

Prevalence of Secondary Traumatic Stress among Social Workers

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Social workers are increasingly being called on to assist survivors of childhood abuse, domestic violence, violent crime, disasters, and war and terrorism. It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected. Secondary traumatic stress (STS) is becoming viewed as an occupational hazard of providing direct services to traumatized populations. The purpose of the present study was to investigate the prevalence of STS in a sample of social workers by examining the frequency of individual symptoms; the frequency with which diagnostic criteria for posttraumatic stress disorder (PTSD) are met; and the severity of STS levels. Results indicate that social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized populations, many social workers are likely to experience at least some symptoms of STS, and a significant minority may meet the diagnostic criteria for PTSD.

KEY WORDS: *compassion fatigue; PTSD; secondary trauma; vicarious trauma*

In the United States, the lifetime prevalence of exposure to traumatic events ranges from 40 percent to 81 percent, with 60.7 percent of men and 51.2 percent of women having been exposed to one or more traumas and 19.7 percent of men and 11.4 percent of women reporting exposure to three or more such events (Breslau, Davis, Peterson, & Schultz, 1997; Kessler, Sonnega, Bromet, & Nelson, 1995; Stein, Walker, Hazen, & Forde, 1997). Although exposure to traumatic events is high in the general population, it is even higher in subpopulations to whom social workers are likely to provide services. For example, 84 percent of psychiatric inpatients have experienced at least one traumatic event and 45 percent have experienced three such events or more (Escalona, Tupler, Saur, Krishnan, & Davidson, 1997). Between 82 percent and 94 percent of outpatient mental health clients reported a history of exposure to traumatic events, with 31 percent to 42 percent fulfilling criteria for PTSD (Davidson & Smith, 1990; Switzer et al., 1999). Among treatment-seeking substance abusers, 60 percent to 90 percent have a history of sexual or physical abuse (Cohen & Densen-Gerber, 1982; Dansky et al., 1996; Dansky, Roitzsch, Brady, & Saladin, 1997; Yandow, 1989), and 30 percent to 50 percent meet the criteria for a diagnosis of post-

traumatic stress disorder (PTSD) (Dansky, Brady, et al.; Najavits, Weiss, & Shaw, 1997). Furthermore, 87 percent of homeless women with mental illnesses reported both childhood and adult abuse, and 97 percent reported some form of abuse over the lifespan (Goodman, Dutton, & Harris, 1997).

Although not exhaustive of the populations with whom social workers practice, these examples illustrate that social workers face a high rate of professional contact with traumatized people. Social workers are increasingly being called on to assist survivors of childhood abuse, domestic violence, violent crime, disasters, and war and terrorism. It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected. The term "secondary traumatic stress" (STS) refers to the observation that people, such as family, friends, and human services personnel, who come into continued, close contact with trauma survivors may also experience emotional disruption, becoming indirect victims of the trauma (Figley, 1995). Figley (1999) defined *secondary traumatic stress* as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). Chrestman

(1999) noted that secondary traumatization includes symptoms parallel to those observed in people directly exposed to trauma such as intrusive imagery related to clients' traumatic disclosures (Courtois, 1988; Danieli, 1988; Herman, 1992; McCann & Pearlman, 1990); avoidant responses (Courtois; Haley, 1974); and physiological arousal (Figley, 1995; McCann & Pearlman, 1990). Thus, STS is a syndrome of symptoms identical to those of PTSD, the characteristic symptoms of which are intrusion, avoidance, and arousal (Figley, 1999).

According to the American Psychiatric Association (APA) (2000), intrusion (or re-experiencing) symptoms include recurrent and intrusive recollections (that is, images, thoughts, or perceptions) of the event or recurrent distressing dreams during which the event is replayed; acting or feeling as if the traumatic event were recurring in the form of illusions, hallucinations, flashbacks, or a sense of reliving the experience; and intense psychological distress or physiological reactivity when exposed to internal or external cues or reminders of the event. Avoidance symptoms involve persistent avoidance of stimuli associated with the trauma, including numbing of responsiveness. This avoidance may take the form of efforts to avoid thoughts, feelings, or conversations that are associated with the traumatic event or efforts to avoid activities, places, or people that are reminders of the traumatic event. A person experiencing avoidance symptoms may be unable to recall important aspects of the traumatic event. Avoidance symptoms also include loss of interest or participation in significant activities, detachment or estrangement from others, restricted range of affect, and a sense of foreshortened future. Arousal symptoms include persistent symptoms of anxiety or increased arousal that were not present before the trauma, such as difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, or exaggerated startle response.

STS is becoming viewed as an occupational hazard of providing direct services to traumatized populations (Bride, 2004; Figley, 1999). Although most literature on the topic of STS is either conceptual or anecdotal, an increasing number of empirical studies are appearing in the literature. Investigators have examined the predictors and correlates of STS in psychotherapists and mental health professionals (Brady, Guy, Poelstra, & Brokaw, 1999; Follette, Polusny, & Milbeck, 1994), sexual assault counsel-

ors (Ghahramanlou & Brodbeck, 2000; Schauben & Frazier, 1995), and trauma therapists (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995). Collectively, these studies have provided empirical evidence that individuals who provide services to traumatized populations are at risk of experiencing symptoms of traumatic stress (Bride). However, the extant literature fails to document the prevalence of individual STS symptoms and the extent to which diagnostic criteria for PTSD are met as a result of work with traumatized populations. Social workers in direct practice inevitably work with traumatized populations; however, there are no published studies that examine the prevalence of STS among social workers. As such, the purpose of the present study was to investigate the prevalence of STS in a sample of social workers by examining the frequency of individual symptoms, the frequency with which diagnostic criteria for PTSD are met, and the severity of STS levels.

METHOD

Data Collection

A survey and business reply envelope were mailed to 600 master's-level social workers randomly selected from 2,886 social workers licensed in a state in the southern United States. One week after the initial mailing, a reminder postcard was sent to the entire sample requesting that they complete and return the survey. Two weeks later, a second survey was sent to the people whose responses had not been received. Of the 600 surveys sent, 294 (49.6 percent) completed surveys were returned. Seven surveys were excluded from analysis because of missing data, and five surveys were excluded because the respondents were not practicing social workers when they completed the survey, resulting in an effective response rate of 47 percent ($n = 282$).

Instruments

Demographic Information Questionnaire (DIQ).

The DIQ was developed specifically for the purpose of this study. Items on the DIQ requested standard demographic information regarding respondents' age, gender, and ethnicity. In addition, the DIQ gathered information regarding aspects of respondents' professional activities such as length of social work experience, average number of hours worked, field of practice, and typical work-related activities. Also included in the DIQ were three self-anchored rating scales that ask the respondent

to rate on a five-point Likert scale the extent to which the respondent's client population is traumatized; the extent to which the respondent's work addresses issues related to client traumas; and the extent to which the respondent has experienced fear, helplessness, or horror in response to the traumatic experiences reported by clients.

Secondary Traumatic Stress Scale (STSS). The STSS (Bride, Robinson, Yegidis, & Figley, 2004) is a 17-item, self-report instrument designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with STS resulting from working with traumatized populations. Respondents indicate how frequently (on a five-point Likert scale ranging from never to very often) each item was true for them in the past seven days. Each item on the STSS corresponds to one of the 17 PTSD symptoms as delineated in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) (DSM-IV-TR) (APA, 2000). The wording of instructions and the stems of stressor-specific items are designed such that the traumatic stressor is identified as exposure to clients. The STSS consists of three subscales, referred to as Intrusion, Avoidance, and Arousal, that respectively correspond to the B, C, and D criteria for PTSD (APA). Scores are obtained by summing the items assigned to each subscale and the entire instrument. The STSS has demonstrated evidence of convergent, discriminant, and factorial validity and high levels of internal consistency (Bride et al.; Ting, Jacobson, Sanders, Bride, & Harrington, 2005).

RESULTS

Sample Characteristics

Analysis of demographic information revealed that study participants had a mean age of 44.8 years ($SD = 10.5$) and were primarily female (81.9 percent) and white (77.1 percent) (Table 1). The majority (56.6 percent) of participants identified mental health or substance abuse as their primary field of practice, followed by health care (20.1 percent), child welfare (7.2 percent), school social work (4.7 percent), community organizing (1.8 percent), public welfare (1.4 percent), and developmental disabilities (1.1 percent). An additional 7.2 percent of participants reported a field of practice other than those already identified (Table 1). Respondents averaged 16.15 years ($SD = 9.59$) in practice and worked an average of 39.99 ($SD = 10.89$) hours per week, with an average of 30.88 hours ($SD = 13.55$) engaged in clinical activities such as direct client contact, case review, and providing or

Table 1: Demographic and Professional Characteristics of Social Workers Responding to Secondary Traumatic Stress Syndrome Survey ($N = 282$)

	<i>n</i>	<i>M</i>	<i>SD</i>	%
Age	275	44.83	10.47	
Experience (years)	277	16.15	9.59	
Hours per week	282	39.99	10.89	
Gender				
Female	226			81.9
Male	50			18.1
Ethnicity				
White	216			77.1
Black	50			17.9
Other	5			1.9
Field of practice				
Mental health/substance abuse	158			56.6
Health care	56			20.1
Child welfare	20			7.2
School social work	13			4.7
Community organizing	5			1.8
Public welfare	4			1.4
Developmental disabilities	3			1.1
Other	20			7.2

Note: Percentages may total more than 100% due to rounding error.

receiving clinical supervision. In rating the extent to which their client population was traumatized, 18.4 percent indicated that their clients were either not traumatized at all or only mildly traumatized, 47.1 percent indicated that their clients were moderately traumatized, and 34.5 percent indicated that their clients were severely or very severely traumatized. Furthermore, study participants reported that their work with clients addresses issues related to trauma rarely or not at all (11.1 percent), occasionally (36.8 percent), often (39.6 percent), or very often (12.5 percent).

Individual Symptoms

An STS symptom was considered to be endorsed if the respondent indicated that the symptom was experienced "occasionally," "often," or "very often" in the preceding seven days. The group of five intrusion symptoms contained both the most and the least frequently reported symptoms. The most frequently reported symptom was intrusive thoughts related to work with clients, with 40.5 percent of respondents indicating that they thought about their

work with traumatized clients without intending to (Table 2). Experiencing psychological distress or a physiological reaction in response to reminders of work with traumatized clients were the next most frequently reported symptoms, with 19.1 percent and 12.4 percent of respondents reporting these symptoms, respectively. The two remaining intrusion symptoms were reported much less frequently, with 5.8 percent reporting disturbing dreams and 5.0 percent reporting a sense of reliving the traumas reported by clients. Endorsement of the seven avoidance symptoms ranged from 10.9 percent for avoidance of people, places, or things that served as reminders of work with traumatized clients to 31.6 percent for avoidance of clients, the latter being the second most frequently endorsed of the 17 symptoms. Rates of endorsement of the remaining avoidance symptoms were as follows: inability to recall information related to work with clients (14.9 percent), detachment from others (22.3 percent), diminished interest or participation in activities (25.5 percent), emotional numbing (25.9 percent), and sense of foreshortened future (28.0 percent). Among the five arousal symptoms, irritability and

concentration difficulties were reported by 27.7 percent and 27.0 percent of the sample, respectively. In addition, sleeping difficulties were reported by approximately one quarter (24.4 percent) of the sample, whereas hypervigilance and exaggerated startle reflex were less frequently reported (13.8 percent and 12.1 percent, respectively).

Diagnostic Criteria

In addition to individual symptoms, the number of respondents who met the diagnostic criteria for PTSD due to exposure to traumatic events through their clients was examined. As delineated in the DSM-IV-TR (APA, 2000), PTSD is precipitated by an individual's exposure, direct or indirect, to a traumatic event, with the person's response involving fear, helplessness, or horror (criterion A). In addition, a person must display at least one re-experiencing (criterion B), three avoidance (criterion C), and two hyperarousal (criterion D) symptoms. Thus, an algorithm can be used to determine PTSD caseness. Therefore, an individual who endorses at least one item on the Intrusion subscale, at least three items on the Avoidance subscale, and at least two items on

Table 2: Frequency of Secondary Traumatic Stress Symptoms Reported by Licensed Social Workers (N = 282)

Criterion (Item No.)	Never n (%)	Rarely n (%)	Occasionally n (%)	Often n (%)	Very Often n (%)	M	SD
Criterion B—Intrusion symptoms							
Intrusive thoughts about clients (10)	88 (31.2)	80 (28.4)	80 (28.4)	29 (10.3)	5 (1.8)	2.23	1.06
Disturbing dreams about clients (13)	206 (73.0)	60 (21.3)	12 (4.3)	3 (1.1)	1 (0.4)	1.34	.65
Sense of reliving clients' trauma (3)	215 (76.2)	53 (18.8)	11 (3.9)	2 (0.7)	1 (0.4)	1.30	.61
Cued psychological distress (6)	149 (52.8)	79 (28.0)	42 (14.9)	10 (3.5)	2 (0.7)	1.71	.90
Cued physiological reaction (2)	167 (59.3)	80 (28.4)	30 (10.6)	5 (1.8)	—	1.55	.75
Criterion C—Avoidance symptoms							
Avoidance of clients (14)	107 (37.9)	86 (30.5)	71 (25.2)	12 (4.3)	6 (2.1)	2.02	1.00
Avoidance of people, places, things (12)	194 (68.8)	57 (20.2)	15 (5.3)	10 (3.5)	6 (2.1)	1.50	.91
Inability to recall client information (17)	178 (63.1)	62 (22.0)	32 (11.3)	9 (3.2)	1 (0.4)	1.56	.84
Diminished activity level (9)	126 (44.7)	84 (29.8)	46 (16.3)	21 (7.4)	5 (1.8)	1.92	1.03
Detachment from others (7)	146 (51.8)	73 (25.9)	48 (17.0)	11 (3.9)	4 (1.4)	1.77	.96
Emotional numbing (1)	129 (45.7)	80 (28.4)	62 (22.0)	10 (3.5)	1 (0.4)	1.84	.91
Foreshortened future (5)	132 (46.8)	71 (25.2)	59 (20.9)	14 (5.0)	6 (2.1)	1.90	1.03
Criterion D—Arousal symptoms							
Difficulty sleeping (4)	126 (44.7)	87 (30.9)	52 (18.4)	13 (4.6)	4 (1.4)	1.87	.96
Irritability (15)	99 (35.1)	105 (37.2)	53 (18.8)	22 (7.8)	3 (1.1)	2.02	.97
Difficulty concentrating (11)	122 (43.3)	84 (29.8)	58 (20.6)	15 (5.3)	3 (1.1)	1.91	.97
Hypervigilance (16)	176 (62.4)	67 (23.8)	26 (9.2)	10 (3.5)	3 (1.1)	1.57	.88
Easily startled (8)	178 (63.1)	70 (24.8)	27 (9.6)	6 (2.1)	1 (0.4)	1.52	.78

the Arousal subscale at a level of 3 or higher meets the diagnostic criteria for PTSD. As previously recommended, a symptom is considered present if the corresponding STSS item is rated 3 or higher (that is, occasionally, often, or very often).

It is encouraging to note that despite working with traumatized clients nearly one-half (45.0 percent) of respondents failed to meet any of the diagnostic criteria other than exposure (Table 3). However, 55 percent met at least one, approximately one-fifth met two, and 15.2 percent met all three core diagnostic criteria for PTSD. As is true with most trauma measures, the STSS is designed to assess only criteria B, C, and D of PTSD, excluding the exposure and response (criterion A), duration (criterion E), and impairment (criterion F) criteria (APA, 2000). This is typical of many trauma measures as the B, C, and D criteria are considered to be the core symptoms of PTSD, and presumably, the exposure and response criteria would be a prerequisite for administering an instrument. In the present study, 97.8 percent of respondents indicated that their client population is at least mildly traumatized, and 81.7 percent reported a moderately to very severely traumatized client population. Fear, helplessness, or horror in response to the traumatic experiences reported by their clients was reported by 86.7 percent of respondents.

Symptom Severity

Total scores on the STSS ranged from 17, meaning no symptoms, to 74, which represents a per-item mean of 4.35 out of 5. In addition, scores were positively skewed, indicating that many respondents had low levels of symptoms, whereas a smaller propor-

tion of respondents were experiencing somewhat severe symptoms of STS. Normative statistics, including means, standard deviations, ranges, and selected percentile scores for the STSS and each of its subscales obtained from the study sample are presented in Table 4.

DISCUSSION

The purpose of this study was to investigate the prevalence of STS in a sample of social workers. Nearly all (97.8 percent) of the respondents indicated that their client population experienced trauma, and most (88.9 percent) indicated that their work with clients addresses issues related to those client traumas. Clearly, social workers are indirectly exposed to trauma as a result of their work with clients and, thus, may be at risk of experiencing STS symptoms. Indeed, 70.2 percent experienced at least one symptom in the previous week, 55 percent met the criteria for at least one of the core symptom clusters, and 15.2 percent met the core criteria for a diagnosis of PTSD. The intrusion criterion was endorsed by nearly half of the respondents, whereas the avoidance and arousal criteria were each endorsed by one-quarter of the respondents. Regarding individual symptoms, the most often reported symptoms were intrusive thoughts, avoidance of reminders of clients, and numbing responses. Among the least reported symptoms were distressing dreams and a feeling of reliving client's traumas. However, it is important to note that nearly half (45 percent) did not meet any of the three core criteria for PTSD.

A secondary outcome of this study is that the results can be used to provide provisional recommendations for interpretation of scores from the STSS. There are at least three approaches to interpreting an individual's responses on an instrument of this sort. The first approach is to use the algorithm approached mentioned earlier. That is, if an individual endorses at least one item on the Intrusion subscale, at least three items on the Avoidance subscale, and at least two items on the Arousal subscale, then that individual may be experiencing PTSD at a diagnostic level due to STS.

A second approach to interpreting scores on the STSS is by comparing an individual's score to the normative scores presented in Table 4. To further aid in this approach, I recommend that scores be used to classify individuals into categories based on percentiles such that scores at or below the 50th percentile (less than 28) are interpreted as little or

Table 3: Frequency of Diagnostic Criteria of PTSD Due to Secondary Exposure Related to Practice with Traumatized Populations

Criteria Met*	n	%
None	127	45.0
Intrusion (B)	128	45.4
Avoidance (C)	71	25.2
Arousal (D)	71	25.2
Intrusion + Avoidance (B + C)	57	20.2
Intrusion + Arousal (B + D)	61	21.6
Avoidance + Arousal (C + D)	49	17.4
Intrusion + Avoidance + Arousal (B + C + D)	43	15.2

*In addition to the exposure criteria (criterion A).

Table 4: Means, Standard Deviations, Ranges, and Percentiles for the Intrusion, Avoidance, and Arousal Subscales and the Full STSS

	<i>M (SD)</i>	Range		Percentile				
		Possible	Observed	25th	50th	75th	90th	95th
Intrusion Subscale	8.18 (3.04)	5-25	5-21	6.00	7.00	11.00	12.00	13.00
Avoidance Subscale	12.58 (5.00)	7-35	7-31	8.00	12.00	16.00	20.00	22.00
Arousal Subscale	8.93 (3.56)	5-25	5-24	6.00	8.00	11.00	14.00	16.00
Full STSS	29.69 (10.74)	17-85	17-74	21.00	27.00	37.00	43.80	48.40

Note: STSS = Secondary Traumatic Stress Scale.

no STS, scores at the 51st to the 75th percentile (28 to 37) are interpreted as mild STS, scores at the 76th to the 90th percentile (38 to 43) are interpreted as moderate STS, scores at the 91st to the 95th percentile (44 to 48) are interpreted as high STS, and scores above the 95th percentile (49 and above) are interpreted as severe STS.

A third approach to interpreting scores on the STSS is by establishing a cutoff value whereby individuals who obtain a score at or above the cutoff value are considered to have PTSD due to STS. Given the proposed score ranges presented earlier, a cutoff score of 38, which is at the lower threshold of the moderate range, is recommended. By comparing scores on the STSS with the algorithm approach, estimates of the sensitivity and specificity can be obtained. Based on the data obtained in this study, a sensitivity of .93 and a specificity of .91 are obtained with a cutoff value of 38. That is, using a cutoff value of 38, 93 percent of those who met the core criteria for PTSD using the algorithm approach would be correctly identified as having PTSD and 91 percent of those who did not meet the core criteria for PTSD would be identified as not having PTSD.

Limitations

As with any research, certain limitations are inherent in this study and must be noted. Although the 47 percent response rate is respectable, the possibility remains that nonrespondents were qualitatively different from respondents. For example, it is possible that the social workers who were experiencing STS symptoms were more likely to respond because the study had personal meaning for them. Alternatively, some social workers may have been less likely to respond because of concerns that the act of completing the instrument would increase their distress. Second, the sample was confined to licensed, master's-level

social workers in a single state; therefore, the results of this study may not be generalizable to the broader population of social workers such as bachelor's-level social workers, unlicensed social workers, and social workers in other parts of the United States or in other countries. Inclusion of any of these or other groups may have led to different results. Third, the results of this study are based on a brief screening measure for STS. Although the STSS has demonstrated reliability and validity, different results might have been obtained if a structured clinical interview had been used. However, given the time investment and response burden associated with such an approach, a structured interview was not practical for this study.

CONCLUSION

Social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized populations, many social workers are likely to experience at least some symptoms of STS, and a significant minority (15.2 percent) may meet the diagnostic criteria for PTSD. It is important to note that the estimate of PTSD due to secondary exposure found in the present study is an estimate of point prevalence. That is, 15.2 percent of respondents reported STS symptoms that occurred in the preceding week, at a level that meets the diagnostic criteria for PTSD. The lifetime prevalence of PTSD in the general population due to all traumas is estimated to be only 7.8 percent (Kessler et al., 1995). Thus, independent of any other traumas that social workers may directly experience, the rate of PTSD in social workers due only to indirect exposure is twice that of the general population.

The experience of STS is believed to be one reason why many human services professionals, including social workers, leave the field prematurely

(Figley, 1999). In addition, Beaton and Murphy (1995) identified short- and long-term emotional and physical disorders, strains on interpersonal relationships, substance abuse, and burnout as costs of not attending to STS in professional helpers. Furthermore, STS may impair social workers' ability to help those who seek their services (Figley, 1999; Rosenbloom, Pratt, & Pearlman, 1999). The present study does not shed light on the role of STS on social workers' decisions to abandon practice, and it does not investigate the impact of STS on the effectiveness of social worker practice; further research is needed to investigate those issues. However, this study is the first to document the extent to which STS, at diagnostic and subdiagnostic levels, is a problem faced by social work practitioners. **SW**

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