Encyclopedia of Trauma: An Interdisciplinary Guide

Social Support and Trauma

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When dealing with trauma victims, social support is commonly thought of in three areas: perceived support, enacted support, and social integration. *Perceived support* refers to an individual's judgment that services or providers will be available to offer effective help and support in times of need. *Enacted support*, also described as support received during a crisis or traumatic situation, refers to specific supportive services or actions provided by agencies, providers, or organizations in times of crisis or need. *Social integration* refers to the extent someone who receives supportive services is connected to or within a social network. These networks can take a number of different forms such as family relationships, church memberships, circles of friends, work environments, and organizations that allow the individual a sense of social integration. Each of these forms of social support has different strengths; for example, some research has shown that perceived support is consistently linked to better mental health, whereas social integration and enacted support are not. Social integration has been linked consistently to physical health outcomes, and enacted support has not been linked consistently to either physical or mental health. In one study, enacted support has been linked to worse mental health. This entry discusses five sources of social support for trauma victims: workplace or occupational, familial, counseling, peer, and community.

Sources of Social Support

Workplace/Occupational Support

When workers are placed at risk in traumatic situations, both organizational and employee support becomes essential in processing the information.

Employee interaction and even process-oriented conversation aid in support for coping with work-related stress, and this carries over when that stress is related to trauma. Peer groups at a workplace can be a significant factor in healing and support when trauma has occurred. In traumatic situations where occupational hazards include physical harm and death, the camaraderie within the organization of coworkers is often what allows emotional processing to occur. Examples of this include firefighters, police officers, emergency medical technicians (EMTs), and nurses. Within the structure of these organizations, supervisors are often supportive in the same way as peers are. This is particularly true when compared with reactions of people outside of an organization, who might not understand the nature of the traumatic event. Processing experiences with others who have had similar experiences can make the difference between developing a traumatic disorder and assimilating and integrating the experience and moving on. There is, however, controversy and mixed evidence regarding the efficacy of social support from peers. And “reverse buffering” (a strong relationship between stressors and strains under conditions of high social support rather than under conditions of low social support) has been found in some of the research findings. What may mitigate this is whether the peer group comes across as supportive or nonsupportive with the individual.

Familial Support

In society throughout the world, the closest social relationships and context for understanding is usually found in the immediate family. Our histories with one another, our formed memories with each other, and our deep connections with family often dictate our perceived support and are very important in the healing process. Although family communication is sometimes

difficult, the level of intimacy opens the way for support to be perceived as benevolent and important. The family environment also buffers stress and stressful reactions to situations that are traumatic. The family structures that contribute to the best outcomes are those that are flexible, communicative, supportive, and cohesive. These families tend to be healthy, supportive, and functional, and they provide a supportive system for growth and healing. Families provide a mitigated factor that increases resiliency in the face of trauma. Research has shown that veterans who return from war zones integrate much better into society when they have stable and supportive family structures. This is in contrast to those individuals who were raised and return to a chaotic, dysfunctional family system. Families that are supportive allow a free expression of emotion, and the telling of stories allows the returning veteran the process of healing. Situations that stifle emotion and expression of experience often lead to an increase of adverse effects and a higher incidence of trauma-related disorders.

Counseling Support

Individual Counseling

Cognitive behavioral therapy has been shown to be particularly useful in the treatment of both acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). Although supportive counseling can be useful in the immediacy of a traumatic event, cognitive behavioral therapy allows for the processing of information, assimilation, and integration of the experience. Another technique available to counselors is eye movement desensitization and reprocessing (EMDR), a therapeutic technique that allows processing of feelings, emotions, and experiences in a rapid pace to process perceived negative self-messaging to reactions in traumatic conditions. EMDR has been shown to be especially effective in the area of anxiety, phobia, and the processing of traumatic events and situations that have led to ASD, PTSD, and dissociative disorders. Both of these strategies have long-term effects and seem to hold over time. These techniques significantly reduce intrusive thoughts and memories, avoidance responses, and depressive symptomatology and have shown themselves to be far superior to just supportive counseling. These techniques have been cited in the mental health literature as having the ability to prevent chronic PTSD, although not all studies have been unequivocally supportive of this conclusion.

In 2003, Steven Taylor, in an article for the *Journal of Consulting and Clinical Psychology*, examined the efficacy, speed, and incidents of symptoms worsening for three treatments of PTSD: prolonged exposure, relaxation training, and EMDR. Treatments did not differ in attrition, in the instances of symptom worsening, or on their effects on numbing and hyperarousal symptoms. Compared with EMDR and relaxation training, exposure therapy produced significantly larger reductions in avoidance and reexperiencing symptoms. Exposure therapy appeared to be faster at reducing avoidance and tended to yield a greater portion of participants who no longer met the criteria for PTSD after treatment. Though effective, EMDR and relaxation did not differ from one another in speed or efficacy.

Group Counseling

One of the significant effects of trauma is often that of isolation. The individual withdraws and limits contact with outside sources. Group therapy can provide powerful support and an opportunity to reconnect with others outside of their immediate family, and this fact alone can be an important step in the process of recovery. Group interventions can offer significant and sometimes unique advantages to deal with issues in which those who have suffered from

trauma have been most affected. In fact, group therapy can be useful for all types of situations in which trauma occurs. Individuals attending group therapy are sometimes placed in groups based on the trauma they experience, the symptoms they are experiencing, or at the stage of recovery in which they are currently working, immediately following trauma or long after it has occurred. Sometimes individuals have difficulty expressing themselves and opening up in group situations. When this happens, group therapy is contraindicated, and individual counseling strategies need to be reconsidered. Participation in groups often depends on the type of group, the goals of a particular group, the structure of the group, and the needs of the individual. Because those who have been through traumatic events are often vulnerable to overwhelming feelings, sometimes known as affective flooding, the structure or techniques used within the group may need to be varied, and intervention may seem different from other types of group therapy. Trauma survivors have a high need for safety, and those issues must be paramount in creating a safe environment for therapeutic exploration. Trauma survivors also need to develop significant coping skills long before they enter group therapy to be able to handle material that may be presented in the group that might be triggering. Group participants need to be careful regarding the discussion of traumatic material because of the emotional flooding that may occur by participants and not assume that any type of reexperience, abreaction, or discussion of material is necessarily therapeutic. Group facilitators must create clear boundaries and an explicit therapeutic agreement for what will transpire within the groups. In working with trauma survivors, four types of groups are identified as being useful: acute debriefing, supportive, cognitive behavioral, and psychodynamic.

Peer Support

Peer support is particularly useful when working with survivors of trauma because it encourages individuals to help one another. Peer support often occurs in natural community settings, and it can be adapted to specific ethnic and cultural circumstances. Peer support has the effect of avoiding the stigma that sometimes is associated with psychiatric care; it emphasizes outreach and focuses on individual strengths. Church groups, for example, tend to be culturally sensitive, and peer support within these groups is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. It can be an important strategy in the recovery process and in helping survivors of trauma reintegrate back into society, find work, engage in the community, deepen religious ties, and integrate their traumatic experiences into their life narrative. Peers can also offer each other practical advice and strategies for coping that professionals may not offer or even know about.

Community Support

Research on traumatic incidents has shown that community progress and developing trauma systems can be a slow and arduous process. The reason for this seems to be locked in a variety of political, financial, social, and organizational challenges. Community representatives from a broad base must be involved for a plan to be successful. Resources need to be tapped and allocated, leaders must be clearly identified, the system of delivery of services must be coordinated, and the financial backing needs to be in place. Often in trauma situations, high numbers of indigent and uninsured patients must also be attended to. In the wake of a natural disaster or traumatic event, communities become instrumental in the recovering process. One of the first areas is the need to connect with social support. It becomes important to establish contact with primary support people, which may include family

members, friends, and helping resources in the community. This social support from the community can come in a variety of forms: emotional support, such as someone listening to one's story, understanding what has happened, and receiving a sense of acceptance, or a social connection, which may include fitting in with a community and being with people with similar interests. Social support can come in the form of being needed; for some, this may take the form of helping others, working with support services, or in other outreach opportunities. Social support from the community includes providing reliable information after a traumatic event has occurred and physical or material assistance, such as offering loans to reestablish businesses or households. After a significant trauma, communities can help reconnect family members who have been separated. Communities can help individuals by connecting people to the services that they need and providing solid information about locations of supplies and be useful in providing shelter, water, food, and other practical assistance. It becomes important for communities to reestablish individuals and families to services that existed before the disaster. These services can include mental health counseling, attention to medical needs and physician services, social support services already mentioned, child welfare services, schools and educational needs, and drug and alcohol support groups, to name but a few. Cities often prioritize needs in the order of dealing with safety and human life, identifying those who are injured or deceased and providing for immediate needs of food, water, and shelter. Communities then begin the process of recovery to restore electricity and the basic infrastructure, including sanitation, water, sewer, and other utilities. Once these are in place, communities begin the reconstruction process. Communities also go through phases in dealing with reactions to trauma. Before a disaster or trauma, they hold drills and thereby experience the threat and warning stages. Communities then go through the process of facing the impact of the trauma and taking inventory regarding the extent of loss and disaster. Following a trauma, there are often stories of heroic intervention, and for a time, the community comes together in a sense of cohesion, often referred to as the *honeymoon phase.* Most of this occurs within 1 to 3 days. This phase is often followed by disillusionment regarding what has happened, services provided, and community response. Depending on the severity of the trauma, it may take 1 to 3 years for the community as a whole to work through the grief process and to come to terms with what has happened to the community. This is also a period involving reconstruction, forming a new identity, and developing a new sense of purpose within the community. This period in working through grief and then reconstruction may be marked by trigger events and anniversary reactions to the original trauma.

Other Factors

ASD and PTSD can develop after any traumatic event, but many people exposed to trauma do not necessarily develop either disorder. One mitigating factor to this may be vulnerability. Individuals with a family history of mental disorders, gender issues, genetic factors, dysfunctional personality traits, early traumatization, negative parenting experiences, and lower education have been found to respond poorly in traumatic situations. Other factors include the magnitude of the stressor, preparation for the event itself, and the specific reactions immediately following the trauma, particularly those of dissociation and coping responses. As stated earlier, an individual's social support system can mitigate symptoms of both ASD and PTSD. Strong emotional support has been shown to be a resiliency factor that significantly aids in the recovery process. It can moderate the effect of stress when social support functions to enhance coping abilities specifically related to the needs of those affected by a traumatic event. A socially supportive environment enhances recovery from trauma, encourages discussion of the event, and can be a mediator for the development of

symptoms for ASD or PTSD. When people feel supported and valued, they experience lower levels of distress.

There are gender differences to the response of social support. Women have a tendency to have a higher risk than men for symptoms of PTSD. Possible reasons for this may be that women tend to suffer more depression and psychological stress because women's social roles expose them to higher levels of social stressors, such as social conflict. Because of this, women might be more likely to experience negative responses from their social network, and therefore negative social support could mediate the difference between gender and distress. Another hypothesized reason for gender differences in psychological distress is women's greater vulnerability to the negative effects of stress. Women may be more sensitive to negative support and would benefit from positive social support.

- trauma
- post-traumatic stress disorder
- social support
- therapy groups
- social integration
- survivors
- recovery

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See Also

- Acute Stress Disorder
- Childhood and Adolescent Trauma: An Overview
- Cognitive Behavioral Therapy
- Eye Movement Desensitization and Reprocessing: Treatment
- First Responders and Trauma
- Posttraumatic Stress Disorder
- Trauma, Identity, and the Workplace

Further Readings

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