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Principles for Secondary Traumatic Stress-Responsive Practice: An Expert Consensus Approach

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Objective: Though research on secondary traumatic stress (STS) has greatly increased in the past decade, to date the field lacks a coherent set of guiding principles for practice that behavioral health providers and organizations can use to mitigate the occurrence and impact of STS. As such it is important to identify effective strategies, grounded in research and professional experience, to reduce the occurrence and impact of STS among behavioral health professionals and organizations. ***Method:*** We conducted a four-stage modified Delphi survey. Thirty-one international STS experts were invited to participate, with a minimum of 19 responding in each round. Thematic analysis was conducted on qualitative data, which was incorporated into revisions of the principles. ***Results:*** Consensus was achieved on 14 principles, seven targeted at individual professionals, and seven targeted at organizations. ***Conclusions:*** This is the first effort to delineate principles for practice intended to reduce the occurrence and impact of STS in individual and organizational practice in behavioral health services. The principles are intended to inform best practices for individuals and organizations providing services to persons and communities who have experienced trauma and thereby improve the quality and effectiveness of services to traumatized populations.

Clinical Impact Statement
Secondary traumatic stress (STS) is recognized as an occupational hazard in the delivery of behavioral health services to persons who have experienced trauma, associated with negative outcomes among individual and organizational service providers. The principles are intended to inform best practices for individuals and organizations providing behavioral health services, and thereby improve the quality and effectiveness of services to traumatized populations.

Keywords: secondary traumatic stress, compassion fatigue, vicarious traumatization, consensus principles, trauma-responsive

Nearly three decades of advancement in secondary traumatic stress (STS) conceptualization, measurement, and research have documented that STS is an inherent occupational hazard in the delivery of behavioral health services to persons who have experienced trauma (Molnar et al., 2017; Sprang et al., 2019). STS is the stress placed on an individual when they are exposed to trauma descriptions, trauma images, or the reactions and responses of others who have experienced primary trauma. This stress manifests in the same way as posttraumatic stress resulting from direct trauma exposure—with symptoms of intrusion, avoidance, changes in cognition and mood, and alterations in arousal aand reactivity (Bride, 2004). Nearly all behavioral health professionals provide services to traumatized individuals and therefore

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are at risk of experiencing STS (Bride, 2004, 2007; Bride et al, 2009; Creamer & Liddle, 2005; Huggard et al., 2017; Perkins & Sprang, 2013; Sprang et al., 2011; Ting et al., 2005). The experience of STS is associated with negative individual outcomes among behavioral health professionals including job dissatisfaction, turnover, functional impairment, poorer physical health, and reduced quality of life (Armes et al., 2020; Lee et al., 2018; Sprang et al., 2007). Furthermore, high organizational rates of STS can result in negative impacts on staff turnover, organizational culture and climate, and the quality and effectiveness of services provided by that organization (Bride & Kintzle, 2011; Sprang et al., 2021). As such it is important to identify and implement effective strategies, grounded in research and professional experience, to reduce the occurrence and impact of STS among behavioral health professionals and organizations.

Multiple documents have been published that articulate competencies, guidelines, or principles of trauma-informed education, training, or practice that have been developed through expert consensus processes. The most prominent of these include principles of trauma-informed services for women (Elliott et al., 2005); trauma competencies for education and training in psychology (American Psychological Association [APA], 2015; Cook et al., 2014); clinical guidelines for the treatment of posttraumatic stress disorder (PTSD; APA, 2017; Bisson et al., 2019); guidelines for recognizing, assessing and treating PTSD in children, young people and adults (National Institute for Health and Care Excellence, 2018); prevention and treatment guidelines for PTSD (Forbes et al., 2020); trauma and resilience competencies for nursing education (Wheeler & Phillips, 2021); and guidelines for trauma-informed social work practice (Council on Social Work Education [CSWE], 2018). Only the latter document explicitly mentions STS but pays it only cursory attention (CSWE, 2018). In fact, only one known set of guidelines, principles, or competencies places significant emphasis on STS—the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision (National Child Traumatic Stress Network [NCTSN], 2018) which, as the title indicates is limited in scope to supervisory practices. There remains a need for a coherent set of principles that extends beyond supervisory competencies to provide direction for STS-responsive individual and organizational practice.

From the beginning, the STS literature has emphasized individual-level strategies to reduce the impact of STS, including psychoeducation, self-care, skills training, use of clinical supervision, and personal psychotherapy (Bercier & Maynard, 2015; Molnar et al., 2017). While the onus of addressing STS has historically fallen primarily on individuals, organizational efforts to mitigate STS are increasingly called for (Bell et al., 2003; Choi, 2011; Sprang et al., 2018). Effective organizational strategies include regular supervision within supportive supervisory relationships, strong peer support networks, balanced and diverse caseloads, and specific training on STS awareness (Sutton et al., 2022). Recent research has confirmed the efficacy of organizational change efforts to improve individual and organizational STS outcomes (Sprang et al., 2021). For these reasons, a panel of STS experts concluded that STS prevention and intervention efforts must dually focus on individual and organizational level targets (Sprang et al., 2019).

Now that the field generally recognizes the importance of a two-pronged approach to reduce the occurrence and impact of STS is necessary, there remains a need to identify the fundamental principles for reducing the occurrence and impact of STS in these spheres of practice. A critical mass is yet to be achieved of empirical studies, specifically randomized controlled trials (RCTs) that examine the effectiveness of strategies to address STS, thus precluding the identification of evidence-based guidelines. In such contexts where the evidence is incomplete, consensus-based practices have been recommended as an alternative approach to providing professional guidance (McKenna, 1994). One such consensus-based approach, the Delphi method, has been used widely in behavioral health research to answer questions where the data are incomplete or not directly applicable to the problem of interest (Jorm, 2015). It is a well-established method of inquiry that solicits opinions of experts in a particular field and uses an iterative, multistage process to transform opinion into group consensus (Hasson et al., 2000). Given the growing yet limited STS evidence base, the development of principles of practice by means of achieving a consensus of expert opinion, guided by the evidence available, using a modified Delphi approach is appropriate.

As such, the purpose of the current study was to employ a modified Delphi approach with the goal to generate consensus-based principles for individual and organizational practice to reduce the occurrence and impact of STS in behavioral health settings.

Method

Participants

Purposive snowball sampling was used to identify potential participants in the expert panel. The research team, all of whom are recognized leaders in STS, identified a list of individuals whose names figure prominently in the professional and research literature related to STS or whose work was otherwise known to the research team. These experts were invited to participate in the study, as well as to identify additional experts that they would recommend for the expert panel. A total of 31 experts were invited to participate in each of the four rounds of the Delphi process, regardless of whether they participated in an earlier round. Because the community of STS experts is relatively small, responses were collected anonymously and were limited to the panelists' opinions and feedback regarding the draft principles. No identifying, personal, and demographic information was collected from individuals who were invited or responded. As such, the Georgia State University Institutional Review Board determined that the study was not human subject research and therefore exempt.

Data Collection and Analysis

For each round, the expert panel was sent an email inviting them to provide feedback via a web-based survey. Following each round, the research team conducted a thematic analysis (TA) of qualitative responses following the phases described by Braun and Clarke (2006): (a) familiarizing yourself with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report. TA is a recursive process in which subsequent steps may prompt the researcher(s) to return to earlier steps in light of new data or newly emerging themes that merit further investigation. TA is a method for systematically identifying, organizing, and offering insight into patterns of meaning across a qualitative data set, allowing the researcher to see and make sense of collective or shared meanings and experiences (Braun & Clarke, 2012). In addition to being a method for describing data, TA also involves interpretation in the processes of selecting codes and constructing themes (Braun & Clarke, 2006). After each round of data collection, TA was utilized to clarify, develop, and refine emerging

perspectives. Quantitative data collection was limited to panelists' rating of in/appropriateness of statements presented in Round 2 and dis/agreement with principles presented in Rounds 3 and 4.

Statement Generation

The first round of surveys was designed to elicit ideas from the panelists for the purpose of statement (principle) generation and was limited to two open-ended questions: (a) What individual strategies effectively mitigate STS? and (b) What can organizations do to effectively mitigate STS? Panelists responded to these questions anonymously via SurveyMonkey. Panelists were instructed that, for the purpose of this study, "STS is defined as the stress placed on a person when that person is exposed to trauma descriptions, trauma images, or the reactions and responses of persons who have experienced primary trauma. STS is further conceptualized as being on a continuum that begins with normative stress and extends to functional impairment and PTSD as illustrated in Figure 1." Responses from 20 panelists were analyzed by the research team using TA to identify common themes and consolidate this information into a preliminary set of principles, resulting in seven principles each for individual and organizational practice.

Principle Development and Revision

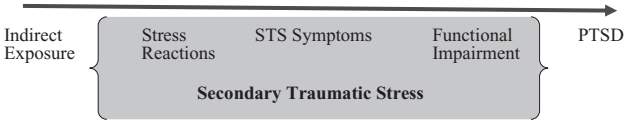
In the second round, the 14 principles that emerged from Round 1 were sent to panelists along with several items for the experts to address for each principle. Panelists were instructed to rate the appropriateness of each statement on a scale of 1 (*extremely inappropriate*) to 9 (*extremely appropriate*). Panelists were also asked to provide qualitative comments regarding their score for each statement, such as "elements you would add, individual exceptions, reasons for agreement/disagreement, cultural considerations, etc." Based on the research team's TA, the 24 responses were consolidated and edited into new or revised principles to reflect the panelists' feedback. This process resulted in 14 statements, seven each in the individual and organizational domains.

The third round asked panelists to rate their agreement with each of the 14 revised principles on a scale from 0 (*completely disagree*) to 10 (*completely agree*). Furthermore, they were asked to respond to the following questions: (a) What is missing from this statement that should be added? (b) Is there anything in this statement that you disagree with? (c) Are you aware of any empirical evidence to support this statement? and (d) Do you have additional comments? Feedback from 19 panelists was collected, discussed by the research team, and integrated into revisions of the 14 principles.

Prior to the fourth round of surveys, feedback on the second revision of the 14 principles was also solicited from three professionals directly engaged in communities representing black, indigenous, and people of color regarding the cross-cultural applicability of the statements, resulting in minor revisions to wording. In Round 4, 20 panelists provided feedback on the 14 revised principles, repeating the procedures undertaken in the previous round. There were no novel substantive comments at this point, therefore consensus was achieved.

Figure 1

Secondary Traumatic Stress Continuum



Note. STS is conceptualized on a continuum that begins with normal stress and extends to functional impairment (subclinical PTSD). STS = secondary traumatic stress; PTSD = posttraumatic stress disorder.

Results

Table 1 displays the finalized principles. In this section, we present each principle with brief discussion regarding interpretation and implementation of the principle.

Individual Principles

The Individual Knows the Risks for Developing and Strategies for Mitigating Secondary Traumatic Stress

Foundational and advanced education about STS is essential to prepare the individual to anticipate exposure, to monitor their responses, and to know what actions to take when reactions are observed. With support from their organization individuals participate in ongoing, evidence-informed education and training on trauma and STS, the risks associated with secondary trauma exposure, and ways to enhance their own resiliency.

The Individual Cultivates and Maintains Beliefs That Support Their Sense of Well-Being in Their Helping Role

Certain beliefs, attitudes, and values play a protective role for staff exposed to secondary trauma. This requires that staff define, cultivate, and enact-specific beliefs and values that impart a sense of meaning, purpose, self-compassion, and openness to the difficult emotions and experiences that their role requires. The professional is, therefore, able to: (a) describe the importance of finding personal meaning in experiencing emotional distress from trauma work; (b) define their own sense of purpose (i.e., personal calling) in seeking and accepting their current job role; (c) make an active determination about their goodness of fit in their job role and in the organization; (d) experience, or actively endeavor to cultivate, compassion for the client and self in difficult circumstances; (e) frequently experience and express gratitude for aspects of their job role, such as the support of their coworkers, the significance of the job role, and the gratitude of clients; (f) experience and express optimism about the effect of their efforts, a belief that what they do matters; and (g) accept the limits and boundaries of their professional role and accept the reality that some difficult circumstances may be beyond their influence.

The Individual Identifies and Monitors Their Own Personal Profile of Strengths and Vulnerabilities to Secondary Trauma Exposure

Preparation for exposure to secondary trauma requires that individuals know their own strengths and vulnerabilities in response to that experience. Examples of vulnerabilities include their personal and/or collective history of trauma, areas of their own emotional susceptibility, their employment in a nonsupportive or difficult work environment, and how their own identities and any experiences of discrimination or oppression might impact their response to work-related trauma exposure. Examples of strengths include strong support from supervisors or peers, ability to regulate after a stressful experience,

Table 1
STS-Responsive Principles for Individual and Organizational Practice in Behavioral Health Services

Individual principles	Organizational principles
The individual knows the risks for developing and strategies for mitigating secondary traumatic stress.	The organization provides ongoing and advanced STS training that is evidence-based and culturally responsive, including training to enable supervisors to provide continuous support to workers.
The individual cultivates and maintains beliefs that support their sense of well-being in their helping role.	The organization explicitly nurtures a culture of psychological safety that acknowledges the hazards of working in a trauma-exposed environment and fosters team support and respect for personal boundaries.
The individual identifies and monitors their personal profile of strengths and vulnerabilities to secondary trauma exposure.	The organization structures workloads to mitigate the secondary trauma exposure of the workplace.
The individual actively monitors their own well-being and uses strategies for mitigating secondary trauma responses.	The organization demonstrates commitment to the well-being of its workforce through secondary trauma-responsive policies and practices.
The individual employs strategies to remain within a zone of tolerance during exposure and recovery.	The organization dedicates time and supports for the provision of qualified, secondary trauma-responsive supervision.
The individual collaborates with a team of trusted colleagues, peers, or a community of practice with whom they can share thoughts and feelings concerning secondary trauma exposure.	Organizational leaders model trauma- and secondary trauma-responsive behaviors and actively develop a supportive and resilient workplace.
The individual determines when they would benefit from counseling or other external support and accesses that support.	The organization prioritizes workforce wellness through defined metrics that are continuously monitored, safeguarded for privacy, and responded to with priority.

Note. STS = secondary traumatic stress.

and capacity for self-reflection. Individuals reflect and identify what these strengths and vulnerabilities are in order to anticipate what thoughts and behaviors they should self-monitor, and what circumstances are most likely to activate their own emotional arousal.

The Individual Actively Monitors Their Own Well-Being and Uses Strategies for Mitigating Secondary Trauma Responses

Professional well-being requires that the individual has the support of their organization and supervisor, but also that the individual be committed to consciously attending to their own physical and emotional health. The individual continually self-monitors the effect that their work is having on their sense of well-being, and actively responds whenever distress occurs. The individual also (a) identifies strategies and opportunities for self-monitoring, (b) articulates the effects of secondary trauma exposure on them personally, and (c) implements identified strategies for emotional regulation in response to exposure.

The Individual Employs Specific Strategies for Remaining Within a Zone of Tolerance During Exposure and Recovery

Individuals working in trauma-exposed environments develop specific emotion regulation and recovery skills to remain within a zone of tolerance and maintain well-being as they are exposed to secondary trauma. These skills include those that prepare them for secondary trauma exposure, as well as skills that support emotion regulation during exposure, and skills to assist them in emotional recovery after exposure. Individuals: (a) continuously assess the presence of signs or symptoms of secondary trauma; (b) employ personal and professional care strategies as indicated; (c) support emotion regulation during exposure (e.g., positive self-talk, active coping strategies, problem-solving, mindful compassion/self-compassion, and breathing techniques); (d) recover from episodes of high-intensity emotion, for example, grounding skills, breathing techniques, mindfulness approaches; and (e) acknowledge, reflect upon, and articulate high-intensity emotion experiences to trusted peers or supervisors as appropriate.

The Individual Collaborates on a Team of Trusted Colleagues, Peers, or a Community of Practice With Whom They Can Share Thoughts and Feelings Concerning Secondary Trauma Exposure

It is important that the individual not be exposed to secondary trauma in isolation. Individual well-being requires that the professional acknowledge and process their thoughts and feelings in response to trauma exposure with a trusted other. This processing should be done in a manner that does not unnecessarily subject others to graphic traumatic material. It is important that the individual has a sense of the support of a team, and that they help to create and sustain a practice of reciprocal support. Team support may be sought from existing internal teams and/or cultivated external to the organization.

The Individual Determines When They Would Benefit From Counseling or Other External Support and Accesses That Support

When reactions to secondary trauma exposure begin to compromise the individual's well-being, knowledgeable individual support external to the workplace is indicated. In this circumstance, the individual seeks help from a trauma-informed behavioral health professional, or spiritual or cultural support as needed. The individual: (a) identifies, on self-reflection or in consultation with a trusted other, when external support is indicated; and (b) accesses such support.

Organizational Principles

The Organization Provides Ongoing and Advanced STS Training That Is Supported by Research and Culturally Responsive, Including Training to Enable Supervisors to Provide Continuous Support to Workers

Organizations provide training and consultation that assist staff in understanding, preparing for, and dealing with secondary trauma exposure. Organizational support of trauma-exposed staff requires ongoing training in consultation with all levels of staff. Training

includes information about the psychobiology of stress and trauma and normalizes responses to secondary trauma exposure. Such training enables a common understanding of the characteristics and risks of work in a trauma-exposed environment, as well as provides clear strategies to mitigate stress and trauma responses and enhance resiliency. Specialized training resources for senior leaders and supervisors guiding trauma-exposed teams must be provided in order to support leaders' ability to mitigate and address the common risks for adverse stress consequences to individual team members, promote reflective practice, and enhance team functioning and client services. The wide range of specialized training and education resources that are provided are culturally sensitive and responsive and include evidence-informed resilience tools and strategies to support individuals, teams, supervisors, and managers.

The Organization Explicitly Nurtures a Culture of Psychological Safety That Acknowledges the Hazards of Working in a Trauma-Exposed Environment and Fosters Team Support and Respect for Personal Boundaries

Organizations must create and nurture a culture and climate that explicitly and implicitly insure psychological and physical safety and well-being for all employees and recognizes and acknowledges the challenges and hazards of working in trauma-exposed environments. An STS-responsive organizational culture: (a) recognizes and responds to the intersection of STS, culture, race, gender identity and sexual orientation, and historical trauma requiring systemic change; (b) fosters a sense of organizational cohesion, reflexivity, active listening, and mutual support; and (c) communicates the scope of the individual role and promotes healthy boundaries at work.

The Organization Structures Workloads to Mitigate the Secondary Trauma Exposure of the Workplace

Organizations systematically define and implement organizational workforce supports to reduce the risk of STS and increase staff wellness and resilience. One such support is a commitment to organizational stress mitigation, including (a) formally allotting time in daily schedules for risk reduction and skills-building activities; (b) developing flexible procedures and setting aside time for trauma processing with a peer or supervisor; (c) encouraging staff wellness activities; (d) providing ongoing staff training; and (e) soliciting input from workers about helpful supports and responses to specific critical incidents. Organizations must also provide critical workforce resources, such as organizational wellness programming, team-building, and focused efforts to create supportive work environments. Furthermore, in addition to supervisors and organizational leadership who are STS-responsive, access is provided to Employee Assistance Program or other external providers trained in STS who can provide clear support for workers experiencing provider distress.

The Organization Demonstrates Commitment to the Well-Being of Its Workforce Through Secondary Trauma-Responsive Policies and Practices

Organizations actively demonstrate their awareness of and commitment to the well-being of their workers exposed to secondary trauma. This commitment is communicated and demonstrated through the implementation of policies, protocols, and practices that promote workforce wellness, stabilization, and recovery. This includes structuring workflow to minimize secondary trauma exposure and active strategies for promoting workforce resilience.

The Organization Dedicates Time and Supports for the Provision of Qualified, Secondary Trauma-Responsive Supervision

A critical support that an organization must provide staff is the support and direction of a supervisor who is STS-responsive. Accordingly, organizations provide supervisors who are trained and equipped to: (a) identify supervisees who may be experiencing secondary trauma exposure and/or STS symptoms; (b) create the space and structure to process reactions to trauma exposure in a supportive and encouraging manner that normalizes the experience; (c) acknowledge, recognize, and address the impact of STS on themselves; (d) use tools to ensure supervision is STS-responsive; and (e) make referrals for additional support as needed.

Organizational Leaders Model Trauma and Secondary Trauma-Responsive Behaviors and Actively Develop a Supportive and Resilient Workplace

Organizational leadership models awareness and promotion of wellness activities, which begins by leaders taking an active role in the establishment of organizational awareness and promotion of a compassionate and trauma-responsive workplace. Trauma-responsive organizational practice includes applying trauma-responsive principles to all staff as well as clients.

The Organization Prioritizes Workforce Wellness Through Defined Metrics That Are Continuously Monitored, Safeguarded for Privacy, and Responded to With Priority

As a means of prioritizing employee wellness and implementing continual organizational oversight, organizations identify data and specific measures to continuously assess employee and organizational wellness. This includes tracking indicators related to STS, such as staff turnover, absenteeism, and avoidance of trauma-related material. As a means of keeping the organizational effort a priority, the outcomes of these continuous measures are prominent in the organization's data reports. Data collection and reporting always respect issues of confidentiality and the privacy of the employee.

Discussion

To the best of our knowledge, this is the first effort to delineate principles for practice intended to reduce the occurrence and impact of STS in individual and organizational practice in behavioral health services that represent the consensus of an international group of STS experts. To achieve this, it was necessary to impose several delimitations in order to efficiently and effectively develop these principles. It is important that readers understand what these decisions were, the rationale behind them, and their implications for implementation.

First, the decision to exclusively use the term *secondary traumatic stress*, rather than *compassion fatigue* (CF), or *vicarious traumatization* (VT) was made to maintain consistent conceptual clarity

throughout the consensus-building process. The literature reveals disagreement and confusion regarding the definition of these concepts, and whether they are interchangeable, overlapping, nested, or divergent constructs (Devilly et al., 2009; Elwood et al., 2011). CF is a particularly troublesome term because authors variously define it as either synonymous with STS/VT (Bride et al., 2004; Figley, 1995), divergent from STS/VT (Okoli et al., 2020), synonymous with burnout (Joinson, 1992), or encompassing both STS and burnout as a higher order construct (Stamm, 2010; Walsh et al., 2017). STS and VT have also been conceptualized as the same (Bride & Figley, 2009) as well as distinct (Pearlman & Saakvitne, 1995) phenomena. In contrast to the conceptual drift in the use of the term CF, the definitions of STS and VT have changed little over the years though the exact wording differs by author and publication (Gottfried & Bride, 2018). STS is consistently used to refer specifically to cognitive and behavioral responses to indirectly experienced traumatic events (Figley, 1995); and VT consistently refers to alterations in identity and usual ways of understanding oneself and the world as a result of empathic engagement with traumatized persons (Pearlman & Saakvitne, 1995).

As the science of traumatology has progressed, the understanding of the phenomenology of traumatic stress has evolved. The DSM5 diagnostic criteria for PTSD now contain in Criterion D ("Negative alterations in cognitions and mood…"), aspects of VT (American Psychiatric Association 2013). Symptom D2—"Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world…"—could have been taken straight from the VT literature. Thus, STS now encompasses key aspects of VT that once differentiated the constructs for some. For this reason, we believe that STS is the most accurate and encompassing term. Though STS is the terminology used in these principles, we are confident that those who prefer the terms CF or VT will find them similarly applicable.

Second, the decision to focus on *behavioral health services* for the development and refinement of these principles was made for both pragmatic and historical reasons. The importance of field-specific language became evident early in the process, as did the recognition that it would be impossible to use vernacular that encompasses all the possible fields that may benefit from such principles. To consistently use contextually relevant language, it became necessary to identify a targeted subgroup of trauma-exposed professionals. The early work conceptualizing and researching STS was largely focused on behavioral health professionals, thus the preponderance of STS literature is directed at this subgroup. As such, we chose behavioral health services to convey clarity to the expert panelists. However, the threat of STS extends far beyond behavioral health services to any profession or field of practice that interacts with traumatized populations. Examples include, but are not limited to, child welfare (Bride et al., 2007; Bride & Jones, 2006; Molnar et al., 2020), education (Hatcher et al., 2011; Lawson et al., 2019), nursing (Beck, 2011; Bock et al., 2020), victim services (Bonach & Heckert, 2012; Letson et al., 2020; Starcher & Stolzenberg, 2020), and criminal justice (Jaffe et al., 2009; Léonard et al., 2020).

The specific language used in the development and final form of these principles is intentional and consistent in order to correspond with the vernacular employed by behavioral health professionals and organizations. Nonetheless the above principles, in whole or in part, are applicable to a much wider range of fields of practice that serve trauma-exposed populations. In some fields such as child welfare, nursing, and education, the principles are easily generalized and applied with relatively minor language modifications. For example, among K-12 professionals the second individual principle might be better reworded as "The individual cultivates and maintains beliefs that support their sense of well-being in their role *as an educator*." In other fields such as law enforcement, first responders, and criminal justice, the principles may be less congruent with the language and context of that profession, and therefore require more significant effort to apply in toto.

Third, the decision to develop *consensus* rather than *evidence-based* principles was made because of the present limitations of the STS knowledge base. The primary difference between these approaches is that in the case of the latter, the evidence is of high quality (i.e., RCTs) and thus speaks for itself, whereas consensus-based principles are developed when the evidence is of lower quality (i.e., absence of RCTs). Experts are, therefore, relied on to consider the extant evidence and arrive at consensus recommendations (Djulbegovic & Guyatt, 2019). Research into STS has greatly expanded in the past decade, and a great deal of evidence now exists regarding the phenomenology and epidemiology of STS. However, the empirical evidence is still nascent in regard to the effectiveness of interventions given the lack of RCTs (Molnar et al., 2017; Sprang et al., 2018).

As such, a consensus-based approach was indicated. Yet, it is important to state that although they do not strictly meet the definition of evidence-based, these principles are indeed grounded in the research. The purpose of creating an expert panel is to ensure that it is comprised of individuals who are well versed in the research and whose input would accordingly be guided by evidence. Thus, these principles are fully informed by evidence in that the expert panel is highly knowledgeable regarding the extant research. This position is consistent with the perspective that evidence-based and consensus-based processes are not mutually exclusive, rather all principles or guidelines should be evidence-based, regardless of the quality of the evidence (Djulbegovic & Guyatt, 2017).

Furthermore, the principles are intricately linked both within and across individual and organizational domains, resulting in a certain degree of interdependence. To fully actualize the individual principles, professionals are dependent upon their employing organization to fully effect the organizational principles. Individuals and organizations should aspire to meet each target that is applicable in the context in which they practice. The principles presented here are intended to inform best practices for individuals and organizations in the field of behavioral health services with the goal of reducing the occurrence and impact of STS, thereby improving the quality and effectiveness of services to traumatized populations. It is important to note that some principles may not apply depending on the individual context. For example, the organizational principles are not necessarily relevant for individuals who are in solo practice. These principles are not intended to contradict or supplant existing trauma-informed principles or competencies, rather they are intended to be a unique contribution that supplements and informs existing principles, competencies, and guidelines with which they should be considered and implemented in tandem.

In summary, these principles were developed by a panel of experts via a consensus-building process informed by the extant STS research. They will need to be revised and updated as emerging research provides new insights into best practices to mitigate STS, eventually becoming evidence-based. While we are optimistic that the recent upward trajectory in both quantity and quality of STS research will continue, we call upon the STS research community

to undertake empirical examination of the effectiveness of these principles in reducing the occurrence and impact of STS. It is incumbent upon researchers to recognize that the principles are intricately linked within and across the individual and organizational domains; and design their studies accordingly. Furthermore, we call upon educational programs training behavioral health professionals to ensure that the knowledge and skills required to implement these principles are integrated into their curriculum. Implementation of these principles is expected to reduce the occurrence and impact of STS in behavioral health service provision and thereby improve the quality and effectiveness of services to traumatized populations.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association (APA). (2015). *Principles on trauma competencies for education and training*. https://www.apa.org/ed/resources/trauma-competencies-training.pdf

American Psychological Association (APA). (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. https://www.apa.org/ptsd-guideline/ptsd.pdf

Armes, S. E., Lee, J. J., Bride, B. E., & Seponski, D. M. (2020). Secondary trauma and impairment in clinical social workers. *Child Abuse & Neglect*, *110*(3), Article 104540. https://doi.org/10.1016/j.chiabu.2020.104540

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing*, *25*(1), 1–10. https://doi.org/10.1016/j.apnu.2010.05.005

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society*, *84*(4), 463–470. https://doi.org/10.1606/1044-3894.131

Bercier, M. L., & Maynard, B. R. (2015). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice*, *25*(1), 81–89. https://doi.org/10.1177/1049731513517142

Bisson, J. I., Berliner, L., Cloitre, M., Forbes, D., Jensen, T. K., Lewis, C., Monson, C. M., Olff, M., Pilling, S., Riggs, D. S., Roberts, N. P., & Shapiro, F. (2019). The international society for traumatic stress studies' new principles for the prevention and treatment of PTSD: Methodology and development process. *Journal of Traumatic Stress*, *32*(4), 475–483. https://doi.org/10.1002/jts.22421

Bock, C., Heitland, I., Zimmermann, T., Winter, L., & Kahl, K. G. (2020). Secondary traumatic stress, mental state and work ability in nurses—Results of a psychological risk assessment at a university hospital. *Frontiers of Psychiatry*, *11*, Article 298. https://doi.org/10.3389/fpsyt.2020.00298

Bonach, K., & Heckert, A. (2012). Predictors of secondary traumatic stress among children's advocacy center forensic interviewers. *Journal of Child Sexual Abuse*, *21*(3), 295–314. https://doi.org/10.1080/10538712.2012.647263

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA Handbook of research methods in psychology, Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association.

Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis: An International Journal*, *7*(1), 29–46. https://doi.org/10.1080/15434610490281101

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, *52*(1), 63–70. https://doi.org/10.1093/sw/52.1.63

Bride, B. E., & Figley, C. R. (2009). Secondary trauma and caregivers of military personnel. *Smith College Studies in Social Work*, *79*(3–4), 314–329. https://doi.org/10.1080/00377310903130357

Bride, B. E., Hatcher, S. S., & Humble, M. N. (2009). Trauma training, trauma practices, and secondary traumatic stress among substance abuse counselors. *Traumatology*, *15*(2), 96–105. https://doi.org/10.1177/1534765609336362

Bride, B. E., & Jones, J. L. (2006). Secondary traumatic stress in child welfare workers: Exploring the role of supervisory culture. *Professional Development: The International Journal of Continuing Social Work Education*, *9*(2), 38–43.

Bride, B. E., Jones, J. L., & MacMaster, S. A. (2007). Correlates of secondary traumatic stress in child welfare workers. *Journal of Evidence-Based Social Work*, *4*(3–4), 69–80. https://doi.org/10.1300/J394v04n03_05

Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and turnover intention in substance abuse counselors. *Traumatology*, *17*(1), 22–28. https://doi.org/10.1177/1534765610395617

Bride, B. E., Robinson, M. R., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, *14*(1), 27–35. https://doi.org/10.1177/1049731503254106

Choi, G. Y. (2011). Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work*, *35*(3), 225–242. https://doi.org/10.1080/03643107.2011.575333

Cook, J. M., Newman, E., & The New Haven Trauma Competency Group. (2014). A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(4), 300–307. https://doi.org/10.1037/a0036747

Council on Social Work Education (CSWE). (2018). *Specialized practice curricular guide for trauma-informed social work practice*.

Creamer, T. L., & Liddle, B. J. (2005). Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *18*(1), 89–96. https://doi.org/10.1002/jts.20008

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373–385. https://doi.org/10.1080/00048670902721079

Djulbegovic, B., & Guyatt, G. (2019). Evidence vs consensus in clinical practice guidelines. *JAMA*, *322*(8), 725–726. https://doi.org/10.1001/jama.2019.9751

Djulbegovic, B., & Guyatt, G. H. (2017). Progress in evidence-based medicine: A quarter century on. *Lancet*, *390*(10092), 415–423. https://doi.org/10.1016/S0140-6736(16)31592-6

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477. https://doi.org/10.1002/jcop.20063

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review*, *31*(1), 25–36. https://doi.org/10.1016/j.cpr.2010.09.004

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). Routledge.

Forbes, D., Bisson, J. I., Monson, C. M., & Berliner, L. (2020). *Effective treatments for PTSD: Practice principles from the international society for traumatic stress studies* (3rd ed.). Guilford Press.

Gottfried, R., & Bride, B. E. (2018). Trauma: Secondary, vicarious, compassion fatigue. In C. Franklin (Ed.), *Encyclopedia of social work*. Oxford University Press. https://doi.org/10.1093/acrefore/9780199975839.013.1085

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*, *32*(4), 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Hatcher, S. S., Bride, B. E., Oh, H., & Pantino, L. (2011). Secondary traumatic stress in juvenile justice workers: An assessment of DJJ education staff exposure to trauma imagery. *Journal of Correctional Healthcare*, *17*(3), 208–217. https://doi.org/10.1177/1078345811401509

Huggard, P., Law, J., & Newcombe, D. (2017). A systematic review exploring the presence of Vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians. *Australasian Journal of Disaster & Trauma Studies*, *21*(2), 65–72. https://trauma.massey.ac.nz/issues/2017-2/AJDTS_21_2_Huggard.pdf

Jaffe, P. G., Crooks, C. V., Dunford-Jackson, B. L., & Town, M. (2009). Vicarious trauma in judges: The personal challenge of dispensing justice. *Juvenile & Family Court*, *54*(4), 1–9. https://doi.org/10.1111/j.1755-6988.2003.tb00083.x

Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, *22*(4), 116–120. PMID: 1570090.

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry*, *49*(10), 887–897. https://doi.org/10.1177/0004867415600891

Lawson, H., Caringi, J., Gottfried, R., Bride, B. E., & Hydon, S. (2019). Secondary traumatic stress, student trauma, and the need for trauma literacy. *Harvard Educational Review*, *89*(3), 421–447. https://doi.org/10.17763/1943-5045-89.3.421

Lee, J. J., Gottfried, R., & Bride, B. E. (2018). Exposure to client trauma, secondary traumatic stress, and the health of clinical social workers. *Clinical Social Work Journal*, *46*(3), 228–235. https://doi.org/10.1007/s10615-017-0638-1

Léonard, M.-J., Saumier, D., & Brunet, A. (2020). When the lawyer becomes traumatized: A scoping review. *SAGE Open*, 1–10. https://doi.org/10.1177/2158244020957032

Letson, M. M., Davis, C., Sherfield, J., Beer, O. W. J., Phillips, R., & Wolf, K. G. (2020). Identifying compassion satisfaction, burnout, & traumatic stress in children's advocacy centers. *Child Abuse & Neglect*, *110*(3), Article 104240. https://doi.org/10.1016/j.chiabu.2019.104240

McKenna, H. P. (1994). The Delphi technique: A worthwhile approach for nursing? *Journal of Advanced Nursing*, *19*(6), 1221–1225. https://doi.org/10.1111/j.1365-2648.1994.tb01207.x

Molnar, B. E., Meeker, S. A., Manners, K., Tieszen, T., Kalergis, K., Fine, J. E., Hallinan, S., Wolfe, J. D., & Wells, M. K. (2020). Vicarious traumatization among child welfare and child protection individuals: A systematic review. *Child Abuse & Neglect*, *110*(3), Article 104679. https://doi.org/10.1016/j.chiabu.2020.104679

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, *23*(2), 129–142. https://doi.org/10.1037/trm0000122

National Child Traumatic Stress Network (NCTSN). (2018). *Using the secondary traumatic stress core competencies in trauma-informed supervision*. https://www.nctsn.org/resources/using-secondary-traumatic-stress-core-competencies-trauma-informed-supervision

National Institute for Health and Care Excellence. (2018). *Posttraumatic stress disorder* [NICE Principle 116]. https://www.nice.org.uk/guidance/ng116

Okoli, C. T., Seng, S., Otachi, J. K., Higgins, J. T., Lawrence, J., Lykins, A., & Bryant, E. (2020). A cross-sectional examination of factors associated with compassion satisfaction and compassion fatigue across healthcare workers in an academic medical centre. *International Journal of Mental Health Nursing*, *29*(3), 476–487. https://doi.org/10.1111/inm.12682

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. W.W. Norton.

Perkins, E. B., & Sprang, G. (2013). Results from the Pro-QOL-IV for substance abuse counselors working with offenders. *International Journal of Mental Health and Addiction*, *11*(2), 199–213. https://doi.org/10.1007/s11469-012-9412-3

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a individual's quality of life. *Journal of Loss and Trauma*, *12*(3), 259–280. https://doi.org/10.1080/15325020701238093

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across individual groups. *Child Welfare*, *90*(6), 149–168. PMID: 22533047.

Sprang, G., Kerig, P., Ford, J., & Bride, B. E. (2019). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research and leading experts. *Traumatology*, *25*(2), 72–81. https://doi.org/10.1037/trm0000180

Sprang, G., Lei, F., & Bush, H. (2021). Can organizational efforts lead to less secondary traumatic stress? A longitudinal investigation of change. *American Journal of Orthopsychiatry*, *91*(4), 443–453. https://doi.org/10.1037/ort0000546

Sprang, G., Ross, L. A., & Miller, B. (2018). A data-driven, implementation focused, organizational change approach to addressing secondary traumatic stress. *European Journal for Person Centered Healthcare*, *6*(1), 62–68. https://doi.org/10.5750/ejpch.v6i1.1400

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). ProQOL.org.

Starcher, D., & Stolzenberg, S. N. (2020). Burnout and secondary trauma among forensic interviewers. *Child and Family Social Work*, *25*(4), 924–934. https://doi.org/10.1111/cfs.12777

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology*, *13*(1), Article 2022278. https://doi.org/10.1080/20008198.2021.2022278

Ting, L., Jacobson, J., Sanders, S., Bride, B. E., & Harrington, D. (2005). The Secondary Traumatic Stress Scale: Confirmatory factor analyses in a national sample of mental health social workers. *Journal of Human Behavior in the Social Environment*, *11*(3–4), 177–194. https://doi.org/10.1300/J137v11n03_09

Walsh, C. R., Mathieu, F., & Hendricks, A. (2017). Report from the secondary traumatic stress San Diego think tank. *Traumatology*, *23*(2), 124–128. https://doi.org/10.1037/trm0000124

Wheeler, K., & Phillips, K. E. (2021). The development of trauma and resilience competencies for nursing education. *Journal of the American Psychiatric Nurses Association*, *27*(4), 322–333. https://doi.org/10.1177/1078390319878779

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