COMMENTARY

In Their Words: Secondary Traumatic Stress in Social Workers Responding to the 9/11 Terrorist Attacks in New York City

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The terrorist attacks of September 11, 2001, traumatized the nation and produced serious mental health issues for many residents of New York City. Social workers and others in the mental health community in the city rallied to help those in need. However, the impact of their exposure to others' pain and suffering and consequent secondary traumatic stress (STS) must be realized.

As a researcher and consultant, I have had since 2003 the opportunity to interview close to 50 social workers involved in the 9/11 recovery effort and provide training in managing 9/11 STS for more than 150 more. The levels of STS encountered were alarming and exacerbated by the lack of supervision and support available to the social workers during the majority of their 9/11-related work. Working with clients who had 9/11-related issues was complex. It is important to keep in mind the unique nature of this attack. The social workers had been exposed to the same disaster as their clients. For many, hearing the clients' stories interacted with the clinicians' own stress levels and concerns about the terrorist attacks, heightening the resultant STS reaction beyond the simple additive effects of the two factors taken alone (Pulido, 2005). Such factors make it important to study STS among 9/11 social workers.

OVERVIEW OF STS

People may manifest symptoms of posttraumatic stress disorder through secondhand exposure to the trauma histories of others (Figley, 1995a). Such cases include Holocaust survivors and their children (Danieli, 1985); intimates of rape victims (Kelly, 1988); and mental health professionals who work with trauma survivors (Figley, 1995b; Stamm, Varra, Pearlman, & Giller, 2002).

An independent body of literature generated from the field of traumatology has emphasized the potential for harm to therapists who specialize in trauma therapy (Figley, 1995a, 1995b; Pearlman & MacIan, 1995). Therapists are exposed to the stressors and psychic pain experienced by their clients and also carry the professional burden of being expected to remain open and available to their clients on an emotional level. It is this empathic involvement that sets the stage for the potentially deleterious effects of therapy to affect the professional (Wilson & Raphael, 1993).

Figley (1995a) defined *STS* as the natural consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other or from helping or wanting to help a traumatized person. In the process of learning about the traumatic material of the client and trying to understand and identify with the experience, the therapist may actually experience emotions and other symptoms similar to those of the victim. Dutton and Rubinstein (1995) categorized STS reactions or symptoms in three areas: (1) indicators of psychological distress or dysfunction, (2) changes in cognitive schema, and (3) relational disturbances.

Individual, organizational, social, community, and traumatic event factors may potentially either increase or decrease one's vulnerability to STS (Beaton & Murphy, 1995). Disaster mental health counselors may be at particularly high risk of STS, as they can be in an unfamiliar, sometimes dangerous setting and have to deal with an overwhelming number of clients and crises issues. STS is expected to be higher in disasters that are low in predictability and high in destruction and duration of impact, as was 9/11. The fact that 9/11 was a deliberate and intentional act may also heighten the potential for STS (Creamer & Liddle, 2005).

WORKING WITH 9/11 CLIENTS

The social workers' experiences differed on the basis of the type of 9/11 client. Some were dealing

directly with family members who had lost loved ones, others dealt with people who fled the burning towers, and others worked with individuals considered "indirectly" exposed, but who were still fearful and symptomatic. Helping families through the ordeal of body part identification, procuring DNA samples, planning memorials or funerals without the family members' remains, and mass bereavement were some of the issues that faced the clinicians. For the majority, the types of problems encountered with clients were new territory. Most were not trained in disaster mental health counseling and did not have prior experience handling the horrific types of problems their clients brought to sessions. "This was a whole new set of issues. What do you say to someone who says to you, 'I was trapped on the 50th floor and was able to escape, but all my colleagues died'?"

STS IMPACT ON THE CLINICIAN

Intrusive, avoidant, and hyperarousal symptoms were reported by the social workers. They reported that as they continued to help clients with 9/11-related issues, their stories became more painful to hear. They most often reported that it was difficult to listen to clients describing their fear and trauma when they were "not much further down that road to recovery" themselves. They described feeling angry and irritable, both during and after the sessions. Others found processing the events of 9/11 with clients extremely distressing and often wept after sessions. Handling children's distress seemed exceptionally provocative, causing anguish for clinicians. They described how they internalized the pain and suffering of their clients who had lost loved ones in the attack. Social workers also reported that they felt as if they were re-experiencing the trauma of 9/11 when their clients discussed their own stories. They also reported experiencing flashbacks of their clients' stories. Other intrusive symptoms varied, from olfactory smells bringing back thoughts of 9/11 to blue skies causing an eerie feeling as if "something is going to happen." One social worker stated, "It's not going to go away. To me, 9/11, it's like a scar that doesn't heal. To this day, I can't stop thinking about it."

The avoidant symptoms reported most often were denial or still feeling "numb" about the event. Social workers stated that they "still could not believe that the attacks occurred." Many still avoided the World Trade Center area. Hyperarousal symptoms seemed to occur most often in relation to transportation and safety issues. In particular, traveling on the subway system, over bridges, or on planes still caused levels of distress.

Social workers expressed that they "could not do enough" for their clients and had anxiety about how they were "failing" them when the services they could provide did not meet their clients' needs. Others cited feeling angry because even though they had the time to devote to their clients, what they could do for them was just not enough. Physical and mental exhaustion were reported as the days stretched to months.

STS DURATION

Many social workers reported that their emotions and symptoms were "held in check" until most of their disaster relief work was completed. They "didn't allow themselves to feel" until one or two years had passed. At that time, they reported experiencing STS symptoms. Others commented that they were still numb almost three years later.

CLINICAL SUPPORT FOR THE SOCIAL WORKERS

It appears that there was an uneven pattern of organizational and professional support for social workers. Surprisingly, for a field that prides itself on and stresses the importance of supervision, individual clinical supervision availability was described as "weak" among those interviewed. Several clinicians sought out their own professional support systems. They found it very helpful to meet with peers and colleagues to discuss case situations and to help them recognize and deal with the STS symptoms they experienced.

IMPLICATIONS FOR PRACTICE

A set of recommendations is offered for social workers providing disaster mental health services, especially those exposed simultaneously to the disaster. First, it is important for mental health professionals and those involved in their training to recognize the impact of this work on individuals. Organizational, professional, and personal measures to prevent and alleviate STS should be implemented by the mental health field. Adequate supervision and support must be provided for clinicians in disaster mental health. Debriefings, supervision, training, and peer support have been shown to be effective methods to ameliorate stress symptoms from traumatic events

and hasten recovery (Catherall, 1999). The clinicians who received these services reported that they were a benefit and helped them reduce their stress levels.

Second, agency administrators should attend training on managing and preventing STS and take appropriate organizational action to boost support for their clinical staff. A greater recognition and understanding of STS risks involved in treating traumatized clients may also engender a supportive milieu for clinicians to use therapeutic support for themselves.

Third, social workers expressed a desire for a central repository of training information readily accessible for response to future terrorist disasters. This repository should include information on dealing with client reactions, therapeutic interventions, and referral sources.

Fourth, a varied caseload and monitoring the time that a clinician spends at the disaster site, or working with disaster victims, may also be helpful to offset STS reactions.

Fifth, follow-up care for social workers once their work ends must be considered a priority and integrated into the overall framework of disaster recovery plans. Many began to experience STS reactions 30 months after the attacks, unfortunately, when their contracts to provide services ended. Unemployed, they were left to deal with their reactions on their own. These clinicians need a forum to both express their emotions and be recognized for their heroic efforts with the mental health recovery effort. This programming should include an overview of STS, why disaster recovery clinicians experience STS, a self-assessment scale, and the organizational, professional, and personal interventions that can be put in place to prevent and manage STS, an unavoidable, but manageable, aspect of disaster trauma recovery work. **SW**

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