The employee victim of violence: Recognizing the impact of untreated psychological trauma

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Abstract

The impact of psychological trauma in the workplace often goes unaddressed. The untreated aftermath of these critical incidents may manifest itself in various states of anxiety, depression, substance use disorders, and even subsequent violence by the victims. This paper reviews common presentations of untreated traumatic events and provides suggestions for outreach to untreated employee victims as well as basic prevention strategies to reduce the risk of additional episodes of violence and enhance safety in health care facilities, including long-term care (LTC) and special-care units (SCU) for dementia patients.

Key words: acute stress disorder (ASD), employee victims, long-term care (LTC), post-traumatic stress disorder (PTSD), special-care units (SCU), workplace violence

Introduction

Psychological trauma is an individual's physical and psychological response to a sudden, usually unexpected, overwhelming, potentially life-threatening event over which the individual has no control, an event which would cause intense fear in the average person.[1-3] It may occur when an individual is confronted with actual or threatened death or threat to one's physical integrity.[1] An individual may be traumatized by experiencing such events directly or witnessing these events happening to others. The victim may experience disruptions in the domains of reasonable mastery of the environment, caring attachments to others, and a sense of meaningful purpose in life as well as the symptoms associated with traumatic events, especially hypervigilance, exaggerated startle response, intrusive memories, and a desire to withdraw from routine activities.[2-3] For 30 days post-event, the immediate distress is known as acute stress disorder (ASD).[1] If the symptoms continue past 30 days or appear for the first time after six months, the victim has developed the medical condition known as post-traumatic stress disorder (PTSD).[1]

Natural or human-made disasters (*e.g.*, a fire in a facility), physical assault (*e.g.*, by a patient, in domestic violence, or in the course of a robbery), and sexual assault (*e.g.*, rape, sexual exposure) are common examples of potentially traumatizing events that may occur in the workplace. Although some employee victims experience minimal distress during these incidents, the more common outcome is the serious disruptions noted above. For many employee victims, these disruptions gradually subside. However, there are exceptions.

Since much psychological trauma is left unaddressed, one of these exceptions may include employee victims who were severely impacted by the event, but received no crisis intervention at the time of the event. A second exception may include employee victims who refused interventions or did not report the critical incident because of a sense of shame, fear of retaliation, appearing "unprofessional," or assuming that nothing can or will be done.[2]

The mind and body do not forget traumatic incidents, and the negative impact of these events may manifest themselves in a variety of health problems that may initially appear as unrelated to the traumatic event. Indeed, the employee victim may not understand the link between the traumatic event and present functioning. It would be of assistance to employee victims and to the workforce at large if administrative managers, union officials, clinical managers, and concerned colleagues were able to identify possible manifestations of untreated trauma and supportively direct their victim colleagues to needed assistance.

The purpose of this paper is to outline briefly some common presentations of untreated psychological trauma as well as some basic ways to provide needed support to these employee victims and to introduce risk-management strategies that may reduce the risk for further traumatic events.

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The faces of untreated traumatic events

In addition to ASD and PTSD,[1] employee victims may develop serious medical and psychological complications after traumatic incidents. These complications may evolve from PTSD, be co-morbid with PTSD, or exist by themselves. The following discussion is not meant to imply that all medical and psychological problems are caused by traumatic events, but to indicate some of the common associations reported in the literature. The employee victim and his or her physician will need to jointly assess the etiology of the symptoms.

Physical health problems

Exposure to trauma compromises one's physical health, even if PTSD has not developed. Those who have been victims are more likely than nonvictims to experience physical symptoms one year after the exposure.[4] Psychological trauma has been associated with heart disease,[5] HIV vulnerability,[6] morbid obesity,[7] encopresis,[8] gynecological problems,[9] and additional medical problems. Previously healthy employees with sudden onset of recurring medical problems may be experiencing unrelated medical illness, but may also be reflecting untreated traumatic sequelae in some cases. This potential association may assume additional importance if the employee was present at a known critical incident at the work site, and the physician or concerned colleague may want to consider this latter possibility.

Mental health problems

The more common psychological issues associated with untreated traumatic events include anxiety states, including PTSD; depressive states; substance use disorders; and violence itself.

Anxiety states

Traumatic events often activate the individual's emergency mobilization system for survival.[2] This response involves the release of adrenaline in the form of epinephrine in the body and norepinephrine in the brain. These neurotransmitters energize the individual to respond to the event and contribute in part to the victim's sense of fear, anxiety, and danger. Thus, anxiety states are one common presentation of untreated traumatic events.

Individuals with intrusive memories,[10] sleep disturbance,[11] and diffuse general anxiety[12] are presenting with the basic symptoms of untreated PTSD, although these individuals may not be drawing the link between a past traumatic event and the current state of impaired functioning.

Other untreated victims may present with panic disorder and its sudden terrifying fear that seems unrelated to immediate life events. While some panic disorder appears to run in families as a genetic illness and in other persons as a component of serious clinical depression,[2] some panic arises in victims who label normal bodily sensations after the event has passed as catastrophic.[13] This may create a cycle of recurring intense fear, which is experienced as panic.

A third common anxiety presentation is found in the emergence of obsessional thinking after the traumatic incident. Although some medical evidence has found that obsessional thinkers are born this way,[14] these individuals have been worriers all of their lives. In cases of traumatic aftermath, the obsessional thinking is sudden in onset and focused on scanning the environment to assess any new source of potential threat. The obsessionally thinking victim remains anxious that some situation is dangerous or may become so. Obsessional thinking in some victims provides the illusion of control.

Somatoform disorders form a fourth possible presentation of anxiety states subsequent to traumatic events. The victim's psychological distress is expressed in bodily symptoms rather than in words or feelings. Gynecological problems[9] or chronic pain states[2] may be expressions of the aftermath of sexual abuse and physical abuse in some victims.

Depression

All victimization involves some form of loss. The loss of choice in sexual abuse, the loss of physical integrity in physical abuse, and the loss of innocence in the world are common experiences of many victims that result in grief and depression. Again, although some depression may be solely medical,[1] much of it remains a response to loss and many victims are included in this grouping.[6,15-16] The victim feels violated, damaged, and does not know how to begin to resume normal daily living. Symptoms may include sadness, hopelessness, irritability, depression, problems with concentration and memory, and possible disruptions in sleep, appetite, and bowel functioning. Some have survivor guilt in that they have been spared where others have been lost.[1-3] In the absence of treatment and a chance to share the grief, the untreated victim may become depressed.

Substance use disorder

While substance use disorder may develop as a result of factors such as genetics, medical conditions, food allergies, and the like,[3] some substance use disorder appears to be associated with victimization.

The subjective distress associated with the symptoms of untreated traumatic events, anxiety states, and periods of depression often results in victims attempting to self-medicate

the untreated distress with alcohol and drugs.[2-4,6,17,18] Signs of possible substance abuse may include poor motor coordination; slurred speech; glazed eyes; dilated pupils; disruptions in appetite, sleep, and bowel functioning; and feelings of depression, hostility, irritability, or elation. Khantzian[19] has proposed a way of understanding this process of self-medication by focusing on the pharmacological properties of the drug of choice. In his experience, alcohol and barbiturates are taken to relieve anxiety, cocaine and amphetamines to relieve depression, and opiates to self-medicate states of rage. If the self-medication has been partially effective in relieving the untreated distress, attempts at sobriety often bring a return of the painful recollections of the critical incident and compound the problem of attempting to stop the substance use disorder.

Violence

One ironic, and sad, outcome of untreated traumatic stress is that some victims of violence themselves become violent toward others subsequent to their own victimization.[20-22] This may occur as the result of self-medication or substance use disorders, which may disinhibit the cortical centers of the victim's brain and result in verbal abuse, harassment, and physical violence in some cases. A second possible pathway is the resultant outcome of the victimization itself. Although the exact mechanisms remain unknown, it has been shown in both children[21] and adults[22] that some victims of violence become perpetrators of violence toward others at subsequent times in their lives. In some cases, the youthful victimization may result in an ingrained maladaptive pattern of behavior that persists over time and is known as antisocial personality disorder.

Implications for health care facilities

Outreach to victims

This overview has noted some of the more common presentations of the physical and mental health issues related to untreated psychological traumatic events.[1-12,15-18,20-22] Untreated trauma is associated with intense human suffering, medical and legal expense, increased utilization of sick leave and industrial accident claims, and decreased productivity.[2,3] Thus, it is in the best interests of employee victims as well as the facility to obtain needed support for untreated victims. This review has also noted that many of the possible presenting problems that appear associated with untreated critical incidents may well be due to other causes.[1-3,13,14,19] This differential diagnosis needs to be addressed in individual cases by a qualified practitioner, as noted earlier. The goal of the concerned facility staff is to provide needed support so that employee victims avail themselves of necessary care.

Research[1-4] has shown that social support or caring attachments to others helps to mitigate victim suffering and provides the supportive environment that enables some victims to come forward for assistance. This network of caring attachments is often disrupted in two basic ways. The first is by the withdrawal of the victim from caring attachments at the time of the crisis. Some event or individual in the health care facility has become dangerous and the victim withdraws. The second disruption may come from nonvictims. Violence teaches us how vulnerable we all are to random acts of violence. Instead of understanding that one's colleague victims of violence may be recipients of that randomness, many try to distance themselves psychologically from the violence by blaming the victims. This provides the nonvictim with the illusion of control under the assumption that the nonvictim would not permit himself or herself to become involved in the same way the victims have.

Since the goal of the caring support network is to resolve the victim's withdrawal, the facility will want to ensure that any victim-blaming attitudes and associated fears have been addressed in the nonvictim staff. The facility will also want to ensure confidentiality for employee victims so that any discussion with the victim and possible referrals for care are in strict confidence and do not become part of a personnel record, employee performance evaluation review, or formal additional incident report. Such formal documentation processes may again traumatize the victim, physically and psychologically, and result in further withdrawal.

If a member of the facility staff has concerns about the presence of untreated PTSD, the staff member can review the noted symptoms with the appropriate health care staff without revealing the identity of the employee victim. If there is agreement that there might possible untreated traumatic aftermath, the concerned staff member would next consider who in the facility could have the strongest links to the employee victim. The designated individual would then approach the possible employee victim, express the individual's concern and the reasons that this matter is being addressed, and gently invite a discussion of the matter. The goal is to express the individual's and facility's concern and to help the employee victim obtain needed assistance. This assistance can be provided by in-house psychological trauma specialists or by referral to qualified trauma specialists in the general vicinity. Outreach might need to be offered repeatedly, and the victim should be given assurances of confidentiality on each occasion.

Since victims may be further traumatized by discussing the critical incident in painful detail, a general rule of thumb is to encourage the victim to discuss the actual event in a modest way with the designated individual and in detail with the trauma care provider of choice. If the employee victim is

overwhelmed and unable to keep from discussing the event with the designated individual, he or she should alert the employee victim that he or she might feel more uncomfortable after having discussed the event. The victim should be encouraged to reach out for assistance with anxiety or depression (and possible suicidal ideation) rather than to withdraw further from others. A short-term plan for any needed immediate assistance could be temporarily put in place. When the employee victim feels supported and seeks assistance for the possible traumatic sequelae, the designated person and the employee victim can then jointly decide whether any additional, brief, follow-up contacts by the designated person are needed.

Prevention

To minimize the possibility of employee victims experiencing untreated traumatic after-effects, facilities can field risk-management strategies to address this need.[23] Of particular importance would be strategies for preventing crime through environmental design. These would include having adequate lighting, photographic identification for staff and visitors, the deployment of campus security, the use of nonbreakable Plexiglas in the emergency room, and similar strategies that would enhance the certainty of an assailant's being caught and thus act as deterrents. These strategies minimize the risk of violence by unknown individuals outside of the facility staff such as would-be robbers.

Facilities may also want to consider policies for addressing domestic violence in both patients and staff.[24] Violence that begins in the home may follow the victim to the facility and put the identified victim and other staff at risk. Campus security, the facility's legal department, human resources, and specialists in domestic violence can be of assistance in crafting a policy tapered to the needs of a specific facility.

Finally, facilities may want to field an in-house crisis intervention team.[25] This team would provide immediate individual crisis counseling to employee victims and reduce the possibility of untreated traumatic distress when critical incidents occur. The inclusion of these outreach and prevention strategies will result in enhanced workplace safety and sustained clinical productivity.

Untreated psychological trauma may be present in all types of health care providers including LTC and SCU staff. Addressing the needs of staff victims and fielding risk management strategies should result in enhanced safety and improved productivity in care settings for dementia sufferers.

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