Predictive Factors of Secondary Traumatic Stress for Social Workers

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Since the 1980s, when trauma researchers studied victims of disaster, Secondary Traumatic Stress (STS) has emerged as a growing issue in social work practice settings (Figley, 1983). Figley (1999) defines STS as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and resulting from helping or wanting to help a traumatized or suffering person" (p.10). Social workers who interact with traumatized populations (defined as any population that has experienced such trauma as violence, crime, natural disaster, or war) are strongly vulnerable to STS (Canfield, 2005; Ochberg, 1988). Working with traumatized clients not only challenges the emotional balance of social workers, but also makes them more vulnerable to overwhelming anger and/or sadness (Herman, 1992).

The symptoms of STS, which parallel those of PTSD, include the following: (1) re-living the client's traumatic event through thoughts, feelings, and imagery; (2) avoiding or feeling numb to emotions that remind one of the event; and (3) experiencing heart palpitations, sweating, or sleep disturbances. STS is triggered when helping professionals empathetically engage with their clients who have endured traumatic histories and/or experiences (Canfield, 2005; Ochberg, 1988).

STS can have dire professional consequences for social workers. Social workers with STS may not be able to do their jobs effectively; many then choose to leave the social work profession (Harris, 1995; Pearlman & Saakvitne, 1995). Moreover, STS can lead to a high turnover in the workplace, forcing social services agencies to function with inadequate staffing. Lowering the incidence of occupational stress symptoms would enable such agencies to retain more experienced staff to better serve their clients.

In the last decade, most of the STS literature examined the salient factors, contributing to the development of STS in helping professionals. The purpose of this paper is to identify the predictive factors of STS based on the previous literature and to clarify the preventive strategies. A comprehensive literature review of documents identified through the Academic Search Premier (via EBSCO), Psych-Info and PILOTS (Published International Literature on Traumatic Stress) database identified the following factors of STS among social workers: 1) level of

exposure to traumatized clients; 2) case type; 3) personal trauma history; 4) workplace support; 5) direct trauma exposure in the workplace (client violence). In this paper, each predictor of STS through the literature review is explained and recommendations are described based on the predictive factors.

Predictive Factors of STS

Direct Exposure to Traumatized Populations

Direct exposure to traumatized populations is recognized as a predictor of STS (Baird & Jenkins, 2003; Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Schwartz, 2008). Previous studies assert that social workers who have more exposure to traumatized clients (including number of hours per client and percentage of caseloads) experience higher levels of STS (Baird & Jenkins, 2003; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). According to a study by Schwartz (2008), 182 licensed social workers who spent 75% or more of their time doing trauma- related work had substantially higher levels of STS than their colleagues who spent less time involved in trauma-related work.

Case Type

Evidence showed that the level of STS for helping professionals is different depending on the type of the clients' trauma. Some researchers have found that STS for helping professionals dealing with sexual assault is more severe than that for other field workers (Baird & Kracen, 2006; Good, 1996; Kassam-Adams, 1995; Pinsley, 2000). Treating sexual assault survivors often involves retelling very painful and graphic traumatic experiences to a therapist who is expected to remain empathic, supportive, and non-judgmental (Pinsley, 2000). Unlike emergency response teams whose exposure to trauma victims is of a short duration, sexual assault workers bear witness to years of sexual abuse and other traumas (Baird & Kracen, 2006). The findings of the research suggest that treating victims of sexual assault imposes greater demands on therapists than treating other types of traumatized clients such as those with chronic disease or victims of natural disaster (Baird & Kracen, 2006; Pinsley, 2000). Kassam-Adams (1995) studied 100 psychotherapists in outpatient mental health agencies in Virginia and Maryland and found that therapists in her sample who had a higher percentage of clients sexually abused or assaulted in their caseload tended to report more STS symptoms.

Personal Trauma History

Some research indicates that clinicians reporting their own personal trauma history show increased STS symptoms (Folette, Polusny, & Milbeck, 1994;Good, 1996; Kassam-Adams, 1995, 1999; Wrenn, 2005). Workers who have unresolved trauma or issues relating to their own victimization may find these issues triggered by their involvement with client's traumatic material (Danis, 2003; Figley, 1996; Rando, 1984). Wrenn (2005) found that having a childhood trauma history increased the risk of STS. He surveyed 250 social workers from the Illinois chapter of the National Association of Social Workers. Especially, it was found that when the social workers' personal trauma history was similar to the clients' trauma experience, secondary exposure to client trauma increased levels of STS.

Workplace Support

Previous literature on STS has identified workplace support, including the levels of supervision and co-worker coherence, as a predictive factor for STS (Dickes, 1998; Randall,

Altmaier & Russell, 1989; Slattery, 2003; Van de Water, 1996). After surveying the psychological symptoms of 79 domestic violence advocates in Massachusetts, Slattery (2003) found that more co-worker cohesion and quality of clinical supervision in the work environment leads to fewer reported STS symptoms.

Direct Trauma Exposure in Workplace (Client Violence)

Social workers might experience direct trauma in the line of duty in addition to being exposed to the trauma of their clients under their care. In a recent survey, more than half (57.6%) of the social workers questioned admitted to receiving such threats (Dalton, 2001). According to some studies, threats and/or abuse from a client or a member of a client's family are predictors of STS for social workers (Dalton, 2001; Horwitz, 1999; Newhill, 1995; Spencer & Munch, 2003; Wrenn, 2005). For example, in the study by Cornille and Meyers (1999), which assessed STS symptoms among a sample of 183 child protective service (CPS) workers, it was found that the majority of the CPS workers (78%) had been assaulted or threatened by a client while on the job. The study showed that having experienced the trauma on the job by CPS workers contributed to increasing STS symptoms in the CPS workers.

Conclusion and Recommendations

Because direct exposure to traumatized populations and severe cases, personal trauma history, inadequate workplace support, and client violence are predictors of STS, it is imperative that social agencies take steps to reduce these factors. Based upon the information presented in this paper, three recommendations are offered for ways to prevent STS in social workers (Joslyn, 2002; Nelson-Gardell & Harris, 2003): (1) Administrators of social agencies should establish support systems, including regular supervisory meetings, to give social workers an outlet for their emotions; (2) Agency administrators should more carefully monitor each social worker's caseload and then rotate social workers out of particularly tough assignments to reduce the degree of exposure to traumatized clients and severe cases; and (3) Agency administrators should institute in-service training sessions that teach social workers the skills needed in treating STS. It is vital that individual social workers make an effort to lessen the effects of STS. To do so, four strategies are recommended. First, self-care techniques of self-reflection and self-monitoring allow social workers to better assess their feelings and reactions to trauma exposure. Second, the informal support from trusted colleagues lets social workers share their experiences and perhaps see things from a different perspective. Third, psychotherapy (talking with a trusted supervisor and/or going to a psychotherapist or a support group) provides the individual social worker with professional help. Finally, individual workers can avoid STS by setting realistic goals and by maintaining healthy boundaries in relationships with others (Badger, 2001). The implementation of these strategies will enable both agency administrators and individual workers to avoid the pitfalls of STS and, in turn, improve the support and care they give to traumatized populations.

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