inSocialWork Podcast Series

Episode 83 - Dr. Carol Tosone: Shared Traumatic Stress: Challenges and Opportunities for Clinicians Living and Working in a Post-Disaster Environment

[00:00:08] Welcome to living proof a podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to address you our regular listeners. We know you have enjoyed the living proof podcast as evidenced by the more than 150000 downloads to date thanks to all of you. We'd like to know what value you may have found it in the podcast. We'd like to hear from all over you. Practitioners researchers students but especially our listeners who are social work educators. How are you using the podcast in your classrooms. Just go to our Web site at www.socialwork.buffalo.edu forward slash podcast and click on the contact us tab. Again thanks for listening. And we look forward to hearing from you as host of Living Proof podcast series. I hear interesting and thought provoking information on a regular basis. Periodically I listen to a podcast that opens a new but familiar Vista and I am reminded of that which makes the profession of social work special. I'm reminded of our unique perspective and the value of that perspective and understanding and address and problems of the human condition through our practice and research. We have a rich heritage that is a tapestry of sorts a tapestry that bears witness to the living proof that we make a difference in people's lives.

[00:02:01] Because thread we pick up on today's podcast focuses on understanding ourselves and improving our work. In the midst of shared trauma Dr. Carol Tosone is an associate professor at the New York University's silver School of Social Work and recipient of the NYU Distinguished Teaching Award. Dr. Tosone is a distinguished scholar in social work in the National Academies of practice in Washington D.C. She is editor in chief of the clinical social work journal and serves on the editorial boards or as consulting reviewer to eight professional journals. Dr. Tosone is author of professional articles and book chapters co-editor of two books and executive producer and writer of six training and community service media since joining the NYU faculty. Dr. Tosone has delivered over 100 professional papers and presentations in academic medical and mental health settings in the United States as well as international venues in Asia Europe the Middle East and South America. In this podcast Dr. Tosone discusses shared traumatic stress a construct used to describe the experience of mental health clinicians duly exposed to a traumatic experience both primarily as citizens and secondarily through the trauma narratives of their clients. Dr.Tosone discusses the results and implications of her research examining long term impacts of 9/11 and Hurricane Katrina on Manhattan and New Orleans clinician's respectively. Whitney Mendel Ph.D. student at the University of Buffalo School of Social Work spoke with Dr. Tosone by telephone thank you for agreeing to speak with us. I really appreciate it. My pleasure. I had a chance to read over all the materials that you sent and it's some really interesting work that you're doing. Thank you. Well if it's OK by you we can just jump right in with the first question. Sure.

[00:04:10] Which is what is the definition of shared trauma. Well the formal definition really is one in which the person is suffering both from PTSD as well as secondary trauma so that both are equally weighted and chair trauma is something that's resulted from clinicians who are exposed now to collective disasters and it seems we're having more and more of them but there's more of an urgency for the concept to really be out there. Absolutely. Specially given the most recent 9/11 anniversary. Absolutely. Absolutely. So how did you become interested in the topic of shared trauma. Well actually I became interested with 9/11. I was sitting with a client when the planes were very close and low over the building. I didn't know what was going on my client didn't know

what was going on and obviously learned a little later. But I think we were trying to interpret the noise in a real benign way. He wasn't sure if it was atmospheric conditions or something. He kept trying to attribute it to something very benign and I think unbeknown to both of us what was going on and when we ended the session you could see the towers burn very close. Actually within a mile or so the towers. Yes so it was like so struck by that. I really wondered what other clinicians experience. What did they feel about the situation and how did their work change as a result of being exposed simultaneously with their clients. And that's really what led to the research study that I did and it makes an awful lot of sense since it was so close to home literally for you. Absolutely.

[00:05:51] Absolutely. I mean it's a new construct in terms of being labeled but the phenomenon is hardly new. Something that people have experience certainly in Israel southern Israel with chronic Kasam rockets that have exploded there four years on and off. This is not anything new but it's really just a time to really formalize it and calls for kind of a paradigm shift. How does shared time differ from PTSD. Well in terms of the sense the apology it doesn't differ the way that we measure shared trauma was taking it piecemeal. See post-traumatic checklist the civilian version and also taking stands professional quality of life the subscale for secondary trauma and waded both equally so that the construct forward is one that involves both. So the symptoms are the same as with PTSD. But the manifestations or will be kind of specific I guess the best way to explain it is that when you think of PTSD it's on traumatized by my primary experience that when you're in sheer trauma I may be traumatized by my client's narrative of trauma. I can be and that can trigger my own trauma experience my own trauma experience can impact how I view what the client tells me. So there's just kind of a fluidity of boundaries that go back and forth and and it can manifest in a whole bunch of different ways. And I can't imagine so now when you look at the most recent study looked at those respondents in New York and New Orleans. Correct. So following 9/11 attacks and Hurricane Katrina what differences did you find between the respondents. Well here's what's interesting.

[00:07:45] We're going to move onto a third study actually in Australia where they've been exposed to bushfires and it's more recent both the 9/11 and the Katrina studies. We're looking at the long term impact of sheer trauma on clinicians. But in Australia we're going to have the opportunity to look at what had just happened because these are very recent events. But in comparing the two I was interested in does it differ. First of all does somebody experience differ if they are in it themselves you know hence your trauma. But then it becomes does their experience differ. If they've been exposed to a one time terrorist event versus exposed to chronic threats of natural disasters and that's what you have going on in New Orleans so that Hurricane Katrina wasn't the first hurricane obviously the most memorable. All kinds of reasons. So we wanted to see does the nature of the environment make a difference in how somebody experiences it. And it was very different in many respects the results were the same in that there were a number of factors that would predict sheer trauma. If you had a history of traumatic life events if you came from a trauma background yourself if you had an insecure attachment style and I'm trained as an analyst one very interested in attachment. So those 11 insecure attachment are more likely to be impacted by 9/11 as well as those with less experience. So these are factors that we found that played a really significant part. I think it's really interesting that there was kind of a little difference depending on the nature of the disaster itself. That was a really interesting way to look at it. Right.

[00:09:35] And another question that we looked at was were you currently affected by 9/11 or Hurricane Katrina. So for both of those populations they were similar. The thing that was striking about Katrina is that they were both more avoided around the demonstrated insecure avoidant attachment styles more so it was predictive of sheer trauma. And also we looked at resiliency. Basically what regression models were predicting resiliency and in terms of that it was basically if you had lower shear trauma you were more resilient. But between those two groups the New Orleans clinicians they were both more traumatized but they were also more resilient. And this is

the thing that I really find striking because we have to find who are the clinicians that kids fare well in these environments. Were the people that don't get burnt out. They aren't overwhelmed by their own experience that they have the capacity to experience what ever is happening to them but also to help others who are going to say would be wonderful to learn what works best you can train other folks more effectively. Exactly exactly that's the goal of what we're trying to do if we can identify what they have going on that helps them to do that. And in New Orleans if you think about the culture it makes perfect sense that they'd be avoidant. I mean it's the biggest party city you have. So they are like in some ways they make merry so to speak. And that's the way in which they handle what's going on to them it's just the norm. They more braced for it. Right.

[00:11:13] I was going to say I would think that it would has something to do with him kind of having a constant threat as opposed to one time very unexpected terrorist attacks. Exactly. They've grown up bracing themselves effectively. Right. Another place where we're going to look at next is in Israel because in Israel in southern Israel I have colleagues I have a colleague who had her office destroyed by a Kasam rocket. There was a student that died in that bombing. And for them it's like a daily threat if a rocket is coming in. They literally have about 15 seconds to seek shelter to do something about it. So imagine practicing under those circumstances I can't even fathom. Right exactly. I mean it's a horrific kind of experience. So I want to see now these are people they've been doing it a long time. And my colleagues particularly there are three that write a lot about it. Rahilly Dhakal or wheaten Schwartz and Ani Hami Baum has written a lot on this topic and they refer to it a sheer traumatic reality because their sense is it isn't just sharing with your client in the confines of the therapeutic setting. Their concern is that not only is it chronic but the entire environment is subject to terrorism at any time so that in other words it goes beyond just the concrete environment. It's really once perception one's sense of reality as to what's occurring. So for them it's clearly in a more dramatic on a much larger scale and they've done a lot of work where they're both dealing with it themselves as well as helping others.

[00:12:58] I mean this is such a relevant topic given all the discourse that we're witnessing around the globe. Absolutely. So this is really wonderful information. What type of changes did clinicians make in their personal and professional lives. Post disaster. Well one of the articles that we had written was we termed it professional post-traumatic growth and that was we had a lot of people after this experience a lot of some really not good things happened and some really good things happened in terms of the self report that they that they had from the open ended questions and on the personal level yet some people who decided to get married. And then you had people who were saying I'm so sorry ever became the therapist. I don't want to just sit and listen to people's problems. You had the whole continuum of responses. But professionally we found that people were doing a better job of taking care of themselves. Shorter hours taking training that they wanted to take. Another thing is around boundaries. Post 9/11 there's a significant shift in boundaries for most clinicians. They find themselves being able to work more intimately with clients. They may be more to self disclosing. Certainly they were about 75 percent of clinicians self disclosed about their own 911 experience with their clients. I mean that's a very high number. And in the New York study we captured more seasoned clinicians that is our group our listserv came from NSW We looked at only people in Manhattan who were in the affected area and the majority the average age was around 60. So these were seasoned clinicians at twenty six plus years in the field.

[00:14:45] And what's striking is many of them had psychoanalytic training so we ended up capturing the people who are in private practice. The average income was like over 100000. So we haven't stood out to me when I read the article. Right. Well any time I present the New Orleans stat I always in New Orleans they were like Really. Oh my God you know they make so much money. I'm like no that'll get on a subway here in New York. I to be impressed impressed but what's striking for them is that even though they were so seasoned and many of them these men even more trained analysts they all said they didn't know what to do. They felt they weren't prepared

intellectually they didn't have the knowledge they needed. And even when they had the knowledge it makes no difference when it happens to you personally. So these are the kind of responses we were getting which I think are really striking the words when it happens. It's a leveling field. They colleagues and I produce a video series called a relational Social Work series and it's all really about how the partnership between you and your client but nowhere is that more equal than when people are exposed to a common thread in this way.

[00:16:02] So with those conditions the changes they were all being more intimate with their clients so that they were more relaxed in their practice more appreciative of both the limits of our profession as well as what it can do and I think it was just kind of an existential awareness that came about as a result of 9/11 that I think that has stayed with most people and I'm going to say it doesn't sound like that's too different from a lot of folks experience who started to re-evaluate where they were and what they were doing after 9/11. Exactly. Exactly. A lot of people took it as an opportunity and we're all guilty generally speaking of trying to make the best of a situation are we. Yes that is true. I think to something that's important to keep in mind is that as social workers I think in general we serve as models of Nasseri for our clients. Many of us have either no trauma or background come from families where there's a history of depression mental illness substance abuse sexual abuse. Many of the human frailties. We know it often draws us to the profession. And I think what happened with 9/11 is that many people myself included when you're going through this what do we do best. We spring into action and we help others. So that the process of helping someone else helps us. That's something that really occurred for a lot of people. Some people were like I I'm dealing with my own stuff. I can't help anybody else. And that was the difference with Katrina in New York. It was the plane flew over the building. But in New Orleans maybe my home was destroyed. And it's very different. My home was destroyed. I'm not getting significant reimbursement. So many issues to deal with that were very different. So their clinicians were saying you've got to take care of your own trauma before you help someone else. So it was very different in New York because it was a discrete one time experience.

[00:18:07] They are better able to use that experience to help others. Whereas in New Orleans they were like let me take care of my own stuff before I help somebody else. Right. So much more effective daily living for those in Katrina from food and shelter on up. Right. Exactly. And another thing the timing of when we collected the data about midway through the BP oil disaster occurred. So we were curious. Was there a difference for and after the oil spill and sure enough people were more traumatized after on the data that we collected after so that the oil spill did make a difference and a resurgence of sheer trauma for people. It's no surprise either. Yes quite amazing. There are problems. That's for sure down there. Absolutely. And we touched on this a bit earlier but what part is resiliency play in the development of shared trauma. I think there's a big debate in terms of what constitutes resiliency. Is it more kind of constitutional in nature. Is it something you can cultivate is it something you can teach supervise. So there's a lot of kind of debate of how to define it an absence of symptoms versus something else. And when we talk about resiliency you've got to talk about it because of the post-traumatic growth because oftentimes what happens following a disaster is that it's not people maintain there they don't go back to let's say a precrisis state of functioning but more they learn from the trauma they change their cognitive scheme of the world and of themselves changes post disaster. And that's where you see post-traumatic growth.

[00:19:53] So with resiliency has a lot to do because people who are innately more resilient will be less traumatized. So if you have an ability if you have an attitude like i can handle whatever comes my way. OK. It seems overwhelming I'll just parcel it out. I'm going to maintain a good sense of humor about it. I'm going to reach out to others for support. Like if you have a certain kind of attitude and stance to anything that comes up then it's going to be easier for you than somebody says oh my god if anything happens I'm not going to be able to handle it more than somebody that's basically predicting their own negative response. It's not going to fare as well. But I think social

workers as a group are a very hardy group but we're also a more traumatized group. That's something Brian Bride talked about in this article I mean the percent I believe was around 15 percent or so with social workers he found were traumatized. That's a fairly high number. But that's what's striking about us. We can be both more traumatized but also more resilient and also more aware and to use that awareness to help self and others need. That's what's so wonderful about our profession. Angry angry. It's wonderful I think that you're looking at both not just the consequences or the ramifications of these disasters but what we can learn and take away from them to better the field as a whole. Absolutely. And your research has just really interesting and I really thank you for sharing all of this with us. My pleasure.

[00:21:26] And I look forward to reading future articles and sounds like you're after some very interesting places. So I present a lot all over are just came back from Sarajevo and where they know it as well. But I'll be happy to make any of the articles available to you and your audience. Wonderful. Well thank you so much. Thank you and good luck with your research. Ok Thanks. You've been listening to Dr. Carol Tosone to sound discuss share traumatic stress. Thanks relisting and join us again next time for more lectures and conversations on social work practice and research. Hi I'm Nancy Smyth Professor and dean at the University at Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do we invite you to visit our Web site at www.socialwork.buffalo.edu. At UB we are living proof that social work makes a difference in people's lives.