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SECONDARY TRAUMATIC STRESS DISORDER SYMPTOMS IN A SAMPLE OF THERAPISTS AND PSYCHIATRISTS WORKING WITH PEOPLE AFTER TRAUMATIC EVENTS

Objectives. To compare the level of secondary traumatic stress disorder symptoms, demographic (age) and work-related variables (years of experience, average number of trauma patients over the past 12 months, and clinical supervision) in a sample of trauma therapists and psychiatrists working with trauma victims.

Method. The study included 160 participants, 80 therapists and 80 psychiatrists, who worked with trauma victims. Participants filled out the PTSD Questionnaire: Factorial Version to assess the level of secondary traumatic stress disorder symptoms and the Berlin Social Support Scales to measure social support. They also provided demographic and work-related information.

Results: The results of our study revealed higher rates of secondary traumatic stress disorder (STSD) symptoms among psychiatrists compared to therapists. We also noticed significant differences with respect to age, years of experience and actually received support between therapists and psychiatrists.

Conclusions: Mental health specialists should be aware of the potentially negative impact of working with trauma victims in the form of secondary traumatic stress disorder symptoms.

Keywords: Secondary traumatic stress disorder (STSD), psychotherapist, psychiatrist

INTRODUCTION

There is growing evidence that mental health professionals may suffer from side effects of treatment of traumatized patients. The harmful effect is called secondary traumatic stress (STS) (Adams, Riggs, 2008; Sodeke-Gregson et al., 2013). Figley (1995, 2002) defined STS as stress resulting from helping or wanting to help a traumatized person, which is a significant psychological burden for helpers and may result in secondary traumatic stress disorder (STSD). STSD is a set of symptoms identical to posttraumatic stress disorder (PTSD; i.e., intrusive rec-

ollection, avoidant/numbing and hyper-arousal, American Psychiatric Association, 1994), but whereas PTSD stems from direct experience of a traumatic stressor, STSD is a consequence of indirect exposition to trauma due to close personal contact with a trauma victim (Pearlman, MacIain, 1995). Similarly as PTSD, STSD not only negatively influences social functioning and performance at work, but also is the source of various co-occurring mental and somatic disorders, such as depression, anxiety, insomnia, alcohol and drug abuse, cardiovascular disease, nervous system disease and gastrointestinal disorders (Pearlman, Saakvitne, 1995).

Many authors have investigated risk and protective factors for STSD among therapists. On the one hand, an intense empathic relationship and high number of traumatized clients in an individual's caseload (Schauben, Frazier, 1995), little experience in the trauma therapy (Neumann, Gamble, 1995) and a therapist's own traumatic experiences or pre-existing psychopathology (Chrestman, 1995) can contribute to higher rates of STSD among those professionals. On the other hand, clinical supervision (Chrestman, 1995), education on the consequences of STS, as well as personal psychotherapy and (Harrison, Westwood, 2009) can act as buffers from the harmful impact of hearing from trauma survivors about their trauma. In addition, perceived social support proved to be helpful in dealing with the negative consequences of working with trauma victims among therapists (Rzeszutek, Partyka, Gołąb, 2015).

However, a paucity of research exists on secondary trauma among psychiatrists. For example, Boscarino (2010) noticed that many psychiatrists, especially working in private practice, are exposed daily to patients' thoughts, feelings, and reminders of traumatic experiences, which can cause secondary traumatization. In particular, Schnyder et al. (1996) found that more than 50% of psychiatrists reported suffering from symptoms of secondary traumatization in treating posttraumatic disorders. Moreover, Gold (2004) mentioned the benefits of supervision for psychiatrists in clinical practice, which can act as a buffer from the harmful impact of working closely with trauma survivors. Other studies, conducted on psychiatric nurses, also highlighted the potentially negative impact of caring for psychiatric patients after traumatic events on the risk of secondary trauma and nurses' well-being (Pearson, 2012). In particular, Finke (2006) found that psychiatric nurses who served in the Vietnam War carried the emotional burden of work with soldiers during the Vietnam war for many years, which, in some cases, forced their resignation from work.

Aim of the study

The main aim of the current study was to compare the level of STSD symptoms in a sample of therapists and psychiatrists working with people after traumatic events, as defined in DSM-IV (American Psychiatric Association, 1994). We also examined differences in selected demographic and work-related variables (age, years of experience, average number of trauma patients over the past 12 months and attending clinical supervision), as well as the level of social support, which may be treated as an explanation for potential differences in the level of secondary traumatic stress disorder symptoms among the aforementioned two groups of participants. Given the exploratory character of studies in this area, i.e. the lack of literature concerning differences in the intensity of STSD among therapists and psychiatrists, this study did not have a priori hypotheses. We also want to underline the exploratory character of the research described in this article, especially in Polish circumstances.

METHOD

Participants

The study included 160 participants, 80 therapists and 80 psychiatrists, who worked with trauma victims. Among the therapists, there were 21 men and 59 women, aged 27–65 ($M = 39.48$; $SD = 9.02$). Among the psychiatrists, there were 27 men and 53 women, aged 25–75 ($M = 45.59$; $SD = 12.08$). The study eligibility criteria in case of therapists encompassed having a therapist's certificate or being in the process of therapist training and declaring working with trauma victims at least 1 year. The study eligibility criteria in case of psychiatrists encompassed having a psychiatrist diploma (or being an advanced student in psychiatry) and declaring working with trauma victims at least 1 year. Some psychiatrists ($n = 21$) also practiced psychotherapy in combination with the prescribing of medications. The years of experience in the occupation among

therapists ranged from 1 to 38 ($M = 9.45$; $SD = 8.02$) and among psychiatrists it ranged from 1 to 45 ($M = 17.15$; $SD = 11.80$). The average number of traumatized clients in the therapists' caseloads over the past 12 months was 31.33 ($SD = 4.78$) and in the psychiatrists' caseloads 34.93 ($SD = 4.18$). Participants from both groups treated survivors of trauma of various kinds. However, the most prevalent traumas were family violence and abuse, sexual assault and road accidents. Out of all the therapists, 66 (82%) were supervised in their therapeutic work. It is worth mentioning that out of all the psychiatrists nobody attended clinical supervision.

Procedure

Participants worked in private practices or in crisis intervention centres and clinics, in public mental hospitals, or a combination of these settings. The study was conducted in various cities in Poland, including Warsaw, Cracow, Wrocław, Gdansk, Poznan, Zielona Gora, Lublin, Tarnow and Katowice. Surveys were disseminated in paper form only. The questionnaires were sent by post to participants' private practices (with return envelopes) and also distributed by the second Author directly at crisis intervention centres and public mental hospitals. Participants were informed about the aims of the study and about the anonymity and confidentiality of individual results. They did not receive any remuneration for their participation. The total response rate among therapists was 56% and among psychiatrists 34%. The research project was approved by the local Ethics Commission.

Materials

The first part of the research questionnaire contained questions about demographic variables such as sex, age and occupation. In this part we also asked for information about details of respondents' mental health practice, such as the average number of trauma survivors the therapists worked with over the last 12 months, years of experience, and kinds of patient trauma the

therapist worked with and whether participants were supervised in their therapeutic work.

To measure the level of PTSD symptoms among trauma therapists, we used the PTSD Questionnaire: Factorial Version (abbreviation in Polish: PTSD-C; Strelau, Zawadzki, Oniszczenko & Sobolewski (2002). This inventory contains 30 items that can be divided into three scales, as identified through exploratory factor analysis: Intrusion/Arousal (15 items), Avoidance/Numbing (15 items) and a Global Scale (all items). The Intrusion/Arousal scale refers to persistent re-experiencing of a traumatic event, causing chronic symptoms of hyperarousal not present before. The Avoidance/Numbing scale refers to avoidance of stimuli associated with the trauma, causing decreased involvement in significant life activities and decreased capacity to feel certain feelings. Participants are asked to report on 4-point Likert-type scales how often in the past several months they experienced a given thought, behaviour, or emotion related to the traumatic event. Cronbach's α , for the Intrusion/Arousal scale, the Avoidance/Numbing scale, and the Global scale are .96, .92, and .93, respectively.

The nature of participants' social support was assessed with the Berlin Social Support Scales (BSSS), adapted to Polish by Łuszczynska et al. (2006). The BSSS is a set of six scales to measure cognitive and behavioral aspects of social support, including: perceived available support (the degree to which help from others is available); need for support (the degree to which social support in stressful situations is important to the respondent); support seeking (the frequency or range of support from others that the respondent seeks); actually received support (the actual amount of support received from others); provided support (a scale filled out by those who provide support to the respondent); and protective-buffering support (this is a new construct that refers to protecting close others from bad news; this scale is filled out by both the person receiving and the person providing support). Taking into consideration that the two last scales

should also be filled out by the support provider, which would be essentially impossible within the temporal and logistical constraints of this study, only the first four scales were used. Participants indicated their agreement with thirty-two statements on four-point Likert-type scales, with the following answer options: strongly disagree (1), somewhat disagree (2), somewhat agree (3), and strongly agree (4). The psychometric properties of the Polish version of the BSSS proved to be satisfactory – results for particular subscales vary between $\alpha = .74$ and $\alpha = .90$.

RESULTS

The statistical analysis of the data was conducted using IBM SPSS 21 statistical software (SPSS, 2009). We compared means and standard deviations for age, work-related variables

(the average number of trauma survivors the therapist/psychiatrist worked with over the last 12 months and years of experience as a therapist/psychiatrist), social support dimensions and secondary trauma symptoms level between therapists and psychiatrists. We used t-Test for independent samples and the Mann-Whitney U Test (see, Z values), when the assumption about the normal distribution was not fulfilled. The results of the analysis are presented in Table 1.

There were significant differences between therapists and psychiatrists when it comes to: age ($Z = -3.18; p < .01$), years of experience ($Z = -4.29; p < .001$), ($Z = -7.98; p < .001$), actually received support ($Z = -4.92; p < .001$) and all secondary trauma symptoms, including the Intrusion/Arousal subscale ($Z = -3.17; p < .01$), the Avoidance/Numbing subscale ($Z = -2.67; p < .01$) and global score ($Z = -3.09; p < .01$).

Table 1. Means and Standard Deviations for Demographic Data, Work-Related Variables, Social Support Dimensions and Secondary Trauma Symptoms in the Sample of Therapists ($n = 80$) and Psychiatrists ($n = 80$).

	Therapists ($n = 80$) <i>M (SD)</i>	Psychiatrists ($n = 80$) <i>M (SD)</i>	Therapists vs. Psychiatrists <i>t</i> test	Cohen's <i>d</i>
Age	39.48(9.02)	45.59(12.08)	-3.18(a)**	-.57
<i>Work – related variables</i>				
Years of experience as a therapist/psychiatrist	9.45(8.02)	17.15(11.80)	-4.29(a)***	-.76
Average number of trauma patients over the past 12 months	31.33(4.78)	34.93(4.18)	-.51	-.08
<i>Social support</i>				
Perceived support	26.13(4.71)	26.30(4.43)	-.24	-.03
Need for support	10.70(2.06)	10.66(2.66)	.10	.02
Support seeking	13.95(2.92)	13.62(3.10)	.68	.10
Actually received support	43.04(7.59)	49.52(8.39)	-4.92(a)***	-.81
<i>Secondary trauma symptoms</i>				
Intrusion/Arousal	15.28(10.49)	19.92(7.31)	-3.17(a)**	.51
Avoidance/Numbing	13.16(10.76)	16.74(7.97)	-2.67(a)**	-.39
Global Trauma Score	28.45(20.56)	36.65(14.29)	-3.09(a)**	-.46

Note: (a) Z = value for the Mann Whitney U Test. ** $p < .01$; *** $p < .001$.

In terms of number of patients over the last 12 months and other social support scales, there were no significant differences between therapists and psychiatrists.

DISCUSSION

Our study showed that psychiatrists revealed higher rates of STSD symptoms compared to therapists. We also noticed that psychiatrists were significantly older, worked more years in their occupation, and received more social support, compared to therapists. Therefore, we were surprised to find these differences in the level of STSD, as previous studies showed that younger age (Adams, Riggs, 2009), fewer experience in working with patients (Figley, 2002) or less social support (Harrison, Westwood, 2009) may be predictive of more severe symptoms of STSD.

However, there is one factor that may shed some light on the differences in the level of STSD between therapists and psychiatrists, i.e., attending clinical supervision. It is worth remembering that while 66 (82%) therapists were supervised in their therapeutic work, out of all psychiatrists nobody had the experience of being supervised. Various studies have demonstrated that one of the important predictors of STSD among mental health specialists dealing with trauma victims is a lack of professional support in the form of clinical supervision (Chrestman, 1999; Trippany et al., 2004). Nevertheless, we did not find significant differences in STSD level among therapists, who supervised their work and those who did not, so the conclusion about the advantages of clinical supervision may be only a hypothesis.

This study was not free of limitations. First of all, it was cross-sectional research, so causality cannot be determined within this study design. In particular, we may only speculate, basing on previous research, whether a lack of clinical supervision among psychiatrists contributed to the higher rates of STSD compared to therapists.

Second, we did not control for participants' own traumatic experiences or pre-existing psychopathology. Finally, we decided to use the PTSD-F questionnaire to measure STSD symptoms. We used this tool for two main reasons. First, researchers in the field of secondary trauma generally agree that symptoms of STSD mirror symptoms of PTSD (Figley, 1995; Schauben, Frazier, 1995). The second argument was a practical one. At the time we conducted our research, there was no questionnaire designed to measure STSD symptoms which was adapted to Polish conditions.

Despite these limitations, our study adds to the literature by comparing the level of STSD symptoms, as well as demographic, work-related variables and social support, between therapists and psychiatrists. Our results indicate that mental health specialists dealing with trauma therapy should be aware of negative impact of working with trauma victims in the form of STSD.

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i Zarządzania w Warszawie**OBJAWY WTÓRNEGO ZABURZENIA PO STRESIE TRAUMATYCZNYM
W GRUPIE PSYCHOTERAPEUTÓW I PSYCHIATRÓW
PRACUJĄCYCH Z OSOBAMI PO ZDARZENIACH TRAUMATYCZNYCH****ABSTRAKT**

Cel. Porównanie nasilenia objawów wtórnego zaburzenia po stresie traumatycznym, charakterystyk demograficznych (wiek), zmiennych związanych z uprawianiem zawodu (długość stażu zawodowego, średnia liczba pacjentów po doświadczeniach traumatycznych w ciągu ostatnich 12 miesięcy, korzystanie z superwizji klinicznej) oraz właściwości wsparcia społecznego kierowanych do osób badanych wśród psychoterapeutów i psychiatrów pracujących z osobami po doświadczeniach traumatycznych.

Metoda. W badaniu wzięła udział grupa 160 osób: 80 psychoterapeutów oraz 80 psychiatrów pracujących z osobami po doświadczeniach traumatycznych. W celu pomiaru nasilenia objawów wtórnego zaburzenia po stresie traumatycznym użyto Kwestionariusza PTSD – Wersja Czynnikowa. Właściwości wsparcia społecznego kierowanego do osób badanych zmierzono za pomocą Berlińskich Skal Wsparcia Społecznego. Badani wypełniali też ankietę, w której zawarto pytania dotyczące niektórych zmiennych demograficznych, jak również zapytano o wybrane szczegóły dotyczące ich pracy zawodowej.

Wyniki: Wyniki niniejszych badań wykazały wyższy poziom objawów wtórnego zaburzenia po stresie traumatycznym wśród psychiatrów w porównaniu do psychoterapeutów. Jednocześnie zaobserwowano, że psychiatrzy byli istotnie starsi, mieli dłuższy staż zawodowy oraz otrzymywali więcej wsparcia społecznego w porównaniu do zbadanych psychoterapeutów.

Konkluzje: Rezultaty niniejszej pracy wskazują na konieczność szerszego uświadomienia osobom zajmującym się terapią osób po doświadczeniach traumatycznych ryzyka wtórnej traumatyzacji.

Słowa kluczowe: wtórne zaburzenie po stresie traumatycznym, psychoterapeuta, psychiatra