Clinical Practice

Psychosocial Stress: Effects on Abuse Professionals
by Holly Ramsey-Klawsnik, Ph.D.*

In various roles, I have much opportunity to work with and receive information from professionals working "in the field" on abuse cases. It is not unusual when providing clinical consultation to speak with staff members who had disturbing or even traumatic experiences while attempting to assist a victim. Accounts of staff upset also emerge during in-service trainings and are particularly common during sessions on alleged perpetrator interviewing skills. The research in which I have been involved also provides a window for eliciting and analyzing the experiences of abuse professionals. A theme emerging from all of these sources of information is the psychosocial stress to which abuse staff is subjected. Having provided direct services to abuse victims, their families, and many of their offenders for years, the accounts I hear from others resonate with my own experience.

It is generally acknowledged that professionals handling adult abuse cases labor under adverse conditions such as resource shortages, time constraints, and a lack of forensic experts. Less often discussed are the potential adverse psychosocial consequences to these professionals. The capacity to recognize and understand these consequences is important, particularly for those who recruit, train, or supervise staff, provide clinical consultation to staff, or administer programs. While job-related stress and negative psychosocial consequences can stem from many sources, this column will address three areas: vicarious trauma, primary trauma, and worker guilt.

Vicarious Trauma

It has been documented that repeated or prolonged exposure to the suffering of others can prove traumatic to responding personnel. The experience of seeing the harm which has been inflicted on victims, listening to their stories, and learning of their suffering can cause professionals to display symptoms of post-traumatic stress disorder. This is a cluster of symptoms that emerge following an extreme stressor. These stressors may entail actual or threatened death or serious injury or threat. Symptoms include distressing re-experiences of a past event through dreams or recollections, avoiding associated stimuli, numbing of responsiveness such as diminished interest in activities, and increased arousal including sleep disturbances, irritability, and hypervigilance. (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 4th ed. 1994.)

"Catching" Symptoms. The phenomenon of vicarious trauma or secondary PTSD involves personnel exposed to primary victims "catching" symptoms from those with whom they work. It has been discussed in the literature primarily in terms of its effect on public safety personnel (police, fire, rescue, emergency medical technicians) and those in the military. It is also widely recognized as a potential problem for child abuse workers. As the field of adult abuse grows and develops, we are seeing plenty of evidence that vicarious trauma is also a risk for this group of professionals. On a daily basis, adult abuse workers interview people who have experienced traumas, some of whom display PTSD.

Illustrative Case. An APS caseworker responded to a report from a utility worker who stated that while in the basement of a home to read a meter he observed an older man caged off in a corner. The responding worker found an elderly man confined to a small section of the dark, damp basement in which a cage had been created with wire. With the man were a number of badly neglected cats and a small cot. The man was covered with his own waste, disoriented, and very fearful. Investigation revealed that his home had been taken over by relatives and he had been imprisoned in his own basement. Upon hospital admission he was found to be malnourished and dehydrated and severely lacked necessary care. For weeks following the discovery, the worker experienced distressing dreams about the situation and sleep disturbances that left her irritable. She found herself extremely fearful of making home visits. When she did enter the homes of clients she experienced overwhelming conflicting urges both to inspect the basement and to flee due to fear of what she would find. She was not the victim of the primary trauma (confine ment, life-threatening neglect, theft). However, the secondary trauma (observing, investigating, and documenting cruelty, greed, and suffering) caused PTSD symptoms.

Primary Trauma

There are also numerous documented situations of abuse workers experiencing primary trauma. One young female caseworker was held captive in the home of a man who was referred for self-neglect. Fortunately, she was able to use previous worker safety training to devise an escape strategy. Following her ordeal, a criminal records check revealed that the man was a convicted sexual offender. Caseworkers have been attacked by vicious pets, threatened by offenders, stalked, and in rare instances, physically attacked both on home visits and in their offices. The murder in October 2006 of a child protective services worker while supervising a parent-child home visit reinforces the fear of protective personnel regarding violence in the field.

In my experience, a worker need not have been personally harmed or threatened on the job to experience adverse psychosocial consequences including fear, worry, and anxiety regarding the possibility of encountering harm. When one member of a team or agency is threatened or harmed, the entire staff is adversely affected. Co-workers, supervisors, and managers often experience alarm, upset, worry, anxiety, fear, and reluctance to engage in necessary duties such as home visits and alleged perpetrator interviews. These feelings can negatively affect not only personal functioning, but also job performance and certainly staff morale.

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Worker Guilt

During professional conversations with abuse workers I have heard many speak of feeling guilty about their work. When invited to discuss this, they speak of several types of guilt. The most frequently discussed is guilt related to what they have been unable to accomplish. Many workers feel bad about potential victims whom they have been unable to assist due to time constraints and high caseloads. At times this has to do with clients who wait for visits or services, other times it relates to a worker feeling guilty that he or she cannot give the client ample time when visits do occur. Workers discuss their guilt about being unable to fully provide for client needs: “There are so many people in need, who do you get to first and what do you do when you just don’t have the resources to solve their problem?” Professionals working in poverty-stricken and extremely resource poor areas are particularly at risk.

Abuse professionals also report experiencing guilt about attempted or provided interventions that have not had the desired effect. One APS team felt guilty and distraught when a woman they had removed from home and placed into a nursing facility died. The woman had been known to the team for some time. Her caregiving son had been dangerously neglectful. The team had come to know and like the woman very much as they monitored her care and addressed the neglect through the provision of in-home services. The woman had dementia, but prior to losing communication ability discussed with several of the caseworkers her deep desire to live out her life and die in her own home. As the dementia progressed, physical and other evidence emerged demonstrating that the woman was being sexually abused by her son. The team sought clinical and legal consultation, which led to the decision to request a court order to remove the woman to a care facility. At the time of removal the woman’s medical condition was stable and she was not considered to be near death. Upon admission to the facility she deteriorated markedly and rapidly and soon died. The caseworkers and supervisors of this team again sought clinical consultation. On an intellectual level they understood that they could not have left this woman under the care of her sexually abusive son and that they did not have an alternative to the removal. On an emotional level, however, they felt they had betrayed her and caused her premature death.

Prevention Strategies and Remedies

Worker Safety Training. Clearly there is a need to address potential adverse psychosocial consequences of abuse-related work on professionals. Many agencies serving victims have recognized the need to provide staff worker safety training. Strategies for keeping abuse personnel physically safe on the job are essential. (See Candace Heisler and Bonnie Brandl, “Safety Planning for Professionals Working With Elderly and Clients Who Are Victims of Abuse,” 4 (5) VED 65 (Jan./Feb. 2002).) Training needs to address harm prevention, recognizing and responding intelligently to possible danger, and minimizing risks. We commonly perceive the potential danger presented by perpetrators who are intoxicated, psychotic, or have criminal histories or intent. The dangers of biohazards (infections, communicable diseases, human and animal waste, etc.) often present in profound self-neglect and neglect by care provider cases must also be included in worker safety training. However, it is important that such trainings not be limited in scope to only potential physical dangers. Potential psychosocial harm to staff must also be addressed. Skillful training prior to exposure to any of these three sources of danger helps staff to effectively cope when confronted with a threat to their safety.

Self-Care. Abuse professionals should be trained and encouraged to engage in practices and behaviors, both on and off the job, which best preserve their own safety, mental and physical health, and effective coping strategies. On-the-job protections include receiving updated education and information; individual and group supervision and consultation; practicing ethically; participating in multidisciplinary teams and networking opportunities; seeking client evaluations and court involvement when appropriate; and careful, accurate, and timely documentation. (See Holly Ramsey-Klawsnik, “Protection for Professionals,” 8 (2) VED 19 (Jul./Aug. 2005).) Effective measures of personal self-care off the job, such as healthy patterns of eating, sleeping, exercise, and spending, are equally as important. The value of supportive personal relationships cannot be overstressed in terms of their potential to buffer individuals from the negative effects of both work and other types of stress. Conversely, it is important for those who listen to and respond to problems all day at work to set limits on the amount of time they spend in off hours being available to those who tend to complain frequently or see the worst in any situation. Additionally, many abuse professionals find it helpful to limit their exposure to real and simulated media violence.

Strategies for leaving the job at the office help many professionals to put emotional distance between themselves and work stress.
I have observed situations in which well-intended supervisors and consultants have joined in the crisis state experienced by the worker, rather than remaining calm and effective as problemsolvers and superiors. This has the effect of exacerbating the upset experienced both by the traumatized worker and the entire staff. Both errors can seriously compound the emotional harm experienced by a traumatized employee. Management personnel may benefit from consultation with trauma experts regarding healthy and helpful agency response to traumatized workers. It is important that senior level personnel validate the harm endured by staff and be available to empathetically assist in stabilization of the worker’s crisis. Individuals who have experienced job-induced psychosocial trauma need to regain their equilibrium and personal and professional self-confidence. In some situations, referral of the involved worker to employee assistance professionals or counselors is warranted, as is time off to recover from the trauma.

Skillful attention to the potential adverse psychosocial consequences to staff of abuse-related work will ultimately improve employee performance, minimize staff burnout and turnover, and contribute to better client service.