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BRIEF REPORT

Responding to Secondary Traumatic Stress: A Pilot Study of Torture Treatment Programs in the United States

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Providers who care for torture survivors may be at risk for secondary traumatic stress, yet there has been little documentation of the effects of repeated exposure to traumatic issues on their emotional health or exploration of the support systems and resources available to address their emotional needs. This study assessed the secondary stress experiences of service providers ($N = 43$) within the National Consortium of Torture Treatment Programs in the United States and examined the supports offered by their organizations. The study found a significant correlation between rates of anxiety and depression among providers, $r(34) = .49, p = .003$. Although these participants reported that their work with survivors of torture was stressful, 91% indicated that their organizations offered a variety of stress-reduction activities. Overall, participants reported that their own personal activities were the most-effective stress reducers. The results are discussed in light of challenges that professionals who work with this population face and the effectiveness of support systems available to support their work.

Survivors of torture face multiple challenges related to their past traumatic experiences, as well as medical, psychological, social, and legal issues related to immigration (Blanch, 2008; Eisenman, Gelberg, Liu, & Shapiro, 2003; Fabri, 2001; Silove, 1999). Mental health concerns include not only posttraumatic stress disorder (PTSD), but depression, anxiety, and somatization disorders (Gerrity, Keane, & Tuma, 2001; Piwowarczyk, Moreno & Grodin, 2000; Wenzel, Griengl, Stompe, Mirzaei, & Kieffer, 2000). Since 1982, nearly 200 specialized torture treatment rehabilitation centers have been established worldwide to care for torture survivors (International Rehabilitation Council for Torture Victims [IRCT], 2003). Approximately 400,000 such individuals are currently living in the United States (Piwowarczyk et al., 2000). The National Consortium of Torture Treatment Programs (NCTTP) is made up of approximately 30 specialized treatment programs for torture survivors spread

throughout 15 states (Blanch, 2008). Psychological services across treatment centers are best described as theoretically eclectic, with most programs providing supportive psychotherapy in conjunction with pharmacological management (Blanch, 2008; Fabri, 2001).

Although there is a growing body of literature describing how to care for torture survivors (Fabri, 2001; Hanscom, 2001; Pope & Garcia-Peltoniemi, 1991), little research has been conducted to understand the impact of this work on those who provide these services. As part of their mission to care for torture survivors, many NCTTP staff members must listen to horrific events while providing physical and mental health services; therefore, it is possible that they suffer from secondary traumatic stress (STS; Jenkins & Baird, 2002). STS describes the adverse reactions people can have while trying to help trauma survivors. STS symptoms include reactions to trauma, and are nearly identical to the PTSD symptoms of intrusion, emotional numbing and avoidance, and hyperarousal (Jenkins & Baird, 2002). Assessing STS is similar to assessing PTSD.

Although a number of organizations within the NCTTP claim to provide psychosocial support to their staff, there has been no evaluation of these services or the symptoms they target. The current study sought to address this gap in the literature by assessing STS among NCTTP service providers and by examining the types of systems and resources that have been put in place to support their emotional needs.

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Method

Participants

In the fall of 2008, 120 service providers within the NCTTP were sent survey packets; 43 (35.8%) completed and returned surveys. Respondents were 62.8% female ($n = 27$) and ranged in age from 25 to 58 years ($M = 40.95$, $SD = 9.06$). Over half were married or were with a long-term partner ($n = 26$, 60.5%). Half had children ($n = 22$, 51.2%) and 30 (69.8%) were White, 4 (9.3%) were Black, 2 (4.7%) Latino, 2 (4.7%) East Asian, 1 (2.3%) South Asian, and 4 (9.3%) were of another racial ethnic group. The highest level of education varied, with 15 (34.9%) having a doctoral degree, 18 (41.9%) a master's degree, 5 (11.6%) an undergraduate degree, and 5 (11.6%) an associate degree.

Procedures were approved by the Institutional Review Board of the City College of New York and participants gave written informed consent. Survey packets were mailed to 120 service providers listed on the websites of NCTTP treatment centers. Included in the survey packets were self-addressed envelopes to ensure return of all completed packets; 4 weeks later, follow-up postcard reminders were sent. In an effort to increase responses, approximately 8 months later the procedure was repeated.

Measures

Demographic data included age, race, ethnicity, gender, marital status, level of education, place and length of employment, and job description. Also measured were type of work stressors, available support services, and coping strategies for work stressors.

The Life Events Checklist (LEC; Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995) is a self-report measure of exposure to traumatic events in a respondent's lifetime. Respondents are asked to rate their level of exposure to 17 traumatic events on a 5-point scale. In the current study, respondents were asked to report the number of times each exposure occurred and if the occurrence was work related.

Secondary traumatic stress was measured using the PTSD Checklist-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993), a self-report measure that lists the 17 symptoms of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994). Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), a 20 item self-report instrument. Cronbach's α for the 17-item PCL-C and 20-item CES-D were .88 and .74, respectively. Both instruments have been validated on a wide range of populations.

Data Analysis

Of the 43 returned packets, 41 (95%) had complete PCL-C scores and 36 (84%) had complete CES-D scores. Frequen-

Table 1

Frequencies of Experiencing, Witnessing, or Learning About Traumatic Events

Event	Overall		Work-related	
	<i>n</i>	%	<i>n</i>	%
Natural disaster	21	48.8	7	16.3
Fire or explosion	9	79.1	7	16.3
Transportation accident	11	25.6	4	9.3
Serious work or home accident	8	18.6	2	4.7
Exposure to toxic substance	4	9.3	1	2.3
Physical assault	11	25.6	19	44.2
Assault with a weapon	14	32.6	19	44.2
Sexual assault	14	32.6	17	39.5
Other unwanted sexual experience	9	20.9	13	30.2
Combat or exposure to a war zone	14	32.6	18	41.9
Captivity	13	30.2	16	37.2
Life-threatening illness or injury	17	39.5	16	37.2
Severe human suffering	12	27.9	18	41.9
Sudden, violent death	9	20.9	13	30.2
Sudden unexpected death	12	27.9	9	20.9
Causing serious injury or death to someone else	9	20.9	9	20.9

Note. $N = 42$.

cies and descriptive statistics were calculated for all variables. Association between predictors and outcomes was determined using two-tailed chi-squared and independent sample t tests as appropriate. Factors that were associated with statistically significant univariate results were entered into a multivariate linear regression predicting psychological outcomes.

Results

Life Events Checklist

Forty-one participants (95.3%) reported having personally experienced, witnessed, or learned about a traumatic event, with the median number of experiences being 14.3 ($SD = 11.1$). Twenty-four (55.8%) reported having experienced at least one work-related traumatic event with the average number of 4.56 ($SD = 5.19$) work-related trauma events. These data are presented in Table 1.

Organizational Support

Fifteen respondents (35.7%) reported that their organization prepares and orients staff working with survivors of torture and refugee trauma *very well*, 15 (35.7%) reported *somewhat adequately*, 6 (14.3%) were *neutral*, and 6 (14.3%) *somewhat inadequately*. Three-quarters ($n = 29$, 74.4%) reported that their

organization provided training programs for staff and about half ($n = 22$, 52.4%) reported that their organization had good policies and programs in place to support staff in at least most areas, while very few ($n = 4$, 9.5%) reported their organization did not have good policies and programs in place to support staff. Most participants indicated their organization provided at least one kind of support service for staff ($n = 39$, 90.7%); the most common support service was the availability of supervisors on an "as needed" basis ($n = 33$, 76.7%). Three quarters ($n = 32$, 74.4%) endorsed that they received at least one type of stress management training; just over half ($n = 25$, 59.1%) indicated they received technical training to cope with patients in distress.

Stress Management

Most participants reported they found their work with survivors of torture and refugee trauma to be *somewhat stressful* ($n = 18$, 42.9%) or *very stressful* ($n = 9$, 21.4%). Common strategies to reduce the stressors experienced included balancing work load by having a variety of tasks ($n = 35$, 81.4%), supervision/consultation ($n = 32$, 74.4%), giving and receiving training ($n = 28$, 65.1%), reducing and distributing client load ($n = 24$, 55.8%), and finding ways to enhance work space ($n = 24$, 55.8%). Most participants found these professional activities to be *very helpful* ($n = 21$, 48.8%) or *somewhat helpful* ($n = 20$, 46.5%) in reducing levels of stress. The most common form of organizational activities used by responders to reduce stress was collegial support ($n = 38$, 90.5%) followed by respect for clinicians and clients ($n = 30$, 70.0%) and supervision ($n = 24$, 55.8%). More than half found these organization activities to be *very helpful* ($n = 23$, 53.5%) or *somewhat helpful* ($n = 16$, 37.2%) in reducing stress. Personal activities were considered the most effective with majority ($n = 26$, 61.9%) reporting these activities were very helpful in reducing stress. Leisure activities were the most highly endorsed personal stress reducers ($n = 40$, 93.0%) followed by making personal life a priority ($n = 28$, 65.1%).

Depression and PTSD

The average score on the PCL-C was 27.1 ($SD = 8.42$) and on the CES-D was 9.6 ($SD = 7.67$). There was a significant correlation between CESD and PCL-C scores $r(34) = .49$, $p = .003$.

Mean PCL-C scores were significantly higher among women ($M = 28.9$, $SD = 8.7$) than men ($M = 23.5$, $SD = 6.7$), $t(39) = 2.03$, $p = .049$. In addition, there was a significant correlation between higher CES-D scores and younger age, $r(34) = -.40$, $p = .019$. There was no difference in experiencing clinical levels of depression, $\chi^2(1, N = 36) = 3.39$, $p = .066$.

Linear multiple regression was used to examine the relationship between the independent variables and symptom variables. Age was significantly associated with depression scores, $\beta = -.32$, $t(33) = -2.46$, $p = .019$; more work-related stress was

Table 2

Regression Analyses of PCL-C Scores With Gender, Traumatic Events, and Work Related Stress

Variable	<i>B</i>	<i>SE B</i>	β	<i>df</i>	<i>F</i>	<i>p</i>
Step 1				1	4.02	.05
Constant	34.42	3.90				
Gender	-5.46	2.72	-.31			
Step 2				2	1.96	.16
Constant	32.28	5.32				
Gender	-4.74	3.00	-.27			
Life events	0.08	0.13	.10			
Step 3				3	3.36	.03
Constant	39.74	6.13				
Gender	-3.94	2.89	-.22			
Life events	0.04	0.13	.05			
Work stress	-3.69	1.70	-.33*			

Note. $N = 40$. $\Delta R^2 = .096$ for Step 1; $\Delta R^2 = .000$ for Step 2; $\Delta R^2 = .123$ for Step 3. PCL-C = PTSD Checklist-Civilian Version.

* $p < .05$.

related to higher scores on the PCL-C but not the CES-D. Work-related stress remained significant against PCL-C scores after gender and number of potentially traumatic events were included in the model (see Table 2).

Discussion

The findings of this study are consistent with research of human rights workers in similar positions reporting increased anxiety and depression (e.g., Holtz, Salama, Cardozo, & Gotway, 2002). Although many providers in this pilot study reported that their work with victims of torture was stressful, they also indicated that their organizations prepared them for working with survivors of torture and had appropriate policies in place. Given these reports, it was striking that despite their organizations' efforts, many found personal activities to be the most effective ways to reduce their stress.

Although it appears that several programs within the NCTTP are working to develop a culture that recognizes the problems STS creates by signaling a commitment to service providers (e.g., diverse caseloads, comfortable work environment, peer support groups, and multiple resources for self-care), these steps vary from program to program. To reduce STS, prevent high turnover rates, and maintain emotional well-being among service providers, it is recommended that the NCTTP considers developing and adopting uniform guidelines for standards of provider self-care.

This small self-selected sample limits the ability to generalize findings to the larger population of professionals who care for survivors of torture. Professionals who may have experienced high levels of STS may have been less motivated to participate in the study to avoid emotionally laden issues. To increase

generalizability, future research should consider outreach to the extensive network of refugee resettlement agencies as well as NCTTP members. Additionally, future recruitment strategies might consider outreach and data collection via web-based surveys.

Although these findings must be interpreted with caution, they offer useful information for approaches to clinical care. For professionals to competently address the needs of survivors of torture and human rights abuses, they also must be cared for.

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