The invisible wounds of supporting trauma survivors: Rethinking secondary traumatic stress

A narrative review of conceptual and practical challenges

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SUMMARY

Secondary traumatic stress (STS) is an increasingly recognized mental health concern among professionals working with trauma survivors. Although STS shares symptomatic overlap with post-traumatic stress disorder (PTSD), its etiology is rooted not in direct trauma exposure but in empathic engagement with traumatized individuals in the course of professional responsibilities. This crucial conceptual distinction is often neglected in both the mental health literature and clinical settings. This narrative review explores the theoretical underpinnings, diagnostic challenges, and psychosocial consequences of STS, with a particular focus on professionals operating in disaster zones. Drawing on models such as compassion fatigue, vicarious traumatization, and ecological frameworks, the review conceptualizes STS as an outcome of the dynamic interaction between individual vulnerability, professional exposure, and contextual stressors. Risk factors are discussed across three levels: individual (e.g., young age, female gender, personal trauma history), occupational (e.g., lack of supervision, limited field experience), and event-based (e.g., exposure to emotionally intense cases, witnessing grief and loss). Despite the growing empirical interest in STS, much of the existing literature is based on cross-sectional designs and lacks culturally adapted assessment tools with robust psychometric properties. Furthermore, STS is frequently treated solely as a clinical condition, while its structural and ethical implications for professional sustainability and care quality remain underexamined. This review highlights the necessity of addressing STS as a systemic occupational risk that requires early recognition, theoretical clarity, culturally sensitive screening instruments, and institutional-level interventions such as trauma-informed supervision and workload support. A comprehensive understanding of STS, informed by multidimensional models and longitudinal data, is critical to safeguarding the mental well-being of professionals exposed to secondary trauma.

Key Words: Stress disorders, post-traumatic, empathy, occupational stress, disasters.

INTRODUCTION

Secondary traumatic stress (STS) is a form of psychological distress that may develop in individuals who are not directly exposed to a traumatic event, but who witness, assist with, or become emotionally involved in the event through empathic engagement (1). This phenomenon differs from primary traumatic stress responses seen in direct trauma victims and emerges through the caregiver's sense of responsibility, valuing of the person, and intense empathic interaction (2,3). Figley (2002, p. 143) described this condition as follows (4): *"We have not been directly exposed to the trauma scene, but we hear the story told with such intensity... and we suffer."*

STS was systematically defined in the 1990s through the work of Charles Figley, who emphasized that ongoing exposure to others' trauma can lead to psychological outcomes such as compassion fatigue and the "cost of caring," especially among professionals in helping fields (5). During this period, it was noted that STS presents with symptoms similar to post-traumatic stress disorder (PTSD), but arises from indirect exposure to trauma.

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In the 2000s, the prevalence of secondary traumatic stress among professionals working with trauma survivors gained attention (4). Large-scale crises such as natural disasters and terrorist attacks highlighted the mental health impact on helping professionals (6). More recently, the COVID-19 pandemic has brought indirect traumatic experiences of healthcare workers to light, revealing widespread manifestations of STS, compounded by personal and systemic stressors (7). In this context, STS has come to be addressed not only as a clinical issue but also as a structural one, bringing preventive intervention strategies into focus alongside discussions of psychological resilience, burnout, and occupational sustainability.

Professionals who serve trauma survivors—such as healthcare workers, search-and-rescue teams, social workers, police officers, firefighters, and lawyers—may experience indirect stress reactions even if they are not directly exposed to the trauma (8). Depressive symptoms and STS have been frequently reported in these groups (2,9-11). However, not every individual develops a PTSD-like disorder, and symptoms vary depending on personal factors.

In large-scale traumatic events such as disasters, STS occupies a unique position. By their very nature, disasters may expose not only victims but also aid workers to trauma, either directly or indirectly.

Professionals deployed or volunteering in disaster areas are often required to work under complex and ambiguous conditions that may include their own trauma histories (1).

Research on STS has shown this form of stress to be prevalent particularly among healthcare workers, social workers, and first responders (4,6,11). Nevertheless, there remain significant gaps in the literature regarding conceptual frameworks and measurement methods. For example, while Figley (1995) defines STS as a response developing from empathic engagement, McCann and Pearlman (1990) describe a similar phenomenon as "vicarious traumatization," emphasizing cognitive schema disruptions (12,13). These two perspectives differ in terms of intervention strategies, contributing to diagnostic and theoretical ambiguities in the field. In addition, the boundaries between STS and burnout remain unclear. Some studies use these terms interchangeably or confuse them (10).

Moreover, there is a noticeable lack of longitudinal studies exploring the long-term effects of STS; most existing research is cross-sectional in design (14). Cross-cultural variations have also been insufficiently examined; there is limited knowledge about how STS is experienced in different cultural contexts (15). These shortcomings underscore the need to approach STS through a multidimensional, culturally sensitive, and integrative framework.

Although secondary traumatic stress has gained increasing recognition over the past two decades, it remains a conceptually and diagnostically debated phenomenon. Overlaps and conceptual confusions among related constructs—such as PTSD, burnout, vicarious traumatization, and compassion fatigue—lead to inconsistencies in both clinical understanding and research findings. Furthermore, the lack of standardized diagnostic criteria and the inconsistent use of measurement tools hinder the identification of STS, particularly in high-risk professional groups such as mental health workers exposed to indirect trauma, and complicate effective interventions.

This narrative review aims to examine the concept of STS through a critical and integrative lens, synthesizing the existing literature to clarify the conceptual boundaries, diagnostic challenges, and associated risk and protective factors of this phenomenon. Within this framework, the review places special emphasis on disaster-based mental health services as a context in which STS symptoms, although often pronounced, frequently go unrecognized. By identifying gaps in the literature and highlighting unresolved clinical and theoretical issues, this review seeks to contribute to the development of more accurate assessment strategies and targeted intervention approaches for addressing secondary trauma in mental health professionals providing psychosocial support.

Understanding secondary traumatic stress: Conceptual, diagnostic, and clinical dimensions

Secondary Traumatic Stress: Definition, clinical symptoms, and diagnostic boundaries

Symptoms of post-traumatic stress disorder (PTSD) may occur not only in cases of direct exposure to traumatic events but also in situations involving indirect exposure, such as witnessing the event, learning that it has occurred, or establishing a professional helping relationship with trauma survivors (8). The psychological condition that develops as a result of this type of indirect exposure is referred to as secondary traumatic stress (STS). STS symptoms resemble the core features of PTSD, such as re-experiencing, avoidance, and increased arousal (16).

The relevant literature shows that the risk of developing STS is particularly high among professionals who work closely with trauma (9, 10). Moreover, it has been reported that following collective traumas, the number of individuals secondarily traumatized may exceed the number of those directly affected. For example, during a natural disaster, the physical injury of one person may lead to psychological distress in approximately 200 others who were not directly exposed to the event (17).

STS symptoms may include re-experiencing, intrusive cognitive content, nightmares related to the trauma, hyperarousal, and avoidance behaviors, as seen in PTSD. However, the defining characteristic of STS is that the traumatic event is not directly experienced by the individual, but is associated with the traumatic experience of someone they are helping (18). This results from the helper being emotionally affected through an empathic bond with the trauma survivor.

In STS, a perception of threat is present; however, unlike PTSD, this threat is not directed toward the helper themselves. Rather, the threat is associated with the experience of someone in their immediate environment, such as a client or person they are assisting. For example, a healthcare worker supporting a client who lost a limb in a traffic accident may experience intrusive recollections of the event, repeatedly see scenes of the accident in their dreams, feel as though they personally lived through the event, or experience intense distress when confronted with reminders. Search and rescue teams working in earthquake zones may develop avoidance behaviors related to the moment of rescue, have difficulty recalling aspects of the intervention, express emotional numbing or a loss of interest. In addition, they may have trouble falling or staying asleep, exhibit hyperarousal, sudden anger outbursts, or problems with concentration (18).

Secondary traumatic stress is not currently a formally recognized psychiatric diagnosis, and there are no standard diagnostic criteria specific to this condition. In primary traumatization and PTSD, the individual is exposed to an event involving actual or threatened death, serious injury, or sexual violence, either directly, by witnessing it, by learning that it occurred to a close other, or through repeated exposure to disturbing details of traumatic events. In contrast, in STS, the life-threatening experience is directed at the trauma survivor—who may be a victim, patient, or client. The individual experiencing STS is typically someone in a helping role—such as a social worker, therapist, healthcare professional, journalist, volunteer, or legal advocate—who forms an empathic relationship with the survivor. Exposure to traumatic content occurs not directly but in an indirect and repeated way through the helping relationship.

Re-experiencing symptoms can be observed in both primary and secondary traumatization. These may include involuntary and distressing memories, nightmares, dissociative flashback episodes, and intense psychological or physiological responses triggered by trauma-related cues. In STS, these symptoms are centered not on the individual's own trauma, but on the trauma experienced by the person they are assisting. Avoidance symptoms, similar to those seen in PTSD, can also occur in STS. These may involve efforts to suppress trauma-related thoughts, avoiding people, places, or situations associated with the trauma, diminished interest, a sense of detachment, and pessimism about the future. Hyperarousal symptoms may include difficulty falling or staying asleep, irritability, sudden anger outbursts, distractibility, hypervigilance, exaggerated startle response, and physiological arousal. These symptoms have been reported in both primary and secondary trauma exposure (19).

One important distinction between the two conditions lies in the duration criterion. While PTSD requires symptoms to persist for at least one month to meet diagnostic criteria, no such duration threshold exists for STS (19). STS symptoms generally emerge quickly and in connection with a specific traumatic event. Acute stress reactions similarly appear within a short time frame, whereas PTSD symptoms may emerge with a delayed onset. However, in all of these conditions, the symptoms cause clinically significant distress and impairment in social, occupational, or other important areas of functioning (20).

In cases of primary traumatization, functional impairment may manifest as increased family conflict, sexual dysfunction, social withdrawal, increased substance use, diminished emotional connectedness, and loss of social support. On the other hand, functional disruptions caused by STS may include workplace conflict, inability to complete tasks, emotional numbing toward survivors, ongoing distress due to repeated exposure to traumatic content, loss of social support, and difficulty coping with stress (2, 19).

The psychological and occupational toll of secondary traumatic stress

Secondary traumatic stress (STS) has multifaceted effects not only on an individual's mental health but also on their occupational functioning and overall physical condition. In the literature, the effects of STS are generally categorized under three main domains: emotional, physical, and professional (21, 22).

On the emotional level, individuals exposed to STS may experience various symptoms, including anxiety, depression, anger, fear, guilt, loss of trust, emotional numbness, feelings of inadequacy, social withdrawal, avoidance behaviors, heightened sensitivity to violence, and changes in perception and memory (21). These symptoms can lead to significant disturbances in both the individual's inner emotional world and interpersonal relationships.

Physical symptoms associated with STS include headaches, gastrointestinal discomfort, muscle tension, chronic fatigue, sleep disturbances, and cardiac problems. In particular, decreased sleep quality and insufficient rest can directly affect both mental well-being and occupational performance (21,23).

The occupational impact of STS is as significant as its emotional and physical consequences. Among helping professionals, common outcomes include avoidance of empathic engagement with clients, reluctance to attend work, loss of motivation, feelings of burnout, and difficulty completing tasks (21, 22). It has also been reported that individuals experiencing high levels of STS may show impaired decision-making capacity, reduced professional motivation, and desensitization toward traumatic content (24). These effects can negatively impact both personal job satisfaction and the overall quality of services provided.

In the long term, STS can also have serious consequences for workforce sustainability. Employees with high levels of STS symptoms have been found to leave their jobs at higher rates, with particularly high turnover observed in the healthcare sector (25). Therefore, STS should be understood not only as an individual-level concern but also as a systemic professional risk factor that requires organizational attention.

Assessment tools for secondary traumatic stress

Among the most widely used tools for assessing secondary traumatic stress (STS) are the Secondary Traumatic Stress Scale (STSS) and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5). The STSS was developed by Bride et al. (2004) based on Figley's theoretical framework and was specifically designed to evaluate symptoms experienced by helping professionals. This scale, grounded in DSM-IV criteria, covers symptom clusters such as re-experiencing, avoidance, and arousal (26). The PCL-5, on the other hand, is a 20-item self-report scale adapted to the updated diagnostic criteria of DSM-5, and it is sensitive not only to direct trauma but also to secondary trauma (27). Both scales have undergone validity and reliability studies in various cultural contexts; however, some findings suggest that these instruments may not be sufficiently sensitive to symptom expression in certain cultural settings. For example, in the Turkish adaptation of the PCL-5 used among disaster survivors, relatively high cutoff scores were reported, which was suggested to be linked to cultural styles of symptom expression (28). Cultural differences may influence both the meaning attributed to traumatic experiences and the linguistic and behavioral expression of symptoms, potentially reducing the diagnostic sensitivity of assessment instruments. Therefore, it is important to critically examine the cultural validity of the tools used to assess STS and to adapt them according to local needs.

Distinguishing related concepts: Vicarious trauma, burnout, and compassion fatigue

In describing work-related psychological impacts, the terms secondary traumatic stress (STS), vicarious traumatization, compassion fatigue, and burnout are frequently used. It is now understood that individuals who provide services to trauma survivors may also experience negative psychological changes as a result of indirect exposure to trauma (8). Although these terms are sometimes used interchangeably, they carry different meanings. Therefore, it is important for professionals working with trauma to clarify the conceptual boundaries of each (18). The concept of secondary traumatic stress emphasizes the emotional and behavioral changes that occur upon acquiring knowledge of another person's traumatic experience. Through indirect contact with traumatic events, individuals may develop PTSD-like symptoms (12). However, some studies have found high levels of correlation among these concepts, suggesting that it may be difficult to distinguish them empirically.

Vicarious traumatisation

This concept was first defined in 1990 (13). While secondary traumatic stress involves changes primarily in emotions and behaviors, vicarious traumatization emphasizes alterations in cognitive processes (29). The literature indicates that there is conceptual confusion between these two terms (18). Both concepts may be observed among professionals working with individuals who have experienced traumatic events (10). For example, professionals working with trauma survivors may develop mistrust toward others or experience negative shifts in their cognitive schemas—hallmarks of vicarious traumatization (13). These individuals may exhibit changes in their worldview, perceptions of psychological needs, and memory processes. This phenomenon is considered a cumulative and almost inevitable consequence of engaging in empathic professional relationships. The concept was introduced within the framework of the Constructivist Self Development Theory, which identifies cognitive schema domains such as safety, trust, esteem, intimacy, and control as being particularly vulnerable to the impact of traumatic experiences.

Whereas STS symptoms tend to emerge acutely, vicarious traumatization is associated with cumulative effects resulting from chronic exposure. From a prognostic standpoint, recovery from secondary traumatic stress may occur more quickly, while treatment for vicarious trauma often requires a longer process (12). Whereas STS symptoms tend to emerge acutely, vicarious traumatization is associated with cumulative effects resulting from chronic exposure. From a prognostic standpoint, recovery from secondary traumatic stress may occur more quickly, while treatment for vicarious trauma often requires a longer process (10).

Burnout

Burnout is described as a specific type of occupational stress that arises from prolonged exposure to emotionally intense and interpersonally demanding work environments (30, 31). Factors such as excessive workload, time-related pressures, and the challenging nature of the work environment contribute to the development of burnout (30). It reflects a chronic dissatisfaction with professional conditions (32).

While burnout typically follows a cumulative pattern, secondary traumatic stress may develop acutely, even in response to a single traumatic incident (12). From a prognostic perspective, se-

Table 1. Comparison of concepts related to secondary traumatic stress

	Secondary Traumatic Stress	Vicarious Trauma	Burnout	Compassion Fatigue
First Defined by	Figley (1995)	McCann & Pearlman (1990)	Maslach (1981)	Joinson (1992); Figley (2002)
Cause	Indirect exposure to traumatic events via empathy	Indirect exposure to trauma + chronic empathic burden + disruption of meaning systems	Interpersonal stress and adverse work conditions - excessive workload, lack of control, low reward - more related to chronic stress than trauma	Continuous display of compassion and empathy - Empathy + intense caregiving effort
Affected Individuals	Professionals working with trauma survivors	Professionals working with trauma survivors	Any occupational group	Professionals providing care to chronically ill individuals
Impact	Emotional and behavioral changes (re-experiencing, avoidance, hyperarousal)	Cognitive and belief changes (negative transformations)	Dissatisfaction, emotional exhaustion, decreased productivity	Linked to depletion of internal resources - reduced tolerance and inclusiveness
Prognosis	Acute onset, rapid course, high reversibility	Often chronic, resistant, low reversibility	Cumulative - chronic stress, moderate to low reversibility	Chronic, moderate to high reversibility

condary traumatization tends to have a more favorable course than burnout, as it may present acutely and resolve more rapidly (12). The etiology of burnout is generally explained by occupational factors, whereas secondary traumatic stress is more directly associated with exposure to traumatic experiences (32). In terms of professional groups, secondary traumatic stress is more commonly observed among those working directly with traumatized individuals. In contrast, burnout can occur across a wide range of professions, particularly those involving high interpersonal demands and difficult working conditions (12,33).

Compassion fatigue

There are costs associated with providing care to individuals with chronic illnesses. Caregivers strive to remain professionally objective while simultaneously aiming to deliver the best possible care. On the other hand, the compassion and empathy they feel enable a deeper understanding of the individual, thereby improving the quality of care. Compassion refers to the ability to tolerate the suffering of others. Empathy functions as a motivating factor for engaging effectively with pain. Although compassion, empathy, and mercy can be motivating in the provision of care, they also come with costs. The continuous demonstration of compassion and empathy depletes internal resources and leads to compassion fatigue. This results in a decreased capacity to tolerate the suffering of others and to remain emotionally responsive—effectively reversing the motivational functio (4). Individuals experiencing compassion fatigue may have difficulty attending work or may experience persistent thoughts centered around their patients. Difficulties in maintaining work performance are prominent in compassion fatigue (19). Secondary traumatic stress and occupational burnout are considered subcomponents of compassion fatigue (34).

Theoretical models explaining secondary traumatic stress

The development of secondary trauma has been explained through various theoretical perspectives. One of these is the concept of energy depletion. Figley and Kleber (1995) stated that the core of STS lies in the burden created by sustained empathy, leading the helper to experience exhaustion both physically and psychologically. A person trying to support a trauma survivor may feel fatigue at both levels. Within this framework, the Energy Depletion Model emphasizes how the motivation to help can become increasingly taxing and draining over time (12).

Another theoretical explanation focuses on the close relationship with the victim. Individuals closely connected to the trauma survivor may also be psychologically affected. The intensity of the traumatic event and feelings of helplessness may also be experienced by the person providing support.

An empathic attitude toward the trauma survivor is a triggering factor in this process. When the traumatic experience is internalized by the support person, the closeness becomes burdensome. The individual may lose their empathic capacity and feel depleted (12). While empathy is necessary for therapeutic connection, when left unchecked, it can become emotionally consuming. Therefore, it is recommended that helpers approach clients first with empathy, then shift to objectivity, and return to empathy as needed (35).

Secondary traumatic stress has also been explained through a resilience-based process model (36). This model is described through a three-part structure: first, empathic engagement; second, secondary traumatic stress; and third, resilience against secondary traumatic stress disorder. In the first component, empathic engagement, elements such as contact with the trauma survivor's suffering, empathic concern and compassion, the ability to empathize, and empathic responses play a role. In the second component, secondary traumatic stress, the emphasis is placed on the perceived threat resulting from exposure. In the third component, resilience, factors such as self-care, psychological distancing from the survivor's pain, a sense of fulfillment, and social support are considered influential. Practicing self-care may help reduce the negative impact of secondary trauma (36).

The ripple effect describes how a traumatic event first affects the person who experiences it directly, and then radiates outward, impacting those around them (37). Family members, friends, and professionals who are close to the primary victim may also develop secondary trauma symptoms. In large-scale societal traumas, the number of secondarily traumatized individuals may exceed the number of those directly affected (17).

The chiasma effect is another concept used to explain the development of secondary trauma. "Chiasma" refers to an X-shaped crossover and is used in biology to describe the exchange of genetic material between chromosomes. Similarly, the concept highlights the transfer of traumatic experiences. For example, parents who are aware of the traumatic experiences of their children may be more deeply affected than the children themselves (38). Likewise, professionals working directly with trauma survivors who feel a strong sense of responsibility may experience higher levels of traumatic stress (39).

The ecological perspective, a foundational principle in social work, posits that individuals are interconnected with their environments. According to this view, any event occurring in one's environment may directly impact the individual. As a result, the trauma experienced by one person may also affect their family, friends, social support systems, and the professionals offering help—leading to secondary trauma (20).

A key feature in the formation of STS is the knowledge of the traumatic event itself (2). Through empathy, the helper may develop feelings similar to those experienced by the trauma survivor. As the event is cognitively represented, the helper may experience re-experiencing symptoms. The theoretical foundations of STS were first systematically introduced by Figley (1995, 2002), who defined STS as a distinct syndrome that may emerge in helping professionals following empathic engagement with trauma survivors. His Compassion Fatigue Model describes STS as a component of empathy-based burnout and incorporates this into the theoretical framework of STS (4,12). In addition, Figley's (1995) Secondary Traumatic Stress Contagion Model suggests that in therapeutic contexts, traumatic content may be emotionally "transmitted" to the helper through empathic listening (5, 12).

On the other hand, several theoretical approaches that do not directly define STS but explain similar psychological processes also appear in the literature. For example, McCann and Pearlman's (1990) Vicarious Traumatization Theory focuses on how prolonged helping relationships may disrupt an individual's cognitive belief systems, such as trust, control, and self-worth (13). Lazarus and Folkman's (1984) Stress Process Model investigates the balance between environmental demands and individual coping resources to explain variations in stress responses, indirectly contributing to the understanding of STS (40). In addition, the

Professional Quality of Life (ProQOL) Model developed by Stamm (2005) provides a multidimensional assessment tool that directly measures STS and considers both compassion fatigue and compassion satisfaction (41). These models, either directly or indirectly, contribute to the theoretical understanding of STS initiated by Figley.

Individual, occupational, and event-based risk factors in the development of secondary traumatic stress

Secondary traumatic stress (STS) may diminish rapidly in some individuals, but in certain cases, it can become more persistent, negatively impacting mental health and overall life functioning (42). This variability is largely influenced by the individual's personal history, psychosocial resources, and occupational conditions. Recent studies have shown that the development of STS is shaped by multidimensional and interactive factors.

Individual risk factors

Individual characteristics that increase vulnerability to secondary traumatic stress (STS) include age, gender, personality traits, previous traumatic experiences, level of social support, quality of family relationships, coping strategies, and overall mental health status (8, 42). Some studies have indicated that being female, younger in age, and having less professional experience may constitute risk factors for STS (43-45). Similarly, a study conducted among psychosocial support workers deployed to disaster zones found that younger age and low psychological resilience significantly increased STS symptoms (46). Awareness of one’s own psychosocial support needs has also been reported to be associated with higher stress levels. Furthermore, individuals with a history of traumatic experiences may be more sensitive to trauma encountered in professional settings (43).

Occupational and organizational risk factors

The emergence of secondary traumatic stress (STS) is influenced not only by individual factors but also by occupational and organizational contexts. In this regard, variables such as years of professional experience, frequency of exposure to trauma-related cases, clarity of professional role, received training, level of organizational support (e.g., supervision, team support), availability of psychosocial resources in the workplace, and relationships with colleagues are among the key factors affecting STS levels (44, 45). It has been reported that less experienced personnel are more susceptible to STS, and that a supportive institutional culture may help reduce this risk (47). In particular, lack of supervision, insufficient organizational support, and avoidance-based coping strategies have been identified as prominent factors increasing STS levels.

Event-based and task-based risk factors

In the development of secondary traumatic stress (STS), not only personal and occupational variables, but also the nature of events encountered during duty plays a significant role. Exposure to situations involving direct or indirect threats, loss of clients during care, emotionally overwhelming cases, inadequate physical conditions, time pressure, high expectations, and lack of social support networks are among the event-related sources of stress (48). Such conditions may intensify the stress responses of professionals who are exposed to traumatic content, thereby increasing the risk of STS. These findings indicate that STS does not emerge solely due to individual vulnerability but rather through the interaction of professional context, organizational environment, and event-based stressors. Therefore, it is essential to address both individual and structural levels when developing preventive strategies.

Addressing STS in disasters: PTSD or STS?

When evaluating the psychological burden of professionals working in disaster zones, the distinction between post-traumatic stress disorder (PTSD) and secondary traumatic stress (STS) is critical, yet often overlooked. PTSD develops as a result of direct exposure to traumatic events. Although STS presents with similar symptoms—such as intrusive thoughts, hyperarousal, and avoidance behaviors—it arises from indirect exposure through empathic engagement with trauma survivors (12).

This distinction becomes especially important in disaster contexts. In such settings, professionals encounter trauma not only environmentally, but also by bearing witness to the suffering of others in a deeply personal way. i man et al. (2025), in their study with psychosocial support workers deployed after the 2023 Türkiye earthquakes, emphasized this distinction. They demonstrated that forms of indirect exposure—such as accompanying a bereaved relative to a funeral or working with individuals who experienced limb loss—were stronger predictors of traumatic stress symptoms than direct exposure to morbid scenes (46). These findings suggest that although professionals in disaster zones may face the possibility of direct trauma exposure, it may be more appropriate to conceptualize their psychological responses within the framework of STS rather than PTSD, especially for those in helping relationships with trauma survivors. Similarly, Tominaga et al. (2020) reported high levels of STS symptoms among clinicians in Japan following the 2011 Tohoku earthquake, particularly among those working with grieving children and families (49).

Taken together, these findings highlight the need for a more nuanced approach in disaster-related mental health interventions. Interventions based solely on PTSD models may not adequately capture mission-specific challenges and empathic vulnerability. Furthermore, the unique nature of the field—which carries risks of both primary and secondary traumatic stress—must be considered. Thus, evaluating these responses solely through the lens of PTSD may obscure critical distinctions in terms of etiology, clinical course, and intervention strategies.

DISCUSSION

Although there are notable findings in the literature regarding the prevalence of secondary traumatic stress (STS) among mental health professionals working in disaster zones, significant research gaps remain in this field (46). It has been reported that, in the aftermath of disasters, these professionals may develop STS symptoms due to continuous exposure to others' traumatic experiences. However, because most existing studies employ cross-sectional designs, methodological limitations arise in establishing causal relationships (44,49).

Moreover, many studies address STS without clearly distinguishing it from related constructs such as burnout, post-traumatic stress disorder (PTSD), and compassion fatigue.This leads to both diagnostic ambiguities and reduced specificity in intervention strategies (5). Factors such as variability in measurement tools, limited cultural validation studies, and the occupational homogeneity of samples further restrict the comparability of findings across different studies.

Nonetheless, some consistent patterns are noteworthy. Female gender, younger age, and lower levels of professional experience have been identified as key risk factors for STS among mental health professionals working in post-disaster settings (43, 45, 46). In addition, occupational experiences such as direct exposure to trauma or witnessing intense traumatic narratives have been shown to significantly increase STS levels (46,49).

On the other hand, protective factors such as social support, perceived professional competence, and trauma preparedness training have been shown to reduce STS symptoms in various contexts (50). However, there are very few studies that systematically examine the impact of these protective factors on psychosocial support personnel working under disaster conditions. Furthermore, the simultaneous exposure to both primary and secondary trauma among these professionals complicates the conceptual and diagnostic distinction between the two clinical presentations (5,49).

Future research should employ longitudinal designs that simultaneously assess primary and secondary trauma exposure while also being sensitive to cultural context. In addition, the development of psychometric tools that can specifically measure STS and distinguish it from related constructs in disaster contexts will enhance conceptual clarity and contribute to the targeted design of intervention programs.

This review highlights the critical importance of secondary traumatic stress (STS) among mental health professionals working in disaster settings. Although STS shares symptomatology with post-traumatic stress disorder (PTSD), its etiology—rooted in empathic engagement and indirect trauma exposure—necessitates a distinct conceptual, diagnostic, and interventional approach. The existing literature suggests that STS is not merely an individual clinical condition but also a structural occupational risk, with serious implications for service quality, ethical care, and workforce sustainability.

From a clinical perspective, early recognition of STS and its differentiation from similar conditions is essential to prevent the chronicity of psychological burden. At the institutional level, the integration of trauma-informed supervision, strengthening of organizational support mechanisms, and implementation of targeted training programs are among the evidence-based strategies that enhance professional resilience.

Therefore, future research should prioritize the development of culturally sensitive and psychometrically sound assessment tools capable of distinguishing STS from related constructs. Furthermore, mixed-method and longitudinal study designs will significantly contribute to understanding the complex interactions between personal vulnerability, occupational exposure, and structural protective factors. Only through such a comprehensive approach can the psychosocial burden faced by disaster-exposed professionals be effectively addressed at clinical, organizational, and policy levels.

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Author Contributions

E.S. conducted the literature review and drafted the manuscript. A.G. revised the manuscript for language and clarity. A.P. supervised the writting process and critically reviewed the manuscript. All authors contributed to the conceptualization, approved the final version, and are accountable for its content.

Ethics Statement

This narrative review did not involve human participants or animal subjects and therefore did not require ethical approval.

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