Vicarious trauma - a critical discussion

A/Professor Maya Drum
Raphael Centre Blacktown
Sydney, Australia

Abstract — **Vicarious trauma refers to a condition that may be experienced by people who are exposed to stressful situations via a third party. It is very prevalent in the healthcare industry where employees are required to deal with situations that have caused pain, anguish and/or harm to the people they are caring for. Left untreated, the consequences of this trauma can be devastating for the employee and increase problems for the employing body. Reflective supervision provided by a skilled supervisor is recommended in an attempt to mitigate the severity of vicarious trauma.**

Keywords - vicarious trauma; supervision; heathcare provision

Vicarious trauma is also known by other names such as compassion fatigue and emotional fatigue [1]. It predominantly relates to people being exposed to stressful situations and the personal consequences of this. It is reported that the more often the exposure the higher the risk of a stress related illness often resulting in people having to take time off from work for treatment and to rest and recuperate [2]. However, for some, one traumatic incident can be enough to render them unfit for work. In fact, when a work related vicarious trauma situation occurs there are both a professional and a personal price to pay. The real cost is with the loss of the employee who is unable to perform their duties which means they have to be replaced and rehabilitated either into their existing role or retrained for another role. The personal cost can be of a greater concern when the individual involved can no longer function in society due to a work related post-traumatic stress disorder [2]. An all too common condition researched and reported on especially with healthcare workers, returned service personnel, ambulance officers and police.

Front line personnel who are involved in life altering or life threatening situations are highly likely to be exposed to vicarious trauma. This means anyone who provides healthcare (which is the focus for this paper) has the potential to be affected by this secondary trauma. This can and often does include the administrative staff who are confronted with a situation that they have not had specific education to manage. And, in many instances, people in senior positions do not recognise the potential for this to cause harm. There is limited formal or informal debrief to support staff when a crisis has occurred. It is an expectation that people who work in healthcare will just manage. It is part of their job! And this author would agree with this however, also believes that there is a responsibility placed on healthcare organisations to prozvide a safe working environment. That means not only the physical environment but also the much less recognised emotional needs of staff.

Pearlman and Saakvitne [1] note that burnout and vicarious trauma can co-occur and that vicarious trauma may in fact be potentiated by counter-transference responses. It could be reasonable to expect that with significant and unresolved or untreated vicarious trauma exposure, burnout could be a very real consequence.

There are some researchers who believe that people with a certain personality type are more prone to vicarious trauma [3]. It could be argued that whilst this might be the case, and that remains questionable, the long-term effect of not managing vicarious trauma carries a high cost for an organisation and the individual.

An example of the potential for vicarious trauma will be described. In this authors place of work we provide care for families suffering from antenatal/postnatal anxiety and/or depression. These mothers and often fathers come to our centre for assessment and care planning to support them through this, for them, a very critical time of their lives. Pregnancy, birth and caring for children is a major stressor in most people's lives and the level of success depends greatly on various predetermined factors (such as their own upbringing and relationship with their mother) and the ongoing support networks. A co-morbidity of a diagnosable mental health illness also adds to the complexity.

The staff who care for these families are exposed to hearing the patients stories throughout their working day. In fact their role is to encourage the patients to share their experiences and fears. The staff member has to ascertain whether there is a real or potential threat for self- harm or harm to others during this time and this in itself puts a great deal of responsibility and pressure on to the staff member. There is no denying that children are very vulnerable when they have a mentally unwell parent.

Staff working in this type of clinical environment should be monitored for signs and symptoms of vicarious trauma. Common signs that staff should be observed for are social withdrawal; mood swings; reduced willingness to contribute to team projects; reluctance to discuss patients; greater sensitivity to violence and so it goes on. It would be appropriate to assume that this constant exposure to trauma being experienced by their patients would have an impact on the

DOI: 10.5176/2345-718X_3.2.111

staff member's personal relationship including issues with intimacy, trust and self-esteem [4-10].

So what is the solution?

Formal reflective supervision and/ or debriefing at least demonstrates the intent of the organisation to support their workers and mitigate risks of a long-term disability such as chronic depression. A basic human right one would think!

Reflective supervision is different to clinical supervision in that it focuses more on exploring the relationship of one's own feelings and reactions to the work they are doing and how they are being affected by the exposure. Clinical supervision is also important but it is more targeting care planning and pathways and requires a different set of skills for the supervisor to those required for reflective supervision. However, it can also be appropriate to incorporate both clinical and reflective supervision if the need arises at the time of a case discussion.

Heffron and Murch [11] state that "reflective supervision is the use of a technique to approach problem solving which creates a shared process of inquiry using open-ended questions to facilitate the supervisee's own insights and reflections, rather than solution–focused advice-giving" (p.5).

"When it's going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences" [12] (p. 39). This is why the supervision requires an appropriately qualified facilitator who should not be a member of the team but rather someone who has been specifically employed for the role. The reflective supervision can be individual or in a group as both are effective but the latter is more reliant on the expertise of the supervisor to manage group dynamics.

It has been noted that reflective supervision is not routinely provided or attended by staff when it has been made available. The reasons given for the lack of attendance could be due to several reasons, e.g., not enough time, too busy or perhaps, the terminology itself? [13]. Do people resent the notion of being 'supervised' especially if they are highly qualified and experienced staff? It should be made clear as to what the purpose of the reflective supervision is and that it is equally important for novices as well as experts and the intent is for self- awareness and support, rather than being supervised to undertake a task.

To achieve a culture where reflective supervision is regarded as the norm, it would be appropriate to telegraph this expectation with beginning practitioners. Universities and Colleges should incorporate this in their preparation for working in the community modules so the students already leave the learning environment with an understanding of the terminology and the importance for attendance.

From the organisation's perspective, it should form part of the staff member's initial orientation and then performance review discussion to volunteer the number of sessions attended and to give feedback on the process. This of course then leads to the opportunity to improve the systems in place and the staff member can, by word of mouth, support and recommend reflective supervision to peers and subordinates. Reflective supervision should be scheduled at regular times and in the same environment wherever possible to promote a sense of security and attendance. The sessions should remain confidential, should not be punitive and nor should they be a measure of performance. The relationship between supervisor and supervisee(s) is key. Attachment theory should be the foundation because providing a secure base will support confidence and trust for the supervisee(s) [13].

It would be strongly recommended that evaluation is factored into the process both from a quality cycle perspective and the learning derived from the feedback but also to ensure that the supervisor is resonating with the supervisee(s). It could be that despite the supervisor having the qualifications (formal or informal) that their style is not conducive to a successful reflective supervision session and that in fact it may be doing more harm than good. Needless to say if this were to be the case then some form of investigation would be appropriate to determine the root cause of the disquiet to ascertain ways to improve for a better outcome.

In conclusion, there is no doubt that reflective supervision should be provided to all frontline healthcare workers as part of the clinical governance framework for organisations. The reflective supervision should be provided by a qualified supervisor with significant expertise and experience in this field. It should be provided on a regular basis with an expectation that staff would be released to attend. Ideally the staff would support each other to attend and make it an educative session that all could benefit from. Reflective supervision should be incorporated into the way of life of an organisation with a consequence of staff feeling supported and cared for which is of course a positive outcome. Attendance records and evaluations are important to meet the objectives of the reflective supervision and to review areas for change or improvement.

All workers have their own life histories that they bring to work as we are all humans and this can, and does have the potential to expose them to vicarious trauma. Left unsupported and for some, untreated, this can have dire consequences both personally and professionally.

There is an opportunity to build on the research that has gone before to determine what education is required for supervisors; what credentialing for supervisors should be introduced; undertake a cost benefit analysis in times of fiscal cutbacks; validate evaluation tools and to publish the findings.

It is absolutely essential to support staff working in stressful environments to deal with their concerns. Successful formal reflective supervision should be viewed as health promotion being provided by the organisation for the staff member's benefit. Promoted positively in a culture where this is the expectation, success would have to follow.

Many organisations advertise that their workforce is their most important asset and staff need to believe that this statement is true and that they are supported and valued in the work they do. After all, they are the backbone of our industry!

REFERENCES

[1] L. A. Pearlman and K. W. Saakvitne, Trauma and the Therapist: Countertransference and Vicarious Traumatisation in Psychotherapy with Incest Survivors. New York: Norton, 1995.

[2] D. J. Rosenbloom, A. C. Pratt and L. A. Pearlman, "Helpers' responses to trauma work: understanding and intervening in an organisation", in Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators, B. H. Stamm, Ed. Lutherville, MD: Sidran Press, 1995, pp. 65-79.

[3] B. Bride, "The impact of providing psychosocial services to traumatised populations", Trauma and Crisis, vol. 7, pp. 29-46, 2004.

[4] M. J. Arvay and M. R. Ulemann, "Counsellor stress in the field of trauma: a preliminary study", Can. J. Couns., vol. 30, pp. 193-210, 1996.

[5] T. Bober, C. Regehr and Y. R. Zhou, "Development of the coping strategies inventory for trauma counsellors.", J. Loss Trauma, vol. 11 (1), pp. 71-83, 2006.

[6] J. Brady, J. Guy, P. Poelstra and B. Brokaw, "Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors", Prof. Psychol., vol. 30, pp. 386-393, 1999.

[7] M. Cunningham, "The impact of sexual abuse treatment on the sexual abuse clinician", Child Adolesc. Social Work J., vol. 16, pp. 277-290, 1999.

[8] M. Ghahramanlou and C. Brodbeck, "Predictors of secondary trauma in sexual assault trauma counsellors", Int. J. Emerg. Ment. Health, vol. 2, pp. 229-240, 2000.

[9] L. A. Pearlman, Trauma and Attachment Belief Scale Manual. Los Angeles: Western Psychological Services, 2003.

[10] L. J. Schauben and P. A. Frazier, "Vicarious trauma: the effects on female counsellors of working with sexual violence survivors", Psychol. Women Quart., vol. 19 (1), pp. 49-64, 1995.

[11] M. Heffron and T. Murch, Reflective Supervision and Leadership in Infant and Early Childhood Programs. Washington D.C.: Zero to Three, 2010.

[12] R. Shamoon Shanok, "The supervisory relationship: integrator, resource and guide", in Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers and their Families: A Source Book E. Fenichel, Ed. Washington D.C.: Zero to Three, 1992, pp. 37-41.

[13] B. Barnett and M. Drum, "Supervision; what's in a name?", CQ: The CAPA Quarterly, pp. 22-25, November 2013.