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The Cognitive and Emotional Concomitants of Secondary Traumatization

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Abstract

Secondary trauma has become a global public health concern due to extensive social, health and economic consequences. Traditionally research has been centered on the symptoms of direct trauma but now it has become a significant concern to explore the impact of indirect traumatic stress symptoms in those professionals who provide help to traumatized people. The concept of secondary trauma has been described in various ways so far, this paper reviews the conceptual links of secondary traumatization with a clear understanding of psychological concomitants including cognitive and emotional domains of an individual. These two aspects viz. cognitive orientation and emotional processing appear to be crucial factors in determining secondary trauma. It is important to acknowledge the need to explore the factors that occur in association with it. An increased awareness can be very helpful in dealing with the stress reactions of secondary trauma in professionals.

Keywords: *secondary traumatic stress, compassion fatigue, burnout, vicarious traumatization, cognitive orientation, emotional processing*

Introduction: The long term consequences of traumatic events are well known by the professionals who treat the traumatized. Evidently the incidences of violence and vulnerability to stress is increasing day by day, it demands the professionals who deal with the people directly in contact to these events. Furthermore, if one is working with the victims of trauma, it can be result into traumatic and emotionally challenging situations, impacting on the lives of such ‘helpers’ (professional and volunteer trauma workers). Therefore trauma is an important area of study (Figley et al, 2003). The symptoms produced by the emotional, cognitive and physical consequences developed by directly helping the trauma victims termed as secondary traumatic stress symptoms. Yet, research in this area shows that there is a lack of empirical evidence concerning the prevalence and incidence of this type of stress reaction. Literature shows that the majority of trauma studies have mainly focused on primary trauma or direct trauma also termed as Post traumatic stress disorder (PTSD) whereas little work has been done on secondary traumatic stress.

Forms of Secondary Traumatization: Indirect exposure to a traumatic event through a firsthand account is defined as secondary trauma. The emotional and cognitive presentation of traumatic event may result in a set of symptoms known as traumatic stress symptoms (TSS). *Vicarious traumatization* (Pearlman and Saakvitne, 1995) and *Compassion fatigue* (Figley, 1995) are other terms also known for secondary traumatization. Compassion fatigue is an evolving concept, this term is the latest that is known as secondary traumatic stress in the field of traumatology. Figley (1982) claimed "Most often this phenomenon is associated with the "cost of caring" for others in emotional pain. This phenomenon can be described by a number of terms. It has been termed as secondary victimization (Figley, 1982), secondary traumatic stress (Figley, 1983, 1985, 1989; Stamm, 1995; 1997), vicarious traumatization (McCann and Pearlman, 1989; Pearlman & Saakvitne, 1995 (Figley, 2003)." Four terms have become popular and conventional in trauma field are secondary traumatic stress, compassion fatigue, burnout and vicarious traumatization.

- i. Secondary Traumatic Stress Disorder (STS, STSD):** Secondary Traumatic Stress (STS) is a stress emerges as a normal consequence of emotions and behavior resulting from helping a traumatized person directly or knowing about a traumatized incident experienced by considerable other. STS can appear all of a sudden and without any caution in contrast to burnout which emerges steadily that is a result of emotional overtiredness. Secondary traumatic stress and emotional burnout collectively represents Secondary Traumatic Stress Disorder (STSD). Even though the symptoms of secondary traumatic stress disorder and PTSD are similar including constant watchfulness, re-experiencing, memory avoidance, deadening in actions and emotions as well as shifts in cognitive beliefs but the milder form of these symptoms are present in STSD.
- ii. Compassion Fatigue:** Although secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD) are the terms that provide most accurate and latest descriptions of the observations through with helpers and sufferers over a long period of time, according to Figley (1995), "compassion fatigue is the most friendly term for this phenomenon". Firstly Joinson used the term 'compassion fatigue' in a nursing magazine in 1992 thus this term has been in existence since then. "Compassion is defined in the Croatian Encyclopaedic Dictionary as sharing a person's grief and sorrow and feeling sorry for who has struck by suffering or some misfortune. (Anić et al. 2002)." At the crux of the theory the concept of compassion is derived from empathy and exposure to traumatized people. In other words if we had not exposed to a person in trauma or have not empathy towards others suffering, there is no reason to have any probability for occurrence of compassion fatigue.
- iii. Burnout:** Generally burnout is associated with the accumulation of the stressors which are responsible to destroy an individual's high morale, dedication and motivation in professional area or career. According to Pines and Aronson (1988), "burnout is a state of physical, emotional and mental exhaustion caused by long-term engagement in emotionally demanding situations" (Pines & Aronson 1988). Burnout is identified as a process which gradually begins and progressively deteriorates. The review of empirical research on burnout symptoms suggests five categories of symptoms (Kahill 1988) are "Physical symptoms (physical exhaustion, sleeping problems, certain somatic problems such as headaches, gastric-bowel disorders, immunity decrease); Emotional symptoms (irritability, anxiety, depression, guilt, helplessness); Behavioural symptoms (aggression, cold-heartedness, pessimism, defensiveness, cynicism, substance abuse); Work-related symptoms (poor work performance, often sick leaves, constant tiredness, break-time abuse at work,

quitting jobs); Interpersonal symptoms (superficial communication with..., inability to concentrate and focus on..., withdrawal from..., and then dehumanizing, intellectualizing etc.).”

- iv. Vicarious Traumatization (Vt):** Vicarious traumatization (VT) can be defined as the accumulative effects of trauma in those who work with the trauma survivors, including victims of domestic violence, incest or rape victims (McCann & Pearlman 1991). The People (social workers, therapists, researchers, lawyers) working with traumatised persons are prone to experience the physical, spiritual and emotional alterations, these changes in their state provide a framework for vicarious traumatization. Workers can be affected by working with traumatised people in many apparent and refined ways. Some examples of this transformative process are insistent feeling of dread and vulnerability, violent and intrusive thoughts, difficulty in trusting others, inability to bring changes in their client’s lives, as well as skeptical worldview (McCann & Pearlman 1991, Pearlman & Saakvitne 1995). Parallel emotional reactions also often experienced by workers and victims (Figley 1995, 1998). It is a theoretical term that emphasizes more on the covert cognitive changes that occur due to the collective exposure to another person’s traumatic material whereas it less focuses on the symptoms of trauma. The primary symptoms of vicarious trauma encompasses the disturbance in one’s cognitive frame of reference in the domains of trust, safety, control, esteem, and intimacy.

Although these terms capture somewhat same elements of the definition of secondary traumatization but are not all interchangeable with it. Moreover Figley claimed “vicarious traumatization overlaps with compassion fatigue; and both are used interchangeably with secondary traumatic stress as they both are a result of working with victims of trauma.” Thus by combining both concepts a more holistic view of trauma workers can be obtained because it concerns not only with the symptoms of trauma but also with other characteristics such as individual traits so that one can have in depth analysis of traumatic stress reactions in trauma workers. (McCann & Pearlman, 1990).

The Cognitive And Emotional Concomitants Of Secondary Traumatization: Though secondary trauma covers a wide range of such factors that can contribute to the response pattern of an individual to indirectly experienced traumatic event but the two most important aspects seems to be one’s cognitive and emotional facets. It is very likely to be possible that a person’s cognitive make-up determines the way how he or she will respond to secondary trauma or indirectly experienced trauma. To get into the view for the best understanding of one’s response to trauma, it is essential to analyze one’s predisposing personality factors which frame the cognitive substrate of an individual. (Kreitler & Kreitler, 1988). These personality factors are best reflected in perspective of cognitive orientation theory which suggests that human behavior is a resultant product of four specific belief types. CO theory holds a cognitive - motivational approach and is very helpful in understanding, predicting and changing of behaviors. CO theory has a great relevance with secondary trauma since it has been presented a wide range of emotional, cognitive, physiological and behavioral phenomenon that are mainly associated with the stress reactions to trauma and coping. (Kreitler, Kreitler, Figer, & Inbar, 2002; Kreitler, Weissler, & Bruner, 1991 Kreitler, Kreitler, Len, Alkalay, & Barak, 2008;). Formally, there are four specific belief types that forms human behavior as postulated by Kreitler. These beliefs are: belief about self, general belief, belief about norms and belief about goals. Belief about self and general are the beliefs which based upon reality whereas belief about norms and goal are based on ideal situations, the former more focuses on reality or

“what is” in contrast latter focuses mainly on “what should be”. These belief types differ in subject and in the relation between subject and predicate, belief about self and goal are related to self; belief about norms and general beliefs are non self.

These beliefs whether reality based or idealized characterize one’s behavior, this turn out to be an important pathway for the identification of faulty cognitions that can be a major source for the development of secondary traumatic stress symptoms. The validation of the relationship between cognitive orientation and secondary trauma has supported by previous studies. ‘Cognitive orientation as predictor of posttraumatic growth after secondary exposure to trauma’ was studied by Shiri, Wexler, & Kreitler in 2010 with the sample of rescuers, nurses, and rehabilitation teams. It was found that the scores of the four belief types and thematic factors predicted the post traumatic growth for majority of variables. In other subsequent studies a clear relationship between CO and traumatic stress symptoms (TSS) was also found.

Emotional Processing: Emotional processing as a concept was very first introduced by Rachman in 1980 who studied and explained this concept in particular relevance to anxiety disorders, later on in 2001 he reiterated the concept of emotional processing and applied it for the posttraumatic stress disorders. Emotional processing refers the way in which stressful life events are processed by an individual. It is “A process whereby emotional disturbances are absorbed, and declined to the extent that other experiences and behavior can proceed without disruption” (Rachman,1980). Since many centuries there have been debates on ‘how emotions work.’ The basic technique for understanding and working with emotions is to ‘process’ them. Kennedy-Moore and Watson explained the outline for processing of emotions developed for the therapists and their clients in their book *Expressing Emotion (2001)*. Basic steps were introduced in the processing of emotions included sensing, naming, attributing, evaluating and acting. These five steps come into the process from the occurrence of an stimuli to a person’s reaction towards it. The physical sensation or automatic impulses our body has is the first building step for emotions, secondly identifying the exact right name of that sensed emotion, third necessary step is the determination of what exactly caused the sensed emotion, this is something very important because people generally fix some common mistakes while attributing to their emotions. Next step is to evaluate the emotion we have felt, for eg. the presence of some particular emotion make us feel comfortable or not. The last step in the processing of emotions is ‘acting’, refers the way how a person will express his or her emotions. Thus it is evident that the set of our responses or our behavior is chiefly guided by our emotions.

The theoretical foundation for this concept was presented in Emotional Processing Theory was developed by Foa and Kozak (1985,1986). This theory provides a way to make a help in understanding anxiety disorders. This theory is based upon the idea that fear is represented as a “program” in our memory for escaping danger. This fear structure includes all related information of the fear stimuli, although this theory encompasses the framework of emotions in particular relevance to anxiety disorders but it also has been studied in the context of PTSD. The idea suggested by this theory may help people to overcome with the traumatic material to which they exposed. If people practiced through confronting trauma memories and reminders repeatedly and simultaneously they learn that nothing bad can happen to them, then it is likely to have some reduction in traumatic stress symptoms positively. In the same field another extensive and worthy work was carried out by Dr. Roger Baker (2007), a very applied and remarkable approach of emotional processing was used by Dr. Baker for the therapies sessions of his clients in his book “Emotional Processing: Healing through feeling”. The Process behind triggering of various emotions may involve various elements

of emotions, cumulatively presented in the 'Model Of Emotion' proposed by Dr. Roger Baker. All the three parts of this model can be easily understood by following figures:

Figure 1: Registering the emotion

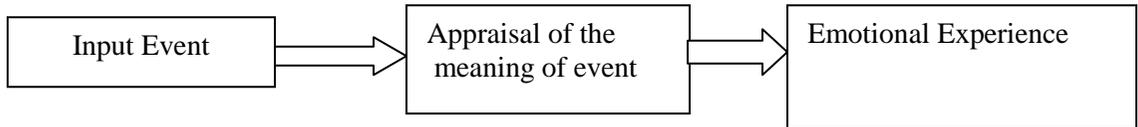


Figure 2: Experiencing emotion

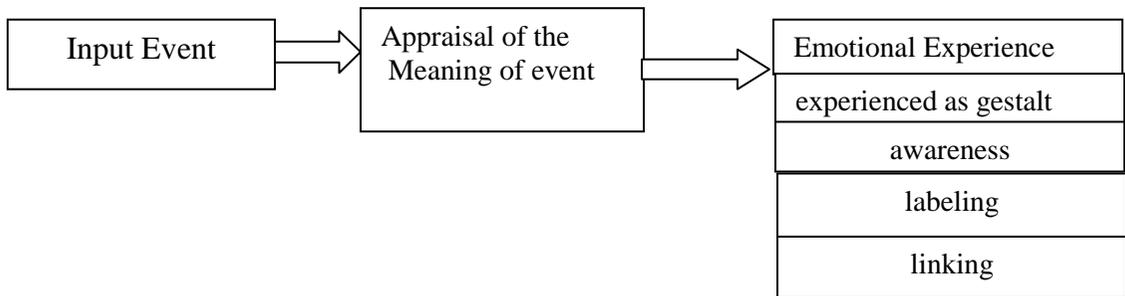


Figure 3: Expressing emotions

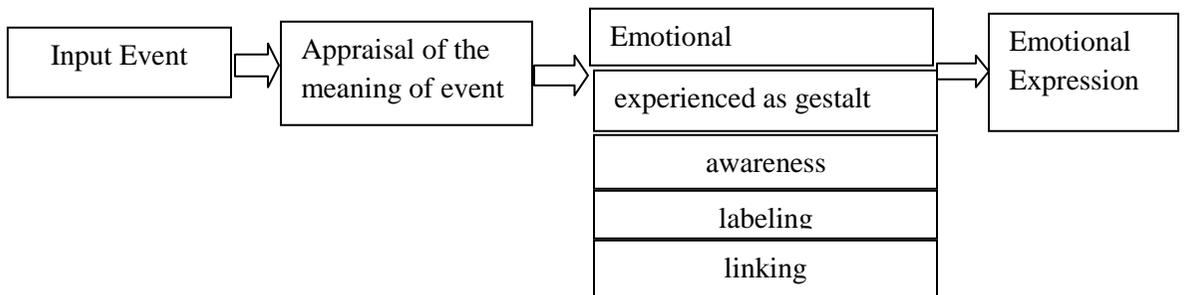
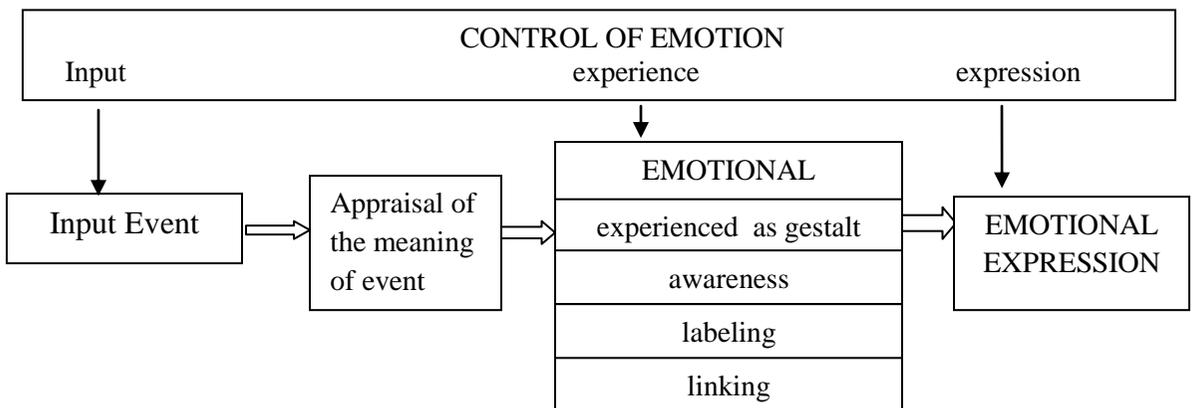


Figure 4: Control Of emotions



Model of emotion (Baker, 2007)

Although input-experience-expression is natural sequential process, but individuals also develop regulation or control for their emotions through the course of their life. Some types of controlling are helpful in some ways and generally tend to get better understanding with others but sometimes control may be very harmful. It was concluded that regulating the experience of emotions is much more harmful than regulating the expression of emotions. It was discovered by Slatcher (2005) that “when a person share or inhibit his thoughts and feelings about a traumatic event, he has the power not only to determine how he cognitively and emotionally process the event, but also to shape the ways in which he interact with others and how others perceive him.” Therefore, it is clear to understand the importance of emotional processing in the development of secondary trauma as this process identifies the way how a person will feel and express his or her emotions to a traumatized event.

Conclusion: So far many studies have investigated the issue of secondary trauma, though it is essential to further study this concept in detail. An individual’s cognitive and emotional makeup directs his/her personality and behavior thus to further investigate this concept, it is necessary to consider how a person thinks about a traumatic material and how he or she will going to process his/her emotions because one’s cognitive and emotional facets are considered to be very crucial in the study of secondary traumatization.

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