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Preventing Secondary Traumatization in the Undergraduate Classroom: Lessons From Theory and Clinical Practice

Eileen L. Zurbriggen
University of California, Santa Cruz

Indirect exposure to traumatic events or to survivors of trauma can itself be traumatizing and lead to symptoms similar to those of posttraumatic stress disorder (PTSD), a phenomenon known as secondary traumatization. Undergraduate students enrolled in courses on trauma are potentially vulnerable to secondary traumatization, although no research on them has been conducted. Literature on trauma therapy and the prevention of secondary traumatization is reviewed and suggestions are made for generalizing those findings to the university classroom. Issues of trauma exposure, safety, education, self-care, empowerment, and social support are discussed.

Keywords: vicarious experiences, emotional trauma, teaching, college students, distress

Secondary traumatization and vicarious traumatization have received increasing attention in recent years (Harrison & Westwood, 2009; Rasmussen, 2005; Shamai & Ron, 2009; Trippany, Kress, & Wilcoxon, 2004), but the focus has mostly been on clinical practice and, to a lesser degree, research (Campbell, 2001; Stoler, 2002; Ullman, 2010). Little has been written about the risks of secondary traumatization for undergraduate students enrolled in a course about trauma (but see Newman, 1999, for a relevant discussion). In this article, I review the research on secondary and vicarious traumatization and on treatment for trauma survivors, and apply the theory and findings to the educational domain: teaching courses about trauma to undergraduate students.

Definitions and Theoretical Frameworks

Research indicates that indirect exposure to traumatic events can itself be traumatizing and lead to symptoms similar to those of posttraumatic stress disorder (PTSD) as well as to changes in cognitive schemata and fundamental beliefs about the world (Elwood, Mott, Lohr, & Galovski, 2011; Shamai & Ron, 2009; Schauben & Frazier, 1995). Two parallel conceptualizations of this phenomenon have informed much of the existing research—*secondary traumatic stress* or *secondary traumatization* (Figley, 1983; Stamm, 1995; later referred to as *compassion fatigue*, Figley, 1995) and *vicarious traumatization* (McCann & Pearlman, 1990). These concepts overlap considerably, and some scholars use the terms interchangeably (Hesse, 2002) or argue that the two labels refer to the same phenomenon (Arvay, 2001). However, there are some differences in the constructs and the ways in which they have been theorized, empirically investigated, and clinically applied.

The two perspectives were developed largely independently, each originating from an attempt to understand a different population: family members and emergency providers (secondary traumatic stress) versus therapists who work with trauma survivors (vicarious traumatization). An important difference between the two perspectives is that secondary traumatic stress is focused on observable physical symptoms that parallel the dimensions of PTSD (avoidance, intrusion, and hyperarousal), and thus has been more closely linked with theory and research on PTSD. In contrast, vicarious traumatization has focused more on changes in internal beliefs, worldviews, and cognitions (e.g., those related to safety, power, trust, and intimacy) and is linked to constructivist self-development theory (McCann, Sakheim, & Abrahamson, 1988). Moreover, although a rapid onset of symptoms is conceived of as possible within the secondary traumatic stress framework (perhaps with indirect exposure to only one survivor or traumatic incident), vicarious traumatization is conceptualized as building over time in response to the cumulative effect of working with multiple survivors of trauma.

It is important to note that much of the existing research (in both the vicarious traumatization and secondary traumatic stress traditions) has been conducted with people who have interacted directly with survivors. Thus, the effects may be due to exposure to the trauma survivor (with the resulting empathic connection that ensues) rather than to the traumatic material per se. Thus, the risk of vicarious or secondary traumatization may be lessened for students who are studying traumatic material rather than interacting with survivors. However, other studies on indirect trauma have shown that exposure to media accounts of traumatic events can lead to secondary traumatic stress symptoms (Perez, Jones, Englert, & Sachau, 2010; Pfefferbaum et al., 2001; Terr et al., 1999) and feelings of being unsafe (Brener, Simon, Anderson, Barrios, & Small, 2002). Levels of distress can be substantial. In one case, researchers reported that the mean level of secondary traumatic

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Correspondence concerning this article should be addressed to Eileen L. Zurbriggen, Department of Psychology, University of California, Santa Cruz, Room 277, Social Sciences 2, Santa Cruz, CA 95064. E-mail: zurbrigg@ucsc.edu

stress was higher among law enforcement personnel who viewed photographs and videos of child pornography (Perez et al., 2010) than was the mean level reported for forensic interviewers of child abuse victims (Perron & Hiltz, 2006). Thus, it seems reasonable to think about possible impacts for students in trauma-related courses, even though these students will generally not be interacting directly with trauma survivors.

Because exposure to traumatic material in a college course is limited to a few months in duration, and because this exposure does not generally involve interacting with actual trauma survivors, the secondary traumatization model seems more relevant to college students than does the vicarious traumatization model. If students experience negative effects, theory and past research suggest that they will more likely be similar to those highlighted in the secondary traumatization model (i.e., observable symptoms such as hypervigilance) rather than those highlighted in the vicarious traumatization model (i.e., changes in fundamental schemas and worldviews). For that reason, I will mostly use the term *secondary traumatization* throughout the remainder of this article. However, because there is considerable conceptual and empirical overlap between secondary and vicarious traumatization (Arvay, 2001; Hesse, 2002), I will draw on research from both traditions as well as other research on indirect exposure to trauma in the discussion and recommendations that follow. When describing previous studies, I generally use the label that the authors used, even if their definition does not map exactly onto the conceptual distinctions that I have described above.

Risk Factors for Secondary and Vicarious Traumatization

Risk factors for secondary and vicarious traumatization can be divided into two overarching categories: characteristics of the individual and structural or situational elements (Kinzel & Nanson, 2000). Characteristics of the individual include such things as a personal history of trauma, emotional reactions, and coping strategies. One consistent finding from this literature is that younger age or relative inexperience in regards to trauma puts one at greater risk of secondary or vicarious traumatization (Adams & Riggs, 2008; Bober & Regehr, 2006; Chrestman, 1995; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). Many college students are in their early 20s and most have little or no training or academic experience with trauma; thus, both risk factors are likely to be present for them.

Although these personal risk factors are important to consider, they are generally not amenable to change through the actions of an instructor. In contrast, instructors have much more control over structural and situational elements (i.e., how the course and curriculum are structured); therefore, they are my focus in this paper. My analysis of these elements is organized into several subsections, following discussions by other scholars writing about care providers (Bell, Kulkarni, & Dalton, 2003; Kinzel & Nanson, 2000; Trippany, Kress, & Wilcoxon, 2004). Subsections include: trauma exposure, safety, education, self-care, empowerment, and social support.

Trauma Exposure

In the general trauma literature, many studies have shown that the level of exposure to trauma is a strong predictor of subsequent symptoms. For example, Mollica and colleagues found a relationship between traumatic history and PTSD and depression in Cambodian and Vietnamese refugees (Mollica, McInnes, Poole, & Tor, 1998). A meta-analysis found a significant relationship between perceived life threat (one measure of intensity of traumatic experience) and PTSD (Ozer, Best, Lipsey, & Weiss, 2003).

A similar finding holds for vicarious traumatization. In their study of sexual assault counselors, Schauben and Frazier (1995) found that female counselors with a higher percentage of sexual violence survivors in their caseload had higher levels of PTSD symptoms and more self-reported vicarious traumatization. Brady, Guy, Poelstra, and Brokaw (1999) also found that posttraumatic stress symptomatology was positively correlated with percentage of sexual abuse survivors in current caseload, number of survivors in current caseload, average number of survivors over the entire career, and exposure to graphic details of the abuse. Similarly, other research suggests that counselors with a diverse caseload have a lower risk of secondary traumatic stress (Chrestman, 1995).

Given that increased exposure to traumatic material is a risk factor for secondary traumatization, what can we do to reduce exposure in the classroom? Just as in a clinical practice, there are some obvious limitations. Given that the class in question focuses on traumatic material, some exposure is necessary. But several strategies come to mind that could mitigate the intensity of this exposure.

The overall strategy is to limit exposure to traumatic material to a level that does not lead to secondary traumatization. This suggests that courses on trauma might not be appropriate for brief, intensive sessions, such as 4-week summer or midwinter January (J-term) courses. Similarly, it might be advisable to schedule an academic-year course to meet two or three times weekly rather than in one long (e.g., 3-hr) block. Students can be advised that it might be challenging to take multiple trauma-related courses at once. For example, a history course on genocide taken simultaneously with a psychology course on violence against women might lead to an overdose of traumatic material.

Instructors might consider (and empirically research) whether a course devoted solely to trauma provides a level of exposure that puts students at risk of secondary traumatization. A contrasting alternative would be to cover this material in smaller segments, spread over multiple courses. For example, violence against women could be covered in a course on the psychology of women, trauma treatment could be covered in a course on abnormal psychology, and so forth. A downside of this approach would be the fragmentation of material and the loss of the opportunity to stress the commonalities of responses to different kinds of trauma (e.g., rape, combat).

Another suggestion is to vary the intensity of the material. Most of the previous research on vicarious and secondary traumatization has investigated the effects of exposure to the *person* of the survivor (and his or her affect-laden stories) rather than the effects of exposure to traumatic *material* per se. Moreover, some researchers have suggested that secondary or vicarious traumatization is mediated through empathic responses to a trauma survivor (Figley, 1995) or an inability to achieve an appropriate level of emotional separation (Badger, Royse, & Craig, 2008). Thus, first-person accounts (guest speakers, personal memoirs, filmed interviews) might be especially symptom-provoking. It therefore seems wise for an instructor to intersperse first-person accounts with

more abstract material. Similarly, films that might be triggering or that would be likely to arouse a strong empathic response could be spread throughout the course, rather than clustered together. Incorporating positive or uplifting material, as appropriate, can help students to feel less overwhelmed. For example, ending each class period with an inspirational story about a trauma survivor, or even with a joke or funny video, can give students a break from the intensity of the focus on trauma.

Safety

Trauma treatment cannot be maximally effective if trauma is ongoing or the client does not feel safe (Dutton, 1992; Herman, 1992). For this reason, assuring that clients are safe is often the first step in trauma therapy and most therapists will not proceed with couples therapy if there is ongoing domestic violence (Dutton, 1992; Johnson & Zlotnik, 2009). Similarly, an increase in safety concerns is one of the symptoms of vicarious traumatization (McCann & Pearlman, 1990), and fears about safety can exacerbate vicarious traumatization in mental health workers (Bell et al., 2003).

An instructor can do many things to help students feel safer in the classroom. Allowing students to leave the room or skip films if they are being triggered by the material is one key idea. Another option is to give students the choice of watching films in a media lab or at the library. That way, they have more control and can fast forward through triggering material or take breaks if they need to. It's important to be aware of the logistics of the classroom. Students are likely to feel more fear immediately after hearing a lecture about rape than they would after a meeting of another class, and this could be exacerbated for an evening class, in which students must walk to their cars or dormitories or wait at a bus stop in the dark. It might be best to avoid late evening hours, if possible.

Students also need to be assured of psychological safety and confidentiality if they disclose a personal history of trauma. Because it is difficult to ensure confidentiality if such disclosures take place in the classroom (more difficult than in an ongoing therapy group), instructors need to think carefully about this issue. In some settings, it might be possible to ask all students to make an agreement that they will keep any such disclosures confidential. In many cases, however, it is preferable to encourage students not to disclose in the classroom, pointing out the differences between an academic and therapeutic context. If such disclosures nevertheless do occur, it is, of course, imperative to instruct students to keep the disclosed information confidential.

Disclosures to the instructor are likely to be more common. Given the high prevalence of traumatic experiences among the general population (Elliott, 1997; Finkelhor, Turner, Ormrod, & Hamby, 2009) as well as the possibility that trauma-related courses are of special interest to trauma survivors, it is likely that there will be at least one (and possibly many) trauma survivors enrolled in the course. Some students may choose to disclose their personal trauma history to the instructor, especially if they are having difficulty with the course material or if the instructor seems empathic and approachable. In such cases, the instructor has the obligation to protect the privacy and confidentiality of the student (e.g., inviting the student to meet in a private office rather than talking in the hallway after class, or asking the student if he or she would like the office door closed). In addition, information on self-care can be provided and referrals to professional counseling should be offered. Throughout, it is essential that the instructor maintain an attitude of respect toward the student (cf. Pearlman & Saakvitne, 1995).

Education About Secondary Trauma

Education about trauma and the normalization of trauma symptoms take place early on when treating trauma survivors (Herman, 1992). For example, in the five-phase model of treatment described by van der Kolk, McFarlane, and van der Hart (1996), client education occurs during the first (stabilization) phase of treatment. This education reassures clients (and their families) that they are not "going crazy," but instead are experiencing normal reactions to traumatic events.

Similarly, educating employees and volunteers about vicarious traumatization and normalizing the experience is important for mental health providers and crisis line centers. Pearlman and Saakvitne (1995) argued that this is an important responsibility of training programs; others have suggested that employers have such a duty as well, and that education can begin as early as the job interview (Urquiza, Wyatt, & Goodlin-Jones, 1997). A theoretical perspective that focuses on client strengths as well as his or her traumatic past experiences can help protect therapists from vicarious traumatization (Bell et al., 2003).

In the classroom, parallel steps can be taken. Consider providing some information in the first class about the possibility of secondary traumatization by describing the phenomenon and symptoms and normalizing the response. This could be considered to be a form of informed consent, ethically necessary when teaching sensitive and potentially stressful topics like trauma (Newman, 1999). Such a presentation could include a discussion of specific symptoms such as anger, frustration, guilt, confusion, physical fatigue, intrusive thoughts, and nightmares. Normalizing the response lets students know that if symptoms occur it is not a sign of personal weakness or mental illness, but a fairly normal response to stressful material.

Of course, care must be taken not to present a long list of every possible symptom or negative response, which could overwhelm students. As has been seen in some implementations of Critical Incident Stress Debriefing (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000), it is possible that a "prebriefing" intervention with intense exposure that overwhelms students' coping mechanisms could lead to increased, rather than decreased, psychological symptoms and physical problems. A good approach might be to talk in a fairly general way about the phenomenon, to mention a few specific symptoms, and to invite the students to notice their reactions and experiences throughout the course.

Instructors might also consider covering the burgeoning literature on posttraumatic growth (Caserta, Lund, Utz, & de Vries, 2009; Tedeschi & Calhoun, 2004). Learning about the possibilities for personal transformation that can ensue following direct or indirect exposure to trauma could help empower students to move in this direction themselves.

Self-Care

Many authors who write about vicarious traumatization stress the importance of self-care as a protective factor (e.g., Stoler,

2002). Rosenbloom, Pratt, and Pearlman (1995) wrote that it is important for care workers to have health insurance that provides mental health coverage. Others have suggested that agencies should provide employees with information about resources and self-care strategies, as well as provide on-site opportunities for stress management or physical activity (Wade, Beckerman, & Stein, 1996).

In a college course, instructors can help protect students from secondary traumatization by stressing the importance of self-care and by giving information on coping strategies. Suggestions from the literature include maintaining a balance of work and leisure, taking vacations or breaks, and getting enough sleep, physical activity or exercise, and healthy food. Meditation (Kabat-Zinn, 1990) and journaling or expressive writing (Pennebaker, 1997) may also be helpful. These suggestions can be presented at the beginning of the course, but it may also be useful to remind students about this material a second time, after a few sessions of the class have been taught. This is a period when symptoms of secondary traumatization might emerge and students would benefit from a refresher (many students might have assumed the information was not relevant to them at the very beginning of the course). It is also a good idea to put detailed information about secondary traumatization (and resources available to confront it) in the syllabus and as part of any online course software system. These are available 24/7 and could be helpful to a student during times when the instructor is not available.

It is important to identify both positive and negative coping strategies, because students might not know which strategies are adaptive and which are generally problematic. Because alcohol and substance abuse are relatively common on college campuses (Slutske, 2005), caution students against the tendency to use substances as a means of avoiding feelings. Other coping strategies that have generally proven to be unhelpful include magical thinking (Mishara & Giroux, 1993), detachment or mental disengagement (Schauben & Frazier, 1995), and feeling a strong sense of personal responsibility (Figley, 1995; Mishara & Giroux, 1993).

Empowerment

Empowering clients is often an important part of trauma treatment (Johnson & Zlotnik, 2009). Herman (1992) discussed the role that loss of control plays in traumatic symptomatology, and the importance of helping clients work with their changed schemas regarding control. Empowerment is important for mental health providers as well, with some data suggesting that when clinicians are involved in efforts for political or social change (in addition to their counseling work), they are less susceptible to vicarious traumatization (Iliffe & Steed, 2000; Regehr & Cadell, 1999).

Empowerment can be incorporated into the classroom in several ways. Students can be required or encouraged to take part in a social action project as part of the curriculum. For small classes, this could be made an integral part of the course. This would be more difficult in a larger class, but more modest opportunities exist even there. For example, an assignment to write a letter to the editor of a local newspaper or a letter to an elected official is brief and relatively easy for all students to accomplish. These assignments may be most effective if students design their own projects. Also, students are likely to feel empowered if they are able to do proactive problem solving in relation to any symptoms that might arise. They will best be prepared to do so if adequate education took place earlier in the course.

Social Support

Social support has long been known as an important predictor of positive outcomes for survivors of trauma (Burgess & Holmstrom, 1978). Two recent meta-analyses (Brewin, Andrews, & Valentine, 2000; Ozer et al., 2003) confirmed that social support mitigates the negative effects of trauma and helps protect survivors from depression and PTSD.

In the clinical vicarious traumatization literature, the importance of adequate support for therapists is stressed. Clinical supervision, generally acknowledged as being important for therapists working in any domain (Scaife, 2008), is seen as essential for those who work with trauma survivors (Pearlman & Saakvitne, 1995; Rasmussen, 2005). Ideally, this should be structured in such a way that the clinical supervisor is not also engaged in evaluation of the therapist. Peer support is also seen as an important avenue to help therapists debrief and process upsetting material (Catherall, 1995; Urquiza et al., 1997), and can help reduce feelings of isolation (Lyon, 1993).

There are some limitations in applying the suggestions for clinical practitioners to students in a college classroom. Intensive one-to-one support, such as a supervisor might provide to a clinical trainee, is generally not feasible or appropriate for a college professor to provide to a student. There really is no classroom analogy to the supervision relationship. However, instructors (and teaching assistants) can provide some individual support for students who need it. For example, instructors can refer students to campus and local counseling, and follow up with them. Students can more easily self-refer to counseling if they know that it exists and if they perceive the counselors to be approachable. One way to build this kind of trust is to ask one of the campus counselors to provide a brief introduction to campus services early on in the course.

Limited support can also be provided during class, with structured exercises to share reactions with others or to process course material (e.g., paired sharing or freewriting exercises). In a large lecture class, it is important to have discussion sections with teaching assistants so that students have an opportunity to discuss material in a smaller setting and so that the teacher-to-student ratio is small enough to allow personal attention to students who need it. Various possibilities for peer support exist as well. Creating a course roster with (optional) contact information makes it easier for students to initiate contact with each other. Mentioning that students sometimes find it useful to meet outside of class for support opens this as a possibility; if any interest develops, the instructor can assist in finding a safe and comfortable meeting space. Course software systems usually provide options for online discussion boards or chat rooms that could be useful methods of providing peer support.

Suggestions for Further Research and Concluding Comments

The previous discussion was an attempt to apply theory and empirical data on secondary and vicarious traumatization developed for other populations (e.g., trauma therapists) to the university classroom. To date, little or no research on secondary traumatization has been conducted on undergraduates (although there is at least one study on

psychology graduate students; Adams & Riggs, 2008). Basic research on the existence and prevalence of secondary traumatization among undergraduates in trauma-related courses would be useful, as would research on the effectiveness of strategies to reduce the likelihood of secondary traumatization. Experimental studies would be especially powerful, and seem feasible (e.g., for large courses with multiple sections, it should be possible to randomly assign mitigating strategies to different sections). A less rigorous methodological design would include a measure of secondary traumatization at several points in the quarter and would assess whether traumatic stress symptoms change over time, as different coping strategies are presented in the curriculum.

It's important to remember that many students taking a course on trauma will experience little or no distress and that those who do display traumatic stress symptoms will likely be at a subclinical level of dysfunction. There is some argument in the literature as to whether relatively low levels of distress in response to indirect trauma should be characterized as traumatization (e.g., Southwick & Charney, 2004). There is a danger of eroding the concept until it becomes almost meaningless. It may be preferable to reserve the labels vicarious traumatization and secondary traumatization for people who are experiencing serious levels of distressing symptoms that are interfering with daily life. Although some students may experience that level of distress from exposure to traumatic material in a college course, most will not. However, even if we do not apply the label secondary traumatization to students with subclinical levels of symptomatology, it is still incumbent upon us to do everything possible to minimize the extent and severity of the traumatic symptoms.

Teaching about trauma to undergraduates, especially undergraduate psychology majors, is a worthy goal. Trauma prevalence rates are high (Elliott, 1997; Finkelhor et al., 2009), so such classes can be personally relevant and helpful to students as they deal with their own traumatic experiences or those of their friends and family members. Moreover, many psychology undergraduates are considering a career in one or more helping professions, including social work, counseling, or clinical psychology. Some exposure to basic theory and data concerning the prevalence of trauma and its sequelae would be useful to these students, especially because they are not necessarily going to receive training about trauma in their graduate programs (Adams & Riggs, 2008; Alpert & Paulson, 1990; Pope & Feldman-Summers, 1992). But students taking a course that covers trauma and traumatic material may be at risk of secondary traumatization, and instructors should be prepared to teach the course in a way that minimizes such risk. By applying knowledge about secondary and vicarious traumatization gained in other domains, the present article was meant to be a first step in helping instructors to design courses that minimize risk, and perhaps even protect students from future secondary traumatization (Adams & Riggs, 2008). Empirical research with undergraduate students on this topic can take us further down this path.

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