NASW Ohio Chapter – 2015 Conference

“Shock, Secondary Traumatic Stress and Vicarious Resilience in Social Worker First Responders”

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In a Daily Post on the *Psychotherapy Networker* website, dated August 22, 2014, Bessel van der Kolk discusses *Easing Trauma’s Lingering Shock* in an interview with Ryan Howes. We intend in this presentation to explore in some detail the nature of that “lingering shock”, especially in the lives of first responders.
Abstract: We review research on Secondary Traumatic Stress and Vicarious Resilience as it relates to first responders, including social workers in many work settings. We introduce the concept of shock as a primary physiological symptom of traumatic stress, and as a primary treatment to enhance vicarious resilience and promote trauma stewardship.
Learning objectives:

• Understand the debilitating presence of shock in the nervous system, and its primary forms.

• Recognize the symptoms of Secondary Traumatic Stress, its three primary forms, and three techniques of containing it.

• Appreciate the potential for Vicarious Resilience in first responders’ work, and behavior patterns that promote it.
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Social workers in many work settings are in fact themselves first responders subject to debilitating Secondary Traumatic Stress . . .

also called

vicarious trauma, compassion fatigue, burnout, or in the extreme PTSD, ‘Post Traumatic Shock Response’

Being a first responding caregiver does not exempt us from being vulnerable to human stress.
One study has shown that 15 percent of social workers engaged in direct practice report Secondary Traumatic Stress symptoms at a level that meets the diagnostic criteria for PTSD.

(Bride, 2007)
Burnout and its common signs and symptoms

Burnout is a common term expressed by professionals to basically communicate, “I’ve had it! I can’t do this anymore!” The definition of burnout is, “An imbalance between the psychological resources of the professional and the demands being made on their physical and emotional resources.”
Secondary traumatic stress is an occupational hazard of providing direct services to traumatized populations.

Secondary traumatic stress is “the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person.” (Charles Figley)
Another definition of **Secondary traumatic stress**: a negative transformation of the helper’s inner experience, resulting from empathic engagement with clients’ and coworkers’ trauma material which we call the *contagion of shock*.

The stress is exacerbated by regulation, insurmountable restrictions, and being held accountable for behaviors of clients.
Symptoms of secondary traumatic stress have been documented in professionals working in a variety of fields, including substance abuse, ambulance personnel, mental health, nursing, domestic violence, health care, child protective services, sexual assault services, social work, military, and mental health care.
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Symptoms that mirror the PTSD or depression experienced by traumatized clients:

- PTSD (nightmares, intrusive traumatic images)
- Depression (e.g., hopelessness, generalized despair)
- Loss of a sense of personal safety and control
- Feelings of overwhelm
- Loss of ability to trust other people and institutions
- Inability to empathize with others
- Social withdrawal
- Disconnection from loved ones
- Cynicism

(Stamm & Figley, 2009)
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Symptoms of secondary traumatic stress (Post Traumatic Shock Response) include:

- Absenteeism, searching for a new career
- Substance abuse
- Intrusive thoughts, easily distracted
- Difficulty sleeping
- Avoidance or conflict in relationships
- Losing your feeling of empathy
- Feeling sleepy, eyes closing, can’t stay present
- Arriving to work or sessions late and leaving early
- Forgetting important, routine tasks
- Losing patience with victims or other co-workers
Discover your own level of Secondary Traumatic Stress.

The Secondary Traumatic Stress Scale
(Bride, Robinson, Yegidis, & Figley, 2004)
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First responders are highly susceptible every day to exposure to stressful or traumatic incidents that will affect their own mental health, and they are often overlooked in terms of needing or receiving treatment.

The first responders as well as their colleagues are often in denial about the reality of the threat and about the need to attend to it.
The two main categories of countertransference reactions for clinicians:

1. Type I associated with avoidance and detachment (withdrawal or repression) which we associate with *parasympathetic* over-activation

2. Type II associated with an active over-identification (enmeshment) which we associate with *sympathetic* over-activation

(Wilson & Lindy, 1994)
Problematic countertransference reactions:
• somatic reactions such as sleep disturbance;
• intense emotional reactions including depression, confusion, fear, anxiety, or rage;
• becoming over-identified with or detached from the client;
• intolerance of working with non-traumatized clients, viewing their problems as insignificant by comparison;
• preoccupied with thoughts about those they have tried but failed to help;
• loss of appropriate boundaries
In the face of extreme stress or a traumatic event, some people begin to feel numb and almost like they are walking around in a bubble. They may not be able to remember the details of the stressful event and may feel like they have entered into a dream state: an over activation of the parasympathetic branch of the nervous system which we call parasympathetic shock.

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Others move into over activation of the sympathetic branch and frantically search for solutions, talking and thinking like a rapid firing gun. They become like the proverbial chicken with its head cut off. We refer to this pattern as sympathetic shock.

Most people respond to a highly stressful situation by cycling back and forth between these two states of shock.
Shock is the habituated state of the autonomic nervous system when it is out of homeostasis, that is when either the sympathetic or parasympathetic branch is perpetually over activated, or when they cycle uncontrollably.

Shock is the *residue of trauma* in the autonomic nervous system, accumulated over time when stress has not been dissipated or released.
Sympathetic shock is the body stuck in fight or flight mode, unable to dissipate the physiological sympathetic response and return to the pre-trauma normal (homeostasis). Behaviors attributed to sympathetic shock include:

- Hypervigilance – overly concerned with safety
- Agitation or anxiety
- Sleep disruption
- Perseverating and intrusive thoughts
- Incessant activity (work-a-holism)
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Parasympathetic shock is the body stuck in

- freeze mode - inability to react productively
- withdrawn - disinterested in social interactions
- dissociated - unable to access or release feelings
- Exhausted - too tired for self-care
- depressed – medicating with SSRIs or recreational drugs which freeze the shock in the body
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- **Sympathetic shock** can be activated by taking on more responsibility than clients for solving *their* problems.

- **Parasympathetic shock** can be activated by becoming overwhelmed by the responsibilities.
When first responders are faced with traumatic situations on a daily basis with no relief in sight, their stress levels build as an adaptive preparation to deal with the situation. This provides a useful *protective mechanism* that allows us to be able to be in the presence of trauma. *So far so good.*

Only when the stress is prolonged or becomes chronic does it become shock, which is dangerously debilitating because it is an unconscious influence on our behavior.
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When is Shock Beneficial?
Going into shock during a traumatic event can actually be very helpful, even lifesaving.

• accident victims
• sexual abuse survivors
• children in domestic violence homes

The Problem is Not going into shock . . .
Rather, the Problem is Not coming out of shock.
Well-known trauma specialist Peter Levine equates the lack of recovery from the freeze, or immobility response with retention of the stored and undissipated energy of the interrupted fight/flight response. This sustained state of sympathetic arousal serves as the drive for the symptoms of trauma and PTSD. He attributes the tendency for traumatization in the human species to blocking the instinctual capability that other wild animal species possess, to "discharge" this retained energy.
Shock is a natural defense mechanism of mammals. However, we also learn these response patterns in our families. Most first responders have learned the role of the *Rescuer*, conditioned by family and society. Being raised in dysfunctional, drug addicted or alcoholic families, children are taught these patterns of numbing their own feelings in order to take care of emotionally immature parents and other siblings.
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What is the difference between providing efficient services and ‘rescuing’?

1. Who’s problem is it?
2. Can they solve it themselves?
3. Do they play the “Yes but . . . ” game with each solution you offer?
4. Are you angry or resentful toward the client?

See *Breaking Free from the Victim Trap* book
PTSD and shock are “bipolar” syndromes reflecting

- remarkable autonomic instability
- cyclical patterns of heightened sympathetic arousal
- alternating at times with clear and dramatic parasympathetic dominance, according to Robert Scaer.

It is the body’s defensive tendency to alternate between these extremes, or to stay stuck in one or the other, that we refer to as shock.
The criteria for PTSD and shock indicates cycling
• from hypervigilence and irritability (sympathetic overactivation),
• to numbing, withdrawal and flattened affect (parasympathetic overactivation)
• and back again.

As Scaer says, “The syndrome of trauma has now literally taken control of the body.” And the first responder is determined to take back that control.
When using substances and behaviors to “take back control”

- the individual is unfortunately blocking the necessary "discharge" of the undissipated trauma-response energy
- rather than finding relief, i.e., release of the overwhelming buildup of fight/flight energy, he or she digs a deeper hole into the captivity to the body’s desperate attempt to find freedom.

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And the body, with a logic all its own, often attempts to create counterbalance. “If I can’t get him to slow down from this unsustainably stressful pace, I’ll just have to create . . .”

- accidents
- disease
- pain
- disability

Such a defense builds a barrier to prevent ultimately prevailing in the battle.
When we are unaware of our shock as an influence in our body, we unconsciously treat it ourselves, resulting in self-sabotaging behaviors.

Too many first responders are looking “in all the wrong places” for ways to keep their stress from becoming chronic and debilitating, and use alcohol, prescription drugs, behavioral addictions, explosive anger, illicit relationships, vicarious or personal violence, depression or disease.
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Why it is so difficult to stop addictive behavior?

... to stick to a diet, to stop smoking or drinking, or to stop playing computer games.

• Most people are unknowingly attempting to regulate their own shock states through these addictive behaviors and activities.

• They are attempting to find an antidote for the poisonous stress (shock) by activating the opposite branch of the nervous system.
Treat the shock, then treat the addiction
The intervention then often becomes focused on the addictive behavior that the first responders choose to ameliorate the effects this shock has on their own bodies.

Treatment of the shock buildup in the nervous system is also necessary.
Both are important: treating the symptoms and resolving the source cause.
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The difficulty with using prescription drugs to treat the symptoms of shock such as depression or anxiety is that the drugs actually lock the shock state into the nervous system, making it more difficult to release shock from the body. For example, people on antidepressants often describe:

- being in a state of suspended animation
- feeling numb without access to feelings
- lost creativity and joi de vivre
- lost spiritual connection and ability to meditate
Effective treatment requires that shock be rooted out of the mind and the nervous system

• releasing/expressing suppressed emotions
• empowering the client to notice and treat the shock symptoms that are stored in the body
• hypnotherapy to get to the deeply stored physiological sources of shock in the subconscious and in early childhood trauma
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Vicarious Resilience
True healing requires seeing the gift in adversity

Vicarious resilience is a relatively new concept developed by Hernandez et al (2007) to indicate positive adaptation to stress or trauma, namely

• the positive transformation and
• empowerment of clinicians through their empathy for and interaction with traumatized clients.

(Friborg, 2009)
Factors contributing to the development of vicarious resilience

- Trauma practitioners bear witness to the enormous resilience of survivor clients
- Acute stress enhances recovery, while chronic stress impedes recovery (Dhabhar, 2009)
- What has been termed “core empathic capacities” (i.e., tolerance, resistance, endurance, capacity)*

*(Hernandez et al, 2007; Engstrom et al, 2008)
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**Trauma stewardship:** empowering and promoting the well-being of trauma professionals

“A daily practice through which individuals, organizations, and societies tend to the hardship, pain, or trauma experienced by humans, other living beings, or our planet itself. Those who support trauma stewardship believe that both joy and pain are realities of life, and that suffering can be transformed into meaningful growth and healing when a quality of presence is cultivated and maintained even in the face of great suffering.” (van Dernoot Lipsky, 2009)
Trauma stewardship involves

- strategies to address or prevent vicarious or secondary trauma (Panos, 2007)
- using first aid and treatment techniques specific to shock
- developing a self-care plan

*Let’s develop your individualized plan now!*
How do I reduce the amount of shock in my life?
Some first aids to reduce the levels of shock
• Meditation and mindfulness practices
• Yoga, exercise, walking, sitting in nature
• Drinking water slowly
• Heat or ice on the neck, forehead or belly
• Be fully in the moment through slow, deep breathing
• Aroma therapy
Hypnotherapy Is Important to Treat Shock

• The subconscious mind, like a computer, is a vast storehouse of regulatory systems and memories. Everything is stored in the computer’s memory system and hypnotherapy provides the “search engine” to go beyond conscious thoughts and deep into the vast storehouse of our mind.

• Shock is located in the nervous system, regulated by the subconscious. Hypnosis allows an individual to actually make adjustments in this regulation in an intentional and permanent way.
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Assess Your Shock with these Instruments

- The Shock Questionnaire
- Human Needs and Need Shock
- Shock in the Addiction Cycle
- Discover Your Shock in Relationships
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You will find a more detailed discussion of this topic and of shock in general in our most recent book.

Available at bookstores and online retailers.

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References


• Figley


• Panos, A. (February 2007). Promoting Resiliency in Trauma Workers. Poster presented at the 9th World Congress on Stress, Trauma, and Coping. Baltimore, MD.


We all owe a debt of gratitude to first responders

- therapists, mental health and social workers
- Psychologists and psychiatrists
- teachers
- nursing home workers
- doctors and nurses
- police
- firefighters
- emergency room workers
- 911 operators
- combat veterans
- And all others who encounter secondary stress and trauma as part of their work every day

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