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Secondary Traumatic Stress: Therapists' Past Trauma and Workplace Interventions

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SECONDARY TRAUMATIC STRESS: THERAPISTS' PAST TRAUMA AND WORKPLACE INTERVENTIONS

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Abstract

Secondary traumatic stress (STS) is a type of indirect trauma wherein listening to the traumatic experiences of another causes a stress reaction. STS can lead to PTSD-like symptoms which can develop after only one instance. STS affects mental health professionals at high rates because they have high rates of exposure to traumatic content. In particular, therapists with a personal trauma history have an increased risk of developing STS, as they are more likely to identify with their client's traumatic experience. This review examines how therapists' STS severity and frequency is impacted by a personal trauma history. It also identifies workplace factors shown to help reduce severity and frequency STS, such as increasing social support, implementing training techniques, and properly managing therapists' caseloads. Potential future directions in this area of research are suggested.

Keywords: secondary traumatic stress, workplace interventions, personal trauma history

Secondary Traumatic Stress: Therapists' Past Trauma and Workplace Interventions

Secondary traumatic stress affects therapists more than the general population because they encounter trauma at a higher rate, and this secondary trauma often negatively affects the person's ability to function. Secondary traumatic stress (STS) is a type of indirect trauma wherein a person listens to the traumatic experiences of another and has a stress reaction (Devilly et al., 2009; Ogińska-Bulik et al., 2021; Tarshis & Baird, 2019). STS can lead to symptoms that look similar to PTSD, and can develop after only one instance (Devilly et al., 2009; Hensel et al., 2015; Ivicic & Motta, 2017; Leung et al., 2022). Some reactions from STS may include hyperarousal/hypervigilance, distressing emotions, intrusive imagery, and avoidance of certain stimuli related to their client's trauma (Devilly et al., 2009; Hensel et al., 2015). However, those who experience trauma indirectly do not react with as severe biopsychosocial symptoms as the primarily traumatized clients (Devilly et al., 2009). While these therapists do not experience as severe symptoms as the primarily traumatized, they are exposed to traumatic content more often which increases the frequency and severity of STS. This comprehensive literature review will examine how personal trauma history and organizational factors impact STS, and will conclude with steps organizations should implement to reduce the STS within their organization.

Terminology

STS causes many issues for the therapist, and it is important to understand the concepts associated with STS to better understand how STS differs from other relevant issues. STS is a unique construct but has been confused with other similar phenomena in the past. For example, *compassion fatigue* was previously used interchangeably with STS as both were classified as the stress reactions from a traumatic experience; researchers later detangled the core aspects of each

(Ivicic & Motta, 2017; Leung et al., 2022). Compassion fatigue, like STS, results from being indirectly exposed to trauma (Leung et al., 2022). Unlike STS, the primary outcome of compassion fatigue is a reduced ability to empathize with others due to overexposure to suffering (Leung et al., 2022). That is, STS results in PTSD-like symptoms such as having maladaptive emotions (e.g. fear, anxiety, depression), intrusive thoughts, avoidance, and hyperarousal. On the other hand, compassion fatigue is mentally distancing from their client or role as well as a reduced ability to *empathize* (the ability to understand emotions and communicate that understanding).

Another term frequently associated with STS is *vicarious trauma,* as this is another potential outcome from exposure to indirect trauma. Vicarious trauma is where a therapist has continuous interaction with the client's trauma which shifts the way that therapist views the world, others, and themselves (Leung et al., 2022). These transformations may lead to a long-term change, as the body reacts in order to adapt to the environment and to protect oneself from engaging with the traumatic content (Rzeszutek et al., 2015). These transformations may also share several reactions with STS (i.e., intrusive thoughts, avoidance of thoughts, hyperarousal, and distressing emotions), as well as compassion fatigue (i.e., mentally distancing self from people and roles and limited ability to empathize with others; Center on Trauma and Adversity, n.d.). Other symptoms of vicarious trauma may include feeling drained, angry, sad, or changing identity systems (Leung et al., 2022; Mihelicova et al., 2019). While vicarious trauma shares many similar symptoms with STS and compassion fatigue, the primary distinguishing factor from these terms is that vicarious trauma is an alteration in that therapist's worldview, beliefs, and pattern of thinking and behaving in their environment. Also, vicarious trauma typically happens over time with multiple exposures to a client or their story while STS has a faster onset

and happens as a result of a singular exposure (Tarshis & Baird, 2019). While all these concepts are important for understanding issues that therapists may deal with, in this paper we will refer to these symptoms and issues as each relate to STS.

Factors Affecting STS

STS is especially prevalent in careers that deal with traumatic work environments, including many careers in the mental health field which often assist people in dealing with their traumatic content (Barceli & Napoli, 2006; Devilly et al., 2009; Winblad et al., 2018). Some examples of careers in the mental health field that frequently deal with trauma in their workplace include child protective services, social workers, counselors, and domestic violence workers (Barceli & Napoli, 2006; Winblad et al., 2018). Specifically, STS affects about one-third of child protective services workers, 15.2% of social workers, 19.2% of mental health workers who assist military personnel, and 5-15% of therapists (Bercier & Maynard, 2014; Cieslak et al., 2015; Ivicic & Motta, 2017). These fields deal with a large quantity of traumatic content which is often a predictor of developing STS. Thus, those working in these mental health fields are more likely to be at risk for STS, especially those working directly with trauma survivors (Bercier & Maynard, 2014). It is important to know the risk factors to understand how to limit factors that may increase the frequency and severity of STS in therapists.

STS is most frequently measured utilizing the Secondary Traumatic Stress Scale which has 17 items to determine the "frequency of intrusion, avoidance, and arousal symptoms associated with STS;" (Cummings et al., 2018, p. 7) all 17 items correspond with the diagnostic criteria for PTSD (Cieslak, 2015; Sprang et al., 2021). These symptoms are reported in a likert-scale ranging from "never" to "very often" (Cieslak, 2015; Cummings et al., 2018; Sprang et al., 2021). STS may also be measured using a combination of subscales on the Professional Quality

of Life: the subscales include compassion satisfaction, burnout, and secondary trauma (Cummings et al., 2018). The Professional Quality of Life scale itself mainly measures the individual's pleasure derived from working, feelings of hopelessness, inability to work effectively, and secondary exposure to stress at work (Cummings et al., 2018). Both measures are valid, and are correlated with one another (Cummings et al., 2018). While currently the research and clinical field most often uses the Secondary Traumatic Stress Scale, the Professional Quality of Life may provide more comprehensive information about the therapist (Cummings et al., 2018). However, more research should be conducted to determine which measure most accurately captures STS and provides the most clinical utility.

There are four dimensions typically used to understand the therapist's exposure to indirect trauma, with higher amounts of each showing greater severity of STS. The four dimensions are diversity, volume, frequency, and ratio. In Cieslak et al. (2015), the researchers looked at these four areas that are frequently mentioned in relation to STS as they impact the frequency and severity of STS. The first term they included in the study was *diversity* which is the variety of exposure to different forms of traumatic content (Cieslak et al., 2015). An example of a less diverse caseload is the therapist helping two clients both dealing with trauma from natural disasters; while an example of a more diverse caseload is the therapist helping two clients where one client is dealing with trauma from a natural disaster and the other from a combat-related experience. The authors conclude that a more diverse caseload is worse for a clinician. Another dimension is *volume* which is the number of clients the therapist treats for exposure to a traumatic event. For example, a therapist who has fifteen clients with trauma has a higher volume than a therapist who has five clients with trauma. STS increases as the volume increases. Next, *frequency* is how often the therapist is exposed to traumatic content (Cielak, 2015). For

instance, a higher frequency may include a therapist encountering a client with exposure to a traumatic event five times a week compared to a therapist who sees a client with exposure to a traumatic event once a week. STS also increases with higher trauma frequency. Finally, the *ratio* is the percentage of clients who are traumatized in the therapist's workload (Cielak, 2015). For example, when 60% of the therapist's clients have exposure to a traumatic event, this ratio is a higher ratio than a therapist where only 30% of their clients had exposure to a traumatic event. Higher ratios result in increased STS. Overall, the more exposure the therapist has to clients who have been traumatized in various ways, the more prevalent STS becomes (Devilly et al., 2009). This is in parallel with people who directly experience trauma because as the frequency and severity of the trauma increases, the worse the outcome (Barceli & Napoli, 2006; Devilly et al., 2009; Santiago et al., 2013; Winblad et al., 2018). These factors influence STS severity, and they are impacted by the therapist's personal factors. One common personal factor that impacts the STS severity is the therapist having a personal trauma history.

Personal Trauma History

The therapist's own personal trauma history may increase the therapist's risk of STS and the number of symptoms that manifest in the individual. Despite the negative impact it may have on their own cognitions, many therapists state that personal trauma history or early family experiences were often motivations for pursuing their occupation (Leung et al., 2022). This personal trauma history may help these individuals understand other people's experiences, and may motivate the individual to assist clients in similar situations they have experienced. These people with a personal trauma history are often referred to as *survivors*; therapists who are survivors are often more vulnerable to negative outcomes and typically report higher STS severity than those without personal trauma history because they experience the toll of their work

differently (Cieslak et al., 2015; Ivicic & Motta, 2017; Leung et al., 2022; Mihelicova et al., 2019). Any therapist has the potential to experience STS; however, previous trauma experience was often a primary risk factor for developing STS partially due to survivors being more likely to relate to their client and their experience. The therapists with a personal trauma history often felt sadness, anger, vulnerability, panic, and dissociation (Mihelicova et al., 2019). Therefore, there are often many negative issues when a therapist survivor encounters traumatic content from the client; however, one that is frequently mentioned is the therapist survivor being reminded of their personal traumatic experience.

The therapist survivor being reminded of their own trauma may cause stress for the therapist when working with the client and their traumatic content. Therapists who have a personal trauma history are more likely to experience negative outcomes from their work, especially because personal trauma history may be a risk factor in relating their experience to the client's experience. For survivors that have not processed their personal traumatic experience, this exposure to their client's traumatic content may cause an opening of past wounds (Leung et al., 2022). This stress from the reminder of their personal trauma is often called *retraumatization* or *activation of threat cues* (Leung et al., 2022; Mihelicova et al., 2019), which can cause or exacerbate STS. In a recent review, Mihelicova et al. (2019) explained that the stress of being reminded of one's own trauma was prevalent in those with a personal trauma history. This stress was not experienced by everyone with personal trauma history, but STS severity is particularly elevated when the therapist's personal trauma history is similar to their patient's traumatic experience. One particular situation that was stressful for those with personal trauma history was their client being asked questions that were unnecessary and may cause pain for their client (Mihelicova et al., 2019). For instance, in Mihelicova et al. (2019) one therapist who is a

survivor stated it was difficult to watch the medical providers ask questions just out of curiosity, wanting to know the entire story in-depth while drawing the victim's blood rather than providing the victim the care they need at that moment. Therapists who are survivors understand the client's pain in explaining or remembering situations, and it may be stressful for them to hear people of authority asking these questions.

When the therapist identifies with the situation, this increases the risk of STS; however, their STS risk may also be associated with the therapist's similarity with the client (e.g., through demographics, personality), as this may remind the therapist of their own traumatic experience (Mihelicova et al., 2019). The therapists who are survivors were significantly more likely to identify with their client than therapists who had not experienced a personal trauma history (Mihelicova et al., 2019). The identification with the client may also cause retraumatization and may also often cause the therapist to use more *empathetic engagement* (actively and empathetically participating in their client's situation). This empathetic engagement increases the risk of developing STS (Nelson-Gardell & Harris, 2003). Survivors when utilizing empathetic engagement are even more vulnerable when listening to their clients due to often understanding their client's situation and mindset better than those without a personal trauma history (Leung et al., 2022). Survivors often feel more emotionally involved with their client which often causes them to be overinvolved in their client's progress as a whole or over-empathize with their client due to this use of empathetic engagement (Leung et al., 2022). Occasionally, the therapist felt as though they were giving advice to themselves. The advice given was frequently hyper-focused on the therapist's personal experience, rather than the client's experience, if the therapist is a survivor (Mihelicova et al., 2019). Often, the therapist simply wants to ensure that their client

does not make similar mistakes they made; however, this advice may not be as beneficial as advice that relates to the client's experience.

Personal Trauma History Positive Aspects

While there are many potentially negative experiences that come from working with clients dealing with trauma when the therapist is a survivor, there are also positive aspects to working with this population. Empathetic engagement may be a positive outcome which causes the therapist to be more successful in meeting the needs of their client, as empathizing allows the individual to understand their experience and connect with the client. The therapist's personal trauma history may cause compassion satisfaction and post-traumatic growth (Leung et al., 2022). Compassion satisfaction is the feeling of personal fulfillment from doing something good for society (Leung et al., 2022). Compassion satisfaction may occur after working with a client and helping them overcome some kind of obstacle, or when the therapist feels an overwhelming fulfillment from the good they do for society. Post-traumatic growth is transformation after the direct or secondary traumatic experience that brings about a positive outcome (Leung et al., 2022). Positive effects are easier found in the survivor population who had processed their trauma, as they were less likely to be retraumatized and more likely to feel confident in their ability to understand the specific situation. The survivors who reported that their personal traumatic experience was resolved typically displayed reduced STS severity and more confidence in their ability to do their job (Leung et al., 2022). Therefore, survivors are particularly affected when there is a lack of closure or lack of defining the purpose and moving forward from their experience; however, it may not cause as much of an issue for those who have already processed this experience.

Workplace Intervention

For several years, the research has focused on individual aspects attributing to STS without looking at the work environment (Sprang et al., 2021). However, because therapists are developing STS due to exposure to traumatic content at work, organizations need to be involved in implementing ways to reduce STS. STS not only affects the individual, but may lead to dysfunction within organizations because it is associated with lower productivity, poor co-worker relationships, and may even cause a threat to public safety if the individual is too distressed to properly function (Sprang et al., 2021). Organizations that do not implement these prevention strategies or do not respond at all may endorse a harmful culture contributing to retraumatization (Sprang et al., 2021). In the mental health field, there is a high likelihood of working with clients who have experienced trauma, so organizations should look to implement support in the workplace, proper training, and caseload management to reduce STS. In the following sections, each of these topics will be addressed in turn.

Support in the Workplace

First, support is shown to be an important factor in reducing STS. Support may come from a therapists' family, friends or from their work. Within organizations, this support may either be supervisory or peer support. Effective supervision involves being engaged, authentic, and empowering (Ivicic & Motta, 2017; Slattery & Goodman 2009). The effectiveness of supervision may relate to the quality of the supervision more than the quantity of supervision (Sutton et al., 2021). Supervisors should focus on providing the therapist with more information as well as acknowledging and supporting their experience of STS, normalizing these emotions rather than blaming the therapist (Salston & Figley, 2003; Slattery & Goodman 2009; Sutton et al., 2021). In particular, utilizing supervisory meetings to identify those who may be struggling and demonstrating they are heard, understood, and known to the supervisor helps create more

positive outcomes for the therapist (Hensel et al., 2015; Sprang et al., 2021). Supervision may also be particularly useful for therapists new in the field, like students, and may focus on developing coping strategies (Tarshis & Baird, 2019). For those more experienced in the field, supervision is still an important aspect of reducing STS severity, though it may be focused less on emotional support and more on discussing cases and providing advice on case management (Sutton et al., 2021). Most studies found that supportive and effective involvement of supervisors was associated with lower STS because supervisors may help reduce and manage the worse effects of STS (Hensel et al., 2015; Mihelicova et al., 2019; Ogińska-Bulik et al., 2021; Salston & Figley, 2003; Slattery & Goodman, 2009; Sprang et al., 2021, & Tarshis & Baird 2019). However, some studies contradict these results and determined that supervision does not affect STS severity (Cieslak, 2015; Ivic & Motta, 2017). Overall, supervision is shown to be an important aspect to helping reduce STS severity, but there needs to be more research on the effectiveness of supervision and the relationship of STS severity and the quantity or quality in supervision. There also needs to be more research in understanding the aspects of supervision that are most related to lowering STS severity.

Supervision is an important modality in efforts to reduce STS severity, but organizations may also encourage peer support. The most effective peer support includes providing emotional and psychological support, as well as creating an environment where the therapist is able to share their reactions to their work and have conversations about their values (Barceli & Napoli, 2006; Slattery & Goodman 2009). Ogińska-Bulik et al. (2021), Slattery & Goodman (2009), Sprang et al. (2021), and Unick et al. (2018) all found peer support to be important in reducing STS severity. One study (Cieslak et al., 2015) found peer support to be unrelated to STS, but the majority of work in this area shows that peer support is helpful in mitigating STS. For therapists,

sharing their emotions and experiences of dealing with clients who have experienced a trauma is particularly helpful to reduce feelings of isolation (Rzeszutek et al., 2015; Salston & Figley, 2003). Peer support may also help the therapist feel heard and validated in their work and reduce the impact of stress (Sprang et al., 2021). In addition to impacting STS severity and frequency directly, increased peer support was negatively correlated with burnout, indirectly lowering STS (Salston & Figley, 2003). While positive peer support may reduce STS, unsupportive interactions increase the risk for STS (Sprang et al., 2021; Unick et al., 2018). Thus, overall there may need to be more research in the effectiveness of social support and the aspects of social support that may be most beneficial for reducing STS. This research should also look at the aspects of peer support that result in negative outcomes, and how organizations may reduce these interactions.

Formal Workplace Trainings

While proper supervision and peer support have been shown to reduce STS, providing formal training may also be helpful in reducing STS. On an individual level, training sessions result in better coping by equipping the therapist to be able to manage negative effects due to indirect exposure to clients' trauma (Mihelicova et al., 2019; Unick et al., 2018). For example, training might include learning about and utilizing self-compassion techniques which helps the therapist care for their own needs and reduce STS. Training may also include informational sessions about STS. Increased knowledge about reducing the impact of exposure to traumatic content may help to improve the therapists' well-being and provide a sense of control over situations they may experience (Unick et al., 2018). In addition to helping improve competencies, formal training may also encourage support by helping peers and supervisors recognize STS and acknowledge when therapists struggle with STS (Hensel et al., 2015).

Another way training may encourage support is incorporating feedback and interactions where conflicts and perspectives in the workplace are shared and resolved (Unick et al., 2018). Thus, proper training not only directly addresses STS, but also furthers the support within the organization, which is also shown to reduce STS. While training is shown to effectively reduce STS, there is currently a gap between the research and what is practiced day-to-day (Unick et al., 2018). This lack of implementation of training programs is particularly noticeable within under-resourced environments (Unick et al., 2018). Overall, organizations should look to implement training programs to help reduce the severity and frequency of STS for therapists.

In addition to addressing STS, formal training programs may also address nontrauma conditions affecting the well-being of the therapist, such as burnout (Sprang et al., 2021). Burnout in the workplace is defined by three primary issues: emotional exhaustion, cynicism/depersonalization, and reduced perception of personal accomplishment (Cummings et al., 2018; Rzeszutek et al., 2015; Shapiro et al., 2005, Tarshis & Baird, 2019). Emotional exhaustion is when an individual becomes overextended at work emotionally (Klint et al., 2021; Leung et al., 2022). Cynicism is feeling detached from or even having a negative attitude towards work (Klint et al., 2021; Leung et al., 2022; Tarshis & Baird, 2019). Finally, a reduced perception of accomplishment is feeling a sense of personal failure or lack of success (Leung et al., 2022; Tarshis & Baird, 2019). For therapists in particular, burnout often co-occurs with STS, but burnout can result from any non-traumatic workplace stressor (Cieslak et al., 2014; Cummings et al., 2018; Leung et al., 2022; Mihelicova et al., 2019). Burnout affects the therapist's overall well-being, and may include an increased risk of depression, anxiety, interpersonal difficulties, and feelings of helplessness/hopelessness (Cieslak et al., 2014; Mihelicova et al., 2019; Salston & Figley, 2003; Shapiro et al., 2005). These negative outcomes

not only affect the therapist, but can also result in reduced effectiveness in the therapist's care for their clients, leading to clients' reduced quality of life (Cieslak et al., 2014; Mihelicova et al., 2019; Salston & Figley, 2003; Shapiro et al., 2005). STS is significantly predicted by high burnout (Cieslak et al., 2014; Cummings et al., 2018). Because STS and burnout are often present together, routine screening for both STS and burnout may be beneficial to help combat the negative effects of each, particularly for those in the mental health field (Cummings et al., 2018). Therefore, organizations should also focus on addressing and preventing burnout to help reduce STS.

One training that workplaces can implement involves increasing therapists' ability to utilize mindfulness. *Mindfulness* involves acknowledging and accepting one's own feelings and thoughts while also remaining present (Shapiro et al., 2005). Some mindfulness activities that may be used may include a breathing exercise, meditation (i.e., awareness of current thoughts, emotions, sensations), body scan (awareness of current body sensations with movement of attention on specific body regions), and yoga (Shapiro et al., 2005, Thieleman et al., 2014). Mindfulness techniques are shown to decrease suffering and protect against compassion fatigue (Thieleman et al., 2014). In addition to increasing the therapist's ability to empathize with their clients, mindfulness techniques help individuals accept their own thoughts and emotions that arise which may directly impact the symptoms of STS such as hyperarousal and negative emotions (Barceli & Napoli, 2006; Salston & Figley, 2003). Utilizing these mindfulness techniques may reduce the frequency and severity of STS while helping to improve the therapists' well-being. Mindfulness techniques also target risk factors for developing STS. For instance, mindfulness techniques reduce burnout, psychological distress, and stress, while they increase factors that protect against developing STS such as increasing empathy, positive affect,

and life satisfaction (Salston & Figley, 2003; Thieleman et al., 2014). Mindfulness techniques are shown to also increase *compassion satisfaction*, or the positive or rewarding outcomes (e.g., pleasure) from being able to help others (Cummings et al., 2018; Giordano et al., 2020). Increased compassion satisfaction helps protect against developing burnout and reduces the severity of burnout, which in turn reduces STS (Cummings et al., 2018; Delaney, 2018; Shapiro et al., 2005). While future research on the impact of compassion satisfaction is still needed, there may be a need for organizations to implement training sessions which focus specifically on compassion satisfaction, as these trainings help reduce both burnout and STS while increasing the therapists' well-being.

Utilizing mindfulness techniques may also help the therapist develop self-compassion, which is another way to reduce STS. Self-compassion is basic caring for one's own needs while acknowledging one's personal suffering, and striving to absolve this suffering (Delaney, 2018; Lopez et al., 2015). Self-compassion is different from mindfulness because while mindfulness focuses on the present moment and responses to thoughts and feelings without judgment, self-compassion focuses on utilizing *actions* in moments of suffering to soothe pain (Bluth, & Blanton, 2014). Utilizing self-compassion is shown to be important because higher levels of self-compassion are associated with lower levels of stress, anxiety, and depression which help to reduce STS (Lopez et al., 2015). Also, self-compassion protects therapists from developing compassion fatigue, which helps reduce likelihood of developing STS (Cummings et al., 2018; Delaney, 2018; Rzeszutek et al., 2015). With this in mind, training sessions in mental health workplaces may focus on providing individuals with more knowledge about self-compassion, practicing self-compassion, and sharing this experience with one another.

Caseload Management

Caseload is defined as a combination of the number of clients a therapist is seeing, and the perceived difficulty of working with this number and array of clients. Research has shown that increased caseload negatively impacts STS (American Psychological Association, n.d.). Thus, prevention may incorporate lowering the therapist's caseload volume, number of clients with trauma, and percentage of caseload with trauma. These are areas that are frequently found to impact the occurrence and severity of STS (Cieslak et al., 2015; Hensel et al., 2015; Nelson-Gardell, & Harris, 2003; Unick et al., 2018). The caseload volume was a risk factor for STS, as higher volumes resulted in an increased risk of STS (Ogińska-Bulik et al., 2021; Salston & Figley, 2003; Sutton et al., 2021). Simply reducing the number of total clients may help reduce risk of developing STS (Cieslak et al., 2015; Ogińska-Bulik et al., 2021). Organizations should properly monitor caseloads to ensure the therapists are not overworked. Even the therapist's *perceived* caseload resulted in a positive relationship with STS showing that their perception, and not just the objective workload, may impact their risk of developing STS (Sutton et al., 2021). Organizations should also look to manage the number of clients with trauma within a therapist's caseload; because an increased number of clients with trauma within the caseload is associated with greater STS symptoms (Hensel et al., 2015; Slattery & Goodman, 2009; Sutton et al., 2021). Related but distinct from the number of clients with trauma, is the proportion of clients with trauma in the therapist's caseload. Higher proportions are shown to be correlated with increased symptoms of STS (Hensel et al., 2015; Slattery & Goodman, 2009; Sutton et al., 2021). The proportion of clients with trauma in the therapist's caseload may impact STS severity and occurrence more than simply the number of individuals with trauma (Hensel et al., 2015). Organizations may help by monitoring the proportion of clients with trauma and have the therapist balance their work so they are not working with too many clients with trauma (Hensel

et al., 2015). Once again, the therapist's perception of their caseload may be more important than the actual proportion of clients with trauma (Sutton et al., 2021). To ensure proper management of therapist caseloads, organizations should also emphasize the importance of therapists having a balance between home and work, making time for pleasure, and setting and maintaining realistic boundaries (Salston & Figley, 2003). Therefore, overall, organizations should better monitor and manage each therapist's caseload to ensure therapist wellbeing.

Overall Conclusions and Future Direction

In conclusion, this literature review looked at personal trauma history and how organizational factors impact STS, as well as how organizations may utilize this knowledge to improve the work environment to reduce STS. Therapists who have a personal trauma history are more vulnerable to negative outcomes, including higher STS. These therapists are at an additional increased risk when they can relate directly to the client's trauma experience and/or have a lot in common with the client. Alternatively, positive outcomes may occur from secondary traumatic experiences, but are most likely in therapists who have processed their own trauma.

The current study also assessed ways organizations may assist in reducing the severity and occurrence of STS for their employees. Research has shown that support in the workplace (i.e., supervisory and peer support) is effective at reducing STS, especially for therapists with a personal trauma history. Another research-based strategy to reduce STS includes providing formal training for employees. Finally, research has found that proper management of caseloads may help reduce STS. Therefore, there are many ways organizations can help reduce STS occurrence and severity. First, organizations should implement encouraging, engaging, and authentic supervisors, increasing appropriate, comprehensive supervision and providing an

environment that encourages peer support. Organizations should also look to implement initial and continued training programs that encompass mindfulness and self-compassion techniques as well as informational sessions about STS. Finally, organizations should properly manage caseloads through monitoring the number of hours the therapist works and the proportion of clients with trauma in a caseload.

Although a lot of research has been accumulated to date, we still need more work in developing and utilizing standardized tools to measure STS. Currently there is a lack of utilization of standardized tools, so the tools currently used may measure a similar concept rather than STS. For example, the Professional Quality of Life may conflate burnout with STS. Therefore, research should look at modifying this tool to better distinguish between the constructs it attempts to measure. In addition, there is currently not a clear operational definition of STS used consistently throughout the literature because slightly different definitions and terms are used interchangeably with STS. Thus, researchers and clinicians need to develop a clear operational definition that will be used across the field. Another area of research may include determining whether secondary traumatic stress should become a diagnosable mental health disorder as defined by the *DSM*. While secondary traumatic stress disorder is a term used in certain articles, it is currently not a diagnostic category. Therefore, there should be more research on whether STS should be a diagnosable disorder separate from PTSD, as a separate diagnosis may provide a more accurate description of the therapist's issues than PTSD. Based on the research contained herein, it is the author's opinion that STSD should be considered as a disorder in the sixth edition of the *DSM*. STSD may better communicate the differences in the root cause of the issues as well as the issues the person struggles with, which may differ from PTSD.

There are also currently some contradictory findings about whether supervision is important in reducing STS, and if it is, which aspects of supervision are most important. This contradiction needs to be addressed to better understand how organizations should respond and train supervisors to reduce STS in employees. There needs to be more research focusing on understanding specific aspects of supervision (e.g. supervisory knowledge about STS) and the extent each aspect affects STS. Finally, when proportions increased, so did symptoms of STS. There was no indication of an actual proportion of when this is typically too high for the therapist. Therefore, more research needs to be completed to determine what proportion often results in STS, defining what proportion seems to be too high for the therapist. In all, STS clearly has implications for therapy outcomes and the lives of the therapists, but more research is certainly warranted in certain areas to understand how to better implement practices within organizations to prevent and reduce STS.

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