Intervention in a Shared Traumatic Reality: A New Challenge for Social Workers

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Abstract

Shared traumatic reality refers to those situations in which social workers help survivors cope with the very traumas that they themselves have been threatened by and/or exposed to, given the reality that they live and work in the same community as their clients. This paper is an initial attempt to present the knowledge gathered to date about providing treatment in shared traumatic realities. It reviews the various definitions and uses of the concept in the literature, the negative and positive impact derived from working in these situations, the unique characteristics that define and might help explain the resultant consequences of working in them, and practical and future research recommendations.

Keywords: Social workers, shared reality, trauma, secondary traumatisation, vicarious traumatisation

Introduction

The profound, long-lasting and harmful effects of working with traumatised clients on those in the helping professions are well recognised in the literature. These effects have been termed 'compassion fatigue' (Figley, 1995), 'secondary traumatic stress' (Figley, 1995) and 'vicarious traumatization' (McCann and Pearlman, 1990). These concepts imply that the traumatised client's distress can be vicariously transmitted through the therapeutic process to the therapist.

However, in recent years, the professional literature has begun to acknowledge that indirect exposure through intervention is not the only way in which mental health professionals in general, and social workers in particular, are exposed or threatened. When social workers live and work in the same community as the people they serve, they are exposed to and/or threatened by the very same traumatising circumstances as their clients. Thus, they are not only clinicians helping survivors cope with the traumas they have encountered, but in some ways they are experiencing the trauma as well. In essence, social workers increasingly find themselves sharing the same trauma that affects their clients. This recognition has introduced a new concept into the professional literature: *shared traumatic reality*.

The concept of shared traumatic reality usually applies to situations in which the social worker not only helps the survivor of a traumatic event, but is also personally threatened and, in some cases, even hurt, by the same event; in these situations, both the social worker and the client are exposed to a similar threat. This phenomenon of 'shared trauma' typifies large-scale events such as terrorist attacks, wars and natural disasters—events that have increased in number and magnitude over the last decade (NCTC, 2007). In the majority of these instances, social workers suffer both from primary and secondary trauma, as they are both members of a traumatised community as well as mental health professionals serving that community (Ostodic, 1999; Saakvitne, 2002; Tosone *et al.*, 2003).

Although recognised, this phenomenon is given scant attention in the professional literature. This paper is an initial attempt to present the empirical and clinical knowledge gathered to date about providing treatment, especially by social workers, in shared traumatic realities. The following five main issues will be examined: the various definitions and uses of the concept in the literature, the negative and positive impact on social workers of working in a shared traumatic reality, the unique characteristics of these situations that might help explain their consequences, suggestions for helping social workers cope with the experience of shared traumatic reality, and recommendations for future research.

Shared traumatic reality: a range of definitions and uses

A review of the literature reveals three main approaches to the uses of the concept of shared traumatic reality. The first includes those who refer to this phenomenon directly, using the words 'shared tragedy', 'shared reality' or 'shared the same stress'. Among the first authors to focus on shared traumatic reality were Kretsch *et al.* (1997) in their paper, 'A shared reality of therapists and survivors in a national crisis as illustrated by the Gulf War'. In this paper, they discussed how, during the Gulf War, therapists and clients in the centre of Israel—equally exposed to the threat of Scud missile attacks—sat together in sealed rooms, wearing gas masks.

The terrorist attacks of 11 September 2001 increased the awareness and recognition of the concept of shared traumatic reality among therapists and others in the field. Saakvitne (2002) used the terms 'shared trauma' and/or 'shared tragedy' when referring to the vulnerability experienced by both patients and therapists. Eidelson *et al.* (2003) used the term 'shared tragedy' and Seeley (2003)—referring to the trauma experienced simultaneously by therapists and their clients—emphasised the fact that some therapists had family members who were injured in the attack, or personal property that was damaged.

Few studies have examined the consequences of continuous terror in Israel on social workers. Somer *et al.* (2004) analysed social workers' emotional responses to working with civilian casualties in the wake of an unprecedented surge of terrorist violence in the year 2000. The authors referred to these social workers as part and parcel of the attacked community. The impact on social workers of ongoing terror attacks was also conducted by Shamai and Ron (2009), who raised the question: 'What happens to social workers in situations in which they share the same reality as their clients?' (p. 4).

In a recent study, Lev-Wiesel *et al.* (2008) focused on the impact of war on practitioners who, as citizens, were living through the same war reality as their patients (p. 2). According to this study, the simultaneous traumas experienced by patient and therapist produced a clinical situation in which workers were shaken, threatened or hurt by the same catastrophic events that had befallen the clients they were treating.

Other studies, too, while giving credence to and actually describing the concept of shared traumatic reality, did not explicitly use the term, reflecting the second approach to the uses of this concept. In Israel, Loewenberg (1992) explored the unique dilemmas faced by social workers in times of war, when both they and their clients confronted the same threat, though the term 'shared traumatic reality' was not used. Likewise, the specific term was not mentioned when Itzhaky and Dekel (2005) examined the factors that contributed to the effectiveness of social workers who lived in communities that were exposed to terror and who worked with victims

of terrorism. Additionally, several studies assessed the emotional burnout and compassion fatigue experienced by workers following their work with 9/11 victims without relating specifically to the unique aspect of their having been exposed to the same traumatic events as their clients (Boscarino *et al.*, 2004; Adams *et al.*, 2006, 2008).

The third approach to the uses of the concept of 'shared traumatic reality' includes studies that recognise this unique phenomenon but exclude to the greatest extent possible the shared aspects. For example, Creamer and Liddle (2005), examining secondary traumatic stress among disaster mental health workers who responded to the 9/11 attacks, purposely excluded from their sample those workers who were within fifteen miles of the attacks when they occurred, or who had a family member or close friend in the vicinity during the attacks. By excluding these workers from the study sample, these researchers were implicitly acknowledging their awareness of the fact that shared traumatic reality has a unique impact on the professionals working with these clients.

While this phenomenon has been given many names, the current review will employ the term 'shared traumatic reality'. We believe this term encompasses the fact that far beyond the single unique trauma shared by a specific therapist and a client, there is a wide reality shared by them as well as by additional workers and clients.

The impact on social workers while working in a shared traumatic reality

Studies exploring the impact on professionals working in shared traumatic realities revealed negative as well as positive consequences.

Negative consequences

Most of the studies that have examined the impact of working in a shared traumatic reality indicate that mental health professionals suffer from emotional distress both in the immediate aftermath of the traumatic event and up to a year later. Eidelson *et al.* (2003) reported that following 9/11, psychologists described feelings of loss, fear, pain and grief. Similar feelings of distress were related by Israeli social workers during times of terror (Cohen *et al.*, 2006)—feelings that included pain, sorrow, fear, threat, uncertainty and sometimes even helplessness. Similar emotional distress was also reported by Shamai and Ron (2009). They indicated that the emotional distress manifested itself in a physical way; social workers reported feeling dirty, craving sweets or feeling the physical need to touch their children. Emotional distress was also found among students

working in a shared traumatic reality following 9/11 (Tosone *et al.*, 2003) and terror attacks in Israel (Baum, 2004).

While the above studies, which collected qualitative data, described a wide range of emotional distress, studies that employed quantitative measures revealed relatively low levels of distress. For example, only a small (7 per cent) percentage of hospital social workers who provided emergency treatment to victims after terrorist attacks in Israel reported secondary traumatisation (Dekel *et al.*, 2007). The workers' levels of distress were significantly lower than those reflected in the general Israeli population. In a study that was based on several quantitative measures collected from 406 social workers from the three different types of agencies involved in helping victims of terror attacks and their families, Shamai and Ron (2009) also reported on low-level secondary traumatisation. A similar trend was found among social workers in times of war (Lev-Wiesel *et al.*, 2008) and following 9/11 (Adams *et al.*, 2006, 2008).

Along with emotional distress, studies reported on a decrease in professional competence. In a Batten and Orsillo (2002) study, some therapists reported that they felt they were less effective than usual. Others reported that they were so tired of hearing about the particular traumatic event in question that they might have subtly and unintentionally discouraged their clients from talking about it. All of them experienced feelings of guilt due to being more oriented to their own needs than to those of their patients. Saakvitne (2002), in exploring her own professional functioning after 9/11, admitted that she became teary in response to her patients' material and that she identified with some patients' responses while not with those of others. Based on her experiences and on those of her peers, she observed that many felt 'de-skilled'—a feeling that, in turn, caused guilt and/or shame. Seeley (2003) describes the way 9/11 rendered many therapists unable to pull themselves out of their patients' subjective worlds. Some therapists saw themselves in their patients' devastation, and seemed comforted by patients who voiced feelings that they shared. In a quantitative study conducted by Eidelson *et al.* (2003), 50 per cent of the therapists reported feeling at least slightly professionally unprepared.

The decrease in feelings of professional competence was also found among social work students. In Tosone *et al.* (2003), students reported a lack of empathy, difficulties in helping others and helplessness with respect to their clinical abilities. These symptoms, excluding lack of empathy, were also mentioned by students in Israel (Baum, 2004; Nuttman-Shwartz and Dekel, 2007).

Positive effects on professional performance

Along with the negative impact of trauma, therapists in a shared traumatic reality reported on positive effects following these experiences. Batten and

Orsillo (2002) mentioned that a number of therapists felt that the level of emotional intensity they experienced in the wake of a terrorist incident actually allowed them to be in better contact with their clients' emotions and helped them to respond more empathically and effectively in session. Findings also indicate that many professionals experienced a renewed commitment to the profession and to their clients (Seeley, 2003), and an increase in positive feelings about their work (Eidelson *et al.*, 2003).

Plummer *et al.* (2008) found that despite the fact that following Hurricane Katrina, students experienced a wide range of personal and familial disaster-related stressors, huge numbers of them responded to the need for voluntary assistance in their communities. Moreover, student voluntarism was positively related to their disaster-related stressors. Thus, their personal exposure led to an even higher level of altruism than might otherwise have been expected.

Surveying a sample that comprised primarily social workers who took part in an outreach service to survivors of the 1993 flood in the state of Illinois, Soliman *et al.* (1998) reported that although the experience was intense, most of the workers indicated that it had had a positive impact on their personal lives. They cited personal growth, rewarding feelings and confidence building as some of the positive aspects they took away from the experience.

Based on a study regarding social workers who worked with terror victims, Shamai and Ron (2009) concluded that these individuals experienced the help that they provided to the victims and their families as having contributed to their own personal and professional growth. Similar findings by Lev-Wiesel *et al.* (2008) show that social workers and nurses who worked in a hospital during the Second Lebanon War reported Post Traumatic Growth (PTG). As with the Shamai and Ron (2009) study, the Lev-Wiesel *et al.* (2008) study also found that PTG coexisted with symptoms of distress.

Similar findings appeared in a study conducted on social work students. Tosone *et al.* (2003) found that the students experienced feelings of gratitude, strength, hope, defiance and love, as well as a renewed desire to find meaning in life. Some of the students also experienced an increase in feelings of empathy and connection towards clients, a greater need to be involved and communicate with them and a newly found sense of confidence as professionals.

In keeping with the above findings, Hernandez *et al.* (2007) suggested the concept of 'vicarious resiliency', based on interviews they conducted with mental health practitioners who had worked with victims of political violence. These practitioners said that witnessing their clients overcome adversity affected and changed their own attitudes and emotions regarding the human being's capacity to heal, and also his/her perception of his/her own problems. They suggested that these effects went beyond therapy, and significantly shaped workers' perceptions, relations and their environment.

The above-mentioned studies document both the emotional distress and the decrease in professional competence alongside the sense of satisfaction and professional growth experienced by mental health professionals working in shared traumatic realities. In order to shed more light on these findings, we will present several potentially unique characteristics resulting from shared traumatic reality.

Sources for distress and professional growth

The sources for the emotional and functional consequences of working in a shared traumatic reality stem from the fact that this reality—this stressful, tragic reality—is, simply, shared. More specifically, the 'sharedness' of the traumatic reality blurs the professional's boundaries, both external and internal. First, we will discuss the implications of the professional having to handle the consequences of a large-scale traumatic event while being part and parcel of the attacked community itself. Next, we will focus on issues that relate to the worker's personal experiences, namely loss of a person to whom he was close, and the 'loyalty conflict'. Finally, we will discuss the sources that are rooted in the nature of the 'helping relationship' and in the meeting between worker and client.

Large-scale traumatic events

Providing help during large-scale traumatic events is a source of distress for mental health practitioners. Most of the helping professionals after 9/11 reported feelings of helplessness due to the challenges posed by the large numbers of people trying to cope with intense pain (Eidelson *et al.*, 2003). Helplessness has also been mentioned by professionals working with victims of terror in Israel, due to their limited ability to help their clients cope with the magnitude of their suffering (Cohen *et al.*, 2006; Lev-Wiesel *et al.*, 2008). Some professionals also report feelings of helplessness due to their sense of being in physical danger while lacking any means of protecting themselves (Shamai, 2005).

Losing a meaningful person outside the immediate family

Studies indicate that a shared traumatic reality may involve a personal loss that the social worker has to cope with while also fulfilling his or her professional duties (Seeley, 2003). Shamai (2005) reported the cases of two social workers who had lost their husband in an attack some years earlier. According to her report, these workers' experience made them more sensitive to the feelings of clients who had suffered a similar loss. Baum (2004)

exemplifies how students who sustained a loss of a meaningful person outside their immediate family coped with the need to continue their fieldwork. Most of the students discussed their struggle to make emotional space for their clients when they themselves could barely contain their own feelings. A similar source of distress was identified by Shamai and Ron (2009), who found that 18.2 per cent of the 406 social workers who participated in their study had sustained the loss of a meaningful person outside their immediate family.

The conflict between personal and professional loyalties

Being a helping professional and at the same time a member of an attacked community exposed these individuals to the blurring of boundaries between personal and professional obligations. In an early paper, Loewenberg (1992) pointed to competing loyalties as one of three major dilemmas faced by social workers in times of war. Based on interviews conducted with social workers in the aftermath of a war, he indicated that many reported situations in which they had to deal with conflicts between loyalty to their clients and loyalty to their own families. They found themselves confronted with questions such as: Is it right for me to leave my family even though there might be another missile attack? What kind of mother leaves her young children when they are frightened and confused by the events of the past hours? Similar questions were raised by mental health professionals in times of continuous terror (Somer *et al.*, 2004).

The need to make a quick transition from the private space of a family setting, for instance, to the workplace is complex. It is not always fully achieved, as vivid pictures of the professionals' own families penetrate their minds and affect their experiences in working with terror victims (Shamai and Ron, 2009).

How do mental health professionals handle this pressure and dual role? Experts in the field who have studied this question indicate that the professionals' immediate thoughts and reactions are directed toward their personal obligations as mothers, relatives and family members; only afterwards are they ready to function as mental health professionals. In other words, before attempting to address their clinical responsibilities, the majority of these individuals need to get their personal distress under control, by ascertaining the well-being of their loved ones. Only then will they feel able to resume their professional roles. Indeed, Granot (1992) reported that in the Gulf War, some of the social workers were young mothers who did not come to work. He suggested that clarifying and defining the nature of their role during an emergency would enable workers to feel that their contribution was essential and would decrease their loyalty conflict.

Changing the professional setting and roles

Large-scale traumatic events disrupt the professional therapeutic setting as well as the roles played by therapist and client. While this disruption is not unique to shared traumatic reality, it is an additional challenge presented by it, especially because in situations of shared reality and in the wake of traumatic events, social workers play a wide variety of roles.

In the acute phase of a traumatic situation, some social workers find themselves having to meet with the affected people where they physically are. Kretsch *et al.* (1997) emphasised that when working with evacuees, it was crucial to ensure that the therapeutic environment created would be stable enough to meet their basic needs and flexible enough to permit psychotherapeutic contact; in addition, the boundaries would have to be sufficiently permeable to foster the evacuees' ability to leave the temporary emergency setting and return to the outside world as quickly as possible.

Flexibility is also needed in adapting the role of the mental health professional to the circumstances necessitated by the traumatic situation. Without question, these situations give rise to changes in the professionals' regular roles and obligations. For example, Gibson and Iwaniec (2003) reported that they served food to the survivors of a traumatic situation—a task that had no less therapeutic importance than the therapeutic discourse they were able to conduct. Shamai and Ron (2009) similarly reported that social workers who helped terror victims in concrete ways perceived the technical tasks and the instrumental help they were providing—tasks that were not usually part of their work—as important to the victims and their families.

Blurring of boundaries between worker and client

While the concept of maintaining boundaries between workers and their clients in the helping professions is well known—and its importance well recognised—being a social worker and at the same time part of an attacked community necessitates the blurring of these boundaries.

Seeley (2003) described the way 9/11 rendered many mental health professionals unable to pull themselves out of their patients' subjective worlds. Many reported on their efforts to help patients while their own wounds and fears were still raw. Therapists saw themselves in their patients' devastation, and seemed comforted by patients who voiced feelings that they shared. Many therapists found it more difficult than usual to separate their lives from their patients' lives. Tosone *et al.* (2003) elaborated on the difficulty experienced by the worker in maintaining any emotional distance from the clients she was serving, as the disaster itself was such an

'equalizing experience'. At the same time, she also realised that caring for her clients in the aftermath of 9/11 fostered the greatest intimacy between her and her clients (Tosone, 2006).

Full discussion of what happens to therapeutic relationships in times of shared trauma and the contribution this dynamic makes to the workers' distress and growth is in its developmental stages. While some authors describe the emergence of a greater intimacy in individual sessions (Tosone, 2006), others suggest an extreme difficulty in maintaining the intervention due to external and internal threats (Benson *et al.*, 2005). A further discussion of these kinds of 'helping relationships' should take into account the variability in type of external event, the type of intervention (crisis, supportive or longer interventions), the method of intervention (group versus individual), the type of organisation that employs the social worker (public organisations or NGOs) and the length of the intervention.

Circles of support

The role of social support from both close relatives and society at large, in terms of the healing process of victims of traumatic events, has been well documented (e.g. Shamai, 2005; Shamai and Ron, 2009). In cases of shared traumatic realities, the circles surrounding the social worker—family, colleagues and professional organisations, as well as the larger society in general—are also part of the attacked community and account for the social worker's resilience or distress.

The closest circle surrounding the social worker is his or her family. Findings show that the social worker's family is an essential source of support. Based on 409 social workers' experiences, Shamai and Ron (2009) concluded that their families were hugely significant and affected them on both a personal and a professional level throughout the entire course of intervention. In addition, the readiness of family members to take over household chores and child-care responsibilities enabled the social workers to fulfil their professional duties. Listening to and containing the social workers' painful experiences were also critical, especially when this type of support came from their partners. Conversely, lack of practical and emotional support from one's own family increased the social worker's distress and caused a decrease in their professional competence.

Dyregrov (1989), detailing the way in which disaster workers are debriefed after a traumatic event, emphasised that they often experience a great deal of distress upon their return home and in their interactions with their families. Sometimes, the tension between their work and the routine of life is too great, and Dyregrov therefore suggests that in order to develop support within the family, family members should be included in the disaster worker's follow-up care. For example, family members should be given a list of support group meetings they can attend; they

should also be provided with written material that might help them better understand the work/family conflict that their loved one is experiencing.

The second circle surrounding the social worker comprises colleagues and professional organisations. Coping with task overload—an ongoing source of stress—and containing the horrifying contents of the clients' experiences are handled more easily when the social worker has support from colleagues and professional organisations. Working in co-worker teams, for example, when treating terror victims was found to alleviate social workers' distress (Cohen *et al.*, 2006). Further evidence supporting this idea comes from Seeley (2003), who found that professionals who had no one (neither peers nor colleagues) with whom they could discuss their work reported high levels of emotional distress.

Managerial and supervisory support was found to be another essential source of resilience for the social workers. Baum and Ramon (in press) found that social workers who felt that they received managerial and supervisory support during times of ongoing terror attacks reported lower levels of distress and higher levels of professional growth.

Campbell and McCrystal (2005) found that approximately one-third of social workers in Northern Ireland were dissatisfied with the support provided by the agencies for which they worked. Moreover, more than one half did not even report their concerns and difficulties when working with particularly troubling incidents that occurred during their employment with these agencies. Workers with a greater number of clients, and basic-grade social workers, were more likely to be critical of agency support.

The third circle surrounding the social workers is society at large and the culture in which the social workers work. Society's reactions to the social workers' efforts and contributions to the community during times of catastrophic disaster are meaningful. After 9/11, for example, the country 'pulled together'—a feeling that provided support for the activities of the mental health providers (Eidelson *et al.*, 2003). Shamai and Ron (2009) suggested that the strong support and recognition received by social workers who were taking care of terror victims helped them to perform their work and increased their sense of satisfaction and professional growth. They suggested that social workers experienced the help they provided to victims of terror as part of their very commitment to their country; they also felt that in doing their work, they were reflecting their country's culture of obligation to these victims of national terror.

Plummer *et al.* (2008) suggested that the students' heightened level of voluntarism following Hurricane Katrina may have been influenced by the fact that the hurricane severely impacted the entire Gulf Coast area and the communities in which the students and their loved ones lived. This possibility reflects the fact that the social worker's commitment to the society in which they live—and their feeling of belonging to it—may have a greater effect on their subsequent behaviour than the type of traumatic event itself.

Clearly, there are many different types of traumatic events (e.g. natural disasters, terror) as well as cultural contexts in which they unfold. Some events, which are characterised by an external threat, find the entire society unified against them; however, in other events, such as those that have taken place in Ireland, the cultural backgrounds of the worker and client will be determining factors in the ensuing relationship between them and may result in different contexts for intervention (Campbell and McCrystal, 2005).

To sum, in the context of shared traumatic reality, support must be seen as more than 'simple support'. Being part of three supportive circles in the attacked community while simultaneously serving this community enhances the workers' feelings of belonging and is critical for the carrying out of this difficult and sensitive work, potentially leading to the development of vicarious resiliency (Hernandez *et al.*, 2007) or secondary post-traumatic growth (Arnold *et al.*, 2005).

Suggestions for practice: what can be done to help social workers cope with situations of shared traumatic reality?

The concept of shared traumatic reality has only recently begun to be explored. We can suggest several possible reasons to explain this avoidance. First, the developmental history of this domain of study is relatively short. Only in the aftermath of the Vietnam War, when the direct effects of exposure to traumatic events on the soldiers who were victims themselves became apparent, were we able to acknowledge and validate their experiences. Notwithstanding this already considerable delay, many more years passed before the 'second clientele'—the families of the soldiers who suffered from PTSD—was recognised in the professional literature (Figley, 1983). Only then did the effects of working with individuals experiencing traumatic events become evident (McCann and Pearlman, 1990; Figley, 1995). The development of knowledge on the effects of trauma therapy on therapists has expanded in the last decade, but there is still debate on the extent (Sabin-Farrell and Trupin, 2003) and the validity of the concept (Jenkis and Braid, 2002). Another reason for this avoidance might be anchored in the basic perceptions of therapy, which differentiate between patients and therapists. Despite the decrease in the importance of maintaining boundaries in some methods of therapy, such as intersubjective perception, boundaries are still a central issue. Thus, the idea of focusing on the shared aspects of an experience in real life and not only in the therapeutic setting presents a real challenge to practitioners of traditional psychotherapy. Moreover, 'putting together' clients and therapists on the same side of the fence might raise unconscious fears of blurring all such boundaries.

This paper should be viewed as an additional step towards exploring this concept. Based on the current knowledge, several strategies can be

suggested to help social workers better cope in situations of shared traumatic reality.

Taking care of the social worker's physical safety

Ensuring the physical safety of social workers, as much as is possible, should be one of the first goals in terms of enabling them to carry out their work effectively. Their workplace should be protected and in times of continuous threat, their way there and back should be guarded.

Taking care of the social worker's personal worries

Managers and supervisors must give priority and legitimacy to the social workers' needs to address the well-being of their family and relatives. As findings repeatedly show, social workers are only able to perform their professional duties after establishing that their loved ones are okay (Shamai and Ron, 2009).

Time limits and taking care of overload

The sheer number of cases and the desire to alleviate the victims' suffering sometimes result in case overload and worker exhaustion (Cunningham, 2003). The number of hours the social workers work during such circumstances should be monitored and the caseload should be controlled.

Improving preparedness

Seeley (2003) highlights the importance of improving social workers' preparedness. In most cases, the basic curriculum for undergraduate students of social work and psychology includes only a theoretical course on the nature and effects of trauma (Cunningham, 2003). Campbell and McCrystal (2005) found that 60 per cent of the individuals in their sample did not appear to have received any training that would have equipped them to deal with the fallout from the troubles that ravaged Northern Ireland in the past. Continuous and advanced education and training for social workers should be provided, so that they will know not only how to help traumatised clients, but also how to recognise and cope with the possible effects on the workers who assist them. According to Ramon *et al.* (2006), special attention should be paid to training social workers in how to handle the ethical dilemmas that might arise during shared traumatic realities, particularly in cases in which political conflict forms the basis of the traumatic

event. For example, social workers need to learn how to respond to clients who espouse views contradictory to basic social work values; they must also receive training on how to relate to clients or colleagues who are from the 'other side'.

Working in pairs

Efforts should be made to enable social workers to work in teams of two. Working together as opposed to alone is crucial in terms of getting the support one needs in traumatic situations. Working as a team also leads to an emotional and professional partnership—during the process and afterwards—and enables both individuals to take time breaks and reorganise emotionally (Gibson and Iwaniec, 2003; Somer *et al.*, 2004).

Identifying workers at high risk

Since an individual's vulnerability might be reactivated in traumatic circumstances, supervisors should make every effort to identify a social worker's situational vulnerability. For example, social workers who have sustained a loss of a meaningful person outside the immediate family might be at higher risk for emotional distress and unresolved grief (Baum, 2009). Workers who are mothers of young children (Granot, 1992) or whose spouses are employed in similarly sensitive sectors (e.g. emergency or medical workers, security or defence units) are also more subject to experiencing a conflict in loyalties. This situation has to be recognised and taken into account in order to assure early preparedness for future events.

Recommendation for further research

Understanding the consequences of working in a shared traumatic reality is currently achieved by using primarily the existing concepts and measures of secondary traumatisation, compassion fatigue and/or vicarious traumatisation. Based on the literature review, these concepts seem to capture only part of the picture. For instance, they do not take into account the blurring of boundaries between the social workers' professional and personal loyalties, and the difficulties in maintaining the boundaries between social worker and client. In addition, the phenomenon of 'shared traumatic reality' is currently used in a too simplistic fashion. Shared traumatic reality is a concept that encapsulates more than common exposure. In order to better understand situations of shared traumatic reality, recommendations for further research are suggested.

Shared traumatic reality has been explored mainly in terms of manmade events, namely ongoing traumatic situations such as wars (Lev-Wiesel *et al.*, 2008), disasters such as the 9/11 terrorist attacks or terror attacks in Israel. There is a need to explore this phenomenon in terms of natural disasters as well. Doing so would enable researchers to find similarities and differences in the ways mental health professionals react to and cope with different types of traumatic events. Exploring the long-term effects of working in a shared traumatic reality would also yield crucial information on the subject.

Large-scale events are not the only events in which social workers must work in a shared traumatic reality. Size-limited catastrophes such as mass shootings and events that occur in smaller communities—dormitories, mental health hospitals or clinics, therapeutic communities for substance abusers—also require mental health professionals to work in shared traumatic realities. We suggest that the examination of the consequences of working in such situations and communities be done using the shared traumatic perspective.

An additional issue worth exploring is the scope of the 'sharedness'. Some social workers live and work in the same area. If a traumatic event occurs in this area, these social workers are required to provide care for the exposed population in the very same place in which their personal lives are conducted. Other social workers, who do not live in the area, come and go; therefore, they are sharing the same traumatic event but only while they are at work. They have the option to leave and to sleep in a distant and quieter place. So, while they share the same reality, they share it to a lesser degree. When comparing these two types of social workers, we hypothesise that the ones with fewer options to leave will have greater difficulties in the treatment process. The conflict between the personal and the professional self will be stronger and this conflict should be further explored.

Another area worthy of further study is just how 'shared' the traumatic reality really is. In other words, it would behove the researchers to look at similarities in the objective level of exposure experienced by both social worker and client (such as type, length and proximity to the event) as well as subjective dimensions of exposure (such as level of fear and help-lessness). If the lives of both the therapist and client were in actual danger, intervention would be far more complex than cases in which both were exposed to the 'same traumatic event' but experienced it differently.

The impact of personal similarities between the social worker and client should also be noted and taken into account. On the one hand, sharing the same race and cultural background could increase identification and could result in boundary blurring between social worker and client. On the other, coming from different backgrounds, particularly if the therapist shares a background with the aggressors—for instance, a Moslem therapist following 9/11—could result in a relationship marked by suspicion and difficulties for the client in developing the necessary therapeutic trust (Seeley, 2003).

Campbell and McCrystal (2005) noted that the majority of social workers in Northern Ireland were Catholic—a situation that did not reflect the balance in the population and may have resulted in the client's feeling uncomfortable and suspicious of the social worker. Ramon *et al.* (2006) explored this issue by looking at social workers from three countries: Israel, Northern Ireland and Palestine. Specifically, they examined how the social workers perceived ethnic and national differences within and between the workforces. They found that although some Israeli Arab social workers felt rejected by their Jewish colleagues in the aftermath of a violent event, in general, the usually cordial relationships simply turned silent, with no real discussion of the issues. A small minority of Israeli Jews questioned the motives of its own group and the way it treated 'the other'.

The social workers' personal characteristics—such as their ability to adapt to new situations and their personal ways of coping—should be examined in order to understand their reactions in shared traumatic realities. Exploring their sense of belonging to the three 'circles' that surround them—family, colleagues, supervisors and organisations, as well as the society and its culture—might also shed light on their level of resilience, and from whom they derive the most relief.

In conclusion, the assumption that governs our discussion is that when the therapist has less 'space', it is more difficult for them to stay out of the traumatic situation and to protect themselves, and the complexity of the treatment therefore increases. If the therapist and client share not only the traumatic event itself, but additional characteristics as well—such as the perception of the event, personal identities or background variables and/or a prior acquaintance—this greater 'sharedness' will make therapy more complex.

In situations of shared reality and in the wake of traumatic events, social workers play a wide variety of roles. Therefore, we believe that the concept of shared traumatic reality should be analysed further in order to better understand and anticipate the difficulties that may arise in the different therapeutic settings. By understanding and researching the challenges faced by our mental health professionals in these situations, we will be providing a valuable service to our patients as well.

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