identify with similar others and to regain a sense of community.

In summary, therapists experiencing secondary exposure were more likely to report slight increases in trauma-related symptomatology and to report increased efforts to protect themselves and their families from harm. As professional experience, income, and post-graduate training increased, symptom reports decreased. Other risk factors associated with increased symp-

toms were higher ratios of clinical versus non-clinical activities and higher percentages of trauma clients in the caseload. Thus, the increase in symptomatology appears to be related to both the percentage of time spent in clinical activities generally and time spent with trauma clients specifically.

IMPLICATIONS

It should be noted that mean symptom scores do not fall in the clinical range. Further, changes in safety behaviors may represent increased awareness of true danger rather than phobic avoidance as the behavior changes are not associated with extreme measures of avoidance on the symptom measures.

This is not to say that most trauma therapists are immune to secondary trauma. Many therapists reported episodes of extreme distress from which they recovered, but which were overwhelming to them for a short period of time. For these therapists, more extreme distress after secondary exposure to trauma appeared to be an acute, rather than chronic phenomena from which they were able to recover with accessing unusual means of coping.

In addition, though mean symptom scores were within normal limits, there were also some therapists in this sample who experienced extreme and enduring distress related to secondary exposure to trauma. This was reflected in higher levels of symptomatology on trauma symptom measures and by narrative responses to open-ended queries included in the questionnaire. Several described extreme distress and debilitating anxiety reactions which necessitated treatment and in some cases resulted in career changes. While such extreme and long-lasting responses were few, they represent an extreme form of secondary stress response.

In seeking to minimize the impact of secondary exposure on therapists, this study supports suggestions for therapist self-care offered by this text and others (McCann & Pearlman, 1990; Dutton & Rubenstein, 1995; Figley 1995). Increased supervi-

sion and support for beginning trauma therapists seems particularly important. In this sample, less experienced therapists suffered the greatest distress. This is not surprising when they experience repetitious trauma, albeit secondary, during a critical period in their professional development. This, combined with data from many sources which suggest therapists report a higher percentage of childhood and other types of trauma than the general population, supports the notion that trauma, or the secondary experience of trauma, has the potential to alter the development of therapists in significant ways.

These data also suggest that certain periodic participation in training activities may perform an important mediating function for trauma therapists. While acquisition of skills and knowledge is the obvious benefit of participation, increased social/professional support and identification of a referral network may help to decrease feelings of isolation and overwhelming responsibility. These activities do not necessarily require a trauma focus. In this sample, the number of non-trauma specific CEU credits was associated with decreased anxiety symptoms.

Participating in a variety of activities rather than engaging in full-time clinical work with trauma survivors appears advisable. This can be accomplished by varying the caseload to include non-trauma cases. It may also involve including non-clinical activities in the professional repertoire. For example, participation in research activities may act as a mediator by necessitating a decrease in clinical contact and by possibly providing a means of thinking about clinical issues from a less interpersonal frame of reference.

Finally, it is important that other sources of life stress be minimized. In this study, income was a salient factor, but it is likely that other, more general sources of stress not assessed in this study may affect the resources of the trauma therapist. These include, but are not limited to, physical health of self and significant others, general job satisfaction, and satisfaction with family and interpersonal relationships. While these suggestions are based on

data collected from therapists who work with trauma survivors, they do not represent a departure from what would be considered adequate self-care for any therapist, or indeed, any person.

A limitation of this study is the extent to which existing measures, designed to investigate symptomatology among survivors of trauma, are sensitive enough to detect differences among mental health professionals with secondary exposure. The differences that were detected do not reflect levels of symptomatology in the clinical range overall, although some subjects did received scores comparable to clinical samples. This suggests that differences, if they do exist, will be less extreme and will require more sensitive measurement techniques if they are to be detected. It is also possible that more extreme distress after secondary exposure to trauma may be an acute, rather than chronic, phenomena in therapists. The current approach may have failed to detect extreme distress because questions were too general, and because specific reactions and responses to specific incidents of secondary exposure were not queried. It will be important in future investigations to collect information about the temporal relationship between secondary exposure and therapists' distress.

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