

A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians

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Abstract

The terms secondary traumatic stress, compassion fatigue and vicarious trauma are often used in literature to describe emotional consequences for health professionals working with traumatised clients. While research has paid some attention to social workers, care givers and other health professions in contact with traumatised clients, little specific attention has been paid to clinicians working in the alcohol and drug field. This article reports on a systematic review of literature that looked at what had been said about one or more of the three terms outlined above, for professionals that work within the alcohol and drug field. The aim of this review is twofold. Firstly, to increase awareness of an issue that appears to have gone unnoticed within this sector. Secondly, to highlight the importance of such awareness for clinicians and those involved in managing services within this sector. The current review found few published papers that investigated these terms with reference to alcohol and drug clinicians. However, the available literature reviewed did show that alcohol and drug clinicians are at risk of experiencing secondary traumatic stress and compassion fatigue. No literature was found that discussed vicarious trauma. The implications of this absence of literature are discussed,

particularly with reference to the health and wellbeing of alcohol and drug clinicians. Recommendations for future research in this area are discussed.

Keywords: *compassion fatigue, secondary traumatic stress, vicarious trauma, alcohol and drug clinicians/counsellors, systematic literature review.*

The aim of the following systematic review was to explore published literature that investigated the terms *vicarious trauma, compassion fatigue* and *secondary traumatic stress* within the Alcohol and Other Drug (AOD) clinician population. The purpose is to generate an increased awareness of these concepts within this sector and to highlight the importance of such awareness, both for clinicians and for managers of AOD services.

Although acknowledged as an important issue by many health and social service sector professionals, limited attention has been paid to this issue and these concepts within AOD professional groups. The terms secondary traumatic stress, compassion fatigue and vicarious trauma are terms describing the potential emotional effect experienced by clinicians and other health professionals that work with clients who have experienced trauma. Their long-term effects on health professionals engaging with clients' trauma have become viewed as an occupational hazard, as described in a range of prior literature (McCann & Pearlman, 1990; Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 2010). Interest in this topic has since been growing within the area of health, concerning professional and occupational groups such as physicians (Nimmo & Huggard, 2013; Huggard, Stamm & Pearlman, 2013), audiologists (Severn, Searchfield & Huggard, 2012), veterinarians (Huggard, 2008), therapists (Pearlman & Saakvitne, 1995), emergency workers (Nimmo, 2011), partners of emergency workers (Alrutz, Buetow, Huggard, & Cameron, 2016), refugee support workers (Ismayilov, 2013) and nurses (Vachon, Huggard & Huggard, 2015).

However, the occupational group of alcohol and other drug (AOD) clinicians has historically received little research attention (Bride & Walls, 2007). This clinical group includes counsellors, social workers,

psychologists and other therapists. In the literature examined, no studies have differentiated between specific staff roles, for example between counsellors and psychologists, concerning their different therapeutic approaches and vicarious traumatization, secondary traumatic stress or compassion fatigue. Therefore, for the purpose of this article, AOD clinicians will be considered as one professional group.

Previous research indicates that it is common for AOD counsellors to treat clients with trauma histories (Bride & Kintzle, 2011; Bride, Hatcher & Humble, 2009). Relevant effects on the personal health of AOD professionals and on the effectiveness of their work have been observed. Some of the effects of secondary traumatic stress, compassion fatigue, and vicarious trauma on clinicians that have been described include: experiences of increased anxiety, depression, hopelessness, and hypervigilance (Perkins & Sprang, 2013; Sprang, Clark & Whitt-Woosley, 2007); and symptoms of intrusion, avoidance and arousal (Bride et al., 2009). It is therefore possible that the clinician may tend to avoid the traumatic material being shared by the client, or may tend to stay overly task oriented. They may also minimize what the client reports, or dissociate from the client at crucial times when clients are sharing their experiences, all as part of a lack of capacity for emotional empathy, which diminishes service quality (Pearlman & Saakvitne, 1995). Furthermore, the clinician may be at a higher risk of making poor professional judgements such as misdiagnoses and poor treatment planning and may withdraw from pleasant activities that they once enjoyed outside of work (Rudolph, Stamm & Stamm, 1997). All or some of these effects can impair the ability of a clinician to work effectively with clients who are seeking their support (Figley, 1999).

Vicarious trauma, compassion fatigue or secondary traumatic stress within the AOD clinician population is important at any given time. However, these dynamics may have greater significance following a major event, such as a disaster, particularly when individuals' psychological functioning may be impaired. The relationship between alcohol abuse and such events has been previously reported by Keyes, Hatzenbuehler and Hasin (2011), North, Kawasaki, Spitznagel and Hong (2004), and by Stewart, Mitchell, Wright and Loba (2004). Individuals with an existing alcohol abuse disorder are more likely to report drinking as a coping mechanism following a traumatic event (Keyes et al., 2011). There is also an extensive literature connecting

posttraumatic stress disorder (PTSD) -like symptoms and disasters, as reviewed by Neria, Nandi and Galea (2008). Although no such research was identified during the current review, PTSD-like symptomatology may be experienced by both AOD clinicians and their clients, as a result of disaster events. With respect to AOD clients experiencing a major traumatic event such as a disaster, having a pre-existing condition such as a substance abuse disorder could result in an increase in excessive alcohol or other substance consumption. With respect to AOD clinicians, any impaired psychological functioning following such major traumatic events may be greater given that they may also be experiencing a degree of emotional trauma in relation to their client caseload. These possibilities reinforce the need for clinicians to routinely engage in supportive processes that aim at mitigating the impact of vicarious traumatization, compassion fatigue, or secondary traumatic stress.

Concept Definitions

The concepts of secondary traumatic stress, compassion fatigue, and vicarious traumatization have been explored in earlier articles. While some research suggests that there may be some slight differences between these terms, they all describe a process relating to the impact of being exposed to, or knowing of, the suffering of others (Huggard, Stamm & Pearlman, 2013; Thomas & Wilson, 2004).

Secondary Traumatic Stress

Secondary traumatic stress (STS) has been described as a natural consequence of caring for another individual who has had a traumatic experience (Figley, 1995; Bride et al., 2009). A STS response by an individual refers to PTSD-like symptoms that occur following indirect contact with traumatic events experienced by a significant other (Bride, Robinson, Yegidis & Figley, 2004; Figley, 1995, 2002). Symptoms can include intrusive cognitions where imagery related to clients' trauma is experienced, along with distressing emotions, avoidance responses, psychological arousal and functional impairment (Figley, 1995; McCann & Pearlman, 1990). The Secondary Traumatic Stress Scale (STSS) developed by Bride et al. (2009) is a 17-item self-report instrument to assess the frequency of negative effects of those that come into contact with traumatised clients. The scale attempts to measure incidents of PTSD symptomatology, intrusion, avoidance and arousal.

Compassion Fatigue

Compassion fatigue has been described as the negative effects experienced by the health professional having come into contact with, or knowing about the distress and suffering of others (Figley, 1995, 2002; Huggard, Stamm & Pearlman, 2013). Research reported by Figley (1995) has shown that compassion fatigue is a consequence of working with traumatised clients and is determined by the level of exposure the clinician has to the trauma and their capacity to empathise. Instruments designed to measure include the Compassion Fatigue Self-test (CFST) (Figley, 1995), and, more recently, the Professional Quality of Life Scale (ProQOL) (Stamm, 2010).

Vicarious Trauma

Vicarious trauma was initially described by Pearlman and Saakvitne (1995) as a cumulatively undesirable transformation in the therapist who engages empathically with a traumatised survivor's life story. They suggest vicarious trauma refers to a transformation of the clinician's inner experience that results from empathic engagement with clients' trauma material which can make the clinician vulnerable to the emotional and spiritual effects of vicarious traumatisation. These changes can take place in the therapist's professional and/or personal life and include symptoms that reveal themselves within physical, behavioural, psychological and spiritual dimensions. This affects the way clinicians view themselves, their world view, beliefs and values, and therefore over time can change their cognitive schema in a negative way (Pearlman & Saakvitne, 1995). More recent research has explored vicarious traumatisation and identified it as a change process (Pearlman & Caringi, 2009) and has conceptualised certain positive changes resulting from trauma work such as vicarious posttraumatic growth (Arnold, Calhoun, Tedeschi & Cann, 2005) or as vicarious resilience (Hernandez, Gansei & Engstrom, 2007). One instrument designed to measure vicarious trauma is the Traumatic Stress Institute Belief Scale – Revision L (TSI-BSL) which measures and assesses cognitive disruptions in psychological areas of safety, trust, control, intimacy, and power (Jenkins & Baird, 2002).

Although some conceptual differences have been proposed between the concepts of secondary traumatic stress, compassion fatigue, and vicarious traumatization (Thomas & Wilson, 2004), they all describe the impact upon a clinician of working with traumatised clients. Therefore, the aim of the current review was to search

literature for articles that featured one or more of secondary traumatic stress, compassion fatigue and vicarious trauma, to determine what has been discussed concerning these dynamics among AOD professionals.

Method

A systematic review of electronic data was conducted using keyword and search criteria to obtain literature for appraisal. Several methods and guidelines exist for reporting of systematic reviews in healthcare research (Nimmo, 2011). This review used the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) (Moher et al., 2009) protocol as a guide. Meta-analysis was not conducted due to the limited range of research articles extracted in the search, the heterogeneity of data, and differences in study design, outcomes, metrics, and participant populations (Ioannidis, Patsopoulos & Rothstein, 2008).

Search Strategy

The electronic data bases searched were Scopus, Cinahl, PsycINFO, Medline, DRUG, Social Work Abstracts, PILOTS and EBASE. Three categories of search terms were used. The first category identified the trauma related concepts under investigation: secondary traumatic stress, compassion fatigue, and vicarious trauma. The second category identified the profession of interest to this review: Counselors, Counsellors, Therapists, Clinicians, Social Workers, Psychologists, and Psychotherapists. Lastly, the third category of interest for the review was to specify what professional field these professionals work in: substance abuse, alcohol abuse, drug abuse, alcohol and other drugs. Search terms for each category were separated by "OR", before categories were combined with "AND". Specific inclusion and exclusion criteria were established for this review, using guidance from Montori, Swiontkowski and Cook (2003). Date restrictions were not included in the inclusion /exclusion criteria in order to identify all available literature.

Literature extracted from each database was then reviewed and screened for relevance according to these criteria. Abstracts were included according to the following: (i) the literature had to mention at least one of the trauma terms under review, (ii) had to mention a profession noted in the above search string, and (iii) had to include members of these professions working in the substance abuse field. Exclusion criteria were: (i) articles not written in English, and (ii) documents other

than journal articles, reports, theses or dissertations. Complete articles were extracted and reviewed for abstracts that met these criteria.

The articles reviewed were then assessed with reference to the criteria in Table 1 which lists the quality standards utilised for this systematic review as previously described by Nimmo (2011) and Nimmo and Huggard (2013). Quality scores were calculated as follows: If a criterion was judged as having been met (“Yes”) this counted as one point; except for criterion three which was broken up into five sub-questions, with each sub-question covering 0.2 points. The points obtained for each study were then summed with a maximum possible score of six points. Total points were then divided by the total number of criteria used within the table to assess and give a maximum result of 1.0.

Table 1
Criteria Used to Appraise the Quality of Reviewed Literature

Quality criterion	Y/N	Score
1. The research question/aims/objective is clearly explained		1
2. An appropriate study design has been used		1
3. The study adequately describes the following:		
(i) Sample/Participants		0.2
(ii) Sample strategy		0.2
(iii) Methods		0.2
(iv) Data collection methods		0.2
(v) Context of collection		0.2
4. Construct description and definition		1
5. Researcher reflexivity		1
6. Ethical concerns mentioned		1

Results

Study Selection

An initial total of sixteen references were extracted from electronic databases and one article was extracted from a non-electronic database. Following the removal of four duplicates, thirteen articles were screened. Six articles did not meet inclusion criteria, leaving seven articles for full review, as shown in Figure 1. These seven references met all inclusion criteria and were included in the systematic review. The review summaries for these articles are shown in Table 2.

Results of Quality Appraisal

Results of the assessment of each article against the criteria shown in Table 1 is reported in Table 3. For

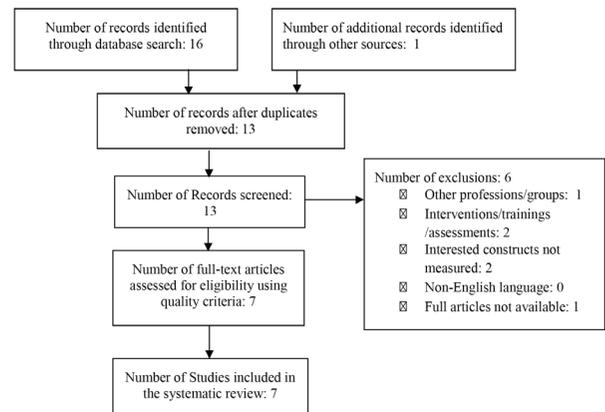


Figure 1. Flow diagram of the modified PRISMA protocol used to select articles included in the systematic review

example, the article by Bride (2007) was judged as meeting all designated quality criteria.

Discussion

The reviewed literature suggested that substance abuse counsellors and other professionals who work with traumatised clients are at risk of experiencing secondary traumatic stress and compassion fatigue. However, no specific AOD literature was found that discussed vicarious trauma. The reason for such an absence of literature is unknown, but may be due to a limited awareness of these concepts within the substance abuse sector.

Bride (2007) reported that 587 (97.8%) of clinicians surveyed ($N = 600$) had experienced trauma, and that 533 (88.9%) indicated their work with clients addressed issues related to client trauma. Bride, Hatcher and Humble (2009) reported that 218 (97%) of the counsellors within their study ($N = 225$) said they had traumatised clients in their caseload, and indicated that 25 percent of their clients had experienced substantial trauma in their lives. Furthermore, three of the articles reviewed ($N = 600$, $N = 225$, $N = 216$) reported that 55-56 percent of clinicians met the criteria for a least one of the core symptoms clusters of PTSD and between 15-19 percent met the core criteria for diagnosis of this condition (Bride, 2007; Bride et al., 2009; Bride & Kintzle, 2011). Two articles ($N = 225$, $N = 412$) mentioned that almost 20 percent of clinicians surveyed met criteria for secondary traumatic stress (Bride et. al, 2009; Ewer, Teesson, Sannibale, Roche & Mills, 2015). One focused on compassion fatigue, saying that out of 20 participants, 9 had high levels of compassion fatigue (Perkins & Sprang, 2013). The extent of PTSD symptomatology and the levels of compassion fatigue reported in these

Table 2.
Summary of Selected Papers

Reference	Research Aims and Measures Used	Findings
Bride (2007)	To investigate the prevalence of secondary traumatic stress in a sample ($N = 600$) of social workers working in a variety of professional roles, of which (56.6%) identified as mental health or substance abuse as their primary field of practice. Examined the frequency participants met diagnostic criteria for post-traumatic stress and the severity of secondary traumatic stress. This was measured by using the STSS scale.	55% of participants met criteria for at least one of the core symptoms, and 15.2% met core criteria for PTSD.
Bride & Walls (2007)	To provide an overview of the conceptual and empirical literature on secondary traumatic stress as well as recommendations for prevention within a number of professions such as sexual assault counsellors, social workers, child welfare worker, psychotherapists, and trauma therapists.	Revealed that secondary traumatic stress is a reality of work in the designated areas. However, at the time of this literature overview it was found that no studies had been published examining the prevalence of secondary traumatic stress among substance abuse counsellors.
Fahy (2007)	Literature review of empirical research on professionals who provide psychosocial services to traumatised populations that takes a look at vicarious trauma, and compassion fatigue within substance abuse practice.	Revealed that STS is a reality of such work and highlights the need for adequate training, Assessment for PTSD in workers should be standard practice, Research must shape practice to create safety for the client and the professional. Identification of compassion fatigue, and secondary traumatic stress should be a regular part of supervision and counsellor wellness programs.
Bride et al. (2009)	To determine to what extent substance abuse counsellors are trained and if they assess and treat trauma and PTSD in substance abuse clients, and secondly to determine to what extent substance abuse counsellors experience STS. To assess level of STS by administering the STSS ($N = 225$).	75% of counsellors experienced at least one symptom of PTSD in the previous week, 56% meet the criteria for a least one of the core symptoms clusters and 19% met the core criteria for diagnosis of Post-traumatic stress disorder (PTSD).
Bride & Kintzle, (2011)	Purpose of the study was to examine the relationship between Secondary Traumatic Stress (STS) and job satisfaction and turnover retention in a sample of substance abuse counsellors. ($N = 216$) STS was measured using the STSS. Job satisfaction and occupational commitment measured using the ProQOL. Also used a Likert scale to measure trauma clients. Data was analysed with a Statistical Package from Social Sciences version 17.0.	Mean age of 56 years. Primarily female (59%) White (90%). 66 percent had completed masters degrees or higher. With 20yrs average experience. 56% met a least one of the core diagnostic criteria for PTSD. Mean for job satisfaction 12.99, and Occupational commitment mean 4.1. Based on these findings, the authors encourage employers to find ways of increasing job satisfaction as a way of enhancing occupational commitment.
Perkins, & Sprang, (2013)	To examine compassion fatigue, burnout, and compassion satisfaction in two groups of counsellors ($N = 20$) specialising in substance dependency treatment in order to identify the unique features of substance service delivery related to professionals' quality of life. Qualitative face to face interviews were conducted; at the end of the interview each participant completed a ProQOL IV scale, and the general empathy scale. A six-step approach was used to analyse data.	5 of the 20 interviewed scored high for Compassion satisfaction, 3 scored high for burnout, and 9 scored high for compassion fatigue.
Ewer et al. (2015)	The aim of the study was to examine the prevalence of secondary traumatic stress among AOD counsellors in Australia ($N = 412$). Levels of trauma training, extent of exposure to clients with trauma history, AOD counsellors own history of trauma exposure and PTSD, and current STS. Analysis compared those that currently met criteria for experiencing STS and who did not. Analysis was conducted with IBM SPSS Statistic version 20.0. (7.1%) social workers and range of other AOD professionals (26.8%).	One in five (19.9%) meet criteria for STS consistent with the findings of (Bride et al. (2009)

Table 3
Summary of Quality Scores

Criterion	1	2	3(i)	3(ii)	3(iii)	3(iv)	3(v)	4	5	6	Total Score
Articles	Research question clearly stated	Appropriate study design used	Samples/ Participants	Sample strategy	Methods	Data Collection methods	Context of collection	Construct Description and definition	Researcher reflexivity	Ethical Concerns mentioned	
Bride (2007)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1.00
Bride et.al. (2007)	Y	N	N	N	N	N	N	Y	N	Y	0.50
Fahy (2007)	Y	N	N	N	N	N	N	N	Y	Y	0.50
Bride et.al. (2009)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	0.83
Bride et.al. (2011)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	0.83
Perkins et.al. (2013)	Y	Y	Y	Y	Y	Y	Y	N	N	Y	0.67
Ewer et.al. (2015)	Y	Y	Y	Y	Y	Y	Y	N	N	Y	0.67

Notes:

For a description of each quality criterion, refer to Table 1.

Scoring: 'Y' = "Yes" criterion is evident. Yes equals 1 point, except for criterion 3, which is broken up into five sub-questions, with each sub-question = 0.2 points. 'N' = the criterion is not evident. Scores were then summed with a possible maximum of 6 and divided by 6 (the total number of criteria used within the table). The resulting score has a maximum of 1.

research findings are of concern. They all exceed levels found in the general population and suggest that clinician's exposure to the traumatic experiences of their client groups is having a negative impact on the clinicians' own health and well-being.

These limited results suggest a possible need for interventions to mitigate the impact of client trauma for clinicians working in the AOD sector. A prior literature review by Fahy (2007) highlighted the importance of assessing clinicians for the presence of PTSD and secondary traumatic stress in all workers. This review also proposed that research must inform practice with PTSD and substance abuse client presentations in a way that creates safety for both the client and the clinician, and that the identification of compassion fatigue, and secondary traumatic stress should be a regular part of supervision and counsellor wellness programs (Fahy, 2007). Furthermore, Ewer et al. (2015) emphasised the importance of substance abuse training in association with trauma training when training clinicians.

Limitations

Few articles could be extracted from the database search, indicating that this is a new area of study that has yet to be given significant attention in the AOD research environment. Of those studies included in this review,

there were limited numbers of participants surveyed and a high percentage of Caucasian middle-aged females, with little representation of other ethnicities. The majority of the data was from the USA, and secondary traumatic stress and compassion fatigue were only two concepts examined. No studies explored vicarious trauma, which may have been systematically neglected or which may simply not form part of the common lexicon. Regardless, the current review results suggest a need for further research in the AOD clinician sector, specifically aimed at identifying clinicians' understanding of the three trauma-related concepts, and particularly their relevance to AOD work. Additionally, research is required that identifies effective approaches to preventing the development of trauma-related consequences as well as to fostering appropriate rehabilitative processes.

Conclusions

The results from this systematic review highlight that research into the presence of secondary traumatic stress, compassion fatigue, and vicarious trauma has received little attention within the AOD field. The implication of this lack of attention is that, with vicarious traumatisation not being acknowledged as an important issue within the AOD clinician population, there is considerable opportunity to conduct research in a variety of areas. These research areas may include

gaining an understanding of the prevalence of vicarious traumatisation impacts in this group of clinicians, the state of psychoeducation for clinicians, and the extent of normalisation of relevant impacts. Additional research could explore differences in the impact of trauma-related experiences between clinicians from different professional groups (counsellors, psychologists, psychotherapists, etc.). Research into interventions for mitigating the impact of vicarious traumatization would be particularly useful.

Research is also required to identify stigmatisation of help-seeking. Although this was not addressed in the articles reviewed, it may be an issue in certain parts of the AOD sector. Any resulting lack of intervention may have a long term negative impact on the health and well-being of AOD professionals. The overall lack of relevant literature indicates that further research opportunities into this area exist, particularly into the effects of the three dynamics, and their impacts on the AOD work force. Research into mitigation remains the most pressing priority. As illustrated in several post-disaster contexts, mitigation measures may be particularly in demand from time to time. Given the overall prevalence of relevant and negative impacts, it seems that secondary traumatic stress, compassion fatigue, and vicarious trauma will require ongoing mitigation as part of standard approaches to support within the AOD practitioner community.

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