



RESEARCH ARTICLES

More to Learn From Adverse Childhood Experiences: Secondary Traumatic Stress Among Mental Health Professionals

Erica Lacey, Ph.D., M.A., M.S.W.¹

¹ Clinical Mental Health Counseling, Le Moyne College

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Secondary traumatic stress (STS) is a known occupational hazard for mental health professionals (MHPs), leading to impaired clinical functioning and diminished empathy. Personal trauma history, particularly adverse childhood experiences (ACEs), has been proposed as a risk factor, but findings remain mixed and rarely examined with updated measures. This cross-sectional study surveyed 214 MHPs in the United States. Analyses included descriptive statistics, Pearson correlations, independent-samples *t*-tests, ANOVA, and hierarchical regression to examine associations between ACEs and STS and test whether years of professional experience moderated this relationship. Results indicated that 92% of MHPs reported at least one ACE, 53% reported ≥ 4 ACEs, 95% endorsed at least one STS symptom, and 77% scored above the clinical cutoff ($M = 48.44$, $SD = 14.07$). ACE scores were positively associated with STS ($r(214) = .20$, $p = .003$), and those with ≥ 4 ACEs reported significantly higher STS than those with fewer ACEs, consistent with a dose–response trend. Regression analyses revealed a significant ACE $\times$ Experience interaction ($B = -0.06$, $p = .004$): ACEs strongly predicted STS among early-career clinicians (0–10 years; $R^2 = .16$) but not among mid- or late-career clinicians. Findings highlight the need for trauma-informed supervision, early-career supports, and systemic workforce protections.

Introduction/Background

Secondary traumatic stress (STS) refers to symptoms of intrusion, avoidance, negative cognitions and mood, and hyperarousal that result from indirect trauma exposure within professional roles (Bride, 2013). For mental health professionals (MHPs) such as peer specialists, case managers, and counselors, STS is a known occupational hazard. STS may manifest as misdiagnosis, diminished empathy, blurred therapeutic boundaries, poor job satisfaction, and low productivity (Caringi et al., 2017; Hensel et al., 2015; Leung et al., 2023; Rayner et al., 2020). In recognition of this risk, the DSM-5 expanded posttraumatic stress disorder (PTSD) criteria to include “repeated or extreme exposure to aversive details of the traumatic event(s)” (Criterion A4), with psychotherapists explicitly named in the DSM-5-TR under diagnostic features (APA, 2013, 2022).

While organizational and caseload factors predict STS, emerging research highlights the role of personal trauma history (Cieslak et al., 2013; Leung et al., 2023). Adverse childhood experiences (ACEs), namely childhood abuse, neglect, and household dysfunction, are related to leading causes of death, maladaptive coping behaviors, and stress reactivity (Felitti et al., 1998). Among MHPs, ACEs may increase vulnerability to STS by activating unresolved emotional responses or blurring professional boundaries (Figley, 2002). Recent studies suggest that MHPs report a higher average ACE score ($M = 2.71$) than the general population ($M = 1.61$). Approximately 83% of MHPs endorsed at least one ACE, compared to 52–61% of the general population (La Mott & Martin, 2019; Merrick et al., 2018). These findings align with “wounded healer” models, which propose that individuals with adversity histories may be drawn to helping professions (Cruciani et al., 2024).

Despite consistent evidence of elevated ACE scores among MHPs, findings on the ACE score–STS relationship remain mixed. Some studies have demonstrated positive associations between trauma history and STS among psychology trainees and other specialized service providers (Corbett-Hone & Johnson, 2022; Makadia et al., 2017), with reported correlations ranging from $r = .09$ to $.37$. Other studies, however, found no significant relationship, particularly in the context of disaster response or national samples (Creamer & Liddle, 2005; Devilly et al., 2009). These discrepancies may reflect differences in measurement tools, conceptualizations of STS, or the role of post-traumatic growth (Brown et al., 2022; Hensel et al., 2015; Leung et al., 2023).

Building on “wounded healer” models (Cruciani et al., 2024), early-career MHPs may be particularly vulnerable, as limited professional coping strategies, less supervision experience, and demanding caseloads amplify the impact of ACEs on stress responses. The present study sought to (a) examine the relationship between ACEs and STS among MHPs using the ACE-Questionnaire and updated STSS-DSM-5 and (b) explore whether years of professional experience moderated this association.

Methodology

Participants and Recruitment

Eligible participants were adults in the United States enrolled in or graduated from a master’s or doctoral program in mental health who were providing direct clinical services (e.g., counseling, case management) at the time of participation. A study description and Qualtrics survey link were distributed via social media, community mental health agencies, and higher education programs identified via accreditation websites (e.g., CACREP). An a priori power analysis ($\alpha = .05$, medium effect size for $R^2 = .09$, power = .80) indicated a minimum required sample size of 82 (Cohen, 1988; Faul et al., 2009).

Measures

Demographics. Participants reported age range, racial and ethnic identity, gender identity, education level, discipline, primary practice setting, years of direct service, and licensure status using Census Bureau-aligned categories with write-in options when applicable.

Adverse Childhood Experiences. Personal trauma history was assessed with the 10-item ACE-Q, which captures abuse, neglect, and household dysfunction prior to age 18 (Felitti et al., 1998). Items were coded yes (1) or no (0), with “unsure” and “prefer not to say” treated as non-endorsements. Scores were summed to produce a total ACE score, with the established cutoff of ≥ 4 ACEs indicating elevated risk (Steen et al., 2020). Missing responses were coded as 0, consistent with ACE-Q scoring conventions (George & Mallery, 2024).

Secondary Traumatic Stress. STS symptoms were measured using the STSS-DSM-5 (Bride, 2013), a 21-item self-report measure reflecting DSM-5 PTSD clusters (intrusion, avoidance, negative alterations in cognition/mood, and arousal/reactivity). Items were rated on a 5-point Likert scale (1 = never to 5 = very often) referencing the past week. Consistent with prior research, a total score ≥ 38 was used to indicate elevated STS. While cutoff interpretations for STSS-DSM-5 scores are not yet standardized, the threshold of ≥ 38 has been used in prior studies and is applied here as a provisional indicator of elevated STS symptoms. Item 5 (“I felt discouraged about the future”) was excluded from DSM-5-aligned scoring due to misalignment with updated PTSD criteria but retained for DSM-IV comparisons.

Data Analysis

All analyses were conducted using IBM SPSS Statistics Version 29. Data were first screened for accuracy, missingness, and conformity with assumptions of parametric testing.

Descriptive statistics summarized sample demographics and item-level responses. Internal consistency of the ACE-Q and STSS-DSM-5 was evaluated with Cronbach’s alpha, and normality of total and subscale scores was examined using Shapiro–Wilk tests.

Primary analyses proceeded in three stages. Pearson correlation coefficients were used to examine associations between ACE and STS scores. Group comparisons were conducted with independent-samples *t*-tests to compare STS scores between MHPs with 0–3 ACEs and those with 4 or more ACEs, consistent with the established ACE threshold. A one-way analysis of variance (ANOVA) further compared mean STS scores across three categories (0, 1–3, and 4+ ACEs) to evaluate potential dose–response trends across increasing ACE exposure. Hierarchical regression analysis was conducted to test whether years of professional experience moderated the relationship between ACEs and STS. Years of experience were recoded into midpoints of

reported ranges and entered alongside ACE scores and the interaction term (ACE $\times$ Experience). Significant interactions were probed with simple slope analyses to estimate the effect of ACEs at early-, mid-, and late-career stages.

Finally, regression assumptions were evaluated. Heteroscedasticity was tested using the Breusch–Pagan procedure, and multicollinearity was assessed using variance inflation factors (VIFs), with values ≤ 10 considered acceptable.

Results

Of 291 respondents, 214 MHPs met the inclusion criteria. Shapiro–Wilk tests suggested minor deviations from normality across ACE and STS totals and subscales (all $p < .05$). Given the large sample size and approximately bell-shaped distributions, parametric analyses were deemed appropriate.

The sample was predominantly White or European (84%), non-Hispanic or Latinx (92%) women (85%) aged 25–34 (43%). Most MHPs held a master's degree (73%) in social work (47%), were independently licensed (55%), and practiced primarily in private settings (34%). One-third (33%) reported one to three years of professional experience.

Reliability analyses indicated acceptable internal consistency for the ACE-Q ($\alpha = .70$) given the sample size and dichotomous items (George & Mallery, 2024). Across the sample, 92% ($n = 197$) reported at least one ACE, and 53% ($n = 114$) reported four or more ACEs ($M = 3.76$, $SD = 2.28$). The STSS-DSM-5 demonstrated excellent internal consistency ($\alpha = .92$). Nearly all participants (95%; $n = 203$) endorsed at least one STS symptom in the past week, with 77% ($n = 165$) scoring above the clinical cutoff of 38 ($M = 48.44$, $SD = 14.07$). Across demographic categories, MHPs ages 18–24 ($M = 56.61$) and those working in crisis centers ($M = 55.60$) reported the highest average STS scores.

Pearson correlation analysis revealed a small but statistically significant positive association between ACE scores and STS scores, $r(214) = .20$, $p = .003$. When ACEs were dichotomized at the established clinical threshold, participants with an ACE score of 4 or more ($M = 51.38$, $SD = 15.27$) reported significantly higher STS scores than those with 0–3 ACEs ($M = 45.10$, $SD = 11.77$), $t(\approx 200) = -3.39$, $p < .001$. An ANOVA using three groups consistent with literature (0 ACEs, 1–3 ACEs, 4+ ACEs) demonstrated a clear dose–response trend, $F(2, 211) = 7.88$, $p < .001$.

A regression model including ACEs, years of professional experience, and their interaction was significant, $F(3, 218) = 7.71$, $p < .001$, explaining ~10% of the variance in STS ($R^2 = .096$). Most notably, regression analyses revealed a significant ACE $\times$ Experience interaction ($B = -0.06$, $p = .004$), indicating that ACEs strongly predicted STS among early-career clinicians (0–10 years; $B = 1.16$, $p < .001$, $R^2 = .16$), but the association weakened and became nonsignificant for mid- and late-career clinicians.

Tests indicated no evidence of heteroscedasticity (Breusch–Pagan $p = .62$), and variance inflation factors were below 10, suggesting multicollinearity was not a concern, despite expected inflation from the interaction term.

Discussion

A comprehensive search of fourteen databases yielded no prior research examining the relationship between ACEs and STS among MHPs using the ACE-Q and the STSS-DSM-5. This study contributes new insights through three key findings.

A statistically significant but small positive correlation was found between ACE and STS scores ($r(214) = .20, p = .003$). Regression analysis demonstrated a modest association ($\beta = 1.04, p < .05$), with ACEs explaining a limited proportion of variance in STS ($R^2 = .032$). These results suggest that while personal trauma history contributes to vulnerability for STS, it is not the sole determinant. Importantly, the finding that MHPs with 4+ ACEs reported significantly higher STS than those with fewer ACEs, alongside a clear dose–response pattern across categories, strengthens the evidence for ACEs as a meaningful risk factor. The use of updated instruments also marks a methodological shift in this line of research, aligning STS assessment with DSM-5 diagnostic criteria.

Both ACEs and STS were highly prevalent. Ninety-two percent of participants reported at least one ACE, and more than half (53%) reported four or more. Similarly, nearly all participants (95%) endorsed at least one STS symptom in the past week, and 77% scored above the clinical cutoff of 38. These rates surpass estimates for both the general population (Felitti et al., 1998; Merrick et al., 2018) and prior studies of MHPs (e.g., Bride, 2007, ~15% above cutoff), suggesting that trauma histories and secondary traumatic responses may be especially widespread in today's workforce. Possible explanations include increased exposure to trauma, systemic workplace stressors, or greater recognition and reporting of symptoms in contemporary contexts. Subgroup trends also warrant note: early-career clinicians, younger adults, and crisis-center workers reported particularly elevated STS scores, underscoring the importance of both developmental timing and practice setting.

Professional experience moderated the ACE–STS relationship. ACEs predicted STS among early-career clinicians (0–10 years), accounting for 16% of variance, but the association weakened and was nonsignificant for mid- and late-career professionals. Independently licensed clinicians reported lower STS despite comparable ACE scores, suggesting that greater autonomy, coping strategies, and professional development may buffer risk over time. Alternatively, clinicians most vulnerable to the combined effects of personal and occupational trauma may leave the field prematurely. This finding highlights the importance of developmental timing: preventive efforts may be most impactful when implemented during training and the early years of practice.

Together, these findings extend prior work linking personal trauma exposure to professional stress responses (e.g., Hensel et al., 2015; Makadia et al., 2017; Rayner et al., 2020). The elevated prevalence of STS compared

to early studies may reflect methodological advances, rising awareness, or worsening systemic pressures, including those exacerbated by the COVID-19 pandemic.

Limitations

While the current study provides valuable insights into the relationship between ACEs and STS among MHPs, three primary limitations need to be acknowledged. The cross-sectional design precludes causal inference, highlighting the need for longitudinal research.

The STSS-DSM-5 remains unpublished, with no publicly available scoring ranges or interpretation guidance. The lack of psychometric validation constrains interpretability, cutoff scores, and comparisons to other studies. These challenges limit the clinical utility of STS scores; however, the decision to use this measure was deliberate. At the time of data collection, no fully validated tool both assessed STS and incorporated current PTSD criteria. Alternative instruments, including the original 2004 STSS (Bride et al., 2004) the Professional Quality of

Life Scale (ProQOL; Stamm, 2009), and the Impact of Event Scale–Revised (IES-R; Weiss & Marmar, 1997), were considered but ultimately not selected because they either predated DSM-5 revisions, measured broader constructs such as compassion fatigue, or were not specific to STS. Consequently, study findings should be viewed as preliminary and hypothesis-generating, warranting replication with validated measures as they become available.

The sample's demographic homogeneity of predominantly White, non-Hispanic women further limits generalizability. This lack of representation overlooks the experiences of underrepresented groups and is especially important given documented racial, ethnic, and gender differences in trauma exposure and professional stress. Future research should prioritize recruitment strategies that enhance diversity, such as partnering with minority-serving professional associations, employing purposive oversampling, and offering participation incentives in underrepresented communities.

Additionally, most MHPs in this sample primarily practiced in private practice settings. The autonomous nature of private practice affords MHPs greater discretion in selecting the clients they serve and the presenting problems they address. Such volition may reduce exposure to more acute, severe, or frequent trauma. By contrast, MHPs in public or community centers such as crisis centers, hospitals, or child protection agencies are more likely to work with populations facing more frequent and intense STS. Future research should examine the role of practice setting as both a potential risk and protective factor.

Implications

Despite these limitations, this study reinforces the need to view STS through an integrated lens—one that considers both personal trauma histories and occupational risk factors. Although this study focused on mental health professionals, the findings highlight actionable strategies for multiple stakeholders, social workers, case managers, and allied health staff in human services settings, who face similar risks of occupational secondary trauma.

Training Programs and Field Educators

Graduate programs should incorporate developmentally responsive support for trainees and early-career clinicians, particularly those with high ACE scores. This includes structured reflective supervision, reduced trauma caseload intensity during practicum and internships, and explicit integration of STS content into coursework on evidence-based practices. Routine self-assessment for ACEs and STS, paired with guided reflection, can help students develop awareness of personal risk factors. Field educators should adopt trauma-informed placement policies that account for both client needs and trainee histories to safeguard student wellness and clinical effectiveness.

Program directors should consider designating indirect training hours for self-of-the-therapist work, allowing students structured space to reflect on their histories and wellness practices in the context of clinical training.

Agencies and Policymakers

Workplaces and professional organizations play a critical role in mitigating STS at a systemic level. Agencies should establish caseload caps, particularly for clinicians working with high-trauma populations. Structured debriefing sessions, peer consultation groups, and flextime scheduling can help reduce cumulative stress. Leaders should be trained in STS awareness, organizational implementation, and workforce risk assessment to build trauma-informed systems. Policy bodies might consider mandating continuing education on STS, similar to existing ethics requirements in states like New York.

Organizations should encourage employees to use their paid time off rather than rely on buy-out options, as consistent rest and recovery time are protective against STS. They should also establish workplace self-care groups and structured peer consultation opportunities to normalize discussion of STS. Leadership must prioritize both the physical and psychological safety of staff by addressing environmental risks and fostering a safe workplace culture. Access to Employee Assistance Programs (EAPs) and partnerships with external providers who specialize in STS interventions can strengthen organizational safety nets.

In addition, agencies should conduct ongoing assessments of staff risk and resilience using validated tools, and organizational leaders—including non-clinical staff—should be trained in trauma-informed workplace practices. Leaders should be held accountable for implementing and evaluating STS mitigation policies to ensure that strategies are sustained and effective.

Individual MHPs

MHPs can engage in workplace peer check-ins, ongoing training on risk reduction, and personalized wellness plans. Actionable strategies include building intentional transitional rituals to separate work from personal life—for instance, turning off devices and work notifications, changing clothes after the workday, and limiting evening screen time to allow for rest and recovery. MHPs should also set clear boundaries, make consistent use of paid time off, and consider participation in external wellness programs or professional partnerships to buffer against stress. Early-career MHPs may require more structured accountability systems—such as enhanced supervision or self-care buddy programs—to reduce vulnerability during this formative stage of their careers.

Future research would benefit from more diverse samples across race, ethnicity, geography, and gender identity to enhance external validity. Using an expanded or weighted ACE measure and including mitigating factors such as positive childhood experiences, social supports, and resilience may help capture nuanced trauma histories. Longitudinal or mixed-methods designs could clarify temporal relationships and provide richer insight into lived experiences. Focused studies on high-risk groups, such as clinical supervisors and counselor educators, may also illuminate the compounded stressors and professional dispositions associated with their dual roles.

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Appendix A. Permitted STSS-DSM-5 Use

Permission is granted.

Please take a close look at the scoring instructions for the version you have. There are 21 items, but only 20 should be included in a summated score based on DSM5 criteria. You would want to drop the foreshortened future item.

Brian

Brian E. Bride, Ph.D., M.S.W., M.P.H.
Distinguished University Professor
School of Social Work
Andrew Young School of Policy Studies
Georgia State University
Atlanta, GA