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# Secondary Traumatic Stress as an Obsolete Concept

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## Editorial

For the last 25 years numerous studies have reported on the prevalence of Secondary Traumatic Stress (STS) among those who provide counseling, support and other care-giving services [1]. This documentation has been invaluable in highlighting the impact of working with people who have experienced a wide range of impactful and traumatic experiences. The benefits to this understanding of the mental health impacts on staff has been important as human service organizations have become more aware of the multiple individual, agency and system-wide factors that exacerbate and ameliorate these work related stressors [2]. However, there are several recent unfolding that suggest STS may have outlived itself as a separate concept and needs to be included in general discussions of traumatic stress in the workplace.

The accuracy of measuring the prevalence of STS is compromised when most studies consist of convenience samples which consistently report response rates ranging from 19% to 49% of those eligible to participate. Currently, most are internet based response rates averaging a rate of 34% at best and in the case of national samples represent less than 3% of eligible respondents [3]. Thus they fail to represent the total eligible population. Reports on completion rates for internet based surveys are sparse. The result is reports of prevalence based on small or inadequate samples and response rates. When response rates drop below 50% of eligible participant or of surveys distributes and returned, there is a serious concern over the characteristics of non-respondents. Issues of non-response vary from lack of participation that is recruited but failing to engage, starting but failing to complete a survey, to omitting answers either sporadically of systematically for specific types of questions. Each failure results in lack of available data for analysis and various dynamics contribute to lack of voluntary participation and survey completion [4].

Conveniences samples are frequently employed in psychosocial research as they yield reports from diverse geographic areas are cost-effective to execute. When a sample is used to study the population as a whole, the underlying assumption is that the sample characteristics will reflect the total population. This assumption may not be valid in instances where emotional sensitive and potentially upsetting information is solicited and volunteers whose psychosocial resources are depleted will more than likely not volunteer for this type of inquiry. The accuracy of prevalence reports is influenced by the common assumption that if participants meet the characteristics of the overall population (e.g. age, gender affiliation, level of education) they are then representative of all who may be impacted by STS. This rationale fails to account for high non-response and attrition rates that may be attributable to the precise attributes of avoidance of triggering questions about trauma that are the focus of the study.

With little exception, research on STS has excluded a differential investigation of whether workplace stress may be attributable to direct traumatic experiences. Almost all studies that look at STS fail to measure direct traumatic stress, and thus they do not provide a discussion of the differences between direct versus indirect trauma [5]. In a scoping review of the VT literature, Branson et al. [6] examined issues of lack of consistent results of the impact of vicarious traumatization and secondary traumatic stress of mental health professionals. These inconsistencies extend to data collection methodologies that influence results, a conclusion also reported by Molnar [1].

The symptoms of STS mirror those of primary stress, with the limitation that they are attributable to work with clients. Most studies fail to determine if participants had prior exposure to trauma, which could act as a trigger for current symptoms, and thus be attributable to direct trauma. Nor do these studies measure the extent to which workers encounter traumatizing situations work (precipitating events). For example, in some occupations, such as work with persons experiencing homelessness, and in child welfare where apprehensions occur in distressing circumstances, traumatic exposure is the norm [7]. In many human services, those with lived experience have also become valued as important assistants in helping others. Where histories of trauma a rampant, such

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as in child welfare and homeless services, staff may have traumatic symptoms reactivated directly. Additionally, the changes to diagnostic criteria from traumatic stress in DSM-5 included the introduction of repeatedly hearing about traumatic events as a qualifying event, thus obviating the need for a separate STS designation.

The diagnostic symptoms of primary traumatic stress are highly correlated with STS [5]. It no longer makes sense to treat them as separate concepts and to imply that they need to be addressed in different ways. There are several implications that should be considered. The term "secondary" implies something of lesser concern. That may not necessarily be true if staff performance suffers as a result of symptoms of traumatic stress. In turn this impacts the extent to which traumatic stress experienced in the workplace leads to and is recognized as an occupational psychological injury. Finally, in this era when we see a greater emphasizes on workplace mental health, workplace exposure to traumatic stress can lead to sick leave and disability claims for psychological injury. These considerations point to the importance of establishing the extent to which staff may be vulnerable to re-triggering events, and the degree to which characteristics of resiliency may buffer those impacts. It also underscores the importance of addressing the impacts of trauma on staff.

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