Secondary Traumatic Stress Reactions: A Review of Theoretical Terms and Methodological Challenges

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Introduction

The field of traumatology, particularly the study of secondary traumatic stress reactions, is a relatively new area of scientific inquiry which often presents methodological issues with the reliable measurement of this concept (Figley, 2002). The literature in this area lacks a universally-accepted definition describing a *secondary traumatic stress reaction*. *Secondary traumatic stress, vicarious traumatization* and *compassion fatigue* are currently used interchangeably in the literature when describing this phenomenon. The need to establish clarity regarding the construct validity of these terms is one of the most pressing methodological issues in this area. This paper provides a review of the concepts in the literature describing secondary traumatic stress reactions and a discussion of the differences between these concepts.

Theoretical Terms

There are three common terms used in the literature describing the negative psychological reactions mental health professionals may experience when working with traumatized clients or patients: vicarious traumatization (VT), secondary traumatic stress (STS), *and compassion fatigue (CF)* (Rothschild & Rand, 2006). The terms *secondary victimization, co-victimization, secondary survivor,* and *emotional contagion* have been used less frequently in the literature to describe these same reactions (Stamm, 1999). The similarities and differences between the three most common terms (vicarious traumatization, secondary traumatic stress, and compassion fatigue) will be described in detail below. Although these terms are used interchangeably in the literature and are similar in nature, there are subtle differences in their conceptualizations which warrant clarification.

Vicarious Traumatization

The term *vicarious traumatization* was first introduced in the literature in 1990 by McCann and Pearlman in *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims* (McCann & Pearlman, 1990). These two authors were the first to clinically describe the effects of trauma as "vicarious" meaning mental health professionals treating trauma victims could actually experience the client's trauma (or other psychological reactions) themselves in the process of treatment. The term vicarious traumatization describes "a process of change resulting from empathic engagement with trauma survivors" (Pearlman & Saakvitne, 1999 p. 52). Pearlman describes trauma work as having the potential to impact the therapist's sense of self, world view, and spirituality, which she collectively refers to as the therapist's "frame of reference" (McCann & Pearlman, 1990; Pearlman, 1998; Pearlman & Saakvitne 1995). Changes in a therapist's *sense of self* refer to disruptions in their personal sense of identity(ies), such as identifying oneself as a helper, parent, or spouse. Disruption of *world view and spirituality* include changes in the therapist's moral principles and religious beliefs and faithfulness (McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1998; Stamm, 1999).

Other resources vulnerable to disruption by work with trauma victims include ego resources and cognitive schemata. Ego resources refer to an individual's ability to manage both

their own intrinsic psychological needs and the ability to manage the extrinsic interpersonal needs of others (Young, Klosco, & Weishaar, 2003; Pearlman, 1999). Vicarious traumatization results in a disruption in the therapist's ability to provide care for both themselves and the client, essentially, their psychological resources and abilities for care are depleted. The term *cognitive schema* refers to the therapist's personal feelings about him or herself and includes their orientation to the world around them (Young, Klosco, & Weishaar, 2003). Therapists working with victims of trauma are particularly vulnerable to disruptions in their sense of safety, trust, esteem, intimacy, and control (McCann & Pearlman, 1990; Pearlman & McCann, 1995; Pearlman & Saakvitne, 1995).

Secondary Traumatic Stress

The term *secondary traumatic stress* was first introduced into the literature by Charles Figley in his early works examining the psychiatric symptoms associated with post traumatic stress disorder (Figley, 1995). As a result of working with individuals diagnosed with post traumatic stress disorder, Figley noted that the trauma literature (including treatment models) only addressed the primary trauma victim- excluding family members, friends, and other members of the victim's support system (Figley, 1995). Figley subsequently sought to identify the psychological maladjustment that many spouses, family members, and friends experience as *secondary* victims of trauma (Figley & Barnes, 2005; Figley & Nash, 2007). This also provoked a separate area of concern for mental health professionals working with the trauma victims in clinical practice (Figley, 2002). The concern for mental health professionals led to the introduction of two very important research questions; first, does treating victims of primary trauma lead to secondary trauma, and second, how similar are the symptoms between primary and secondary trauma?

In his early work, Figley referred to this phenomenon as *catastrophic stress reaction* and *traumatization by concern* (Figley, 1995). In 1995, with the publication of *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder,* Figley introduced his conceptualization of these two terms (i.e. compassion fatigue and secondary traumatic stress) and the corresponding symptoms. Figley defines *secondary traumatic stress* as the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995, p.7)." A secondary traumatic stress reaction may also result from engaging in an empathic relationship with a significant other (or client) suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that particular person's trauma (Figley, 1995).

Figley's definition of secondary traumatic stress is very similar to Pearlman's definition of vicarious traumatization; however, there are differences in the conceptualization of the two concepts. Pearlman's conceptualization and framework for vicarious traumatization involves both a psychodynamic and cognitive perspective and describes the phenomenon as a process resulting from empathic engagement in which the outcome is vicarious traumatization (McCann & Pearlman, 1990; Pearlman, 1998; Pearlman & Saakvitne 1995). Figley's conceptualization of secondary traumatic stress is grounded in the field of traumatology and places more emphasis on the behavioral symptoms (Figley, 1995). Figley argues that psychological and behavioral symptoms of secondary traumatic stress actually mirror symptoms of posttraumatic stress and the experience of a secondary traumatic stress reaction may include a full range of PTSD symptoms, including intrusive thoughts; traumatic memories, or nightmares associated with client trauma;

insomnia; chronic irritability or angry outbursts; fatigue; difficulty concentrating; avoidance of clients and client situations; and hypervigilant or startle reactions toward stimuli or reminders of client trauma (Figley, 1995).

Compassion Fatigue

The term compassion fatigue, also often used interchangeably in the literature with secondary traumatic stress and vicarious trauma, is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout (Figley, 1995). Although these two terms are used interchangeably in the literature, I believe they are actually two different phenomenon and warrant separate investigation. A mental health professional experiencing secondary traumatic stress typically develops this reaction as a result of working with traumatized clients and the secondary exposure to the client's trauma during the treatment process (Figley, 1995, 2002; Stamm, 1999). Compassion fatigue is a more general term describing the overall experience of emotional and psychological fatigue that mental health professionals experience due to the chronic use of empathy when treating patients who are suffering in some way (Figley, 1995, 1999). For mental health professionals who treat victims of trauma, secondary traumatic stress may contribute to the overall experience of compassion fatigue; however, mental health professionals who treat populations other than trauma victims (such as the mentally ill) may also experience compassion fatigue without experiencing secondary traumatic stress.

Countertransference

The phenomenon of countertransference has also been compared to secondary traumatic stress in the research literature; much like secondary traumatic stress there are varying approaches in the literature describing the concept of countertransference (Figley, 1995; Pearlman & Saakvitne, 1995; Rothschild & Rand, 2006). Countertransference is generally associated with the psychoanalytic school and was introduced by Freud to describe the influence of the psychoanalyst's conscious and subconscious feelings on the relationship and interaction with the patient (Rothschild & Rand, 2006). Freud felt the mind of the analyst should be like a "blank slate" allowing the patient to "transfer" his or her neurotic feelings onto the analyst for interpretation uncomplicated by the analyst's own interpersonal conflicts and neuroses (Rothschild & Rand, 2006; Appignanesi & Zarate, 1979). Freud recognized that it would be impossible to completely block all conscious and subconscious feelings from the patient and described the existence of these reactive feelings by the analyst as "countertransference" (Rothschild & Rand, 2006; Appignanesi & Zarate, 1979). There is variation in the literature regarding what constitutes a countertransference reaction between a therapist and a patient. Pearlman and Saakvitne (1995) describe the process of countertransference in two different ways, (1) as an "affective, ideational, and physical response a therapist has to his or her client, the client's clinical material, transference, and reenactments, and (2) the therapist's conscious and unconscious defenses against the effects, intrapsychic conflicts, and associations aroused by the former (Pearlman & Saakvitne, 1998 p. 23)."

Figley (1995) describes countertransference as "a distortion on the part of the therapist resulting from the therapist's life experiences and associated with his or her unconscious, neurotic reaction to the client's transference (Figley, 1995, p. 9)." Figley argues that in it's truest form, as defined by Freud, countertransference is a reaction that should only occur within the context of psychotherapy (Figley, 1995; Sexton, 1999). Essentially, in order for

countertransference to occur, there first has to be some form of transference, which is typically associated with psychoanalysis. Secondary traumatic stress may occur in any person involved in a relationship with a traumatized person (therapist, family member, friend, and co-worker) and is not limited to therapeutic interactions, which is the case with psychoanalysis. Countertransference also represents the process of displacing the analyst's conscious and subconscious neuroses onto the patient; secondary traumatic stress may occur regardless of the individual's inner neuroses and does not necessarily involve the displacement of inner neuroses onto the traumatized person (Sexton, 1999; Figley, 1995). Lastly, secondary traumatic stress occurs when working with victims of primary trauma, however, countertransference may occur in psychoanalytic process with an individual suffering from any type of mental illness and is not limited to trauma victims.

Methodological Challenges

The lack of consensus regarding the specific meaning and parameters of a *traumatic stress reaction* has hindered the methodological development of this area (Farrell & Turpin, 2003; Sexton, 1999). These terms are currently used in the research literature interchangeably as if they were one phenomenon with different names (i.e. cup and glass). Therefore, one major methodological question in this area is whether these phenomenons (or conditions) actually exist as they are currently defined, and do they exist independently of one another; or are all of these terms referring to the same experience? Because there are various theoretical terms in literature describing secondary traumatic stress reactions, there is great difficulty determining whether instruments claiming to measure this phenomenon have any psychometric value. Furthermore, the instruments in existence that do claim to measure secondary traumatic stress reactions have not been rigorously tested for psychometric validity. For example, there is still some speculation that scales such as the Compassion Fatigue Self-Test (Figley & Stamm, 1996) are actually measuring other pre-existing theoretical constructs, such as professional burnout, rather than compassion fatigue. It has been suggested that it may simply be too difficult to develop a standard measure of secondary traumatic stress due to the extensive co-morbidities that may exist between secondary traumatic stress and other anxiety and/or mood disorders (Dunkley & Whelan, 2006). Additionally, the impact of the working environment and other non-trauma related stressors on the effects of secondary traumatic are also difficult to control when attempting to obtain a true measure of this phenomenon.

Conclusion

In order to provide a clear understanding of the current theoretical concepts in this area, it was best to discuss the most commonly used concepts in the literature individually, rather than discussing the phenomenon of traumatic stress reactions as one entity combining *vicarious traumatization, secondary traumatic stress, compassion fatigue* and others. Based on a careful review of this literature, my interpretation is that although these concepts are similar, they may in fact be independently occurring phenomenon. In other words, it may be possible to suffer from compassion fatigue but not necessarily secondary traumatic stress. One might also experience a change in their cognitive self as described by vicarious traumatization, but not experience compassion fatigue or secondary traumatic stress. The meshing of these terms makes it very difficult to reliably measure these phenomenons in trauma workers. In addition to conceptual issues, there is a lack of strongly validated instruments for measuring these concepts, which further limits reliable research in this area. The development of well standardized instruments to

measure secondary traumatic stress and compassion fatigue should be a priority for future research agendas. Finally, the conceptual differences presented in this paper between the terms secondary traumatic stress, compassion fatigue, and vicarious traumatization should caution researchers attempting to measure these phenomenon to be good consumers of research instruments and methodology (i.e. *caveat emptor*).

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