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Secondary Traumatic Stress and the Role of the Human Service Practitioner: Working Effectively with Veterans' Families

Laurie M. Craigen, Rebekah Cole, Ione Paiva, Kathleen Levingston

Abstract

Posttraumatic Stress disorder (PTSD) is an increasing mental health concern in the military veteran population. It is important to note that PTSD is a systemic diagnosis, meaning that the well-being and emotional health of family members is impacted by living with a veteran suffering from PTSD. Some family members may develop secondary traumatic stress (STS) symptoms. This manuscript will describe secondary traumatic stress and will explore the role of the human service practitioner in working with family members with STS. Future research in this area will also be explored.

Secondary Traumatic Stress and the Role of the Human Service Practitioner: Working Effectively with Veterans' Families

As of March 2013, approximately 2.5 million veterans were deployed to Iraq and Afghanistan (Adams, 2013). Many veterans are deployed multiple times during their careers, which has caused an increase in service related disability status for veterans (Spiegel, 2008). Multiple deployments have resulted in increased mental health issues among the veteran military population. Approximately, 5 to 20% of U.S. soldiers returning from service in Operation Enduring Freedom (OED), Operation Iraqi Freedom (OIF), and Operation New Dawn have signs of depression or Posttraumatic Stress Disorder (PTSD) and about 30% of veterans on their third or fourth tours have experienced some form of emotional “illness” (Fisher & Schell, 2012; Spiegel, 2008).

As rates of PTSD in the military are increasing (U.S. Department of Veterans Affairs, n.d.a), the family system of veterans is also experiencing increased stressors, demonstrating that PTSD is a disorder with far-reaching implications (Gavloski & Lyons, 2004). According to Cook, Slater-Williams, and Harrison (2012), 55% of veterans are married and 43% have children under the age of 18. Symptoms of PTSD can also impact the veteran’s spouse, children, community, friends, and overall family and social functioning (Brainlinemilitary, 2004). Trauma, and the symptoms associated with PTSD, can be transmitted to individuals within the veteran’s family and is often referred to secondary

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traumatic stress (STS) or secondary traumatization (Cook, Slater-Williams, & Harrison, 2012). In this article, we will briefly discuss PTSD and explore the impact the trauma/stress disorder can have on the family, notably the children and spouse, in the form of STS. We will also examine how the human service practitioner (HSP) can work effectively with family members of veteran's experiencing PTSD.

What is Posttraumatic Stress Disorder (PTSD)?

Once considered an anxiety disorder, PTSD has now been reclassified as a "trauma and stressor-related disorder" in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (American Psychiatric Association, 2013a; U.S. Department of Veterans Affairs, n.d.b). According to the American Psychiatric Association (2013b), the diagnostic criteria identify "the trigger to PTSD as exposure to actual or threatened death, serious injury, and/or sexual violation" (para. 3). The exposure must result from directly witnessing or experiencing the traumatic event, learning a close family member has been exposed to a traumatic event, and/or experiencing repeated or extreme exposure to the aversive details of the traumatic event. The disturbance must cause "clinically significant distress or impairment" (para, 3) in important areas of functioning such as, work, family, and social interactions.

According to the American Psychiatric Association (2013a), the DSM-5 focuses on the behavioral aspects of PTSD and divides the condition into four diagnostic clusters: re-experiencing, avoidance, negative cognition and mood, and arousal. Re-experiencing is characterized as experiencing intrusive memories, flashback, or other significant psychological distress related to the traumatic event. Avoidance refers to the evasion of reminders of the traumatic event, including memories, thoughts, feelings or external stimuli. Negative cognitions and mood can represent various feelings, perceptions, and behaviors such as blaming self and others, estrangement from others, inability to remember key aspects of the event, and diminished interest in daily activities. Finally, arousal is characterized by impulsive and/or self-destructive behavior, sleep disturbances, aggression, hyper vigilance, and other related issues.

Stigma of PTSD in the Military

Hindering their chances of receiving the treatment they need, veterans may be reluctant to disclose their trauma and stress-related symptoms (Newman, 2011). According to the U.S. Department of Veterans Affairs (n.d.a), there are

treatments available for PTSD, but many veterans will not seek out this assistance. One reason for this refusal is the potential stigma with regard to being labeled as having a “disorder.” The label of a disorder may negatively affect how a veteran is treated in determining eligibility for security clearances and/or readiness for deployment (Fisher & Schell, 2013). One way military leaders approach this issue is by proposing that the mental health community change the language to Posttraumatic Stress Injury (Fisher & Schell, 2013; The American Legion, 2012). Proponents of this argument suggest that the term injury may increase access to treatment and may decrease the stigma associated with the word, disorder. However, there is little empirical evidence pertaining to the use of the term “injury,” and despite a request by senior military leadership, the APA decided not to change the name of PTSD (Fischer & Schell, 2013).

One major consequence of failing to disclose PTSD symptoms and seek appropriate mental health services is the alarming suicide rates of veterans (Ilgen et al., 2010). According to Cook, Slater-Williams, and Harrison (2012), veteran suicide rates are twice the rate of civilian suicide rates with suicide rate surpassing combat related deaths (the suicide rates reported only capture completed suicides and not suicide attempts). In addition, 20% of veterans who made suicide attempts and 21% of veterans with completed suicides also had a history of substance abuse (Cook et al., 2012).

Secondary Traumatic Stress

PTSD is a system phenomenon and it can impact the veteran’s spouse, children, community, friends, and overall family and social functioning. Trauma can be transmitted to individuals within the veteran’s family and is often referred to as secondary traumatic stress (STS). STS is “the natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from wanting to help a traumatized or suffering person” (Figley, 1995, p.7). STS can also be characterized as the psychological distress experienced by an individual who is exposed to recollections of the trauma experiences of the others—also referred to as indirect trauma exposure (Dekel & Goldblatt, 2008). Symptoms can mimic those seen in PTSD and can affect the families of veterans as well as human service professionals who work with these individuals (The National Child Traumatic Stress Network, n.d.). STS is not recognized by the DSM-5 as an official mental health diagnosis and is often used interchangeably with vicarious trauma and Intergenerational Posttraumatic

Stress Disorder (Dekel & Goldblatt, 2008; The National Child Traumatic Stress Network, n.d.).

Effects on the Family System

While STS is not recognized by the DSM-5, the familial effects are almost inevitable. According to Friedman (2006), veterans face a multitude of psychological challenges in their transition from the war zone, where they were in an unremitting combat-ready hypervigilant state to one's home life. When a military parent or spouse has PTSD, there is an increase in anxiety, marital problems, verbal abuse, substance abuse, and economic distress, which can lead to higher divorce rates, behavior problems in children, and an overall increase in family stress (Brainlinemilitary, 2014). Families can become more isolated due to social anxiety or avoidance from their veteran family member. If the veteran engages in acting out behaviors (e.g., aggressive behaviors, argumentative responses with others), it can also lead to family alienation (Jordan et al., 1992; U.S. Department of Veterans Affairs, n.d.c). According to Jordan and colleagues (1992), family members may not understand the nature of PTSD and know how to react to the veteran's behavior, which can further impact the veteran's PTSD symptoms. According to The U.S. Department of Veterans Affairs (n.d.c.), family members can experience a variety of reactions to a veteran's PTSD symptoms including: sympathy, negative feelings, avoidance, depression, anger, guilt, and health problems.

Effects on the Spouse

In addition to the familial effects, a veteran's PTSD can also affect the spouse. When the veteran shows PTSD symptoms after returning from war, his/her spouse is often torn between caring for the veteran and protecting the children from abusive behaviors. In addition, if a veteran's PTSD prevents her/him from maintaining employment, the spouse may need to leave her/his job in order to care for the veteran. This can cause additional emotional and economic strain on the spouse by having to be the primary caregiver for both the veteran and children (Hayes et al., 2010). Overall, caring for a veteran with PTSD often results in overall higher levels of emotional distress and lower levels of marital satisfaction (Dekel, Solomon, & Bleich, 2005).

Effects on the Child

According to Klarić et al. (2008), “children react more intensively to parental emotional states and behavior than to real danger” (p. 496). Whether a parent with PTSD is exhibiting rage and violent behaviors or avoidance and emotional distance, his/her behavior will impact the child’s development (Dekel & Goldblatt, 2008). These circumstances can affect children throughout their lifetime because parents have difficulty providing a “safe base” that would promote appropriate psychosocial development (Klarić et al., 2008; Levinson, 2011). The more severe PTSD symptoms expressed by the parent, such as witnessing the parent’s reactions to flashback and nightmares, paranoia, rage, and extreme fear, the greater emotional distress the child will experience (Dekel & Goldblatt, 2008). A parent can further affect the child’s emotional wellbeing and development by failing to celebrate a child’s successes, focusing on the negatives, and imposing unreasonable or inconsistent punishments, which are additional symptoms of PTSD in veterans (Cook et al., 2012; Dekel & Goldblatt, 2008; Klarić et al., 2008). In turn, according to Cook et al. (2012), the child will react by mimicking the parent’s hyperarousal and avoidance (over-identification), taking a parent role (rescuer), and/or isolating from the parent (emotionally uninvolved). In addition, the child may experience depression, anxiety, guilt, somatic complaints, nightmares, isolation, behavior problems, irritability, decrease in academic performance, difficulty maintaining and making friends, regressive behaviors, substance abuse, and disassociation.

Role of the Human Service Professional

In recent years, there has been a surge of research on the most effective treatment interventions for veterans with PTSD, including cognitive processing therapy (CPT), eye movement desensitization reprocessing (EDMR), and Prolonged Exposure Therapy (PE) (Department of Veterans Affairs Department of Defense, 2010). While there is value in these investigations, the research has largely ignored the treatment of secondary traumatization of family members living with a veteran with PTSD (Galvoski & Lyons, 2004). Thus, this section will outline the four strategies that HSPs can utilize when working with secondary traumatization: education, mobilizing services, brokering resources, and advocacy. Each of these strategies aligns with the defined roles and skill standards of HSPs.

Strategy 1: Education

HSPs are defined as educators, tutoring and mentoring clients in a variety of different contexts (Neukrug, 2013). This role is aligned with the “Education, Training, and Self-Development” skill standard which suggests that HSPs should be able to share knowledge with others (Taylor, Bradley, & Warren, 1996). HSPs in a variety of different contexts will work with veterans with PTSD as well as the spouses and children of these veterans (Military One Source, 2013). Thus, this section will outline how the HSP can effectively take on the role of educator when working with secondary traumatic stress.

Research indicates that educating children about a parent’s trauma response may actually serve to inhibit their potential of acquiring secondary PTSD (Cook et al., 2012). Conversely, without education about the symptoms of PTSD and the expected outcomes of the disorder, it is not uncommon for children to imagine things to be much worse than they actually are (Grosse, 2001). Thus, the HSP working with children of veterans can provide information and knowledge to the child about PTSD using age appropriate dialogue. More specifically, it is important that the information provided helps children understand what PTSD is, what the effects of PTSD are in terms of parent functioning and/or the symptoms that the parent may experience, and what to expect over time. Additionally, the child may need reassurance that PTSD (and the parents’ change in behavior) is not their fault and that specific symptoms/emotional changes in the parent are to be expected (Grosse, 2011). By educating the child about PTSD, the HSP can help the family to normalize and contextualize their current difficulties. The HSP can also help children understand what is happening in their family (Brainlinemilitary, 2014). Spouses, in addition to children, can also benefit from education. Thus, the HSP can provide the spouse with explanations of the clinical diagnosis of PTSD, symptoms of PTSD, and the effects that trauma can have on relationships and on families (Buchanon, Kempainen, Smith, MacKain & Walsh, 2011).

In addition to educating the family system about PTSD, the HSP should also educate the family members about secondary PTSD (Huebner & Mancini, 2008). This approach may help to understand the root cause of the child’s behavior. For example, a HSP can help parents to realize that their behaviors directly impact their child’s well-being. However, it may be particularly difficult for a veteran with PTSD to evaluate what information their children can process and comprehend when they are struggling with their own emotional responses

(Cozza & Lieberman, 2007). Additionally, HSPs can educate the parents about the importance of having regular and open communication with their children. For many children, a parent's manifested symptoms of PTSD can be stressful to witness, and if the veteran is unable to discuss his/her symptoms, the child may feel that their parent does not care for them and may no longer love them (Price, 2009).

Strategy 2: Mobilize Services

Mobilizing is one of the primary roles and functions of a HSP. When mobilizing services, a HSP organizes support and services for their clients (Neukrug, 2013). The role of mobilizer also aligns with the community and living skills and support skill standard, which encourages the HSP to match specific support and interventions to the unique needs of individual participants and recognize the importance of friends, family, and community relationships (Taylor, Bradley, & Warren, 1996). Thus, with regards to these aforementioned role and skill standards, it is critical for the HSP to know what type of support (civilian and military connected) is available to the family.

Given the systemic nature of PTSD (Galovski & Lyons, 2004), strategies like family therapy and couples therapy may also be beneficial. Additionally, psycho-education for children and for spouses who are living with a parent with PTSD can be helpful (Galovski & Lyons, 2004; Nader, n.d.). Support groups for children and spouses who may be experiencing symptoms of secondary traumatization may also be a place for the child and spouse to talk about their feelings and experiences in a safe environment with other participants' who may have similar circumstances (Cook et al., 2012).

Strategy 3: Brokering Resources

A broker, another one of the 13 defined roles and function of a HSP, helps clients find and use resources (Neukrug, 2013). Brokering resources also aligns with the community and service networking skill standard which encourages HSPs to be knowledgeable of the supports and services available and skilled in assisting their clients to gain access to these services (Taylor et al, 1996). Thus, as a broker working with families of veterans, the HSP can provide his/her client with a list of resources that will offer support to those experiencing symptoms of secondary traumatic stress. The following list represents a sample of resources that are both government and non-government affiliated:

Government resources.

- U.S. Department of Veterans Affairs: the branch of the federal government that offers benefits and medical care for veterans and their dependents.
- Military One Source: a Department of Defense website that provides information, support, and resources at no cost to active duty, National Guard, and Reserve members and their families. The website offers support 24 hours a day, 7 days a week (Military One Source, 2013).
- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury: a Department of Defense organization that serves as a center of excellence to advance psychological health and traumatic brain injury prevention and care. The organization offers a 24/7 call center and live chat resource staffed by health consultants to provide confidential answers and resources (Defense Centers of Excellence, 2014).

Non-government agencies.

- Veteransandfamilies.org: an organization dedicated to advocate for the wellness of veterans and their families.
- Veterans of Foreign Wars (VFW): a non-profit organization that provides information, resources, and a sense of community for veterans
- Veterans' Families United Foundation: a non-profit organization that provides immediate support for veterans and their family members who may be in need of mental health services.
- Operation Homefront: Hearts of Valor: a program that seeks to support family members who are caregiving for wounded service members. The program runs retreats, support groups, and online forums for caregivers (Operation Homefront, 2014).
- Camp C.O.P.E.: a program that runs weekend camps for children and families of military personnel. At the camp, certified mental health professionals teach children coping skills to assist them with issues such as deployment and/or living with a service member who has been wounded or killed in action (Camp C.O.P.E., 2014).
- Operation Purple: a program that provides camps for military families. The camps offer support for various phases of military life,

deployment, reintegration, and coming together after physical or emotional injuries. There are three different camps: one for children, one for families, and one specifically for wounded service members and their families (National Military Family Association, 2014).

- **Courage to Care, Courage to Talk Campaign:** an educational campaign for hospitals and other healthcare sites. The goal of this program is to facilitate and improve communication around war injuries between healthcare providers and families and within the family, especially in regards to talking to children (Center for the Study of Traumatic Stress, 2014).
- **Military Kids Connect:** an online community for military children (ages 6 to 17) to support one another and find resources in dealing with the psychological challenges of military life (Military Kids Connect, 2014).
- **Family of a Vet:** a non-profit organization that offers online support and resources for family members of veterans with PTSD and TBI. The organization also offers community education packets that can be used with community organizations, civic institutions, and school systems (Family of a Vet, 2014).
- **Seed of Hope Books:** a website that aims to empower families who are dealing with issues of war, trauma, or mental illness by providing information, encouraging communication, and offering support. The website features helpful books for families and children of service members.

Strategy 4: Advocate

HSPs are finally called to embrace the role of advocate, supporting and defending the client's causes and rights (Neukrug, 2013). Taking on the role of advocate is also aligned with the advocacy skill standard, which encourages HSPs to identify and use effective advocacy strategies with their clients (Taylor et al., 1996). Additionally, given that PTSD is a systemic phenomenon (Gavloski & Lyons, 2004), the HSP is encouraged to raise awareness and promote understanding about the potential effects of living with a veteran with PTSD. Within an agency setting, the HSP might advocate for changes in agency policies that may affect veteran families (Bayne, Pusateri & Dean-Ngana, 2012). Many

military-connected families prefer to seek mental health support outside of the VA system in community-based agencies due to issues surrounding confidentiality and/or fear that seeking help within the VA system could harm their career (NYS Health Foundation, 2011). Thus, the HSP could advocate for adding information about military affiliation and deployment history on agency intake forms. If a client responds affirmatively about a deployment history, the HSP could then inquire further about the possibility of parental PTSD and symptoms of vicarious traumatization in children and/or spouses.

HSPs can also advocate for clients experiencing symptoms of secondary traumatization. In recent years, the government and society at large has focused on providing support and interventions to veterans with PTSD (Galovski & Lyons, 2004). While this is certainly important, the HSP is encouraged to also advocate for services and programs for family members experiencing secondary traumatization. Advocating for clients with secondary traumatization could occur within both military connected and non-military connected agencies (Fisher & Schell, 2013). The HSP is also encouraged to advocate for the needs of children experiencing secondary traumatic stress within schools (Nader, n.d.).

Future Research

Future research on effective treatment strategies for secondary traumatization would fill a major gap in the literature and would assist HSPs working with veterans' families. Presently, the research is limited on secondary traumatic stress. STS is currently not recognized by the DSM-5 as an official mental health diagnosis (Dekel & Goldblatt, 2008; The National Child Traumatic Stress Network, n.d.). While the authors of this manuscript are not advocating for the inclusion of STS in the DSM-5, more research is needed on the psychological impacts and effects of secondary traumatic stress on individuals. One avenue for gaining more information would be through phenomenological qualitative studies. Phenomenological studies examine one's lived experiences and perceptions by accessing the participant's voices (Patton, 2013). Thus, qualitative phenomenological studies could explore the experiences of veteran family members (specifically spouses and children), focusing on the psychological impact of living with a veteran with PTSD.

In addition, more research is needed to examine the experiences of providers working with PTSD and STS. In this manuscript, a section is included on the role of the HSP. While this information is extrapolated from the roles and

responsibilities of HSPs, research that focuses on the pre-service training of HSPs could be useful for human service educators. For example, a quantitative or mixed methods study could explore to what extent, if at all, knowledge about military families, PTSD, and secondary traumatic stress is integrated into the practitioners' pre-service education or professional development experiences.

Summary

PTSD is a major concern within the veteran population (Adams, 2013). While PTSD has gained increased attention in recent years, the secondary impact of living with an individual suffering from PTSD has been largely ignored (Cook et al., 2012). This manuscript provided the reader with information about PTSD and secondary traumatic stress and concluded with a section on how HSPs can effectively work with individuals suffering from secondary traumatic stress. Given the increasing rates of PTSD in veterans, HSPs will undoubtedly encounter family members experiencing STS, and it is imperative that they are educated and informed about family members' specific needs. While the research on STS is valuable, future research on the psychological impacts of living with a family member with PTSD is warranted. Furthermore, studies on the pre-service experiences of HSPs related to the topic of STS and PTSD could be valuable to human service educators.

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