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Shared Trauma of Crisis Counselors and Other Disaster Relief Workers After the 2010 Haiti Earthquake

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Abstract

The purpose of this article is to raise awareness of shared trauma. A brief overview of the development, signs and symptoms, as well as strategies used by counselors to attend to this phenomenon is provided. Training and educational needs of counselors and counselors-in-training are also addressed.

In recent years there has been increasing recognition of the emotional distress that crisis counselors and disaster relief workers (e.g., nurses, physicians, EMTs, chaplains, etc.) experience from listening to the survivors' trauma narratives. This emotional distress is manifested as vicarious trauma, compassion fatigue, and/or secondary trauma. These terms, although often used interchangeably, each have a specific definition. Vicarious trauma focuses on the cognitive and emotional transformation that happens from the empathic engagement with trauma survivors (e.g., a counselor's previously held belief that the world is a relatively safe place has permanently changed to one in which the world is an unsafe place; Pearlman & Saakvitne, 1995); compassion fatigue is the long-term cumulative stress from the "cost of caring" (e.g., a counselor feels burned out, with little to give in his/her personal and professional life; Figley, 1995, 2002); and secondary trauma occurs suddenly (i.e., it is not a cumulative effect) and is related to the trauma survivor's experience (e.g., after a client's description of being trapped in a forest fire, the counselor responds with anxiety when seeing a campfire; Stemm, 2002). Research and greater awareness of vicarious trauma, compassion fatigue, and secondary trauma have helped crisis counselors and other disaster relief workers understand their reactions to the survivors' trauma narratives when serving in disaster zones. While vicarious trauma (Cohen & Collens, 2012; Michalopoulos & Aparicio, 2012), compassion fatigue (Lynch & Lobo, 2012; Zerubavel & O'Dougherty, 2012), and secondary trauma (Motta, 2012; Pearson, 2012) have been well described in the literature, less attention has been given to shared trauma. Shared trauma is something that all crisis counselors and disaster relief workers are affected by as they live and work in the disaster zone. More specifically, it has been widely recognized that crisis counselors,

as well as other disaster relief workers that are deployed to large scale disasters (human generated and natural), often suffer considerable emotional stress rooted in the "shared trauma" experienced by both the counselor and client, helper and helpee (Saakvitne, 2002). Shared trauma is the phenomenon used to describe the crisis counselors' as well as other disaster relief workers' experiences when living and functioning in a disaster zone.

Shared Trauma

Although not new, the phenomenon of shared trauma described above has not been given much attention in the literature, although after the terrorist attacks on September 11, 2001, more attention was given to it (Eidelson, D'Alessio, & Eidelson, 2003). There is a need to bring more visibility and understanding to shared trauma so that crisis counselors and other disaster relief workers can be more knowledgeable about this phenomenon and how to attend to this trauma. Shared trauma involves:

- Crisis counselors and other disaster relief workers being deployed to disaster zones while they still are very chaotic. Workers are often exposed to unpleasant and at times dangerous environments, extreme emotional and physical pain of survivors, death, and large scale destruction of property and communities.
- The number of those in need of services, who often have acute needs, can be unpredictable.
- Traditional service delivery and treatment might not be possible or appropriate.
- Work schedules can be intense, with long hours and little time to rest and sleep.
- The environment itself can expose both the crisis counselors and other relief workers to unpleasant and even dangerous situations.
- The living environment for the crisis counselors and other disaster relief workers can parallel those of the disaster survivors, such as living and sleeping in makeshift shelters, no running water, limited food, no electricity, and compromised safety.
- Crisis counselors and other disaster relief workers can be at risk of illness and even death.

Shared trauma can be complex and impact the crisis counselors and disaster relief workers as they work with survivors in the disaster zone. However, the shared trauma impact goes beyond living and functioning in the disaster zone. The shared trauma parallels the impact seen on disaster survivors' core beliefs about themselves (e.g., the ability to keep themselves and others safe versus the inability to do so), others (e.g., people are basically good versus those who engage in terrorism and the destruction of other human lives and property), the world (e.g., it is a safe place versus terrorism, war, natural disasters), and their spiritual/religious values and beliefs (e.g., they can trust and believe versus finding no comfort or peace). Since shared trauma can have a profound impact on crisis counselors and disaster relief workers, and have long-term impact, it is something that needs to be attended to during and after disaster service delivery/deployment. Some crisis counselors and other disaster relief workers will find it beneficial to seek out family and other support, as well as professional help.

It is important to have more awareness and understanding about shared trauma so that crisis counselors and other disaster relief workers can better understand their

reactions and needs. A case example illustrates the shared trauma experienced by crisis counselors and other disaster relief workers. The following narrative, written in the third person, illustrates the complexity of shared trauma. It describes the experience of one disaster relief team (one crisis counselor and five relief workers) deployed by an international relief organization which responded after a local organization invited them to a partnership. The team arrived after one surgical team had been rotated out and relief efforts had begun to be more coordinated. Regular meetings were hosted by United Nations (UN) representatives to better coordinate the available relief efforts and avoid duplication of services. During the later part of the deployment local government representatives also attended the meetings and became a source of collaboration for immediate and long-term needs/service delivery.

Case Example

When the team arrived February, 2010, the country was still in chaos, with far-reaching destruction of great magnitude. Many people were displaced, living in tent cities, sleeping in fields, or on the street. Resources were limited, as local markets were gone after many stores were destroyed. Food was sparse, as was drinking water, and the sewage system was impacted. Electric lines were down and often intertwined with building debris. Aftershocks, especially early on, were not unusual, creating fear of another major earthquake. Already damaged buildings were at great risk of collapsing.

Services (crisis counseling and medical care) were provided by the team throughout Port-au-Prince. On some days, services were provided in the hills surrounding the city, and required military escorts to assure the teams' safety. Other times, the team went to tent cities, which did not require escorts, or to more isolated places, such as orphanages in the country. The service sites were uniquely equipped. Most had no building or structure to work in, and even if there was a building, there was hesitation about using it because of structural problems and overall safety should another earthquake or aftershock occur. In addition, some Haitian survivors did not feel comfortable being in a building. Sites were generally makeshift, in which only available resources were used, such as a door serving as a table top, large rocks as a place to sit, and at times the floor was the only place to sit. Most times, the service delivery occurred in the sweltering heat, with no shade for the counselor, relief workers, or survivors.

Each day, after working in makeshift settings, the team went back to their living quarters, which were ten minutes to one hour away, depending upon where the team had been providing services that day. Transportation was in vans crammed with medical and other equipment that had to be transported along with the team. The roads were generally congested, and often it was not safe to open windows or keep the doors unlocked. There were large potholes in some areas, and other roads were rough country roads. In some places, the streets had large cracks from the earthquake. Driving to and from the service delivery sites included seeing tent camp after tent camp, mile upon mile of endless destruction from collapsed buildings, such as a grocery store with 100 people buried in the earthquake's rubble, to homes small and large, businesses, churches, government buildings, etc. No one, rich or poor, was spared. People were trying to salvage things from the collapsed buildings, but it often seemed impossible, as the destruction was so severe and the situation so unsafe due to the threat of further building collapse. Markets

were empty, as there were no goods to be sold. In the mornings, there were locations where the U.S. military gave out rice, with long lines of tightly packed women (males were not allowed to be in these lines, in order to avoid conflict/aggressive behavior), who often needed to stand in the scalding sun for hours, with no water or shade to protect them.

The team stayed in a house that Haitians were not willing to stay in for fear of another earthquake and/or aftershocks, and the potential of the building collapsing. Some team members slept in tents on the roof, others on the ground, exposed to the severe rain showers at night, as were so many Haitians. Food was adequately available, but the meals were different regarding preparation. There was no running water, so water was kept in a big wooden barrel and was scooped out with a bucket. Bucket showers were the norm. The sewage system was inoperative. It was hot and humid most of the time. A generator worked on and off, but was shut off for the night at 10:00 P.M. Like the rest of the city, the house was dark and the team depended on flashlights, often stumbling in the dark over medical bags. Rats were seen by some team members.

The team, like many Haitians, encountered medical problems. One person slipped due to the uneven ground, and broke a bone. A number of team members were struggling with stomach and intestinal problems, serious enough that several were unable to perform their duties, and were on intravenous solutions. Their illnesses lasted for several days. No one knew if the illness was caused by the living conditions, parasites, or something else. One of the disaster relief workers, who seemed especially ill after a particularly difficult night, unexpectedly stopped breathing. Despite all efforts to revive him (in an environment of limited medical services and facilities), he died, evoking much frustration and a sense of helplessness. The loss of a team member impacted everyone. Like so many Haitians, the team had lost one of its own. They were not expecting such a loss, despite a chaotic environment of destruction, displaced people, great loss, and lack of regular services. The team member was a young father who was supposed to go back home to his wife and two sons. The team had to deal with the sudden loss and grief, similar to what so many Haitians were dealing with.

The weeks in Haiti were filled with helping others and giving to those affected by the earthquake who had lost so much. In a parallel process, the crisis counselor and the disaster relief workers struggled with living conditions and the sudden death of one of their own. During the deployment, there were various ways of trying to cope, from individual journaling to talking with each other, to reaching out and doing something for others. After returning home, there was reaching out to family, friends, and others, as well as connecting with some team members.

It is important to understand that crisis counselors and other disaster relief workers deployed to large-scale disasters often deal with dual trauma (both primary and secondary), since they are part of the disaster-affected community during the deployment, and concurrently function as professionals serving the disaster-affected community (Ostodic, 1999). The impact that shared trauma has on the individual crisis counselor or disaster relief worker depends on the nature, intensity, extension, and duration of the shared trauma, as well as individual factors (e.g., age, gender, etc.), resiliency and stress buffers (e.g., optimism, extraversion, etc.). Emotional and psychological effects of shared trauma can include sadness, crying, depression, confusion, intrusive thoughts, sleeping

problems, nightmares and night terrors, as well as a break in their basic beliefs about themselves, others, and the world.

Shared trauma can result in crisis counselors and other disaster relief workers feeling a unique identity with the survivors and others they served when they were deployed. After deployment to large scale disasters, it is not unusual that crisis counselors and other disaster relief workers have an increased need for security of self and others.

Counseling can be an effective way to help crisis counselors and other relief workers deal with the effects of shared trauma, however not everyone who has been deployed will need these services. When shared trauma is addressed in counseling, it is important that focus is given to (a) empowerment (to help crisis counselors and other disaster relief workers take responsibility for their own lives), (b) validation (of the experience and what has happened during their deployment), (c) hope (for others and themselves for a better future), (d) relationships (with deployed team members, but also family and friends), and (e) safety (the western phenomena of a person's sense of safety about themselves, others, and the world). In addition, focus needs to be on talking and processing out the shared trauma experienced. Traditional talk therapy, as well as techniques such as relaxation and guided imagery, can be very helpful. When looking at the benefits of counseling, it is important to remember that shared trauma can also provide an opportunity for post-deployment growth.

More attention needs to be paid to shared trauma by both researchers and counselors in order to gain a better understanding of the short and long-term effects of shared trauma on relief workers' personal and professional lives, as well as on how resiliency and stress buffer the impact of shared trauma. In addition, research should look at how education/training and supervision impact shared trauma. It is important to explore how best to educate counselors and counselors-in-training about shared trauma. The inclusion of one course in a student's counseling curriculum does not seem to be enough (Cunningham, 2003) as there is a need to provide counselors with more comprehensive training (e.g., a series of courses leading to a certificate) that would address shared trauma along with the other important topics in the field of traumatology.

Conclusion

This paper is an effort to capture the importance of crisis counselors and other disaster relief workers becoming more aware of and knowledgeable about the phenomenon of shared trauma. Similar to vicarious trauma, compassion fatigue, and secondary trauma, shared trauma should become something that is not only well researched, but also well understood by crisis counselors and other disaster relief workers so that it can be attended to proactively. The above example was chosen to illustrate how crisis counselors and disaster relief workers can be challenged by physical and psychological challenges similar to those of disaster survivors, by living and functioning in the disaster zone.

When dealing with shared trauma, it is important that crisis counselors and disaster relief workers become knowledgeable about this phenomenon so that they can deal with their own needs during and after deployment. These needs might include seeking out social and professional support as well as other resources and services. There

is a need to do more research in the area of shared trauma and self needs of crisis counselors and disaster relief workers.

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