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Secondary Trauma Among Caregivers Who Work With Mexican and Central American Refugees

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Abstract

Thousands of refugees have fled Mexico, Honduras, Guatemala, and El Salvador to escape violence, criminal victimization, and persecution as a result of the breakdown of public safety that has accompanied the rise of organized crime and drug-related violence. Many of these migrants have experienced torture, rape, abduction, forced labor, arson, and kidnapping. Caregivers and professionals who work with these refugees, including social workers, volunteers, attorneys, and advocates, have repeatedly witnessed severe trauma among refugees as the migrants recount horrific stories about their journeys. We conducted in-depth interviews with 31 individuals who have worked extensively and repeatedly with traumatized refugees. Participants completed the Secondary Traumatic Scale (STSS) and the Professional Quality of Life (ProQOL)-Compassion Fatigue (CF) scale. While most participants reported signs and symptoms of secondary traumatic stress, many also demonstrated high levels of compassion satisfaction. In addition, most were involved in self-care. Hispanic participants reported that elements of their culture were protective.

Keywords

refugees, secondary trauma, migration, compassion fatigue

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The border city of El Paso Texas and other border communities have witnessed an influx of migrants from Mexico and Central America who have been adversely affected by trauma. Over the past 7 years, there have been approximately 130,000 murders related to drug violence and organized crime in Mexico (Molloy, 2013). In neighboring Ciudad Juarez, among the country's most dangerous cities, there have been at least 10,500 drug war–related murders during the same period (Molloy, 2013). Around 2% to 3% of the population of Mexico has left their homes to escape violence, extortion, and criminal victimization (Olivares, 2012). There has been significant migration away from the border city of Juarez, both to the interior of Mexico and to the United States, as people seek safer environments and flee from traumatic events that they have experienced or witnessed.

Sources in Mexico report that since 2008, approximately 7 in 10 businesses in Juarez have closed, 230,000 city residents have migrated to the United States, and between 50,000 and 125,000 Mexicans have migrated to greater El Paso (Cardenas, 2013). More recently, a wave of tens of thousands of refugees from Central America, including children, have joined the migration to the United States, as public safety has declined in Honduras, Guatemala, and El Salvador due to the rise of organized crime and drug violence (Immigration Policy Center, 2014a, 2014b).

Many of those who have migrated have directly experienced or witnessed traumatic events such as kidnapping, murder, assault, rape, torture, death threats, and extortion. Mental health and non-profit agencies that serve migrants have been swamped with individuals who have the signs and symptoms of acute anxiety disorder, post-traumatic stress disorder (PTSD), panic attacks, and depression (Lusk, McCallister, & Villalobos, 2013; Lusk & Villalobos, 2012). In interviews of agency directors, mental health service providers, para-professional caregivers, and volunteers who work with refugees,[1] we encountered staff members who seemed stressed, burned out, and possibly affected by secondary trauma.

As a result, in this study, we examined the nature and severity of secondary trauma in caregivers and mental health providers who work with traumatized refugees. Bi-lingual providers of Hispanic origin almost exclusively serve the client population of refugees. We explored how this group is affected by prolonged and extensive exposure to severely traumatized clients. We have been particularly interested in uncovering coping mechanisms, identifying protective factors, and finding self-care strategies that are culturally appropriate.

Those who work directly and repeatedly with individuals who have experienced trauma can be adversely affected and display the signs and symptoms of secondary trauma stress disorder and compassion fatigue (Baird & Kracen,

2006; Bride, Robinson, Yegidis, & Figley, 2004; Darr & Johns, 2008; Figley, 1999). Secondary traumatic stress has been documented among social workers (Adams, Boscarino, & Figley, 2006), substance abuse workers (Bride, Hatcher, & Humble, 2009), physicians (Huggard & Dixson, 2011; Nimmo & Huggard, 2013), nurses (Mealer & Jones, 2013; Neville & Cole, 2013), psychotherapists (Figley, 2002), disaster responders (Boscarino, Figley, & Adams, 2004), HIV workers (Garrett, 1999), family members of combat veterans (Nash & Litz, 2013; Yambo & Johnson, 2014), and hospice workers (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanijan, 2013).

Importance of the Problem

Secondary trauma can be debilitating to professional and para-professional caregivers. Those who are themselves harmed by secondary exposure to trauma may be less effective in working with clients. Such individuals may experience loss in quality of life, impaired functioning, family dysfunction, and isolation (Figley, 1995, 2002).

Workers at agencies in the border region that serve traumatized migrant populations are at risk of secondary trauma because their clients include migrant women marked by violence, the vulnerable children of refugees, victims of severe crimes, survivors of torture and kidnapping, and individuals who have been trafficked. Staff members and volunteers at these organizations are overextended and exposed repeatedly to highly traumatized clients.

Impact on Clinical Practice

Unidentified and untreated compassion fatigue and secondary trauma can negatively affect mental care providers, those they care for, and the agencies they work for. Secondary traumatic stress is characterized by excessive blaming, bottled up emotions, and social isolation. Professionals and para-professionals who report experiencing secondary traumatic stress voice excessive complaints. They may abuse substances to manage symptoms, have difficulty handling their anger, or may engage in compulsive behaviors such as overspending, overeating, and gambling. Others may have nightmares and flashbacks to traumatic event. Yet others report chronic physical ailments, gastrointestinal problems, or recurrent colds. Some experience apathy and no longer find normal activities to be pleasurable (dysphoria). Secondary trauma also may result in poor concentration and fatigue. Of importance, secondary trauma may have adverse effects on the quality of care provided by caregivers (Figley, 1999).

Compassion fatigue symptoms are normal displays of chronic stress resulting from the caregiving work. Leading traumatologist Eric Gentry suggests that people who are attracted to caregiving often enter the field already compassion fatigued (Gentry, 2002). A strong identification with helpless, suffering, or traumatized people or animals is often behind this.

If secondary trauma among caregivers is not identified, managed, and treated in the mental health and social service communities of the border region, clients and patients may be adversely affected by receiving services from workers who are themselves impaired by psychological injury. The condition can result in apathy and may be a factor in the high turnover and attrition rate in the helping professions. Caregivers may look for other less psychologically demanding positions or leave their positions. The implications of both are significant to clients. The needs of these workers must be addressed to avert an increase of trauma in the region.

Theoretical Framework

The process of migration, especially forced refugee migration, is accompanied not only by the stress of the migration itself but also by acculturative stress (Kim, Hogge, & Salvisberg, 2014; Wiese, 2010). This means that in addition to the stress associated with moving across borders, losing friends, missing family members, loss of employment, decline in social status, and other major stressors, migrants must also confront the hazards of adapting to a new culture. Thus, refugees and forced migrants are at greater risk of severe trauma. Hispanic therapists and caregivers who work with such migrants have, for the most part, already gone through acculturative stress, either as migrants, descendants of migrants, or minority group members who regularly cope with adjusting to a dominant culture. As a result, caregivers and therapists may have some additional protective factors in coping with and treating trauma among refugees by virtue of having successfully navigated through acculturative stress themselves. Moreover, being Hispanic may be a protective factor in working with traumatized migrants due to the incorporation of beliefs that mitigate and mediate trauma, such as religiosity and faith, community, familism and kinship networks, cultural conceptions of social control such as fatalism, and informal social networks as support systems.

Stress and trauma are mediated and interpreted through ethnicity and culture (Kim et al., 2014; Marsella, 2010). The dominant Western paradigm of trauma in general and PTSD in particular does not fully account for the many ways in which trauma and stress are experienced (Kira, 2010). We identify mediating effects among Hispanic caregivers who work with severely traumatized refugees to build supportive strategies for prevention of secondary trauma and effective methods of self-care.

Method

Methodologies of measuring, treating, and mitigating secondary trauma draw primarily from the work of Brian Bride and Charles Figley (2007, 2009). In this perspective, the authors emphasize the development of counterbalance to mitigate the harmful effects of repeated exposure to traumatized or toxic individuals. They stress the development of resilience through changes in the office and treatment environment, self-care, and the maintenance of professional boundaries. The means by which individuals can cope with repeated contact with traumatized persons is through building positive affect, self-monitoring, self-care, physical exercise, humor, and empathic discernment. These strategies have been validated empirically in studies of professionals who work with injured and traumatized people.

Our experience in the border region has identified other protective factors that promote resilience, which have their origin in Hispanic culture. Our work with refugees and survivors of torture, abduction, and severe injury has revealed that Hispanic migrants utilize cultural coping systems, including religiosity and faith, community, familism and kinship networks, cultural conceptions of social control such as fatalism, and informal social networks as support systems (Lusk et al., 2013; Lusk & Villalobos, 2012). The present project has evaluated how Mexican American cultural attributes act as protective factors in mitigating secondary trauma among caregivers. This is new and has not been investigated.

Participants

The 31 respondents in this study were professionals and para-professionals who work directly with refugees in various settings, including legal aid offices and counseling centers. The majority of the participants were Hispanic, 67.7%, and female, 77.4%. Over 70% of respondents were between 20 and 39 years old (age $M = 42.74$, $SD = 13.27$). All 31 respondents spoke fluent Spanish regardless of their ethnicity. Most respondents (67.4%) reported earning a bachelor's degree, and 32.3% hold a master's degree. Just over half (54.8%) of the respondents were born in El Paso with the remaining respondents being born in various parts of the United States and Mexico.

Research Design

This two-pronged study incorporated structured interviews and quantitative measures in the form of two self-administered measures to professional and para-professional caregivers who provide mental health and supportive services to refugees. Study participants were selected from 10 agencies that

serve affected populations, including migrant women marked by violence, children of migrants and refugees, victims of severe crimes perpetrated in Mexico, victims of torture, kidnapping survivors, and individuals who have been victims of human trafficking.

Persons eligible for inclusion were 18 years of age or older, residing in El Paso, and currently providing mental health or support services to migrants who have experienced severe trauma as defined above.

Measures

Participants were administered two scales: the Secondary Traumatic Stress Scale and the Professional Quality of Life Scale 5 (ProQOL). All interviews were conducted by the authors at a location chosen by the respondent. Interviews were transcribed verbatim, coded, and validated through consensus data.

The Secondary Traumatic Stress Scale (STSS) is a 17-item self-report measure that assesses three domains of traumatic stress associated with secondary exposure to trauma: intrusion, avoidance, and arousal. Internal consistency was found to be acceptable by generating the most common statistic coefficient alpha, which for the STSS and its subscales resulted in alpha levels for the STSS, $M = 29.49$, $SD = 10.76$, $\alpha = .93$; Intrusion, $M = 8.11$, $SD = 3.03$, $\alpha = .80$; Avoidance, $M = 12.49$, $SD = 5.0$, $\alpha = .87$; and Arousal, $M = 8.89$, $SD = 3.57$, $\alpha = .83$ (Bride et al., 2004). Bride et al. (2004) reported STSS alpha score of .93 among a sample of master-level social workers. The STSS over all scores range from 17 to 85, Intrusion 5 to 25, Avoidance 7 to 35, and Arousal 5 to 25. The following items are illustrative of the STSS: *Q 1. I felt emotionally numb*; *Q 4. I had trouble sleeping*; *Q 10. I thought about my work with clients when I didn't intend to*; and *Q 11. I had trouble concentrating.*

The ProQOL is a self-administered 30-item scale designed to measure professional quality of life. Stamm (2010) reported ProQOL alpha scores of .88. The ProQOL consists of three psychometrically unique subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue. It is a common measure of the positive and negative effects of working with people who have experienced trauma (Stamm, 2010). The following are representative items from the scale: *Q 3. I get satisfaction from being able to help people*; *Q 12. I like my work as a helper*; *Q 22. I believe I can make a difference through my work*; and *Q 24. I am happy that I chose to do this work.*

Results

An examination of each item of the STSS provides a rich view of how respondents experienced their work with refugees. More than 50% of the respondents

reported at least occasionally experiencing emotional numbness, trouble sleeping, intrusive thoughts, and being easily annoyed. All respondents reported thinking about their clients to some degree when they did not intend to, that is, intrusive thoughts. Most respondents (83.8%) reported having trouble sleeping and also reported having trouble concentrating (87.2%). An item analysis of the ProQOL found that 90% of the respondents reported that they gain satisfaction from helping people, such as their work as helper, and believed they make a difference through their work. All respondents reported being "proud" of the work they do, and 86% reported being "happy" they chose their line of work.

Cronbach's alpha statistic was computed to assess the reliability of the STSS and ProQOL for this study. We calculated Cronbach's alpha for the STSS as .946 and for the ProQOL as .805, which was consistent with alpha statistic found by Bride et al. (2004) and Stamm (2010). The mean scores for the STSS and its respective subscales were $M = 29.49$, $SD = 10.76$; Intrusion, $M = 8.11$, $SD = 3.03$; Avoidance, $M = 12.49$, $SD = 5.00$; and Arousal, $M = 8.89$, $SD = 3.57$. The Avoidance subscale mean score ($M = 14.84$, $SD = 6.41$) was the highest among the three subscales and 6 (19.4%; see Table 1). Approximately 30% of the respondents scored in the *severe* to *high* range on the STSS with the remaining respondents scoring in the moderate to no STS range (see Table 1). On the ProQOL, 61.3% of the respondents scored high in *compassion satisfaction* meaning that the majority of the respondents reported a high degree of professional satisfaction with their work and the ability to help others through their work (see Table 1).

We examined the existence of associations between the STSS, ProQOL, and specific variables that were conceptualized as exposure variables: weekly caseloads, years working with migrants, years living in El Paso, and hours per week working with migrants. Both parametric and non-parametric associations were generated after descriptive statistics were used to determine the normality of the distribution of each variable and measure. Spearman's rho was calculated, $r_s(31) = .405$, $p = .024$, between the ProQOL and exposure variables, and we found a positive association between the ProQOL subscale Compassion Satisfaction and years' experience working with migrants. The moderate positive association between these two variables means that respondents with more number of years' experience working with migrants had higher compassion satisfaction. Positive associations were found between the ProQOL subscale Compassion Satisfaction and years living in El Paso, $r(31) = 480$, $p = .001$, and hours per week working with migrants, $r(31) = .378$, $p = .036$. Compassion satisfaction is positively associated with living in El Paso and hours working with refugees.

This suggests that respondents who resided in El Paso and who had some connection with the region and were exposed to reports of torture and the

Table 1. STSS and ProQOL Severity Categories (n = 31).

STSS frequency	Severe		High		Moderate		Mild		No STS	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
	6	19.4	3	9.7	6	19.4	8	25.8	8	25.8

ProQOL frequency	Compassion satisfaction		Burnout		Secondary traumatic stress	
	n	%	*n*	%	*n*	%
Low	0	0.0	18	58.1	14	45.2
Average	12	38.7	13	41.9	17	54.8
High	19	61.3	0	0.0	0	0.0

Note. STSS = Secondary Traumatic Stress Scale; ProQOL = Professional Quality of Life Scale; STS = Secondary Traumatic Stress.

narratives of trauma from refugees and migrants also reported their work with these groups as positive and rewarding. While respondents report symptoms of secondary traumatic stress, they also tended to report satisfaction with their work and believe their work to be meaningful.

Qualitative Findings

Caregivers who work with refugees and migrants are compassionate people. All of the respondents spoke with concern and empathy about their encounters. It was clear that they were drawn to the work and felt fulfilled by the nature of the challenges they face as professionals and volunteers. Each of the respondents was eager to share his or her stories about the work of helping people who had fled their country. None seemed cynical or uncaring.

That being said, it was clear to us that to work with the refugee population is daunting. None of the participants were unaffected by their encounters with migrants. They all thought that the situation of the people with whom they worked was difficult at the least, and even overwhelming and tragic for many.

Exposure to traumatized clients. A common theme in the interviews was that participants were shocked, saddened, and often horrified by the stories that their clients told them. This is completely understandable given the testimonies of their clients. Asked to recount the most challenging or difficult case, no story was tame or conventional.

One pregnant client who had been trafficked recounted being beaten until she aborted. Another account was about two unaccompanied minors who, prior to being taken into custody by U.S. immigration authorities, had been raped on

their journey northward. One child reported that he had witnessed his father and uncle being murdered by the infamous *Mara Salvatrucha* gang in Honduras before he fled. A Guatemalan boy in U.S. custody was not able to reunite with his parents because they claimed he had raped his sister. Another unaccompanied minor had been forced by the cartel to kill his best friend; this led him to flee the gang and travel to the United States. A boy lost his sister who had fallen off the northbound train in Mexico. The train decapitated her. One girl had been sold to clients for "favors" including food. A woman was scalped by her partner and told that if she reported him, he would have her deported.

A refugee had been present when her father was shot in the head and was so close that the blood splattered on her face. A woman was deported after her partner reported her for sexual abuse of their child when he was the one who sexually abused the minor. After a mother from Guerrero Mexico refused to be a drug mule, her husband, daughter, and 2-year-old grandchild were murdered so she crossed the border through the Arizona desert. She remains in detention.

Workers heard such cases on an ongoing basis. These examples are not outliers. Refugees' recounted stories of rape, abduction, murder, kidnapping, forced separation from family, torture, extortion, and the "disappearance" of family members.

Adverse reactions to vicarious exposure to trauma. Not unexpectedly, participants who work with refugees reported adverse reactions such as sleeplessness, nightmares, crying, trouble concentrating, arousal, avoidance, numbing, intrusive thoughts, and emotional distancing. All said that the stories made them "sad." Several reported that they were "horrified." One respondent told of her distress at hearing a refugee recount how they had killed her brother by "putting him through a meat grinder."

"The violence is pretty visceral. You are wading in it 6 feet deep. You are just swimming in it," reported one young volunteer at a shelter for refugees.

Respondents agreed that it was "stressful" to have heard such things. Some were "angry" that this could happen to people. They often noted that it was "upsetting" that so few people in the United States seem to care about the refugees and said it was "unfair," making them "frustrated."

> It makes me feel sad that humanity treats them so unfairly because they are brown. The racism upsets me.

A shelter/sanctuary worker said,

> I am literally the first person to hear what happened to them. I think that's really challenging and hearing their stories and knowing that they probably won't get

> immigration relief or the help they need in this country. I think that those two things together are pretty devastating.

Several felt "frustrated" or "helpless" by their inability to change the situation for clients. In many cases, participants became more "guarded" and placed more "distance" between themselves and the clients. They reported that it was necessary to "shut down" their responses, to erect a "wall" between them and the client.

Nearly half said they felt "burned out" from the stress and repeated interactions with individuals who had experienced such hardship. While almost all of the respondents noted strong support from supervisors, they did say that there were few resources at their disposal for self-care, and the pressures of the job were sometimes overwhelming and often isolating.

> I don't think anybody understands what I do, my work with refugees, nor do they really want to know.

Positive reactions to vicarious trauma. It is very important to report that many participants also had positive reactions to their exposure to traumatized clients. Respondents indicated that they were "impressed" by clients because of what they saw as their "strength," "resiliency," and their "courage." One said, "They are incredibly strong and amazing." It was "rewarding" to see how well clients coped with adversity. Many commented on the "hope" and "faith" of clients. "They succeed through the adversity."

"I have learned a lot from the migrants and refugees, just seeing their resilience and their willingness to work hard and take care of their family." "These horrible stories, yet I am so impressed by the clients, completely impressed that they are turning this into an opportunity." "They are so down on their luck, yet they have this great faith; it gives me so much hope."

The sense of hope and inspiration that respondents had to their work is indicative of compassion satisfaction, an attribute of the workers that reflects their resilience and enrichment from the pleasure they take in their work (Stamm, 2010). Over 60% of the participants reported compassion satisfaction.

Coping strategies and self-care. Recognizing that there was secondary traumatic stress and burnout among personnel who work with refugees, we were eager to determine how they managed that stress through self-care. Charles Figley and others have documented that many types of helping professionals lack adequate self-care when dealing with traumatized clients and patients (Boellinghaus, Jones, & Hutton, 2014; Figley, 2002; Ling, Hunter, & Maple, 2014). In order to combat depression, sleep disturbances, intrusive thoughts,

fatigue, detachment, loss of hope, and other symptoms of secondary traumatic stress, clinicians have used meditation, exercise, therapy, journaling, prayer, yoga, and other self-care strategies. Participants in our study were no exception.

Over half used exercise as a method of coping with STSS, including running, bicycling, walking, yoga, Zumba, working out at the gym, and stretching. Others choose less active ways to manage stress including listening to music, meditating, praying, cooking, journaling, reading, and listening to music. *All* of the participants said that their family and friends were important resources for self-care by sharing, venting, or spending quiet time together. None of the participants reported using alcohol or drugs as a strategy for coping or relaxation.

Cultural resilience. Resilience, as defined as resistance to the effects of exposure to trauma, is not just an individual's capacity to overcome challenges but is the capacity of a person's "informal and formal social networks to facilitate positive development under stress" (Ungar, 2013, p. 255). It is a function of an individual's social ecology and culture. The ability of individuals to effectively manage high stress is tied to their sense of belonging, social bonding, social support, ethnic identification, and connection to their culture (Naoshi, Marsiglia, Parsai, & Castro, 2011; Ungar, 2013). The difference between flourishing and languishing in the face of adversity is tied to the degree of grounding one has in a social support system, including their ethnic culture.

Caregiving has a special place in Latino culture (Evans, Coon, & Belyea, 2014). For example, it is seen as a duty and obligation to care for family members and the elderly. The role of caregiving is so important in Latino tradition that it is culturally inappropriate to describe caregiving as a "burden," so it is often referred to as "worry" (Evans et al., 2014). It is also closely tied to religiosity, which can be seen as a protective factor that promotes resilience (Rehm, 1999).

When we studied refugees from Mexico, we were initially surprised by the resilience of the migrants as they adapted to a new culture and overcame the traumatic experiences that had led them to flee their home country (Lusk et al., 2013). So it came as no surprise to us to have seen similar resilience and strengths among Hispanic caregivers who work with refugees. As we have noted, in contrast to being depressed, traumatized, and burned out, study participants reported high degrees of compassion satisfaction, excellent self-care management skills, hope, optimism, and strong connections to family and community. Respondents repeatedly referred to the support they receive from their extended family system and identified the importance of family among Hispanics as a strong protective feature. In addition, respondents

alluded to faith, community, spirituality, ethnic identity, tradition, and group orientation as factors in their culture that sustain and protect them. In contrast, the *Anglo*[2] participants reported more compassion fatigue, stress, burnout, depression, and lack of connection.

An older therapist noted, "I'm working with the people of my culture and I think that Mexican culture is very group oriented and very family oriented. Also I think there is a healthy outlook on death; it is not taboo." A young man who works with unaccompanied minors said, "My Hispanic culture is welcoming, accepting and supportive." Another notes, "As Hispanics, we are always trying to help somebody out, lending a hand. My parents were migrants, so now I am trying to help the children out." "It makes me think of being Hispanic and when I've experienced racism. I am saying that we, the Hispanics, tend to empathize." "I can relate to the clients because I come from them; they are my people."

A common theme was connection to family and faith: "I'm of Mexican descent. Our culture is family oriented. I know that as long as you have family, you have everything. Work hard and your family backs you." "Hispanic culture is family oriented; you are not judged." "In my Hispanic roots, we use prayer, family and tradition." "I believe I have a very strong sense of cultural identity. I'm very well embedded within my roots. I've been brought up knowing about my culture, growing up with cultural events, knowing about yourself, where you came from." "I am a cultural Catholic. As a Latina, it is as much a culture as it is a religion. It is comforting and my family, with its strong family unity . . . I can go to them with anything or just sit with them without saying anything."

When asked whether their culture sustained them, Anglo participants did not perceive that it did. "That's hard . . . because my culture is the guilty party," said one young border volunteer. Another concurred, "I feel more removed from White culture or U.S. culture, even averse to it." Similarly, "I am part of the dominant culture and I do not find my identity in it." Indeed, opposition to dominant culture was a theme among the Anglos. One highly educated volunteer offered,

> I am not a part of the suburban culture that I came from. I am definitely part of the progressive activist culture. Elie Wiesel said, "Neutrality helps the oppressor, never the oppressed." I translate that for the suburban culture I came out of to neutrality.

Another volunteer at the same agency said, "My culture is White suburban culture and I think that is the problem. My culture goes against what I do. I am now part of missional culture—serving and loving other people. That's

the source of meaning and success." Many of the Anglo participants had found new meaning in the work with refugees that they did not find in their culture, while Hispanics seemed to be more grounded by their culture and able to confront the injustices they witnessed within their cultural base.

Discussion

Participants had to address the challenge of coping with traumatized clients. They reported being saddened, shocked, and frustrated by the perilous situation of refugees. Many experienced secondary traumatic stress. Notwithstanding, participants demonstrated compassion satisfaction, hope, and optimism. Several reported that they had experienced emotional numbing as a consequence of confronting ghastly stories on a frequent basis, but this is quite understandable and perhaps even adaptive considering the horrors that were recounted to them. They also reported increased compassion for the refugees and were consistently impressed by the observed resiliency of the migrants.

We noted that culture was a protective factor for Hispanic participants who with unanimity reported on the importance of the extended family network as a refuge and source of strength. They also noted that their traditions as Latinos were protective specifically acknowledging ethnic identity, holidays, language, customs, and church as sources of strength and comfort.

More than half of the respondents scored in the mild to no STS range, suggesting that many respondents have the capacity to cope with high levels of secondary exposure to trauma. Respondents in this study were more likely to avoid thoughts, feelings, or discussion about traumatic events. This avoidant behavior may explain how half of the respondents did not present with STS because they were able to modulate their exposure to traumatic content.

Program directors and supervisors should take note of the consequences of working within a context filled with trauma and be prepared to be responsive to the needs of their staff. Respondents in the study reported at least occasionally having trouble sleeping (58%), having intrusive thoughts (77.5%), and having trouble concentrating (51.7%). Conversely, most respondents scored in the average or low range of the Burnout subscale of the ProQOL. Many (81%) reported that they felt "support" from their supervisors; however, based on an examination of specific items of the STSS, it appears that they would benefit from specific supervision strategies or a program structure that would reduce the effects of their exposure to clients who have experienced serve trauma.

Both parametric and non-parametric statistics were used to examine the associations between the STSS and ProQOL with exposure variables. The compassion satisfaction dimension of the ProQOL was found to be moderately positively associated to the number of years respondents worked with migrants.

While exposure to traumatic content by professionals and para-professionals may increase secondary trauma, it also is a factor in their perceived job satisfaction. This may indicate a protective factor that mitigates the negative symptoms of STS. Job satisfaction also points to a positive work climate and culture that may include a work culture that is supportive enough to help professionals and para-professional cope with their extremely difficult work.

Compassion satisfaction was positively associated with the number of hours working with migrants. A Pearson's *r* statistic was generated that found a moderate association with hours worked and the compassion dimension of the ProQOL. This suggests that the more time respondents spent at work, the more satisfied they were. Many of the respondents spoke of the importance of their work and the inspiration they received from clients who persevere in the face of immense hardships and often-horrific experiences. This humbling and inspirational facet of their work may be at the center of why respondents who were more exposed to traumatic content as part of their job also had higher satisfaction with their work.

Implications

Secondary traumatic stress, left unaddressed, can be costly to the agency and harmful to the individuals they serve. Secondary stress is characterized by excessive blaming, bottled up emotions, and social isolation. It is a negative feeling driven by fear, anxiety, and work-related trauma. Professionals and para-professionals who report experiencing secondary traumatic stress may voice excessive complaints and have reoccurring nightmares or flashbacks of traumatic events. Some report chronic physical ailments, gastrointestinal problems, or recurrent colds. It is not uncommon to experience apathy and dysphoria. Secondary trauma can also result in poor concentration and fatigue. Yet, it is important to acknowledge that secondary traumatic stress can coexist with compassion satisfaction. Participants in this study were able to persevere through the adversity of their clients and engage in positive self-care. They also used their cultural and family systems to sustain them. Being Hispanic may be a protective factor in working with traumatized migrants due to the incorporation of beliefs that mitigate and mediate trauma, such as religiosity and faith, community, familism and kinship networks, cultural conceptions of social control such as fatalism, and informal social networks as support systems.

Assessing the prevalence of secondary stress among caregivers is an important first step to resolving the issue, both on a personal level with individual providers and on a more systematic level with area agencies. The implementation of steps to minimize or alleviate secondary stress in the community can ensure quality care is provided to many of our most vulnerable populations.

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Notes

1. For purposes of this research, we define refugees as individuals who flee their country out of fear for their lives or to escape serious violence and/or criminal victimization without regard to their formal governmental immigration status.
2. *Anglo* is the term widely used in the border Southwest for non-Hispanic Whites.

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