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Secondary Trauma

Silent Suffering and Its Treatment

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This work is dedicated to my wife, Teresa. Her inspiration and support have been foundational in bringing this work to fruition.

Introduction

This book is intended to increase the understanding of the concept of secondary trauma and its treatment. Secondary trauma and secondary traumatic stress disorder (STSD) refer to the emotional upset one experiences in response to the distress encountered by others. The notion that the distress of others could lead to emotional disruption in those who care for, or are involved with that person or persons, was popularized by Charles Figley (1995) and was often referred to as "compassion fatigue" (p. 1), but it is not a novel concept. The economist Adam Smith wrote of the reactions to the distress of others as early as 1759. For example, taking care of a family member who is coping with a serious medical or psychological condition can result in emotional turmoil and exhaustion in the caretaker. The caretaker's distress is but one example of a secondary trauma. Another example might be that of firefighters, police officers, EMTs, and other frontline workers who attempt to help those in crisis and who then acquire emotional distress as an outcome of their witnessing the pain of those they are trying to assist. The spouse of a combat veteran who has been diagnosed with PTSD might develop symptoms that look much like PTSD. A final example is that of the psychotherapist whose caseload is composed primarily of highly traumatized individuals such as those who have been physically or sexually assaulted. After listening for many hours to details of such assaults, the therapist begins to become wary and anxious around people who might bear any similarity to the described attackers. The therapist's thoughts and dreams might encompass images of abuse and they might begin to develop panic and other unexplained fear responses. The therapist might begin to doubt the security and safety of their environment. All of these are examples of what is referred to in the literature by terms such as secondary traumatic stress disorder (STSD), burnout, secondary trauma, vicarious trauma, or "compassion fatigue" (Figley, 1995). Regardless of the terms that are used, these people suffer in silence. They shoulder the burdens of others and often do so without complaint.

Given the variety of terms describing secondary trauma and given the wide array of instances in which secondary trauma might occur, certain guidelines will be adhered to in this book to provide structure and clarity. The first is that secondary trauma will be used as a generic term to apply to instances in which distress is

transferred from one person or persons to others primarily as a function of one or more individuals caring for, supporting, or attending to others. The interchangeability of terms such as vicarious traumatization, secondary traumatic stress, empathic strain, and compassion fatigue has precedent in the literature (e.g., Phipps & Byrne, 2003; Sexton, 1999). The next guideline to be followed will be that the *primary* sources of secondary trauma occur in situations involving (a) *the family*, that is, one or more family members caring for a traumatized, physically ill, or emotionally troubled family member or members; (b) *professional caregivers*, that is, situations in which a therapist, medical doctor, nurse, or other health-care provider becomes emotionally depleted or otherwise distressed because of the incapacitation, illness, injury, or emotional distress of a person or persons that the professional care provider is treating; and (c) *first responders*, that is, firefighters, police officers, EMTs, paramedics, disaster response workers, and other community helpers whose job entails the provision and overseeing of public safety, security, and well-being. These individuals can become emotionally overwhelmed or depleted because of the demanding nature of their jobs and the witnessing of the trauma and distress of others.

There are many other circumstances and occupations where secondary trauma might occur such as insurance claims adjusters, librarians, or pharmacists who are desperately called upon to provide information or other support for those in distress (Figley & Ludick, 2017) and even in those who are engaged in foster care (Hannah & Woolgar, 2018). In fact, Motta (2015, p. 68) includes a partial listing of situations in which secondary trauma has been investigated including in family members (Catherall, 1992), in partners of those who have been abused (Nelson & Wampler, 2000), in wives of combat veterans with PTSD (Waysman et al., 1993), in adult children of Vietnam veterans with PTSD (Suozzi & Motta, 2004), in wives of police officers (Dwyer, 2005), in grandchildren of Holocaust survivors (Kassai & Motta, 2006; Kellerman, 2001; Perlstein & Motta, 2012), in family members of those with a serious medical illness (Boyer et al., 2002; Libov et al., 2002; Lombardo, 2005), and in children of parents with mental illness (Lombardo, 2007). Gilbert-Eliot (2020, pp. 4–7) includes law enforcement workers, firefighters, paramedics, emergency medical technicians, mental health therapists, emergency room staff, child welfare workers, spouses and family members of people in trauma-prone professions, and caregivers of someone with a serious medical issue, and states, “That’s not an exhaustive list” (p. 7). However, in the interest of clarity and focus and in consideration of the fact that the major thrust of the literature is seen in the three areas above, that is, in families, in professional caregivers, and in first responders, these will be the primary areas of focus in this book.

Diagnostic Overlap

Secondary trauma is not as precisely defined as post-traumatic stress disorder (PTSD) in the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed. [*DSM-5*]; American Psychiatric Association, 2013). In fact,

secondary trauma is not a diagnostic category in the *DSM*. Nevertheless, *The Secondary Trauma Scale* (Motta et al., 1999, 2001) provides cutoff scores for diagnosing secondary trauma and provides descriptors such as intrusive thoughts and avoidance behaviors. Additionally, there can be overlap between PTSD and secondary trauma, and this can create confusion in understanding the two terms. For example, the police, firefighters, and other first responders who frequently witness the distress of others are often diagnosed as having been secondarily traumatized, but they can also develop PTSD. In the *DSM-5*, we find the following listed among the diagnostic features of PTSD: "Witnessed events include … observing threatened or serious injury … physical or sexual abuse of another person due to violent assault, domestic violence … or a medical catastrophe in one's own child (e.g., a life-threatening hemorrhage)" (p. 274). The point being made here is that there are times when first responders might be exposed to the observance of "threatened or serious injury." These instances might then become potential stressors leading to PTSD. A recent book by Bryant (2021) specifically addresses PTSD and its treatment in first responders. In the absence of PTSD, however, when their daily obligations and routines to assure the safety of others become emotionally draining, then a diagnosis of secondary traumatization might be more appropriate. Despite this potential diagnostic overlap, in general PTSD is most often associated with serious personal threats and extreme fears, while secondary trauma is the acquisition of emotional distress arising from close association and involvement with others who are traumatized.

Activities Associated with Secondary Trauma

In addition to the categories noted above that are sources of secondary trauma, a partial listing of *activities* from which secondary trauma might arise is provided by Gilbert-Eliot (2020). These activities include those of law enforcement workers, firefighters, paramedics and EMTs, mental health therapists, emergency room staff, child welfare workers, spouses, and other family members of people in trauma-producing professions, and caregivers of someone with a serious medical condition (pp. 4–5). A good deal of the existing literature on secondary traumatization has to do with the negative impact on health-care providers that occurs in response to working with trauma victims. This major focus on the distress of health-care workers seems to be due to the fact that the secondary trauma literature is often produced by those with some association with the health-care field, including psychotherapists, physicians, occupational therapists, nurses, and rehabilitation specialists. However, most secondary trauma episodes have little to do with health-care providers and far more to do with family members or close friends who are negatively impacted by their association with an emotionally or physically traumatized individual or individuals (National Alliance for Caregiving [NAC], 2020).

This situation, where the knowledge base regarding secondary trauma is derived from health-care provider experiences rather than family members, is like that of

PTSD where the knowledge base is derived from studies of military combatants. But surprisingly, military experiences represent a comparatively small source of actual PTSD cases. Most of the PTSD diagnoses arise from distress originating in the civilian world. There are far more cases of PTSD due to rapes, assaults, various forms of child abuse, spousal maltreatment, extreme financial hardships, life-threatening ailments, auto accidents, natural disasters, and other civilian experiences than there are from the military. This in no way trivializes the potential negative impact of military experience but rather highlights that a comparatively small percentage of PTSD diagnoses arise from combat simply because there are far fewer people involved in military conflicts in comparison to civilians who encounter a wide range of traumas. Similarly, most secondary trauma cases evolve from experiencing the distress of family members and friends rather than the distress of health-care providers or first responders. The major sources of trauma, whether primary, as in PTSD, or secondary, occur among those who are noncombatants and non-frontline personnel.

Secondary traumatization, unlike PTSD, is the negative emotional, physical, and perhaps spiritually negative state that occurs in people who work with those who are in distress, such as those who are enduring a traumatic experience, including PTSD. Those suffering PTSD have encountered primary traumatic experiences and react with extreme fear. In contrast, those with secondary trauma are negatively impacted by their involvement with a primary trauma sufferer. The person experiencing secondary trauma will often feel that their ability to cope has been compromised and as a result feel overwhelmed. They are burdened, sullen, and often despairing and yet they often bear their burdens in silence. In many ways, they have been emotionally impacted by, and carry the burdens of, a person or persons who have experienced primary trauma. However, describing secondary trauma and PTSD as highly similar is unjustified. "Compassion Fatigue is a more user friendly term for Secondary Traumatic Stress Disorder, which is nearly identical to PTSD …" (Figley, 2003, p. 3). Despite this statement, these two concepts are dissimilar in terms of etiology, symptomology, and treatment. The concept of "emotional contagion" (Hatfield et al., 1994) or the spreading of emotions from one to another is a good descriptor of what takes place in secondary traumatization but not in PTSD.

Related Terms

As noted previously, there appear to be several terms, all of which are relevant to the negative impact that is encountered when one is exposed to, and perhaps must deal with, traumatized individuals and environments. For example, vicarious traumatization, a concept coined by McCann and Pearlman (1990), refers to the transformation of health workers' inner experience following the conducting of extensive trauma therapy sessions. This transformation includes alterations in one's sense of meaning, connection, identity, and work experiences, as well as "one's affect

tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery" (Pearlman & Saakvitne, 1995, p. 151). "Compassion fatigue," similarly, reflects the emotional drain and depletion resulting from working with those who are traumatized (Figley, 1995, p. 1). A related term, "empathy-based stress" (Rauvola et al., 2019) is also used synonymously with compassion fatigue.

Burnout, a term initially presented by Freudenberger (1974) and fully explicated by Maslach (1976), is applicable to work environments, often those environments involving the providing of assistance to health-impaired individuals, that results in the worker's feeling of emotional exhaustion and demoralization. These work environments might be counseling centers, schools for those with handicapping conditions, hospitals, and so on. However, burnout need not be the result of working with people. Exhausting and emotionally draining labor of any kind might be the cause of burnout. Another area where the term burnout has been applied is with families experiencing secondary trauma; see, for example, *Burnout in families: The systematic costs of caring* (Figley, 1998). Emotional contagion (Hatfield, 1994), although not necessarily trauma-specific, refers more broadly to the tendency to be influenced by and "feel" the emotionality of others. The term secondary traumatic stress disorder (STSD; Figley, 1995) is also of relevance here and is described below in the treatment section.

Despite definitional nuances that arise from, and seem related to, the source of the secondary traumatic experience, there is no widely agreed-upon and empirically validated differentiation among these various terms. One of the few exceptions is that of Adams et al. (2008) who found that among social workers involved with the September 11, 2001, attack on the World Trade Center in New York, exposure to traumatized patients increased vicarious trauma but not job burnout. In turn, both vicarious trauma and job burnout were related to the experiencing of psychological problems. But in general, both burnout and secondary trauma involve an emotional depletion that occurs because of giving of oneself and both are associated with psychological adjustment difficulties. For this reason, the various terms including "secondary traumatization," "secondary trauma," "vicarious trauma," and others will be used in this book to describe the transfer of emotional distress from one individual to another regardless of the context in which this transfer occurs.

Trauma Treatment

In addition to misconceptions about the major sources of, and differences between, primary and secondary trauma, there appears to be some confusion regarding how to deal with trauma, whether primary or secondary. Many of our trauma interventions are heavily influenced by a medical model that emphasizes "diseases," "illnesses," "treatments," and "cures," and this emphasis becomes a source of potential confusion in our investigation of secondary trauma. This medically derived mode of reasoning has had an impact on the world of psychotherapy where we encounter

terms such as mental "illness," "chemical imbalances," "treatments," and the need for "psychotropic medications." It is not that serious mental disturbances don't exist. They do and they create significant pain for all who are involved. And it is true that medication can be of value in treating some of the more serious disorders such as schizophrenia, bipolar disorder, and obsessive-compulsive disorder. Medical intervention is of substantial benefit in these cases but the prevalence of these disorders in the general population is small and ranges from approximately 1–3% for each (Jamison, 1999). These "illnesses" are doubtlessly serious and are damaging to well-being, but most psychological problems are not medically based illnesses. Rather, they are problems that are encountered by those who are having difficulty coping with distressing experiences and problematic environments. Secondary traumatization is this type of problem. Figley (1995, p. 8), for example, describes the condition of secondary traumatic stress disorder (STSD) in the following way:

> A syndrome of symptoms nearly identical to PTSD [post-traumatic stress disorder], except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress.

STSD is not an illness but a form of emotional distress for which several practical, nonmedical interventions are helpful. While Figley's (1995) definition does not imply that the condition of STSD is a medical problem, paradoxically, an aspect of medical terminology can be helpful in grasping a problem like secondary trauma. For example, some medical illnesses are contagious such as flu or the highly communicable COVID-19 virus. The contagious nature of viruses helps us in understanding secondary trauma. Trauma can be said to be "contagious" in so far as it involves the transfer of emotional pain from the sufferer to the observer. The observer can be a family member, close friend, frontline worker, or health-care member. Caring for others can sometimes result in being "infected" by their pain. This "infection" is what characterizes secondary trauma regardless of the definitional nuances in some of the terms that are used. Because secondary traumatization is the negative emotional, physical, and perhaps spiritually negative state that occurs in people who work with those who are in distress, such as those who are going through a traumatic experience, it can come across as being contagious. Thus, while medical model conceptualizations of trauma and the transfer of trauma reactions may not accurately reflect what is taking place, they can serve as a way of grasping the contagious nature of trauma.

The various "treatments" for secondary trauma are oriented toward easing or lessening the impact of this psychological stressor. Many interventions involve life adjustments and alterations, such as maintaining balance in one's personal life and using personal and group therapy (Norcross, 2000; Pearlman & Saakvitne, 1995). The use of meditation, yoga, exercise, interaction with animals, and outdoor environments have also shown themselves to be of value at least as far as managing PTSD is concerned (Benedek & Wynn, 2016; Motta, 2020) and would presumably be beneficial for secondary trauma. Despite theoretical claims and convictions, there is little empirical support for the notion that there exists specified individual or

group therapy interventions that are demonstrably better or more effective than others and this is true for both primary and secondary trauma. The current widely accepted view is that the best mode of treatment for PTSD, a primary trauma, is cognitive-behavioral psychotherapy. "The treatment of choice for PTSD … is exposure based cognitive therapy" (Preston et al., 2002, p. 137). However, when one digs into the literature to examine double-blind, placebo-controlled studies with random assignment, there is no universal support for this position. Wompold et al. (2010), for example, following extensive meta-analyses, maintained that it is the therapeutic relationship that is beneficial and curative, and the impact of specific therapeutic techniques is comparatively less important.

If we are uncertain regarding the most effective treatment for PTSD, then we are even more unaware of the best treatment for secondary traumas as these sorts of traumas are far less researched than PTSD (Maynard & Bercer, 2015). Given the relative lack of knowledge regarding secondary trauma treatment, there is little reason to believe that interventions that have proven valuable in treating primary trauma and PTSD would or would not be useful in treating secondary traumatization. In a thorough review of studies relevant to the treatment of compassion fatigue (CF), secondary traumatic stress (STS), and vicarious trauma (VT), Bercier & Maynard (2015, p. 87) conclude, "While there may be some aspects or techniques of primary trauma treatment that can inform and be adapted to treat CF, STS, and VT, we should be careful to not assume that trauma interventions intended to treat primary trauma will be effective in treating CF, STS, and VT." In fact, in their review they found virtually no treatments for secondary trauma that were empirically supported as being better than others and as a result they found no data-based conclusions regarding treatment efficacy for secondary trauma. So, in addition to delving into various issues related to secondary trauma, this book will examine various treatment approaches that might be of value in its treatment. A particular emphasis will be placed on nontraditional treatments. Nontraditional treatments refer to interventions that do not follow traditional models of treatment such as CBT, behavioral therapy, analytic procedures, and the like. This emphasis on nontraditional treatment is chosen for three reasons. First, there is little evidence to suggest that those suffering from secondary trauma have the cognitive misconceptions or errors in thinking that point to the selection of CBT or other traditional treatments. These cognitive misconceptions are a principal target of cognitive-behavioral psychotherapy. Rather, those with secondary trauma appear to be experiencing a somewhat expected kind of distress and emotional depletion that results from working with distressed individuals. Their reactions are generally not psychopathological or irrational and therefore traditional forms of therapy may not be needed. Second, nontraditional treatment interventions such as yoga, meditation, and exercise are often less intrusive than traditional CBT treatments are as a result are less likely to be avoided (Motta, 2020) by those suffering from secondary trauma. And finally, the alternatives to traditional treatments that are presented are those that have received some degree of empirical support at least as far as treating PTSD is concerned, and this support usually comes through controlled studies or metanalyses, or both.

Chapter Overview

Many actual case examples are provided throughout this book. Case names, localities, professions, and other possibly identifying information have been altered to maintain confidentiality. Nevertheless, the essential aspects of these cases have been maintained to be as close to reality as possible while not risking the possibility of identification of those involved. The only exception is when a well-known case that has already been publicized in the media is being presented.

The origins of the development of secondary trauma and empathy are covered in Chap. 1. Here, it is shown that empathy in humans develops at a very early age. It is also shown that empathic and compassionate responding is not uniquely human but is shown by primates and other animals. The evolutionary advantage of empathy and secondary trauma is highlighted. The role of "mirror neurons" is also addressed. Chapter 2 continues to trace the evolution of secondary trauma by highlighting secondary trauma in childhood and the overarching importance of loss of attachments in children's lives. Chapter 3 addresses the most common sources of secondary trauma and consequent emotional exhaustion, namely that which occurs when members of a family must attend to and care for another member who might be seriously physically ill or emotionally distressed. Chapter 4 focuses on professional caregivers such as psychotherapists, physicians, nurses, and physician assistants. An important element in the development of PTSD and secondary trauma is highlighted, namely the perceived inability to escape one's professional demands and obligations. In Chap. 5, there is a presentation of the unique stressors experienced by first responders such as police officers, firefighters, EMTs, paramedics, and disaster relief workers. The role of personality characteristics and how those characteristics play into the development of secondary trauma is addressed. Chapter 6 examines considerations for treating STSD and contrasts such treatment with what might be provided in cases of PTSD. Some authors claim that STSD and PTSD are nearly identical and that their treatment is also highly similar. The chapter highlights the actual dissimilarities between PTSD and STSD and questions the need for similarities in treatment. Chapter 7 deals with structural interventions for secondary trauma. These are pragmatic intervention strategies that focus on the restructuring of work activities and the seeking out of self-care activities. Structural interventions are contrasted with traditional, individually administered therapeutic approaches such as those employed in CBT. Chapter 8 highlights the important role of social support in lessening the negative consequences of secondary trauma within families, among first responders, and in professional care providers. It also investigates those factors that might mitigate the utility of social support. Chapter 9 focuses on the role of physical exercise as a means of coping with and reducing the impact of secondary traumatization. Various theoretical views are presented that attempt to explain why exercise might be helpful in cases of secondary traumatization. Chapter 10 deals with the role that mindfulness meditation plays in alleviating trauma and secondary trauma symptoms. Examples of mindfulness practices are highlighted along with empirical research supporting the value of meditation in managing

secondary trauma. Chapter 11 covers the increasingly popular practice of yoga as a way of dealing with life stressors including those due to secondary trauma. Reviews of the research literature are presented showing empirical support for yoga as a way of managing secondary trauma. A variety of the more popular forms of yoga practice are also presented. Chapter 12 deals with the unique role that animals play in reducing the stress levels of humans. A wide variety of animals have been identified as helpful in reducing stress of the kind found in both PTSD and secondary traumatization. Chapter 13 includes systematic studies of paraprofessional interventions and self-care strategies for managing secondary trauma. The novel and important role of natural environments as a source of secondary traumatic stress relief is also reviewed. Chapter 14 provides summary comments and observations.

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