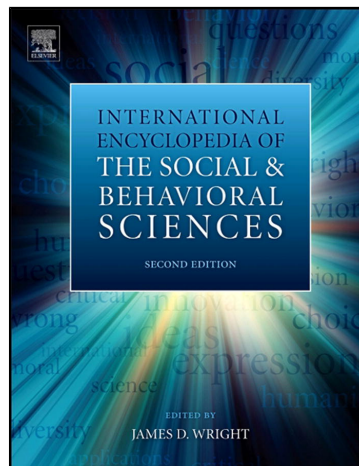


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## Post-Traumatic Stress in Social Work

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### Abstract

Over 60% of all individuals around the world have been exposed to traumatic events. Responses to those events range from pathological symptoms and vulnerability to healthy responses, hardiness, and resilience. These responses derive from individual, family, community, and social resources, as well as from the ability of individuals to cope with the events, and to work through the consequences of their exposure. This article relates to the role of social workers before, during, and after traumatic events. A brief definition and description of the main responses to these situations is provided, followed by a discussion of social workers' approaches and strategies of intervention. Implications for educational and professional training, the cost of care, and for practice are also discussed.

### Introduction

Over 60% of all individuals around the world have been exposed to traumatic events such as violence, abuse, terror, civil and political wars, racial strife, human trafficking, forced migration, human immunodeficiency virus/acquired immunodeficiency syndrome, and technological and natural disasters. Traumatic events are private, public, or international, and they significantly affect individuals, families, groups, and communities in a variety of contexts such as the war in Croatia (1991–95), the London bombings (2005), the September 11 terrorist attack (2001), and the Israeli-Palestinian conflict. In addition, many traumatic events have occurred in civilian environments. For example, in the United States there have been the shootings at Virginia Tech University (2007), at a movie theater in Dallas (2012), and at an elementary school in Connecticut (2012). Traumatic events also result from natural disasters such as Hurricane Katrina in New Orleans (2005), the Tsunami in Asia (2004), and the earthquake in Haiti (2010).

In recent years, there has been increasing recognition that individual differences in responses to traumatic events cover a broad spectrum, ranging from pathological to healthy responses and from short-term to long-term responses. They also include the ability to cope, recover, and work through these events, as well as to identify risk and protective factors. Finally, numerous transpersonal factors can contribute to or detract from healthy functioning in the aftermath of such events. These factors combine person-centered variables (e.g., disposition and personality) with sociocontextual variables (e.g., family interaction and community support systems) and risk and protective factors.

These understandings have led to a shift from a medical approach, which focuses on traumatic responses, to a psychosocial approach, which is based on the results of theoretical and empirical research evidence indicating that individual responses to traumatic events are affected by one's subjective perspective of the event. This approach is well known as stress theory (Lazarus and Folkman, 1984). It has also been argued that responses to traumatic events are the result of personal and social resources that enable people to cope with the aftermath of those events, as coined in the Conservation of Resources (COR) theory (Hobfoll et al., 1995).

In addition to the increasing rate of traumatic events, the above understandings have been heightened by the growing identification of social workers with the field of trauma and their need to face unprecedented challenges in responding effectively to their clients' trauma-related experiences. Therefore, this article will relate to the role of social workers before, during, and after traumatic events that result from civil and national traumas as well as from natural disasters. Following a brief definition and description of the main responses, social workers' approaches and methods of intervention in situations of trauma will be discussed. The article will conclude with a critical reflection on the uniqueness of being a social worker dealing with traumatic events in today's world, which is full of violence.

### The Ramifications of Trauma

Two seemingly opposing notions relate to the negative ramifications of trauma on the one hand, and positive responses in the immediate and long-term period after traumatic events on the other. The current understanding is that the responses to a potentially traumatic event fall within a spectrum ranging from pathological to salutogenic (healthy) responses, and from vulnerability to resilience on the other.

### Pathological Responses

The first notion, which is most prevalent, is based on the assumption that trauma has a pathogenic effect. Traumatic events jeopardize physical and psychological equilibrium, and give rise to a wide range of physical and mental health complications. There is extensive empirical research evidence in support of this view, which has documented increased rates of posttraumatic stress disorder (PTSD), depression, anxiety, somatization, and alcoholism following traumatic events (Dohrenwend et al., 2006). PTSD is one of the most substantial long-term psychopathological sequelae of such distress. Its symptoms can be grouped into three main clusters. The first consists of persistent reexperiencing of the traumatic event, such as recurrent dreams and flashbacks. The second is persistent avoidance of internal or external cues, such as avoiding

thoughts and activities associated with the trauma, diminished interest, detachment, restricted affect, and sense of foreshortened future. Finally, increased arousal is manifested in difficulty sleeping, irritability, difficulty concentrating, hypervigilance, and exaggerated startle responses (American Psychiatric Association, 1994). The core symptoms of PTSD (intrusive images and thoughts, avoidance, and arousal) severely impair day-to-day functioning, and have a significant negative impact on one's intrapersonal and social life. Although over 90% of the exposed population shows acute stress responses immediately after traumatic events, the majority successfully returns to normal routines, and cope remarkably well. Only 5–11% of these individuals have long-term distress effects, and have been diagnosed with PTSD (Bonanno and Mancini, 2012). Although most of the existing literature on trauma and posttraumatic stress focuses on the effects of trauma on the primary survivor, i.e., the person who directly experienced the traumatic event, direct exposure to trauma not only jeopardizes a person's own physical and mental health, but also undermines that person's familial, occupational, and social functioning (Solomon, 1993).

### Salutogenic Responses

An alternative perspective proposes that trauma has a salutogenic effect, and that survivors may gain psychological benefits. According to this perspective, which is in line with positive psychology theory, individuals can develop a positive outlook and further experience positive psychological changes in the wake of traumatic events. The commonly held concept of posttraumatic growth (PTG, Tedeschi and Calhoun, 1996) proposes that individuals transform in new ways that go beyond their pretrauma level of psychological functioning. PTG is described as the subjective experience of positive psychological change reported by an individual as a result of coping with trauma. PTG relates to a variety of positive psychological changes, including increased appreciation of life, setting of new life priorities, a sense of increased personal strength, identification of new life possibilities, improved closeness in intimate relationships, appreciation of life, and/or positive spiritual change.

Without underrating the pathogenic impact of trauma, there is growing research evidence of PTG reported by survivors following various physical and psychological traumas. Such outcomes have been documented following a variety of traumatic events, including natural disasters, war, and terror (for a review, see Linley and Joseph, 2004).

### Continuing with the Routine and Resiliency

Despite these emotional reactions, many people tend to maintain their usual routines. Several theorists have used the term resilience in reference to the ability to overcome, to recover, and even to cope well with extreme stressors (Bonanno et al., 2011).

The capacity for resilience has been defined as "the ability of human being in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event,

such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning" (Bonanno, 2004: p. 20). Ungar (2008), using a broader psychosocial perspective, defines resilience as "The capacity of individuals to navigate their way to resources that sustain well-being; the capacity of individuals' physical and social ecologies to provide those resources; and the capacity of individuals, their families and communities to negotiate culturally meaningful ways for resources to be shared" (p. 225).

Ungar's definition highlights the importance of considering the broad systems surrounding the individual, such as family, community, nation, and state, as factors that explain the ability to cope with exposure to traumatic events and the society's role in times of crisis (Breckenridge and James, 2010).

This current and broader definition of resilience is in line with stress theory, which focuses on how individuals perceive traumatic events (Lazarus and Folkman, 1984), and with COR theory (Hobfoll, 1989), which is based on the idea that both the availability of resources and the change in resources that often results from highly disruptive events play a crucial role in human adaptability to extreme stress. These resources are economic and material resources (e.g., income and income loss), energy resources (e.g., the availability of health insurance, of money and knowledge), interpersonal resources (e.g., positive and negative interpersonal support, availability of affinity groups), and work resources (e.g., gainful employment or loss of employment).

This concept is also consistent with the 'person-in-environment' approach, which is a prevalent approach in social work, and supports the idea that it is important to interweave social and environmental resources while working with service users (Hare, 2004). Based on this perspective, the social work profession seeks to augment the ability of individuals, families, and communities to solve their problems and realize their potential (Breckenridge and James, 2010).

### Trauma and Social Work

In social work, trauma is often defined and subsumed within its impact on microlevel fields of practice such as child protection, family violence, military social work, and social and interpersonal violence. These definitions present social work education with the conceptual and philosophical challenge of aligning concepts of trauma with notions of strength, recovery, and resilience.

Historically, there is a plethora of literature substantiating the importance of responding to individuals who have experienced trauma. More recently, however, there is evidence of a growing recognition emanating from both the disciplinary and interdisciplinary literature regarding the effects of traumatic events on communities (including nations) as well as the importance of community responses to promote well-being and healing among traumatized individuals. Moreover, individuals and communities themselves are more aware of the potential effects of trauma on health and well-being, thus creating a consumer-led demand for appropriate services. In addition, in the mid-twentieth century, social work journals began publishing articles using the crisis intervention framework and

promulgating specialized training of social workers in agencies that work with clients in crises (NASW, 2008).

Simultaneously, social workers have been trained to work with clients experiencing both acute and chronic stress, to intervene before and during crises, and to implement prevention and postintervention services. These services include individual, family, and group interventions aimed at helping trauma victims achieve 'reasonable mastery' and caring relationships after a traumatic event. In addition, today social workers routinely work in the global arena with people who have experienced multiple traumas. As a result, it is essential for social workers and all human service providers to have an understanding of trauma and the range of its possible effects in order to provide effective, multifaceted intervention in health and welfare contexts.

Moreover, in line with its mission, social work aims to promote social justice and well-being for all people, particularly those who are vulnerable, oppressed, marginalized, and live in poverty. The majority of clients that social workers encounter have experienced numerous and diverse traumatic experiences. As a result, trauma intervention has been incorporated as part of the concepts and values of social work. Within this, the Person in Environment (PIE) approach has been used as a basis for training and for intervention with individuals, families, communities, and societies that have experienced trauma (Joseph and Murphy, 2013). Cultural, ethnic, racial, and other socioeconomic differences have been addressed in an attempt to create policies that strengthen people who need to cope with traumatic events, to reduce conflicts and inequity, and to promote reconciliation and social justice.

In this context, social workers and professionals from other disciplines have been increasingly engaging in forms of 'multifaceted intervention,' which both encompass and depart from traditional approaches that focus primarily on individuals. Notably, these more comprehensive responses promote the integration of community development approaches with psychosocial interventions.

Not surprisingly, the use of combined or multifaceted responses has found increasing support in a number of trauma-related fields, including work with refugees, interventions in disaster-affected communities, and interventions in schools affected by youth suicide and violence, as well as interventions with victims of sexual and physical violence. The rapid development of research-informed practice that has occurred in the field of trauma presents a new and immediate challenge for educators: to prepare students and professionals to provide informed multifaceted interventions in their future practice.

### Diversity of Client Populations

Besides providing first aid to trauma victims, the first obligation of social workers is to populations served by various social service agencies. These populations include people with physical and mental disabilities, and children and adolescents at risk living in residential out-of-home settings, as well as young people with learning disabilities, older persons in institutional and community settings (state, municipal, and private), and prisoners. These populations are defined as disadvantaged,

excluded, and even invisible, and have been referred to as the 'first recipients of assistance' (Lobley, 2007).

The basic assumption is that as results of social structural problems, these populations are at high risk for developing pathological responses following exposure to traumatic events. They have limited environmental and personal resources at their disposal at times of crisis, because they usually rely on assistance from social workers in routine situations. Accordingly, social workers have to help make decisions, such as those regarding the need to evacuate people from danger zones during natural (e.g., hurricane or flooding) or (hu)man-made disasters (e.g., war and terror attacks) and the need to give them access to psychosocial assistance as well as provide life-saving medications, food, water, shelter, and clothing. In addition, social workers provide psychological and emotional assistance to help them cope with danger, exposure to threat, and the consequences of such situations.

The 'second recipients of assistance' refers to populations that are known to social services but are not in active contact with a helping professional at the time of the traumatic event. In this context, social workers have to evaluate the extent to which these individuals and their families need assistance following the traumatic event. It is important to examine whether they require assistance due to the new situation that has arisen, what individual and family support systems are available to them, and what role the community they live in can play in helping them. In emergency situations, social workers have to actively initiate assistance, because they are supposed to have the information about individuals and communities that have been exposed to traumatic event.

The 'third recipients of assistance' refers to the community at large, the region, or the state/nation. In this context, social workers need to make constant, long-term help available in accordance with the nature and scope of the event. Assistance provided at this level includes intervention in acute stress situations as well as identification, mediation, and cooperating with key figures from various disciplines and helping the community return to a daily routine. In addition, before being exposed to the traumatic event, social workers need to initiate policies that facilitate their implementation in situations of crisis and trauma by influencing processes of decision making and policy making. In addition, they need to train the system of psychosocial services before the event so that the procedures for working with the population will be clear. These procedures should be based on pooling community, environmental, and national resources. Moreover, it is no less important to base the procedures on strengthening the community and promoting its resilience during and after the events. In so doing, social workers not only need to be concerned with bringing the community back to a normal routine in terms of physical, social, and emotional functioning and with self-care but also need to worry about themselves. The last circle relates to the trauma workers themselves including social workers as direct and indirect exposure to the traumatic events (see STR subsection below).

### Types of Interventions

Social workers deal with trauma among individuals, families, groups, communities, and policy makers while focusing on

interventions aimed at prevention, therapy, and return to routine. For example, they analyze the differences between supportive counseling interventions and interventions that aim to process trauma and reduce symptoms of distress. In relation to the community, social workers highlight the importance of local and informal social and support networks, as well as the role of public acknowledgment of traumatization. Given the nature of their role, they focus mainly on minorities and subculture populations, and deal with the trauma at the levels of ambiguous loss (of country, culture, and place) and real loss (e.g., Atkinson, 2006).

Traditionally, social workers engage in individual direct practice, which is based on a variety of psychological approaches such as crisis intervention, first aid, and narrative therapy. Recently, there has been a shift to behavioral and cognitive therapy techniques such as critical incident stress debriefing, cognitive behavioral therapy, prolonged exposure, and eye movement desensitization and reprocessing (e.g., Lee and Drummond, 2008), and trauma and stress management, which have been found to be more effective than traditional psychodynamic ways of intervention (e.g., Foa et al., 2000). In addition, family child therapy has become more common as a result of the acknowledgment that there is a relationship between parental responses to traumatic events and the responses of children, babies, young people, and adolescents. In the same vein, child-parent therapy that focuses on a behavioral approach has become common (e.g., Fredman et al., 2011).

In light of the increasing prevalence of traumatic events, which have affected a wide range of populations, group intervention methods have become very popular. These interventions range from debriefing groups and short-term interventions to open groups, long-term interventions, and self-help groups. Through the groups, trauma victims can share their stories with their partners or with others who have experienced similar situations (see also Weinberg et al., 2005).

Recently, as part of the strengths-based approach, the multidisciplinary perspective of mindfulness and creative therapy has become more common as a way in which the community/social network facilitates healing and recovery among individuals. In addition, social workers can help individuals and communities engage in social action or legal reform efforts aimed at increasing awareness and exercising rights to security in their unstable situation before or after the traumatic events.

Finally, global issues are illuminated when vulnerable populations in different parts of the world experience natural or technological disasters. In those situations, social workers tend to engage in disaster and crisis management in contexts such as refugee camps, which require cultural sensitivity and relativity (Gray, 1996).

### The Trauma Helpers – Secondary Traumatization, Vicarious Traumatization, and Compassion Fatigue

It has been recognized that a traumatic event may also have far-reaching consequences for significant others, especially for family members. A wide range of emotional symptoms has been identified among family members of Holocaust survivors,

children of combat soldiers, and therapists working with victims of violence (Dekel and Monson, 2010). The ramifications of working with trauma survivors have been described through a variety of well-known concepts, including vicarious traumatization (Pearlman and MacLan, 1995), compassion fatigue (Figley, 1995), secondary traumatic stress (Stamm, 2002), and burnout (Maslach and Leiter, 1997). Specifically, Figley (1995) proposed the term 'compassion fatigue' to describe the long-term cumulative stress resulting from the 'cost of caring.' He articulated a comprehensive description of the cognitive, emotional, behavioral, spiritual, and somatic symptoms that can manifest themselves in compassion fatigue, as well as ways in which it can negatively influence one's personal relations and work performance. Secondary traumatic stress, by contrast, can occur suddenly and is directly related to the client's experience of trauma rather than to cumulative professional stress per se. Secondary trauma symptoms are akin to those of posttraumatic stress, and involve anxiety, depression, avoidance, and hyperarousal. These symptoms are in response to the client's trauma narrative, and the clinician's reaction may mirror that of the client. Highly empathic and neophyte clinicians are more prone to develop secondary traumatic stress than are seasoned mental health professionals. Vicarious trauma, like secondary traumatic stress, occurs in the context of work with trauma survivors. Unlike secondary traumatic stress, however, it is not considered a pathological process. Rather, emphasis is on the cognitive and emotional transformations that occur as a result of empathic engagement with trauma survivors. As with secondary traumatic stress, these changes are most pronounced among highly empathic and neophyte therapists as well as among clinicians with a previous trauma history. These changes take place in the totality of the therapist's life. They interfere with the therapist's feelings, cognitive schemata, memories, self-esteem, and/or sense of safety, and they include permanent alterations in one's self-concept and worldview. Vicarious trauma is a unique, albeit common consequence of trauma work, and it does not reflect psychopathology in either the therapist or the survivor client (Pearlman and Saakvitne, 1995).

### Shared Traumatic Reality

In the wake of the recent increase in acts of terror and natural disasters, both the clinical and research literature have focused more attention on the problems that arise in a situation where both the social worker and the client are exposed to a similar threat, and on the implications of such exposure for the helping professions.

This situation, which has been referred to as *shared (traumatic) reality* (STR), is defined as the affective, behavioral, cognitive, spiritual, and multimodal responses that clinicians experience as a result of exposure to the same collective trauma as their clients. Like vicarious traumatization, these reactions have the potential to cause permanent alterations in the clinician's existing mental schema and worldview. However, in contrast to vicarious traumatization, the primary experience of shared trauma causes therapists to become potentially more susceptible to posttraumatic stress, as well as to blurring of professional and personal boundaries, and to increased

self-disclosure. Shared trauma symptoms are attributed to the dual nature of the exposure. Findings indicate that under these circumstances, therapists feel that their ability to help is impaired, and they experience heightened work-related stress as a result of greater demands on their professional time, the sense that they are professionally unprepared for the situation, and loss of boundaries between their personal and professional selves (Cronin et al., 2007; Tosone et al., 2012).

### The Other Side of the Coin – ‘Vicarious Resilience’

Parallel to the PTG process, Hernandez et al. (2007) have also discussed a relatively new concept referred to as ‘vicarious resilience’ (VR). This concept provides a basis for considering how the stories of trauma survivors may also sustain and empower workers, and is congruent with many of the strengths-based approaches to practice. VR offers a counterbalance to the negative effects of trauma work on therapists. This concept suggests that if the therapists are open to and aware of the possibility and utility of VR, their ability to reframe negative events and coping skills may be enhanced through work with trauma survivors. Research findings have also shown that therapists who succeed in finding new methods of intervention that help both their clients and themselves have reported an increased sense of competence (Bauwens and Tosone, 2010). A supportive environment and a part-time position can also enhance their ability to develop VR in their work with disadvantaged and traumatized populations and in STR situations (Stevenson et al., 2011).

### Models of Training for Intervention in Situations of Stress and Trauma

Considering how the experiences of trauma pervade social work practice, there is a growing body of literature on models that have been employed in trauma education. The most common one is the classic model, a theoretical course on the nature and effects of trauma, which provides an essential foundation for helping professionals and students to understand the context in which they operate (Cunningham, 2003). In addition, training workshops that emphasize practical skills have also been developed (Fournier, 2002). Besides providing theoretical knowledge and skills in respect to stress situations, trauma, and PTSD, the workshops also elicit active participation to create a suitable learning environment and fashion the group as an educational-experiential space, which is very common in the social work education process. A third model often used in training social work supervisors places emphasis on creating a supportive group space that aims to help social workers manage stress successfully and reestablish and enhance their confidence in their professional and personal capabilities (Cwikel et al., 1993). This model is of particular value in a shared traumatic reality, where it is essential to combine client-focused training and work with the care providers themselves, who have been exposed to the same anxiety and insecurity.

As a rule, these models have all been employed with professionals. However, studies conducted among students of

social work have revealed that the students are especially vulnerable due to lack of suitable training and insufficient knowledge (Cunningham, 2003). Moreover, the students have not yet acquired and internalized stable theoretical foundations for their work, nor have they developed a clear understanding of the meaning of secondary traumatization or adequate coping strategies. In addition, students have been found to display a tendency for isolation, scapegoating, and interpersonal distance (Cunningham, 2004). Thus, social workers as supervisors need to address the issues raised by students and prevent the development of isolation and feelings of being neglected. The social workers need to keep in mind their important role in supporting students, to help them implement emotional self-regulation, offer a containing and holding environment, and legitimate concerns about being less effective while they themselves are exposed to a threat.

Another relevant issue is coping with trauma in a traumatized society, particularly against the background of national conflict and threats to security. This situation also impacts on the dynamic processes that typify helping relationships, as well as on study and supervision groups. As a result, efforts have been made to develop a global curriculum for social work in the context of social and political traumatic events and conflict, and to incorporate this content in professional core knowledge (Duffy et al., 2013).

### Summary and Conclusion

Although social work and other disciplines share universal aspects of understanding and responding to the needs of trauma survivors, the perspective of social work is unique, in that it reflects the values of the profession and emphasizes two aspects. First, social work focuses on understanding the development, functioning, challenges, and needs of people and social systems in situations of trauma from a relational viewpoint and within the context of their environments (e.g., immediate and extended family relationships and cultural, social, racial, ethnic, and religious/spiritual affiliation). Second, social work views people and systems through a holistic, multidimensional lens, which addresses individuals, families, groups, and communities from a perspective that recognizes strengths, resilience, and the ability to cope and thrive in addition to challenges, difficulties, and pathologies (Berger, 2012).

In many cases, social workers serve as ‘first-aid helpers’ who provide assistance immediately after traumatic events, in addition to providing long-term assistance that is similar to the help provided by other professionals. The multidisciplinary approach to trauma is expressed in training provided at social work schools as well as in the establishment of professional organizations and accreditation. The Council on Social Work Education, for example, has recently published a manual for social workers on work in situations of trauma. In addition, there are studies that have highlighted the complexity and difficulty of social work with clients who have experienced traumatic events, including research reports on the implications of working in a shared reality.

Nonetheless, the question arises: How do social workers respond to the unique challenges of their profession, which

combines interventions ranging from prevention and policy making to short- and long-term interventions that focus not only on the microlevel but also on the macrolevel, as well as on promoting growth, strengths, and resilience? Another question is whether the methods and levels of interventions implemented by social workers are consistent with evidence-based practice and cultural sensitivity, and whether they meet the demands of the complex reality preceding traumatic events, and especially following those events. Research findings have shown that more efforts need to be invested in training social workers and providing them with methods for working with clients who have lived through loss, extreme stress, and trauma when they have been exposed to the same traumatic events as those clients.

To conclude, in line with the residual concept of social work, the contribution of trauma intervention by social workers is as follows:

1. *Incorporating the PIE approach before, during, and after the event:* Emphasis should be placed on prevention, provision of responses, returning to a routine, and even creating and promoting sustainability.
2. *Seeing the person and environment as a whole:* Incorporating the positive and strengths-based approaches that have been found to be effective in promoting healing, recovery, health, and well-being as a result of the fact that the majority of the population is resilient and can cope successfully with the traumatic events. As such, the chances of recovery also depend on individuals and their social resources, identity, sense of belonging, and sense of support.
3. *Incorporating culturally sensitive concepts* in the intervention methods used by social workers while responding to traumatic events and providing suitable assistance to minorities, different cultural subgroups, and others.
4. *Implementing interventions at all levels* such as working with policy makers, communities, families, and individuals. This will also help social workers devote time to working with populations at risk and advocating for those who have been referred to as 'invisible populations.'

In the light of the above, future effort is needed to implement evidence-based practice, as well as to expand existing knowledge and update this with biomedical and alternative perspectives. Toward this end, there is a need to incorporate relevant cultural, biological, and historical dimensions of trauma. In addition, social workers in the field of trauma need to address global processes. It is important for social workers to be trained in dealing with international traumas and the social effects of those traumas (e.g., forced relocation and displacement). This work should be based on antioppressive and postcolonial approaches (Marlowe and Adamson, 2011).

**See also:** Psychosocial Work; Social Work Theories.

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