Working on the frontline

***Sue Lightfoot** discusses the impacts of secondary traumatic stress*

Introduction

There has been increasing attention over the past several years to the effects on staff of working in emergency situations, with traumatised clients or with very stressful distressing material. Secondary traumatic stress (STS), sometimes called vicarious traumatisation (McCann and Pearlmann, 1990), can be defined as the impact on a worker of repeated exposure to traumatic client material (Steed and Downing, 1998), or the stress reaction that comes from assisting or wanting to assist a traumatised person (Beaton and Murphy, 1995). In research literature a variety of terms may be used interchangeably: traumatic countertransference (Danieli, 1980), compassion fatigue or secondary traumatic stress disorder (Munroe, Shay, Fisher, Makary, Rapperport and Zimering, 1995).

STS is most commonly seen in frontline staff such as social workers, crisis and trauma counsellors, law enforcement officers, rescue workers, and medical staff (Beaton and Murphy, 1995). In these positions, exposure to occupational trauma is generally frequent and repetitive, but it may not be directly experienced. Other employees in these organisations, such as dispatchers, typists or supervisors, may also be vulnerable because the traumatic event is still 'absorbed' (Beaton and Murphy, 1995). No one is immune from STS (Collins and Long, 2003; Munroe et al, 1995), and it should be emphasised that this condition is different from burn-out or other forms of occupational stress (Kassam-Adams, 1995). The concept of burn-out was originally proposed by Maslach (Bell, Kulkarni and Dalton, 2003), as a process of occupational stress that results when social service professionals become emotionally exhausted from high levels of work demands, particularly in interpersonal work, and poor levels of organisational or structural support to assist in meeting those demands. The effects are clear in three dimensions (Bell et al, 2003).

> This condition is different from burn-out or other forms of occupational stress

1. Emotional exhaustion.
2. Negative attitudes towards clients and a personal detachment.
3. Reduced work performance and a lowered commitment to the profession.

Symptoms of post-traumatic stress are not generally present in burn-out.

Effects on workers

Detrimental effects are more likely to occur if the workers have their own history of traumatic experience, especially with events from their

childhoods (Follette, Polusny, and Milbeck, 1994; Kassam-Adams, 1995). New therapists/workers are also more likely to experience detrimental effects and there is an interaction effect between the 'newness' of the worker and any personal trauma history (Collins and Long, 2003).

Effects can be apparent in all areas of functioning. In the cognitive area, there may be shifts in areas of dependence/trust (chronic suspicion of others), safety (heightened sense of vulnerability and risk), power (increased sense of helplessness) and independence (feelings of loss of power and control) (Collins and Long, 2003). In the psychological area, there are typically indicators of psychological distress or dysfunction, including traumatic symptoms such as intrusive imagery, numbing or avoidance, feelings of guilt (for enjoying life while survivors struggle) or victim-blaming (for making the worker feel this way), and feelings of isolation, alienation and lack of appreciation (Collins and Long, 2003).

Emotionally, a key indicator is 'compassion fatigue', which is emotional exhaustion or emotional detachment and distancing (Munroe et al, 1995; Thomas and Wilson, 2004). But there are physical symptoms, too. These typically include somatic complaints, headaches and gastrointestinal problems, and symptoms of physiological arousal, such as palpitations and hypervigilance (Collins and Long, 2003). Behaviourally, there may be relationship problems with partners and children (Beaton and Murphy, 1995; Collins and Long, 2003), compulsive behaviours (Collins and Long, 2003), and addictions or substance abuse (Beaton and Murphy, 1995).

It is likely the worker's professional life will show the effects of STS through impairment in day-to-day functioning, poor professional judgements, missed and/or cancelled appointments, a decreased use of supervision, chronic lateness, and general problems with their professional relationships (Collins and Long, 2003). Workers won't necessarily recognise their own symptoms, especially if working alone (Munroe et al, 1995).

Effects on workers' families

Research has indicated that a worker's family may also be subject to the effects of STS. A worker's partner may experience symptoms similar to post-traumatic stress (Nelson and Wright, 1996; Waysman et al, 1993), or be placed in a situation of having to 'look after' their partners and cope with their psychological symptoms (Nelson and Wright, 1996). Partners may be more likely to have unmet psychological and emotional needs (Nelson and Wright, 1996). There may also be increased risk for conflict and violence in the relationship (Nelson and Wright, 1996; Waysman, Mikulincer, Solomon and Weisenberg, 1993), or emotional abuse (Nelson and Wright, 1996).

For workers' children, there may be 'trauma transmission'

For workers' children, there may be 'trauma transmission', either from frequently hearing about events or through experiencing a conspicuous silence about an event a child knows their parent was involved in (Nelson and Wright, 1996). Research has revealed children may develop post-traumatic stress symptoms (Dan, 1996; Rosenheck and Nathan, 1985) and/or somatic complaints, anxiety, social and attention problems, and aggressive tendencies from living with a parent who is working in

the area of trauma (Dan, 1996; Rosenheck and Nathan, 1985).

Social services field

There is now a reasonable amount of research detailing effects for those who work in the area of child protection or with issues such as child abuse. Research involving child protection social workers revealed secondary trauma in 37 per cent of workers, with strong relationships between personal and work factors (Cornille and Meyers, 1999). Research with child welfare social workers has also found a link between a personal history of primary trauma, childhood abuse or neglect, and a heightened risk for STS (Nelson-Gardell and Harris, 2003). Research with sexual abuse counsellors indicates these workers feel the effects of STS (Steed and Downing, 1998) and there is also a significant impact on forensic interviewers (Conte, 2002).

Effective prevention

There are strategies that will lessen the likelihood that STS will occur. Working in teams, rather than alone is a strong protective factor (Bell et al, 2003; Munroe et al, 1995; Trippany, Kress, and Wilcoxon, 2004). Good clinical supervision is invaluable for balancing a worker's frame of reference, assisting the worker in early identification of potential traumatic impacts, providing emotional support, and educating staff about these processes in a way that is responsive to individual needs (Bell et al, 2003; Steed and Downing, 1998). Education and awareness programmes about the possible impact of STS are also an effective strategy (Bell et al., 2003; Collins and Long, 2003; Steed and Downing, 1998; Trippany et al, 2004). Access to confidential counselling will assist workers who are more vulnerable or who notice the symptoms of STS (Collins and Long, 2003), and regular clinical supervision is another very important feature of worker support (Bell et al, 2003; Collins and Long, 2003; Trippany et al, 2004).

A working environment that values staff and promotes their care, such as by monitoring workloads and providing effective administration, is essential (Bell et al, 2003; Collins and Long, 2003; Edwards, Burnard, Coyle, Fothergill and Hannigan, 2000; Trippany et al, 2004). These measures assist to promote a culture where staff feel supported and comfortable in accessing services (Collins and Long, 2003; Trippany et al, 2004). Opportunities for staff to debrief informally and create peer support groups, as well as more structured arrangements such as critical incident stress debriefing, are all valuable ingredients of an organisation's response to protecting staff against the effects of chronic, recurring and traumatic stress (Bell et al, 2003; Collins and Long, 2003). Staff who are confident in their own professional expertise and competence are less likely to suffer the effects of STS (Edwards et al, 2000).

Workers must also take responsibility for their own self-care strategies. Personal coping mechanisms such as good eating, sleeping and exercise, as well as pursuing enjoyable activities outside their professional lives, are all protective factors (Bell et al, 2003; Steed and Downing, 1998; Trippany et al, 2004; West, 1997).

How a worker perceives the nature of their work may also represent a protective factor. Family violence counsellors were less likely to develop symptoms of STS who had a personal sense of competence and coping, their own positive role models of coping, resolved any personal trauma, and were able to maintain an objective motivation (Bell, 2003). A sense of coherence in

life and good levels of social support may also be protective factors (Ortlepp and Friedman, 2002). A 'buffering' spiritual belief, or other sense of meaning about life and experience, has similarly been found to assist workers to manage the effects of trauma work (Bell et al, 2003; Trippany et al, 2004; West, 1997).

When detrimental impacts do occur, a range of services, including individual counselling, family psycho-education, support groups, and couple or family therapy, may all be appropriate (Nelson and Wright, 1996). It is vital that workers take advantage of these services and that workplaces ensure this is possible. When the social services take care of their workers, best practice is achieved and better outcomes for clients.

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