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WORK-RELATED SECONDARY TRAUMATIC STRESS

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The great controversy about helping-induced trauma is not "Can it happen?" but "What shall we call it?" After reviewing nearly 200 references from PILOTS, Psychlit, Medline, and Social Sciences Index, it is apparent that there is no routinely used term to designate exposure to another's traumatic material by virtue of one's role as a helper. Four terms are most common: "compassion fatigue" (CF); "countertransference" (CT); "secondary traumatic stress" (STS); and "vicarious traumatization" (VT).

Field-specific literature emerged as early as 1980 in relation to emergency services workers (Dunning & Silva, 1980). In 1985, Hartsough and Myers wrote the now classic *Disaster Work and Mental Health.* One of the early, well-cited empirical studies is Durham et al. (1985). None of these papers attempts to create a specific diagnostic or nomological term for worker-related stress.

Among therapists, the reaction was originally subsumed under the moniker of "countertransference." The importance of Haley's 1974 paper about therapists' reactions to war atrocities cannot be underestimated. Wilson and Lindy's (1994) book continues to use the countertransference construct to discuss a vast array of specific interventions and therapists' reactions. McCann and Pearlman's (1990) pivotal paper recognizes the life-pervasive effects of working with trauma victims. While they discuss countertransference, they raise questions about the construct's adequacy, suggesting it is too narrow because it does not address the lasting and pervasive schema alterations (McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). "Vicarious traumatization," the term they propose, describes the negative cognitive schema and behavioral changes in therapists.

In 1991, Figley first used the term "compassion fatigue" in relation to PTSD in his book, *Helping Traumatized Families.* In 1992, he proposed re-defining PTSD in his paper, "Traumatic Stress Reactions and Disorders: Re-configuring PTSD," at the First World Conference of the International Society for Traumatic Stress in Amsterdam, The Netherlands (June 21-26, 1992). He argued that "primary traumatic stress disorder" should refer to those who were directly in harm's way. For Figley, "secondary traumatic stress disorder" represents disorders displayed by supporters/helpers of those experiencing PTSD, and "tertiary traumatic stress disorder" applies to the supporters of supporters of those experiencing PTSD. At that same conference, Varra and I presented the paper, "Vicarious Traumatization in Emotional Support Providers for Victims of Sexual and Physical Assault," and used the term "confiding" to describe the primary emotional support providers and "secondary confiding" to describe the support providers' conversations with others. Time has shown these proposals are too cumbersome to be appealing to a broad audience.

Recent Major Works. Wilson and Lindy's countertransference text was published in 1994. In 1995, three major texts were published, including edited volumes by Figley and by me and one written by Pearlman and Saakvitne. These three books show triadic cross-fertilization; each person's work appears in the other two books. Yet, each book chooses a different word to describe the effects of working with traumatized individuals. Figley uses CF in the title; CF and STS both appear in the text. Pearlman and Saakvitne use VT. I use STS in the title and all terms in the chapters. Paton and Violanti's 1996 book circumnavigates the label issue by choosing a descriptive title. Other terms are also used. Perhaps the most common is "burnout," but examination of the etiology generally shows increased work load and institutional stress are the precipitating factors, not trauma. Another term is "indirect-trauma": it is the name of an Internet list led by Pearlman and me (<helpdesk@listp.apa.org>). Thus, even with the sudden increase in the literature, there is no uniform designator, nor is there a meaningful taxonomy for the multiple words.

I believe countertransference is a broader concept that refers to our reactions to our clients and their material. It may direct our therapeutic choices and is a state condition tied directly to the patient. By contrast, CF/STS/VT, which results from working with trauma victims, induces more trait-like changes to our values, beliefs, and behaviors. The differentiation, while possibly academic, certainly is elusive. Countertransference can occur outside of the context of exposure to traumatic material. CF/STS/VT always arises as a result of exposure to a client's traumatic material. I believe countertransference applies more to how our patients affect our work with them, and CF/STS/VT is about how our patients affect our lives, our relationships with ourselves, and our social networks, as well as our work.

I suggest "secondary traumatic stress" (STS) as

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the broadest term, with other terms, such as "compassion fatigue" and "vicarious traumatization," and even some forms of "countertransference," serving as specific types of STS. At this point, none of the words is truly satisfying for describing helper-encounters with another's traumatic material. In fact, even the descriptive definition becomes an issue. Does this apply only to those who are professionals, or also to volunteers? To all health care professionals? To researchers? What about teachers teaching about trauma? Are emergency service workers exposed secondarily because of another's trauma, or is rescue in perilous situations, or body handling, direct trauma? These are difficult questions. In reality, the taxonomy will emerge as consensus arises from use.

For the purposes of this review, I first mention the new comprehensive texts. Next, I sort the literature into two broad groups: theory and populations. Each of these is further categorized by types of theory or populations.

Comprehensive Texts. These books have been mentioned above and will only be briefly discussed here. Wilson and Lindy (1994) cover a wide range of topics and the effect of client material on providing interventions. It is somewhat different from the texts below in that it is focused toward the provision of services more than the effect of providing services. Figley's (1995) book examines the extant literature to lay the groundwork for legitimizing CF. Pearlman and Saakvitne (1995) provide us with a comprehensive theory for understanding VT. My (1995) book entered into development after Figley's and Pearlman and Saakvitne's books were nearly finished, and, as such, builds on the two books above. The book makes the assumption that healthy caregivers are better caregivers; chapters are focused toward protection of the professional's overall well-being. Paton and Violanti (1996) focus on risks for emergency service personnel developing traumatic stress reactions. The authored chapters cover a variety of professions discussing assessment and interventions.

General Theory Papers. There are a number of papers on ethics, including four in my book (1995). In a paper mixing ethics and legal issues, Simon (1993) discusses the obstacles faced by mental health professionals who are trying to become involved in cases of human rights violations. He also discusses the increasing number of cases in which mental health professionals have been successful in surmounting these obstacles. Recognizing STS is an organizational legal dilemma, because this may lead to STS-based lawsuits. Howard (1995) notes that there have been fewer claims in jurisdictions where claims require the injury to be the fault of the defendant, than in other jurisdictions where fault is not required to be established. Many organizations choose to be proactive in attempting to prevent STS rather than defend against litigation. Richards (1994) discusses how this model fits with the conceptualization of the "new public health movement," in which causality and prevention are merged into a comprehensive view of health.

Emergency Service Provision. There are many good theoretical and empirical papers in this area. It is undoubtedly the best documented segment of the professional STS literature. I will not reiterate the chapters from the books above, although the reader should not overlook them. Drawing on theoretical and clinical experience, Foreman (1994) discusses primary and secondary prevention and the characteristics of the traumatic event which contributes to the greater likelihood of the development of PTSD among responders. In two new empirical papers, Marmar, Weiss and colleagues focus on EMS workers responding to the Nimitz Freeway collapse during the 1989 Loma Prieta earthquake in the San Francisco Bay Area (Marmar et al., 1996; Weiss et al., 1995). Summing across the papers, 9% of EMS workers exhibited symptoms similar to psychiatric outpatients; shy, inhibited individuals were more likely to have dissociative responses; and dissociative responses at the time of the event were predictive of poorer outcomes.

Health Care Providers. These papers include mental health and general health care providers. There are few empirical papers at this point, perhaps because of the newness of the area of study. Although somewhat dated, Riordan and Saltzer's (1992) offers a good literature review of the effects of patient trauma on general medical providers. As a group, Pearlman and colleagues are the most frequent contributors to this area of the literature. In addition to the previously mentioned theoretical works, Pearlman and Mac Ian's (1995) empirical study found that therapists with personal trauma histories reported more difficulties with client material than those without.

Exposure Due to Research and Teaching About Trauma. Direct service providers, while confronted with difficult material, can ameliorate feelings of helplessness by intervening to change the patient's life. Teachers and researchers may not be able to seek this redemptive alternative. In fact, researchers can be exposed to traumatic material, including risks such as suicidality, without ever being able to identify the person at risk. Pickett et al. (1994) discuss the use of debriefing to reduce researchers' traumatic reactions to the research material. McCammon (1995) discusses teaching techniques, both preventative and remedial, for addressing the effects of (a) exposing students to traumatic material during teaching, or (b) triggering students who have a personal trauma history with traumatic material.

Exposure Due to Other Occupations. There are other occupations that place the worker in the path of traumatic material, but few papers discuss them. Here is a sample of the ones that do. McCarroll et al. (1995) discuss museum workers' responses to preparing the Holocaust Memorial Museum exhibit. Hafemeister (1993) alerts us to the difficulties of jury work. Freinkel et al. (1994) studied media eyewitnesses of an execution and found higher levels of dissociative symptoms than should be expected. Clergy receive little attention but may be exposed to a great deal of traumatic material as a result of their work. Bricker and Fleischer (1993) discuss the social support systems of Roman Catholic priests.

Summary. There is a rapidly growing literature on the risks, reactions, and prevention of harm from exposure to another's traumatic material by virtue of a professional relationship with the primary victim. There is a small but

cohesive body of ethics literature. The empirical literature regarding emergency service personnel is quite well developed, and the empirical literature about health care providers is growing. Other professions are lagging behind, but show promise of developing an expanded awareness of the problem. One continuing difficulty is the dilemma of nomenclature. At this point, there is no consistent or truly satisfying language to describe the phenomenon. Perhaps one area of research could be developing operational definitions of the terms used to describe the costs of caring.

REFERENCE

FIGLEY, C.R. (1989). *Helping traumatized families.* San Francisco: Jossey-Bass.

SELECTED ABSTRACTS

BRICKER, P.L. & FLEISCHER, C.G. (1993). **Social support as experienced by Roman Catholic priests: The influence of occasionally imposed network restrictions.** *Issues in Mental Health Nursing, 14,* 219-234. This qualitative descriptive study explored the experience of social support as perceived by four Roman Catholic priests who are community caregivers subject to role-related stressors, and who have vocational limitations placed on their social support networks. The data collection process consisted of two semistructured interviews employing open-ended questions. Content and concept analysis techniques yielded seven core themes (person-role disharmony, intimate connections, network leveling, moving networks, caregiver survival, vocation-person esteem, caring relationships); three prevailing themes (subsistent relationships, person-priest being, reciprocal fulfillment); and one contextual theme (presence). The priests actively sought support as a means of coping with the daily stress associated with their caregiving roles. Large and diffuse networks were unable to compensate for restrictions resulting from vows of celibacy, discord accompanying midlife transition, or conflicts associated with socially prescribed role expectations of the priesthood. The instability of their support networks resulting from mandatory transfers may have been a contributing factor. Existential presence, an enduring theme, was identified as an inherent quality of caregiving and social support.

FIGLEY, C.R. (1995). **Compassion fatigue: Toward a new understanding of the costs of caring.** In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* (pp. 3-28). Lutherville, MD: Sidran Press. Discusses the emergence of information that forms the basis of our understanding of compassion fatigue and compassion stress and the recognition that something specific must be done to counteract these challenges. We now know that we can help caring health professionals to recognize their shortcomings—their special vulnerability to compassion stress and fatigue—and help them to cope more effectively with the cost of caring. There is no doubt that traumatic events will continue to occur and affect hundreds of thousands of people each year. These traumatized people require the services of professionals who are well prepared to help, and, in turn, to help themselves; therefore, we need to keep these caring professionals at work and satisfied. The chapter also addresses the following topics: the question of why there are so few reports of secondary trauma; why STSD (secondary traumatic stress disorder); definition of secondary traumatic stress (STS) and stress disorder; contrasts between STS and other concepts; countertransference and secondary stress; burnout and secondary stress; why compassion stress and compassion fatigue; and implications for training and educating the next generation of professionals. [Adapted from Text]

FOREMAN, C. (1994). **Immediate post-disaster treatment of trauma.** In M.B. Williams & J.F. Sommer (Eds.), *Handbook of post-traumatic therapy* (pp. 267-282). Westport, CT: Greenwood Press. Certain features of traumatic events contribute to the greater likelihood of the development of PTSD among survivors and rescue workers. In this chapter, the author draws upon current research and his own professional experience relating to three traumatic incidents from northern California. Aspects of trauma, features of survivors, and subsequent provision of services are presented and discussed. [Adapted from Text]

FREINKEL, A., KOOPMAN, C., & SPIEGEL, D. (1994). **Dissociative symptoms in media eyewitnesses of an execution.** *American Journal of Psychiatry, 151,* 1335-1339. The first execution in California since 1976 took place recently in the San Quentin Prison gas chamber. 18 journalists were invited as media eyewitnesses. The authors postulated that witnessing this execution was psychologically traumatic, and that dissociative and anxiety symptoms would be experienced by the journalists. To investigate the prevalence and specific nature of these symptoms, questionnaires were sent to all the journalists about a month after the execution. The questionnaire contained 17 items assessing dissociative symptoms from the authors' questionnaire of 35 highly intercorrelated acute stress items. 15 of 18 of the witnesses returned the questionnaire. Items were endorsed on a scale of 0 ("have not experienced") to 5 ("very often experienced") and analyzed as being dichotomously present or absent. The mean age of the respondents was 37.6 (SD = 8.6), and mean years as a journalist were 15.2 (SD = 9.0). 9 subjects were men and 6 were women. Journalists witnessing the execution endorsed an average of 5.0 dissociative items, ranging from "I saw, heard, or felt things that were not really there" (endorsed by no one) to "I felt estranged or detached from other people" (endorsed by 60 percent). This prevalence of reported dissociative symptoms is comparable to that seen among persons who endured the recent Oakland/Berkeley, California, firestorm. The experience of being an eyewitness to an execution was associated with the development of dissociative symptoms in several journalists.

HAFEMEISTER, T.L. (1993). **Juror stress.** *Violence and Victims, 8,* 177-186. Media reports have focused on the impact of the trial process on jurors, exploring the intense pressures and stress they may be required to undergo. This article explores this subject and reports on the findings of a pilot study of a survey instrument used in Howard County and Baltimore County, Maryland, in conjunction with the Psychology Department at the College of William and Mary, to find elevated stress levels in jurors serving on trials where the evidence was particularly graphic and gruesome. [Adapted from Text]

HOWARD, G. (1995). **Occupational stress and the law: Some current issues for employers.** *Journal of Psychosomatic Research, 39,* 707-719. The principles and illustrations from the case law in England and Wales relate to the common law which forms the basis of the English legal system. Any claim, therefore, requires fault to be shown on the part of the defendant and also that the injury was caused by the fault of the defendant —at least 'on the balance of probabilities.' So far as this system is unique to England and Wales (albeit inherited by a number of Commonwealth jurisdictions), the principles illustrated and discussed will relate only to the English legal system. However, in other jurisdictions, fault is not required to be established, and in countries

such as the USA, the case law has developed in the area of stress-related claims far more quickly in recent years than in the UK. The English Courts may, and often do, refer to authorities in other Commonwealth jurisdictions for guidance on liability and the extent of the duty of care. Australian cases, for example, have proved very helpful in stress-related cases and cases on the harm caused by passive smoking. The first successful claim for stress against an employer in the UK occurred at the end of last year, involving a social worker, John Walker, working for Northumberland County Council. This important decision is discussed. [Adapted from Text]

MARMAR, C.R., WEISS, D.S., METZLER, T.J., & DELUCCI, K.L. (1996). **Characteristics of emergency services personnel related to peritraumatic dissociation during critical incident exposure.** *American Journal of Psychiatry, 153,* 7 Festschrift Supplement, 94-102. The aim of this study was to identify characteristics of emergency services personnel related to acute dissociative responses at the time of critical incident exposure, a phenomenon designated "peritraumatic dissociation." The authors studied 157 rescue workers who responded to the Nimitz Freeway collapse during the 1989 Loma Prieta earthquake in the San Francisco Bay Area, as well as 201 rescue workers who were not involved in that disaster. Demographics, level of critical incident exposure, perceived threat at the time of exposure, personality attributes (assessed by the Hogan Personality Inventory), coping strategies (assessed by the Ways of Coping Questionnaire), and locus of control were related to subjects' scores on the Peritraumatic Dissociative Experiences Questionnaire. According to univariate tests, the subjects with clinically meaningful levels of peritraumatic dissociation were younger; reported greater exposure to critical incident stress; felt greater perceived threat; had lower scores on the adjustment, identity, ambition, and prudence scales of the Hogan Personality Inventory; had higher scores on measures of coping by means of escape-avoidance, self-control, and active problem solving; and had greater externality in locus of control. Linear modeling with multiple logistic regression analyses indicated that greater feelings of perceived threat, coping by means of escape-avoidance, and coping by means of self-control were associated with a greater likelihood of being in the peritraumatic dissociation group, above and beyond age and exposure to stress. Rescue workers who are shy, inhibited, uncertain about their identity, or reluctant to take leadership roles, who have global cognitive styles, who believe their fate is determined by factors beyond their control, and who cope with critical incident trauma by emotional suppression and wishful thinking, are at high risk for acute dissociative responses to trauma and subsequent PTSD.

MCCAMMON, S.L. (1995). **Painful pedagogy: Teaching about trauma in academic and training settings.** In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* (pp. 105-120). Lutherville, MD: Sidran Press. The melodic title of "Painful Pedagogy" belies the potential struggle that lurks beneath the convoluted issues of teaching about trauma. Many of the people drawn to trauma training carry with them trauma histories. While supervision in psychotherapy training can be difficult, at least the supervisor is expected to work with the student. Imagine seeing a student flee the room in tears when you deliver a lecture to a large undergraduate class. Experiences like these can leave the professor with a sense of helplessness and without institutional guidelines. McCammon's chapter offers succor to the teacher preparing difficult course material and suggests pedagogical strategies to lessen the negative impact of trauma material while preserving its integrity and the heart of the professor.

MCCARROLL, J.E., BLANK, A.S., & HILL, K. (1995). **Working with traumatic material: Effects on Holocaust Memorial Museum staff.** *American Journal of Orthopsychiatry, 65,* 66-75. Preparation for the opening of the United States Holocaust Memorial Museum in Washington, D.C., in April 1993, exposed workers to potentially disturbing personal artifacts of Holocaust victims and other reminders of the horrors of the Holocaust. The process of psychological consultation is described, and the resultant approaches to interventions designed to lower distress among museum workers and volunteers are discussed.

NEUMANN, D.A. & GAMBLE, S.J. (1995). **Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist.** *Psychotherapy, 32,* 341-347. Psychotherapy with survivors of chronic childhood trauma poses unique challenges to therapists. In this article, we describe countertransference responses that are common to work with survivors. We also examine the phenomenon of vicarious traumatization (i.e., the impact upon the therapist's psyche of empathic engagement with trauma survivors). Both aspects of trauma therapy are framed in light of their particular impact on new trauma therapists. Last, we address organizational and personal factors that can ameliorate these negative correlates of trauma work. By proactively addressing these issues, organizations, training programs, supervisors, and therapists can promote the personal and professional development of new clinicians.

PATON, D. & VIOLANTI, J. (Eds.) (1996). *Traumatic stress in critical occupations: Recognition, consequences and treatment.* Springfield, IL: Charles C. Thomas. Describes traumatic stress phenomena in terms of the complex interactions between the person, the traumatic event, and the social and organizational background against which performance takes place. Focuses primarily on police officers, fire fighters, and emergency medical service professionals. The narrative provides a comprehensive overview of current theory in this area and draws upon this to demonstrate its use in developing and implementing practical solutions to the individual and organizational issues that emerge in disaster and other traumatic contexts. Strategies designed to promote the recognition and identification of the diverse personal, organisational and event-related factors that contribute to traumatic reactivity are discussed. [Adapted from Text]

PEARLMAN, L.A. & SAAKVITNE, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton. Our goal has been to cover the breadth of issues for the therapist working with survivors of childhood sexual abuse in enough depth to be useful clinically and theoretically. We strive to address the issues with enough clarity to be useful to therapists new to psychotherapy with trauma survivors, and with enough complexity to be thought-provoking for experienced therapists and experienced trauma therapists. The book is divided into five parts: Theoretical underpinnings; Countertransference in psychotherapy with incest survivors; Vicarious traumatization in psychotherapy with incest survivors; The interaction between countertransference and vicarious traumatization; and Therapist self-care. [Adapted from Text]

PEARLMAN, L.A. & MAC IAN, P.S. (1995). **Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists.** *Professional Psychology: Research and Practice, 26,* 558-565. This study examined vicarious traumatization (i.e., the deleterious effects of trauma therapy on the therapist) in 188

self-identified trauma therapists. Participants completed questionnaires about their exposure to survivor clients' trauma material as well as their own psychological well-being. Those newest to the work were experiencing the most psychological difficulties and Symptom Checklist-90-Revised symptoms. Trauma therapists with a personal trauma history showed more negative effects from the work than those without a personal history. Trauma work appeared to affect those without a personal trauma history in the area of other-esteem. The study indicates the need for more training in trauma therapy and more supervision and support for both newer and survivor trauma therapists.

PICKETT, M., BRENNAN, A.M.W., GREENBERG, H.S., LICHT, L., & WORRELL, J.D. (1994). **Use of debriefing techniques to prevent compassion fatigue in research teams.** *Nursing Research, 43,* 250-252. Nurses often study subjects who have experienced traumatic events involving intense and emotionally charged consequences. This paper describes how the process of crisis debriefing can be used to mitigate the concerns of interviewers who collect data from such subjects. Some clinical practice settings, such as emergency, trauma, intensive care, and home hospice settings, provide debriefing sessions that incorporate some of the elements directed toward the prevention of secondary PTSD. However, debriefing sessions designed specifically for research team members who interview traumatized persons have not been reported in the literature. [Adapted from Text]

RIORDAN, R.J. & SALTZER, S.K. (1992). **Burnout prevention among health care providers working with the terminally ill: A literature review.** *Omega, 25,* 17-24. A review of the literature on burnout and its prevention among caregivers to the dying is presented in this article. The literature shows that health care providers who work with the dying do experience many stressors unique to the specialty, but also many which are common to other health care workers. External and internal stressors common to this specialty field are summarized, and suggestions for reduction or elimination of these stressors are generated from the literature. A self-care wellness program is extracted from the various literature sources and provides what is thought to be an essential foundation to burnout prevention.

SIMON, B. (1993). **Obstacles in the path of mental health professionals who deal with traumatic violations of human rights.** *International Journal of Law and Psychiatry, 16,* 427-440. This paper is divided into two parts. The first part, the longer, deals with obstacles in the path of mental health professionals becoming more involved in issues of human rights violations. The second part deals with a few of the increasing number of instances in which mental health professionals have become more involved. These discussions center around issues involving children, although most of what is said applies to both children and adults. In referring to "human rights" violations, the boundaries between the devastation of large scale wars between nations and within nations (such as the Holocaust and the Cambodian genocide) and the harm done in more narrowly defined "human rights" violations (such as the arrest, torture, and often "disappearance" of thousands in Argentina and Chile) are not exactly clear. For our purposes, the rough working definition of human rights violations includes the devastation wrought by plans to persecute and destroy individuals, classes, ethnic groups, or religious sects, independent of the absolute numbers involved. [Adapted from Text]

STAMM, B.H. (Ed.) (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran Press. The authors of this book begin with the premise that engaging empathically with another's traumatic material carries risks. The book begins with a summary paper by Figley, in which he raises the issues of compassion fatigue—or, as he puts it, the costs of caring. The next three chapters (Pearlman; Rosenbloom et al.; and Catherall) offer suggestions for ways in which trauma therapists can create safe environments in which to work. McCammon's paper introduces ideas that are beginning to take hold in clinical training and university settings. Harris and Linder raise a beguilingly simple issue: How do we communicate when we are under stress? Bills, who is trained both as an internist and a psychiatrist, offers a systematic approach with which the primary care provider can diagnose trauma. One of the more sweeping approaches to addressing secondary traumatic stress is presented by Terry in "*Kelengakutelleghpat.*" This paper outlines a region-wide, community-based intervention program that includes everyone in the community as part of the healing community. Recognizing that not all people will be able to create elaborate treatment communities in which to practice, Pearce and Stamm offer an alternative strategy for developing professional community. The last four chapters directly address ethical issues related to self care and STS. [Adapted from Text]

WEISS, D.S., MARMAR, C.R., METZLER, T.J., & RONFELDT, H.M. (1995). **Predicting symptomatic distress in emergency services personnel.** *Journal of Consulting and Clinical Psychology, 63,* 361-368. This study identified predictors of symptomatic distress in emergency services (EMS) personnel exposed to traumatic critical incidents. A replication was performed in two groups: 154 EMS workers involved in the 1989 Interstate 880 freeway collapse during the San Francisco Bay area earthquake, and 213 counterparts from the Bay area and from San Diego. Evaluated predictors included exposure, social support, and psychological traits. Replicated analyses showed that levels of symptomatic distress were positively related to the degree of exposure to the critical incident. Level of adjustment was also related to symptomatic distress. After exposure, adjustment, social support, years of experience on the job, and locus of control were controlled, two dissociative variables remained strongly predictive of symptomatic response. The study strengthens the literature linking dissociative tendencies and experiences to distress from exposure to traumatic stressors.

WILSON, J.P. & LINDY, J.D. (Eds.) (1994). *Countertransference in the treatment of PTSD.* New York: Guilford Press. This is a book about what we go through as we listen to and work with our trauma patients, and how our own experiences may help or hinder the recovery process. It is also about how awareness of our human reactions to patients' trauma is indispensable in keeping these powerful treatments on track. It is a book about how we must apply this awareness judiciously, functioning not outside but within the boundaries of our professional relationships with survivors. In this way, we strive to help our clients regain a sense of continuity and meaning in life, and to enhance our own function as clinicians. Part I is a theoretical and practical introduction to the book, outlining the general issues raised historically and currently in the areas of countertransference and trauma. In Part II, we examine the special forces at work in countertransference when helping women and children who have witnessed, or been the victims of, violent and/or sexual assault. In Part III, we examine countertransference arising in those who treat the survivors of political violence and war. In Part IV, we expand our discussion of trauma to indirect trauma survivors, as well as direct ones. [Adapted from Text]

ADDITIONAL CITATIONS
Annotated by the Editors

DANIELI, Y. (1994). **Countertransference, trauma, and training.** In J.P. Wilson & J.D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 368-388). New York: Guilford Press.
Addresses the problem of countertransference in training professionals who work with trauma survivors, particularly in light of the professionals' trauma histories. The author presents a training program that can be used to help professionals identify and process trauma-related countertransference reactions. Case material is included to illustrate various aspects of these reactions.

DERRY, P. & BAUM, A. (1994). **The role of the experimenter in field studies of distressed populations.** *Journal of Traumatic Stress, 7,* 625-635.
Describes problems that researchers may confront when studying traumatized populations and suggests strategies for managing these problems. The authors propose that trauma researchers adopt a flexible behavioral style, explicate their values with coinvestigators (especially values regarding how much support to provide to research participants), develop relational and communication skills, and learn about posttraumatic stress.

DUNNING, C.M. & SILVA, M.N. (1980). **Disaster-induced trauma in rescue workers.** *Victimology, 5,* 287-297.
Studied rescue workers who responded to either a plane crash or a mass suicide. The authors encourage rescue agencies to be aware of and respond to the traumatic stress reactions of rescue personnel.

DURHAM, T.W., MCCAMMON, S.L., & ALLISON, E.J. (1985). **The psychological impact of disaster on rescue personnel.** *Annals of Emergency Medicine, 14,* 664-668.
Assessed PTSD and coping in 79 police, fire, emergency medical, and hospital personnel following a disaster. Ten percent had 8 or more of 21 PTSD symptoms. Workers who had been at the disaster had more symptoms than did hospital staff.

FOLLETTE, V.M., POLUSNY, M.M., & MILBECK, K. (1994). **Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors.** *Professional Psychology: Research and Practice, 25,* 275-282.
Examined predictors of posttraumatic symptoms in professionals exposed to traumatic stress through their jobs. Multiple regression analysis showed that among 225 mental health professionals, posttraumatic symptoms were associated with negative coping, stress, and negative clinical response to sexual abuse cases, but not with trauma history or sexual abuse caseload. Among 46 law enforcement professionals, symptoms were associated with negative response to investigating sexual abuse cases, stress, and trauma history.

HALEY, S.A. (1974). **When the patient reports atrocities: Specific treatment considerations of the Vietnam veteran.** *Archives of General Psychiatry, 30,* 191-196.
Presents several cases that illustrate the special problems encountered by the therapist whose war-veteran patient reports witnessing or participating in atrocities. The first step in treating such cases is for the therapist to come to terms with feelings that reinforce seeing the patient as "bad" and the therapist as "good."

HARTSOUGH, D.M. & MYERS, D.G. (1985). *Disaster work and mental health: Prevention and control of stress among workers.* Rockville, MD: National Institute of Mental Health (DHHS publication, (ADM) 87-1422).
Provides practical information for dealing with stress in disaster response work. The practical information is presented in terms of a solid theoretical discussion. This manual, now over 10 years old, is still used today for training trauma workers.

MCCAMMON, S.L., DURHAM, T.W., ALLISON, E.J., & WILLIAMSON, J.E. (1988). **Emergency workers' cognitive appraisal and coping with traumatic events.** *Journal of Traumatic Stress, 1,* 353-372.
Continued the analysis by Durham et al. (1985) of PTSD and coping in 79 police, fire, emergency medical, and hospital personnel following two disasters. The most frequent coping strategies reported were attempts to reach cognitive mastery over the events and to ascertain meaning.

MCCANN, I.L. & PEARLMAN, L.A. (1990). **Vicarious traumatization: A framework for understanding the psychological effects of working with victims.** *Journal of Traumatic Stress, 3,* 131-149.
Uses constructivist self-development theory to discuss therapists' reactions to clients' traumatic material. Such vicarious traumatization may disrupt the therapist's mental images and schemas for trust, safety, power, independence, esteem, intimacy, and frame of reference. Strategies for dealing with these disruptions are presented.

RICHARDS, D. (1994). **Traumatic stress at work: A public health model.** *British Journal of Guidance and Counselling, 22,* 51-64.
Presents a model for handling traumatic stress in the workplace. The model, which includes primary, secondary, and tertiary prevention, is illustrated by an organizational case example. The strategies employed include inter-departmental working, appropriate use of management and social support, pretrauma training, and cognitive-behavioral therapy.

SUTKER, P.B., UDDO, M., BRAILEY, K., VASTERLING, J.J., & ERRERA, P. (1994). **Psychopathology in war-zone deployed and nondeployed Operation Desert Storm troops assigned graves registration duties.** *Journal of Abnormal Psychology* , 103, 383-390. Abstracted in *PTSD Research Quarterly, 7(1),* 1996.

THEORELL, T., LEYMANN, H., JODKO, M., KONARSKI, K., & NORBECK, H. E. (1994). **'Person under train' incidents from the subway driver's point of view—a prospective 1-year follow-up study: The design, and medical and psychiatric data.** *Social Science and Medicine, 38,* 471-475.
Longitudinally studied 40 subway drivers who had experienced a "person under train" (PUT) accident. Compared with matched control drivers who had not experienced an accident, PUT drivers had more sick days at 3 weeks and 12 months. At 3 weeks, the PUT drivers had mild prolactin elevation and increased sleep disturbance, relative to controls. PUT drivers also reported a deterioration of their psychosocial work environment at 12 months, relative to no change in controls.

PILOTS Thesaurus Revision

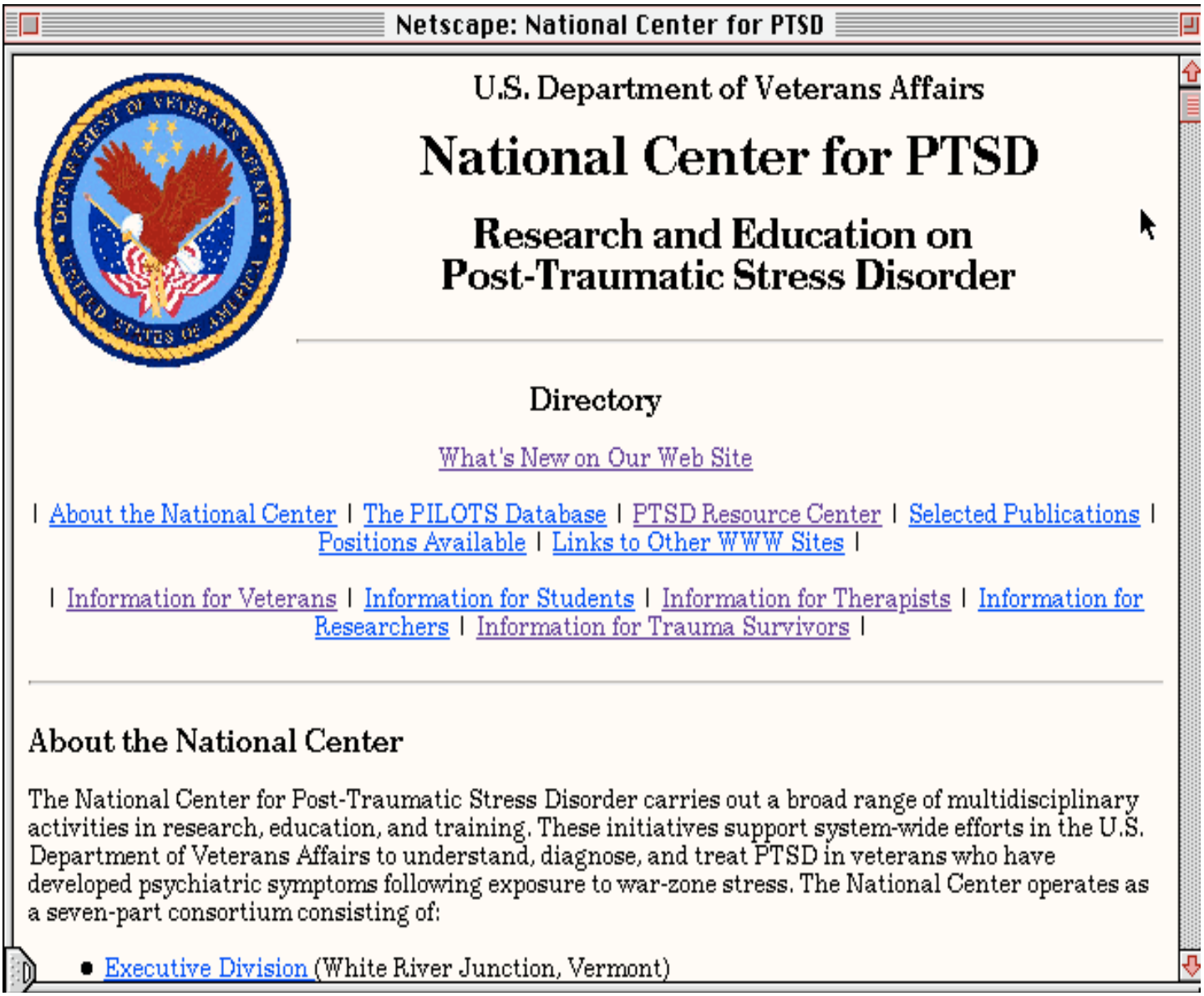
One of our projects for this summer is the triennial revision of the PILOTS Thesaurus. This is the list of terms ("descriptors") that we use to indicate the subject content of papers indexed in the PILOTS database. We shall be evaluating potential new descriptors, and examining existing descriptors to determine whether making changes might make searching the database easier for its users. As part of this process, we would welcome any suggestions for new descriptors or for modification of existing ones. Please address these to Fred Lerner at our headquarters in White River Junction, Vermont.

PILOTS UPDATE

We receive many requests for information on PTSD, from all segments of the public. We hear from veterans and others who have been diagnosed with PTSD, and from members of their families; from therapists treating their first traumatic stress cases and from lawyers representing trauma survivors; from middle school students doing class reports, and from university professors compiling definitive textbook chapters and literature reviews. We receive their requests by letter and telephone and, increasingly, by electronic mail.

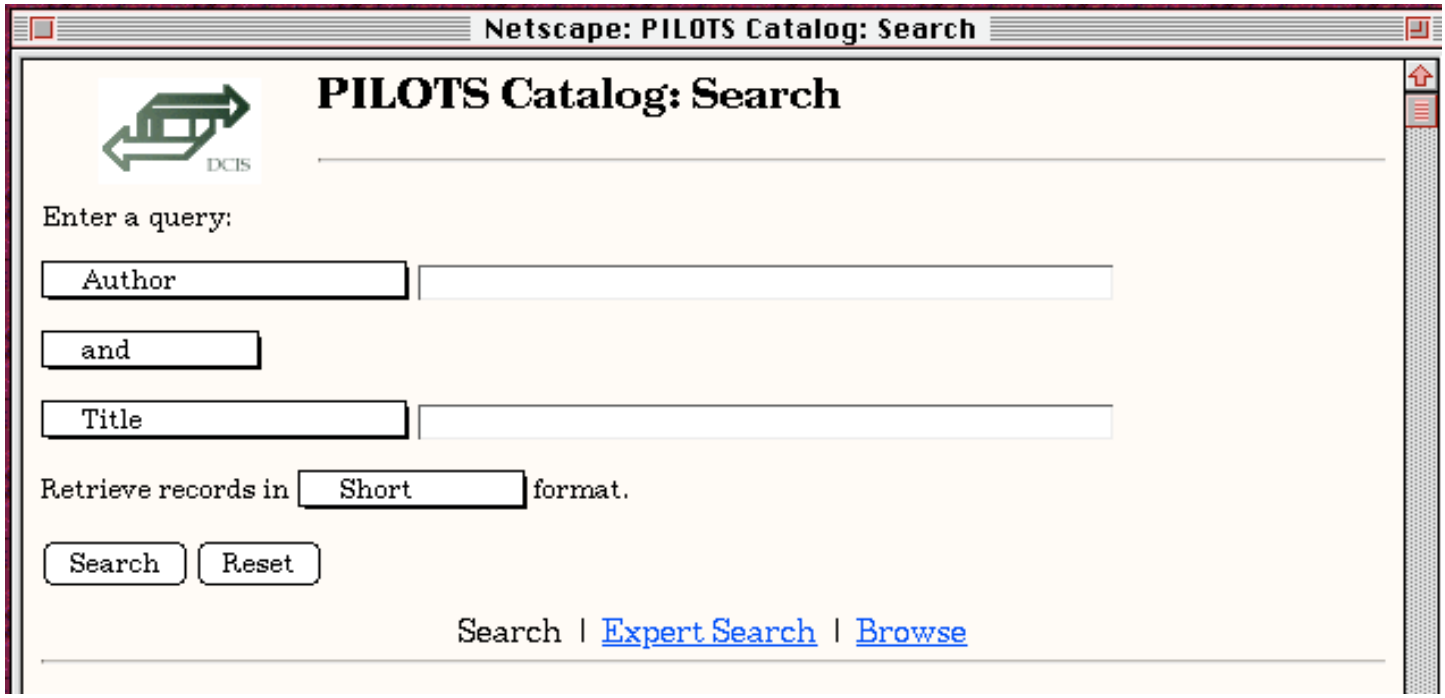
To meet their needs, we have begun to produce a range of fact sheets and reading lists, and we are looking at new ways to make available the technical reports, assessment instruments, and other specialized materials emerging from National Center research and educational activities. These documents are expensive and cumbersome to print and store, and it is impossible to ensure that we will always have sufficient supplies on hand to respond immediately to urgent requests. So we are increasingly relying upon our World Wide Web site to make this material available to the many publics we serve.

We have redesigned our Web site to make it easier for visitors to find what they need, and to ensure that anything copied or printed from our site contains an indication of its origin. When you log on to our site, the first thing you see is our home page, with its directory of our Web site's contents:



If you are a frequent visitor, you can use our "What's New" list to see material added since your last visit. If you wish to find out more about the National Center or use its services, the second part of the directory will take you to the right place on our home page from which to begin. And if you are a veteran, student, therapist, researcher, or trauma survivor looking for authoritative information, you will find a contents page describing—and linking you to—material produced with your particular needs in mind.

Our Home Page describes the National Center's most important activities and services. One of these is the PILOTS database, and our Web site offers PILOTS users a new graphical interface. This makes it easier than ever to find things in PILOTS: just use the pull-down menus to select the type of search you wish to perform. For more complex searches, click on "expert search" to bring up a box into which you may type multiple search terms.



Many PILOTS users are accustomed to the robust search capabilities of the older command-based textual interface. This version of the database remains available, and may be accessed either through our Web site (if your browser software is equipped to use the telnet protocol) or by direct telnet connection to `<lib.dartmouth.edu>`

Our Web site does not attempt to include everything that the Internet has to offer on PTSD. By restricting its content to material produced by the National Center, we are able to ensure its validity and timeliness. Our goal is to make

`<http://www.dartmouth.edu/dms/ptsd/>`

the World Wide Web's most authoritative source for information on PTSD.

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