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Upfront

Stopping the Spread of Trauma: How organizations can protect their frontline providers from psychic distress

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Stopping the Spread of Trauma

How organizations can protect their frontline providers from psychic distress

Treating Iraq War veterans feels different from treating Vietnam War veterans, says Victoria Beckner, a psychologist who studies post-traumatic stress disorder (PTSD) at the San Francisco Veterans Affairs Medical Center and the University of California, San Francisco. Many Vietnam War veterans are haunted by memories of killing an enemy in hand-to-hand combat. Their therapists, in turn, also feel "the horror of almost losing one's own life, plus the pain of taking someone else's," she says.

Many Iraq War veterans, in comparison, can't shake the feeling of being constantly imperiled. "Therapists sometimes walk away from them with that eerie, anxious feeling that nowhere is safe," she says.

For a surprising number of caregivers, these disturbing secondhand feelings bloom into full-blown PTSD, reports Brian E. Bride in the January 2007 issue of *Social Work*. Bride, a professor at the University of Georgia's School of Social Work, estimates how many social workers currently have secondary traumatic stress syndrome (STSS) – a set of symptoms, almost identical to those of PTSD, that people may experience after close contact with traumatized people, including survivors of war, childhood abuse, domestic violence, violent crime, and natural disasters.

"All I expected to find was that some people were having symptoms," Bride says. "I did not expect that more than 15 percent have PTSD."

Working with trauma survivors, as Bob Bahr does with Iraq veteran Melissa Stockwell, can cause caregivers to develop traumatic stress symptoms themselves.

The 17 symptoms of both STSS and PTSD fall into three core categories: intrusion, which is the unbidden recall of the traumatizing event, such as in dreams and flashbacks; avoidance of the people, places, things, thoughts, or feelings that remind the victim of the trauma; and arousal, which includes anxiety, trouble sleeping, angry outbursts, and difficulty concentrating.

Using a mailed survey, Bride asked 282 master's-level social workers to what extent they had suffered from these symptoms over the past week in response to their jobs. He discovered that 15.2 percent of the social workers – more than twice the general population – qualified for the American Psychiatric Association's diagnosis of PTSD. He also found that a full 70 percent had at least one symptom.

Unfortunately, secondary trauma directly interferes with caregivers' ability to help trauma survivors, says Bride. To avoid thinking about clients' traumas, caregivers may write incomplete notes, miss appointments, not ask questions about upsetting details, or simply zone out during sessions. "A number of social workers talk about realizing that they have not heard the last five minutes of their session because they were going over their grocery list," rather than reliving an unpleasant event, says Bride.

Yet the most effective treatments for PTSD, says Beckner, require clients to talk repeatedly about traumatic episodes. By retelling their trauma stories, people desensitize themselves to their emotional impact. If caregivers don't help clients do that, "the client isn't going to get over the trauma," says Bride.

Bride concludes that secondary trauma is therefore "an occupational hazard" for social workers and other people who work with trauma survivors. "They will experience this no matter their strength or what they do to take care of themselves," he says.

Nevertheless, "in some organizations, people pathologize the workers, saying that it's an issue of them being lazy or not cut out for the job," Bride says. This is especially true in many

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state child welfare systems, he notes, where many of the employees and even supervisors are not trained to recognize or deal with secondary trauma. Ironically, state welfare workers have the highest caseloads, made up of the most disturbing instances of child abuse and neglect.

Organizations that are serious about helping workers heal when they "catch" trauma from their clients should first educate themselves about secondary traumatic stress, says Bride. "I recommend assigning required reading to everyone in any organization that deals with trauma survivors," agrees Beckner.

Beckner and Bride also agree that organizations should offer support to people who begin suffering from secondary trauma symptoms. Beckner suggests setting up a weekly support group at which caregivers can talk about what they're experiencing. Bride adds that a clinical supervisor – as opposed to an administrative supervisor who is overseeing paperwork and caseloads – should attend these meetings or meet individually with workers to monitor whether anyone is experiencing secondary trauma. "People who experience secondary trauma think there is something wrong with them or that there will be retribution," he says, and so may be loath to admit that they are suffering from traumatic stress symptoms. When supervisors do detect that workers are carrying too much of their clients' burdens, they can give them direction about how to heal.

Sometimes healing means taking a break from talking about trauma, says Beckner. She recently returned from co-teaching a course on PTSD treatments at the National University of Rwanda, where most of her students were survivors of that nation's genocide. Because these counselors are already contending with their own psychic wounds, "we don't want them to be bombarded with other people's traumas. And so we teach them techniques that don't involve talking about trauma," she says. These techniques, such as methods for managing anxiety, help people cope with PTSD. –*A.C.*