

Awareness, Management and Resolution of Secondary Trauma in Therapeutic Practice

A Review of Existing Strategies and Somatic Experiencing as a Preventative and Healing Modality

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ABSTRACT

Management and prevention of secondary trauma is hampered by inconsistent terminology, with related constructs often used interchangeably in both academic literature and professional practice. This reflexive paper argues that clearer conceptual distinctions are necessary to strengthen both research and workplace responses to secondary trauma among clinicians working with traumatic material. It offers clear definitions for the different presentations of secondary trauma along with a critical review of the existing literature on prevention and management strategies. The research reviewed suggests that approaches that explicitly recognize secondary trauma and incorporate targeted interventions within supervision may play an important role in preventing and resolving these symptoms. Drawing on evidence from trauma treatment and practitioner training contexts, Somatic Experiencing, a resilience-based trauma modality, is suggested as a promising addition to existing strategies in the prevention and alleviation of secondary traumatization.

Keywords: secondary trauma, vicarious trauma, secondary traumatic stress, Somatic Experiencing, embodiment, somatic awareness, resilience

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Sharing the burden of what I was holding, and attending to my physical experience made a noticeable difference to my energy levels, and thus my capacity to be present for my clients in the therapy room.

My early clinical work with trauma survivors coincided with the unexpected emergence of unexplained physical symptoms including persistent joint pain, fatigue, and a growing sense of irritability and social withdrawal. This experience prompted a deep examination of how therapists may be affected by prolonged exposure to traumatic material, and what strategies might help mitigate the impact. The following paper explores the literature on secondary trauma and considers the potential role of Somatic Experiencing in supporting practitioner resilience.

Introduction

It is widely accepted that counselors and psychotherapists are exposed to a number of personal and

professional challenges while working with clients (Grover, 2018; Posluns & Gall, 2020). Examples of such are professional impairment due to increased stress and emotional exhaustion (Posluns & Gall, 2020), depression, anxiety, and self-doubt (Kaeding *et al.*, 2017). However, it is suggested that not all forms of therapy exert an equivalent toll on the therapist (Kadambi & Ennis, 2004; Posluns & Gall, 2020). The impact on therapists working with traumatic material cannot be overstated (see McCann & Pearlman, 1990; Kadambi & Ennis, 2004; Winblad *et al.*, 2018; Velasco *et al.*, 2023), with studies showing that effects can include changes to “neurological, emotional, mental, cognitive, sexual and spiritual” aspects of their lives (Branson, 2019, p. 3). Furthermore, symptoms associated with post-traumatic stress disorder (PTSD) are specifically noted (Kadambi & Ennis, 2004; McNeillie & Rose, 2021; Velasco *et al.*, 2023) and include sadness, changes in worldview, hypervigilance, exhaustion, and nightmares, as well as a host of physiological symptoms with no medical explanation such as chronic pain, nausea, and difficulty breathing, to name but a few (Winblad *et al.*, 2018; Branson, 2019; Barros *et al.*, 2020; McNeillie & Rose, 2021). The process by which these symptoms occur is referred to as “secondary trauma” (Tosone *et al.*, 2012, p. 232; van der Merwe & Hunt, 2019, p. 10). Research that attends to the impact of trauma work on therapists is particularly relevant given the importance of practitioner wellbeing for effective therapeutic work with trauma survivors (Isobel & Angus-Leppan, 2018; McNeillie & Rose, 2021).

Following a deep interest in trauma work, and having shifted my clinical focus toward specialist trauma treatment, my caseload quickly became comprised predominantly of clients seeking support for trauma-related issues. Notably, many of these individuals had intentionally pursued body-based therapeutic approaches following unsuccessful attempts to resolve their trauma through other modalities. Within a few weeks of this work, I noticed physical symptoms that had no obvious medical explanation. Of particular curiosity was an unusual bruise-like pain in the joints throughout

my body. This was not something I had experienced before and there was no clear physical cause. A few months later, I experienced excruciating abdominal pain caused by kidney stones¹. Around the same time, I also noticed a growing sense of fatigue following my clinical sessions, an irritability that was unfamiliar to me, and an increasing desire to withdraw socially.

I subsequently sought the support of a Somatic Experiencing (SE) practitioner to help me understand and resolve the physical and emotional symptoms I was experiencing. Impressed that my initial symptoms dissipated within a few sessions, I embarked several months later on the SE training myself. It became clear almost immediately that much of the learning was about how to remain present to the sensations in my own body as a therapist (Winblad *et al.*, 2018). This aligns with the assertion that therapists should remain vigilant to the signs of vicarious trauma (Isobel & Angus-Leppan, 2018) and that employers, supervisors, and trainers should be aware of the phenomenon and speak openly about it to ensure that practitioners have effective strategies to manage it (Trippany *et al.*, 2004; McNeillie & Rose, 2021). This is further supported by Isobel and Angus-Leppan (2018) and Tabor (2011), who assert that one of the most effective protective factors against, and preventative measures for, vicarious traumatization is the cultivation of awareness, not just cognitively, but to the physical responses to client material as well (Isobel & Angus-Leppan, 2018; Lane, 2021).

My relatively sudden reactions, and the unexpected speed of their resolution, led to my increased awareness of the tangible impact of working with traumatic material, but it also prompted me to question if somatic interventions were being given the attention they deserved. While anecdotal, my experiences reflect a growing body of research documenting the psychological and physiological toll that trauma work can have on clinicians. It is hoped that by highlighting the potential role of Somatic Experiencing as a targeted intervention for secondary trauma, counselors and other helping professionals working with traumatic material may be armed with more of the necessary knowl-

1. While I do have a family history of kidney stones, it has been shown that stress activates the fight and flight response, which in turn activates the neuroendocrine system (the interaction between the nervous system and endocrine system), thus increasing the risk of the formation of kidney stones (Miyaoaka *et al.*, 2012; Najem *et al.*, 1997).

edge and tools to prevent the lasting effects of this kind of work.

Secondary trauma, and specifically vicarious trauma, along with its effects on practitioners, has been well-researched and established since the early 1990s (see McCann & Pearlman, 1990; Figley, 1995; Ogińska-Bulik *et al.*, 2021). However, clearly defined parameters for secondary trauma are difficult to come by, and this has a notable effect on the efficacy and consistency of research in the field. Confusion and disagreement lead to terms such as burnout, compassion fatigue, countertransference, secondary traumatic stress (STS) and vicarious trauma (VT) being used interchangeably (Makadia *et al.*, 2017; Kim *et al.*, 2021; Velasco *et al.*, 2023), and so, the ability to cross-reference and critically analyze literature is significantly hampered (Najjar *et al.*, 2009; Makadia *et al.*, 2017; Branson, 2019). In response to the interchangeable terminology used in various recent studies, Branson (2019) and Tabor (2011) assert that it is essential for the reliability of research that, for example, STS, burnout, countertransference, and compassion fatigue be differentiated from each other, but most notably from the narrowly defined parameters of VT (Branson, 2019).

This conceptual ambiguity has practical consequences as well. When terminology is used inconsistently, research findings become difficult to interpret and translate into effective workplace responses or preventative strategies for practitioners. It is for these reasons that I have included definitions of the key terms before considering the potential contribution of Somatic Experiencing (SE) as an effective strategy for supporting practitioner resilience.

Rationale

With increasing recognition and acceptance of trauma within the general population (Becker-Blease, 2017; Foreman, 2018), studies show that up to 94% of individuals seeking therapy have experienced some form of trauma (Bride, 2004; Kilpatrick *et al.*, 2013; Foreman, 2018). Clinicians are therefore very likely to be seeing clients with trauma histories regardless of their presenting issues (Trippany *et al.*, 2004; Bober & Regehr, 2006; Foreman, 2018) and are consequently at risk of vicarious traumatization (Kadambi & Ennis, 2004; Trippany *et al.*, 2004; Lane, 2021). While the per-

sonal consequences for practitioner wellbeing have already been introduced and are discussed in more detail later, there is also cause for concern when counselors experience vicarious trauma or secondary traumatic stress, particularly in relation to the wellbeing of their clients. Research shows that therapists who experience secondary trauma are at risk of impairment that could compromise their clients' welfare (Trippany *et al.*, 2004; Foreman, 2018). Specific impairments include apathy toward the work, anger or cynicism toward clients (Branson, 2019; Barros *et al.*, 2020), lack of empathy (Andaházy, 2019), loss of professional boundaries (van der Merwe & Hunt, 2019), and a general decline in the quality of care (Trippany *et al.*, 2004). While some practitioners experience "vicarious resilience" (Hernandez-Wolfe *et al.*, 2015, p. 154), discussed later, many others may not, and so it is imperative that clinicians are made aware of and given effective ways to manage secondary trauma (Trippany *et al.*, 2004) to ensure the integrity of the therapeutic relationship in order to protect both the client and the therapist. Understanding how these impacts are conceptualized in the trauma literature is therefore an important starting point.

PTSD is a clinically recognized psychiatric diagnosis associated with exposure to traumatic events and characterized by symptoms such as intrusive memories, hyperarousal, avoidance, and alterations in mood and cognition (Branson, 2019; Stileman & Jones, 2023). Although PTSD is typically associated with direct exposure to traumatic events (Solomon *et al.*, 2021), research asserts that professionals working extensively with traumatic material may experience similar symptom patterns through repeated indirect exposure to the traumatic experiences of others. In some cases, these symptoms may become severe enough to meet diagnostic criteria for PTSD (Lemieux-Cumberlege *et al.*, 2024), thereby supporting the inclusion of secondary trauma within the clinically recognized PTSD criteria (Solomon *et al.*, 2021). However, much of the impact on helping professionals is discussed in the literature through a range of related, yet distinct, constructs.

For this reason, this paper is primarily concerned with a cluster of related constructs that are used to describe the impact of indirect trauma exposure on helping professionals, including vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout. These constructs are frequently con-

flated in the literature, and are used to describe responses to trauma exposure that may not meet full diagnostic criteria for PTSD, yet nevertheless have significant psychological and physiological effects on clinicians.

Given the inconsistent use of terminology in the literature, it is first necessary to clarify the key concepts that underpin this discussion. Many of the terms used to describe the impact of trauma work share overlapping symptoms, so clarifying these distinctions is important both for research precision and for identifying appropriate strategies for prevention and intervention.

Key terms

Vicarious trauma

In a comprehensive review of terminology – one that appears to be unique within the existing body of literature – Branson (2019) draws upon and synthesizes findings from a range of studies conducted over the past fifteen years, highlighting persistent ambiguity surrounding the precise definition and symptomatology of vicarious trauma (VT). Originally defined by McCann and Pearlman (1990), VT is used to describe the process by which a therapist is “profoundly and permanently changed” (Kadambi & Ennis, 2004, p. 3) through the holding of traumatic material brought by clients, and the unique, negative changes to the therapist that can occur (McCann & Pearlman, 1990). Importantly, it is specifically related to empathic exposure, within a therapeutic relationship, to detailed disclosure of traumatic experiences (Branson, 2019; van der Merwe & Hunt, 2019). VT is differentiated from other forms of secondary stress by the negative cognitive shifts within the therapist that occur on repeated exposure to this material (Kadambi & Ennis, 2004). In other words, it has an impact on the therapist’s worldview, or cognitive schemas (Branson *et al.*, 2014; Sui & Padmanabhanunni, 2016; Barros *et al.*, 2020), sense of self (Kadambi & Ennis, 2004), emotional behavior (McCann & Pearlman, 1992), self-esteem (Andaházy, 2019), and the way they think, feel, and relate to themselves and to others (Sui & Padmanabhanunni, 2016). Ashraf (2015) rejects the assertion that VT is unique to therapists and other helping professionals, and suggests that it can present in anyone who, for example, watches a nightly newscast of a ter-

rorist incident. Although no personal relationship exists between the watcher and the people suffering on the newscast, there is arguably the potential for empathic engagement with the material, and so this could well rise to the level of vicarious traumatization as it can change the cognitive schemas of the viewer.

Many of the symptoms of VT overlap with those of PTSD, such as cynicism, anger, emotional detachment, changes in worldviews or spiritual beliefs, increased physical ailments and illness (Osofsky *et al.*, 2008), intrusive imagery, arousal, and avoidance behaviours (Branson, 2019). It is for this reason that PTSD is considered to be an element of VT (Sui & Padmanabhanunni, 2016).

Secondary traumatic stress

Similar to the above distinction, secondary traumatic stress (STS) is specifically characterized by symptomology nearly identical to that of PTSD (Figley, 1995; Newell & MacNeil, 2010) following indirect exposure to single or multiple traumas (van der Merwe & Hunt, 2019), and the overwhelming desire to provide help or comfort to those who have suffered (Jenkins & Baird, 2002; Boscarino *et al.*, 2004). First responders and medical practitioners are examples of professionals who are at risk for STS (Branson, 2019; Ogińska-Bulik *et al.*, 2021). Symptoms include avoidance, disturbing images, hypervigilance, and hypersensitivity to related stimuli (van der Merwe & Hunt, 2019). However, STS does not rise to the level of VT, because an empathic relationship has not been developed between the person observing the effects of the trauma and those who have experienced it (Figley, 1995; Branson, 2019). Furthermore, it is not believed that STS results in a permanent change to the helper’s cognitive schemas (Cohen & Collens, 2013).

Compassion fatigue

Compassion fatigue, like STS, is a term coined by Figley (1995), who suggests that the two terms can be used interchangeably (Figley, 1995; Branson, 2019) in that they are both represented by an overwhelming desire to assist a trauma victim, and are often accompanied by a sense of helplessness and an eventual diminished capacity for empathy (Boscarino *et al.*, 2004). While VT and compassion fatigue share the commonality of developing over

time (Trippany *et al.*, 2004; Bush, 2009; Winblad *et al.*, 2018), STS can be experienced after a single exposure to traumatic material (Winblad *et al.*, 2018; Branson, 2019), which would suggest enough of a differentiation that the two terms (compassion fatigue and STS) should not be used interchangeably.

Burnout

Burnout can occur in any profession (Trippany *et al.*, 2004), but in the context of therapy is described as a psychological strain of working with people who experience difficulty. It is not limited to trauma, and includes the chronically ill, people living in poverty, and people with psychiatric issues (McCann & Pearlman, 1990). Burnout is associated with isolation, continual output of empathy, a sense of overwhelm with the workload (Trippany *et al.*, 2004), and importantly, is differentiated from the other terms mainly by a lack of social or workplace support (Simionato *et al.*, 2019). Unlike VT and STS, all therapists are at risk of burnout. While burnout includes symptoms common to STS, VT, and compassion fatigue, such as emotional exhaustion (Kadambi & Ennis, 2004), a disconnect and diminished empathy and quality of care for clients (Kadambi & Ennis, 2004; Trippany *et al.*, 2004), and self-doubt with regard to professional efficacy (Kaeding *et al.*, 2017), burnout is considered to be transient. It is also limited to the workplace, and is not a cause of permanent cognitive shifts in the person experiencing it (Kadambi & Ennis, 2004).

Countertransference

Countertransference refers to an emotional reaction on the part of the therapist to material presented in the therapy room, and is punctuated by signs that the practitioner has unresolved personal issues that may be playing a role in the therapeutic relationship (Barros *et al.*, 2020; Branson, 2019). It is present in all therapeutic relationships and is unique to each client-therapist dyad (Adams & Riggs, 2008). Studies have noted that the measures used to assess VT have not always taken into account the therapist's own trauma history (Tosone *et al.*, 2012; Ashraf, 2015), and so it is quite possible that the prevalence of VT is skewed by incidences of countertransference and activation of the therapist's personal trauma history. It is also important to note that there can be an interplay between countertransference and vicarious trauma (Barros

et al., 2020). As the therapist is exposed to vicarious traumatization, they are also more susceptible to countertransference of that material (Kadambi & Ennis, 2004).

For the purposes of this reflexive paper, and to remain within the confines of my personal experience, I will refer only to secondary traumatic stress and vicarious trauma as defined above, and will use the collective term of "secondary trauma" (van der Merwe & Hunt, 2019, p. 10) to denote both phenomena, unless specifically referring to one or the other.

Review of the literature

Efficacy of the research

Having coined the phrase and defined the process of vicarious trauma, McCann and Pearlman (1990) went on to create a framework based on these constructs by which the effects of VT could be understood. They called this framework "constructivist self-development theory" (CSDT) (McCann & Pearlman, 1990, p. 136). CSDT asserts that one constructs a personal reality as one interacts with a given environment (McCann & Pearlman, 1990). Thus, working with trauma has an impact on the self-development of the therapist (Lee, 2017). Trauma can disrupt individual beliefs and the cognitive schemas that shape and provide meaning to one's perception of the world. These cognitive schemas are vulnerable to significant events (Tehrani, 2007), and so areas of trust, safety, power, independence, esteem, and intimacy can be altered in working with victimized individuals (McCann & Pearlman, 1990; Lee, 2017; McNeillie & Rose, 2021). Therapists may experience shifts in their perception of themselves and of the world (Kadambi & Ennis, 2004), become cynical or distrustful of people, become hypervigilant to danger, lose their sense of empowerment or independence, and struggle with intimacy in relationships (McCann & Pearlman, 1990; Trippany *et al.*, 2004; Lee, 2017; Barros *et al.*, 2020).

Kadambi and Ennis (2004) note the lack of empirical evidence for this construct, and suggest that the prevalence and impact of the phenomenon may have been exaggerated, and that scholars and practitioners rushing to find interventions for it may have been premature. This is a view also held by Makadia *et al.* (2017), who go as far as to sug-

gest that the acceptance of VT be reconsidered, and that specific interventions for the condition cease. While qualitative studies, which rely on descriptive reports and subjective self-assessments (Andaházy, 2019; Aafjes-van Doorn *et al.*, 2020), have been consistent in their findings (Kadambi & Ennis, 2004), Kadambi and Ennis (2004) found that quantitative studies reveal no link between traumatic stress symptoms and working with survivors of trauma.

However, while Bride (2004) suggests that there is little evidence to support the assertion that VT results in shifts to cognitive schemas, findings suggest traumatic stress among therapists ranges from mild (or not within a clinical range) to symptoms similar to those of outpatient PTSD clients, and in some cases is significantly higher than normal for non-psychiatric patients (Bride, 2004). While neither Kadambi and Ennis (2004), Branson (2019), nor Bride (2004) dispute the existence of vicarious trauma, they do point out the questionability of the measure by which VT is assessed, along with the possible reasons for the lack of consistent research.

These inconsistencies abound in the research, the complex interplay between therapist and client (Rasmussen, 2005), the evolving definition of PTSD, increased demands on practitioners (Branson, 2019), as well as disregarding their life experiences (Finklestein *et al.*, 2015; Ogińska-Bulik *et al.*, 2021), which all make consistency and comparison in research a challenging, if not impossible, prospect. This is an observation also made by Tosone *et al.* (2012) and Aafjes-van Doorn *et al.* (2021), who point out that we are living in an increasingly traumatogenic society where we are all, therapists included, exposed to the risks of terrorism, climate change, and other human-made or natural disasters (Tosone *et al.*, 2012). These factors further muddy the waters when attempting to find a measure for the impact of trauma stories on therapists when primary trauma may already exist within or without their awareness. It is important to note that double exposure to trauma, i.e. exposure to the same traumatic event as the client (Finklestein *et al.*, 2015), as well as pre-existing primary trauma unrelated to the client material, have been shown to have a bearing on the outcome of vicarious traumatization studies (Ashraf, 2015; Makadia *et al.*, 2017).

In the research found, secondary traumatic stress suffers the same turbidity as VT in use and definition, with studies using burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization interchangeably (Bell *et al.*, 2003; Kellogg *et al.*, 2018), while others seemingly subjectively pick terms that they believe best fit the research they are undertaking (see Boscarino *et al.*, 2004, Sui and Padmanabhanunni, 2016, for example, van der Merwe & Hunt, 2019). When faced with such a wide array of differing opinions and no consensus in sight, it is easy to see how researchers are forced to narrow their focus and make a definitive choice of term(s) for their research projects based on their subjective understanding of the material available.

Physical impact

Very little detailed attention is given to the physical impact of the conditions associated with secondary traumatic stress, the symptoms most noticeable in my personal experience. Only a few studies were found to mention specific somatic reactions to secondary trauma (see Sui & Padmanabhanunni, 2016, and Lane, 2021, as examples). Most studies, if they mention it at all, go no further than to mention physical or somatic symptoms (see Kim *et al.*, 2021, for example), preferring to focus on the psychological impact (see Kellogg *et al.*, 2018; van der Merwe & Hunt, 2019; and Kuhfuss *et al.*, 2021 for example). It has already been established that PTSD is an element of secondary trauma, and has been shown elsewhere to be comorbid with systemic autoimmune diseases (Miller-Archie *et al.*, 2020) exhaustion, headaches, migraines, shortness of breath, dizzy spells, asthma (McNeillie & Rose, 2021), fibromyalgia (Häuser *et al.*, 2013), widespread pain and gastrointestinal issues (Kolacz *et al.*, 2019), arthritis (Boscarino *et al.*, 2010) and even cancer (Chida *et al.*, 2008; Maté, 2011; Giuseppe, 2020). Flashbacks, intrusive thoughts, and memories are often cited (Johnson *et al.*, 2020), while unexplained somatic complaints such as the above as well as dizziness, tinnitus, pain, blurred vision, gastrointestinal disorders, cardiovascular, respiratory, neurological and musculoskeletal disorders (Gupta, 2013; Lane, 2021) are not consistently mentioned in the context of secondary trauma. Furthermore, one cannot discount the indirect impacts on the body as in the case of depression and anxiety (Sui & Padmanabhanunni, 2016). De-

pression, for example, often co-occurs with PTSD (Armenta *et al.*, 2019) and has been shown to lead to a variety of conditions including cardiovascular disease, dementia, and diabetes (Danese *et al.*, 2009; Sui & Padmanabhanunni, 2016). The long term effect of anxiety can lead to “increased rates of heart attack, hypertension, obesity, addiction, anxiety, depression, and other disorders.” (Fink, 2016, p. 3).

Studies that specifically research the link between trauma and physiological ailments, as listed above, are few and far between, and yet trauma survivors are three times more likely than others to have somatic symptoms or syndromes following their experiences (McMahon, 2017). The recent seminal works of specialists in their field, Van der Kolk (2014), Maté (2011), and Levine (1997a) include anecdotal and academic evidence from decades of experiential work and academic study (see Van der Kolk, 1994; Maté, 2012; Payne *et al.*, 2015, for example), and there is a growing body of research that shows a strong connection between exposure to trauma and physical symptoms and disease (McMahon, 2017). An increased understanding of how trauma affects the body and the brain is one of the reasons that these links are now being made (Van der Kolk, 2014; McMahon, 2017).

Managing or preventing secondary trauma

While recognizing that the terms vicarious trauma, secondary traumatic stress, and compassion fatigue are often conflated, Andahazy (2019) suggests that there has been a paradigm shift in the field of counseling from treatment of “vicarious trauma” (p. 41) to a focus on resilience and prevention. The recommended coping strategies for vicarious trauma include supervision, management of caseloads, self-care, and psychoeducation (Trippany *et al.*, 2004; Bober & Regehr, 2006; Kim *et al.*, 2021), with supervision and self-care being specifically emphasized as effective ways of preventing VT (Bell *et al.*, 2003; Neswald-Potter & Trippany Simmons, 2016; Cleary, 2021). However, Bober and Regehr (2006) assert that while there is a correlation between case load and traumatic stress, there is no evidence to show that supervision or self-care has any impact on the prevention of traumatic stress in counselors working with traumatized individuals. This is supported by van der Merwe (2019), who observed that supervision was not sufficient in a study of second-

ary trauma researchers and counselors. Perhaps effective supervision may require the supervisor to have an awareness of the existence and effects of VT on therapists (Rasmussen, 2005; Neswald-Potter & Trippany Simmons, 2016) as well as effective and, at times, creative strategies to manage or prevent it (Neswald-Potter & Trippany Simmons, 2016). The studies reviewed did not detail supervisor background or experience, making conclusions around the outcomes of supervision for secondary trauma difficult. However, it can be argued that the self-reflective nature of supervision, and a supervisor who encourages a conscious awareness of the felt senses during therapy, can be effective preventative measures (Tassie, 2015).

In contrast, research shows that cognitive coping strategies used to mitigate the stress-related symptoms of PTSD have limited impact (Winblad *et al.*, 2018), and this would support the need for more inclusion of approaches that have a body-oriented emphasis, both for clients and clinicians alike. Regular mindfulness among mental health practitioners has been shown to have a positive influence on clinical outcomes, while a combination of mindfulness and increased resilience through sensate body awareness on the part of the therapist even more still (Winblad *et al.*, 2018). However, Heller and LaPierre (2012) assert that where there is a lot of trauma, traditional mindfulness, which might involve prolonged periods of open awareness, can be very difficult, and risk overwhelming the nervous system. This highlights the importance of approaches that support titrated embodied awareness rather than sustained open attention. Somatic therapists are considered to be simultaneously more at risk of VT because of the physical attunement to themselves and to their clients in sessions (Andahazy, 2019). Yet they also benefit, in clinically significant ways, from their increased somatic awareness, self-regulation tools, and education around trauma and the body (Winblad *et al.*, 2018). This would suggest that the way in which bodily awareness is cultivated and supported may be a key factor in both vulnerability to and protection from secondary trauma.

Despite the considerable risks associated with exposure to traumatic material, research suggests that therapists may also experience positive psychological effects from witnessing their clients' recovery. This phenomenon has been described as “vicarious resilience” (Hernandez-Wolfe *et al.*,

2015, p. 154), or “vicarious post traumatic growth” (Neswald-Potter & Trippany Simmons, 2016, p. 77). While vicarious trauma can negatively impact a therapist’s cognitive schemas (Barros *et al.*, 2020), being witness to the resiliency of a trauma survivor can do the opposite. Therapists can enjoy an increase in compassion and empathy, a positive change in finding meaning in their lives, fulfillment and satisfaction in their work, and a heightened sense of personal strength (McNeillie & Rose, 2021). Some therapists may experience a positive cognitive shift as they undergo a process of meaning-making, assimilating both positive and negative aspects of trauma work, and resulting in an enriched worldview (Linley *et al.*, 2005; Cohen & Collens, 2013). Resiliency to secondary trauma has been shown to be the result of a variety of factors: experience, trauma training (Maguire & Byrne, 2017), personal characteristics (McCann & Pearlman, 1990), work environment (Sansbury *et al.*, 2015; Cleary, 2021), access to supervision or support systems (Neswald-Potter & Trippany Simmons, 2016) and case load (Maguire & Byrne, 2017). It is also associated positively with the use of mindfulness, self-care (Winblad *et al.*, 2018), consistent self-awareness (Rothschild & Rand, 2006), and psychoeducation (Trippany *et al.*, 2004; Sansbury *et al.*, 2015), all of which are key elements of Somatic Experiencing work (McMahon, 2017; Kuhfuss *et al.*, 2021; Özcan, 2021). The overlap between these protective factors and the core principles of Somatic Experiencing suggests that this approach may offer a useful framework for both the prevention and management of secondary trauma among clinicians.

In support of Somatic Experiencing

While a range of somatic-based therapies exist, Somatic Experiencing is supported by a growing body of evidence demonstrating the benefits of directly addressing nervous system dysregulation (McMahon, 2017), as well as emphasizing individuals’ internal capacity for self-regulation and the body’s inherent resilience (Winblad *et al.*, 2018). One of the core principles of SE is a process called titration (Payne *et al.*, 2015; Brom *et al.*, 2017), whereby small amounts of nervous system activa-

tion are introduced at a time to ensure that the system is not flooded (Brom *et al.*, 2017). Where cognitive therapies (top-down) focus on how thinking and processing of information influence our internal regulatory system, Somatic Experiencing has a “bottom up” focus that attends to the regulation or dysregulation of the nervous system in the body, and how this affects our cognitive processes (Heller & LaPierre, 2012). Porges (2017) posits that trauma responses are physiological processes with their origin in the nervous system, and so it would stand to reason that interventions that are aimed at regulating this system be used.

Evidence for Somatic Experiencing thus far has primarily focused on outcomes for trauma survivors, but there are also a handful of studies that suggest that SE and similar body-based therapies can be effective in increasing resiliency and reducing symptoms of PTSD in people who assist, both in the immediate aftermath of trauma (Leitch *et al.*, 2009) and in post-trauma therapy (Leitch, 2007). As a resiliency-based model (Levine, 1997b), Somatic Experiencing puts the emphasis not on the pathology but on the body’s innate capacity for self-regulation and healing (Winblad *et al.*, 2018). This is done through, among other practices, engaging in meaning-making and cultivating awareness of felt senses. Such strategies are supported by Tassie (2015), who posits that assisting clients to find meaning in their experience can increase resiliency through post-traumatic growth, and is an effective prevention of VT. Furthermore, Rothschild and Rand (2006) state:

“we are most vulnerable to compassion fatigue or vicarious traumatization when we are unaware of the state of our own body and mind” (Rothschild & Rand, 2006, p. 103).

This emphasis on self-awareness as a resource in preventing vicarious trauma is supported by Foreman (2018), Kuhfuss *et al.* (2021), and Kim (2021). In addition, Andahazy (2019) suggests a more specific approach: that self-awareness be used as a tool to enhance the therapeutic relationship, as a way of constantly adjusting or retuning the mind and body connection in order to remain in the social engagement system^[2], avoid secondary trau-

2. The social engagement system is described by Porges (2005) as the behavioral and visceral mechanisms that form the social cues that facilitate psychological closeness with others.

matization, and thus protect the therapeutic relationship. This strategy of remaining in the here and now and maintaining awareness of the inner body sensations is an important element of SE, and has been shown to increase resilience and reduce levels of post-traumatic stress (Özcan, 2021).

The benefits of self-awareness also extend to those training in Somatic Experiencing. In measuring anxiety and somatic symptoms, Winblad *et al.* (2018) point out that trainees going through the SE program show a significant decrease in physical symptoms, and general anxiety falls well below the clinical range. A large component of the SE training is the teaching and encouraging of increased self-awareness of the trainees' internal processes. Students are encouraged, in between training sessions, to work with each other and with their clients while practicing self-regulation. It is noted in the study that this decrease in symptoms occurs even while trainees are working with their own traumatized clients, fellow trainees' traumas, as well as their own personal histories (Winblad *et al.*, 2018). This suggests that cultivating embodied self-awareness may not only reduce existing symptoms, but may also buffer against the ongoing impact of exposure to traumatic material. These results are supported by Kuhfuss *et al.* (2021), who report significant improvement in physical symptoms, quality of life, post-traumatic stress symptoms, depression, and anxiety, for both individual SE client sessions and participants in SE training modules when compared to a control group.

There remains a lack of research that explores the use of SE specifically targeting the symptoms of secondary trauma. That said, my lived experience, though limited, would support the use of SE for the alleviation and prevention of secondary trauma. Furthermore, since it has been established that secondary trauma and vicarious trauma share symptoms with PTSD, and that SE has consistently impressive and published outcomes when treating those with PTSD, one can deduce that SE interventions will be similarly successful in the resolution of secondary trauma.

Implications for clinical practice

As therapists, we have an ethical obligation to our clients to ensure that we are working within our limit of proficiency (BACP, 2018), upholding standards and doing no harm (BACP, 2018; An-

daházy, 2019). As shown in this paper, the impact of secondary trauma can be profound and have a significantly deleterious effect on client work (Trippany *et al.*, 2004; Foreman, 2018). With varying opinions on whether any of the current coping strategies recommended for reducing distress in counselors are effective, Kim *et al.* (2021) suggest that interventions are largely effective if tailored to their specific settings. Tailored research on resourcing and supervising professionals who work with traumatized individuals has been identified in the current paper as lacking, along with a need for the inclusion of somatic awareness and education for practitioners, a view supported by Kim *et al.* (2021).

As mentioned previously, the vast majority of clients who come to counseling will have experienced a trauma in their lives (Kilpatrick *et al.*, 2013; Foreman, 2018), and so there is good reason to ensure that trauma training is given as standard practice to counseling trainees as well as supervisors, as a lack thereof can have a detrimental effect on both client and therapist (Adams & Riggs, 2008; van der Merwe & Hunt, 2019). Kadambi and Ennis (2004) point out that several studies show that more experienced practitioners are less likely to experience VT than their neophyte colleagues, and so the current system of supervision or management may be an effective way to support practitioners and to disseminate new findings in secondary trauma prevention or symptom management.

Finally, if therapists can remain aware of their arousal state during sessions, and learn how to self-regulate in real time, they are more likely to be able to remain connected to their social engagement system (Heller & LaPierre, 2012; Andaházy, 2019), thus protecting the therapeutic relationship and empathic engagement with the client (Andaházy, 2019) alongside the prevention of secondary traumatization (Foreman, 2018; Kim *et al.*, 2021; Kuhfuss *et al.*, 2021).

Conclusion

This paper's aim was to explore the current academic awareness, management, and prevention of secondary trauma, with a focus on Somatic Experiencing as an additional tool in the mitigation or prevention of the phenomenon. However, getting a clear and uncontested definition of vicarious trauma and secondary traumatic stress respectively

has been a challenge, and this would suggest that vicarious trauma, for example, has entered the zeitgeist of our society and become a broad term used for the experience of listening to, or even knowing of, another person's trauma story, rather than a clinical definition for a specific phenomenon (Branson, 2019).

Having reviewed the literature, it is my assertion that compassion fatigue, burnout, countertransference, secondary traumatic stress, and vicarious trauma are all interrelated (Kadambi & Ennis, 2004; van der Merwe & Hunt, 2019), can be comorbid (Jenkins & Baird, 2002), but are not interchangeable to the point at which there is no differentiation (Jenkins & Baird, 2002; Isobel & Angus-Leppan, 2018; Branson, 2019). They are all, however, the result of an overwhelm on the listener's psyche, leading to diminished personal and professional capacity (Winblad *et al.*, 2018; van der Merwe and Hunt, 2019), a compelling argument for ensuring counsellor education in the area.

Drawing from my recent experience, my symptoms were almost exclusively physical, and their onset sudden. This would align with the current research on STS (Tosone *et al.*, 2012) and elements of VT (Trippany *et al.*, 2004). Alongside these physical symptoms, I experienced significant mental exhaustion, both of which were alleviated considerably by my supervision and Somatic Experiencing sessions. Sharing the burden of what I was holding, and attending to my physical experience made a noticeable difference to my energy levels, and thus my capacity to be present for my clients in the therapy room. Supervision has been an effective tool to alleviate my symptoms of secondary trauma, in spite of the research to the contrary (see Bober & Regehr, 2006; van der Merwe & Hunt, 2019, for example). Furthermore, my awareness of the state of my regulation or dysregulation through SE has afforded me a greater insight into my felt sense, and undoubtedly alleviated and prevented a downward trend in the secondary traumatic symptoms I was experiencing.

Looking back to the initial experience that prompted this research, I find that my first symptoms of withdrawal, exhaustion, unexplained pain, and a sense of needing to protect my children are among the symptoms found to be common in therapists working with trauma victims (McNeillie & Rose, 2021). While I have had thoughts about the safe-

ty of the world, I do not believe that my cognitive schemas have been altered to a significant degree. My symptoms, therefore, align more with secondary traumatic stress than they do with vicarious traumatization. This is supported by Makadia *et al.* (2017), who found that trainee psychologists working with trauma clients showed clear evidence of secondary traumatic stress symptoms, but no evidence of altered cognitive schemas, which are considered a defining component of vicarious traumatization (McCann & Pearlman, 1990). Makadia *et al.* (2017) go on to suggest that their findings are generally consistent with others, but concede that their study was short-term, and that shifts in cognitive schemas occur over a prolonged period, which would be consistent with the general view of VT (McCann & Pearlman, 1990; Toosheh, 2011; Molnar *et al.*, 2017; Aafjes-van Doorn *et al.*, 2021).

Somatic Experiencing is still a relatively under-researched modality (Almeida *et al.*, 2020; Kuhfuss *et al.*, 2021), but the existing studies show the promise of lasting change, specifically for the treatment of trauma-related disorders (Brom *et al.*, 2017; McMahon, 2017; Kuhfuss *et al.*, 2021). The paucity of literature on the effectiveness of somatic-based therapies to help prevent or mitigate the effects of secondary trauma is surprising, given the favorable research outcomes on the long-term effects on PTSD using Somatic Experiencing (Leitch, 2007; Payne *et al.*, 2015; for example, see McMahon, 2017; Kuhfuss *et al.*, 2021). This gap is further underscored by evidence highlighting the benefits of self-awareness interventions in the mitigation or prevention of VT among therapists (Rothschild & Rand, 2006). Accordingly, further research is needed to specifically address vicarious trauma and secondary traumatic stress disorder in using this somatic approach so that it can be added to the already established tools in the prevention and mitigation of physical symptoms and their comorbid conditions.

While researchers debate over terminology and accurate measures, I would suggest that the answers may be found in the body. It is a miraculous and adaptive system that responds to the stimuli of traumatic experience in a relatively predictable manner (Ross, 2006; Levine, 2010). One could posit that such debates may, at times, impede progress toward healing, and that greater attention should be afforded to the somatic experience within research, not only in definition and diagnostics, but

also in relation to the resolution, treatment, and prevention of the very tangible consequences as-

sociated with therapeutic work involving traumatic material.



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