

RUNNING HEAD: WHEN IT HURTS TO HELP

When it Hurts to Help: A Review of Secondary Trauma in Helpers

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Introduction

Reason for Study

There are many helpers in our service professions who are not able to continue their work after a certain number of years, becoming jaded and hardened to their helpees. They often lose the passion and energy they once had in their work. This reflects that the work they do is challenging and comes with a cost. Perhaps the most difficult population to help is people who live with and/or are the survivors of trauma. This study seeks to review the rates of Secondary Trauma (ST) that helpers of traumatized people experience from various professions and offer a review of the literature surrounding how it develops and what can be done to address this trauma in our helpers.

Terms and Premise

There are several key terms in this review. In order to help the reader to follow along the following list is included. Each of the following terms are related, but this study will focus on ST which is related to compassion fatigue because it contributes to it, but different in that it is a more specific set of symptoms that relates to trauma and not only a loss of empathy and compassion which could be caused by a variety of issues. Some of our sources (Hydon, Wong, Langley, Stein, & Katoaka, 2015; Beck, 2011) use the terms interchangeably, but we choose here to differentiate them with compassion fatigue being brought on by multiple factors and STS by working with a person who was directly traumatized.

Key Terms	
STS	Secondary Traumatic Stress, when someone takes on the social, emotional, or cognitive symptoms of people they are helping.
STSS	Secondary Traumatic Stress Scale
PTSD	Post Traumatic Stress Disorder, a diagnosis which describes trauma's effect on a person. The STSS measures three domains of PTSD symptoms: arousal, avoidance, and intrusion.
Compassion Fatigue	When a person struggles to maintain the same level of compassion they originally had in their work.
ST	Secondary Trauma, the experiences which cause STS i.e. caring for a traumatized person, hearing a story of trauma.

Literature Review

Our studies were found using Milligan College's "MC Search" feature, which scans numerous scholarly databases at once. Search terms included "Secondary trauma in helpers", "the stss", and "impacts of helping" and then using references from sources to find other sources.

Concepts/ Symptomology

STS is what occurs when a helper takes on the cognitive, emotional, and social symptomology of a person who has experienced a direct or primary trauma. The person experiencing STS has parallel symptoms that are nearly identical to the traumatized person who they are helping or care about (Bride, Robinson, Yegidis, & Figley, 2004). The person experiencing STS has continued close contact with trauma survivors (Bride, Robinson, Yegidis, & Figley, 2004). It results from either helping or wanting to help the survivor of a trauma (Bride, Robinson, Yegidis, & Figley, 2004; Beck, 2011; Hydon, Wong, Langley, Stein, & Katoaka, 2015). Empathy is a link for people who experience secondary traumatic stress (Motta, 2012;

Hydon, Wong, Langley, Stein, & Katoaka, 2015). At times even just hearing about a trauma can be a ST for a person (Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015; Hydon, Wong, Langley, Stein, & Katoaka, 2015). It can become impairing and the symptoms are nearly identical to PTSD (Bride, Robinson, Yegidis, & Figley, 2004; Motta, 2012; Bride and Walls, 2006). In fact some sources describe it as the “development of post traumatic stress symptoms following indirect exposure to traumatic material” (Kintzle, Yarvis, & Bride, 2013, p. 1310). The only theory cited about why we can develop STS is that perhaps it has some survival value for us as a species, helping us to develop an adaptation to face and overcome dangerous situations we’ve heard about others facing (Motta, 2012).

There is no specific cause, but there are some patterns that emerge in studying helpers as to why they experience STS. In one study clinicians rates of STS were positively correlated with the number of trauma clients on their caseload (Bride, Robinson, Yegidis, & Figley, 2004; Kintzle, Yarvis, & Bride, 2013). STS has also been correlated to simply the number of a clinician’s caseload (Cornille, & Meyers, 1999). There are associations between severity and whether the helper themselves has experienced a primary trauma (Cornille, & Meyers, 1999; Kintzle, Yarvis, & Bride, 2013; Bride & Walls, 2006). Several studies cite education or the lack thereof and inexperience as contributors of STS (Alisic, 2012; Bride, Robinson, Yegidis, & Figley, 2004; Kintzle, Yarvis, & Bride, 2013; Beck, 2011).

Measures

We have a sample of studies which measured STS in specific populations. There were four principal studies which offered us the best measures for comparison. Three of these studies used the secondary traumatic stress scale (STSS). The STSS was first developed by Bride, Robinson, Yegidis, and Figley (2004) with a sample of 294 clinical social workers from across

the country. In that initial study social workers had a mean score of STS of 29.49 with a SD of 10.76. His scale measures the domains of PTSD from a secondary perspective. His scale has a very high internal consistency with an $\alpha = .93$ (Bride, Robinson, Yegidis, & Figley, 2004). The scale was further validated by several confirmatory factor analyses, one of which we'll discuss here. The authors attempted to determine the internal consistency reliability and the factor structure with a national sample of mental health social workers (Ting, Jacobson, Sanders, Bride, & Harrington, (2005). They also found a high α of .94 in measuring the internal consistency reliability and the three factors of the subscales were highly correlated to one another (Ting, Jacobson, Sanders, Bride, & Harrington, 2005).

The other measure used in our review was the Basic Symptoms Inventory (BSI) which was used with Child Protective Service (CPS) workers before the STSS was developed and before any measure specifically designed for STS existed (Cornille, & Meyers, 1999). CPS workers help survivors of primary trauma, but they are not in a therapeutic role. Instead they investigate alleged abuse and neglect of children, link families to services, and placing children in foster or adoptive homes (Cornille, & Meyers, 1999). The BSI is a self-report, brief scale with subscale coefficients ranging from .71 to .85 (Cornille, & Meyers, 1999). A description of several of these studies can be found in Appendix A.

Data

There were four studies which looked specifically at the level of STS in a single helper population using quantitative means of analysis with one population. These studies are carefully examined and compared here because of their similarity in method.

Children's Advocacy Center (CAC) forensic interviewers were a population to be given the STSS. They had a mean score of 36.69 (Cornille, & Meyers, 1999). The researchers compared the rates of STS with certain correlates such as environmental factors.

For CPS workers there were subscale means listed in the table below. They also had a significantly higher rate of psychological distress than non-psychiatric people who take the BSI while also being less than psychiatric people who have taken the test (Cornille, & Meyers, 1999). In other words they were more distressed than people not hospitalized but less distressed than inpatient clients. With that said between 6% and 37% of participants still scored at or higher than the psychiatric population for a subscale of the measure (Cornille, & Meyers, 1999).

Juvenile justice education workers ($n = 118$) were studied using the STSS as well. Their primary work is with youth who have been significantly traumatized (Smith Hatcher, Bride, Oh, Moultrie King, & Franklin, 2011). The primary role of these workers is to teach youth while they are in the juvenile justice system (Smith Hatcher, Bride, Oh, Moultrie King, & Franklin, 2011). They had an average score of 37.74 on the scale, and 39% of those surveyed met all three diagnostic core criteria for PTSD (Smith Hatcher, Bride, Oh, Moultrie King, & Franklin, 2011).

Military primary and mental health were the final population we were able to compare based on the STSS. This study looked at 70 military health care providers which included mental health providers such as social workers, psychologists, and psychiatrists as well as primary health providers such as primary care doctors, and nurses (Kintzle, Yarvis, & Bride, 2013). A majority of participants (79%) identified as being mental health workers with 17% identified as primary care (Kintzle, Yarvis, & Bride, 2013). The authors of this study suggested that the participants endorsed having the STS symptom if they responded "occasionally," "often," or "very often" to any item on the scale (Kintzle, Yarvis, & Bride, 2013). The authors suggest that

the low overall score of their data may be because of a small sample size (Kintzle, Yarvis, & Bride, 2013).

Rates of Secondary Traumatic Stress in Helpers

References	Population	Sample	Scale	Result
Bonach, K., & Heckert, A. (2012).	Children's Advocacy Center Forensic Interviewers	Convenience sample of 257 members of CACs from across the country	STSS	$M = 36.69$ $SD = 12.13$
Cornille, T., & Meyers, T. (1999).	Child Protective Service Workers	Convenience sample of 360 CPS workers from a southern state	BSI	CPS mean vs. non psychiatric sample mean. Anxiety: $M = .76$ vs. $.34$, Depression $M = .64$ vs. $.28$, Interpersonal-Sensitivity $M = .71$ vs. $.32$
Hatcher, S., Bride, B., Oh, H., King, D., & Catrett, J. (2011).	Juvenile Justice Education Workers	Convenience sample of 118 members of the Georgia Department of Juvenile Justice Education Staff	STSS	$M = 37.74$ $SD = 10.74$
Kintzle, S., Yarvis, J., & Bride, B. (2013)	Primary and mental health military providers	Convenience sample of 70 providers from two military hospitals	STSS	$M = 30.76$ $SD = 12.33$

**The Secondary Traumatic Stress Scale (STSS) is a 17-item Likert-type scale measuring Intrusion, Arousal, and Avoidance symptoms.*

The Brief Symptom Inventory (BSI) is a brief inventory measuring 9 psychological symptom categories.

In addition to these populations we also studied a systematic review of STS in Nurses which used the STSS as well as other scales, qualitative studies of STS in educators, and one conceptually focused study on STS in substance abuse counselors.

The systemic review of nurses looked at six studies with 7 nursing populations including oncology, nurses in pediatrics for patients with chronic medical conditions, sexual assault nurse examiners, oncology nurses, hospice nurses, children's hospital nurses, and intensive care unit nurses (Beck, 2011). Interestingly, the population with the lowest percent of subjects experiencing STS was the forensic nurse examiners and the highest were hospice workers with a wide range of 25% - 78% (Beck, 2011). Participants were given several different measure of compassion fatigue, STS, and burnout and the author chose to use the terms interchangeably (Beck, 2011). For the two studies which used the STSS hospital oncology and emergency room in community hospital nurses were the populations that were given the instrument. With oncology 38% had moderate STS and in ER nurses 33% met all the diagnostic criteria for PTSD. This study also used a score of 38 or higher on the STSS to determine the presence of STS (Beck, 2011).

Educators, although they are not uniquely exposed to helpees who have experienced trauma, are facing primary trauma in a large percentage of their students (Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015; Alisic, 2012). Like mental health workers, teachers may experience similarly high rates of STS because of their large class sizes and heavy workloads (Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015).). In two of the qualitative studies, challenges faced by teachers included the being new to the field, not being able to help students who were traumatized, and a lack of training on how to help traumatized students (Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015; Alisic, 2012; Alisic,

2012). This study suggested that dialogue between colleagues is an effective mitigator for STS (Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015) which reflects Beck's advocacy for support groups as an effective help for nurses living with STS (2011). It is important to note that one study found not only the lack of experience or education to be a contributor to distress in helping traumatized students, but also specific training on how to help traumatized students (Alisic, 2012; Hydon, Wong, Langley, Stein, & Katoaka, 2015).

One source which described ST in substance abuse counselors offered an overview of the concept as well as some particular applications for substance abuse counselors. In the article, the authors essentially state that there are no empirical studies of STS in substance abuse counselors but with all we know about trauma and the nature of the therapeutic relationship it is highly likely that they experience STS (Bride and Walls, 2006). People living with addiction are yet another highly traumatized population, and this article brings to light the rates of trauma in our society and the need to support all helpers who experience it (Bride & Walls, 2006).

Interpretation

With the potential link between environmental factors contributing greatly to STS it is important to consider the systemic work that surrounds helpers. Many of the studies referenced here had lower rates of STS than the score of 38 recommended by several of our others to suggest the presence of STS (Beck, 2011). With that said, each of our sources that used the STSS still had higher rates than Bride in his initial sample with clinical social workers which yielded a mean score of 29. This could reflect that in each study there were participants who had very high rates of STS, and at the very least these other forms of helper experienced more STS than the social workers sampled. It is also indicated in this review that the type of helping is not a significant factor in the development of STS. That is to say, it is not only mental health providers

who are doing intensive trauma recovery work who are susceptible. In fact this study seems to point to a possibility that those mental health practitioners, for whatever reason, are somewhat more equipped to address the ST that they face and less likely to develop STS; whether or not the population being helped is traumatized is the significant factor.

Means of Mitigating STS

While several sources consider STS to be an occupational hazard of helping which is almost inevitable (Bride, Robinson, Yegidis, & Figley, 2004; Ting, Jacobson, Sanders, Bride, & Harrington, 2005; Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015; Bride and Walls, 2006), there are some points of hope for helpers to recover and maintain their wellness. A significant positive factor across several of our studies was education level, with higher levels of education correlating with reduced levels of STS (Cornille, & Meyers, 1999; Kintzle, Yarvis, & Bride, 2013; Beck, 2011).

A necessary comment is that the reduction of STS and support for helpers living with STS can and should come through the organizations which employ said helpers such as supervision, positive leadership behaviors, and confidential counseling offered to workers since these work environments greatly contribute to or reduce the wellness of employees (Cornille, & Meyers, 1999; Kintzle, Yarvis, & Bride, 2013; Bonach & Heckert, 2010; Carnigi, Stanick, Trautman, Crosby, Devlin, & Adams, 2015; Bride and Walls, 2006). Several of our sources also see social support as a primary mitigator for STS, particularly support from colleagues who do the same work as any helper population (Motta, 2012; Beck, 2011; Alisic, 2012). Finally a basic appreciation for and practice of self-care is invaluable for helpers to mitigate the impact of ST

and prevent themselves from experiencing STS (Hydon, Wong, Langley, Stein, & Katoaka, 2015; Alisic, 2012).

Discussion

This review was able to draw from a wide number of previous studies with a high total population of 805 not including populations studied for the development and later confirmatory analysis of the STSS, meta-analysis of nurses experiencing STS, and qualitative studies with educators. With this in mind and the fact that data were collected from at least 6 helper populations we can be confident in the potential depth and context for our comparisons and interpretations.

A neutral factor in this review is the lack of effort to define what rates of STS on the STSS are mild, moderate, or severe in our sources. While we did have some studies that determined 38 and higher indicates the presence of STS, and some authors determined severity based on the PTSD criteria that the STSS mirrors in its measurement, at some point a continuum and way of standardizing severity will be necessary to properly intervene with helpers. At this early stage, however, it may be a benefit that we refrain from labeling the STSS score of a person until we have a more proper understanding of the construct.

With that said it also is to be noted that the only studies with any replication were with a population of clinical social workers and two studies within Beck's meta-analysis that each sampled from nurses, although two different types of nurses. With that in mind several of our studies need more validation and repetition. To get a more confident picture of secondary trauma in helpers replicative studies with each population are necessary. A final drawback with this review is the lack of consensus among some sources as to defining STS, compassion fatigue, and

vicarious trauma. There is some chance that the data assessing populations using measures other than the STSS were not measuring the same construct.

One area in which our authors were consistent was in the idea that training or education on helping traumatized people mitigates STS, and a lack thereof is a significant risk factor for its development. Because we live in a world that is coming to see trauma as a public health crisis we need to consider all the helper populations who are working with directly traumatized people and which have not previously been considered at risk of STS. In truth, based on this review of the literature and comparison of populations, these understudied populations of helpers may be more at risk than mental health practitioners. Levels need to be assessed amongst teachers, nursing home staff, clergy, and any other form of helper who encounters people with trauma.

Additionally studies cited in this review need to be replicated to give a clearer picture of the condition of these helpers. Finally once we begin to determine which populations are impacted by STS the responsibility falls on their respective organizations, agencies, and employers to create systemic interventions for the treatment and mitigation of STS. Self-care is not enough to address a problem that originated from empathetic exposure to trauma, we have to help the helpers.

Appendix A

Alicic, E. (2012). Teachers' perspectives on providing support to children after trauma: A qualitative study. *School Psychology Quarterly, 27(1)*, 51-59. <https://doi-org.milligan.idm.oclc.org>

This source takes a careful look at the ways in which students experience trauma, and by default provides insight into the reasons an educator may experience indirect trauma. The author begins by detailing the numbers of children who have been exposed to at least one traumatic event: 54% of 9-13 year olds, which increases for impoverished and at risk populations. With that in mind, the author conducted a study to see how teachers respond to childhood trauma and assess how a teacher can help “facilitate children’s recovery” (pg. 52). The majority of the sample of 21 elementary school teachers interviewed felt under empowered and a lack of training in regards to their competency to work with traumatized children. It was noted that teaching in the first few years is the most difficult, but that over time they develop means of coping. This study is insightful for our research because it gives us a better understanding of the environment these helpers work within. When teachers go without support, or with only having social support from their peers, they are highly susceptible to experience STS. This source gives several helpful definitions but it fails to provide quantitative data that could be used in a chart or comparison.

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing, 25(1)*, 1–10. <https://doi-org.milligan.idm.oclc.org>

Nurses experience caregiving uniquely as they tend to the body and the mind. This source examines the levels of STS in seven different studies which in some of these targeted specific sub groups of nurses. One such subgroup, the forensic nursing category, is closely related to our forensic interviewer study. This study is also particularly useful because it can be compared with the meta-analyses we have of social workers. In addition, one of three scales used in the assessment process of this study is the STSS, a frequent subject of other sources and an instrument I hope to discuss in my paper. Of their studies two used the STSS. They determined that a score of 38 or higher indicated the presence of STS and they found that 38% of oncology nurses studies in that sample had a score of 38 or higher. In a study of emergency room nurses that Beck cited, 33% had all the criteria or PTSD measured by the STSS.

Bonach, K., & Heckert, A. (2012). Predictors of secondary traumatic stress among children's advocacy center forensic interviewers. *Journal of Child Sexual Abuse, 21(3)*, 295–314.

Retrieved from <https://doi-org.milligan.idm.oclc.org>

This study provided an assessment of yet another population of helpers. It provides further definition. It focuses on finding particular predictive variables in the population. This study also used the STSS which was then somewhat adapted for Forensic Interviewers, the people who interview a child who has been allegedly abused, specifically changing the dates of symptoms to the past six months rather than the past 7 days. With this change the scale still had a Cronbach's alpha of .94. They had a mean score of 36.69 on the STSS.

Bride, B., Robinson, M., Yegidis, B., & Figley, C. (2004). Development and validation of the secondary traumatic stress scale. *Research On Social Work Practice, 14(1)*, 27-35.

Retrieved from <https://search-ebSCOhost-com.milligan.idm.oclc.org>

This study analyzed a scale for measuring secondary traumatic stress. They assert that secondary trauma is a prevalent phenomenon which they define as “helping or wanting to help a traumatized or suffering person” (pg. 27). They include the qualities of STS as intrusion, avoidance, and arousal symptoms. For their study validating the scale they used surveys among a random sample from 600 social workers within a national agency sample. It was a self-report instrumental design. They found a correlation between the presence of secondary traumatic stress with the number of trauma clients in each caseload. The study was found to be valid and statistically significant in measuring the severity of STS in the population studied, and they found that the symptoms of STS and working with traumatized clients go hand in hand.

Bride, B. E., & Walls, E. (2006). Secondary traumatic stress in substance abuse treatment. *Journal of Teaching in the Addictions, 5*(2), 5–20. Retrieved from <https://search-ebSCOhost-com.milligan.idm.oclc.org>

This piece offers input from counselors who specifically work with people who abuse substances, another population of helper. It is an overview of the concepts of STS and Compassion Fatigue that applies them uniquely to Substance Abuse work. This study also helps to provide clearer definition between the terms compassion fatigue, secondary trauma, and burnout. It provides unique analysis as to the particular factors that surround the development of STS, like empathy, which resonates with the rest of our literature.

Caringi, J. C., Stanick, C., Trautman, A., Crosby, L., Devlin, M., & Adams, S. (2015). Secondary traumatic stress in public school teachers: Contributing and mitigating factors. *Advances*

In School Mental Health Promotion, 8(4), 244-256. Retrieved from <https://search-eds-b-ebshost-com.milligan.idm.oclc.org>

These authors produced a qualitative study to examine the experiences of teachers relative to their secondary traumatic stress along with the assessment of a quantitative study conducted prior. They define secondary trauma as emotional and behavioral problems that result from helping or wanting to help a traumatized person. For them it “mirrors” PTSD. With children and adolescents spending between 7 and 8 hours in schools each day, and at least “one quarter of American children experience one high magnitude traumatic event by age 16” (pg. 245). They cite a study which found rates of STS with teachers to be equivalent to mental health workers. This study offers some good insight into the way that STS plays out in human life. While it will not work as one of my primary sources to review and put in my table, it does provide some shading around the question.

Cornille, T., Meyers, T. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology, Vol 5(1)*. Retrieved from [eds-b-ebshost-com.milligan.idm.oclc.org](https://search-eds-b-ebshost-com.milligan.idm.oclc.org)

While this source is a bit outdated, it provides valuable feedback as to the prevalence of STS in another population: Child Protective Services (CPS) workers. Interestingly it found only 37% of workers to be experiencing STS. I think this will be a valuable point of comparison for our other studies. I am trying to find a more updated review of STS in CPS workers, however, this may be because the study was written before the opioid epidemic and the ensuing failure of our systems, including the child welfare system. It also finds interesting environmental correlates of STS which is

observed in other studies we cite. Like some other sources, this work also acknowledges that an individual's own primary trauma may make them more vulnerable to STS.

Hydon, S., Wong, M., Langley, A. K., Stein, B. D., & Kataoka, S. H. (2015). Preventing secondary traumatic stress in educators. *Child And Adolescent Psychiatric Clinics Of North America*, 24(School Mental Health). Retrieved from <https://doi-org.milligan.idm.oclc.org>

These authors also attribute the potential to experience secondary trauma as stemming from empathy. They cite the US department of education and Charles Figley as describing secondary trauma and compassion fatigue synonymously, and they use these two terms almost interchangeably in their research. They describe the variety of issues faced by educators that can be sources of ST. Interestingly, middle schools statistically have the highest rates of violence and bullying. The authors describe a variety of symptoms that can result from ST. For our specific research into secondary trauma in helpers, this study has some valuable insights to offer. For one thing it further presents us with the problem of defining vicarious and secondary trauma. They describe the two to be significantly different and present compassion fatigue and secondary trauma as almost identical. The opinion that empathy is a gateway for indirect trauma is also noteworthy and shared by other sources for this research.

Kintzle, S., Yarvis, J. S., & Bride, B. E. (2013). Secondary traumatic stress in military primary and mental health care providers. *Military Medicine*, 178(12), 1310–1315. Retrieved from <https://doi-org.milligan.idm.oclc.org>

This study is helpful in its similarity to our nursing and mental health populations while also being distinctive. It defines STS in a different way, describing it as PTSD caused by indirect trauma. It gives average scores from the STSS as well, indicating that these results will be a good way of providing comparison across our studies. This sample was about 70 people who are all highly educated with a master's degree or higher. Interestingly, this sample had significantly lower rates of STS symptoms.

Motta, R. R. (2012). Secondary trauma in children and school personnel. *Journal Of Applied School Psychology, 28(3)*, 256-269. Retrieved from <https://search-ebscohost-com.milligan.idm.oclc.org>

Robert Motta describes secondary trauma as the “transfer and acquisition of negative affective and dysfunctional cognitive states due to prolonged and extended contact with others who have been traumatized”. For him it is acceptable to use the terms vicarious trauma (VT) and secondary trauma (ST) synonymously. These types of indirect trauma effect cognitive schemas and are transferred “through empathetic exposure” to the victim of direct trauma. A challenge comes when we assess his definition for secondary trauma and vicarious trauma and compare it to other authors, we see that there is a somewhat inconsistent manner of defining those terms in the mental health community. He uses the two synonymously. He makes a link between empathy and the transfer of traumatic emotions, behaviors, and cognitive schemas which is shared by other sources for this research. He describes in detail the Stroop procedure, a potential assessment for measuring secondary trauma in adults. He helps define STS.

Ting, L., Jacobson, J. M., Sanders, S., Bride, B. E., & Harrington, D. (2005). The Secondary traumatic stress scale (STSS): Confirmatory factor analyses with a national sample of

mental health social workers. *Journal of Human Behavior in the Social Environment*, 11(3/4), 177–194. Retrieved from <https://doi-org.milligan.idm.oclc.org>

This study provides another meta-analysis, like our nursing source, but looks at mental health social workers. It points out the potential causes of STS and also explores briefly defining it. It gives the most comprehensive review of the STSS which is used by multiple sources. This makes it very helpful for the brief discussion of the instruments that I hope to have in my paper. They found the scale to be highly valid but found some issues between the three categories of the scale. It had a high national sample (n=275) so it is also generalizable to our purposes.

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