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**UNIVERSITY OF KWAZULU NATAL**

***THE DEVELOPMENT OF AN INTERVENTION MODEL  
TO MANAGE SECONDARY TRAUMATIC STRESS IN  
MENTAL HEALTH WORKERS IN RWANDA***

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2010

**THE DEVELOPMENT OF AN INTERVENTION MODEL TO MANAGE SECONDARY  
TRAUMATIC STRESS IN MENTAL HEALTH WORKERS IN RWANDA.**

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**Dissertation submitted in fulfillment of the requirement for the  
degree of Doctor of Philosophy in Mental health**

**Faculty of Health Sciences,  
School of Nursing  
University of KwaZulu Natal**

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**Year: 2010**

## DECLARATION

I, Jean Damascene IYAMUREMYE declare that this dissertation entitled “*THE DEVELOPMENT OF AN INTERVENTION MODEL TO MANAGE SECONDARY TRAUMATIC STRESS IN MENTAL HEALTH WORKERS IN RWANDA*” is my own work and has not been submitted for any other degree or examination in other University other than University of KwaZulu Natal. I have given complete acknowledgement to the resources referred to this study.

Signed

.....

Date .....

Jean Damascène Iyamuremye

Supervisor

.....

Date .....

Dr. Petra Brysiewicz

## DEDICATION

This dissertation is dedicated to my wife, **Julienne BAYISENGE**, our son **Didier ISHIMWE**, and our daughter **Diane IZABAYO**, who agreed to stay in Rwanda while I was in South Africa busy with my studies.

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## ABSTRACT

**Introduction:** It was previously established that mental health workers in Rwanda experience secondary traumatic stress when working with trauma survivors. The effects of secondary traumatic stress can be serious and permanent in mental health workers when working with traumatized clients. It interferes with mental health worker's ability to do their work effectively.

**Aim:** This study aimed to explore STS and to develop an intervention model to manage secondary traumatic stress in mental health workers in Kigali, Rwanda.

**Methodology:** This study was carried out into five cycles using action research approach. In the first cycles of the study a quantitative design was used to explore secondary traumatic stress in mental health workers in Rwanda. For this cycle, the particular aim was to determine the extent of the secondary traumatic stress in mental health workers in Rwanda. A total of 180 participants were selected using convenience sampling to be part of the quantitative study. In the second cycle of the study a qualitative design was used to explore mental health workers' experiences of secondary traumatic stress. For this cycle 30 unstructured interviews were conducted. The third cycle aimed at developing the model to manage secondary traumatic stress. Action research approach was used in this phase. Experts from mental health services involved in the study were asked to participate in the study based on their availability as research team members. The fourth cycle of the study consisted of implementing the model in one mental health service and the fifth cycle consisted evaluation of the implementation of the model after six weeks period. The main aim of this cycle was an observation of the model implantation.

**Results:** A diagrammatical model to manage secondary traumatic stress was developed by mental health professionals. In the model development cycle of the study, it emerged that there are very strong

concurrency between the findings from experts in mental health care system and literature in terms of what needs to be included in the intervention model to manage secondary traumatic stress in mental health workers in Rwanda. The key elements to include in the model were based on preventive, evaluative and curative strategies to manage secondary traumatic stress in mental health workers in Rwanda. During the evaluation of the implementation, it emerged that participant noticed a change in coping strategies when facing the stressful incident in the practice.

**Recommendations:** include an emphasis on more psychological support for mental health professional in their workplace and for more concrete aids such as supervision, guidelines on stress management on workplace, education on secondary traumatic stress management and implementation of counseling service for mental health workers.

**Conclusion:** The model developed in the present study outlined different ways to manage STS at the individual, social and organizational levels. There is a need to translate the interventions to manage STS into active ongoing coping activities to be conducted at the individual, group and organizational levels. Organizational responses, such as creating a supportive organizational culture that acknowledges the potential for secondary traumatic stress, may help mental health workers to deal with workplace related secondary traumatic stress.

**Keywords:** *Model, secondary traumatic stress, mental health workers, Trauma Attachment Belief Scale (TABS), Rwanda, intervention model.*

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## CHAPTER ONE: INTRODUCTION

### 1.1 Introduction

Mental health workers who listen to stories of fear, pain and distress of traumatized clients may develop deleterious emotional, cognitive and physical consequences (Cairns, 2007). Secondary traumatic stress can occur indirectly and this is consistent with the Diagnostic and Statistical Manual of Mental Disorders (4th ed.), criteria A, for post-traumatic stress disorder (PTSD), which affirms that traumatisation is possible without personally having been harmed or threatened with harm (APA, 2004). Secondary traumatic stress can happen when mental health worker hears narratives stories of primary trauma victims.

The disagreeable emotional consequences of working with primarily traumatized individuals have been illustrated in diverse ways: secondary traumatic stress (STS) (Stoesen, 2007), compassion fatigue (Bride, Radey & Figley, 2007) and vicarious traumatization (Pearlman & McKay, 2008). Mental health workers may feel negative changes in their professional functioning, self and worldviews, sense of security, self-capacities and psychological needs as result of indirect exposure to secondary traumatic stress (Shah, Garland & Katz, 2007).

Little has been done to explore what effects that caring for traumatized clients has on mental health workers or on how to manage secondary traumatic stress. It is documented that mental health professionals do often experience negative effects as symptoms of secondary traumatic stress. According to Shah, Garland and Katz (2007), primary traumatic stress is the term used for individuals who react with extreme fear or helplessness after having directly experienced a

traumatic event, while secondary traumatic stress (STS) occurs as a result of indirect exposure to trauma through a firsthand account or narrative of a traumatic event.

This emotional distress often goes unnoticed until individuals develop more severe symptoms such as clinical depression, anxiety disorder, substance abuse, burnout or PTSD. Frequent interactions with traumatized clients might enhance the probability of developing secondary traumatic stress (Babbel, 2008).

Insofar as mental health workers are exposed to the primary trauma of their patients, their work conditions could be presumed to be hazardous as they risk the above outcomes which make them personally vulnerable (Sprang, Clark & Whitt-Woosley, 2007). In Rwanda, a country suffering from the consequences of the 1994 genocide and a subsequent shortage of mental health professionals, mental health workers find themselves in a position where they have to offer significant emotional support (Munyandamutsa & Mahoro, 2009). However, the question remains as to what extent they are exposed to secondary traumatic stress and how the STS experienced by them should be managed.

## **1.2 Background**

Mental health workers (MHWs), who treat traumatized clients, may develop symptoms of post traumatic stress disorder (PTSD) as an indirect reaction to their clients' traumatic stress. This experience has been described as secondary traumatic stress (Babbel, 2008). Secondary traumatic stress (STS) arises when a mental health worker is indirectly exposed to trauma through personal descriptions or stories of traumatic events (Shah, Garland & Katz, 2007).

Secondary traumatic stress is also described as the normal subsequent behaviours and emotions resulting from information about a traumatic event experienced by a significant other. It is also referred to as the stress resulting from helping, or a desire to help, a traumatized patient or suffering individual (Bride, Radey & Figley, 2007). Goldblatt (2009) stated that the encountering of traumatized clients can have psychological influences on mental health workers, known as vicarious traumatization or secondary traumatic stress. Health workers may feel incompetent in dealing with such devastating stories and may avoid screening traumatized clients. As a consequence, mental health workers caring for traumatized clients must take cognisance of their own attitudes, feelings and various reactions during a therapeutic relationship (Goldblatt, 2009).

The dissonance between the disruption of their personal values, attitudes and emotions and the desirable professional intervention procedures might hinder mental health workers' performance in caring for traumatized clients or psychiatric patients. The implementation of training programmes for screening and intervening with traumatized clients might decrease the emotional labour required, increase mental health workers' reactions to secondary traumatic stress and facilitate personal development (Goldblatt, 2009).

According to Bride, Radey and Figley (2007), individuals such as mental health workers are particularly at risk for secondary traumatic stress, as they work in direct contact and on an ongoing basis with victims of traumatic events. When working with such victims, mental health workers often experience strong reactions when hearing violent and dramatic narratives. Consequently, as a result of working with traumatized clients, mental health workers experience changes in their views of the world, themselves and their families. To protect themselves, they

may detach to some degree, distance themselves from others, become overwhelmed with helplessness or become emotionally numb (Salston & Figley, 2003).

The Diagnostic and Statistical Manual (DSM-IV-TR) of the American Psychiatric Association (APA), which is widely used and accepted as a method for diagnosing psychological disorders, states that trauma can occur both directly and indirectly (American Psychiatric Association, 2004). The diagnostic criteria for secondary traumatic stress are almost the same as those of post traumatic stress disorder. The only distinction is that one occurs directly while the other occurs indirectly (Deighton, Gurriss & Traue, 2007). Deighton, Gurriss and Traue (2007) stated that there is no consistently used expression concerning the impact of being exposed to traumatic material as a result of being a mental health worker. Current literature reveals the use of different terms that are, or approximately, identical with secondary traumatic stress. These include compassion fatigue (Bride, Radey & Figley, 2007); countertransference (Pearlman, 2003); burnout; and vicarious traumatization (Pearlman & McKay, 2008).

Secondary traumatic stress is a broad term for a disorder which can affect a variety of individuals such as journalists, health care workers and insurance workers. The two terms that are more specific to mental health workers are compassion fatigue and vicarious traumatization (Salston & Figley, 2003). The physical, emotional and cognitive consequences of directly helping victims of traumatic events can produce what is termed secondary traumatic stress (Deighton, Gurriss, & Traue, 2007). Secondary traumatic stress is a major work-related hazard in the mental health profession as the consequences augment and may change the way in which the mental health workers view themselves and their world (Shah, Garland & Katz, 2007).

Mental health workers regularly listen to stories of severe human distress and observe the emotions of panic, powerlessness and horror registered by their traumatized clients. Up to date research relate that these professional duties may cause emotional symptoms in those who bear witness to the survivors' stories of trauma (Shah, Garland & Katz, 2007). There is an apparent link between mental health workers who have a high proportion of survivors of traumatic incidences in their caseload and symptoms of secondary trauma. Insufficient training, identification with the victims, insufficient support in the workplace, and insufficient social and familial support were suggested as potentially predictive factors of secondary traumatic stress in mental health workers (Baird & Kracken, 2006).

Secondary traumatic stress can involve distorted beliefs and frames of reference, a negative impact on feelings and relationships, poor decision-making skills, social and professional withdrawal, substance abuse and clinical problems (Rothschild, 2006). Unfortunately, most mental health workers are unaware of the nature and extent of secondary traumatic stress, lack access to supportive resources and have little or no training about how to recognize symptoms in themselves and others, or how to respond to the resulting distress. As a result, people are likely to adopt coping mechanisms and engage in self-protective defensive manoeuvres to create distance and reduce their own discomfort, anxiety and, in some circumstances, pain to tolerable levels (Munyandamutsa & Mahoro, 2009).

Rwanda is well-known throughout the world for the 1994 genocide, when hundreds of thousands of people died in a planned campaign of horrible violence. Up to one million people were massacred during the 100-day genocide of the Tutsi and the recovery process has presented huge national and personal challenges (Schaal & Elbert, 2006).

During the genocide, Rwandan women were subjected to sexual violence on a massive scale, committed by elements of the notorious Hutu militia groups well-known as the Interahamwe (Mukamana & Brysiewicz, 2008). Rape was exceptionally extensive and many of women were individually raped, gang-raped, raped with objects such as sharpened sticks or gun barrels, held in sexual slavery (either collectively or through forced marriage) or sexually injured (Schaal & Elbert, 2006). While the country, as a nation, is struggling to reconstruct its physical infrastructure, institutions and government services, individual Rwandans are trying to restore their homes and lives and, even more challenging, to recover from trauma and personal pain.

### **1.3 Problem statement**

The impact of secondary traumatic stress on mental health workers in Rwanda and their insufficient support system need to be investigated, as mental health workers, who are overburdened with work, stress and their own traumas, have few resources left to care for and comfort others (Iyamuremye & Brysiewicz, 2008; Schaal & Elbert, 2006).

The Rwandan genocide, one of the biggest in human history, not only led to unbelievable personal loss and grief, but also to the loss of all kinds of human resources, experiences, talents and staffing needed for the efficient functioning of a whole society. The very tangible costs of this genocide are still noticeable socially, emotionally, culturally, morally, politically and economically (Schaal & Elbert, 2006). Most of the mental health workers in Rwanda are themselves survivors of the genocide and the experience of secondary traumatic stress in these mental health workers need to be understood in the context of that unique work environment (Iyamuremye & Brysiewicz, 2008, Schaal & Elbert, 2006).

In their study on nurses providing mental health care in one of the mental health services in Rwanda, Iyamuremye and Brysiewicz (2008) reported that there was a disruption in the cognitive schema of these nurses and that the total scores were high in all areas of their beliefs, namely safety, esteem, trust, intimacy and control. This indicates that there is a disruption in the cognitive schema and beliefs of mental health workers in Rwanda.

Although attention has been paid to the process of healing primary victims of trauma (Bicknell-Hentges & Lynch, 2009, an enquiry into the therapeutic practice of mental health workers helping traumatized patients shows that very little has been done to manage the trauma of secondary victims. There is very little literature in the field of secondary trauma which focuses on its prevention. The present study intends to provide a comprehensive and multilevel model integrating primary, secondary and tertiary interventions in managing the effects of secondary traumatic stress in mental health workers operating in Rwanda.

Since numerous mental health workers operating in Rwanda are themselves victims of trauma, it is imperative to ensure that appropriate psychological support services are developed to assist them to deal with secondary traumatic stress. Given the important position of mental health workers in Rwanda regarding the care they provide for trauma survivors and psychiatric patients, it is vital to understand the effects of secondary traumatic stress and to develop a model to manage it. Mental health workers are human, too. They suffer from what other persons suffer, and they see a lot more than the average individual does. They necessitate a particular approach to manage the negative effects that secondary traumatic stress has on them (Nelson, 2007).

#### **1.4 Aim of the study**

The overall aim of the study was to explore the secondary traumatic stress experienced by the mental health workers in Rwanda and to develop an intervention model to manage it.

#### **1.5 Objectives of the study**

The objectives of this study were to:

- explore traumatic stress in mental health workers providing mental health care in mental health services in Rwanda
- describe the work-related aspects that contribute to secondary traumatic stress in mental health workers in Rwanda
- describe the available support system for mental health workers who work in mental health care service in Kigali, Rwanda
- develop an intervention model to manage the secondary traumatic stress experienced by mental health workers in Kigali, Rwanda
- implement this model in one mental health service in Kigali, Rwanda
- evaluate the implementation of the model to manage the secondary traumatic stress in mental health workers in Kigali, Rwanda

#### **1.6 Research questions**

To achieve the aim of the study, I wish to answer the following research questions:

- What is the extent of secondary traumatic stress among mental health workers providing mental health care in Kigali, Rwanda?

- What work-related aspects contribute to the development of secondary traumatic stress in mental health workers in Kigali, Rwanda?
- What support systems are provided for mental health workers in Kigali, Rwanda?
- What variables are related to the secondary traumatic stress experienced by mental health workers in Rwanda?
- What are the crucial concepts and process of an appropriate intervention to manage secondary traumatic stress in mental health workers in Kigali, Rwanda?
- How do mental health workers in Kigali, Rwanda, perceive the implementation of the model to manage the secondary traumatic stress?

### **1.7 Significance of the study**

The significance of this study is that it will document secondary traumatic stress in mental health workers who provide mental health care in Rwanda. There appears to be a gap in available literature regarding the management of secondary traumatic stress in mental health professionals working with traumatized patients in Rwanda. To our knowledge, there is no model available to manage secondary traumatic stress in mental health workers in the Rwandan context. Rwanda has a number of challenges, especially the consequences of the genocide, which make it unique and thus necessitates such research. This study could create an awareness of possible shortcomings in the support system of mental health workers in the clinical field. The findings could facilitate future planning of additional support, which could be rendered to mental health workers who are experiencing secondary traumatic stress. The significance of this study can be summarised as follow:

### **1.7.1 The significance for mental health workers**

The results of this study will assist mental health workers to optimally manage secondary traumatic stress. The results from this study could also be used to identify, implement and utilise support systems that contribute towards more conducive and less stressful working conditions for mental health workers in Rwanda.

### **1.7.2 The significance for the mental health profession**

The ability of mental health workers to cope effectively with stressors in their daily professional activities will improve the quality of mental health care which, in turn, will contribute to an improved credibility of the mental health profession in Rwanda. The development of a model to manage secondary traumatic stress in mental health workers could also improve the practice of mental health care.

### **1.7.3 The significance for the mental health care system in Rwanda**

The implementation of a mental health system requires mental health workers, as frontline mental health service providers, to develop coping skills that will assist them in effectively addressing the changing demands placed on them. This study may inform the authorities of the mental health system in Rwanda regarding the psychological needs of mental health workers in order to prevent and manage the adverse effects of secondary traumatic stress. It will assist managers in the mental health system to ensure efficiency, effectiveness, quality and acceptability of the mental health system in Rwanda.

#### **1.7.4 The significance for the community**

The community may benefit by an appropriate mental health service, which is only possible when the mental health workers know how to effectively manage and prevent secondary traumatic stress in their daily activities.

### **1.8 Operational definitions**

#### **1.8.1 Secondary traumatic stress**

Secondary traumatic stress is the psychological consequence resulting from repeated exposure to accounts of trauma experienced by patients (Slattery & Goodman, 2009). Stoesen, (2007) defines secondary traumatic stress as disruption to a therapist's inner experience, as a result of repeated exposure to the trauma narratives of their clients. In this study, secondary traumatic stress is the emotional disturbances to mental health workers' inner experiences as a result of repeated exposure to their clients' traumatic narratives.

#### **1.8.2 Mental health service**

Flisher, Jansen, Lund, Martin, Milligan, Robertson, and Winkler (2003) define mental health services as services that are rendered to mentally ill individuals or groups on inpatient and outpatient basis. In this study, mental health services relate to the services rendered by mental health workers in rural hospitals, the psychosocial service and the psychiatric hospital in Rwanda, as well as to in-community based services to mentally ill patients and their families.

### **1.8.3 Mental health care**

Mental health care includes a wide variety of treatment approaches that foster and promote mental health and also prevent mental health conditions arising in at-risk individuals (Flisher et al., 2003). In this study, mental health care provided by mental health services in Rwanda refers to the treatment approaches that the mental health workers apply to clients and their families who have been exposed to trauma, in order to promote mental well being and prevent mental illness.

### **1.8.4 Mental health worker**

A mental health worker is defined as a person who provides specialist services for people with mental health needs (Alem, Jacobsson & Hanlon, 2008). For this study, the term mental health worker is used to define all qualified workers (psychiatrist, medical doctors, registered nurses, psychologists, counsellors and social workers) providing mental health care in Rwanda.

### **1.8.5 Model**

A model is a pattern, plan, representation (especially in miniature) or description designed to show the main object or workings of an object, system, or concept (Berger and Weiss, 2009). In the present study, the term model will be the plan to prevent, assess and manage the secondary traumatic stress experienced by mental health workers in Rwanda.

### **1.8.6 Support system**

A support system is defined as a network of personal or professional contacts available to a person or organization for practical or moral support when needed. A support system can also be defined as a formal or informal network of goods, services, personnel and organizations that sustains an entity in its survival and growth (Cauce & Srebnik, 2005). In the present study, a

support system means a network of facilities and people who interact and remain in formal and informal communication with mental health workers to assist them and enable them to prevent and mitigate secondary traumatic stress in their daily activities.

## **1.9 Theoretical framework**

Numerous authors have developed theoretical models to explain the nature of secondary traumatic stress and provide a framework within which results from empirical studies can be understood (Figley, 2003; Pearlman, 2003). Although there are a number of models that provide theories which attempt to explain secondary traumatic stress, no model has been found in the reviewed literature which focuses on the alleviation of STS. Among the models to explain STS are the Trauma Transmission Model, the Ecological Framework of Trauma and the Constructivist Self-Development Theory. This study will focus on the Constructive Self-Development Theory (CSDT) to serve as a theoretical foundation for the present research. The CSDT has been chosen as it appears to be more relevant to mental health workers than other models in the field of secondary traumatization because it provides a framework for the systematic assessment and practical treatment of the aspects of the self that are affected by trauma (Pearlman, 2003). It is more comprehensible and applicable than the other models and can easily be incorporated into a working model of managing secondary traumatic stress.

### **1.9.1 The Trauma Transmission Model**

Figley's (2003) Trauma Transmission Model consists of two parts (model of compassion stress and model of compassion fatigue). This model tries to explain the process of trauma transmission and why some people develop secondary traumatic stress, while others do not. The main concept

of this model is empathy while other aspects include the mental health workers' behaviour towards their clients, their exposure to trauma, their sense of satisfaction resulting from helping and their ability to disengage from the process (Bride, Radey & Figley, 2007).

The first part of the model explains the beginning of secondary traumatic stress and posits that mental health workers attempt to understand the trauma survivors by identifying with them. Figley (2003) stated that compassion stress is a function of six interacting variables and is defined as the stress resulting from helping, or wanting to help, a traumatized person. Compassion stress differs from compassion fatigue, which is a state of exhaustion and dysfunction, biologically, psychologically and socially, as a result of prolonged exposure to compassion stress and all that it evokes (Figley, 2003). According to Bride, Radey and Figley (2007), empathy is the main aspect of the Trauma Transmission Model and the development of compassion fatigue in mental health workers. Najjar, Davis, Beck-Coon, and Doebbeling (2009) separate empathy into three types: empathetic ability, empathetic concern and empathetic reaction. Empathetic ability is associated with the efficacy of the mental health worker and their capacity to identify with the pain of others.

Another important aspect of the Trauma Transmission Model is emotional contagion. According to Najjar et al. (2009), emotional contagion is defined as experiencing the feelings of the victim as a function of exposure to the victim. Najjar et al. (2009) associate emotional contagion to the mental health workers' empathetic ability which, in turn, gives rise to secondary traumatic stress. The mental health workers' assessment of their empathetic reaction and their ability to detach themselves from the relationship establishes the degree to which they develop symptoms of secondary traumatic stress. If mental health workers can successfully detach themselves from the

process, they will experience a sense of satisfaction from caring, rather than any negative effects (Bride, Radey & Figley, 2007).

According to Najjar et al. (2009), mental health workers become affected by prolonged exposure to traumatic material because they feel that it is their responsibility to take care of their clients and continually listen to their traumatic stories and recollections, the extent of which can cause the carers to experience secondary symptoms and other related stress responses (Najjar et al., 2009). During such therapeutic relationships, mental health workers feel that they are solely responsible for their patients and, thus, find it difficult to reduce their own stresses.

### **1.9.2 The Ecological Framework of Trauma**

This model attempts to provide a theoretical framework for secondary traumatic stress. According to this model, there are a range of reactions that mental health workers may experience due to their work with trauma survivors and psychiatric patients. Dubow, Huesmann and Boxer (2009) explained that these reactions are divided into three categories. The first category relates to symptoms of psychological distress (e.g. avoidance efforts, intrusive imagery, addictive behaviours and/or social impairment). Symptoms of secondary traumatic stress may include distressing emotions, impairment in day-to-day functioning, somatic complaints, physiological arousal, numbing or avoidance and intrusive imagery.

The second category of trauma reactions experienced by mental health workers refers to changes in their assumptions and beliefs about the world (i.e. changes in cognitive schema) (Pearlman & McKay, 2008). Normal everyday living is based on assumptions that allow people to set goals, plan activities and order their behaviour. These assumptions exist on a preconscious level and are

thought to be disrupted by exposure to trauma (directly or indirectly), which then causes psychological stress and symptom formation (Buchanan, & Anderson, 2007).

Relational disturbances form the last category of reactions experienced by mental health workers who have been exposed to trauma. Firstly, relational disturbances may occur within the counselling relationship as a result of mistrust between clients and mental health workers. In addition, both the professional and personal relationships of the mental health workers may suffer as a result of secondary exposure. Research shows that this is particularly the case when working with victims who have been traumatised by abuse, as this may increase the mental health workers' sensitivities to those same dynamics in their personal relationships (Dubow, Huesmann and Boxer (2009).

With regard to these categories, the Theoretical Model of Secondary Traumatic Stress consists of four components: the traumatic event to which the mental health worker is exposed; mental health workers' coping strategies; the mental health workers' PTS reactions; and personal and environmental factors (Buchanan, & Anderson, 2007).

### **1.9.3 The Constructivist Self-Development Theory (CSDT)**

The CSDT, which will be the foundation of the present study, is a developmental interpersonal theory that gives an understanding of the psychological, interpersonal and alteration effects that traumatic events have on individuals who supports victims of trauma (Miller, Flores & Pitcher 2010). The Constructivist Self-Development Theory combines psychoanalytic theories with cognitive theories to offer a useful theoretical viewpoint for understanding the genesis for

conceptualizing the influence of secondary trauma on mental health workers (Buchanan & Anderson, 2007).

It highlights the individual nature of trauma and describes the various characteristics of personality that are affected by trauma (such as self-capacities, ego resources, psychological needs and related cognitive schemas, and frames of reference). These characteristics are sensitive to disruption by secondary traumatic stress and can cause minor and/or severe effects, depending on disparities between the client's traumatic memories and the mental health worker's existing schemas. According to the CSDT, there are five aspects of the self that are impacted by psychological trauma. These include: frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, memory system and perception. . Alterations to these schemas based on trauma adaptation needs are reflected in the mental health workers' viewpoints (Pearlman, 2003).

### **1.9.3.1 Frame of reference**

Frame of reference refers to the framework by which individuals view themselves and the world. Frame of reference is important as it refers to how each individual perceives and interprets their life experiences (Nelson, 2007). According to Sessanna, Finnell, and Jezewski (2007), a meaningful frame of reference for human experience is a fundamental human need and it encompasses an individual's world-view, identity and spirituality.

World-view refers to beliefs about the world which include attitudes about others and their worth, intentions and role of others in an individual's life (Miller, Flores & Pitcher 2010). Identity reflects each individual's inner experience of self, which includes their personal stories,

relationships with themselves and their perceptions of themselves in relation to others (Pearlman, 2003). Spirituality refers to the meaning assigned by each individual regarding their place in the world. This includes four components, namely; orientation to the future, sense of meaning in life, awareness of all aspects of life, relation to the non-material existence and the connection with something beyond themselves, for example, a god or higher power (Pearlman, 2003).

### **1.9.3.2 Self-capacities**

Self-capacities refer to the inner capabilities that allow individuals to maintain a consistent, coherent sense of identity, connection and positive esteem (Pearlman & McKay, 2008). These self-capacities allow individuals to manage emotions, maintain interpersonal relationships and sustain positive feelings about themselves. When nurses experiences secondary traumatic stress, these self-capacities become disrupted they may experience loss of identity, interpersonal difficulties, difficulty in controlling negative emotions and self-doubt in meeting the needs of their significant others (Trippany, White Kress & Wilcoxon, 2004).

### **1.9.3.3 Ego resources**

Ego resources are the inner faculties that individuals make use of to navigate the interpersonal world and meet their psychological needs (Miller, Flores & Pitcher 2010). There are two types of resources: those important to the counselling process, namely; intelligence, willpower and initiative, awareness of psychological needs and striving for personal growth; and those to protect oneself from harm, which include the ability to conceive consequence, the ability to set boundaries and the ability to self-protect (Nelson, 2007). A disruption of these resources may

promote perfectionism and the inability to be empathetic (Trippany, White Kress & Wilcoxon, 2004).

#### **1.9.3.4 Psychological needs and cognitive schemas**

Cognitive manifestations of the psychological needs such as safety, trust, esteem, intimacy and control are known as schemas (Pearlman & McKay, 2008).

##### **Safety**

Pearlman (2003) claims that the illusion of safety is important in maintaining a positive attitude towards life as it allows a sense of security. However, working with victims of crime can result in a heightened sense of vulnerability which might increase an awareness of the fragility of life. Mental health workers may also feel the need to take precautions against acts of violence, especially when dealing with victims of rape (Pearlman, 2003). When a mental health worker becomes involved with victims of crime or psychiatric patients their feeling of invulnerability may be destroyed, resulting in feelings of insecurity and lack of safety in the world (Omigbodun, Odukogbe, Omigbodun, Bella & Olayemi, 2006).

##### **Trust**

Trust refers to the need to rely on one's own judgment and the expectancy that others will meet one's needs. However, it is crucial that one does not trust completely and should learn to integrate trust and distrust with regard to others and self (Pearlman, 2003). Those working with victims of trauma and psychiatric patients are exposed to the countless cruel ways in which individuals deceive, betray or violate the trust of others. This may disrupt their schemas about trust, thus making them more sceptical of the motives of others (Pearlman, 2003).

## **Esteem**

Everybody has a need to believe that others are kind and worthy of respect. Acts of violence may lead to a victim having a diminished esteem for others and themselves. In turn, mental health workers may also find that they lose respect for other people; they may start to feel angry, pessimistic and bitter towards others (Pearlman, 2003). Furthermore, mental health workers usually start the helping relationship feeling powerful, resourceful and capable of coping with all the demands that they face. If these expectations are not met, feelings of personal failure and inadequacy are formed (Vandeusen & Way, 2006).

## **Intimacy**

Intimacy refers to belonging and connecting with others. This need is central to mental health workers (Pearlman, 2003). However, when exposed to violent crimes, individuals often experience alienation from others and the world (Vandeusen & Way, 2006). Furthermore, mental health workers may also feel a sense of alienation due to being exposed to terrifying imagery and the reality of the world (Pearlman, 2003).

## **Control**

A central theme in trauma literature is control (Pearlman, 2003). Control refers to the need to regulate one's feelings and behaviours and to manage others. Exposure to criminal victimization makes one aware of the illusory nature of control. When indirectly exposed to criminal violence, the mental health workers' memories may stir up concerns about their own sense of control in the world. In extreme cases, mental health workers may find themselves experiencing depression or anguish about the unpredictability of the world (Pearlman, 2003). The CSDT views the responses of mental health workers to their clients' traumatic narratives as being shaped by the mental health workers' own psychological needs of safety, trust, esteem, intimacy and control,

their cognitive schemas and by the characteristics of the situation. All individuals possess these five psychological need areas which appear to be very sensitive to psychological trauma. As individuals are unique beings, any of the need areas can be affected to a lesser or greater degree in each individual. It follows, therefore, that if a mental health worker has disrupted safety needs, they would experience an increased feeling of insecurity when working with trauma victims (Nelson, 2007).

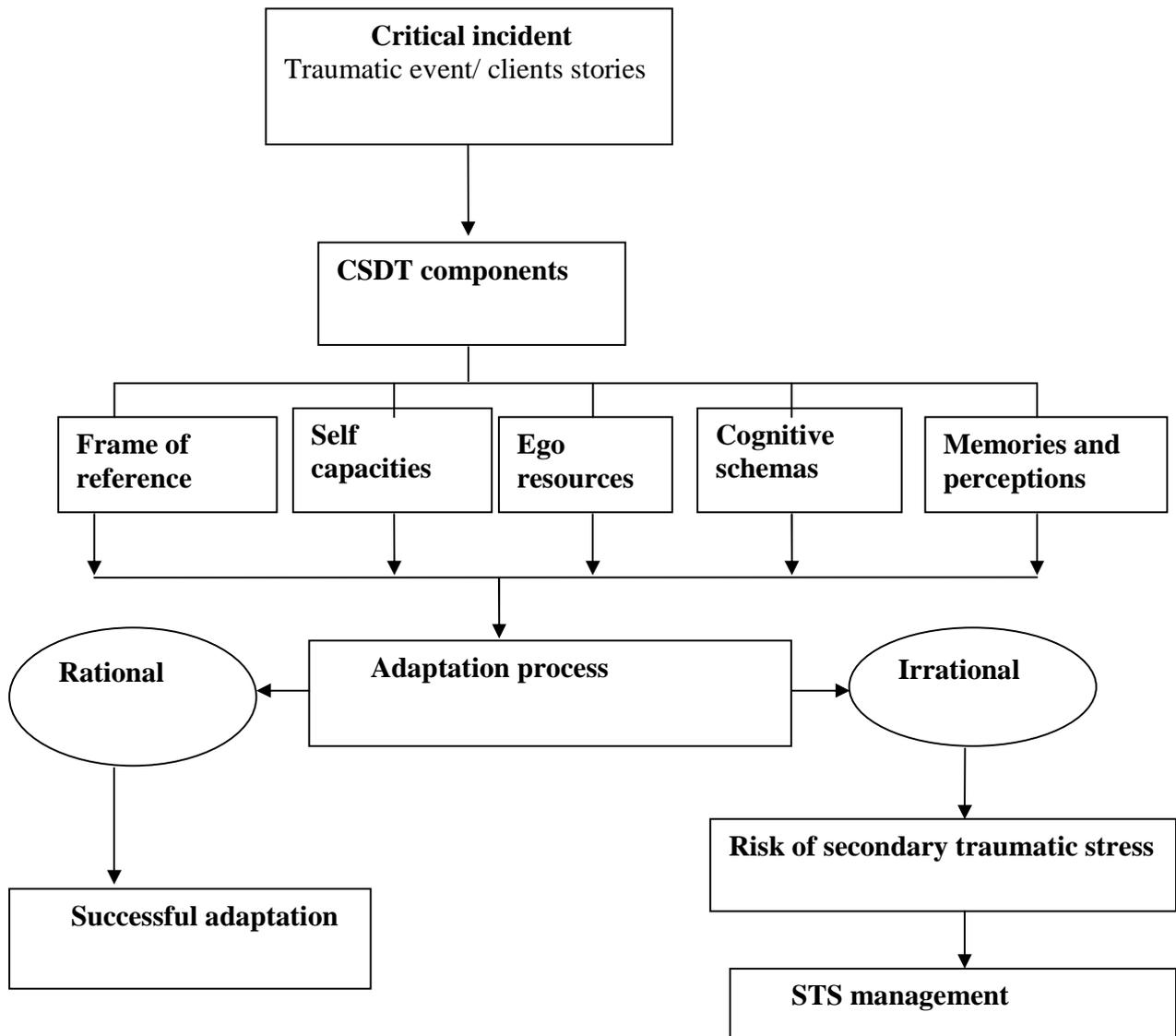
### **1.9.3.5 Memory system and perception**

Within the CSDT framework, traumatic memory is descriptive. Pearlman (2003) identifies five aspects of the memory which are:

- Verbal memory (cognitive narratives)
- Imagery (pictures in the mind)
- Affect (emotions experienced)
- Somatic memory ( physical sensations)
- Interpersonal trauma (dynamics in current interpersonal relationships).

When a person experiences trauma, each aspect of memory can represent a fragment of the event. According to the CSDT, these fragments may interfere with one's awareness if they are not therapeutically integrated (Trippany et al., 2004). Trippany et al. (2004) maintain that the memories of traumatic narratives remain with mental health workers after their counselling sessions have ended. Mental health workers treating victims of trauma can experience intrusive thoughts, flashbacks and dreams that have no meaning. Because imagery is a part of the mental health workers' memory systems, these traumatic memories can become permanently entrenched within them. Some mental health workers use defence mechanisms such as numbing, avoidance

or denial to cope with secondary traumatic stress, but these only offer temporary relief. Adams and Riggs (2008) refer to the profound psychic numbing that occurs in mental health professionals who are exposed to intense, long-lasting or repetitive trauma. According to Ortlepp and Friedman (2002), some people change their state of awareness, facilitating them to detach themselves from the state of intolerable arousal related with trauma. Adams and Riggs (2008) found that some participants might hesitate to acknowledge that traumatic situations have affected them, stating rather that they are used to coping with trauma. The framework for understanding the interrelationships between these components is illustrated in the following figure



**Figure 1.1** Conceptual Diagram of Secondary Traumatic Stress: Adapted from Baird and Kracken (2006).

According to the Conceptual Diagram of Secondary Traumatic Stress above (Figure 1.1), mental health workers' exposure to the details of their patients' narratives and re-enactments causes them to question their concepts of meaning, purpose and hope. The mental health workers then try to cope by applying the five CSDT components. For some, if the CSDT components are irrational, exposure to clients' shocking information becomes, at some point, overwhelming and difficult to digest. It is at this point that secondary traumatic stress may manifest itself. On the other hand, if the five components of CSDT are rational, the mental health worker adapts successfully. When the mental health workers are overwhelmed by a critical incident or clients' traumatic narratives, they cannot comfortably handle their emotions or the questioning evoked. In these instances, they will need support through supervision, consultation, education or psychological debriefing.

### **1.10 Conclusion**

This chapter presented an introduction to the study, the background of the study, the problem statement, research questions, and the aim, objectives and significance of the study. I defined the key terms related to secondary traumatic stress, discussed the basic assumptions and presented the theoretical framework. A discussion of the literature review on the effects of secondary traumatic stress on mental health professionals working with traumatized clients is presented in Chapter 2.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

A literature review involves the identification and location of information on a particular topic or topics (Babbie, 2009). This procedure obliges the reviewer to develop an understanding of the state of knowledge in the given area and a critical understanding of the information available in that area. In this section, the literature reviewed concerns secondary traumatic stress among mental health workers.

In order to put this study in perspective, I undertook a global search for data on aspects of secondary traumatic stress and the development of models to manage secondary traumatic stress or compassion fatigue in mental health workers. The literature search included the following computer-assistance, data-based bibliographies namely; MEDILINE (Medical Literature Online), Academic Search Premier, Nexus, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Google and Google Scholar. It also included concepts such as secondary traumatic stress, vicarious traumatisation (Kadambi & Truscott (2006), compassion fatigue (Babbel, 2008) counter-transference and post-traumatic stress disorder (American Psychiatric Association, 2004). All these terms are associated with the effects mental health professionals experience when working with trauma survivors or psychiatric patients.

### **2.2 Conceptualising secondary traumatic stress**

Secondary traumatic stress is the experience of occupational stress caused by working intimately with traumatized clients. Bride, Radey and Figley (2007) use the terms compassion fatigue, compassion stress and secondary traumatic stress synonymously. They argue that both

compassion stress and compassion fatigue can be used interchangeably for those who feel uncomfortable with secondary traumatic stress, as the latter term is often perceived to be offensive in that it is perceived to indicate some sort of pathology.

Furthermore, other specialists in the field of trauma often use the terms secondary traumatic stress, vicarious traumatization and compassion fatigue interchangeably with reference to their studies and theories (Bride, 2007). Bride (2007) maintains that compassion fatigue is associated to the cognitive schema (social and interpersonal perceptions or morale) of mental health workers and is, therefore, related to vicarious traumatization.

The notions of compassion fatigue and vicarious traumatization all point to the effects of trauma work on mental health workers. Moreover, vicarious traumatization overlaps with compassion fatigue; and both are used interchangeably with secondary traumatic stress as they are both a result of working with victims of trauma. Therefore, a combination of both concepts provides material for a holistic, in-depth analysis of traumatic stress reactions in mental health workers (Kadambi & Truscott, 2006). Stoesen (2007) states that secondary traumatic stress is a better term to use as it is broader and that vicarious traumatization and compassion fatigue are actually specific types of secondary traumatic stress.

### **2.2.1 Compassion fatigue**

However, compassion fatigue has become a growing concept in the field of trauma and is often used interchangeably with secondary traumatic stress (Figley, 2003). It does, nevertheless, reflect a particular focus on the impact of counselling or working with trauma survivors. Hence, it specifically elaborates on the notion of secondary traumatic stress in relation to mental health

workers and other health workers. Figley's (2003) work on compassion fatigue came about in relation to PTSD and the recognition that mental health workers seem to experience symptomatology similar to that experienced by their clients who suffered from PTSD (Najjar et al., 2009).

Secondary victims, unfortunately, are the ones who attempt to alleviate the pain and suffering of the primary victims, and in so doing become victims themselves (Figley, 2003). Mental health workers may take on board the traumatic stress of those they help. This puts them at risk for compassion fatigue. Figley (2003) stated that outside the natural consequences of therapeutic engagement there appear to be four additional reasons as to why mental health workers are at risk of compassion fatigue. These are empathy, trauma history, unresolved trauma and children's trauma (Sprang, Katz & Cooke, 2009).

#### **2.2.1.1 Empathy**

From recognizing the parallel effect of symptoms from client to therapist, Figley (2003) argued that those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress (Figley, 2003).

#### **2.2.1.2 Trauma history**

Individuals do not exist in a vacuum and may have a trauma history of their own. They might work with a client who has experienced a similar traumatic experience as they have. Thus, there is a danger of mental health workers over generalizing their experiences and methods of coping to the client and over encouraging similar (though possibly inappropriate) resources (Baird, &

Kracen, 2006). However, a trauma history should not be seen as a disadvantage to the mental health workers' ability to function or as making them more vulnerable to developing secondary traumatic stress (Sprang, Katz & Cooke, 2009). Having been a victim themselves can be an advantage in understanding their clients and being able to model healing. On the other hand, if their traumatic incident went unacknowledged or unresolved, it appears that secondary traumatic stress may be intensified (Baird, & Kracen, 2006).

### **2.2.1.3 Unresolved trauma**

Mental health workers who are survivors of previous trauma may not have resolved their trauma. This may be provoked during the therapeutic relationship with their clients (Figley, 2003). In addition, due to the range of traumatic events to which mental health workers are exposed, it is inevitable that at some stage they will care for traumatized clients who have experienced events similar to their own. Any unresolved trauma that the mental health worker may have may also be triggered by reports of similar trauma in clients (Figley, 2003).

### **2.2.1.4 Childhood's trauma**

Working with children is also challenging for mental health workers. Furthermore, persons who are exposed to traumatized children are especially vulnerable to compassion fatigue (Sprang, Katz & Cooke, 2009). Another term that is used in the context of secondary traumatic stress is vicarious traumatization which represents a further enhancement in the understanding of secondary traumatic stress and is important in contextualising the consequence of trauma work (Stoesen, 2007).

### **2.2.2 Vicarious traumatisation**

Vicarious traumatisation is defined as the transformation in mental health workers' inner experiences resulting from doing therapeutic work with trauma clients (Pearlman & McKay, 2008). It results from empathetic engagements with trauma survivors. Research showed that there are a number of common changes that frequently occur among mental health workers and their clients. These changes are not considered to be pathological, as described for secondary traumatic stress, but are normal cognitive and emotional changes (Sabin-Farrell & Turpin, 2003). However, these changes may be disruptive or painful and can persist for months or years after work with the traumatised person has ceased (Kadambi & Truscott, 2006).

Pearlman (2003) identifies the following features of the effects of vicarious traumatisation: repeated exposure to trauma material may strengthen the gradual change in beliefs; they are intrusive and painful; they are changeable as they can be minimized or ameliorated; and they may be permanent with regards to how one sees the world and oneself (Kadambi & Truscott, 2006).

### **2.2.3 The signs and symptoms of secondary traumatic stress**

Symptoms of secondary traumatic stress in mental health workers can contain a number of the similar symptoms found in the direct victims of trauma. These symptoms comprise increased fatigue or illness, social withdrawal, decreased efficiency, feelings of hopelessness, despair, nightmares, feelings of re-experiencing of the event, having unwanted thoughts or images of traumatic events, anxiety, excess vigilance, avoidance of people or activities, or persistent anger and sadness (Stoesen, 2007).

The symptoms of secondary traumatic stress may also consist of alterations in how individuals view themselves and others, such as alterations in feelings of safety, high level of cynicism, and detachment from colleagues and/or loved ones. Exposure to terrible information about atrocious treatment of patients often obligate mental health workers to reconsider their perceptions about religious conviction, God, families and life itself (Rothschild, 2006). In the mental health institutions, secondary traumatic stress has been linked to higher rates of physical sickness, greater absenteeism, higher turnover, lower self-esteem and lower output.

Mental health workers may also come across with problems in their personal or professional relationships, in controlling boundaries and in managing their emotions. They may have sleeping disorders, overeat, alcohol misuse, be anxious about their loved ones and exhibit irritability toward their co-workers and family members (Stoesen, 2007).

#### **2.2.4 Contributing factors to secondary traumatic stress**

Secondary traumatic stress is a hazard, not only for mental health workers such as psychiatrists, psychologists, psychiatric nurses, counsellors and social workers (Deighton, Gurriss, & Traue, 2007), but also for anybody intimately related to traumatized individual such as spouse living with partners with PTSD, children living with a traumatized parent and spouses of war veterans (Dekel, Goldblatt, Keidar, Solomon & Polliack, 2005). In addition, professionals who work as advocates of rape survivors, psychosocial rehabilitation counsellors, lawyers, judges, researchers, journalists and bank employees may be significantly affected by their exposure to primary victims (Salston & Figley, 2003).

Definitely, when two factors namely exposure and empathy are present, everyone is at risk for developing symptoms of STS. An efficient mental health worker must have the aptitude to empathize with the patient in order to increase sufficient trust and relationship, to evaluate the problem and to initiate a treatment approach. Paradoxically, however, it is that very ability of understanding their clients' traumatic experiences that puts mental health workers at risk (Adshead, 2005). With that being the case, and the fact that STS is a normal, predictable and inevitable result of working with traumatized clients (Salston & Figley, 2003), it is vital that we persist to increase an understanding of all that is involved in the development of STS and to recognize possible protecting factors.

#### **2.2.5 Factors influencing secondary traumatic stress in mental health workers**

Several researches that explored secondary traumatic stress in mental health workers show that this type of health professionals has a high level of STS symptoms (Deighton, Gurriss, & Traue, 2007). The intensity of exposure to traumatized clients has often been identified as a significant factor for the development of STS symptoms. However, there are also researches which have failed to establish such a relationship (Adams, Figley & Boscarino, 2008).

Although few studies have explored STS in mental health workers who treat traumatized clients, experience in working with traumatized patients has been found to have a protective effect for some mental health worker. Other factors, however, have been reported to be associated to STS symptoms which comprise the lack of a supportive work environment and having little trauma-specific training and interpersonal resources (Gwagwa, 2007). Having a history of personal

trauma appears to be quite clearly associated to the development of high levels of work-related symptoms such as STS in mental health workers (Moore, 2004).

Nelson (2007) suggested that post traumatic stress disorder symptoms and secondary traumatic stress represent delicate risk to mental health workers working with traumatized clients. The same author also emphasised that the risk of the systemic dissemination of secondary traumatic stress throughout a team, possibly being evident in dysfunctional group dynamics such as mobbing (collective workplace harassment of mental health workers). Working with traumatized clients involves particularly powerful sources of stress; including the nature of traumatic event.

#### **2.2.6 Personal trauma history and STS in mental health worker**

Some authors suggest that the incidence of STS in mental health workers is high (Stoesen, 2007). According to Nelson-Gardell & Harris (2003) that mental health workers are taught to be empathetic, but hypothesize that this ability to empathize with clients may itself be a risk factor for STS. Mental health workers may also come into the field of trauma work with their own histories of trauma which may increase their risk of developing STS.

Having been abused or neglected as a child also increases the risk of developing STS. Mental health workers with a trauma history suffer post traumatic symptoms, whether their own trauma is actually being re-triggered or whether they are suffering STS. Research confirms that trauma can create biological and emotional vulnerabilities in some individuals and that the consequences of trauma can be cumulative. So, persons with personal trauma may be more at risk or have fewer resources to cope with later stressors and traumatic events. It is also more likely that mental health workers will be exposed to more traumatic events when they provide services in

subpopulations than when they work amongst the general population (Bride, 2007). Bride (2007) says that one of the reasons why many health providers leave the field prematurely is because of experience of STS.

### **2.2.7 Prevention of secondary traumatic stress in mental health services**

Unresolved trauma reactions can be detrimental to the health of mental health workers, both physically and mentally. This impacts morale, turnover and the general functioning of the mental health service which, in turn, affects the service's ability to help clients achieve positive outcomes (North Carolina Division of Social Services and The Family and Children's Resource Program, 2007). Mental health care, by its nature, will expose mental health workers to events that have been extremely stressful for trauma survivors and psychiatric patients, including traumatic grief.

A significant amount of psychological issues displayed by traumatized clients could be associated with loss and/or trauma. It is essential for mental health services to set up training and policies that are reliable with existing knowledge of the risk and prevention of secondary traumatic stress (Shah, 2008). Mental health services can fight against stigma of secondary trauma through organizational recognition and acknowledgement. At the very least, being open to talking about trauma can indicate that the mental health service cares about mental health worker well-being. Mental health services must also encourage a work culture that promotes getting timely mental health diagnosis and management (Shah, 2008). Support networks, including peer support, are helpful, as are professional consultations, training and individual

counselling (Badger, Royse & Craig, 2008). Safety training may be another way for mental health services to reduce mental health workers' risk of developing STS.

Secondary traumatic stress can make some mental health workers embarrassed about their strong reactions and uncomfortable about burdening colleagues or loved ones at home with their pain (Shah, 2008). Therefore, mental health services should also ensure that employee health plans are covered. Supervisors should assist mental health workers set up limits between themselves and their clients give them a possibility to converse about how they've been affected by trauma and facilitate them identify the need to find equilibrium in their work and personal lives (Shah, 2008). Mental health workers should know and use stress management techniques (North Carolina Division of Social Services and The Family and Children's Resource Program, 2007).

It is important that the managers within the service are committed to leadership. They need to be supporters of resilience and hope. They may need to create a trauma support position within the service to set up trauma education and support services. Professional isolation is believed to be a main risk factor to amplify the symptoms of secondary traumatic stress or burnout. At the unit level, trauma support is very important. In the majority of mental health services, staff identify with each other and the closest relationships they have are with their colleagues in their units (Rothschild, 2006). Isolation can also be consequence of geography, climate, population density and social barriers such as gender. Many mental health workers in rural areas are isolated from other mental health workers, peer support, continuing education and access to new information.

Cairns (2007) point out that rural mental health workers are more expected to report clinically significant secondary traumatic symptoms than their urban colleagues. A communication

network may be a helpful support for those mental health professionals who work in the rural areas (Cairns, 2007).

### **2.2.8 Preventive strategies of STS for mental health workers.**

According to Deighton, Gurriss, & Traue (2007), being aware of STS symptoms, getting enough sleep and exercise, eating well, getting social support and asking for help can help mental health workers to reduce effects of STS. Mental health workers should have a life outside of their day occupation and beware of volunteering for the same type of work they do for a living. It is especially essential for mental health workers to maintain equilibrium, practice stress management, exercise, spend time with family and friends, and to take holiday and personal time (Deighton, Gurriss, & Traue, 2007).

Mental health workers also require to be aware of their own personal trauma history and to find an outlet where they can give voice to their emotions. Having a concrete liaison with colleagues and supervisors who can assist is imperative. Good supervision is essential to assist mental health workers sustain perspective and equilibrium (Shah, 2008). Supervision in some mental health practice settings has become more bureaucratic and has moved away from support. Preventing and managing traumatic stress must be shared by the service as mental health workers cannot do it alone (Lowery & Stokes, 2005). Mental health work is stimulated and maintained by optimism, empathy and knowledge. It is essential for mental health workers to find relief from everyday tasks by engaging in activities or interactions that reinstate hope and serve as reminders of the benevolent side of humanity.

Rothschild (2006) identified four areas that are essential to the prevention of STS in mental health workers:

- Professional strategies (balanced caseloads, accessible supervision, planned assignment rotation)
- Organizational strategies (sufficient release time, safe physical space, access to employee assistance programme)
- Individual strategies (respecting limits, taking time for self-care)
- General coping strategies (self-nurturing, seeking connection).

### **2.2.9 Organizational strategies for STS prevention**

The primary focus on the prevention of STS has been on the individual (Shah, 2007). However, the organizational context of the mental health service has been considered as being a factor in the development of secondary trauma. a number of authors have written about their own experiences in mental health services that serve traumatized clients and have recommended both prevention and intervention strategies in the areas of organizational culture, workload, work environment, education, group support, supervision and resources for self-care (Shah, 2008).

#### **2.2.9.1 Implementation of Organizational Culture**

The values and culture of an organization set the expectations about the work. When the work involves contact with traumatized clients, they also set the expectations about how mental health workers will experience trauma and deal with it, both professionally and personally. Of primary concern is that organizations that serve traumatized clients, acknowledge the impact of trauma on the individual mental health worker and the organization (Kaplan, 2009).

It is not unusual for emotions and reactions generated by trauma to leave mental health workers feeling ineffective, inexperienced and even powerless. Rothschild (2006) recommended that managers and mental health workers should work together to develop an environment which prevents employees from being affected by their work. An organizational culture that “normalizes” the effect of working with traumatic clients can provide a supportive environment for mental health workers to deal with those effects in their own work and lives. It also encourages mental health workers to take care of themselves.

Figley and Nash (2007) provided an example of a potentially harmful “norm” that can frustrate mental health workers’ attempts at self-care: In some settings, it may be assumed that if employees do not work overtime, they are not committed to their work, or that mental health workers who do not take vacations are more committed to their work than others. A supportive organization is one that not only allows for holidays, but also creates occasions for mental health workers to vary their caseloads and work activities, take time off for illness, participate in continuing education and make time for other self-care activities (Cordelia Foundation, 2007).

Mental health services might specify their commitment to their staff by making staff self-care a part of the mission statement in the understanding that it does eventually affect client care. Managers might also monitor staff vacation time and encourage those with too much accrued time to take time off. Self-care issues could be addressed in staff meetings, and opportunities for continuing education could be circulated to staff (Cordelia Foundation, 2007). Regardless of how small, such commitments are not inconsequential within the mental health services which typically operate with inadequate resources and relentless service demands (Kaplan, 2009).

### **2.2.9.2 Decreased Workload**

Research has revealed that having a more varied caseload is correlated with a decrease in secondary traumatic stress (Nelson, 2007). Such variety can assist the mental health workers to maintain the traumatic material in perspective and prevent the formation of a traumatic worldview (Pearlman & McKay, 2008). Mental health services could develop intake procedures that try to allocate clients among staff in a way that pays attention to the possibility of secondary traumatic stress certain clients might present to mental health workers. Where possible, trauma cases should be distributed among a number of mental health workers who possess the required skills (Lipp, & Fothergill, 2009). In addition, mental health workers whose primary occupation is to provide direct services to traumatized clients may benefit from opportunities to participate in social change activities (Lipp & Fothergill, 2009). Mental health services that do not already provide such services might consider providing community education and outreach or encouraging their staff to participate in such policies. Such activities can provide a sense of hope and empowerment that can be revitalizing and can reduce the negative effects of secondary traumatic stress.

Organizations can also preserve an attitude of respect (Pearlman & McKay, 2008) for both clients and mental health workers by recognizing that working with traumatized clients often involves numerous, long-term services. Organizations that are proactive in developing or connecting clients with adjunct services - such as self-help groups, experienced medical professionals for medication, in- and out-patient hospitalization and resources for paying for these services - will support not only clients, but also diminish the workload of their staff (Pearlman & McKay, 2008). Developing partnership between mental health services that work

with traumatized clients can provide material support and prevent the sense of isolation and dissatisfaction felt by having to “go it alone.”

### **2.2.9.3 Improvement of work environment**

A secure, relaxing and private work environment is vital for those mental health workers who operate in settings that may expose them to traumatic stress (Pearlman & McKay, 2008). Some mental health services situated in high crime neighbourhoods are so dangerous their staff may actually experience primary trauma, rather than secondary traumatic stress. Pulido (2007) found that being threatened by a client or a member of a client’s family was strongly associated with secondary traumatic stress.

Although it is more of a challenge in certain mental health institutions, protecting mental health workers’ safety should be the primary concern of the mental health service administration. Paying for security systems or security guards may be a necessary cost of doing business for some mental health services that provide services to traumatized clients. Responsible supervision creates interactions in which mental health workers feel safe in communicating fears, concerns and inadequacies. Failing that, mental health services may think about developing a buddy system so that if one mental health worker is threatened by a client, another can summon for security intervention (Kaplan, 2009).

In addition to basic safety, Pearlman and McKay (2008) have suggested that mental health workers need to have personally meaningful items in their workplace. These can include pictures of their children or places they have visited, scenes of nature or quotes that help them remember who they are and why they do this work. Managers can encourage staff to make these small

investments in their workplace. By placing inspiring posters or pictures of scenic environments (rather than mental health service rules and regulations) in the waiting rooms, staff meeting rooms and break rooms, the organization can model the importance of the personal in the professional. In addition, mental health workers also need places for rest at the workplace, such as a break room that is separate from clients (Figley, & Nash, 2007). Within such spaces, the organization could address the self-care needs of staff by providing a coffee maker, soft music and comfortable furniture.

#### **2.2.9.4 Education**

Trauma-specific education also diminishes the potential of secondary traumatic stress. Information can help individuals to name their experiences and provide frameworks for understanding and responding to them. Training settings, such as schools of social work, have a responsibility to provide this information to field interns entering placements where they will encounter trauma (Pearlman & McKay, 2008). Pulido (2007) stated that mental health workers with master's degrees had lower levels of secondary traumatic stress compared with those with baccalaureate degrees. This difference suggests that the type of clinical training available in master's programmes, such as information about client empowerment, self-care and the ability to recognize destructive behaviours may be a missing, but important, part of training mental health workers in the baccalaureate programmes.

Efforts to educate staff about secondary traumatic stress can begin in the job interview (Pearlman & McKay, 2008). Mental health services have a responsibility to warn applicants of the potential risks of secondary traumatic stress and to assess the resilience of the new mental health workers

(Pearlman & McKay, 2008). New mental health workers can be educated about the risks and effects associated with secondary trauma, as those who are new and inexperienced are more likely to experience the most impact (Nelson, 2007). Ongoing education about secondary trauma theory and the effects of secondary traumatic stress can be included in staff training (Bober & Regehr, 2006) and discussed on an ongoing basis during staff meetings.

Mental health services can take advantage of the flourishing number of workshops by sending staff members for training and asking them to share what they have learned with the rest of the staff. This information provides a useful context and helps mental health workers to feel more competent and have more realistic expectations about what they can accomplish in their professional role. Preparation for stressful events, whenever possible, protects individuals from the effect of stress (Neuner, Schauer, Catani, Ruf & Elbert, 2007).

Learning new ways to address clients' trauma may also help prevent vicarious trauma. Theories, such as the Constructivist Self-development Theory, on which the theory of vicarious trauma is based, maintain a dual focus between past traumas and the current strengths and resources of clients (Miller, Flores & Pitcher 2010). Working from a theoretical framework that acknowledges and enhances client strengths and focuses on solutions in the present can feel empowering for both clients and mental health workers, and can reduce the risk of vicarious trauma.

#### **2.2.9.5 Group Support**

Literature relating to both burnout and vicarious trauma emphasize the importance of social support within the organization (Rothschild, 2006). Staff opportunities for informal debriefings

and the processing of traumatic material with supervisors and peers are helpful (Bober & Regehr, 2006). Critical incident stress debriefing is a more formalized method for processing specific traumatic events, but may be less helpful in managing repetitive or chronic traumatic material.

Support can also take the form of assisting mental health workers with paperwork or giving emergency backup. Making time for social interaction between colleagues, such as celebrating birthdays, organizing team-building activities or staff retreats can increase feelings of group cohesion and mutual support. Peer support groups may help because peers often have the ability to clarify the insights of their colleagues, listen for and correct cognitive distortions, offer perspective/reframing and relate to the emotional state of their co-workers (Hyman, 2005).

Group support can take a variety of forms, such as consultations, treatment teams, case conferences or clinical seminars, which can either be peer or professionally led. Groups could meet after work on a regular basis and members could learn about vicarious trauma and ways in which to deal with it in their own work and lives. Peer groups and treatment teams also offer the opportunity for traumatic re-enactments, such as splitting the group members into the roles of exploiter and exploited, which are common in working with trauma survivors (Baird, & Kracen, 2006). Such groups would cost the mental health service nothing, would not interfere with work and would provide an opportunity for mental health workers to give each other much-needed support. Regardless of the form group support takes, Baird & Kracen (2006) warned that it should be considered an adjunct to, not a substitute for, self-care or clinical supervision.

According to Baird and Kracen (2006), there are some potential difficulties of group support. One is the tendency toward “groupthink” and conformity. Another is that members hearing about

a mental health worker's distress may use distancing and victim-blaming as a defense mechanism. When groups are held within mental health services, there is also the potential problem generated by conflicting roles in the group, such as a supervisor who is both supporter and evaluator or a mental health worker/supervisor who is also a friend. Finally, group members may be more, rather than less, traumatized by the necessity of hearing each other's worst horror stories.

Mouldern and Firestone (2007) have suggested a number of ways for members of such groups to talk about their experiences without further traumatizing group members by making use of psychodrama and art therapy. To further minimize the potential problems in support groups, Mouldern and Firestone (2007) have suggested that group members discuss such a possibility before it happens and normalize the experience of vicarious trauma and its impact on the individual and the group.

#### **2.2.9.6 Organization of supervision**

Effective supervision is an essential component of the prevention and healing of secondary traumatic stress. Responsible supervision creates a relationship in which the mental health worker feels safe in expressing fears, concerns and inadequacies (Slattery & Goodman, 2009).

Organizations with a weekly group supervision format establish a venue in which traumatic material and the subsequent personal effects may be processed and normalized as part of the work of the organization (Slattery & Goodman, 2009).

In addition to providing emotional support, supervisors can also teach staff about vicarious trauma in a way that is supportive, respectful and sensitive to its effects (Bober & Regehr, 2006).

If at all possible, supervision and evaluation should be separate functions in an organization because concerns about evaluation might make mental health workers reluctant to bring up issues in their work with clients that might be signals of vicarious trauma. Pulido (2007) indicated that there was a positive relationship between low levels of secondary traumatic stress and mental health workers who received more non-evaluative supervision.

In situations where supervisors cannot separate the supervisory and evaluative functions, mental health service administrators might consider contracting with an outside consultant for trauma-specific supervision on either an individual or group basis. The cost of such preventive consultation might be well worth the savings that would result from decreased employee turnover or ineffectiveness as a result of vicarious trauma.

#### **2.2.9.7 Providing resources for self-care**

Bober and Regehr (2006) suggested that mental health services can make resources available for all staff who interact with traumatic material. If there are many employees experiencing the same type of trauma in the mental health service, mental health services may consider the feasibility of forming a peer support group, as discussed earlier. Mental health workers also need health insurance that provides mental health coverage (Rothschild, 2006). Way, Vandusen, and Cottrell (2007) also suggested that in addition to providing resources for therapy, mental health services should provide opportunities for structured stress management and physical activities.

Mental health services with limited resources might consider exchanging training in areas of their expertise with other mental health services that have experts in stress management. Again, sending one staff member to a conference or workshop to learn stress management techniques

and then asking that person to present what he or she has learned to the others is a cost-effective way to circulate this information throughout an organization. The organizing of something as simple as walking or meditation groups during the lunch hour, or after work, might also contribute to staff wellness at no cost (Slattery & Goodman, 2009). According to Slattery and Goodman (2009) the physical and cultural environment of work may prevent or predispose mental health workers to vicarious trauma.

### **2.3 Traumatic stress reaction and genocide**

According to Semelin (2005) the issue of genocide, or mass violence, has been a devastating reality. The United Nations Convention on the Prevention and Punishment of the Crime of Genocide defines Genocide as *“any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part and forcibly transferring children of the group to another group”* (United Nations, 1948). The psychological damage of genocide has been established in psychological studies of the genocides of the indigenous peoples of the Americas, Africans in the Trans-Atlantic Slave Trade, Jewish people in the Holocaust, Armenians in 1915, Tutsis in Rwanda, Cambodians, Guatemalans, Ukrainians, Chinese in the Nanking massacre, Muslims in Bosnia (Bush, 2007)

According to Waller (2006) and Finzsch (2005), genocide can be an outgrowth of multiple factors including promotion of self advancement at the cost of other’s human rights; crisis of resources; compliance with dictatorial leaderships; and prejudice, which is unfavourable

affective reactions or evaluations of groups and their members. Genocide is the ultimate display of hate, fear and violence, which are learned attitudes and behaviours (Staub, 2006). Genocide has negative cognitive, behavioural, affective, relational and spiritual effects on child and adult victims, as well as on perpetrators, historically and contemporarily (Dutton, Boyanowsky & Bond, 2005).

Lang (2006) states that genocide threatens the basic human rights of survival, security, development and social participation. Genocide is often combined with systematic rape (Mukamana & Brysiewicz, 2008), displacement of victims and severe mental health consequences for survivors that have been shown to increase anxiety, depression, self-defeating thoughts, post-traumatic stress disorder, substance abuse, suicide, homicide and a host of health complications within the targeted communities (Bolton, 2001). Genocide has been shown to severely alter the developmental trajectory of children who have been exposed to it by negatively impacting academic and social development, self-esteem and self-efficacy (Kaplan, 2006).

Genocide intersects with race, ethnicity, gender and socio-economic status in ways that are unique in creating disenfranchisement and environments of vulnerability; (Gangoli, 2006; Bryant-Davis, 2005). Genocide has long term intergenerational traumatic effects on whole communities (Ritchie, Watson, & Friedman, 2005). Genocide also negatively affects the perpetrators by perpetuating distorted thinking about the self and others, including cognitions that dehumanize those who are targeted (Staub, Pearlman, Gubin, & Hagengimana, 2005).

Genocide has negative effects on intergroup relations by magnifying distrust, fear, vigilance, suspicion, anxiety, stereotypes and disconnection, and has continually occurred throughout

human history (Lal, 2005). The struggle against genocide requires continued active resistance through science and practice that promotes social justice and human rights globally (McMillion, 2005). The United Nations has confirmed that genocide and systematic rape are crimes against humanity (United Nations, 2004).

In Rwanda, the genocide and massacres resulted in human and material losses, psychological trauma and many social problems. Losses occurred at different levels (human, physical and psychological) and have had a strong negative social impact. As a result of the genocide, entire families and extended families were completely wiped out and many homes were destroyed resulting in the loss of privacy, identity and a safe place, all of which foster family union. People fled or were displaced, many families having lost communication with their relatives. This loss is felt strongly during marriage ceremonies where survivors have to look for people to stand in for dead parents.

All Rwandans feel victimized by the events of the genocide and subsequent migration. Despite government commitments to create ethnic unity and reconciliation, the wounds are still deep and both sides are having difficulty in healing. Since both groups have to live together, a national healing process would probably decrease the emotional barriers between Hutu and Tutsi and facilitate reconciliation.

#### **2.4 Consequence of genocide on mental health services in Rwanda**

In Rwanda, the genocide destroyed the infrastructure necessary for the effective treatment of trauma and PTSD and as a result there is little to address the psychosocial needs of these people. Although the Ndera Psychiatric Hospital did exist in 1995, it was not operational because all of

the patients and most of the staff had been killed the year before. All of Rwanda's psychiatrists had either left or been massacred during the war (Schaal & Elbert, 2006).

According to Satel (2005), even in 2005 there was only one psychiatrist in the whole of Rwanda. By the end of 2008, there were three psychiatrists practicing in the country with a few psychiatric nurses. As a result of the destruction of the public health infrastructure during the genocide, post-genocide recovery and trauma healing programmes began their efforts with considerable difficulties and many of these were instituted without a solid foundation. Most programmes represented a Western philosophy as they were the efforts of international NGOs or of partnerships between the Rwandan government and international organizations.

The Mental Health Co-ordination Service, under the Ministry of Health, was created in November 1994. In June 1995, the National Trauma Centre was opened under the Ministry of Rehabilitation and Social Reintegration. The Mental Health Co-ordination Office supervised the Ndera Psychiatric Hospital and the National Trauma Centre. The Ndera Psychiatric Hospital offered in-patient psychiatric care while the National Trauma Centre was responsible for outpatient counselling to those suffering from trauma. The main objectives of the National Trauma Centre include capacity building; the provision of outpatient clinical services to severely traumatized children, adults and families; the organization of campaigns to sensitize communities around trauma; research on genocide; and government assistance (Neugebauer, Fisher, Turner, Yamabe, Sarsfield & Stehling-Ariza, 2009).

In the aftermath of the genocide, NGOs' activities in trauma healing helped address a dire need that could not be met by the Rwandan government. In an effort to provide safe spaces for victims

of the genocide, large NGOs gave minimal training in trauma counselling to local mental health workers. The aim of CNT activities was to enable mental health workers to give counselling at a very basic level, but unfortunately these programmes have not provided an effective long term solution to the widespread trauma created by the genocide. According to Staub (2006), people living in the urban areas are still more likely to have access to trauma counselling than those living in the rural areas.

Many organizations are now switching their limited resources from genocide trauma counselling to focus on more current issues like HIV treatment and care. However, the gap between the need and delivery of trauma care still exists in Rwanda. Fifteen years after the genocide, there is still the need to expand the capacity of existing mental health treatment programmes and to invest in new programmes to address the underlying trauma and its impact on the capacity of individuals and communities to effectively rebuild after war.

## **2.5 Psychological consequences of the Rwandan genocide**

The tragic events of 1994 in Rwanda shocked the world, and the intensity and cruelty of the atrocities committed have left long lasting scars (Salloum, & Lewis, 2010). There are no simple explanations or solutions for such a human disaster. Rwandan society remains traumatized by the 1994 genocide perpetrated against the Tutsi, and societal interventions are required to heal the physical and psychological wounds. The final outcome of such interventions is, however, difficult to predict. Mental health involvement in Rwanda's suffering has been small and examination of literature reveals a paucity of data.

Everyone who was involved in the genocide was changed by their experiences. Of the survivors, 70% were women (Avega Agahozo, 2004). Many had been raped and left with unwanted children (Mukamana & Brysiewicz, 2008), while many others, on the other hand, had lost their children. Many had been widowed, being left with minimal or no property rights. By the end of 1994 over 100 000 children had been orphaned (Neugebauer, et al., 2009).

Among the major psychological problems encountered by Rwandan genocide survivors are Post Traumatic Stress Disorder (PTSD) and chronic traumatic grief. According to the Human Rights Watch (2004), most of the women survivors of the Rwandan genocide showed signs of trauma. (Neugebauer et al, 2009) found that between 54 and 62% of children in Rwanda exhibited probable PTSD.

Chronic traumatic grief was found to be highly prevalent in the survivors. Since most of them had not had a chance to bury their relatives or perform mourning ceremonies, their process of bereavement was affected. The majority of survivors had not even seen the corpses of their loved ones. Since 1995, nationwide funeral ceremonies have been conducted and this has helped the healing of the lucky ones who have managed to identify the remains of their relatives who had been buried in mass graves. However, many still have no knowledge of the circumstances of how their relatives died or where they have been buried. For widows and orphans anniversaries of the deaths of their relatives has become very painful (Munyandamutsa & Mahoro, 2009).

The national grieving week in April revives all the suffering. For some, every weekend reminds them of happy times they had had with husbands, parents or children. Since different family members may have died at different times and in various circumstances, many survivors are grieving the deaths of several people. Now, after the genocide, many young Rwandans are

exhibiting unusual anti-social behaviours such as promiscuity in young girls or widows, excessive drinking that was not present before the genocide and excessive aggression and irritability directed to anybody (Munyandamutsa & Mahoro, 2009).

The 1994 genocide affected almost every social class in Rwanda. Large segments of the population were subjected to losses and various traumatic events, particularly the women and children (Neugebauer et al., 2009). Some children were forced to kill relatives or other children and the majority of surviving children still live in the districts in which the atrocities took place. Damaged landscapes, sites of execution (often churches), maimed and disabled civilians and veterans, and the continued presence of armed soldiers all act as potent reminders of the genocide. The children's losses include loss of faith, of normal parenting, of trust (seeing parents killed or seeing them kill others) and of boundaries (killing others themselves).

Although delayed psychological problems are possible, they are not inevitable as children's reactions are complex and interpretive. They may have been either victims or pupils of war and may or may not have a clear understanding of what they were caught up in. They will require education (at an appropriate time) to aid their understanding and contextualization of what happened to them and their families. Violence has been described as a drug that assuages hopelessness and the grief of loss. Those pupils of war who have been socialized into an aggression that has provided them with a *raison d'être* may now be more susceptible to dropping out of society, gang and criminal behaviour or falling into (or continuing) substance misuse. According to Palmer (2002), child soldiers need a step-by-step 'detuning' of aggression and violent behaviour through specific programmes.

Children affected by war require general psychosocial support (United Nations 2004), but children should merely not be seen as passive victims: their active participation is required to help communities heal the wounds of war. In caring for the children, the importance of women in the re-integration process cannot be overstated. Although there is a Rwandan tradition of caring for children other than one's own, there are now many orphanages, but of variable quality, understaffed and often overcrowded. If not competently staffed and administered with enough (basic) equipment to undertake educative tasks and evaluate their outcomes (social and educational), they have the potential for worsening children's problems. Cultural and local beliefs, attributions and understandings about death, community, family, spirituality, disability, memory and illness should all be used to aid assimilation and accommodation to the new realities. Children should be provided with the means to express their emotions if they wish to. Play is important and includes art, drama, storytelling, fairy tales and myths, dance, and holding and touching games.

## **2.6 Mental health workers' resiliency for secondary traumatic stress**

Even with support, however, mental health workers should try to build up their own resilience. Naturale (2007) stated that mental health workers need to learn to identify their own reactions and the significant symptoms of STS; develop awareness of their own specific somatic signals of distress; understand early warning signs of secondary traumatic stress in themselves; and accurately name and articulate their own trauma-related inner experience and feelings. Rakoczy (2009) suggested coping skills that mental health workers could use to avoid experiencing STS namely: appropriate detachment, staying busy at work and after hours; accepting one's limitations with the help of a wise supervisor; setting limits for self and clients; and cutting off.

Hernández, Gangsei and Engstrom (2007) propose a list of priorities for the treatment of STS. There are certain obstacles to such treatment which include threats to treatment continuity, dishonesty or withholding in session, contract breaches, in-session acting out and between-session acting out. With a plan, however, mental health workers can dramatically enhance their own feelings of preparedness, and preparedness engenders feelings of competence and resiliency. Firstly, mental health workers should address overt transferences such as verbal references to the mental health worker, and acting in after which they should work on their non-transferential affect-laden encounters. These main concerns help mental health workers keep control of their exposure to charged emotional reactions from their patients' traumas and provide a framework for discussions after the sessions between them and their supervisors.

As Slattery and Goodman (2009) suggested, mental health workers need five strengths namely: competence about coping; maintaining objective motivation; resolving personal traumas; drawing on personal role models of coping; and having buffering personal beliefs. Mental health services can help mental health workers to develop these strengths.

## **2.7 Influence of culture on secondary traumatic stress**

According to Wilson and Drozdek (2007), there is increasing recognition that culture profoundly shapes the experiences of suffering and healing. It follows, therefore that the cultural background or diversity status of mental health workers may also have an influence on how they cope with secondary traumatic stress (Myers & Wee, 2005). Like most people, spiritual beliefs and culture play an integral part in their life experiences. In term of spirituality, McSherry (2006) recommended that mental health services allow their staff a personal cathartic releasing of

traumatic material to help them improve their capacity to integrate the traumatic material into their lives. Inter-cultural work confronts mental health workers with many kinds of differences and how they approach these differences reflects their clinical skills and orientation. They also depend, however, on larger social values and an environment where they can interact with others with safety and mutual respect. The key is for mental health services to be flexible enough to allow mental health workers catharsis when needed by not being so focused on efficiency only.

The mental health profession is recognized as being emotionally demanding. Mental health workers are called upon to be empathic, understanding and giving, yet they must control their own emotional needs and responsiveness in dealing with their clients. When engaging empathically with a client who has been traumatized, mental health workers are at risk of experiencing a state of emotional, mental and physical exhaustion (Babbel, 2008). Within the mental health profession, emphasis on the importance of sensitivity to the cultural background and diversity of clients is well supported in the expanding professional literature (Vandenberghe, 2008).

Stress response styles have been described as having different characteristics for ethnic/culturally diverse individuals who are experiencing post-traumatic stress disorder following a massive natural disaster (Vandenberghe, 2008). The mental health workers' cultural or diverse background may represent an important link to coping with stress across a variety of contexts and practice environments. Babbel, (2008) has identified mental health workers' psychological well-being as a contributing factor in the avoidance of secondary traumatic stress symptoms.

### **2.7.1 Spirituality and mental health workers' wellness**

Sessanna, Finnell, and Jezewski (2007) reported that spirituality is an important component of mental health. These authors found a positive correlation between spiritual health and immunity to stressful situations (Sessanna et al., 2007). Spirituality has been increasingly supported as relevant to both physical and mental health (Bosworth, 2006). It is not the same as religion and although they share common ground, they are distinctly separate. Spirituality is fundamental to understanding the ways in which a person finds purpose in life (Miller & Kelley, 2006). It is a unique, personally meaningful experience, which is positively related to religiosity, but is not reliant on any given form of religion (Bosworth, 2006).

An increasing body of research has explored the relationships of various spiritual principles to multiple aspects of health. Simpson (2005) concluded that spirituality provides a protecting factor to mental health. Bosworth (2006) stated that spirituality has been associated with higher self-esteem and a decrease in depression. Studies indicate that those who are more spiritual experience a better sense of well-being and cope better with stress (Simpson, 2005). Shah (2009) reported that individuals who lack spiritual beliefs are at risk of experiencing excruciating pain and feelings of rejection as they search for meaning in the world. Thus, it can be suggested that spirituality is a source of hope, meaning and purpose, particularly in stressful times (Miller & Kelley, 2006).

Furthermore, Shah (2009) suggested that the development of secondary traumatization may be linked to the sense of spirituality in mental health workers. According to (Pearlman and McKay, 2008), those who have a larger sense of meaning and connection are less likely to experience symptoms of secondary traumatic stress. While there is literature available pertaining to

spirituality in the mental health practice and to the prevention of secondary traumatic stress among mental health professionals, there is virtually no literature, conceptually or empirically linking the two areas (Miller & Kelley, 2006). External issues such as caseload limits and supervision have been investigated, yet the internal coping mechanisms of mental health workers have been largely ignored (Simpson, 2005).

Although there is a positive relationship between the number of trauma victims in a mental health worker's caseload and the potential of developing secondary traumatic stress (Simpson, 2005), the level of spirituality and the potential for developing secondary traumatic stress correlated negatively, implying an inverse relationship: as the level of spirituality decreases the likelihood of STS increases (Simpson, 2005).

Simpson (2005) suggests that the internal coping resources of mental health workers have the potential to play a significant role in protecting them from debilitating secondary traumatic stress responses. It seems that education regarding the concepts of secondary traumatic stress may be a key to assisting mental health professionals in the avoidance of STS or coping with its symptoms (Simpson, 2005).

## **2.8 Secondary traumatic stress in the context of HIV/Aids**

Mental health professionals who have worked closely with clients suffering from HIV/Aids have demonstrated trauma symptoms (Smith, 2007). There is limited literature available, both in scope and volume, relating to secondary traumatic stress among health workers in general, and mental health workers in particular, who are treating patients with HIV/Aids. The available literature does, however, provide an indication of the complex variables, both individual and systemic,

which must be considered in larger, prospective studies of the future and in the development of interventions for formal caregivers of HIV/ Aids patients. The way is being paved toward the development of effective and rational interventions for health care professionals working in diverse contexts.

With an HIV prevalence estimated to around 2.8%, there is an estimated 150.000 people living with HIV in Rwanda, including about 19,000 children (UNAIDS, 2008). An estimated 210,000 children have been orphaned due to HIV/Aids. Currently, approximately 45,000 people in Rwanda are receiving antiretroviral treatment (ICAP-Rwanda, 2008). The phenomenon of secondary traumatic stress in health care professionals practicing in environments with high numbers of patients with HIV/Aids constitutes a major problem for mental health workers in Rwanda.

With regard to HIV/Aids, most of the research on how health workers have been coping with the problem has been descriptive in nature, highlighting various ways in which health workers are influenced by HIV/Aids in the workplace and identifying the root causes which include lack of knowledge, lack of protective measures and lack of emotional and technical support in dealing with HIV/Aids at work (Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, van der Kwaak & van der Wilt, 2007). Most of the research in this area has been conducted in resource-rich countries, focussing on burnout and individual coping strategies, with specific attention being given to staff fears, issues of association with patients, professional and role issues, stigma, discrimination and ethical issues (Dieleman et al., 2007).

Bellani, Furlani, Gnechi, Pezzotta, Trotti, Bellotti, Benevides-Pereira, Das Neves Alves (2007) have studied burnout and related factors among health care workers working with HIV/Aids in Italy. The results suggest important correlations among burnout, sense of personal accomplishment, anxiety and depression. These results suggest the development of precise strategies of prevention, intervention and treatment of secondary traumatic stress in the context of HIV/Aids, considering not only the importance of occupational and institutional characteristics, but also of individual ones (Bellani et al., 2007).

Bennett and Kelaher (2006) have spent the past decade trying to understand the importance of internal versus external coping styles and the positive psychological and sociological dimensions of Aids care provision on the well-being of providers in Australia. Secondary stress due to HIV merits concern as the severity and intensity of the HIV epidemic is often perceived as overwhelming, leaving many professionals with intense feelings of hopelessness and despair. Ehlers (2006) examined work related stress among health workers caring for patients with Aids, reporting that stress was not related to time spent in clinical work, HIV work or from patients' suffering. Rather, work overload and the stresses derived from social relationships at work were the main predictors of psychological distress, emotional exhaustion and depersonalization.

Bennett and Kelaher (2006) reported that in health care professionals, grief is associated with higher levels anxiety and identification with patients and higher levels of grief are associated with burnout. Bennett and Kelaher (2006) suggested that health workers should be taught ways of separating their work from their private lives to reduce the risk of over-identification with patients, and that there certain techniques can reduce anxiety and provide support for staff.

Research examining the experience of health care workers in more resource-limited settings has tended to focus on occupational safety concerns with regard to the risk of needle-sticks, contact with body fluids of infected patients and knowledge, attitudes and practices of health workers with respect to HIV/Aids (Dieleman et al., 2007). Recommendations by Bellani et al., (2007) included the need for health workers to take better care of themselves, the enhancement of training and the creation of support groups for people who work directly with HIV positive patients.

### **2.8.1 Factors influencing STS in health workers providing care to HIV/Aids clients**

The working conditions of the mental health practice are critical determinants for the future of the profession. There are a number of complex factors, including, but not limited to HIV/Aids, which present tremendous challenges to mental health professionalism in the Rwandan context. The dilemmas presented by HIV/Aids for Rwandan mental health practitioners have compounded professional concerns, rather than having created them, with HIV representing only one stress-causing agent among a number of others which adversely affect the professional and personal self-perceptions of practitioners and their ability to work effectively in treating the sick.

However, HIV-related illnesses have become increasingly common, thus presenting problems in mental health hospitals and clinics by placing an increased burden on mental health workers as many aspects, such as explanations, counselling and care of the infected, have been passed on to nurses, auxiliaries, counsellors, voluntary workers, or the patients' family and friends (Smith, 2007).

The incurability of patients; poor and unsafe working conditions; the effects of stigma; challenges regarding diagnosis; issues of confidentiality; mental health workers themselves becoming infected with HIV; and general demoralization with an erosion of confidence and ability to cope with the situation have all been cited by Smith (2007) as features complicating the practice of mental health care since the appearance of HIV/Aids. Despite these challenges, mental health workers in Rwanda have performed an important service in maintaining the objective rationality that lies at the heart of their professional tradition: displaying their continuing faith in modern medicine and exhibiting devotion to their patients in the midst of a widespread collapse of morale (Iliffe, 2006).

### **2.8.2 Moral and ethical dilemmas in caring for HIV/Aids patients**

It was noted that in environments where the ability to cure was becoming more and more limited by the increasing number of people contracting the illness, not only were physicians facing very specific moral dilemmas, for example, how to ration insufficient resources and obtain expensive medications, or how to inform families that a loved one is HIV positive, but the very moral foundations of medicine as a scientific and caring profession were being called into question (Bellani et al., 2007). With the loss of the variety of disease patterns due to the extent of the pandemic, HIV/Aids is perceived to be contributing to an erosion of fundamental intellectual assumptions about medicine as a system of knowledge.

As mental health workers' ability to respond effectively to human suffering was being compromised, so too was their sense of professional competence and empowerment. Some mental health workers expressed concern that too much emphasis was being directed at discussing and researching HIV/Aids, thus adversely affecting the care of patients suffering from

other conditions (Bellani et al., 2007). During the mid to late 1990's anecdotal evidence was emerging from a number of medical sources reinforcing the notion that the menace of HIV/Aids was increasing significant professional dilemmas for physicians and other health care providers.

Thomas and Valli (2006), investigating stress and burnout in South African physicians, found that the majority of doctors reported that they had experienced symptoms consistent with burnout since graduation from medical school. Responses from this study revealed that when health workers suffered such symptoms, they tended to endure them rather than seek help. Many viewed the idea of joining a support group as a reflection of an inability to cope (Thomas & Valli, 2006). Nevertheless, when questioned about their perception of the usefulness of a support group, 63% of the participants thought that such a group would be helpful. The author reported being impressed by how many had identified with the symptoms of burnout and recommended the recognition of early signs of burnout, the teaching of concepts of stress and burnout in schools, the development of strategies for the prevention and management of burnout and an increased availability of non-judgmental counselling (Thomas & Valli, 2006).

Some subsequent reports and investigations have sought to describe and clarify the relationship between the knowledge, attitudes and practices of health workers who work with people with HIV/Aids (Dieleman et al., 2007), including issues such as infection risk and fear of infection, lack of resources, stigma and discrimination (Ogunbodede et al., 2005; Oyeyemi, Oyeyemi, Bello, 2006). Other reports have focused specifically on the stresses experienced by both formal and informal caregivers.

Van Dyk (2007) stated that caring for people who have AIDS is not only a humanitarian imperative, it is a social and economic necessity, and that stress management is an essential need, not a luxury. This author identified a number of factors which cause stress and burnout which include ill preparedness, lack of training for new tasks, inadequate support and lack of supervision and recognition. The report provided several general observations on ways to manage stress and burnout among caregivers including: strengthening the capacity of the individual caregiver to cope with the duties and responsibilities of the role; ensuring that the working conditions, practices and policies of care programmes offer a supportive environment to caregivers and are not causes of stress in themselves; and advocating for national policies and laws that are sensitive to the needs of caregivers (Van Dyk, 2007). The report also suggested several specific prevention strategies, including peer counselling, personal mentors, supervision, appropriate training and a better distribution of tasks (Dieleman et al., 2007). Among other important conclusions, the report called for more systematic studies of stress among caregivers at all levels and in all settings, with more formal documentation of findings. Despite these recommendations, few studies have since focused on specifically relating caregiver concerns to the mental health of caregivers.

## **2.9 STS vs. PTSD**

In the field of psychological trauma it is documented that those who interact with trauma survivors are themselves exposed to a form of traumatic stress. Whereas the trauma survivor is exposed to a primary trauma and the accompanying traumatic stress, the mental health worker is exposed to the trauma survivor and an accompanying secondary traumatic stress (Shah, Garland and Katz, 2007). This distinction between primary and secondary exposure is blurred somewhat

by the evolution of the Diagnostic and Statistical Manual's definition of PTSD. DSM-IV now defines the stressor event to include learning of a trauma occurring to a loved one. In the language of DSM-IV, the traumatic event is the discovery that a loved one has been in a trauma. The DSM IV-TR constructed criteria for the condition "posttraumatic stress disorder" to describe the condition and experience of a person when the effects of a distressing event persist for at least a month after the event (APA, 2004).

According to American Psychiatric Association (2004), to be diagnosed with PTSD a person must have been directly exposed to a catastrophic event (the A1 criterion) and must display emotional distress because of the exposure (A2 criterion). Pulido (2007) stated that it is within the domain of interacting with someone affected by trauma that the concept of secondary stress remains applicable. The mental health worker is usually not involved with the survivor until after the trauma has occurred. Thus, the mental health worker's experience is generally confined to secondary exposure. According to Stoesen (2007), STS is diagnosed according to a group of symptoms. These symptoms are nearly the same to PTSD except the exposure to a traumatizing event experienced by one person becomes a traumatizing event to the second person (Stoesen, 2007).

Figley (2003) also provided an understanding of STS by drawing attention to the link between the symptomatology of PTSD and STS. As noted by Figley (2003), the main difference between the two conditions is the source of the trauma: in the case of PTSD, the affected individual experiences the trauma directly; in STS, an individual witnesses, or has knowledge of, the trauma as it affects a significant other.

## **2.10 Conclusion**

This chapter discussed the reviewed literature, both local and international, to gain an insight into the effects of secondary traumatic stress that health clinicians experience by working in mental health services. It also discussed various strategies recommended to prevent and deal with symptoms of secondary traumatic stress in mental health workers and other health practitioners. Secondary traumatic stress and related concepts were explained according to the CSDT. The research design and methodology used for the present study were described in chapter three.

## **CHAPTER THREE: METHODOLOGY**

### **3.1. Introduction**

Research methodology concerns the processes implemented in conducting research. The research process can be compared to a guide or map. On a map some paths are better charted than others, some are difficult to travel on and some are more interesting and attractive than others. Gratifying experiences may be gained during the journey and it is important to remember there is no particular right path or best path for any journey. The road one takes depends on where one wants to go and the resources (money, time, labour and so on) one has available for the trip (Zikmund, 2003). Burns and Grove (2007) define research methodology as the application of all the steps, strategies and procedures for gathering and analysing data in a research investigation in a logical and systematic way. Methodology can also be defined as the set of methods used for study or action in a particular subject, as in health sciences or education.

For the purpose of the present study, the research paradigm, design, setting, population, sampling plan and data collection procedure have been addressed and are described. In addition, the research team discusses the ethical considerations involved in the present study, the analysis of data, validity of the instrument, reliability and applicability of the findings, as well as the limitations of the study.

### **3.2. Research paradigm**

In this study, I was guided by a post-positivism paradigm. A post-positivism paradigm try to analyze the situation of interest by examining the inhabitants of the environment in situ, gaining insight into their behaviours based upon social interaction. Post-positivism is in opposition to

positivism in that it does not admit that individuals operate in isolation. Post-positivism recognize that people influence and are influenced by other social contacts and the environment in which they live. Becoming involved and elevating the awareness of participants enhance an attentiveness of the issues (Blackstock, Kelly & Horsey, 2007). This results in the participants being more than merely the recipients of the results; they add new dimensions to the problem and may have new viewpoints on the resolution. In the context of a post- positivist dependent framework, data collection is usually qualitative in nature.

### **3.3 My personal paradigm**

Lincoln and Guba (1985) describe a paradigm as a set of beliefs dealing with basic principles. According to Lincoln and Guba (1985), a paradigm is a person's perspective about the world based on their best answers to metaphysical questions. These basic beliefs must be accepted or their realism cannot be established. I believe that a personal paradigm directs the manner in which we observe the world and assists us to look at research with a certain lens. A paradigm is a fixed conceptual framework that one can accept and work within, which then becomes a filter for seeing, interpreting and correlating experience. Everyone has a personal paradigm, although it is often hard to express because so much of it remains deep in the unconscious. It is part of what we feel, it is where our intuition resides and it generates our feelings. It is truly a filter, an interpreter, continuously running a multi-dimensional correlation analysis on our incoming information stream. Being aware of our personal paradigms is essential in research.

I believe that every person is a unique individual, and I am no exception to that rule. I truly do not know anyone else like me. Although I have some strong tendencies, I am a complex person

with areas of my personality that fluctuate depending on the situation. There are subtle interplays between the different facets of my personality and although I am steady and reliable, sometimes I surprise myself by doing something unexpected. No one who knows me truly and completely knows the real me, even I don't. The culture in which I was raised is supportive of shared participation. This has helped me to empathize with the people in my community who are suffering from traumatic stress or mental disorders and motivated me to set up a social support network for them. I work hard and become extremely dissatisfied when I feel that I am not reaching my potential. I am very determined to do things right.

I am a half-full glass kind of person. However, if there is a down side to anything, I have the ability to see it because I am a perfectionist. I am often dissatisfied with things I have done, wishing I had done more or better. I feel I do not get enough exercise and know that I should read more. Sometimes I just wish I could turn back the clock and start all over again so that I could do everything right.

Thinking about my personality, I discovered more about my personality traits and myself, and how the combination affects my work as a mental health worker, manager and I. My personality traits indicate that I have a moderate internal locus of control, implying that I have a tendency to believe that I control my own destiny. This is because I believe that the outcomes of certain situations relate to my own actions, giving me a feeling of control over my surroundings and my well being. I am usually successful in the workplace. In my capacity of managing some of the mental health workers in Rwanda, I have the propensity to have lower absenteeism rates due to my health conscious attitudes and also a lower individual turnover rate.

I have faced many challenges on my journey as a doctoral student in mental health and have been forced to re-examine the manner in which I observe individuals and the manner we function in the world. In conducting research, I had developed a reputation for being a positivist, quantitative researcher. More recently, however, much of my work has been seen to have a more 'qualitative' approach, with a particular focus on mixed methods and action.

Throughout my education, one thing trapped my consideration as being critical when determining which approach to use when investigating a phenomenon. I strongly believe the question of interest in the research should direct the methodology. I am intrigued by the values and beliefs that I hold and the way in which they affect my research in mental health. How do I live with the dichotomy of being a researcher whose methods are determined by the question being asked, yet see a diversity of questions and truths in front of me? Further, what do I make of the analysis? How do I generalize to multiple realities? It is interesting in looking for answers to these questions that has determined my interest in post-modern research.

These contrasting questions suggest a shift of position in my outlook, which leaves me with a certain amount of uncertainty of my position as a researcher. My methodological repertoire has seemingly expanded a primary adherence to qualitative research. However, exploring the meanings and experiences of participants requires a degree of interpretation and, therefore, the existing knowledge and inherent pre-conceptions of the researcher inevitably becomes a part of that process. As the principal researcher in this study, I am a qualified mental health worker, experienced in working with survivors of traumatic events in Rwanda. I have considered what impact such work might have on my own sense of self, but, at such an early point on my journey as a mental health worker, I have not yet formalized a conclusion. My personal experiences

have, however, led me to develop certain assumptions. I realized that working with trauma clients does have an impact on the way I view myself, others and the world. I also began this research with the assumption that the effects of secondary traumatic stress that mental health workers might describe could be both positive and negative.

In order to avoid bias, the assumptions I held were monitored throughout this research through the process of supervision and keeping a research diary. Interestingly, my assumptions regarding the impact of STS experienced by mental health workers were challenged, with regard to the meanings they had constructed for these experiences. This was discussed with the research team during the process of triangulation.

### **3.3.1 My shifting from positivism to post-positivism position**

My previous work and research orientations were guided by a positivist paradigm which influenced both my research and practice, allowing me to discover the nature of this methodology. I am a strong collaborator by nature. I assume that I have been educated well and bring a certain expertise to my work in the mental health profession in Rwanda. However, in no way do I consider myself to be specialist of how other people live. I consider myself to be a post-modernist.

I have found myself focussing on the big picture and asking myself how my personal point of view influences my research and practice. As a mental health student, I get caught up in just attempting to know how all the parts are linked and find it simple to forget that all the sum of the parts make a whole. As a result, I have been trying to understand whether this big picture has been subconsciously influencing all that I do.

Education has shaped much of my experience, thus influencing my viewpoint on what happens around me. My education has changed my views, beliefs and my thinking of life. My studies at the University of Nancy (France), where I gained a bachelor degree in Public Health, and my training at the University of KwaZulu-Natal, where I gained a master degree, taught me to be reflective. In asking myself questions such as “*how do I describe who I am?*” and “*how does this influence how I carry out the study?*” I realize now, that as a mental health student and professional, I was educated to think like a post-modernist.

I was trained to look at how I see myself in connection to others and how my perception of self influences my work and research. However, as a researcher, I find I have just started to examine and learn who I am. At the University of KwaZulu-Natal, especially as a PhD student, a new world has been opened up to me, a world of opportunities. Curiosity directed my research. In fact, when carrying out this study, which was in reality my first experience with action research, I used mix-methods. This helped me to be as complete as possible in the research process. However, I realized that having struggled with the issues of how my paradigm would influence the research questions and how I should conduct the study; I worried that I might have similar problems within the research field.

I believe that self-reflection and continued work in the field of mental health has assisted me in the research process. This has challenged me to look for the research methods that best fit with who I am as individual. I realized that a post-positivism paradigm fits best with my actual viewpoint because I need to determine how meaning is created so that I can try to understand and

assist in constructing new meaning by applying the research results to practice. I wish also to be able to associate my research theories and methods with practice.

### **3.4 Research approach and research design**

According to Zikmund (2003), a research design is a master plan specifying the methods and procedures used for collecting and analyzing the needed information. In developing a model to manage secondary traumatic stress, an action research approach has been adopted using a mixed method. According to Lomax (2002), action research is a self-reflective, self-critical and critical enquiry undertaken by professionals to improve the rationality of their own practices, their understanding of these practices and the wider contexts of practice. Reason and Bradbury (2008) argue that action research is grounded in a participatory worldview emerging at the present historical moment. The research itself is a participative, democratic process concerned with developing practical knowledge in the pursuit of worthwhile human purposes. Action research can be illustrated as one of research methodologies which are based on change and understanding at the same time (Dick, 2006). It is characterized by the cyclical review of action followed by reflection, often ending in improvement of the understanding and uses methods such as modelling. The iterative character of the methodology promotes convergence to a greater understanding (Dick, 2006). Once explored, action (change) can be deliberately insert to the situation to develop it, and its resulting effect observed. Reflection on the change and resultant effects are then made to produce potential further action. Assessment, action and reflection are key elements of the research methodology. Dick (2006) confirms that the action-research design serves a dual purpose, namely, to yield simultaneous change and understanding.

As a method, action research is turning into a popular model for research in social and health science, particularly those involving primary care (McNiff & Whitehead, 2006). The methodology includes both the structural procedure of traditional research with a sociological perspective. As an overarching methodology, the action research cycle supports evaluation of punctual question raising, planning, fieldwork, followed by analysis and reflection. Action research has been revealed to take diverse theoretic framework structure (Ågerfalk et al., 2006).

### **3.4.1. Philosophical assumption underpinning of action research approach**

According to Reason and Bradbury (2008), action research is a process for developing practical knowledge for worthwhile purposes, leading to health and happiness for people and communities. It is about knowledge and practices that contribute to human well being and happiness. Dick (2006) states that action research is action-and-research and combines twin aims in a single process namely improvement of some aspects of professional practice or social process while generating new knowledge at the same time. Action research is typically described as a cyclic process involving a number of stages which involve planning, acting and reviewing or reflecting on the outcome.

According to Dick (2006), action research can also be alluded to as a participatory cyclic process design. In this current study, a participatory cyclic process design was used. According to Dick (2006), the cyclic process refers to a flexible spiral process which participants go through, which allow action (change, improvement) and research (understanding, knowledge) to be achieved at the same time. Dick (2006), referring to the cyclic process, indicates that it is the natural cycle used by action research that achieve its twin outcomes of action (for example, change) and research (for example understanding). Each cycle consists of action and critical reflection.

During reflection, people examine what has previously happened and review this material. They then decide what to do next and implement their plans.

Dick (2006) stated that the common element in participatory researches was that research was undertaken collectively with and for the individuals, groups or communities who were its subjects. In this study, the managers and mental health workers were participants. The research design was not detailed before the research started. Instead, the research design was refined as the research team and participants learnt more about the situation which was being researched. The design improved and fitted the situation better as the study proceeded. Through the cyclic process, the research team and participants were able to refine the activities they wanted to undertake and decide when they wanted to do them. Thus, the cyclic process was flexible and responsive. In this way, the agenda was set by the research team and the participants and all of them were willing to implement the model in their institutions. Thus, the participants were involved in the data gathering, analysis and outcome. The advantage here is that the research does not have to be designed in detail before it begins. Instead, the research design can be refined as more is learnt about the situation being researched.

According to Dick (2006), there are three main approaches to action research, each with a distinct goal. These are the technical collaborative approach, the mutual collaborative approach and the enhancement approach.

#### **3.4.1.1 Technical collaborative approach**

The underlying goal of a researcher using this approach is to test a particular intervention based on a pre-specified theoretical framework. The question is to see if the intervention can be applied

in a particular setting. The nature of the collaboration between I and the participants is technical and facilitatory. The researcher enters the collaboration with an identified problem and specific intervention. The aim is to gain the participants' interest in the research, as well as their co-operation in facilitating its implementation. Generally this approach results in an efficient and immediate change in practice (Dick, 2006).

Technical collaborative action research uses a positivist, scientific frame of reference. Action research is seen as a method of solving problems. Projects tend to be instigated and managed by researchers who are seen as skilled experts. Technical action research promotes efficient and productive practice. It includes experimental action research leading to the accumulation of predictive knowledge to refine existing theories in an essentially deductive process (Reason & Bradbury, 2008).

#### **3.4.1.2 Mutual collaborative action research approach**

In this approach, the researcher and practitioners come together to identify potential problems, their underlying causes and possible interventions. In the action of this dialogue, the researcher and practitioners arrive at a new common understanding of the problem and its causes, and plan for initiating a change process (Kidd & Kral, 2005). The practitioners involved gain a new understanding of their practice and any change implemented tends to have a more lasting character than just the immediate enthusiasm caused by the change itself. However, the changes tend to be connected to the individuals who are directly involved in the change process and, therefore, tend to be short-lived because those individuals either leave or new people enter the

system. The type of knowledge generated from this approach is generally descriptive and moves towards the development of new theory (Kidd & Kral, 2005).

Interactive or mutual collaborative action research often (but not always) uses systems theory. Mutual collaborative action research is divided into two types; organizational (involving organizational development); and professionalizing (building autonomous reflective practice). This type of action research project requires the researcher and the practitioners to come together in order to identify potential problems, their underlying causes and possible interventions (Reason & Bradbury, 2008). After dialogue, the researcher and the practitioners define the problem and a mutual understanding is reached. This type of research has even been called practical and/or pedagogical because it seeks to improve practice through the application of the personal wisdom of the participants (Kidd & Kral, 2005). The communication flow in this type of action research must be unimpaired between each member of the group and the facilitator (Kidd & Kral, 2005).

#### **3.4.1.3 Enhancement approach**

According to Reason and Bradbury (2008), there are two underlying goals of the researcher using the enhancement approach. One is to increase the closeness between the actual problems encountered by practitioners in a specific setting and the kind of theory used to explain and resolve those problems. The second goal, which goes beyond the other two approaches, is to assist practitioners in collectively identifying fundamental problems and making them explicit. The researcher raises questions about underlying assumptions and values and involves the practitioners in critically reflecting on their practices. This brings to light the difference between the stated practices and the underlying assumptions and unwritten laws which really govern the

practices. The emphasis here is on bringing to the surface the underlying value system of certain practices, including norms and conflicts, which may be the core of the problems identified.

According to Reason and Bradbury (2008), enhancement action research often employs a critical perspective to address issues of social change and emancipation. This way of working with and relating to others promotes liberation and critical consciousness in participating actors, which shows itself in practical action to improve the lives of disadvantaged people. Emancipative action research projects have twin goals. The research aim is to reduce the gap between the problems experienced by disadvantaged people in specific settings and the theory by which they understand and explain their situation.

For the present research, I followed the interactive/mutual collaborative action research approach to develop a model to manage secondary traumatic stress in MHWs in Kigali, Rwanda. Zuber-Skerritt's (2002) model influenced the methodology of the present research. Zuber-Skerritt (2002), states that action research is '*critical (and self-critical) collaborative enquiry by reflective practitioners being accountable and making the results of their enquiry public, self-evaluating their practice and engaged in participative problem-solving and continuing professional development*' (Zuber-Skerritt,2002).

Zuber-Skerritt (2002) further said that action research is considered to be an appropriate research model to use for organizational change. Action research aims not only at technical and practical improvement, the participants' transformed awareness and change within their organization's existing boundaries and conditions, but it also aims at changing the system itself or those conditions which hinder desired improvement in the organisation. (Zuber-Skerritt, 2002)

#### **3.4.1.4 Rational for using collaborative action research**

Collaborative action research is the research approach which takes into account knowledge, problems and environment as understood and defined by the participants of the study (Kidd & Kral, 2005). It has a purpose to find solutions to problems and conflicts and, at the same time, contribute knowledge. The researcher's approach was not that of an expert, but of a person whose intention was to guide and learn from the participants (Mitchell, Reilly & Logue, 2009). Kidd and Kral (2005) describe three elements that distinguish collaborative action research from other approaches:

- The researcher has to be aware of his or her own limitations, sense of insecurity and some level of ignorance, acknowledging that the participants have much to offer in the study.
- Having acknowledged one's ignorance, the researcher tries to learn from the participants concerned, their problems, needs and feelings through empathy and friendship. This is done through data collection from the official records and through group discussions.
- Once knowledge has been acquired, the researcher involves participants in discussions as they search together for possible solutions.

Collaborative action research is a powerful tool to advance both science and practice, and acknowledges the independence between science and politics (Mitchell, Reilly & Logue, 2009). It evolved out of three streams of intellectual development and action which are:

- Social research methodology, which has the view that the researcher should aim at discovering basic scientific facts or relationships and not get directly involved. A process of change is observed with the limitations of the professional expert model.

- Participation in decision making by low ranking people in organizations is influenced by democratic values and is more in line with the quality of life for humans. Decisions are made through the involvement of people at grass roots level.
- A socioethical framework acknowledges that understanding human behaviour at work depends on integration of social and technological factors. It allows for the invitation of different sectors to participate under study (McNiff & Whitehead, 2006).

Collaborative action research is a continuous mutual learning strategy, where researchers are offered the opportunity to check the facts with those having first-hand knowledge. It is recognised as a process, not only to achieve results of current benefit to organisations, but also can lead to a rethinking and restructuring of relations (McNiff & Whitehead, 2006). Collaborative action research is a cyclical process. Its processes exist interdependently and follow each other in a spiral or cycle, requiring partnerships in all cycles. It allows for feedback discussions, also known as the feedback loop, which may lead to further developments in the study. It is a collective self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social practices (Reed, 2005). The principle and values (participation and collaboration, empowerment, supportive relationship, knowledge and social change) set it apart from other traditional research approaches (Dick, 2006).

### **3.4.2 Mixed methods**

In the present study, both qualitative and quantitative methods were used. The motivation for choosing both research methods arose from the basic assumption on my part, as a researcher, that

each method has advantages in particular areas which, when used together in a complementary way, can work to enhance the quality and utility of research results.

Mixed methods refer to the use of two or more quantitative and/or qualitative strategies within a single research project (Onwuegbuzie & Johnson, 2006). Mixed methods are exemplified when a single study uses multiple or mixed strategies to answer the research questions and/or test hypotheses. The use of mixed methods research designs is a growing tendency in health sciences (Twinn, 2003). By combining various methods, other options in addressing complex health problems are offered. Mixed methods promise new insights and perspective in the understanding of phenomena.

Using more than one method offers the potential for a deeper understanding of the complex health problems frequently faced by the health care profession. Today, health professionals need to expand their understanding of all methods and all combinations of methods so they are prepared to answer the research questions that arise from the complex health care situations they are faced with (Driessnack, Sousa & Mendes, 2007).

#### **3.4.2.1 Advantages of mixed methods**

According to Creswell and Clark (2007), a mixed method is an approach to inquiry in which the researcher links, in some way, both quantitative and qualitative data to provide a unified understanding of a research problem. Quantitative research has traditionally provided a measurement orientation in which data can be gathered from many individuals and trends assessed across large geographic regions (Driscoll, Appiah-Yeboah, Salib & Rupert, 2007). Qualitative research, on the other hand, yields detailed information reported in the voices of

participants and contextualized in the settings in which they provide experiences and the meanings of their experiences (Driscoll et al., 2007).

When researchers bring together both quantitative and qualitative research, the strengths of both approaches are combined, leading, it can be assumed, to a better understanding of research problems than either approach alone. There are five main purposes for using mixed methods when studying a phenomenon of interest. These include triangulation, complementarity, development, initiation and expansion (Creswell & Clark, 2007).

### **3.4.2.2 Triangulation**

The most well known purpose of using mixed methods is triangulation. It refers to the junction or corroboration of data gathered and various interpretations about the same phenomenon, although the exact approach or form of data gathering and/or interpretation can vary (Breitmayer, Ayres & Knafl, 2007). The concept of triangulation, that is using different data collection modes, is supported by Babbie (2009), who defines triangulation as the use of multiple methodologies, methods and investigators in the same study. In this study, triangulation of research designs complemented each other and made a stronger research design with potentially more valid and reliable findings.

### **3.4.2.3 Complementarity**

Complementarity is attained, beyond triangulation, by focusing not only on overlapping or combining data, but also on the different facets of the phenomenon, thus providing a greater range of insights and perspectives (Creswell, & Clark, 2007).

#### **3.4.2.4 Development**

Development combines, or uses, the findings from one method of studying a phenomenon to develop another method. For example, workshops are sometimes used to gain feedback on what have been done (Creswell & Clark, 2007).

#### **3.4.2.5 Initiation**

Initiation involves the intentional analysis of new perspectives on a phenomenon of interest.

#### **3.4.2.6 Expansion**

Expansion is the overall widening of the scope, breadth or range of a study. To date, health professional researchers have primarily focused their efforts on triangulation (Sandelowski, 2007). However, it is also important to note, that as mixed methods continue to develop and evolve, researchers, when describing their studies, should clearly define their purpose and approach to these methods.

### **3.5. Establishment of the research team**

At the beginning of the study, a research team, consisting of experts in mental health care, was set up in keeping with the interactive/mutual collaborative action form of research. Once the team had been established, the team members worked together with me to develop and guide the research. One of the inclusion criteria for research team members was that they held a qualification as a medical doctor, psychiatrist, psychologist, mental health nurse, social worker or trauma counsellor. The team also included people involved in the mental health system in Rwanda who were interested in the area under research. Because this action research was all about creating change for the better, the research team members guided the research process

from the beginning to the end and were actively involved in ensuring that a process of change took place. The team was involved in all aspects of the planning and implementation of the research and it was anticipated that when the research had been completed, they would be able to continue the process of running the new model.

### **3.6. Research setting**

The research was carried out in four mental health services in Rwanda. Those services consisted of the Ndera Psychiatric Hospital, the Kigali Psychosocial Consultation Service, AVEGA and ARCT. The Republic of Rwanda is in east of central Africa and is bordered on the north by Uganda, on the east by Tanzania, on the south by Burundi, and on the west by Lake Kivu and the Democratic Republic of the Congo (formerly Zaïre). The area of Rwanda is 26,338 sq km (National University of Rwanda, 2004). The capital city is Kigali. The country is still in the process of emerging from the tragic events of 1994. In 1998, it was reported that 70% of Rwandans lived below the poverty line and that approximately 38% of households were headed by women as a consequence of genocide (National University of Rwanda, 2004).

Rwanda's mental health delivery system is a tiered set-up. The bottom tier is made up of the community workers and health centres followed by the district hospital which has the facilities to manage mental disorders. The third tier is formed by two specialist mental health institutions, the Ndera Psychiatric Hospital and the Psychosocial Consultation Service (Ministry of Health, 2008). There are an estimated 308 mental health workers working in the four mental health services (Rwandan national mental health coordination, 2008).



Figure 3.1 Map of Rwanda in Central Africa

The Ndera Psychiatric Hospital aims at becoming a national reference institution in inpatient mental health care in Rwanda. Major responsibilities of this hospital include providing specialized psychiatric and mental health care, prevention strategies and training. It also provides supervision of the mental health services in district hospitals and technical support in mental health care to referral and district hospitals. The Ndera Psychiatric Hospital is located in the Gasabo district of Kigali, the capital city of Rwanda. The total number of mental health staff at the hospital includes 67 nurses (3 registered nurses with honours degrees, 42 registered nurses and 22 enrolled nurses), 4 medical doctors, 2 psychiatrists, 1 neurologist, 12 social workers, 3 psychologists and 10 counsellors. The hospital has 220 beds and is divided into 6 wards: male acute; female acute; male rehabilitation; female rehabilitation; children; and chronic. The hospital also has an outpatient department providing services for trauma counselling and psychotherapy, occupational therapy, neurology, electroencephalography and social work. It has a pharmacy as well as laboratories (Ndera psychiatric hospital, 2008).

The Kigali Psychosocial Consultation Service was founded in Kigali on 22<sup>nd</sup> June 1999, in order to replace the National Trauma Centre (NTC) that had been founded on 22<sup>nd</sup> June 1995 by the Ministry of Rehabilitation and Social Affairs in collaboration with UNICEF to support the large number of people who suffered from post traumatic stress disorder as a consequence of the 1994 genocide. After the NTC had been replaced by the Kigali Psychosocial Consultation Service, it became one of the services of the Ministry of Health in Rwanda and is now a leading institution in mental health care for out-patients.

AVEGA is an acronym of *Association des Veuves du Genocide d'Avril 1994*, which, translated from French, means The Association of the Widows of the Genocide of April 1994. AVEGA is a non-profit organization conceived and created on 15<sup>th</sup> January 1995 by 50 widows, who were themselves survivors of the genocide. The association was approved by Ministerial decree n°156/05 on 30<sup>th</sup> October 1995. AVEGA's head office is based in the Remera area of Kigali City. However, a strategy of decentralisation, which aims to help AVEGA meet the needs of its members all over the country, has led to the establishment of two regional offices in both the Eastern and Northern Provinces in Rwanda. The women and children of AVEGA are assisted through various programs namely:

- A financial aid programme, which helps women to improve their social and economic situation.
- The advocacy programme with the goal to publicize the association and to defend and promote the rights of widows and children who were victims of genocide
- A job training programme where the association organizes training for women in practical skills such as sewing, basket weaving etc.
- A psycho-socio-medical programme, which offers different services such as counselling for women or other survivors of genocide suffering from trauma and treatment of various physical illnesses (AVEGA, 2004).

ARCT is an acronym of *Assosiation Rwandaise des Conseillers en Traumatisme*, which means The Association of Trauma Counsellors in Rwanda. ARCT is a non-profit organization which was conceived and created on 30<sup>th</sup> April 1998 and approved by Ministerial decree n°97/11 on 28th July 2004. The primary function of ARCT is to contribute to the rehabilitation of victims of

trauma by promoting their self confidence and assisting them to integrate into a working life and actively participate in the reconstruction of Rwanda. ARCT is an institution which provides professional prevention strategies and care for victims of psychological trauma and has a direct influence on the national policy on issues of trauma. ARCT aspires to lasting peace and national reconciliation as it works towards freeing Rwanda from any form of psychological trauma by using its framework of integrated services for the prevention and management of psychological trauma.

**Table 3.1: Mental health workers working in four mental health facilities**

	<b>Ndera Psychiatric Hospital</b>	<b>Psychosocial Consultation Service</b>	<b>AVEGA</b>	<b>ARCT</b>	<b>Total number</b>
Psychiatrist	2	2	-	-	4
Neurologist	1	-	-	-	1
Medical doctor	4	3	1	-	8
Mental health nurse	45	10	6	2	63
General nurse	22	5	5	3	35
Psychologist	3	3	1	1	8
Social worker	12	4	24	22	62
Trauma Counsellor	10	4	45	68	127
Total	99	31	82	96	308

### **3.7. Population, participants and sampling technique**

The target population for the present study was mental health workers in Rwanda. In order to conduct this study, a non-probability sampling was applied by the researcher, based on the availability of individuals. Based on purposive sampling, participants of this study were mental health workers working in the four selected mental health services who met the following inclusion criteria:

- a) They were 18 years old or older,
- b) They had at least 6 months experience working in public or private mental health services in Rwanda
- c) They were currently employed as mental health workers in the mental health services in Rwanda
- d) They were involved on a daily basis with counselling clients who were victims of trauma or other psychiatric conditions

For cycles 3 and 4 of this study, the participants were all mental health workers from the mental health service in which the model had been implemented.

### **3.8. Data collection instruments**

#### **3.8.1 Questionnaire**

For the quantitative data necessary for cycle I of this study, a questionnaire was used which had been developed by the researcher for a previous study. This questionnaire contained four sections, namely: demographic data; personal trauma history; work related experiences; and

support systems. The research team checked the questionnaire and was happy to use it. The Trauma and Attachment Belief Scale (TABS), made up of 84 items, was also used. Participants responded to each item using a 6- point Likert Scale. The scale ranges from 1 (*disagree strongly*) to 6 (*agree strongly*). The TABS, previously known as the Traumatic Stress Institute Belief Scale (TSI-BS), is a self-reported instrument intended to assess the disrupted cognitive schemas in people working with traumatized clients (Pearlman, 2003). The TABS measures beliefs related to the five needs areas (safety, trust, esteem, intimacy and control) that are sensitive to the effects of traumatic experiences (Pearlman, 2003). These five areas have a self and other dimension, yielding ten subscales. Each of the ten subscales consists of a number of different items. The TABS has been used by Iyamuremye and Brysiewicz (2008) in their research to explore secondary traumatic stress in nurses working in mental health services in Rwanda.

### **3.8.2 Interviews**

For qualitative data, a semi-structured interview method was used. The semi-structured interview consisted of a number of open-ended questions developed into an interview schedule intended to extract mental health worker's individual experiences with secondary traumatic stress. According to Burns and Grove (2007), in semi-structured interviews, the researcher does not guide the interview; rather, he/she facilitates the participant to illustrate experiences and register the responses. I utilized numerous open-ended questions considered to direct the participants to express experiences associated to secondary traumatic stress. After every interview and discussion it was audio-taped and transcribed.

### **3.8.3 Field notes and research journal**

I aimed to maintain a reflective balance by using field notes together with my research journal. I used my research diary to document my observations and to reflect on what had transpired during the research process. Clandinin and Connelly (2000) state that field notes combined with a research journal of one's field experiences provide a reflective balance. The information in my research diary provided me with a reflective balance as I used it together with the other data that had been collected. In putting together field notes, I aimed to record a detailed reproduction of the occurrences during the research process. A research journal is a systematic attempt to facilitate the interpretive process that forms the heart of qualitative research. Keeping a research journal encouraged me to document my observations and routinely reflect on my emerging understanding of the data (Clandinin & Connelly, 2000).

### **3.9 Data collection process**

According to Zikmund (2003), a data collection process is a plan specifying the methods and procedures for collecting the required information in a research project. The action research approach was applied throughout the whole process of the study. Data was structured in such a way as to provide information and answers to the research questions posed. A questionnaire was used in the first cycle of this study to investigate the extent of secondary traumatic stress in mental health workers in Rwanda. Data was collected from mental health workers in the four services, based on a convenience sampling. In the second cycle, an unstructured interview was conducted with a maximum of 30 mental health workers selected from the four mental health services participating in the study. In the third cycle, a literature review was conducted to obtain

data to use in the discussion about the model development. During all four cycles, field notes and workshops were used to obtain data on model implementation. Field notes and workshops were used also to evaluate the implementation of the model.

The idea of mixing approaches, as supported by Creswell & Clark (2007), was referred to as within method triangulation and involved the use of different methods of collecting data within one general approach. The value of triangulation in data collection cannot be over emphasized, because it is a means of validating conclusions based on more than one perspective.

Triangulation in this study also helped to uncover some of the unique characteristics of the participants which would have been neglected if a single method had been used. In some cases, participants themselves were unaware of these characteristics and failed to reveal them. Creswell and Clark (2007) refer to this as illumination of context because a deeper dimension of the participants emerges, thus enriching the researcher's understanding of them. In this study, triangulation also built on the strengths of different methods and therefore neutralized the problems that could have occurred if a single method had been used. The present action research was conducted in five cycles.

### **3.9.1 Cycle 1: Extent of STS in mental health workers**

Cycle I of the present study aimed to explore the extent of secondary traumatic stress among mental health workers in Rwanda. This part of the research was carried out in four mental health services in Kigali, the capital of Rwanda, and included the Ndera Psychiatric Hospital, the Kigali Psychosocial Consultation Service, AVEGA and ARCT. A quantitative approach was used to

collect data. Participants in this cycle included all the mental health workers working in the four mental health services who met the inclusion criteria as following:

- They were at least 18 years of age or older,
- They must have had at least 6 months experience working in a public or private mental health service in Rwanda.
- They must be currently employed as a mental health worker in one of the mental health services in Rwanda.
- They must interact directly with trauma survivors and psychiatric patients on a daily basis.

The questionnaire included demographic data and the Trauma Attachment Belief Scale (TABS). The TABS is made up of 84 items and respondents were required to respond to each item using a 6- point Likert Scale. The scale ranged from 1 (*disagree strongly*) to 6 (*agree strongly*). Before commencing data collection for this cycle, an introductory and informative session was held with the mental health managers to explain the purpose of the investigation and to negotiate when it would be convenient to collect the data.

After the introductory and informative session, I made appointments with the mental health workers at their convenience. Each participant was seen individually and the questionnaire was delivered by hand to each participant. Clear and concise instructions for completing the questionnaire were also provided. Participants were asked to return the questionnaires within the following two weeks and to place their sealed responses in the designated box which was available in each of the participating units.

### **3.9.2. Cycle 2: Experience of STS in mental health workers**

This cycle aimed to investigate the experiences of secondary traumatic stress in mental health workers. Qualitative data was collected using 30 in-depth interviews. This part of the research was also carried out in the same four mental health services. For this cycle, I selected in-depth interviewing as the strategy and content analysis as the favoured qualitative method.

All participants were asked to sign a consent form to be part of this study. Then I made contact with each participant to organize an interview. Previous to commence the interviews, he explained the purpose of the study, clarified the conditions of consent and notified them about confidentiality and their rights. He explained that they could decline to respond to any specific question or choose to stop their participation at any time. The tape-recorded, in-depth interviews were carried out in a tranquil way, in a confidential location. The audiotape was utilized to decrease the possibility of recorder bias. A period of about 45 - 60 minutes was used for each interviewer using open-ended questions for which participants were encouraged to discuss. The aim of the interviews was for participants to recognize problems around factors which cause secondary traumatic stress, strategies that assist them deal with stress and support systems that facilitate to prevent work related stress.

The in-depth interviews were consisted of five phases:

*Introduction:* This phase incorporated a general introduction to the study with the objective of launching rapport and familiarizing participants to the interviewing procedure. During the introduction phase, it was highlighted that the interview would focus on their experiences of secondary traumatic stress and on how they cope with their stress as mental health workers in Rwanda.

*Sources of stress:* During this phase participants were requested to explain sources of stress that occur during daily activities when dealing with traumatized clients or other psychiatric patients

*Strategies of coping with secondary traumatic stress:* In this phase, participants were required to explain coping strategies they utilized to decrease and prevent workplace related stress as well as any behaviors they performed for health promotion.

*Conclusion:* During this phase, I expressed thanks to each participant for their collaboration. Each interview took between 45 and 60 minutes. To protect participants' privacy, the interview was transcribed onto an anonymous form before it was distributed for analysis. Trustworthiness was ensured through inter-rater reliability of the transcripts and auditing by a research team.

### **3.9.3. Cycle 3: Model development**

Only two of the mental health facilities (the Ndera Psychiatric Hospital and the Kigali Psychosocial Consultation Service) were included in this cycle of the research. The research team used data collected from cycle I to identify the experiences of mental health workers and consulted literature to familiarize themselves with the theoretical and empirical work already carried out in the development of models to manage secondary traumatic stress, vicarious traumatization, compassion fatigue or occupational stress. Model development workshops were held with me to develop a model. Once the model had been selected, the participants were invited to a workshop to give them the opportunity to voice their suggestions regarding any changes they might like to make to the model.

While developing the model, the research team established a clear understanding of the concepts of the model and delineated relationships between these concepts (Smith & Liehr, 2008). The

model development followed the steps outlined by Chinn and Kramer (2007) by first describing what model they were trying to represent and the concepts active in this domain, and then analyzing them in relation to STS management. The order of occurrence and relationship between variables was identified and a visual representation of the model was developed and refined. In developing the model, Chinn and Kramer's (2007) criteria of clarity, simplicity, generality and empirical applicability were taken into account.

### **3.9.3.1. Clarity**

Chinn and Kramer (2007) recommend that determining the clarity of theory involves consideration of the following: semantic clarity, semantic consistency, structural clarity and structural consistency. Semantic clarity questions the theoretical meaning of the concepts. Therefore defining the concepts in the theory is an essential component of clarity. Structural consistency and clarity reflect the connections between the concepts in the theory and the rest of the theory. STS has been defined in such way that the relationships between attributes make sense and are understandable. Definitions of secondary traumatic stress that are both specific and general were included. The concept of STS was reflected throughout the development of the model.

### **3.9.3.2. Simplicity**

The defined concepts were applied throughout the development of the model to manage secondary traumatic stress. This permitted a simple understanding of the study and the model. It also allows application in practice for mental health workers (Chinn and Kramer, 2007).

### **3.9.3.3. Generality**

According to Chinn and Kramer, (2007), generality of the model refers to the extent of its scope and purpose. The model was developed to demonstrate how it could be used by mental health workers in order to manage the secondary traumatic stress experienced by them. However, the model can be generalized to other health professionals or other professionals involved in helping traumatized people by using the concepts of the developed model. For example this model could be applicable to nurses working in critical care units or emergency departments.

### **3.9.3.4. Empirical applicability.**

Empirical applicability is the result of asking, “*What is this and how does it work?*” (Chinn & Kramer, 2007:123). In developing this model, the concepts as well as all purposes of the model were clarified.

## **3.9.4 Cycle 4: Model implementation**

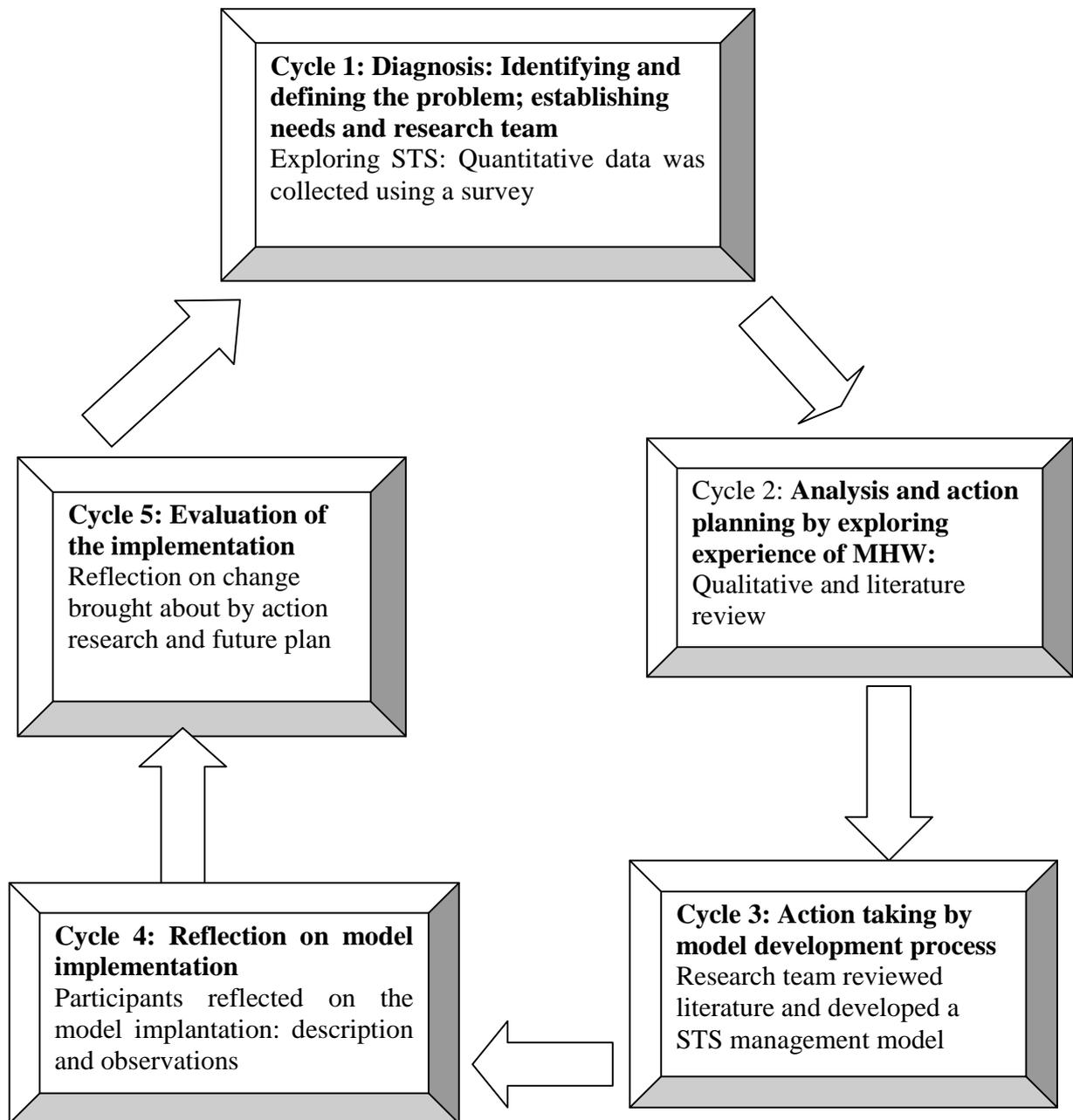
Once the model had been developed, it was implemented in one of the mental health facilities participating in the research. The Ndera Psychiatric Hospital was chosen by the research team because it was interested in implementing the model. All mental health workers and managers from the Ndera Psychiatric Hospital were invited to participate in this cycle of the research and were presented with the model. Feedback was requested from the participants regarding the developed model in the form of suggestions or comments. I was listening for similarities and differences, and asked the participants to reflect back on these (Larkin, Dierckx de Casterlé & Schotsmans, 2007). While the implementation was in progress, I attempted to be attentive to any

problems or difficulties experienced by the mental health workers. Regular contact was maintained with the implementation team in order to discuss the implementation, identify problems arising from the implementation and find solutions to such problems.

### **3.9.5 Cycle 5: Evaluation of the implementation of the model**

After implementation, an evaluation of the implementation of the model was carried out. This cycle aimed measuring the implementation, reflecting on any changes and formulation a future plan. Meetings with clinical and management staff were arranged in order to explore what they had experienced during the implementation of the model, which allowed me to gain a full view of the experiences of participants. The research team reflected on the empowerment and change brought about by the whole process and began to contemplate how a long term implementation of the developed model could be sustained in the future.

Their future plan was to improve practice by taking this change forward. Thinking about the direction the action research process had taken and planning for the future was also paramount in my mind. Although evaluation of the model was beyond the scope of this study, it was contemplated. Figure 3.2 presents a diagrammatic representation of the action research process as it applied to the present study and a summary of research cycles is presented in table 3.2 below.



**Figure 3.2 Action research and integrated cycles. Adapted from (Zuber-Skerritt, 2002)**

**Table 3.2: Research plan.**

	<b>Cycle I</b>	<b>Cycle II</b>	<b>Cycle III</b>	<b>Cycle IV</b>	<b>Cycle V</b>
<b>Broad objective</b>	Extent of STS	Experience of STS	Model development	Model implementation	Evaluation of implementation
<b>Research approach</b>	Quantitative	Qualitative	Qualitative	Qualitative	Qualitative
<b>Research participants</b>	MHW from 4 mental health services	30 selected participants	Research team	Research team and MHW in 1 service	Research team and MHW in 1 service
<b>Research setting</b>	4 services	4 services	2 services	1 service	1 service
<b>Data collection process</b>	Questionnaire	Interviews	Literature review workshops	Workshop Field notes	Workshops Field notes

### **3.10. Data analysis**

Hatch (2002) regards data analysis as a systematic search for meaning and processed data as a way of communicating to others what has been learned. The quantitative data analysis was used to synthesize the descriptive statistics pertaining to the research participants. The quantitative data was gained from the demographic questionnaire and the TABS (Appendix 3), using SPSS

version 15. Averages and percentages were used to portray the description of the sample under study.

The qualitative data collected was analysed using content analysis. This process of analysis necessitates the researcher to actively engage in listening, reflecting, clarifying and intuiting throughout the interview process. The structure of content data analysis integrated six phases. First, the transcripts were read to restore the experience of the interviews and then the transcripts were re-read in combination with the taped interviews to understand the meaning of the experience as a whole for each participant. Phase two concerned manually extracting important assertion that directly pertained to the phenomenon being studied. Phase three implicated the creation of meanings from the phrases by placing similar phrases into piles to generate understanding and classify themes. This stage utilized the phenomenological procedure of intuiting to determine the meaning behind the participants' words. The fourth phase concerned arranging the themes into clusters. The fifth phase implicated comprehensive descriptive writing which was intended to obtain the experience of the event as it presented to the participants. Once the writing had been concluded, I moved into the final phase by returning it to the supervisor and research team members in order for them to review the completed process and ensure that saturation of data had been achieved.

### **3.11. Trustworthiness of the qualitative data**

It is important that the information collected by the researcher reflects the truth and is of high quality. In the present study, I used the action research approach. According to a number of researchers, to confirm thoroughness of action research, credibility, transferability, dependability and confirmability of the research should be demonstrated (Lincoln & Guba, 1985). Researchers

in the field of action research explain that validity is demonstrated by the procedure itself, through the repetitive research cycles which facilitate reflection and authentication of each preceding experience by those implicated.

It is obvious that there are no agreed criteria for the evaluation of action research studies. However, even though the evolutionary nature of the research, rigor can be sustained if the action research approach is clearly explained and each stage documented. In addition, statement of the research hypothesis and objectives, together with previous information of the researcher, can limit impartiality concern. Also, it is indispensable that the researcher displays a full consideration of the impact his own beliefs may have on the research (Corbin & Strauss, 2008).

### **3.11.1 Credibility**

Credibility involves two aspects namely: carrying out the investigation in such a way that the believability of the findings is enhanced and taking steps to demonstrate credibility. Credibility refers to the truth of the data collected which includes prolonged engagement. This means spending a lot of time with the participants in the field and seeing them regularly. Prolonged engagement was ensured as the researcher was actively involved at the research site during the research period.

The individual interviews usually lasted approximately forty-five minutes and the workshop discussions about one hour. Therefore, it is believed that sufficient time was spent collecting data on the effects of secondary traumatic stress on mental health workers in order to test for misinformation and distortion; to build trust with informants; and to develop a good understanding of the meaning of data in relation to the culture and dynamics of the group. Also,

the technique known as triangulation was used to improve the likelihood that the qualitative data was credible. Triangulation is the use of multiple referents to draw conclusions about what constitutes the truth and was used to address the research problem in the form of individual interviews and workshop. According to Shenton (2004), the use of multiple methods assists with sorting true information from error information.

Credibility was also addressed by doing an extensive literature review during all phases of the research (O’Leary 2005), which enhanced the continual observations throughout the study. Data was consistently collected by means of observation and was interpreted in different ways by following a process of constant and tentative analysis. During the data analysis stages of the research, a research assistant was employed to co-code the data and research team members authenticated the coded data (Birks, 2008). Member checking was also enhanced during this stage by the members of the research team, who read through the field notes and transcribed notes and then discussed the data analysis through critical reflection (Graneheim & Lundman, 2004). This, in turn, enhanced credibility.

### **3.11.2. Transferability**

Transferability refers to the degree to which the findings can be applied to other contexts or with other respondents (De Vos, 2005). Transferability assesses whether the researcher has provided sufficient descriptive data to enable consumers to evaluate the applicability of the data to other contexts (Lincoln, & Guba, 1985). Transferability in action research is not always possible, but in this study the sampling and context was described in detail to enable a certain level of transferability.

Action research differs from other types of research in that its unique social contexts have to be taken into account. However, this does not necessarily mean that the findings of one specific context cannot be applied to other contexts. A researcher should be able to apply the knowledge and skills learnt in one situation to another setting (Birks, 2008). This action research project was appropriate for the context in which it was used, as actions to manage secondary traumatic stress were specifically planned according to the needs of the mental health workers in Rwanda. The aim of the research was not to generalize the findings, but to address specific challenges in a specific context. The transferability of the findings of this study will depend on the individuals who might want to use it for future research (Graneheim & Lundman 2004).

### **3.11.3. Dependability**

The dependability was assessed through the inquiry audit. This involves the scrutiny of the data and relevant supporting documents by an external reviewer; an approach that also has a bearing on the confirmability of the data (Shenton, 2004). I ensured that a dense description of the research design and methodology was provided. Field notes, a reflective diary, personal logs and audiotapes were kept throughout the research. The supervisor, who is experienced in action research, supervised the collection procedure and verified the findings. Tape recordings and notes were taken during the individual interviews and the group discussions. Triangulation was enhanced by comparing the research team members' data analysis with the researcher's own version, as well as using more than one source of data. The code-recode procedure was followed by means of a consensus discussion between the research team members.

#### **3.11.4. Confirmability**

Confirmability is a concept which refers to the objectivity or neutrality of the data. It is the agreement between two independent people about the data's relevance or meaning. The investigator can develop an audit trail through the systematic collection of materials or documents that will allow an independent auditor to draw conclusions about the data (Shenton, 2004). In addition to the research supervisor, experienced external reviewers were consulted during the analysis of the data. There was a consensus of agreement on the findings based on the analysis of the data between me, supervisor and the research team members. In addition, as this was action research, participants were consulted to confirm the interpretation of the data collected.

#### **3.11.5 Expert Reviews**

Once I had a final set of themes, I shared them with the members of the research team, all of whom have extensive experience with mental health care, and asked them for feedback. Being very familiar with the research and also with the work related stresses that mental health workers face, they commented on the above themes. They agreed that the themes were closely related to mental health workers' experiences when working with traumatized clients. They found that the themes painted a comprehensive picture of the experience of working with traumatized clients and other psychiatric patients and confirmed that they accurately captured the reality of mental health care in Rwanda. Team members agreed that the study holds pragmatic value for mental health workers because it validates the experience of mental health work. They were also of the opinion that the themes would resonate in all areas of mental health. The strategies that were applied to this research to ensure trustworthiness are described in table 3.3

**Table 3.3: Strategies to ensure trustworthiness**

Strategies	Criteria	Implications
Credibility	Prolonged and varied field experience	I am a mental health worker in Rwanda and in the setting of research
		Time has been spent in direct contact
	Reflexivity	Field notes were taken and workshops were held
		I was constantly reflecting on how I may have influenced the data
	Triangulation	Field notes were taken
		Quantitative data was collected
		Qualitative data was collected and analysed
		Unstructured interviews
		Data analysed by external co-coder (research assistant)
	Peer examination	Consensus with research team members
		Discussion with supervisor
	Authority of researchers	I have completed a master's degree in psychiatric nursing at the University of KwaZulu-Natal
		I have experience in the setting researched and in the field of mental health in Rwanda
		My supervisor has a PhD and is a senior lecturer at the Nursing School of the University of KwaZulu-Natal
		Research team members were mental health workers experienced with variety responsibilities in mental health care system in Rwanda
	Dense description	In deep description of the background, duration, research methodology, literature control and validation workshop

Transferability	Dense description	In deep description of the background, duration, research methodology, literature control and validation workshop
Dependability	Dense description of methodology	In deep description of research design and methods that was used
	Triangulation	As discussed
	Dependability audit	Primary data will be kept in a safe place by my supervisor and I for a period of five years
		Dense description of methodology and decision making
		Correct reference techniques
		External reviewers, supervisor and consensus discussion with research team members
Specific strategies with data collection	As discussed in methodology	
Confirmability	Confirmability of data	Between research team members and me
		Safekeeping of the primary data and field notes for five years
		Thorough description of the research design and method
		Literature review
	Triangulation	As discussed
	Reflexivity	As discussed

### 3.12. Validity and reliability

According to Burns and Grove (2007), validity is defined as the degree to which an instrument measures what is supposed to measure. Burns and Grove (2007) describe reliability as the consistency with which an instrument measures the attributes. The TABS, which was used in

cycle I of the current study, has demonstrated validity and reliability as it has been used in previous studies (Way, Vandeußen, & Cottrell, 2007). The validity and reliability of the TABS has been established with four groups (n=807) namely, mental health professionals (n=247), students (n=256), outpatients (n=186) and chronic patients (n=118). The overall reported reliability (Cronbach’s alpha) of the TABS is 0.98 (Pearlman, 2003). Other questions were developed by the researcher, himself, using the research objectives and research questions as a point of departure. The research supervisor assisted with formulating these questions and the questionnaire. Content validity refers to the extent in which the questionnaire included all the major elements relative to the concepts being measured (Burns & Grove, 2007) (Refer to Table 3.4 below).

**Table 3.4: Content validity**

Objectives	Theoretical framework	Questionnaire
To explore traumatic stress in mental health workers providing mental health care in mental health service in Rwanda.	Frame of reference Self capacities	<b>Section D:</b> 1,4,9,15,19,24, 25,27,31,32,34,35,36,39, 40,44,47,50,55,56,64,65, 66,68,70,74,80,84
To describe the work-related aspect that fosters secondary traumatic stress in mental health workers working in Rwanda.	Ego resources	<b>Section D:</b> 2,3,5-8,22,23, 26, 29,30,33,54,57-61, 83 <b>Section B:</b> 8- 10.
To describe the available support system for mental health workers who work in mental health service in Rwanda.	Memories and perception	<b>Section D:</b> 16-18,20-21, 46,49,51-53,73,75-79, 82 <b>Section C:</b> 11-15

### **3.13 Ethical considerations**

An ethical consideration is one of the key issues likely to confront the researcher at the beginning of the study (Kerkale & Pittila, 2006). According to Burns and Grove (2007), to carry out a research requires not only expertise and indulgence, but also a high degree of honesty and integrity. In order to ensure high standards of research, ethical standards and measures are set to direct research. Authorization for the carrying out this study was granted from the authorities of mental health services in Rwanda and the research committee of the University of KwaZulu-Natal prior to initiation of data collection. This was done to ensure that mental health workers involved in this study were protected and that appropriate methods were used to secure the risks (Burns & Grove, 2007). I was responsible for conducting the research in an ethical manner. Although the general ethical considerations were adhered to in this study, there were a few issues specifically pertaining to the use of action research approach that required further consideration and attention (Streubert-Speziale & Carpenter, 2003).

According to Koshy (2005), the following ethical considerations require attention when using action research and therefore applied to this research:

- participation was voluntary throughout the research
- participants gave informed consent
- participants retained the right to withdraw from the study and/or to retract consent
- the names and identities of the participants were kept confidential and unrecognizable (confidentiality and anonymity)
- the data produced by the study was accurately recorded and safely managed

- the information was shared with participants, critical friends and supervisors in order to verify the relevancy and accuracy of findings
- I was sensitive to the feelings of the participants
- I was as non-intrusive as possible during the data collection
- when researching socially sensitive issues, I took extra care in sharing the purpose and objectives of the study

Although I aimed to adhere to all the above-mentioned ethical considerations while conducting action research, he did experience some difficulties in the scope of this study, specifically with issues of informed consent, confidentiality and exploitation.

### **3.13.1 Informed consent and autonomy in the action research**

Burns and Grove (2007) state that obtaining informed consent is regarded as essential for the conduct of ethical research and informed, written voluntary consent was obtained from all participants. The three fundamental principles that guide researchers, namely respect for persons, beneficence and justice (Hemmings, 2006) were adhered to. All elements of informed consent were included in this research prior to data collection. An information document was added to the informed consent form and given to each participant who took part in the research process. Each of these documents was based on the specific role the participant was required to play in the study. It always included the title, purpose and/or objectives of the research and/or data collection techniques that were to be used. All essential information was disclosed. Voluntary consent was obtained by assuring each participant that participation was voluntary and that they had the right to refuse to participate or stop at any time without stating a reason. Comprehension

was assured by providing all the participants with as much knowledge as possible regarding the rationale and purpose of the study and/or the data collection techniques, and by briefing the participants on the issue of informed consent.

However, although letters of consent had been obtained from research team members and mental health workers at the beginning of the study, their right to withdraw from the project may have been impossible once the project had started (Hemmings, 2006). This was specifically relevant to the research team members who had committed themselves to the research in advance. Participation had been negotiated before the research commenced and the research team members understood that they had committed themselves to a long-term involvement and acknowledged their responsibility. The research team members and managers also recognized that they were accountable for their actions and omissions once the project had been initiated.

### **3.13.2 Confidentiality issues in action research.**

The participants were assured of their anonymity and were told that although the data obtained from them might be reported in scientific journals, no information that could identify them as participants, or their specific institution, would be disclosed. They were also assured that their rights of privacy and confidentiality would be strictly respected in any research report.

In this light of the confidential nature of information obtained during this research and the possible legal consequences of any violation of confidentiality, I was bound to maintain high professional standards regarding the issues and to direct the research accordingly (Brydon-Miller & Greenwood, 2006). Although the principle of confidentiality was strictly respected, certain problems were encountered, specifically for research team members. The first problem was that

to them the participants were easily identifiable. Secondly, research ethics requires the raising of issues without naming individuals, whereas managerial pressure from within the organization required people to be identified in order to validate findings. By encouraging individuals to analyze the report and maintaining continuous feedback to both the research team members and the mental health workers may have partly resolved these concerns. I indicated from the start that no names would be mentioned when reporting findings to the managers. Throughout the project, I referred to the group as a whole, rather than to individuals.

### **3.13.3 Freedom from harm**

Due to the sensitive nature of the topic being studied, there was the risk that the participants would experience negative emotional and psychological effects as a result of talking about their experiences with clients' trauma stories. A qualitative approach can be regarded as invasive because it required entry into the mental health workers' workplace as well as their lives in the workplace. Since discomfort and harm may be physical, emotional, spiritual, economic, social or legal (Hemmings, 2006), a new awareness or insight, as well as reminders of traumatic experiences could have resulted from the interview process. The risks to participants were minimized as far as possible by making sure that the data gathering techniques were conducted in a safe framing of questions so that no harm would be caused to the participants. Participants were informed of the possible risks implicated in this study, including fear and anxiety when recalling or telling their uncomfortable and/or stressful experiences. I provided the participants with contact information for resources that were available to them should they feel in need of any support after the interviews. A psychologist was made available to the participants at no cost in case they experienced any stress due to the research, but none of them had need of his services.

### **3.13.4 Freedom from exploitation**

Participants were assured that their participation and/or their information that they provided would not be used against them in any manner whatsoever. The risk/benefit ratio was considered in terms of whether the risks for the participants would be equal to the benefits for society. It was felt that this research would benefit Rwandan society as well as the mental health profession, although the immediate benefits would be limited to mental health workers in Rwanda, where the research was conducted. Koocher and Keith-Spiegel (2008) identify a problem with exploitation, where researchers view the participants as objects of change, rather than starting with the needs and concerns of the practitioners. This was overcome by establishing the research team at the beginning of the study. I was concerned not only with his own development and empowerment, but more particularly with assisting to enable the research team members and mental health workers to create a better management of secondary traumatic stress in their respective institutions. This too, prevented exploitation as I was not simply focussing on my own agenda. Because this study was for my academic purpose, ownership of the data was discussed with the members of the research team.

### **3.13.5 Principle of respect and human dignity**

This principle involved diminished autonomy, the right of self determination, the right to full disclosure and the right to fair and equitable treatment. In this research, individuals with diminished autonomy were protected by not having their identities disclosed in any way whatsoever. The right to self determination was guaranteed by ensuring the right of the participants to participate voluntarily in the research and by refusing to disclose information of

any kind at any stage of the research. Participants could, at any stage of the study, ask for clarifications about the purpose of the research or any other matter concerning the research. Had any person refused to participate, no means of coercion would have been applied. The right to full disclosure was never withheld at any time during or after the research. The full nature of the research, the participants' responsibilities, and the likely risks and benefits that could be incurred were fully disclosed in writing. Each participant's right to fair and equitable treatment before, during and after his/her participation in this research was ensured by applying the following measures:

- All mental health workers were invited to participate in the research process
- Participants who declined to participate or who withdrew from the research would not suffer any ill effects whatsoever
- All agreements between me and participants were honoured
- Participants were treated with respect and courtesy at all time

### **3.14. Data management**

In this study, to ensure confidentiality, a neutral research assistant, who holds master degree in social sciences and has an English background, was used to facilitate discussions and verify qualitative data after it had been collected and transcribed me. He had been informed about all aspects of the study and had been provided with mini training and instructions before the data collection commenced. The digital voice recorder containing the data was stored under lock and key. Hard copies of data were controlled and handled by me, and electronic data was saved on a computer which required a password. The data will be stored by me in a secure place accessible only to himself and his supervisor. I will be accountable for the proper maintenance and

availability of the primary research collected for this study and this will be maintained for 5 years, after which it will be destroyed. The report of the findings will be submitted to the Faculty of Health Sciences and to the Ministry of Health in Rwanda.

### **3.15 Conclusion**

The development of an intervention model to manage secondary traumatic stress required a concerted effort. This chapter discussed the research design and methodology in detail, including the research instrument, methods of collecting data, validity, reliability and ethical considerations. The use of triangulation in obtaining data was necessary to achieve the required objectives. Whether I relied on quantitative methods, qualitative methods, or both, depended on the question I was seeking to answer at the time. Credibility was maintained by involving mental health workers in devising the secondary traumatic stress management model. Because they were actively involved in the provision of mental health care, they were able to provide valuable input.

## **CHAPTER FOUR: FINDINGS OF THE RESEARCH**

### **4.1 Introduction**

This chapter focuses on the results of the research carried out to explore secondary traumatic stress, as well as the development, implementation and evaluation of the implementation of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda. As the research intended to use action research, the first step was to establish a research team who would be working together throughout all research phases of the study. The first cycle and second cycle of the study focused on exploring the extent of secondary traumatic stress and experiences of mental health workers in Rwanda. The third cycle focused on the data which was collected during discussions with research team members, managers and mental health worker as well as a literature review for developing the model to manage secondary traumatic stress in mental health workers in Rwanda. The fourth cycle focused on the implementation of the model while the fifth cycle emphasised an evaluation of the implementation.

### **4.2 Cycle 1: Extent of secondary traumatic stress in mental health workers**

This cycle started with an initial meeting held with research team members and managers in order to discuss the objectives of the study and obtain their support for it. The overall aim of this cycle was to explore the extent of secondary traumatic stress experienced by mental health workers providing mental health care in Rwanda. Work-related aspects were analysed and presented, bearing in mind that the mental health workers not only treat victims of trauma, but also care for patients with major psychiatric illnesses. Quantitative data was collected in this cycle by using self reported questionnaires. Initially, the total population of 308 mental health

workers working in the four selected mental health services in Rwanda (the Ndera Psychiatric Hospital, the Psychosocial Consultation Service, AVEGA and ARCT) were identified to participate in this cycle. However, some of them were unavailable to complete the questionnaire.

#### **4.2.1 Identifying the need for research and support for it**

All the mental health workers operating in the four institutions were invited to participate in the research. The participants consisted of medical doctors, psychiatrists, psychologists, registered psychiatric nurses, registered general nurses, social workers, trauma counsellors and unit managers. It was customary that a staff meeting was held each week which was attended by all the mental health workers from the four institutions. I was invited to attend the meeting to talk to them about the research. I also had several opportunities to meet the staff in their respective units to discuss the relevance of the study. I made notes as the participants answered various questions or made comments during our discussions. The participants were aware of the note taking and had no objection to it. I explained the purpose of the research and the ethical considerations and asked each participant to answer questions according to the guides for individual interviews or workshops. A great deal of time was spent discussing whether the proposed area of research was actually important to the mental health workers, or if they had other areas of interest for research. I explained that action research would be the research methodology used and that I wanted to ensure that the mental health workers and managers were involved in all aspects of the research. The mental health workers from the Psychosocial Consultation Service and the Ndera Psychiatric Hospital were very enthusiastic and excited to be involved in the research and a number of participants volunteered to be members of the research team.

A total of 200 questionnaires were distributed with a response rate of 90% (n=180). Bryman and Bell (2007) stated that a response of 50-60% was considered an acceptable return rate for survey research. The standards for acceptable return rates are shaped by how many responses a researcher can get as against how many she/he should get. According to Bryman and Bell (2007), four factors particularly influence the expected rate of return. These are the purpose of the research, the type of case or subject being investigated, the method of data collection and the relationship between the researcher and respondents. In this study, a number of other specific factors influenced the rate of return. Questionnaires were delivered to the relevant workplaces, I was well known to the participants, participation was requested in advance, enough time was allowed to the participants to complete the questionnaires, I provided clear instructions and sent reminders during the survey period for those that had not completed the questionnaire. The results from the quantitative data were analyzed using SPSS version 16. The data was presented clearly with the aid of tables and graphs.

#### **4.2.2 Characteristics of the sample**

In this study, the demographic data covered the gender, age, marital status and professional qualifications of the participants, their years of experience as mental health workers and their years of experience in the mental health service. The overall sample reflected mostly females which is representative as, currently, those who are involved in the health sciences as mental health workers in Rwanda are largely female. Demographic descriptions of the sample grouping are presented in table 4.1

**Table 4.1 Demographic characteristics of the sample**

<b>Variables</b>		<b>Frequency</b>	<b>Percentage</b>
<b>Sex</b>	Female	121	67.2%
	Male	59	32.7%
<b>Age</b>	25 years and less	15	8.3%
	26 – 35 years	141	78.3%)
	36 – 45 years	15	8.3%
	45 years and more	9	5.0%
<b>Marital status</b>	Single	87	48.3%
	Married	65	36.1%
	Separated	0	0.0%
	Widow	28	15.5%
<b>Qualification</b>	Undergraduate	131	72.7%
	Bachelor degree	47	26.1%
	Masters	0	0.0%
	PhD/Doctorate	2	1.1%
<b>Work status</b>	Psychiatric nurses	38	21.1
	General nurses	20	11.1%
	Medical doctors	5	2.7%
	Psychologist	5	2.7%
	Psychiatrist	2	1.1%
	Social worker	36	20.0%
	Counsellor	74	41.1%

According to Table 4.1, 67.2% (n=121) of the respondents were female and 32.7% (n=59) were male. These findings suggest that females serve predominantly as mental health workers in the mental health service in Rwanda. This is consistent with Moor (2007) who found that the majority of social work clinicians rendering services to victims of trauma were female. Sarasa (2007) is of the opinion that females generally assume the “caring” role and, therefore, work in helping professions as mental health workers, social workers and teachers. According to Ben-

Ezra, Essar and Saar, (2006), symptoms of STS have been found to be more prevalent among females than among males, regardless of occupation (Ben-Ezra, Essar & Saar, 2006). In their study, Pinguart, and Sörensen (2006) noted that there is a gender difference in caregiver stressors.

8.3% (n=15) of the respondents were younger than 25 years old; 78.3% (n=141) were in the 26-35 year old age group; 8.3% (n=15) were between 36-45 years old and 5% (n=9) were older than 45 years old. These findings indicate that the majority of the mental health workers were aged between 26-45 years old.

Of the respondents, 48.3% (n=87) were single, 36.1% (n=65) were married and 15.0% (n=27) were widows. It has been speculated that the greater the amount of social support a person has following an extremely stressful event, the less likely the person is to develop traumatic symptoms (Perez, Jones, Englert, & Sachau, 2010). This indicates that a social support system has the potential to build up the resilience of mental health workers to combat the effects of secondary traumatic stress. The high percentage of respondents who were either single or widows suggests that the majority of mental health workers in Rwanda may not have enough social support. According to Hyman, (2005), the severity of secondary traumatic stress symptoms may be mitigated by various factors, including availability and satisfaction from social support.

11.1% (n=20) of the respondents were general nurses, 2.7% (n=5) were medical doctors 2.7% (n=5) were psychologists, 21.1 (n=38) were psychiatric nurses, 41.1% (n=74) were trauma counsellors, 1.1% (n=2) were psychiatrists and 20% (n=36) were social workers. This indicates

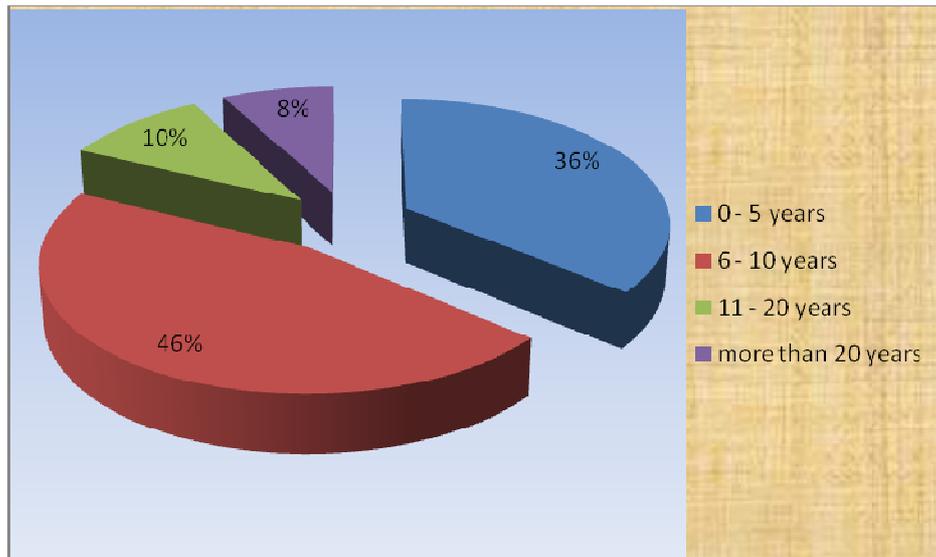
that mental health care in Rwanda is provided mostly by trauma counsellors and psychiatric nurses, while the number of psychiatrists and psychologists is still low.

As far as qualifications go, 72.7% (n=131) of the respondents held undergraduate degrees; 26.1% (n=47) held bachelor degrees, 1.1% (n=2) had a PhD, but none of them held a masters degree. These findings reveal that mental health workers in Rwanda have a wide range of qualifications. As they work independently of each other, the researcher is of the opinion that these qualifications assist the mental health workers in their daily work. Educational levels, longevity of career, and increased contact with clients have been positively correlated with severity of STS symptoms (Baird & Kracken, 2006).

Research findings reflect contradicting views as to whether one's level of qualification makes one vulnerable to secondary traumatic stress (Gates & Gillespie, 2008). A study conducted by Gates & Gillespie, (2008) found that those mental health workers who were more qualified were at lower risk of experiencing secondary traumatic stress. Other studies, however, have shown that working in the field of trauma on a full-time basis may make them more susceptible in developing secondary traumatic stress (Ortlepp & Friedman, 2002). Baird and Kracen (2006) suggest that factors such as level of social support, severity of exposure and the nature of the traumatic event may have more of an impact than the level of experience or qualification of the mental health worker.

### 4.2.3 General experience as mental health workers

Of the respondents, 36.0% (n=65) had less than 5 years general experience as mental health workers, 46.0% (n=83) had between 6-10 years experience; 10.0% (n=18) had 11-20 years experience and; 8.0% (n=14) had more than 20 years experience. This is illustrated in Figure 4.1.



**Figure 4.1: General experience as mental health workers**

These findings reveal that the majority (82%, n=148) of the mental health workers have been working in the field of mental health for less than 10 years and have, thus, had limited experience. According to Way, Vandusen, & Cottrell (2007), mental health workers who have had less experience in providing treatment to survivors are more likely to encounter greater 'intrusive' symptoms. Furthermore, they also suggest that those who have been most affected by trauma may leave the field prematurely. Bober & Regehr (2006) found that the longer mental health workers worked in the field was associated with more disruptive beliefs regarding

intimacy with others. These authors also suggested that their symptoms may be recognized to a lesser extent over time, becoming normalized and so less noticed.

#### 4.2.4 Length of time working in current institution

As shown in Figure 4.2 below, most of the respondents (62%, n=112) had been working in their current institution for less than 5 years and 31% (n=56) had been working for between 6-10 years. Only 7% (n=12) had been working in the same place for 11-20 years and none had been there for more than 20 years. This indicates that the majority of mental health workers in Rwanda are new and inexperienced because they have not been working in the same place for any length of time, and that the level of turnover could be high. This is illustrated in Figure 4.2.

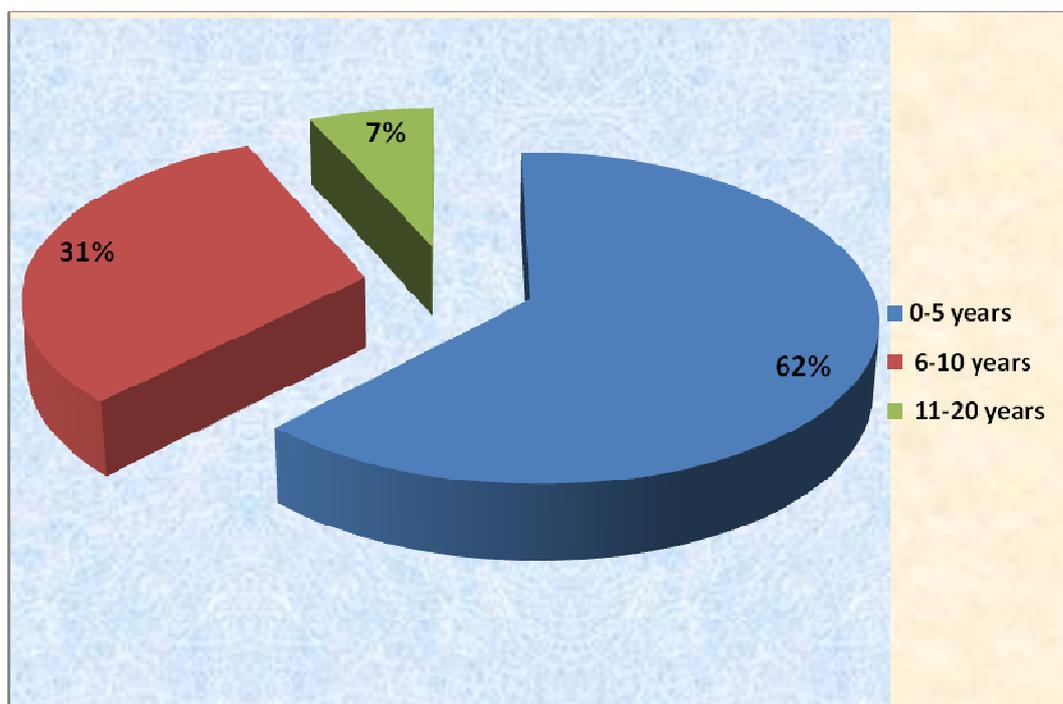
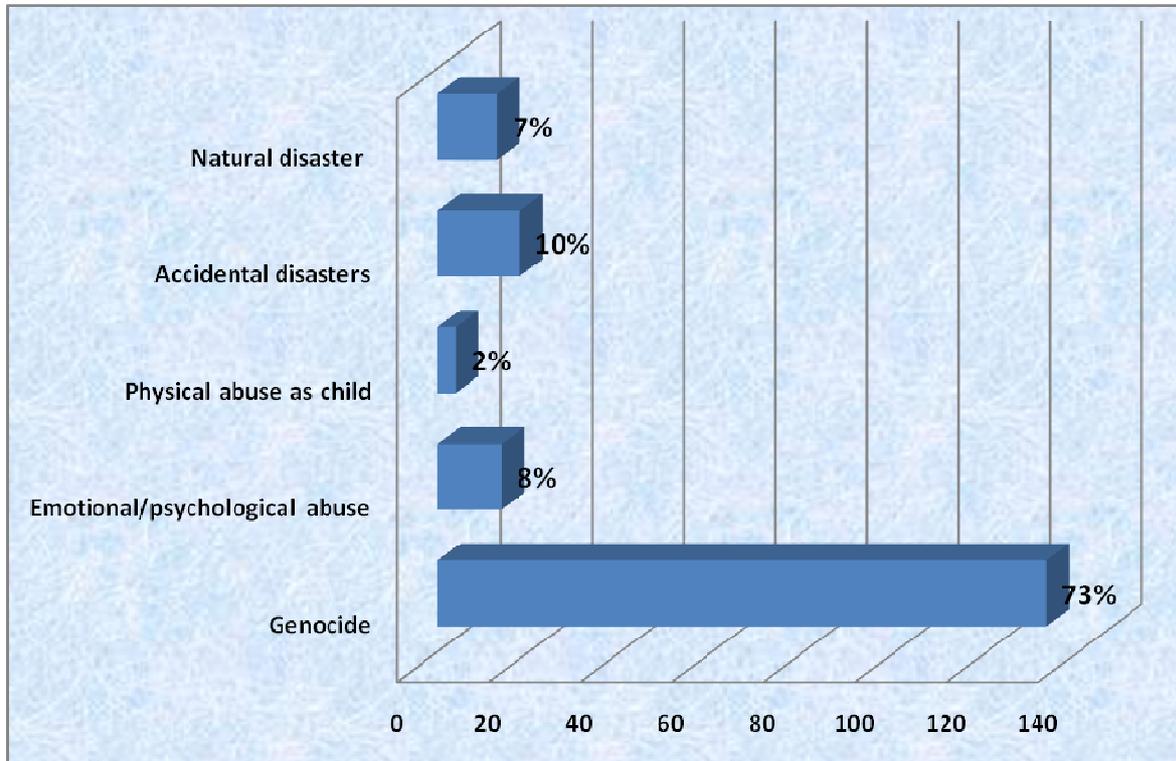


Figure 4.2: Length of time working in current institution

Cunningham (2003) found that new and inexperienced members of staff are more likely to experience secondary traumatic stress. Deighton, Gurriss and Traue (2007) concurred and reported that therapists who are new are more susceptible to developing STS symptoms. Osofsky et al. (2008) also reported the impact of secondary traumatic stress on the work environment, listing such issues as increased absenteeism, impaired judgment, low motivation, lower productivity and high staff turnover. Research carried out by Dekel, Goldblatt, Keidar, Solomon & Polliack, (2005) showed that close and long-term contact with emotionally disturbed people may cause chronic stress in the persons providing help, which in time leads to various emotional problems such as higher levels of depressive symptoms and anxiety, problems in concentration, emotional exhaustion, pain syndromes and sleeping problems. A few other studies revealed that length of experience did not buffer the effects of exposure to trauma material. Pearlman and McKay (2008) reported that secondary traumatic effects increased with the number of years in trauma work. More years of experience working in mental health services was found to be associated with more disruptive beliefs regarding intimacy with others (Bober & Regehr, 2006). Level of experience may also be relevant in predicting secondary traumatic stress, but existing research on this is contradictory (Way, Vandusein, & Cottrell, 2007).

#### **4.2.5 Personal trauma history.**

Mental health workers are not immune to becoming victims of traumatic events themselves. The breakdown of the traumatic events experienced by the mental health workers is illustrated in figure 4.3. This depicts the number of participants who have personally dealt with a traumatic event and the frequency of those events. Personal trauma history includes any psychological trauma experienced by the respondents, their family or friends.



**Figure 4.3 the respondents' personal trauma history**

Of the respondents, 73.8% (n=133) had personally experienced the events of the genocide. In addition to this, 10% (n=18) had experienced accidental disaster in their past, 7.7% (n=14) had experienced emotional and psychological abuse, 7.2% (n=13) reported that they had experienced some kind of natural disaster (e.g. flood, earthquake) and 2.2% (n=4) reported physical abuse as a child. It is evident that most of the respondents had experienced personal trauma due to the genocide in 1994, which is a situation is unique to Rwanda. It appears that physical abuse as child (2.2%) is the least frequent traumatic event encountered by the participants.

A personal history of trauma is another factor that is contentious in previous research. Creamer and Liddle (2005) reported that a personal history of past trauma was a risk factor in the development of secondary trauma and that it requires further study. Pearlman and McKay (2008) suggest an association between personal history of abuse and experiencing secondary traumatic stress. In one study of trauma therapists, counsellors with a personal trauma history showed greater disruptions than those without such a history.

Bober and Regher (2006), on the other hand, found that personal histories of abuse were not associated with secondary traumatic stress, except in individuals who had sought treatment, which suggests that those who were distressed or had unresolved personal histories were likely to seek appropriate assistance. What the research does show, however, is that while personal experience of trauma may sometimes be salient to the experience of secondary trauma, and sometimes not, it is traumatising within itself to be exposed to traumatic material. Hembree, Street, Riggs and Foa (2004) found that variables such as prior trauma, assault severity and type of assault are associated with natural recovery and would also predict trauma work outcome. Among the most robust predictors of failure to recover from trauma were prior victimization; trauma severity and type of trauma (Buchanan & Anderson 2007).

The impact of the mental health workers' own history of traumatic occurrences on this current report of secondary traumatic stress are unclear. In a survey conducted by Pearlman and McKay (2008), 60% of the mental health workers who reported a personal history of trauma showed significantly more symptoms of secondary traumatic stress. They also found that mental health workers without a trauma history were more likely to report intrusive imagery than those with a history. However, Killian (2008) found that mental health workers with a history of trauma were

not more distressed by working with survivors than were mental health workers without such a history. Hof, Dismore, Hock, Scofield and Bishop (2009) found that mental health workers with a significant history of childhood trauma history did not experience significantly more negative responses to trauma survivor clients than those without such a history. They also reported significantly more positive coping strategies.

#### **4.2.6 Extent of STS and levels of beliefs disruptions**

In the current study, the Trauma and Attachment Belief Scale (TABS) was used to measure disruptions in cognitive schema and, thus, secondary traumatic stress. The TABS is based on the Constructivist Self Development Theory. It is intended to measure disruptions in beliefs about self and others (e.g. safety, trust, esteem, intimacy and control) which arise from psychological trauma or from vicarious exposure to trauma material through psychotherapy or other helping relationships. This scale makes allowances for vicarious traumatisation and can be a measure of secondary traumatic stress (Pearlman, 2003). The TABS is made up of 84 items. Respondents respond to each item using a 6- point Likert Scale. The scale ranges from 1 (disagree strongly) to 6 (agree strongly) with positive items reversed scored. Examples of items of this scale includes “*I find myself worrying a lot about my safety*” and “*They can’t trust anyone*”. The TABS has shown strong reliability and validity in previous studies (Pearlman, 2003). As depicted in the Table 4.2, the subscales had varying means since they consisted of a different numbers of questions.

In a previous study on nurses operating in mental health services in Rwanda the highest scored subscale was other-safety with a mean of 79.58 and the lowest scored was self-trust at 63.74 (Iyamuremye and Brysiewicz, 2008). As shown in Table 4.2, all respondent (n= 180) in this

study answered the 84 questions that were asked for the 10 subscales. The subscale other-safety had the highest mean at 77.56, whilst self-trust had the lowest at 61.72. The higher the scores, the greater the risk factor for secondary traumatic stress. It is suggested that the cut-off point for secondary traumatic stress is 50, above which a moderate or severe disruption is indicated (Pearlman, 2003). The standard deviations also varied, indicating more or less symmetrical distributions. Statistics of the means and standard deviations of scores for the TABS utilized in the current study are presented below. Table 4.2 shows the scoring of the TABS total scores with a mean of 77.04 and a standard deviation of 1.154. According to Pearlman (2003), scoring for TABS subscale should be interpreted as follows: 29 or less = extremely low risk (very little disruption), 30-39 = very low risk; 40-44 = moderate risk; 45-55 = high risk; 60-69= very high risk; and 70 or more = extremely high risk (substantial disruption).

**Table 4.2 Total scores for TABS**

Items	N	Mean	Std. deviation
Self – Safety	180	67.86	2.001
Other – Safety	180	77.56	2.970
Self – Trust	180	61.72	4.136
Other – Trust	180	63.14	3.806
Self – Esteem	180	70.44	2.660
Other – Esteem	180	69.50	3.827
Self – Intimacy	180	65.02	3.602
Other – Intimacy	180	70.18	3.497
Self – Control	180	76.88	1.626
Other – Control	180	75.00	3.836
T- Score of scale	180	77.04	1.154
Valid N (listwise)	180		

In order to get a general sense of the level of secondary traumatic stress experienced by the sample, table 4.2 reflects the frequency of a participant's level of secondary traumatic stress. As Pearlman (2003) suggested that the cut-off point for secondary traumatic stress is 50, it is clear that all of the respondents are above the cut-off levels for significant traumatisation. This indicates that there is a disruption in all schemas of the participants and that they are all at risk of secondary traumatic stress.

According to Pearlman (2003), disruption in safety arises from experiences of violation or credible threats of violation of one's body, home, property or loved ones. It can also originate in near-death experiences, exposure to death or death images (as in war), or immersion in danger

and situations of extreme terror (as in genocide, terrorism or ongoing abuse in the home). This sums up the situation of many people in Rwanda where the majority experienced the genocide and the violence after the genocide. Pearlman and McKay (2008) said that people with elevated self-safety scores are struggling with issues with their own safety and may worry that they might be victimized or harmed by another person, or that they might harm themselves. The same author states that respondents with elevated other-safety scores are concerned about the safety of their significant others. According to Gates and Gillespie (2008) most people who have been traumatized or who have treated traumatized individuals start to worry about the safety of their loved ones. This corroborates with the results shown in table 4.2, where the majority of the respondents have experienced genocide and other types of traumatic events.

Disruption in the need of control is often linked to traumatic experience in which one was unable to help while others suffered, as when a child must watch a sibling or parent take abuse. Similarly control disruption may result from being forced to collaborate in administering harm to others, as sometimes happens in situations of torture, war, genocide or childhood abuse (Gates & Gillespie, 2008). Self-control disruptions may be accompanied by fear or anxiety over losing control over one's emotions or behaviours. Individuals with high self-control scores will find association, a very common correlate of traumatic stress, extremely frightening or intolerable. On the other hand, individuals who had high other-control scores feel uncomfortable when they are not in charge. They need to control others all the time in their relationships and when they are unable to do so, they become enraged or aggressive, or may simply withdraw. They are often in conflict with others, especially others who value or demand their own autonomy (Pearlman & McKay, 2008).

Gates and Gillespie (2008) said that experiences that inhibit the development of positive self-esteem or that damage self-esteem are characterized by defilement, degradation, humiliation, rejection or devaluation, or in other words, a sense of moral failure. A sense of entitlement, chronic anger, shame and depression may accompany esteem disruptions. People with self-esteem scores signifying disruptions may engage in self-punishing, self-injurious or suicidal behaviours (Pearlman & McKay, 2008). These bad feelings may often cause respondents to generalize, believing that they don't deserve acknowledgement or positive regard from others. It is easy for people with low self esteem to slip either onto their depreciation or blame others. According to Pearlman (2003), people with elevated other-esteem scores view others with disdain and disrespect. These views are usually based on experiences of abuse and violation by others. Disrupted other-esteem may then be reinforced by negative interactions with others. When these respondents feel disrespected, they may behave towards others in the ways that are shaming, blaming or humiliating.

Traumatic events that often give rise to disruptions in intimacy include the loss of an important attachment figure, such as death of a parent or other caregiver, or the loss of a loved one. People with elevated intimacy subscale scores are often withdrawn from others and avoid personal conversations or experiences that might invite emotional closeness (Pearlman & McKay, 2008). Individuals who score high on the TABS intimacy subscale may be disconnected and isolated from others, either interpersonally or emotionally. They may live a reclusive existence, leaving the house only to go to work, and avoiding others as much as possible. For those people interpersonal situation are highly demanding and can even be frightening. On the hand, people

with high self-intimacy subscales scores may find it challenging to spend time alone and may avoid it altogether. They may have difficulty reflecting on their experiences.

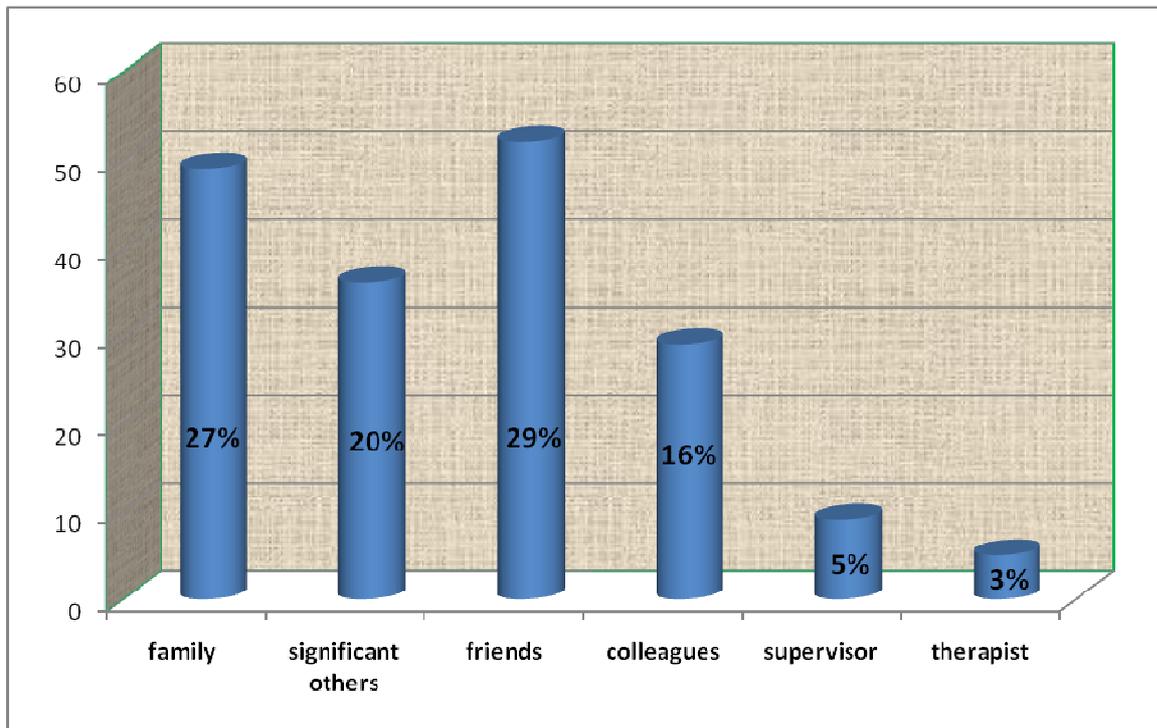
Those who have other-intimacy disruptions are likely to engage in pseudo-intimate relationships, in which they keep their emotional distance by avoiding true friendships or closeness. These individuals may have many acquaintances, but no friends, no one who knows their inner hopes, dreams, fears and longings. They may prefer sexual encounters, or sex with multiple partners, to loving sexual relationships (Adams, Boscarino & Figley, 2006).

Emotional states that reflect disrupted trust include fear of normal dependency, chronic anger, bitterness, disappointment in others and ambivalence about others' dependency. Disrupted trust needs can be reflected in extreme behaviours to avoid dependency and restrictions in interpersonal relations. Respondents for whom self-trust is the most elevated TABS score may be struggling to trust their own judgments and perceptions. They may rely heavily on others because they doubt their own decision-making abilities or instincts. It is believed that those who have elevated other-trust scores, at least to some extent, cannot trust or rely upon other people and that such individuals may be cautious to the point that they cannot form trusting relationships and suspect the motives of others at every turn (Adams, Figley & Boscarino, 2008)

#### **4.2.7 Sources of psychological support for mental health workers**

Participants were asked to indicate what kind of psychological support they received when they experienced traumatic stress related to their work. More than one source of support was indicated and the frequency of responses to each source was calculated separately out of 180. The responses are outlined in Figure 4.4 which helps to get a general idea of the support networks

available to mental health workers. The mental health workers received support from their friends (29%), family (27%), significant others (20%), colleagues (16%), while the least psychological support was received from supervisor (5%) and therapist (3%).

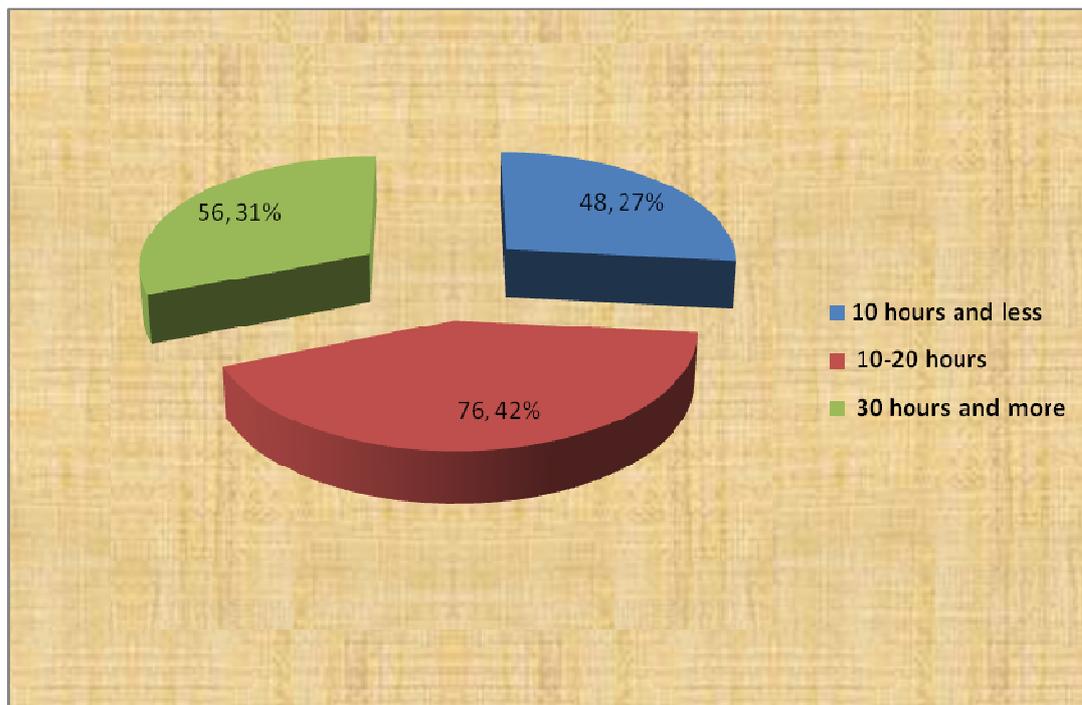


**Figure 4.4 Sources of psychological support for mental health workers**

Although they get most of their support from family and friends, the findings reveal that they are getting very little support from their organisation. These findings were supported by Lincoln, Chatters and Taylor (2005) who suggested that high levels of social support moderate the adverse psychological effects which the experience of a trauma can have on a person. According to Slattery and Goodman (2009), effective supervision is said to be an essential component in the prevention and healing of secondary traumatic stress.

#### 4.2.8 Work time per week spent in the counselling unit

As shown in Figure 4.5, 27% (n=48) of the respondents spend 10 hours or less per week in the counselling unit, 42% (n=76) spend between 10-20 hours per week in the counselling unit while only 31% (n=56) of the respondents spend 30 hours or more per week in the counselling unit.



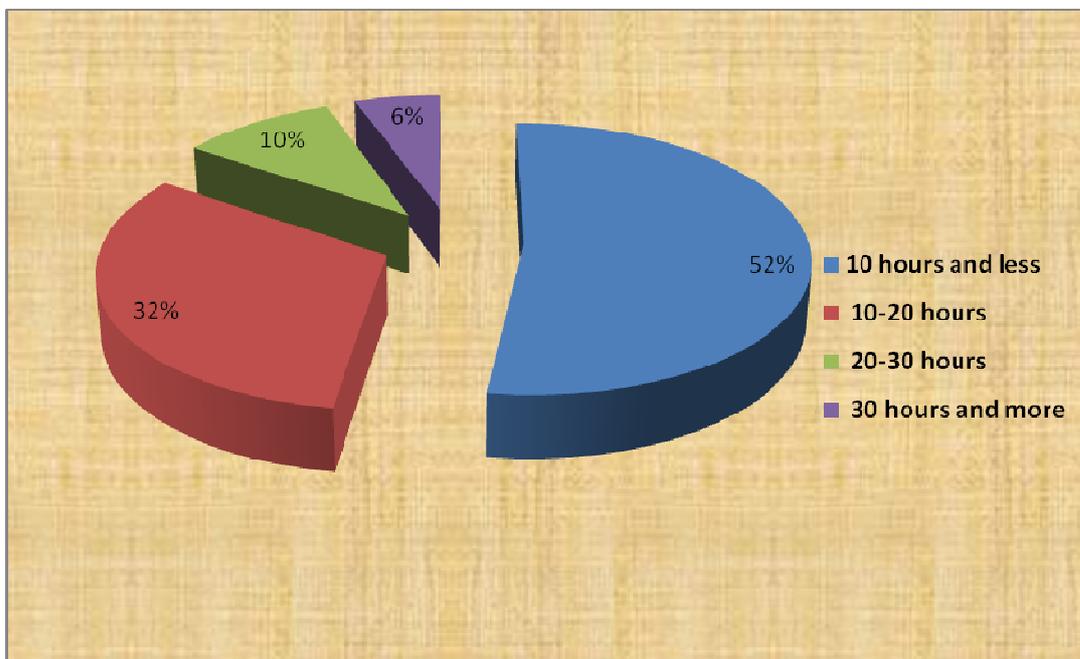
**Figure 4.5 Work time per week spent in the counselling unit**

According to (Pearlman & McKay, 2008), more time spent with traumatized clients seems to increase the risk of stress reactions in mental health professionals while, on the other hand, spending time on other work activities decreases the risk. Having a more diverse caseload with a greater variety of client problems and participating in research, education and outreach also appear to mediate the effects of traumatic exposure. According to Bober and Regehr (2006), the

amount of time spent counselling traumatized clients is one of the best predictors of secondary traumatic stress among mental health workers.

#### 4.2.9 Number of hours per week spent counselling trauma victims

As shown on Figure 4.6, 52 % (n=94) of the respondents spent 10 hours and less counselling traumatized clients, 32 % (n=58) spent 10-20 hours counselling trauma victims, 10% (n=18) spent 20-30 hours per week and 6% (n=10) spent 30 hours or more per week counselling traumatized clients.



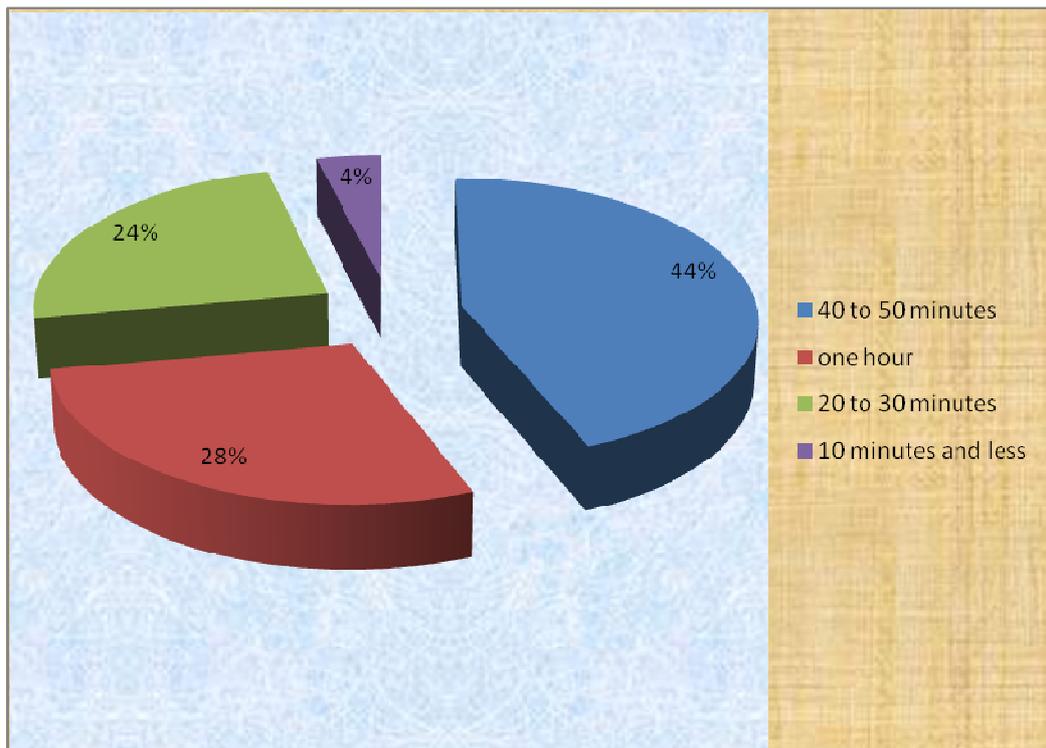
**Figure 4.6 Number of hours per week spent counselling trauma victims**

Killian (2008) found that counsellors with a higher percentage of traumatized clients in their caseload reported more disrupted beliefs, more PTSD symptoms and more self-reported symptoms of secondary traumatic stress. Levin et al. (2003) found that, compared to other health

professionals, mental health workers had significantly higher levels of secondary traumatic stress. The researchers went on to state that this is likely due to higher case loads, lack of supervision or support and lack of education with regard to the impact of ongoing exposure to traumatic material and events.

#### 4.2.10 Counselling time for new cases

Figure 4.7 depicts the average time spent by respondents counselling new traumatized clients. The results showed that 28% (n=51) usually spent one hour counselling new cases, 44% (n=79) of the respondents spent 40- 50 minutes; 24% (n=43) spent 20 to 30 minutes, and 4% (n=7) spent 10 minutes and less counselling new cases.

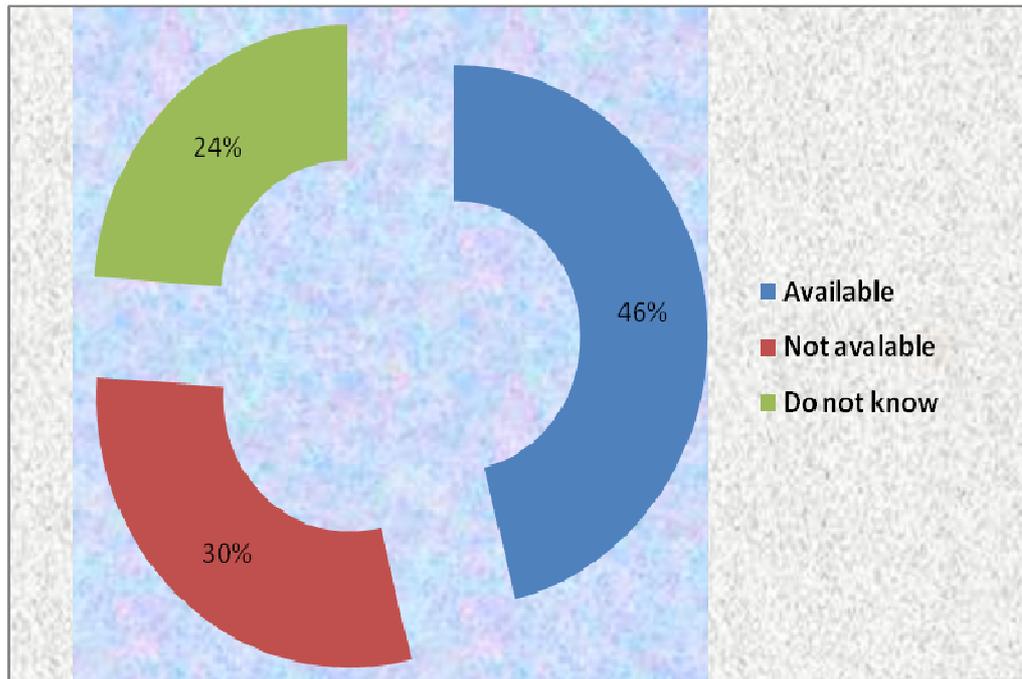


**Figure 4.7 Counselling time for new cases**

According to Adams and Riggs (2008), 50 minutes counselling sessions are necessary to deal with distressing events such as trauma in an individual's life. The amount of time spent counselling trauma clients is the best predictor of trauma scores among mental health workers (Bober and Regehr, 2006). Research has also found that mental health workers with a higher percentage of trauma survivors in their caseload reported more disrupted beliefs, more PTSD symptoms and more self-reported secondary traumatic stress (Killian, 2008).

#### **4.2.11 Availability of a support system**

Figure 4.8 illustrates the availability of psychological support in the workplace as reported by the respondents. Of the respondents, 46% (n=83) indicated that there was no psychological support system for mental health workers working in Rwanda, 30% (n=54) indicated that there was a psychological support system and 24% (n=43) did not know if such a psychological support system existed or not. This would indicate that only 30% of the respondents seem to be aware that a support system is available for mental health workers in Rwanda.



**Figure 4.8 Availability of support system**

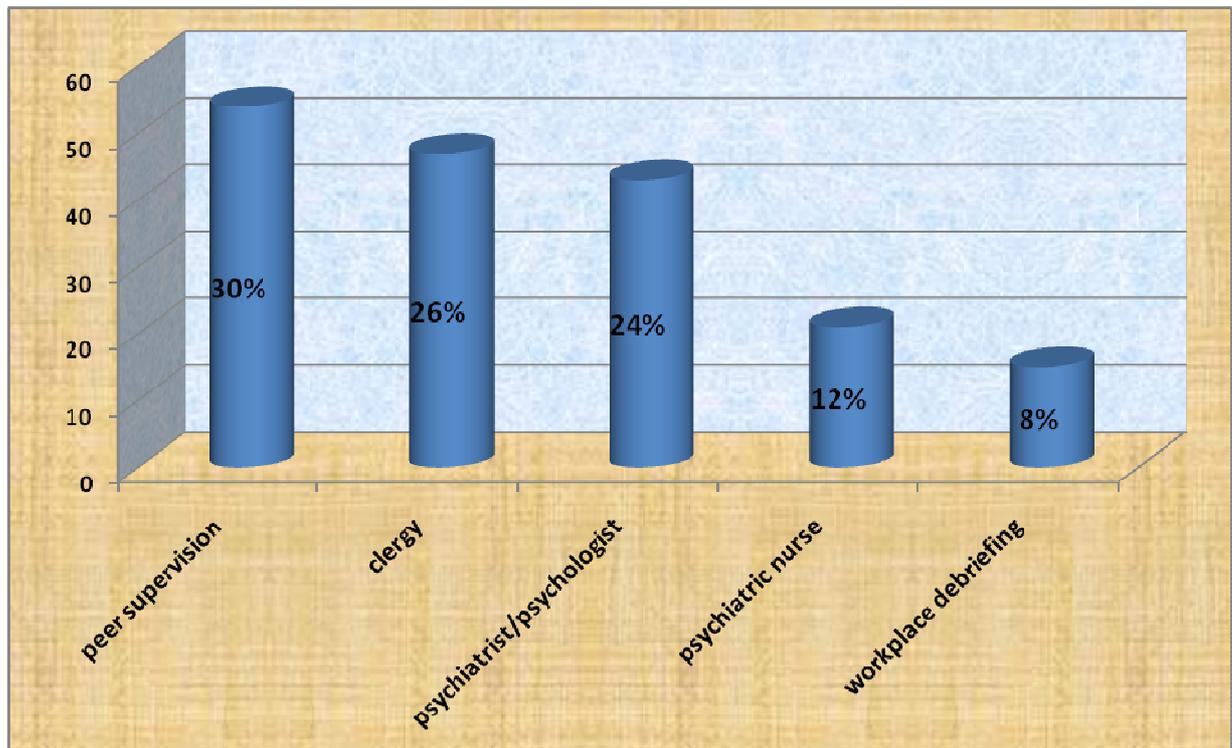
Adams and Riggs (2008) found that staff members were often unaware of support services provided by their organization and that it was often the case that even if support systems were available for staff, they were not being used.

Some mental health workers who have not had adequate training in trauma work find themselves in a position where they have to provide important psychological support to traumatized clients without the support of a formal organizational system. Rothschild (2006) stated that personal trauma history, inadequate training, identification with the victims, insufficient support in the workplace and insufficient social and familial support are predicting factors for mental health professionals to develop STS. The benefit of mental health workers maintaining a range of supportive professional relationships with whom they can process their personal reactions and

arising issues needs to be stressed in all mental health systems. Managers in mental health services can help prevent and manage STS by providing training and information on handling STS; providing a healthy work setting that makes the environment as supportive as possible; providing adequate security precautions; and instituting a buddy system for workers to offset STS reactions. It is important that management ensures that there is an adequate support system for the mental health workers, particularly in times of crisis. Accessibility to supervisors is essential, as they can validate and normalize mental health worker STS reactions, thereby hastening quick recovery. Management must also set good practice policies for preventing STS in the form of reasonable work hours with regular break schedules.

#### **4.2.12 Types of support systems provided to mental health workers**

When asked what types of psychological support was available to them 30% (n=54) of the respondent indicated that they get support from peer group supervision; 26.1% (n=47) indicated that their support was provided by a member of the clergy; 23.8% (n=43) indicated that they received psychological support from psychiatrists or psychologists working within the mental system; 11.6% (n=21) indicated that psychological support was provided by a psychiatric nurse working in the same service and 8.3% (n=15) reported they received support during debriefing sessions in the workplace. This is illustrated in Figure 4.9



**Figure 4.9 Types of support systems provided to mental health workers**

Adams and Riggs (2008) emphasize that the support of family and significant others is important for the individual to maintain a healthy physical, psychological and social life and, furthermore, that the absence of support from significant others creates feelings of alienation and loneliness in the individual.

#### **4.2.13 Benefits of psychological debriefing**

The respondents were asked to indicate whether psychological debriefing was helpful to them. All respondents (100% n=180) reported that psychological debriefing is helpful to mental health workers. These findings are supported by Slattery and Goodman (2009) who stated that informal staff opportunities to debrief and process traumatic material with supervisors and peers are

helpful. However, Geyer (2004), points out that although not all mental health practitioners agree that psychological debriefing is helpful, it does have positive outcomes in that staff can express their feelings and obtain support to cope with trauma. Debriefing and peer support were identified as the most important strategies for dealing with the after-effects of a stressful session (Bober & Regehr, 2006). It follows that mental health workers dealing with traumatized clients need to have access to regular debriefing. Critical incident debriefing is a formalised method for processing specific traumatic events and is an important component of organisational support.

Indeed, it has been suggested that talking in a semi-structured setting may be an integral part of dealing with trauma work. Therefore, a key way in which mental health services can support their staff is by providing opportunities for them to verbalise their work-related stress to supportive listeners which may be difficult for them to arrange in other areas of their lives.

#### **4.2.14 Suggested support systems to limit or prevent STS in workplace**

Figure 4.10 reflects the respondents' views on what support systems could be applied to limit or prevent psychological trauma in mental health workers. Of the respondents, 36.1 % (n=65) suggested that better working conditions would assist mental health workers to limit or prevent secondary traumatic stress, 23.8% (n=43) suggested that sensibility by non mental health colleagues and management would assist them in limiting or preventing psychological trauma, 20% (n=36) suggested that supervision or debriefing are the best ways to limit secondary traumatic stress, 11.6% (n=21) reported that a better salary would help and 8.3% (n=15) suggested that support with transport would assist in limiting or preventing psychological trauma in workplace.



**Figure 4.10 Suggested support systems to limit secondary traumatic stress**

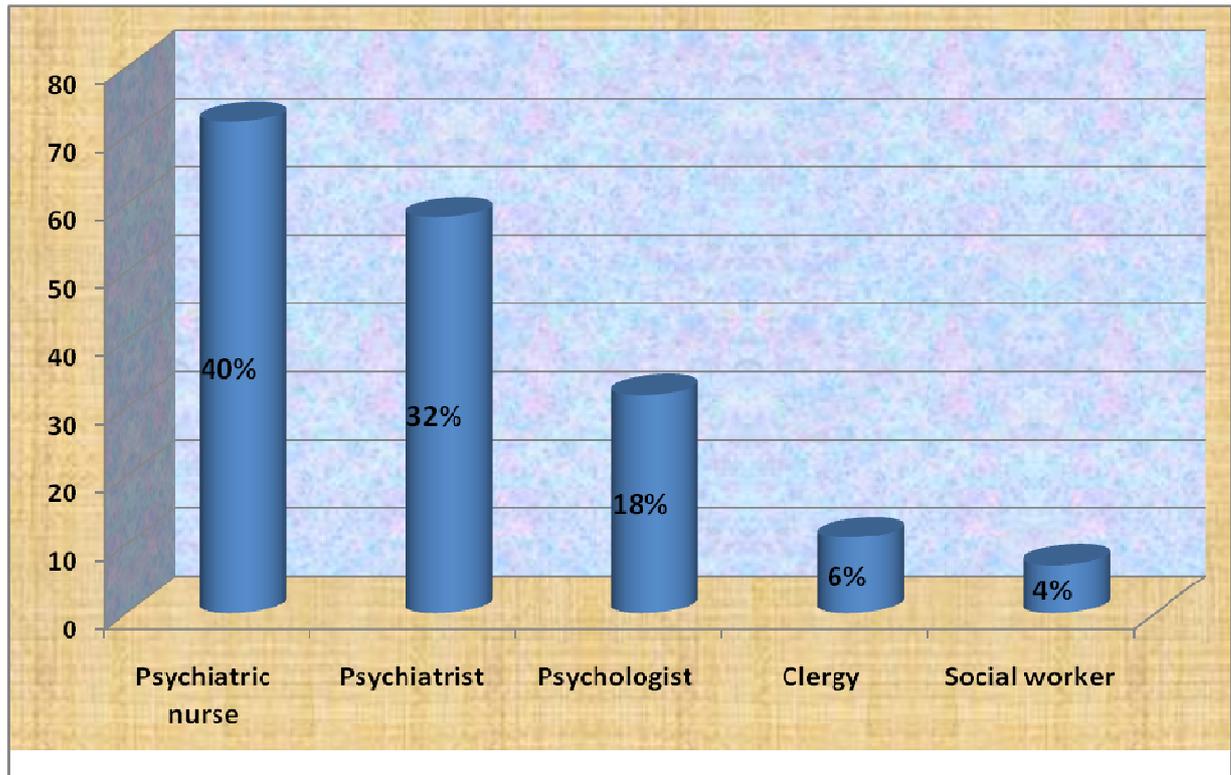
Slattery and Goodman (2009) found that the extra workload that mental health workers carry because of staff shortages results in them experiencing high levels of stress. Osofsky et al. (2008) also identified similar organizational and job issues which contribute to the development of secondary traumatic stress. The factors they identified included large caseloads, minimal support from supervisors, lack of peer support, excessive paperwork, inadequate resources to meet demands and limited job recognition. These factors, coupled with some of their cultural beliefs, discourage mental health workers from recognizing the signs of secondary traumatic stress or disclosing the fact that they are struggling and prevent them from seeking assistance. Geyer (2004) is of the opinion that management and the employer have a responsibility to ensure that the workplace remains a healthy and supportive environment. Furthermore, Bride (2007) states that decreased job satisfaction is a consequence of secondary traumatic stress because

mental health workers do not have support systems they can rely on to help them deal with their problems.

Group support within the mental health service can be formal or informal, take a variety of forms and can be peer or professionally led. It may involve case conferences, clinical seminars or even reading groups. Time for social interaction between co-workers (for example, celebrating birthdays and specific achievements, team-building activities or staff retreats) can increase workers' feelings of support.

#### **4.2.15 The most appropriate professional to provide support to mental health workers.**

Figure 4.11 reflects the respondents' views on who should be appointed to render psychological supervision. Of the respondents, 40% (n=72) were of the opinion that supervision to mental health workers working in mental health service should be provided by a psychiatric nurse; 32 % (n=58) felt that it should be provided by a psychiatrist, 18% (n=32) felt that a psychologist should do it; 6 % (n=11) indicated the clergy and 4% (n=7) indicated a social worker.



**Figure 4.11 The most appropriate professional to provide support**

Rothschild (2006) suggested that more highly trained and experienced mental health professionals should provide training, support and supervision to their less highly trained colleagues. Inexperienced mental health workers require much closer monitoring, support and supervision than their more experienced colleagues. When close support is not available, the quality of the service may be compromised. Placing young professionals in situations where they are dealing with traumatized clients without adequate support, such as supervision, is unethical and dangerous. According to Mackereth, White, Cawthorn and Lynch (2005), the purpose of supervision is to promote continuous improvement in the care delivered by mental health workers. Everyone involved in the provision of mental health care should be under some form of regular supervision. Supervision is a continuous process that is carried out in a range of mental

health settings (Mackereth et al., 2005). Vandenberghe (2009) argues that it is, therefore, crucial to focus on the physical and mental wellbeing of mental health workers and explore creative means for self-care and the release of emotions and personal feelings by providing supervision. Mackereth et al. (2005) highlight the importance of obtaining supervision from someone that understands the dynamics of working with traumatized clients, as well as engaging in ongoing discussion groups with peers, whenever possible.

Cycle 1 of the present study aimed to explore the extent of secondary traumatic stress in mental health workers in order to identify the need for research on the development of an intervention model to manage STS. A quantitative data collection was conducted in four mental health services using a convenience sample of 180 mental health workers who provide mental health care to traumatized clients and psychiatric patients. A questionnaire was compiled consisting of the Trauma Attachment Belief Scale (TABS) and several open ended questions pertaining to the respondents current work situation and psychosocial support system. The research team participated in this cycle by checking the questionnaire, collecting and compiling the collected data, reflecting on the data and analysing it. It became clear that working with traumatised clients may negatively impact the well-being of mental health workers. The total scores were high in all areas of beliefs indicating that the majority of the participants were found to be at very high risk for secondary traumatic stress. This could indicate that there is a disruption in the cognitive schema of the mental health workers operating in Rwanda.

### 4.3. Cycle 2: Mental health workers' experiences of secondary traumatic stress

#### 4.3.1 Participants

Mental health workers from all four mental health services were involved in this cycle of the research. A total of 30 mental health workers were interviewed over a period of three weeks. The sample comprised of nurse managers, medical doctors, social workers, trauma counsellors, psychologists and psychiatric nurses. Table 4.3 below illustrate the profile of participants

**Table 4.3: Profile of the participants**

<b>Participant ID</b>	<b>Characteristics of participants</b>	<b>Experience</b>
1	Female, 30 years, married, social worker	6 years
2	Female, 28 years, psychiatric nurse, married	4 years
3	Male, 27 years, single registered nurse	3 years
4	Female, 25 years, single.	1 year
5	Female, 30 years, married, general registered nurse	6 years
6	Male, medical doctor, 38 years, married	5 years
7	Male, 28 years, single, bachelor degree	4 years
8	Female, married, 35 years registered general nurse,	8 years
9	Female, 32 years, training in trauma counselling	5 years
10	Male, 35 years, married, registered general nurse	7 years
11	Female, 30 years, nurse, married	1 year
12	Male, 27 years registered mental health	3 years
13	Male, 25 years, single, enrolled nurse	2 years
14	Female, 30 years, married, general registered nurse	5 years
15	Male, psychiatric nurse, 38 years, married	6 years
16	Female, 28 years, married.	3 years
17	Female, married, 35 years, registered general nurse	5 years
18	Female, 33 years, training in trauma counselling	7 years
19	Female, 30 years, married.	5 years
20	Female, 28 years, psychiatric nurse	3 years
21	Male, 29 years registered mental health	5 years
22	Female, 25 years, training in trauma counselling	2 years
23	Female, 30 years, married, general registered nurse	4 years
24	Male, general registered nurse, 40 years, married	12 years
25	Female, 27 years, married, bachelor degree	5 years
26	Female, married, 35 years registered general nurse	7 years
27	Female, 32 years training in trauma counselling	6 years
28	Female, 35 years, married, general nurse	8 years
29	Female, 26 years, psychiatric nurse	3 years
30	Male, 27 years registered mental health	3 years

### **4.3.2 Data collection**

Initial meetings were held with managers of the mental health institutions in order to explain the purpose of the cycle and to request access to staff in order to hold the individual interviews. Managers granted permission for all interviews to take place while participants were on duty. Qualitative data was required to explore the nature of mental health workers' lived experience with secondary traumatic stress. According to (Sandelowski, 2007), an in-depth interview refers to a one-on-one interview which uncovers people's underlying motivations and attitudes beyond straightforward responses to structured questions.

The interview questions were designed to elicit descriptions from the mental health workers about their experiences with secondary traumatic stress and work-related stress. For the purpose of the study, I anticipated interviewing approximately 4 to 5 participants per research setting, depending on when I reached data saturation. However, due to participants' overwhelming interest in the research and their desire to be involved and tell their experiences, I ended up interviewing 30 participants and did indeed reach data saturation.

### **4.3.3 Data analysis**

To analyze the collected qualitative data, I employed the thematic analysis steps following a deductive and inductive mode of reasoning of data analysis outlined by De Vos (2005). The completed transcripts were reviewed line by line and words that were thought to be significant were highlighted. These words were then grouped according to their similarities. From these groups, five themes emerged from the data with a series of sub-themes under each theme. Table 4.6 illustrate the themes and sub-themes which emerged from the data analysis.

**Table 4.4: Themes and sub-themes**

<b>Themes</b>	<b>Sub-themes</b>
Experience of STS	Feeling under-pressure and loss of control
	Feeling of anger and frustration
	Feeling of physical and emotional fatigue
	Uncaring and dysfunctional relationships
Contributing factors to STS	Stressful work environment and work conditions
	Personal trauma history
	Lack of support
Strategies to cope with STS	Verbalization and letting go
	Determination.
	Internalization and spiritualization
	Use of humour and personal hobbies
Support systems to limit STS	Informal support system
	Organisational support system
Gratifying features in mental health	Helping others
	Sense of reward.

#### **4.3.4 Mental health workers experiences of secondary traumatic stress**

In relating their experiences of secondary traumatic stress, the mental health workers' descriptions centered around four sub-themes, namely: feeling under pressure and loss of control, feelings of anger and frustration, feelings of physical and emotional fatigue and uncaring and dysfunctional relationships.

#### **4.3.4.1 Under pressure and loss of control.**

Many of the mental health workers reported that they experienced feelings of being under pressure and loss of control. According to them, these feelings occur when something does not go as planned or when the work environment becomes so overwhelming that they cannot handle the demands placed on them. The service within which mental health staff performs is often described as “stressful”. Some mental health workers attributed feelings of pressure and loss of control to outside issues which they had no power to manage and, as a result, they were unable to meet goals that they had established for their patients. One of the psychiatric nurses said:

*“I think most that you experience secondary traumatic stress is when you don’t have control over situations. There is something that you want to do but you can’t for whatever reason. There are external factors that make it difficult”.*

Some described feelings of pressure and loss of control as being the consequences of helplessness. Others described pressure and loss of control as not being able to handle the demands placed upon them which resulted in feeling out of balance with the environment. Their inability to spend an adequate amount of time with each patient due to the heavy patient volume and increased patient acuity also resulted in feelings of loss of control. One of participant said:

*“I’m stressed all the time when I arrive at my work. My thing is not having enough time to spend with each patient. I think that is what gets me. And then when I get home, it’s like, “Did I do right by that patient?” It may be one particular patient that was sick and it just spins off for the rest of the day”.*

Feelings of being under pressure and losing control often left the mental health workers doubting their own abilities. Several of them explained that loss of control affected not only how they felt about themselves, but also how they felt about the care they provided to their patients. Many of them stated that they worried that the care they provided was less than adequate when they felt as though they had lost control, and they feared that the patients would suffer as a result. Some of the mental health workers stated that they felt angry with themselves and sometimes blamed themselves when they could not handle multiple demanding situations because these situations often interfered with patient care delivery, potentially causing adverse patient outcomes. One participant said:

*“I feel sad and I feel frustrated because we can’t really help [the patients] much, I feel that it’s just not fair, many times I just feel it shouldn’t be this way.”*

Mental health workers are placed under pressure when the amount of work to be done is too overwhelming to accomplish and during any given period, they are generally experiencing a multitude of patient problems. Many described the workload in the mental health service as ‘insurmountable’ due to the large volume of patients, the increased number of patients and the shortage of mental health staff to help take care of them. In describing his experience of secondary traumatic stress, one participant working in a psychiatric hospital stated:

*“A secondary traumatic stress is a moment in time or several moments in time when you are under pressure. You have more than one thing that needs to be done right at that moment and you are not capable of doing that. It’s the pressure that you feel at that one moment when*

*you can't do everything that you need to do and you either have too many patients and too many things to get done or not enough help”.*

A number of mental health workers expressed concern over the lack of time available to care for their patients. Many of them stated that they felt as if they were cheating the clients out of quality mental health care simply because the volume of clients prevented them from spending the time they felt was necessary to provide therapeutic care.

*“There are times when our hands are tied and due to our mission we are unable to continue to support our clients. There are times when so much needs to be done that we cannot possibly meet all the clients’ needs. Although I respect our mandate and realize that we cannot meet everybody’s needs, I find it hard at times to look at clients leave with so many needs left to be addressed and at times no possible options as to how to address them.”*

The lack of trained staff to help with patient care also contributed to feelings of pressure since many of the mental health workers stated that they relied on their colleagues to assist them.

*“I feel working under pressure, when there is a shortage of staff and no consultation with management or supervision occurs. I don’t want to work under pressure and if someone is not on duty to care for clients”*

For many mental health workers, secondary traumatic stress may present itself with elements of emotional exhaustion, depersonalization and reduced personal achievement. It also has effects that are unique and specific to trauma work. One of the mental health workers, talking about her experiences in working with traumatized clients, stated:

*“Sometimes after a session with a client, I will be traumatized.... I will feel overwhelmed, and I can remember a particular situation with a traumatized client where I just didn’t want to hear any more of her stories about what actually happened. The client seemed to want to continue to tell me those over and over and I remember just feeling almost contaminated, like, you know, like I was myself traumatized. You know? And so I set limits with her after some supervision about that but followed her in a different way. I think it has an impact. I’m just not sure of what”*

Some mental health workers found their job more difficult because of the institutional barriers that their clients were forced to navigate within the legal and mental health systems. According to the participants, they were not only affected by secondary traumatic stress, but their work stress also contributed to personal relationship difficulties at home. One counsellor said:

*“The work environment is sometimes more traumatic on mental health than the traumatic stories we hear about. ...and then unfortunately it takes your attitude of what has been happening at work you take it home and you find that at home, you are not the person who you know yourself to be. You are short-tempered, you are agitated, you are irritated, you become aggressive yourself at home.”*

Several studies have described the experiences of secondary trauma in mental health workers in more detail. Ortlepp and Friedman (2002) stated that experience of secondary traumatic stress can include immediate effects such as loss of control, increased fears for the safety of oneself and loved ones, avoidance of patients with traumatic stories, difficulty listening to clients’ accounts of events, irritability and feelings of pressure. They can also include longer term effects

such as emotional and physical depletion, a sense of hopelessness and a changed world view in which others are viewed with suspicion and cynicism.

#### **4.3.4.2 Anger and frustration**

Feelings of anger and frustration were also very common among the mental health workers as they described their experiences of being confronted with too many traumatized clients. Several expressed their feelings of anger and frustration which resulted from the large volume of patient and the lack of mental health staff. They felt overwhelmed and neglected and, as a result, became angry and frustrated with the work environment. A few of the interviewees were able to recognize their feelings of anger and used coping techniques to deal with these feelings so that they would not be projected onto the patient. However, it seemed that many of the mental health workers occasionally allowed their feelings of anger and hostility to interfere with the care that they provided to the patients.

*“At times, it makes you very angry, very hostile, especially with your colleagues some difficult patients you may catch yourself not being as caring, friendly, or nice as you would have been if it had been a different circumstance”.*

Many of the mental health workers described feeling more short-tempered and less tolerant toward their patients as a result of the secondary traumatic stress they experienced from their clients. A few of them described feeling hostile toward the patients simply because they had come to the mental health service seeking care. Those mental health workers explained that this was a direct result of their experience with stress and their inability to cope with it. One nurse said:

*“Sometimes it gets so busy that I don’t have the time to take a moment to calm myself and when I go to the next patient I feel like I get mad at them for being sick, for being there. It doesn’t matter to me why they are here – the stress has gotten to me”.*

Mental health workers described feeling angry and frustrated because some difficult and traumatized patients did not appreciate the care that was being provided to them. They explained that it was very difficult for them to provide compassionate care to patients who were hostile and aggressive toward them. A number of them stated that they often became irritated with these patients. One general nurse working in a psychiatric hospital said:

*“I get angry and frustrated because they don’t see the big picture –they don’t realize how much we are doing trying to take care of them – they are nitpicking and it is very frustrating to me”.*

Feelings of anger, frustration, irritation and resentment were frequently expressed by the mental health workers as they illustrated the relationship between the patient care they provided and their encounters with secondary traumatic stress. Many of them directly associated the amount of work stress with the feelings of anger they displayed toward their patients. One participant explained in the following words:

*My experience with secondary trauma is mainly anger. It’s my defence mechanism. Instead of reacting in fear, I chose to act on anger. It’s easier for me to manage, and then I’m in control. Even if it’s feeling overwhelming sometimes, it’s more controllable than fear.*

It became apparent that if the mental health workers had experienced a very stressful shift then they had more unpleasant interactions with their patients. On the other hand, if the shift had not been perceived as very stressful, then the patient interactions were more therapeutic. Mental health workers also indicated that they became angry and frustrated when they felt that they could not be in all places at one time due to the volume of patients that they have to care for. One general nurse working in the acute ward in the psychiatric hospital explained:

*“The excessive number of patients in the mental health service caused by increased acuity and lack of mental health staff made me feeling as if there is too little to fill all of the gaps.”*

Many of the participants described feelings of anxiety and anger which they believed were the consequences of secondary stress due to their working with traumatized and other psychiatric patients. They also became frustrated when they felt incapable of providing therapeutic care to their patients. Some of them explained that they became irritated with their patients as a result of their own frustration. One social worker explained her experience of feeling of anger and frustration in the following words:

*“Secondary traumatic stress is anything that gets me flustered or makes me having negative attitude towards all the people and all my patients. It doesn't matter if someone's real sweet and they've come in and asked for, you know, some ice water. And I'm just like “I don't have time to get it right now. And when I feel like I am not able to do my job because I am just anxious”.*

Many mental health workers who were interviewed explained that difficult patients and families, especially in the psychiatric inpatient setting, also contributed to feelings of anger and

frustration. While the mental health workers wanted to provide care to these patients, the negative attitudes, such as aggressive behaviour, of these patients caused them to feel unappreciated in their capacity to provide care. One of mental health worker explained this as follows:

*“At times I feel that mental health workers experience stress by their clients as secondary traumatic stress. We are often the recipients of verbal aggression by clients and at times physical threats. Even though this aggression is not as harmful as it would be if it came from someone who was in my personal life, I am aware that it still has an effect on me.”*

According to many of the respondents, difficult patients triggered anger and frustration because they were not only demanding time and attention, but were also taking time away from other patients who could have benefited more from the time and therapeutic care. One psychiatric nurse explained this as follow:

*“You try to help patients and you get irritated by an aggressive patient and things thrown at the time. They are challenging. And I guess the high level of frustration for me comes from the fact that patients who seem to be the most difficult are the ones that are wanting all the time, wanting all the attention. Yet, you have another client who is really sick and you know that you need to be spending more time with him/her but you can’t because you are dealing with this one over here who is doing all the squalling”.*

Many mental health workers explained management can also be the cause of anger and frustration. Some stated that managers were very demanding of their time, which added to their

already overwhelming workload and increased their feelings of anger and frustration. One participant said:

*I feel sometimes the managers don't realize when they come to us and ask why we didn't provide care according to care plan of each patient. And they want to know why I didn't do interview to the patient. I am trying, I am getting there, bear with me. I know I did the interview and the care plan needs to be elaborated for this patient. The managers need to understand that when there is a shortage of mental health workers while there are a large number of patients, it is not possible to follow all procedures"*

The frustration experienced by mental health workers in dealing with traumatized and psychiatric patients in Rwanda is rooted in their heavy workload which is the result of increased patient volume due to overcrowding and staff shortages. These mental health workers explained that while they worked attentively in providing therapeutic patient care, the demands placed upon them by the work environment often impeded their efforts which often resulted in anger, irritation and annoyance. One mental health worker explained how secondary traumatic stress affects him and his therapeutic relationships:

*"I worked with one client who was being sadistically abused during 1994 genocide against Tutsi in Rwanda. Her situation seemed so desperate that I became more and more involved. I gave her my home phone number and accepted calls at any time. My colleagues questioned me about my lack of boundaries; other services providing support were frustrated by my need to be present. It didn't matter what anyone told me, I couldn't stop. I became angry and*

*exhausted. I don't know what made me stop; I only know that I jeopardized so many important personal and professional values."*

According to Buchanan and Anderson (2007), anxiety, depression, anger, fear, sadness, frustration, guilt and shame are common effects of secondary stress. Anger and frustration are the most common outcome of ongoing emotional stress (Mouldern and Firestone, 2007).

#### **4.3.4.3 Physical and emotional fatigue**

Many of the mental health workers who had been interviewed described feelings of fatigue after experiencing secondary traumatic stress. Many described feeling not only physically fatigued, but mentally fatigued as well. Some reported that this mental fatigue was often tremendous due to their continuous use of coping mechanisms in order to deal with several secondary traumatic stresses. They added that this exhaustion frequently led many of them to question whether or not they could continue with their care giving efforts. One psychiatric nurse working in acute ward said:

*"After a particularly busy day I have felt stressed. I was exhausted, tired, and fatigued. There have been some nights where after I have worked all night in acute ward of psychiatric hospital and went home in the morning, I thought I just can't go back to that place."*

Occasionally, the negative environment created by the work-related stressors caused feelings of increased fatigue among the mental health workers in comparison to the amount of work that had to be accomplished. Several of the mental health workers stated that although taking care of the

patients can be tiring, the nature of the encounters with patients, family members and hospital staff often amplifies the exhaustion felt at the end of the shift. One participant said:

*“I feel more tired out of amount to the work that I have done if it has been a really bad day. I feel particularly exhausted if I have had numerous negative encounters be it staff members or patients.”*

While many of the mental health workers described feeling exhausted because of the enormous workload, several of them stated that they have often worked through their exhaustion in order to provide care to those they felt really needed their attention and mental health expertise. During the discussions about their experiences of secondary traumatic stress, feelings of helplessness emerged as a common theme of how they felt after experiencing work-related stressors. They used words such as alone, neglected and dumped to describe their feelings of helplessness. One of the participants said:

*“Sometimes it feels like you are in it all by yourself and you are trying to wade through mud and sinking fast”.*

Many of the participants explained that teamwork is essential in order to handle the huge workload and to accomplish the goal of providing safe, therapeutic care. However, several of them stated that there had been times when other mental health workers had not been available to assist them with patient care because they had been just as busy trying to take care of their own patients. One mental health worker described feeling helpless during a busy day because she had had no one to help her accomplish the large number of patient care tasks she faced. She stated:

*“I felt helpless because I thought that the management staff had let me down because there were not enough mental health workers to cover the shift that day”.*

The lack of support from management and non mental health workers also figured prominently with feelings of helplessness. One of the participants explained in this manner:

*“A lot of times it feels like you have nobody on your side. Nobody going to bat for you trying to get the patients out of the acute unit onto the rehabilitation service or wherever”.*

According to Stoesen (2007), effects of secondary traumatic stress trauma can create biological and psychological vulnerabilities in mental health workers. In connection with fatigue, Marcora, Staiano and Manning (2009) noted a few milder symptoms of secondary traumatic stress such as headaches, colds, muscle aches and physical fatigue. The more serious symptoms included asthma, coronary heart disease, heart attacks, diabetes, and the inability to perform one’s job and experience a positive personal life. Marcora, Staiano and Manning (2009) also identified mental symptoms of secondary traumatic stress which included being overwhelmed, demoralised, withdrawing from friends and families, and fear and distrust of others.

#### **4.3.4.4 Uncaring and dysfunctional relationships**

During the interviews, mental health workers reported that the secondary traumatic stress experienced at work affects the way they interact with their patients and the relatives or friends of their patients. They expressed uncaring behaviour and dysfunctional relationships as they described their patient interactions when faced with an amount of work related stressors. Mental

health workers should offer kind, gentle and considerate care to their patients. However, these mental health workers described feeling cold and uncaring toward patients when under pressure from numerous work-related stressors. Several of them explained that their perception of the legitimacy of the patients' reasons for seeking mental health care often influenced their feelings. Many of them stated that if they thought the patients' reasons for seeking mental health care were not emergent, or if they felt that patients were manipulating or using the system, they became indifferent toward them and delivered care that was less than compassionate. Many felt that this was a waste of their time which could have been better used to help someone else who was truly in need. A psychiatric nurse working in an inpatient psychiatric service said:

*“It kind of corned me. I think it’s stressful sometimes knowing that you have patients coming into the acute ward and they are arguing with you why they are not seen fast when you have serious patients that really needs your care at that time and that you know that you can use your time more beneficially to those patients.”*

Another mental health worker further illustrated this indifference displayed toward patients who were perceived as weighing down the system. He said:

*“It has affected me to the point where I don’t care anymore. It’s just a job. But that’s not true for the people that really need to be there. My heart really aches for those people. It’s you “I sprained my ankle three nights ago” that affect my care. I give it and there’s nothing wrong with it except that I know I’m not projecting an air of compassion to those patients. I am just there to sign them out and let them go. I am not friendly – I am very blunt and to the point.”*

Although many of these mental health workers admitted that the care they deliver is less compassionate to those whose legitimacy they question, they did realize that this approach is not therapeutic and did not promote a healthy therapeutic relationship. However, the burden of a heavy workload played a significant role in their delivery of uncaring actions toward patients.

*“It has made me very jaded. You are very insincere. Instead of seeing one patient as what’s going on with that one, the kind of develop this mentality that everybody’s a drug seeker or everybody’s whining and complaining.”*

The lack of caring displayed by mental health workers towards their patients was also related to their encounters with work stress and their perceptions of the level of stress associated with these encounters. According to Mouldern & Firestone (2007), it is essential that mental health workers maintain a sense of order in terms of what is happening around them so that they are able to provide safe, therapeutic care to their patients, while still maintaining their own ability to think clearly.

Explaining their uncaring behaviour and dysfunctional relationships as the effects of secondary traumatic stress, mental health workers explained that they were transformed by negative attitudes which profoundly impacted their view of the world, as expressed by one of the participant working in trauma counselling unit:

*“When I experienced stress related to my work, I began to change in a way that mimics a client’s trauma related symptoms. My inner experience and worldview were changed as a direct result of secondary exposure to trauma through my work. I began then to interpret*

*and relate to a worldview in a new way as my inner experience was distorted by exposure to traumatic stories of my clients”.*

Another participant explained:

*“As we know, working with traumatized and psychiatric patients changes who we are and how we view things. Often, whether I am at work or not, I find myself in a group of people (on the bus, out speaking) wondering to myself which of these people are victims, survivors. I never did this before working here; I will probably do this for the rest of my life.”*

Regarding interpersonal relationships with family and friends, mental health workers reported that interpersonal relationships have been affected by their work. They pointed out the ways in which the emotional impact of secondary traumatic stress had affected their home or family lives. One participant said:

*Sometimes you take home your work in your head ... it owns you I suppose ... it takes over your life and that's it”*

Others said that negative comments or perceptions about their work by those in their social circle caused them to feel hurt, unappreciated, misunderstood and disconnected, prompting them to make changes in their social relationships. One participant said

*“Since I've worked in mental health service I've let quite a few friends go because ... I've got nothing in common with them anymore. Yeah, my whole circle of friends apart from a few very close friends has changed quite considerably.”*

The experiences of secondary traumatic stress may also include changes in how individuals experience themselves and others, such as changes in feelings of safety, increased cynicism and disconnection from co-workers and/or loved ones (Rothschild, 2006). Uncaring and dysfunctional relationships were reported as a result of the frequent exposures to clients' stories of traumatic stress. This is maintained by the finding of Vandusen and Way (2006), who noted that uncaring behaviour and dysfunctional relationships are often the outcomes of secondary traumatic stress which can be result of stressful work conditions when working with traumatized clients or psychiatric patients.

#### **4.3.5 Factors contributing to STS in mental health workers**

In their discussions on factors contributing to secondary traumatic stress, three sub-themes emerged, namely; stressful work environment and work conditions, personal trauma history and lack of support.

##### **4.3.5.1 Stressful work environment and work conditions**

All of the participants complained about the tremendously stressful work environment that they encountered on a regular basis and expressed their fears of being unable to keep up with the hectic pace of the mental health service as a result of the increased patient volume and acuity as well as the lack of skilled staff. One mental health worker said:

*“I got into working as a mental health worker because I believed I could make a difference. Each day we are confronted with more realities in the workplace, all needing new solutions. It's too much; there are too many traumatized clients and psychiatric patients. I have lost hope that anything will change.”*

One of the trauma counsellors said:

*“There are times when our hands are tied and due to our mission we are unable to continue to support our clients. There are times when so much needs to be done that we cannot possibly meet all the clients’ needs. Although I respect our mandate and realize that we cannot meet everybody’s needs, I find it hard at times to look at clients leave with so many needs left to be addressed and at times no possible options as to how to address them.”*

Some of the participants said that it was the types of stories they heard from their clients that caused secondary traumatic stress. A psychologist from the psychiatric hospital said:

*“Hearing stories day after day about the horrible things that humans inflict on others fills me with rage—not only toward the patients or other people but also against our systems for repeatedly failing to support.”*

One of the factors that figured prominently was that mental health workers were of the opinion that the shortage of trained staff who could assist with patient care had a significant impact on the overwhelmingly stressful work environment that they faced, which in turn affected their perception of their patient care delivery. One psychiatric nurse said:

*“I feel like that the patient load is so big that you cannot spend a lot of time with your patients and then they are out the door and you feel like you should have done something different. I don’t feel like I am doing everything I can do as a real mental health worker”.*

Several mental health workers expressed their anxiety about trying to manage their workload and still being able to maintain their own judgment. One of the participants stated that the enormous

workload she has to encounter on a regular basis has often brought her to tears. Many expressed their fears in being able to sustain sound judgment in the face of the massive workload they must confront day after day. One mental health explained as follow:

*“One aspect of the work, which increases vulnerability of mental health worker to secondary traumatic, is the long hours that staff works. The more tired one becomes the less able you are to separate yourself from your work. It is in maintaining that distance that I have been able to keep my level of stress down. Yet, when I am tired I feel things creeping in and I am aware that it is harder to shut off my day when I go home. In other words, I end up carrying people’s stories with me.”*

Lack of time was another common theme expressed by the mental health workers. Several of them explained that the demands placed upon them by lack of resources, increased patient volume and lack of mental health staff affected the time they had available in which to deliver therapeutic mental health care. The lack of time to spend with patients led to increased frustration, anxiety and anger. Many of them stated that lack of time often affected the quality of care delivered to patients.

*“I don’t feel like I can interact with patients hardly at all. You start a counseling session and sometimes you forget to tell the patient your name because you are trying to get done so fast because you got four other patients waiting for you”.*

Several mental health workers expressed concern over their inability to perform thorough assessments for each patient because of the lack of time available to them as a result of the heavy

workload they faced. One of them explained that superficial assessments could lead to missed information that may be important in determining a patients' plan of care.

*“At times you don’t feel like you can give the care that you would like to give. The time you spend with your patients, you actually get a lot more information about the patient and when you are busy and stressed out, you don’t have that time. You are trying to get their immediate needs met and that’s not always ideal for the patient. You might miss something.”*

Worry and concern about the rushed care provided to patients because of the lack of time was evident throughout the interviews. Many participants felt that they did not have enough time to deliver the necessary care to their patients. A number of them described feeling overwhelmed when trying to provide care for several patients who all needed their attention at the same time and many of them found it difficult to focus on providing care to one patient while knowing that others also needed their attention. One psychologist expressed it as follows

*“The feeling of being overwhelmed and knowing that you are working on one patient and there’s another patient that needs you just as sick as that patient does and you are only one person in unit. I think it takes away from your patient care. You are not giving 100% on that particular patient when you know there’s another patient next door that needs the same amount of attention”.*

The lack of time available to deliver effective patient care weighed heavily on the minds of these mental health workers. A number of them described feelings of inadequacy because they could not deliver the quality of care that they thought was essential. Others described feeling frustrated and angry because they felt inadequate in fighting the overwhelming demands of the work

environment. For most of mental health workers interviewed in this study, the stressful work environment and work conditions within the mental health service played a considerable role in their experiences of secondary traumatic stress. Because mental health service is stressful due to the large volume of patients with mental health care problems varying in complication, many of the mental health workers described this environment as harmful. In relation to the work environment, a number of mental health workers described secondary traumatic stress as anything in the work environment that causes stress to the mental health worker or anything that they encounter during the work period that causes stress. Some participants explained that the work environment in the mental health service in Rwanda is frightening and can arouse feelings of anxiety. One psychiatric nurse working in the acute ward of the psychiatric hospital said:

*“Mental health work is really frightening. I began this work here as a new psychiatric nurse and I prayed for six months on the way to work. It’s traumatic and terrifying in a work environment like this because it’s pressure and high stressful. You’ve got so many things happening at one time and there is risk of all kinds of violence”.*

Many of the participants said that the distress they endured related to the large volume of patients that they treated daily. Psychiatric services in Rwanda are required to treat all those who seek mental health care and, therefore, all patients presenting themselves to the mental health service must be treated, whether there is space available for them or not. One psychiatrist working in the psychiatric hospital explained that the psychiatric hospital never closes its doors, regardless of whether its maximum capacity has been reached, and that space must be found to treat all patients. This often resulted in caring for patients in less than desirable conditions. He explained this experience in the following words:

*“This hospital is the only one psychiatric hospital for whole country. It is always full of patients. Like when the work in the acute ward, we only have a limited number of beds and when those beds are full, we don’t stop admitting patients. Here in the psychiatric hospital, the clients never stop coming. It is a continuous influx of patients. Some time we have two patients on the same bed”.*

The stressful work environment that these mental health workers endure causes both physical and mental stress. They described feeling physically fatigued, exhausted and damaged as a result of their workload. Mentally, they felt irritated and upset because they were unable to meet the needs of all the patients simply because the volume of patients was too big. Because of such large volumes, several mental health workers were fearful that they might fail to notice a critical piece of information that could make a difference in a patient’s outcome. As one of the psychologists said:

*“You can’t meet everybody’s needs and there are times when could say that you should have done something different. Especially under stressful times when you have those feelings come up and that’s irritating and in those times too is when you are afraid you are going to miss something”.*

Because participants believe the mental health service in Rwanda is hazardous and unsafe due to the heavy volume of patients, increased patient acuity and the lack of mental health staff, they fear not only for their patients’ safety, but also for their own well-being. This fear, coupled with their daily experiences in the harmful work environment, added tremendously to their feelings of

secondary traumatic stress. With reference to the relationship between work conditions and secondary traumatic stress, one counsellor pointed out:

*“I think for somebody who doesn’t do this type of work it would be extremely stressful, but after twelve years, I’ve just—I’ve handled so many cases and dealt with so many people, I know my limitations and the court’s limitations and I just don’t get as worked up about each case as I used to.”*

Regarding factors contributing to secondary traumatic stress in mental health workers, Bober & Regehr (2006) stated that unsupportive administration, low salaries and difficulties encountered in providing services are all predictive of higher rates of STS and burnout. According to Killian (2008) several factors contribute to STS in mental health workers such as long hours, time constraints and deadlines, large and professionally challenging client caseloads, limited or inadequate resources, low pay and safety concerns. Other factors that influence symptom levels include the number or percentage of trauma cases on a therapist’s caseload, the availability of social support and personal histories of trauma and abuse (Ortlepp & Friedman, 2002). Time spent counselling trauma victims is the best predictor of secondary traumatic stress among mental health workers (Bober & Regehr, 2006).

#### **4.3.5.2 Personal trauma history**

While discussing a possible connection between personal history and secondary traumatic stress, participants explained that personal history plays a major role in the occurrence of secondary trauma. One participant explained:

*“I had experienced a traumatic event many years ago. I had done a lot of personal work and believed myself to be a strong mental health worker doing excellent intervention work with traumatized clients. I was working with a client who had a similar experience and the story really shook me up. I felt myself spiraling backward. The unit manager accused me of not being able to do the work that I needed to personally get control. She suggested that given my history this kind of work was not appropriate”.*

Pearlman and McKay (2008) suggested that a personal trauma history was the most powerful variable in determining the impact of STS. Boscarino, Figley & Adams (2004) suggested that personal trauma history, degree exposure, lack of social support and inadequate work environment are predicting factors of secondary traumatic stress. Figley (2003) warns that mental health professionals with personal trauma histories are at risk of developing trauma symptoms when working with survivors. In support of this, Trippany, White, Kress and Wilcoxon (2004) have found that trauma history increases symptoms of secondary traumatic stress and generally greater disruptions to cognitive schemas. Lincoln, Chatters and Taylor (2005) argued that people with a trauma history may find it difficult to adjust to a recent critical incident if they are having recurrent, distressing memories of past traumatic events. Similarly, according to Deighton, Gurrissand Traue (2007), mental health workers who had experienced sexual abuse in the past had significantly more distorted beliefs of safety and self-esteem than those who did not have a trauma history.

#### **4.3.5.3 Lack of supprt.**

The lack of support from management and colleagues was a common theme repeated by many of the mental health workers interviewed in this study. A number of them felt that they didn't

receive enough psychological support from management. They felt that the managers should take time to ask them if they are coping. They reported that they were expected to cope with stressful events on their own. For some, management was seen as being unsupportive and not able to understand the nature of mental health work.

It is imperative that all members of the mental health staff operate in conjunction with one another in order to promote the health, safety and well-being of the patients. A number of participants explained that other members of staff within the service did not support their work in the field of mental health. Some affirmed that many other staff members did not carry their share of the workload, thus increasing the workload of those in the mental health service. Many of them felt that they were not supported by the management, explaining that management didn't understand what it's like to be mental health therapist. One participant explained:

*“The management staff is not “in touch with what is going on, how we feel, or what we are up against.”*

Many mental health workers believed that the cohesiveness of the mental health service staff was undermined by this lack of support from management and that it affected staff morale as well as patient care delivery. The feelings expressed by many of the mental health workers were often angry and harsh. One of the nurses said:

*“Managers that run this place think they know but they don't. And I think if they would come and see, it might open their eyes to see how we struggle because we're short staffed. I think they need to see what everybody goes through”.*

A number of mental health workers stated that they depend upon their colleagues to help with patient care delivery and increase morale through positive attitudes. One of them explained that teamwork is essential in order to fight against the traumatic events that they experience daily and said that colleagues who do not do their share of the workload unconsciously add to the workload of others, which leads to feelings of anger and hostility. Another mental health worker explained that support from colleagues is also important in diffusing the stress they experience from interacting with the work environment. One participant explained that pessimism from colleagues breeds more pessimism; thereby creating an unfriendly and aggressive atmosphere which has often affected patient care delivery.

*“Lack of support from colleagues. You know the walk in and there are happy and it’s like you hit a wall with someone who is already making bad comments about how their work day is going to go”.*

Support in the work environment from management, other non mental health staff and co-workers are necessary in order to ensure the delivery of quality patient care as well as to ensure the mental and physical well-being of the mental health staff. Several mental health workers felt that the lack of support from colleagues caused them to question the usefulness of their efforts in caring for patients. For some, the causes of secondary traumatic stress are multiple, as one mental health nurse said:

*“The effect of secondary traumatic stress on mental health worker comes from a multitude of directions; the stories from patients, colleague staff members, management, boards of*

*directors, our own personal material, "it's everything." The work we do changes our lives forever." The vital work faces obstacles from every direction."*

A number of the participants said that they were lacking various facilities which they felt could help them cope with secondary traumatic stress. In explaining this, they mentioned that they needed some training on secondary traumatic stress and how to deal with it when working with traumatized clients. One of the mental health workers said:

*"It would be nice to have a guideline to give you ideas on what to do and how to do during stressful case"*

Many of them felt that they would like more psychological support services in order to prevent secondary traumatic stress. They believed that such support services should be available when they are needed, and not later when they had forgotten about the stressful incident. One of the counsellors said:

*"If we say we would like counselling, you know, I feel we should get it within a week of asking. Not two to three months down the line, and it has gone when we dealt with it. It is like supposed to be getting heard two weeks ago and we are still waiting. We don't need it now. I don't think we do, but we, most of us we feel we don't need it now. We want it when we ask for it."*

Several researchers have found that high patient loads, stress and life demands, personal trauma history, anxiety, questioning of ability, unreasonable policies, staffing shortages, system dysfunction, lack of support and not being able to give a desired standard of care were all factors

that increase the risk of secondary traumatic stress (Frank & Karioth, 2006; Abendroth & Flannery, 2006). Badger, Royse and Craig (2008) stated that supportive social support was associated with decreased secondary traumatic stress. The same authors proposed that competency and control could both be enhanced and sustained by collegial support, which is an important element of structural and functional social support. According to them, caregivers who had more time to sustain relationships and engage in basic self-care seemed to be less at risk for experiencing negative effects of their work related stress

#### **4.3.6 Strategies used to cope with secondary traumatic stress**

Four sub-themes emerged when discussing strategies used to cope with secondary traumatic stress as result of working with traumatized clients and other psychiatric patients. These sub-themes are verbalization and letting go; determination; internalization and spiritualization; and use of humour and personal hobbies.

##### **4.3.6.1 Verbalization and letting go**

The coping strategies preferred by the mental health workers in Rwanda are verbalization and letting go. Verbalization of their feelings allowed many of them to refocus and regroup enabling them to recharge and to move on to the next patient care task without any residual effects. Consequently, verbalization, no matter what the form, is a popular way for mental health workers to ventilate about the stressors they encounter on the job. This method of coping is supported in the literature. Most participants reported that verbalization involves talking about the stressful cases, either with colleagues, management, or family and friends. One participant explained how helpful verbalization is

*“I think that verbalization seems to work best for me. When it’s all over with, if I can talk, then I can seem to let go of it. If I don’t talk, then I hold on to it and it destroys the rest of my day even if the stressful part of the moment is over with”.*

All of the mental health workers described talking over their fears, frustrations and anger with someone else as a way of coping with the secondary traumatic stress that they faced on a daily basis. Many of them stated that sharing their feelings with colleagues allowed them to express their thoughts as a way of diffusing the irritation that occurred when they felt overwhelmed by their work environment.

*“I find I have to debrief a lot in order to deal with the emotions of work. Just like talking to people, I talk a lot because if I don’t then I cry a lot more, sleep a lot less and eat a lot less.”*

Many mental health workers also explained that expressing themselves at work allowed them to “let off steam”, thus giving them an outlet to release the emotions associated with feeling weighed down by the heavy workload and feeling ineffective and incompetent in providing therapeutic care because of the large volume of patients and lack of trained mental health staff.

*“I talk to people I work with because they’ll understand, not just because they happen to be there but I think because we are in the same situation they will understand.”*

Some of the mental health workers acknowledged that they used to get angry with others when they were stressed by their work, but, as they have become more experienced and mature, they have realized that anger is not the most effective way to deal with stress. They reported that they talked over their secondary traumatic stress with their family members ad nauseam.

*“I talk until it’s out of my system; I talk to my friends until I can breathe. I talk to my husband too but it’s easier to talk to people who understand the situation.”*

However, several mental health workers stated that they did not want to take home their feelings that resulted from encounters with secondary traumatic stress. They further explained that they did not want their stressful work environment to have an impact upon their family lives. Several of them stated that they have been successful at being able to “let it go” while others stated that they occasionally needed additional coping measures, especially after a particularly stressful work day.

*“An hour of walking from work to home gives the time to wind down and then I can kind of review the work’s events and discuss what could have been better or what could have been prevented. And that helps me a lot to just kind of vent my anger and my frustrations of the work’s events. I try to have all of that cleared up by the time I get home”.*

For some of the participants, simply going home and seeing their own children was a way to “melt away” the negative feelings that had accumulated during the work day. For many, going home after a remarkably stressful work day was a way to recharge and refuel in preparation for their future encounters with work-related stressors. One of the counsellors said:

*“I have found that while working in mental health service I constantly have to take the time in order to take care of myself. I do this by enjoying time with friends, watching kids play in the park. I also take the time out to play and have vacations from here. Without this balance, I think it would be very easy to develop secondary traumatic stress and that I had to hide away in order to protect myself.”*

One of the general nurses working in psychiatric hospital said that walking is another way to cope with secondary traumatic stress.

*“When I am having a bad day all I need to do is walk through the garden outside the service, and see the flowers. My heart sings again with their courage and I feel lucky and happy to be me. I go back and tackle my problems in the same practical ways we show patients “one step at a time, breaking down the pieces into something I can handle”.*

Verbalization and letting go are considered the most available resources of support to mental health professionals when dealing with traumatized clients. Talking to friends or family members, or talking to colleagues under professional supervision were found to be good strategies to reduce the effects of secondary traumatic stress (Osofsky, Putnam and Lederman, 2008). Moor (2007) stated that the coping mechanism most frequently used by mental health workers was seeking emotional support by talking to others. In support of this, Phelps, Lloyd, Creamer and Forbes (2009) found that the most helpful coping strategies for mental health workers were the use of peer support, clinical supervision, consultation and personal therapy.

#### **4.3.6.2 Determination.**

Determination was another coping strategy used by mental health workers when confronting secondary traumatic stress. Determination is the ability to persist or to endure. While many of the participants preferred to talk things over with colleagues, close friends or family members, sometimes doing this was not feasible, especially if the workload was particularly heavy or the work environment was very turbulent. In these situations, many of them chose to hunker down, push through and persist with their care giving efforts. One psychiatric nurse explained that

when faced with a position in which she cannot share her feelings with her colleagues, she takes a deep breath and keeps going. Another nurse stated that she tries to keep a steady pace and keep at it. When faced with a heavy workload and having no other way in which to deal with the stress that it evokes, others turned inward and relied upon themselves to keep a positive outlook.

*“I think to myself that tomorrow is another day and that’s just the way things are around here. I have to just try to get through it the best way I can”.*

Some mental health workers used a rational approach when confronting stressful moments which involved stopping for a moment and analyzing the entire situation. This pause allowed them to take a moment to think about the situation at hand and also served as a calming measure giving them the strength to momentarily overcome the disorder and confusion evident in the work environment. Using this technique enabled them to accept the fact that they could not do everything for everybody. They also realized that what they were doing was worthwhile, despite the chaos that surrounded them.

#### **4.3.6.3 Internalization and spiritualization**

Internalization and spiritualization were also reported by participants as coping strategies for work related stress in mental health. Many of them mentioned that they initially internalized the traumatic stories of their patients, at least until a more appropriate time presented itself to deal with those stressful stories. Some of them declared that spiritualization is the coping strategy that gets them through traumatic stress in the short-term. They said that internalization is effective at first, but it does not meet their therapeutic needs and can, in fact, become harmful for those relying on it. One mental health worker said:

*“I more or less internalized. I tried to maintain calmness. When I am having a bad day all I need to do is walk through the garden outside the service, and see the flowers. My heart sings again with their courage and I feel lucky and happy to be me. I go back and tackle my problems in the same practical ways we show patients “one step at a time, breaking down the pieces into something I can handle”.*

Another type of internalization coping strategy described by the mental health workers was to deal with the stress alone.

*“When it’s really bad I just shut off completely from everything I do, I just kind of retreat into myself and I don’t really feel anything. I don’t socialize, I don’t do anything, I just kind of sit and try and work through it on my own.*

Many of the participants described activities they engaged in, either at work or outside work, which enabled them to deal with the pressure and frustration that resulted from experiencing secondary traumatic stress. When at work, they removed themselves from the stressful situation which gave them an opportunity to think about and process what they had just endured, and to refresh themselves psychologically, so that they could go back ready to face new challenges. One counsellor admitted:

*“Sometimes I just have to go to the office and sit for a few minutes and hope that nobody is knocking on the door. Or just leave the ward for a few minutes and come back and I know I am mentally equipped to finish the challenge.”*

When away from the work environment, participants said they engaged in both physical and mental activities. The mental activities included relaxing with friends, reading non-work related material and sitting alone contemplating life and one's place in it. One mental health worker stated that after very stressful shifts, she often sat alone and thought, telling herself that she must continue with her work for the sake of her family. In this way she gave herself a mental energy talk in order to revive her worn out spirit. She explained in these words:

*“Realizing that if I don't do this job and I don't stay with it, then I won't have my house. I guess a way to cope is to realize that this is just a job and you will do what you will do sometimes.”*

Many mental health workers indicated that they used internalization strategies constantly, both throughout the work day and after leaving the work environment. Several of them stated that their continuous efforts to control their reactions to work-related stressors allowed them to navigate their frequent encounters with work stress.

Regarding spiritualization as a coping strategy to cope with secondary traumatic stress, some mental health workers specifically mentioned that prayer and their spiritual beliefs helped them cope with secondary traumatic stress when working with traumatized clients. One counsellor in the private mental health service explained prayer as her coping strategy in the followings words:

*“When I get up every morning, I just say a little prayer that my guardian angel is with me all day and that I have the ability to think and make correct decision. I have done that since I started to work in mental health service. So, that is how I start my day, and my guardian angel has not abandoned me yet.”*

Another mental health worker affirmed that she had strong Christian values and when she felt herself becoming stressed at work, she stepped aside and prayed. She said:

*“To cope with secondary traumatic stress from my work I usually pray before a counseling session. I prayed God to deliver us from evil help with the client: This is my private prayer and repeat when I hear about yet another client trying to flight against the physical and emotional control. I pray that the evil will never win over and succeed because at times I felt there was nothing else I could do or say to help. I pray that there will never be another person who is persuading into saying the prayer backwards.*

Engaging in spiritually oriented activities have been cited by some researchers as being the most personal coping strategies used by mental health workers to mitigate secondary traumatic stress (McSherry, 2006). Russinova, Z. and Cash, D. (2007) have also referred to spirituality and internalization as significant coping strategies which provide a sense of hope, connection and meaning when working with traumatized clients and mentally ill patients.

#### **4.3.6.4 Use of humour and personal hobbies**

The use of humour and personal hobbies were also reported by many mental health workers as strategies to cope with secondary traumatic stress related to traumatized clients. They said they employ humorous comments and jokes to help them get through a stressful situation or stressful day as humour and laughing provide a vent for work related stress, especially with workload. The use of irony is another type of humour which is also prevalent among mental health workers.

All the participants were involved in various hobbies outside of work. Those hobbies included gardening, reading, sewing, all kinds of exercise, running, church, music, travel, family, shopping, eating and photography. Most of the mental health workers reported that their hobbies help them when they are feeling stressed.

*“I have found that while working in mental health service I constantly have to take the time in order to take care of myself. I do this by enjoying time with friends, watching kids play in the park. I also take the time out to play and have vacations from here. Without this balance, I think it would be very easy to develop secondary traumatic stress and that I had to hide away in order to protect myself.”*

Many participants in this study stated that they used verbalization and venting in order to cope with effects of secondary trauma which enabled them to continue with their care giving efforts.

#### **4.3.7 Support systems to limit STS**

Two sub-themes emerged during the discussions about support systems which limited secondary traumatic stress. These were informal support systems, such as friends and family; and organisational support systems, such as counselling service and debriefing sessions. Organizational support systems in the context of trauma work have already been discussed as a factor in preventing secondary traumatic stress. Several mental health workers expressed their own experiences of support systems that serve to deal with secondary traumatic stress in their institutions. They have suggested both prevention and curative strategies in the areas of individual and organizational support systems.

#### 4.3.7.1 Informal support systems

Many participants mentioned that they often received informal psychological support after having experienced a stressful case. They explained that they might have a cup of tea in the canteen and talk to colleagues about what was worrying them or what went well in the counselling session. When asked about psychological support received to limit secondary traumatic stress in their service, one participant explained in these words:

*“We normally do that when we have a chance. When we are having a cup of tea after wards’ work or in lunch time.”*

On the question of what support systems are used by the mental health workers to deal with secondary traumatic stress, one participant said:

*“When it’s a real stressful situation, I kind of hunch over the phone and kind of like focus here on my computer and I sometimes try to consciously tell myself to sit back and look at one of my pictures that I have up to remind me of happier times”.*

A number of the mental health workers said that family members provided great informal support. One of the participants said

*“My daughter who is big will continue with the house hold duties if she see I am tired(when) coming from home”*

Some of them described how they would discuss the stressful day with their family members even though they could not understand; just having them listen helped a great deal.

*“I am able to speak to my twin sister who will listen to me when I want to talk about my problem at work. My friends also will listen, comfort and encourage me when I am down and not feeling happy”*

#### **4.3.7.2 Organisational support system**

Support from the administration of mental health services has been cited by many of the participants as important to mitigate secondary traumatic stress.. Some of the organisational support systems are supportive organisational culture, counselling services and debriefing sessions. One of social workers working in a psychiatric hospital explained this in following words:

*“In my workplace they get on me if I have just a few hours of overtime. Sometimes I really wanted to stay, especially if I have made a good connection with a client. When I challenged this I was told that modelling good boundaries is good for staff and clients, that there is more to life than work and that it is easy to get into an overtime trap that leads to feeling overtired and overworked. I was kind of happy that management took this position.”*

Although many mental health workers reported that the management didn't provide enough psychological support, some of the managers who were interviewed for this study affirmed that the unit managers were sometimes seen as a source of psychological support as mental health workers could go and talk to them about their stressful situations. One unit manager in psychiatric hospital explained:

*“I am a unit manager in a psychiatric hospital. The mental health workers tells us all the time about a difficult working conditions, a horrible story they have just heard, how crazy busy our mental health service is. We only hear about the situation, the high-risk alerts and the problems and then I go into the service and see how stressful is the situation. It breaks my heart.”*

One of participants explained:

*“A supportive organization culture is one that not only allows for vacations, but also creates opportunities for mental health workers to vary their caseload and work activities, take time off for illness, participate in continuing education, and make time for other self-care activities. Mental health services might signal their commitment to staff by making staff self-care a part of the mission statement, understanding that ultimately it does affect client care.*

A psychiatric nurse said:

*“Administrators might also monitor staff vacation time and encourage staff with too much accrued time to take time off. Self-care issues could be addressed in staff meetings, and opportunities for continuing education could be circulated to staff. In social work agencies, which typically operate with inadequate resources and relentless service demands, such commitments, regardless of how small, are not inconsequential.”*

Mental health services should develop procedures that attempt to distribute clients among staff in a way that pays attention to the risk of secondary traumatic stress certain clients might present to mental health workers. One participant said:

*“Participative management is both a philosophy and a method for managing human resources in an environment in which employees are respected and their contributions valued and utilized. From a philosophical standpoint, participative management focus on the belief that people at all levels of the organization can develop a genuine interest in its success and can do more than merely perform their assigned duties. The most important thing to do is to build the organization around information and communication instead of around hierarchy.”*

According to Pearlman and McKay (2008), in order to prevent STS in mental health workers, organizations can maintain an attitude of respect for both clients and mental health workers by acknowledging that caring for trauma survivors often involves multiple, long-term services. An organizational culture that “normalizes” the effect of working with trauma survivors can provide a supportive environment for social workers to address those effects in their own work and lives. An organizational culture also gives permission for mental health workers to take care of themselves. In some mental health services in Rwanda, it may be assumed that if employees do not work overtime, they are not committed to their work, or that mental health workers who do not take time off are more committed to their work than are others. Perez, Jones, Englert, and Sachau (2010) maintain that lack of social support is linked to secondary traumatic stress. Sufficient support from supervisors is especially important, even more so than support from co-workers.

Some of the mental health workers in Rwanda reported that they did have access to counselling services should they feel the need. All they needed to do was to approach one of the managers and ask for it to be arranged. Others said that there was nothing available to help them cope with the secondary stress they encountered on a daily basis.

*“It just sort of comes when you least expect it, you’ll suddenly start thinking [about an event)... and all of the thoughts and feelings that you had at that time...”If we say we would like counselling, you know, I feel we should get it within a week of asking. Not two to three months down the line, and it has gone when we dealt with it. It is like supposed to be getting heard two weeks ago and we are still waiting. We don’t need it now. I don’t think we do, but we, most of us we feel we don’t need it now. We want it when we ask for it.*

It was revealed that the availability of counselling services differed a great deal between the different mental health services in Rwanda, especially between private and public mental health services.

With regard to debriefing sessions, some of the private mental health services in Rwanda had arranged for formal debriefing sessions, especially during the period of commemoration of the 1994 genocide against the Tutsi, but they are still too few. A number of managers from the public sector stated that they are busy trying to formalize a systematic debriefing programme in their mental health settings. One manager said that they are going to start group supervision.

Findings have shown that challenging environments increase mental health workers’ vulnerability to secondary traumatic stress. In respect of support systems that limit secondary trauma in mental health workers, an organisational supportive culture can be a key to helping staff vent, process or debrief about traumatic material (Wasco & Campbell, 2002). According to Cairns (2007), the level of support system is an important component in minimizing the effects of secondary traumatic stress in mental health workers treating traumatized clients. In order to reduce or limit secondary traumatic stress in mental health workers, some researchers in the field

of STS emphasise the importance of maintaining a balance between work and personal life (Hanna and Romana, 2007). Naturale (2007) suggested that peer consultation, supervision and professional training to reduce the sense of isolation and increase feelings of efficacy are effective strategies to reduce STS in mental health workers. Cairns (2007) stated that mental health workers should have adequate training to effectively assist traumatized clients, which can reduce the sense of hopelessness that may accompany secondary traumatic stress (Naturale, 2007).

#### **4.3.8 Gratifying features of the mental health profession**

In their discussion of whether mental health workers found anything gratifying about their work, some participants reported that they not only experienced negative effects as result of working with traumatized clients, but there were also some positive aspects. They identified two sub-themes: helping others and a sense of reward.

##### **4.3.8.1 Helping others.**

The ability to help others in their time of need is the essence of mental health care. Many of the mental health workers interviewed stated that being able to help others in their greatest time of need is what drew them into mental health profession. Many also derived pleasure from knowing that their actions made a positive difference to patient outcomes. Saving lives was a common denominator expressed by many of the mental health workers.

*“Knowing that the mental health care I provided were beneficial to the individual. Knowing that I saved somebody’s life. That is the most rewarding thing in mental health care”.*

One of the participants explained that knowing that one has made a difference in someone's life, even if it was only one patient during a particular session, makes coming to work worthwhile.

Describing her experience another counsellor said:

*“One day I was in staff office and I saw a patient coming in accompanied by the family members walk through and she was very depressed with physical symptoms as she refused to eat since a week ago. I took her in one of the private rooms and immediately I started an IV infusion. After the IV infusion I called the doctor to examine her and prescribed the medication. The following two days I was off duty. When I come back to the service I was surprised to see the patient sitting and talking. After one month of hospitalization under antidepressant treatment she was healthier and discharged. The delay in treatment of the patient would lead her to commit suicide. She is alive and she has been back to visit us numerous times to thank us. We really made a difference in that patient' life. That's the most gratifying thing I remember. Feeling that you really made a difference in somebody's life and you really did something that was significance to save somebody's life, you have some reason for being happy to be in mental health profession.”*

Another participant said:

*“It has made me more aware of the sad, poor home circumstances. Hopefully more compassionate and understanding. Focused me more on the need for the development of pastoral care structures in hospital. It has allowed me to grow as a person because of the learning one gets from helping others. It's also helped me look creatively at the situation. I get to hear of*

*trauma experiences they have had that day or earlier I learnt to listen to my client and try to refer them to counseling or relevant help”*

#### **4.3.8.2 Sense of reward.**

The theme of sense of reward is closely related to the theme of helping others. Many mental health workers explained that by helping others and knowing that their mental health care has been beneficial to the patient resulted in feeling a sense of reward. Providing comfort to patients gave them a sense of accomplishment in their work.

*“To me it’s not just the patients that you save but it’s also the patients that you can be there to comfort. One time I had a guy that came into who was aggressive patient. I knew that he was going to acting out. I really tried to go above and beyond with the family. And that was meaningful to me because when the patient was discharged, the family came to me as a whole and thanked me for being there and thanked me for trying to make them feel comfortable. I went above and beyond trying to make this experience as comfortable as possible”*

The mental health setting often gives rise to many exciting and thrilling moments due to the large volume of acute psychiatric patients seeking care. Most of the mental health workers experienced a sense of reward when they felt they had done something valuable, made a difference in some way in a patient’s life or established a healing relationship with a patient. One mental health worker explained that the adrenaline rush she received by saving lives gave her a sense of reward.

*“When a clients come in like traumatized. They are struggling and you keep helping them to restore their state. To improve their status, to see the improvement, and to get thanks from them. Even if they don’t thank you, you can tell by looking at them that they are better. That’s rewarding”.*

Several mental health workers explained that feeling a sense of reward is important in maintaining their well-being because, in addition to their personal feelings of satisfaction that they were able to help others through their actions, it makes them feel valued for their abilities. Even though there are a huge number of work-related stressors in mental health services in Rwanda, many of the participants stated that they still feel a sense of reward at the end of some therapeutic relationships because they were able to provide mental health care to those who needed it. One mental health worker explained that she usually felt good about how her work had gone even though she was exhausted when her therapeutic relationship with a traumatized patient was over. For others, simply surviving the stress of their trauma work resulted in a sense of reward. One of the trauma counsellors expressed this in the following words:

*“If I have done well with coping with the stress from my trauma client experience , then I feel a satisfaction at the end of the therapeutic relationship that yes, it was very demanding but I held my own, I did a good job at taking care of the patients that I had and I did all that I could do. I feel like I get some fulfillment out of that. It’s the feeling of satisfaction you get surviving that stress. It’s like going to war and making it home. It’s feeling like you have accomplished what you came to do and, yes, it kicked your butt, but you did a fine job when you were done”.*

Knowing that one has made a difference also results in feeling a sense of reward although this often comes from within. According to several mental health workers, patients treated in the mental health service rarely give thanks for the care that has been given to them, but they are usually able to see if their actions have made a difference by witnessing an improvement in the patient's condition. One of the participants explained that knowing that one had done the best he/she could under the circumstances using the resources available also resulted in feeling a sense of accomplishment. This was explained as follows:

*I go away from the work feeling pretty good that I did the best job that I could with what I had to work with. Sometimes I come away thinking "Thank God, I helped that patient."*

Mental health workers in this study also reported feeling a sense of reward when they succeeded in coping with work-related stressors and were able to provide appropriate care to their clients. This finding is supported by Satkunanayagam, Tunariu and Tribe (2010) who reported that when mental health workers take the time to care for themselves, then interventions become more gratifying.

It has been acknowledged by various sources that there are gratifying effects which mental health workers can experience when working with traumatized clients. Arnold et al., (2005) found that a large majority of mental health workers reported positive consequences of their work. Nelson (2007) suggested that having a more diverse caseload is associated with decreased secondary traumatic stress in mental health workers. Such diversity can help the mental health worker keep the traumatic material in perspective and prevent the development of a traumatic worldview (Pearlman and McKay, 2008). According to Arnold, Colhoun, Tedeschi and Cann (2005), mental

health workers treating trauma survivors can experience a deeper and more nuanced understanding of the entire spectrum of human behaviour. Engstrom, Hernandez and Gangsei (2008) have found that through a process of introspection mental health workers can apply clients' resilience to their own lives, which helps them to reframe and cope better with personal difficulties and troubles. Engstrom et al. (2008) also discuss the difference between vicarious resilience and posttraumatic growth. The same authors state that vicarious resilience is concerned with the process whereby the mental health workers are positively affected by resilience. .

Through the process of action research in cycle 2, the participants of this study shared their experiences of secondary traumatic stress with the research team. During this cycle, while I was conducting the individual interviews, the research team members were involved in planning and reflecting on data analysis as expert reviewers. While reflecting on the data analysis, I had described the sub themes that had emerged from individual interviews to the research supervisor and then discussed them with the research team members to validate the findings. It is quite clear that the experience of secondary trauma in mental health workers is multifaceted and complex. The themes that emerged from this cycle indicated that secondary traumatic stress experienced by mental health workers in Rwanda led to certain immediate and long term responses, having both emotional and physical effects. Although there were a few positive aspects to working with mentally disturbed patients, the effects of secondary traumatic stress impact negatively on the professional functioning and interpersonal relationships of mental health workers.

#### **4.4 Cycle 3: Model development**

The third cycle of this study deals with the process of developing a model to manage secondary traumatic stress in mental health workers in Rwanda. After permission from mental health services had been obtained, I identified certain people and invited them to join the research team. They had been selected because they were experts and were experienced in the mental health profession in Rwanda, and had a vested interest for change in their institutions. The ten research team members consisted of one psychiatrist, two psychologists, two psychiatric nurses, two managers, two trauma counsellors and one social worker.

The first meeting with the research team on the development of a model was to reflect on the findings from cycles 1 and 2 of the current study. In this meeting, the research team decided to develop an intervention model to manage secondary traumatic stress in mental health workers. A further meeting was held in which the research team came up with the draft of the model. In the same meeting, the research team members agreed to utilize the model in the implementation cycle. I asked the members to re-examine the model and finalize it.

Chinn and Kramer (2007) indicated that models are structural designs consisting of organized and related concepts. Models are pictorial representations which show simplified details of concepts considered relevant to measuring specific outcomes of a discipline. Models are developed to provide diagrammatically how one concept logically or casually influences and connect with another.

The major purpose of an intervention model to manage secondary traumatic stress was to recognize and understand the process required to manage secondary traumatic stress. The other

purposes were to recognize the symptoms and effects of secondary traumatic stress and to establish positive teamwork behaviours which are important in improving mental health care for psychiatric clients and traumatized survivors.

In ensuring collaborative and technical support, I maximized mental health workers' participation at every level of model development. The technical and collaborative support facilitated effective and efficient utilization of the plan. Effective and efficient secondary traumatic stress management requires staff participation in planning, monitoring and evaluation of preventive, curative and rehabilitative intervention activities. Effective participation of the research team was facilitated by the development of mutual trust, respect, integrity and good will between participants. Commitment to change and support of implantation were encouraged in the process of the development of the model.

I invited the research team to a meeting to present the finalized model. Through a spiral process the participants critiqued the model and decided that they needed to implement the model and assess if it was practicable in their institutions.

#### **4.4.1 The need of the model**

All participants seemed to agree that the intervention was needed in order to develop a model to manage secondary traumatic stress in mental health workers in Rwanda,

#### **4.4.2 Process of developing the model**

The current model to manage secondary traumatic stress in mental health workers in Rwanda was developed following the procedures outlined in Chinn and Kramer (2007). This process

included the following steps: literature review, review of archival material, collection and compilation of potential items, focus group meetings, revisions of the instrument, development of operational definitions for each concept and development of the model.

#### **4.4.3 Literature and documental review process**

The research team members conducted a thorough review of literature related to secondary traumatic stress, with particular attention to the effects of STS on mental health workers, as well as models proposed to mitigate STS in mental health workers. I sought to determine whether there were any existing models which adequately mitigate secondary traumatic stress in mental health workers who care for traumatized clients in Rwanda. In consultation with the research supervisor and research team members with expertise in mental health practice, I concluded that there is no existing model which adequately manages the secondary stress experienced by mental health workers in the Rwandan context.

The research team then reviewed literature related to secondary traumatic stress with the objective of identifying theoretical constructs and empirical data related to the effects of STS on mental health workers. They then extracted information from this literature review into three broad categories: theory-based definitions of STS; clinical descriptions of STS and related concepts; and empirical research related to STS in mental health workers population. Information from this literature review was included into the operational definitions of the concepts that contained the model to manage secondary stress in mental health workers in Rwanda. These concepts were also guided by the findings from the qualitative interviews with the participants in cycle 2. In order to develop a comprehensive model, I conducted a review of

documents relevant to STS and stress management. I thoroughly reviewed literature related to interventions of secondary traumatic stress management in mental health practitioners. The information from this documental review was used to further elucidate and refine the components that comprise the current version of the model developed to manage secondary traumatic stress in mental health workers in Rwanda.

#### **4.4.4 Collection of potential elements**

I worked closely with the research team as to collect and compile a set of elements for potential inclusion in the model to manage STS. This list was based upon the previously mentioned literature review and documental review and comprised of several concepts gathered from existing intervention models to mitigate traumatic stress and related concepts such as compassion fatigue and vicarious traumatization. The elements also originated from the quantitative findings of cycle 1, the interviews with participants in cycle 2 and the relevant supporting literature. Each concept represented a particular phase of intervention in the process of managing secondary traumatic stress. Additional potential items were generated through discussions between me, the research supervisor, research team members and other mental health workers such as medical doctors, psychiatrists, psychologists, nurses and trauma counsellors with advanced training in trauma work who had extensive clinical and academic experience in mental health care, especially with trauma survivors.

#### **4.4.5 Process for generating the model**

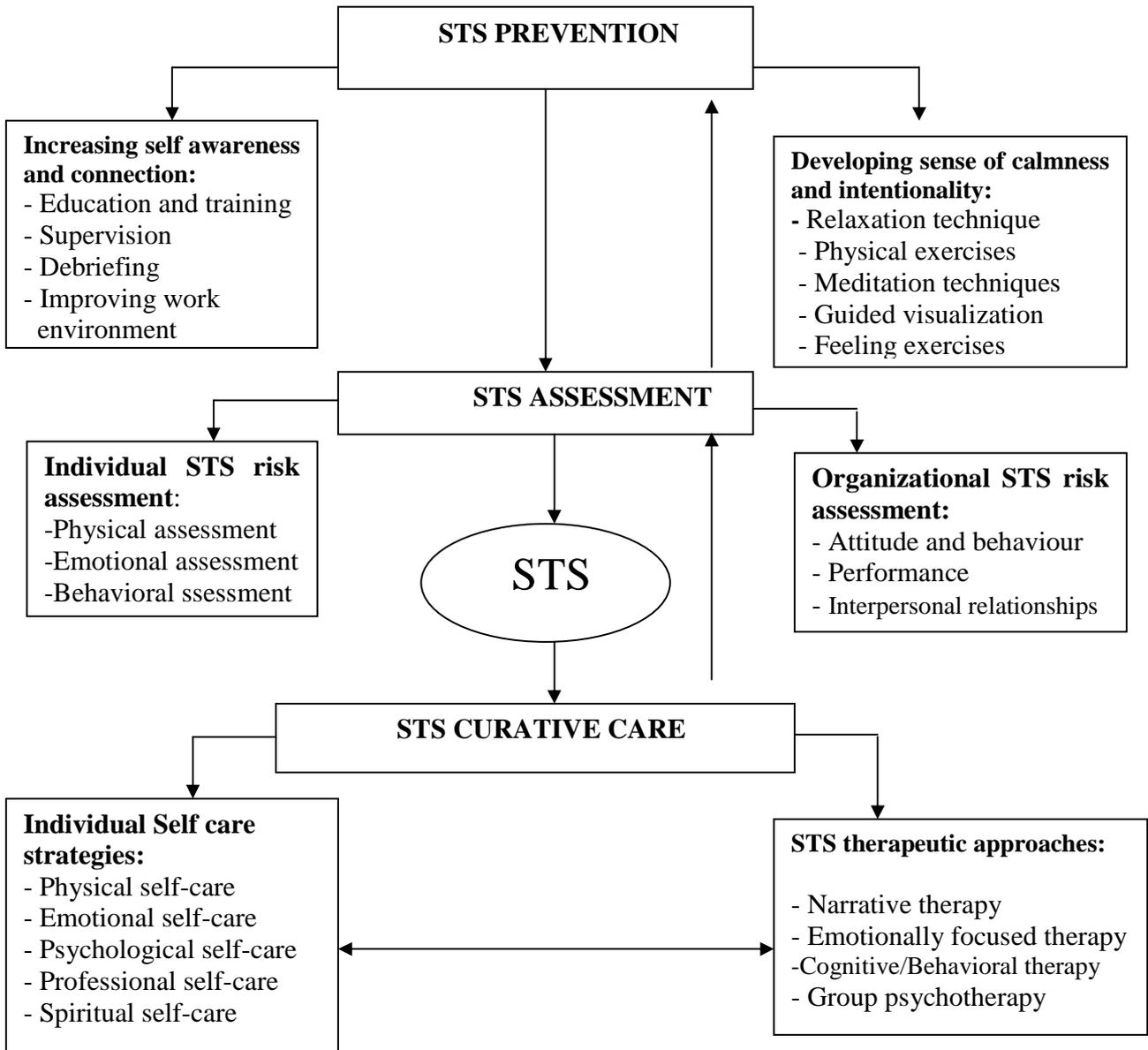
In the process of generating the model, the research team started by describing what the model was trying to represent and to identify and describe the concepts active in the domain of STS

management and then analyse them in relation to the phenomenon of interest. The research team also attempted to develop a visual representation of the model. They attempted to use the idea of an algorithm as a way of visually presenting the model because in the mental health practice, staff are familiar with the use of algorithms. This process was suggested by different authors (Netemeyer, Bearden, and Sharma, 2003).

Numerous amendments of the model were produced. The research team members reflected on the proposed components of the various adapted models and discussed how to best capture the components they had identified as most significant to the concept of secondary traumatic stress in mental health workers in Rwanda. They then provided verbal and written feedback related to the general applicability of the model as a whole. The feedback was then integrated into later versions of the model as it was being developed, which were subsequently presented to the research supervisor. I and research team viewed this reciprocal process as the most effective way to clarify the constructs related to the model to manage secondary traumatic stress. The research team thought of the best ways to capture the important concepts from the literature and the findings from cycles 1 and 2. My role in the research team was mostly drawing the research team back to cycles 1 and 2 of the study and making sure that this data was being incorporated so that they did not just base everything on the reviewed literature.

This repeated process of refinement and clarification resulted in a draft model that had the items that served as the basis for forming the concepts to be included in the current intervention model to manage secondary traumatic stress in mental health workers in Rwanda. I and research team engaged in a rigorous process of deliberation in order to clarify specific concepts, to ensure that the concepts were conceptually mutually exclusive in a manner to have clinical effectiveness.

We then evaluated the potential concepts for inclusion in the secondary traumatic stress management model. Each concept was evaluated based on whether it seemed relevant to the management of secondary traumatic stress and whether it seemed useable when presented to participants. We all agreed that, due to the complexity of secondary traumatic stress, the model should contain a limited number of concepts. The developed model is diagrammatically presented in the Figure 4.12 below.



**Figure 4.12: Interventional model to manage STS in mental health workers**

#### **4.4.6 Description of the model**

The aim of this intervention model was to improve the management of secondary traumatic stress in mental health workers by describing an intervention process based on mental health workers' experiences in their daily activities. A flexible diagram process was used to create the interventional model to manage secondary traumatic stress in mental health workers in Rwanda. The intervention model illustrated in figure 4.12 attempted to describe the essential interventions in the management of secondary traumatic stress experienced by mental health workers in Rwanda. The model was devised by the participants and research team, in collaboration with me. It serves as a framework reference for mental health professionals to mitigate secondary traumatic stress in individuals and the mental health service as a whole. The process of the intervention model has three major categories of interventions, namely; providing preventive interventions; providing STS risk assessment interventions; and providing curative care and STS management interventions for mental health workers who have been affected. The model illustrates directional relationships and these are indicated by black uni-directional arrows going from the antecedent variable to a variable on which it is thought to exert its influence.

A participatory leadership method was used in developing and implementing the model which emphasizes the value of building the capacity of every mental health worker in order to reduce their own stress and to help manage secondary traumatic stress in their colleagues.

These interventions are expressed in the form of mental health workers promoting effective communication, leadership and professional skills in order to mitigate STS within their mental

health services. The interventions also involve managers in encouraging staff self-care, sharing information and identifying their needs about the model.

#### **4.4.7 The purpose of the model**

The purpose of this model is to provide a theoretical frame of reference for mental health workers in Rwanda to mitigate the effects of secondary traumatic stress as consequences of working with traumatized clients and other psychiatric patients.

#### **4.4.8 Model assumptions**

The following are the assumptions of the model:

1. Since most Rwandans have personally experienced major losses or life-shattering events in the 1994 genocide, it follows that mental health workers in Rwanda are vulnerable to secondary traumatic stress and its effects.
2. It is very important for mental health workers in Rwanda to learn how to recognize, monitor and mitigate the impact of secondary traumatic stress experienced by them.
3. Often mental health workers do not realize that they are suffering from secondary traumatic stress until it is too late and they are already affected.
4. The effects of secondary traumatic stress can be quite serious, devastating and everlasting. It interferes with mental health workers' ability to carry out their occupations effectively.

#### **4.4.9 Providing STS preventive interventions**

Providing STS preventive strategies is concerned with protecting mental health workers from secondary traumatic stress when dealing with traumatized clients. For the purpose of this current model, there are two categories of preventive interventions involved in the management of secondary traumatic stress. The first category involves improving self awareness and connection by providing education on STS, as well as supervision and debriefing, and improving work conditions by providing adequate communication and ensuring adequate resources and support systems. The second category involves developing a sense of calmness and intentionality by means of personal and professional strategies which encourage physical activities, relaxation techniques, meditation techniques, guided visualization and feeling exercises. This means that the two categories of interventions to minimize secondary traumatic stress need to be used optimally to ensure that mental health workers and the service are equipped to manage secondary traumatic stress.

##### **4.4.9.1 Process one: Improving self awareness and connection**

One of the ways secondary traumatic stress affects mental health workers is to leave them with a sense of disconnected isolation. A common symptom is the progressive loss in their sense of connection to themselves and to others. Many mental health workers become increasingly isolated as their symptoms intensify. Fear of being perceived as weak, impaired or incompetent by peers and clients, along with time constraints and loss of interest, have all been cited by mental health workers suffering from secondary traumatic stress as reasons for diminished self awareness and connection to self and others.

To reduce secondary traumatic stress, mental health workers must first be able to identify the signs and symptoms of STS in themselves which requires self awareness. It is important for them to understand what secondary traumatic stress is and it takes practice to become aware of how they respond to trauma-related stress and what works best to reduce this stress. Self-awareness is not something that can be achieved in a single exercise. Instead, it is a continuous process of paying attention to any changes in themselves, such as changes in their feelings, attitudes, beliefs, physical health and daily activities (Pearlman, 2003). There are many interventions that have been designed to help mental health workers develop self-awareness.

Managers of mental health institutions where people work with traumatized clients also need to develop awareness of secondary traumatisation and its effects on their staff. Mental health workers need support from their managers in managing trauma-related stress. Many of the contributing factors in the work setting are caused by lack of awareness and support within organizations.

### **Concept One: Education and training**

In order to build awareness and connection, mental health services need to recognize and acknowledge that secondary traumatic stress exists and to identify how it impacts the mental health professional and the quality of patient care. To achieve this objective, educational and training programmes could be helpful to the mental health workers. Managers should be sensitive in addressing this issue and educate their staff as well as encouraging them to debrief their high trauma cases on a regular basis in a supportive atmosphere. Individual and peer supervisions should be organized in order to provide emotional support. Secondary

traumatization can occur if mental health workers start questioning the meaning of life and feel frightened and out of touch with other people. They may also feel helpless to do anything about what has happened to them (Hof, Dismore, Hock, Scofield, and Bishop, 2009).

According to Pearlman (2003), maintaining connections with people who provide support and love is especially critical in addressing the feelings of isolation, loneliness, hopelessness, grief, and despair that often accompany secondary traumatization. At work, supportive connections between colleagues can be established by having structured, planned opportunities to talk about secondary traumatization. If these opportunities are not already in place in the institutions, support groups can be created to serve this purpose.

It has been found that a few secondary traumatic stress symptoms in mental health workers seemed to be at least partially caused by working beyond their level of skill. Working with traumatized individuals is a highly skilled activity that demands many years of training in many different areas before a sense of mastery is gained. Trying to shortcut this process by prematurely working with trauma survivors without adequate training and supervision can very easily overwhelm even seasoned clinicians, much less neophytes (Stoesen, 2007). While empirical research has not yet addressed the effects of working beyond levels of competency has upon mental health workers, or providing services while impaired with stress symptoms, especially in contexts of mass casualties like the 1994 genocide in Rwanda, it is believed that these factors contribute significantly to the frequency, duration and intensity of secondary traumatic stress symptoms.

Education and training of mental health workers are vital in preventing and combating secondary traumatic stress. Slattery and Goodman (2009) suggested that mental health workers need five strengths, namely: competence about coping, maintaining objective motivation, resolving personal traumas, drawing on personal role models of coping, and having buffering personal beliefs. With education and training mental health workers can be helped to develop these strengths. For the purpose of the present model, education is aimed at helping mental health workers to understand the signs and symptoms of STS in order to improve their level of knowledge and self awareness of STS. The mental health workers should be alerted to the signs and symptoms of STS which bring about general and specific changes to their lives.

They should also be taught which factors contribute to STS, emphasizing contributing factors such as the nature of the work, the nature of the patients, exposure to traumatic material; and individual factors such as personality and defence styles, coping styles and supervision. By means of education, mental health workers will become equipped to identify coping strategies to address or lessen symptoms of secondary traumatic stress. This should help them to distinguish between addressing and transforming STS. Each mental health worker should be encouraged to focus on exercises concerning themselves.

### **Concept two: Supervision**

Effective supervision is an essential component of the prevention and healing of secondary traumatic stress and the building of self awareness and connectivity in mental health workers. Responsible supervision creates a relationship in which mental health workers feel safe in expressing fears, concerns and inadequacies (Trippany, White Kressand Wilcoxon, 2004).

Mental health services with a weekly group supervision format establish a venue in which traumatic material and the subsequent personal effect may be processed and normalized as part of the work.

In addition to providing emotional support, supervisors can also teach staff about secondary traumatic stress in a way that is supportive, respectful and sensitive to its effects (Bober & Regehr, 2006). Pulido (2007) suggested that supervision and evaluation should be separate functions in a mental health service and expressed concern that evaluation might make a mental worker reluctant to bring up issues in his or her work with clients that might be signals of secondary traumatic stress. In situations where supervisors cannot separate the supervisory and evaluative functions, managers in mental health service might consider contracting with an outside consultant for trauma-specific supervision on either an individual or group basis.

Proper supervision is vital in the mental health profession to build self awareness in mental health workers and help them to reduce secondary traumatic stress related to their work. It is widely debated whether supervisors should address personal issues during supervision or whether those issues may be better suited for a therapy session. Trippany, White, Kress and Wilcoxon, (2004) place high priority on the close supervision of mental health workers who deal particularly with a clientele of trauma survivors.

Sometimes, training in the area of treating trauma can have a powerful ameliorative effect upon secondary traumatic stress, bringing a sense of empowerment to mental health workers who have previously been overwhelmed. The caveat here is that the danger that mental health workers who have been trained in one of these powerful techniques may emerge from the training with an

inflated sense skill and potency and may be tempted to practice even further beyond their level of competence and skill. This scenario highlights the importance of good professional supervision.

In addition, many mental health workers working with trauma survivors have found it helpful to receive periodic “check ups” with a trusted professional or peer supervisor. This has been found especially helpful during the annual commemoration of the genocide. Professional and peer supervisory relationships can serve as excellent opportunities to share, and therefore dilute, the effects of the artefacts of secondary traumatic stress that may have been collected while in service to trauma survivors. Professional supervision is also reported to have an overall ameliorative effect upon secondary traumatic stress symptoms (Trippany, White Kressand Wilcoxon, 2004).

### **Concept three: Debriefing**

Debriefing is a psychological treatment intended to reduce the psychological morbidity that arises after exposure to trauma (Kinchin, 2007). Debriefing involves promoting some form of emotional processing catharsis or ventilation by encouraging recollection/ventilation/reworking of the traumatic event. Debriefing has two principal intentions. The first is to reduce the psychological distress that is found after traumatic incidents, and the second is to prevent the development of psychiatric disorder, usually secondary traumatic stress in secondary victims. The effectiveness of debriefing in achieving either of these aims is very uncertain. Exponents of debriefing draw attention to its popularity and claim that it is meeting important needs (Kinchin, 2007). Previous reviews have drawn attention to the limited evidence and have raised the possibility that debriefing may actually be harmful. Psychological Debriefing (PD) is an early

intervention administered to trauma victims in order to prevent the onset of post-traumatic stress disorder (PTSD).

Successful debriefings allow feelings to be openly acknowledged and resolved so that the stress of the incident is not carried forward into new work. Talking on a regular basis with colleagues who understand is supportive and is seen to be helpful. This involves talking about the traumatic material, how one thinks and feels about it, acknowledging how one is personally affected by it and putting a plan in place for balance (Kinchin, 2007).

As secondary traumatic stress has the capacity to silence and isolate individuals, debriefing is a way of building mental health workers' awareness and connection. Connection to something or someone beyond themselves brings meaning to their own lives and reminds them that they are not alone, although they may feel alone at times. By means of debriefing, mental health workers can break the silence and isolation and make it possible to heal themselves and hope for a better future. Debriefing can be divided into three categories:

***Operational debriefing*** is when mental health workers are asked for information about the work performed, and what was achieved.

***Personal debriefing*** is when mental health workers are asked how they related to the experience (What was best/ worst? How is the readjustment process going?). Personal debriefing aims to help mental health workers integrate their experiences into their lives as a whole, perceive them more meaningfully and bring a sense of closure.

***Critical incident debriefing (CID)*** is a highly structured form of personal debriefing which can take place after a traumatic experience (such as a natural disaster, a violent incident, or a traffic

accident) or after listening to particularly traumatic stories when dealing with traumatized clients.

Debriefing is designed to mitigate the adverse psychological consequences of traumatic events by attenuating the intensity of acute symptoms of stress, thereby reducing the risk of subsequent psychiatric problems. A single debriefing session will generally alleviate the acute stress responses which appear at the scene and immediately afterwards and will eliminate, or at least inhibit, delayed stress reactions (Kinchin, 2007). Originally developed for emergency service personnel, debriefing is now deemed helpful for primary victims (Kinchin, 2007)

A debriefing session has seven phases: the introduction phase; the fact phase; the thought phase; the reaction phase; the symptom phase; the teaching phase; and the re-entry phase. In the introduction phase, the debriefing facilitator explains the procedure to the participants, answering any questions they might have. He or she emphasizes that debriefing is not psychotherapy; it is a method for reducing normal stress reactions triggered by a traumatic event. The facilitator then initiates the fact phase by asking each participant, in turn, to describe what happened during the critical incident. He or she might say: "Tell me who you are, what your role in the incident was, and just what you saw and/or heard take place" (Kinchin, 2007:36). The purpose is to enable each person to describe the traumatic incident from his or her perspective. Each person takes a turn adding in the details to make the whole incident come to life again in the debriefing room (Kinchin, 2007). However, the facilitator reassures participants that they can remain silent if they feel uncomfortable speaking in the group. The option of silence also applies to subsequent phases of the debriefing.

Next, the facilitator shifts to the thought phase by allowing each participant to describe his or her cognitive reactions to the traumatic event. The facilitator might say, “Now, I’d like you to tell us what your first thoughts were in response to the crisis” (Kinchin, 2007). The purpose of this phase is to move closer to the expression of emotion. The facilitator then moves to the reaction phase designed to foster emotional processing of the trauma by having participants experience catharsis through expressing their feelings about the event. The facilitator might begin by asking, “What was the worst part of the incident for you personally?” (Kinchin, 2007). The facilitator may ask how each person felt at that particular time and also how each person is feeling during the debriefing itself. As Gist and Devilly (2002) have emphasized, everyone has feelings which need to be shared and accepted. The main rules are that no one criticizes another and that all listen to what was, or is, going on inside each other.

Advancing to the symptom phase, the facilitator asks, “What physical or psychological symptoms have you noticed, if any, as a result of this incident?” (Gist and Devilly 2002). The purpose of this phase is to identify stress reactions that members wish to share, and to begin the transition from the affective realm back to the cognitive one. In the teaching phase, the facilitator tries to show that the stress reactions members have been experiencing are normal and not necessarily a medical problem, by stating, for example, “We’ve heard numerous symptoms that are being experienced, let me explain their nature and give the some suggestions on how to reduce their negative impact” (Kinchin, 2007). In addition to providing secondary stress-management tips, he/she endeavours to convince participants that their reactions do not signify psychopathology.

Finally, in the re-entry phase, the facilitator aims to achieve closure to the traumatic event. He or she summarizes what has been covered in the session, answers any questions that have arisen, and assesses whether any members may need follow-up or referral for additional services.

Kinchin (2007) recommends that anyone exposed to a critical incident should be offered debriefing, regardless of whether the person is experiencing any stress symptoms. In addition to mitigating distress and preventing secondary traumatic stress problems, these interventions may reduce sick days taken by stressed employees. The mental health service's failure to implement some such psychological service in the immediate wake of a critical incident may constitute negligence, thereby increasing the risk of legal liability to stressed employees who may file suit. To avoid the threat of litigation for failing to meet the standard of care, mental health services should make debriefing compulsory for people exposed to critical incidents such as mental health workers dealing with traumatized clients or psychiatric patients (Kinchin, 2007).

#### **Concept four: Improving work environment**

Improving the work environment of the mental health service is important to prevent secondary traumatic stress in mental health workers. The work environment is geared towards caring for the physical rather than the psychological aspects of the staff. In addition, the mental health services do not assign much importance to communication patterns, mental health and staff values. Mental health services should ensure that adequate resources are available such as clinical supervision or consultation. Regularly scheduled clinical meetings are an informal way of allowing staff to have cathartic interactions with peers, plan possible solutions with the service's approval and have access to managers in a non-threatening way. Attendance to personal therapy

can also be a great source of release for a struggling mental health worker (Trippany, White Kressand Wilcoxon, 2004). Sometimes it is useful to engage external consultants in order to provide objectivity in dealing with secondary traumatic stress where the organisational dynamics may be part of the problem (Naturale, 2007). Communication between the mental health professionals in the mental health service refers to open communication between the different teams of the mental health workers, managers and clients, in order to achieve optimal understanding of and support for every individual.

Hojat, Mangione, Nasca, Rattner, Erdmann, Gonnella and Magee (2004) emphasized that interdisciplinary collaboration improves clinical outcomes and patient satisfaction. The communication channels between all members of staff should be assessed according to their qualifications, and changes made where necessary to ensure a cohesive health team. This mutual collaboration between mental health workers can be influenced by educational factors as well as societal roles and cultural norms. All mental health workers within the service need to be supportive of each other and see themselves as complementary team members in the mental health service (Hojat, et al., 2004).

Mental health service management need to acknowledge the uniqueness of mental health work as this would improve relationships between mental health professionals and others in the service. Open communication between mental health workers and the managers is essential. In order to improve the culture of the mental health service, mental health workers need to reach consensus as to what they view as caring when managing secondary traumatic stress among themselves. To achieve this, they need to consider their philosophy of caring. Naturale (2007) emphasizes meaningful involvement in order to create positive client care and organizational outcomes.

#### **4.4.9.2 Process Two: Developing sense of calmness and intentionality**

Calmness and intentionality in the context of secondary traumatic stress management refers to mental health workers being able to witness the traumatic events and suffering of their clients and emerge from these experiences having made use of positive, adaptive coping strategies. According to Cairns (2007), hearing and witnessing the trauma of others on a daily basis places mental health professionals at risk for developing secondary traumatisation.

Knowledge of adaptive and maladaptive coping strategies is necessary in order to have better knowledge of one's own coping strategies and those used by one's colleagues. Adaptive coping mechanisms allow individuals to successfully achieve the goals they want, whereas maladaptive strategies do not (Mikolajczak, Petrides and Hurry, 2009).

Osofsky, Putnam, and Lederman (2008) described coping with a potential crisis as either changing the stressful situation or managing the stress by direct action or avoidance. Coping also depends on past experiences, personality, relationship with others and the environment. Personal difficulties that mental health professionals may experience when exposed to clients' traumatic stories, may make them ineffective in managing the secondary stress (Vrklevski and Franklin, 2008).

The mental health service culture can be improved by encouraging open channels of communication, a caring philosophy and adaptive coping strategies for the mental health workers.

Organizational culture consists of the shared beliefs and values within an organization and this has a great influence on the success of the organization (Kodjo, 2009). The finding of phase 1 of the present study has illustrated the lack of collaboration and cohesiveness amongst mental health workers in the mental health service in Rwanda. Members of staff appear to be very individualized, following their own ideas and beliefs and giving little attention to their colleagues. The mental health service in Rwanda is an environment of great pressure and complexity and Kodjo (2009) has suggested that collaboration between the mental health professionals will improve their effectiveness. This author suggests ways to build a culture within an organization and that one needs to start from where the group is currently and then build forward. Open discussion should be established, shared values and mission of the group identified; strategies determined and then planned action taken. Identifying values and beliefs can form the foundation of the mental health workers' direction, aims and objectives (Kodjo, 2009)

Initiation of effective resolution of secondary traumatic stress symptoms requires specific recognition and acceptance of the symptoms and their causes by the mental health workers, along with a decision to address and resolve these symptoms (Wietse, Komproe, Jordans, Thapa, Sharma & De Jong, 2009). Many mental health workers who experience symptoms of secondary traumatic stress will attempt to ignore their distress until a threshold of discomfort is reached. For many, this may mean that they are unable to perform their jobs as well as they once did, or as well as they would like, due to the symptoms they are experiencing. For others, it may entail the progressive debilitation associated with somatic symptoms or the embarrassment and pain associated with secretive self-destructive comfort-seeking behaviours (Wietse et al., 2009).

Wong (2008) suggested that successful amelioration of secondary traumatic stress symptoms requires that mental health workers intentionally acknowledge and address, rather than avoid, these symptoms and their causes. Additionally, the use of goal-setting and the development of a personal/professional mission statement have been found to be invaluable in moving away from the reactivity associated with the victimization of secondary traumatic stress and toward the resiliency and intentionality of mature care giving (Adshead, 2005).

### **Concept One: Relaxation techniques**

Relaxation techniques help to develop a sense of comfort and assist in the development of imagined future wellness. These techniques will be used to help mental health workers to develop a sense of comfort, whereby they will explore their future professional selves. During relaxation exercises mental health workers will visit their future selves to see what wisdom they can gain. After they have experienced a sense of calmness, the facilitator will ask them to imagine their future selves' workplace, which will be followed by a wind down phase whereby the mental health workers will be guided back to the present. Two kinds of relaxation techniques can be used to reduce secondary traumatic stress, which are deep breathing and progressive muscle relaxation.

**Deep breathing:** Deep breathing is one of the easiest stress management techniques to learn and the best thing about it is that it can be done anywhere! When a person becomes stressed, one of the body's automatic reactions is shallow, rapid breathing, which can increase his/her stress response. Taking deep, slow breaths is an antidote to stress and is one way people can 'turnoff'

their stress reaction and ‘turn-on’ their relaxation response. Deep breathing is the foundation of many other relaxation exercises.

In order to do effective deep breathing, it is necessary to get into a comfortable position, either sitting or lying down. Put one hand on the stomach, just below the rib cage and then slowly breathe in through the nose feeling the stomach rising and expanding outward. Exhale slowly through the mouth, emptying the lungs completely and letting the stomach fall. This should be repeated several times until the person feels relaxed.

**Progressive Muscle Relaxation:** Human muscles respond to perceived threats with tension, which is one of the most common symptoms of secondary traumatic stress experienced by mental health workers on a daily basis. Too much tension can cause stiffness and may result in headaches, stiff necks and backaches. One way to relieve this tension is through Progressive Muscle Relaxation (PMR) which involves tensing, then relaxing the body muscles from head to toe. Since PMR can increase blood pressure, people with hypertension should not use this technique.

### **Concept two: Physical exercises**

Physical exercises serve to increase the mental health workers’ awareness of the impact of STS on the body and to identify resources for self-care and connection to self. Physical exercise is one of the most effective ways of relieving stress, either on ones’ own or as a part of a stress management plan. Getting into better shape improves mental health as well as physical health (Myers & Wee, 2005).

Physical exercise not only promotes overall fitness, but helps to manage emotional stress and tension as well. Being fit and healthy also increases the ability to deal with stress as it arises. Exercise can help with stress relief because it provides a way for the body to release tension and pent-up frustration.

Aerobic exercise is sustained activity, such as swimming, running, or brisk walking, involving the major muscle groups. It increases the heart and respiratory rate, and thus more oxygen is circulated through the body. This kind of exercise also strengthens the cardiovascular system and increases overall strength and endurance. It improves muscle strength and flexibility and can be a good outlet for negative feelings. Physical activities can be either high or low impact, depending on the suitability for different ages and levels of condition or general health. It is recommended to find a group of people to exercise with. Participating in a group exercise programme increases the likelihood of enjoying and continuing the activity. Stress relief activities can be done for duration of 15 minutes to one hour, 2 to 3 times a week, depending on activity and physical abilities.

### **Concept three: Meditation techniques**

Meditation has been practiced to enhance psychological and spiritual well being and to promote the qualities of compassion, equanimity and awareness. The inclusion of meditation techniques into the self-care practices of mental health professionals may help reduce secondary traumatic stress while enhancing their self-awareness and connection (Eifert, McKay & Forsyth, 2006).

Fulton (2005) hypothesized that meditation cultivates several characteristics that are beneficial to therapeutic relationships and proposed that the practice of meditation may be an untapped

mechanism for training therapists. According to this author, the benefits of meditation can extend to both the development and well-being of mental health workers of any theoretical orientation. Meditation allows individuals to become more open to their suffering, and through this openness they surrender the need to escape and reject the subjective feeling of distress (Fulton, 2005). Meditation allows for the development of self-control where mental health workers can come to value all experience in non-judgmental ways. Negative affective experiences are not avoided, but accepted and viewed with a stance of inquiry and acceptance. This non-judgmental and open stance is similar to self-kindness and self-compassion (Neff, Kirkpatrick, & Rude, 2007). A number of studies have documented the beneficial effects of meditation on stress (Chambers, Chuen Yee Lo, & Allen, 2008). Given the positive outcomes documented in these studies, one could hypothesize that meditation could be instrumental as a mechanism for re-calibrating the body and the mind (Kelly, 2008). The literature consistently identifies two broad forms of meditation, which are concentrative meditation and insight meditation.

**Concentrative Meditation:** Concentration meditation typically involves focusing attention on an internal object or an external object (Kristeller & Johnson, 2005). In concentrative meditation, individuals contract their field of awareness so that everything is reduced to one element that requires little thought (Kelly, 2008). The development and enhancement of concentration is necessary for any form of meditation and this concentration is typically taught by encouraging individuals to focus on the physical process of breathing. Each time that attention wanders to past memories, future plans or anxieties, the individual gently, but firmly returns his or her attention to the breath. Eifert, McKay and Forsyth (2006) explained that the breath is traditionally used as the primary focus for meditation because it is always present, ever

changing and is the link between the body and the mind. Although individuals are paying attention to the breath, in actuality they are developing the skill in paying attention to each present moment, and this skill can be applied to other aspects their lives. Concentrative meditation is found to produce sensations of enhanced peacefulness, calm and mental serenity.

**Insight meditation:** Insight meditation is a practice of cultivating awareness by giving careful attention to everyday life. The discipline of insight meditation fosters the development of clarity and non-judgmental mindfulness, which many find to be highly effective in promoting serenity, relaxation and equanimity. According to Kristeller and Johnson (2005), insight meditation can also lead to greater wisdom and compassion and ultimately to the end of suffering. The techniques of insight meditation are simple to learn, yet require practice and discipline to master.

These techniques do not offer new experiences, but new ways of relating to experiences. As the individual's concentration develops, he or she develops insight which emerges through observing the constant stream of thoughts, emotions and sensations that comprise the totality of one's experience. Ideally, the practitioner observes all thought, emotion and sensation without judgment or preference. Shapiro, Oman, Thoresen, Plante, and Flinders (2008) indicated that insight meditation involves broadening the perceptual field to a more comprehensive view or understanding of the meditator's world view.

From this perspective, the individual, when meditating, expands his or her field of awareness so that all thoughts, feelings and sensory experiences are viewed with an attitude of acceptance and equanimity. This constitutes the core of insight meditation and results in a clearer perception of what makes up the practitioner's conscious experience. Insight meditation can be practiced in a

number of ways (Eifert, McKay & Forsyth, 2006). One can practice meditation while sitting, walking, standing, or moving in more complex ways, as in yoga. The most basic practice involves sitting and using breathing as the focus of the meditation (Kelly, 2008).

Basic insight meditation is easy to practice. It has been demonstrated simply as “sitting on the ground, assuming a good posture, and developing a sense of one’s posture or one’s place on the ground (Chambers, Chuen Yee Lo, & Allen, 2008). Correct posture is important because it allows for a free flow of breath, and because it helps provide a sense of being in place (Kelly, 2008). Breathing is used as the object of meditation; in other words, individuals focus their minds on the physical process of their own breathing. Concentration on the breath is used for developing an attentiveness of the current moment. As Kristeller and Johnson (2005) described the exercise of meditation, each breath is separate from the next and is fully seen and fully felt, not in a visualized form, nor simply as an aid to concentration, but it should be fully and properly dealt with. Just as a hungry man, when he is eating, is not even conscious that he is eating food. He is so engrossed in the food that he completely identifies himself with what he is doing and almost becomes one with the taste and enjoyment of it. Similarly with the breathing, the whole idea is to try and see through that very moment in time (Kelly, 2008)

Insight meditation is a means of cultivating an awareness of what exists in the present moment, without objective, ambition or judgment (Kristeller & Johnson, 2005). Practicing insight meditation allows the development of an innate ability to recognize thoughts and emotions as they arise (Shapiro, Oman, Thoresen, Plante, & Flinders, 2008). Conscious and deliberate choices can then be made in light of the thoughts and emotions that are being experienced at that moment.

#### **Concept four: guided visualization**

Guided visualization is a form of guided meditations, in that one person guides another through a journey of the mind. The purpose of guided visualization is to practice relaxation skills, improve inner attunement and focus, and increase awareness of inner resources as well as intentionality. An effective visualization consists of a well worded affirmation combined with a clear image of what the person wants. The visualization can be either taped, or if the person has a willing partner, read slowly to him or her. The tone of voice of the person speaking is very important. It should have a soothing quality (Crampton, 2005).

Guided visualization is one tool among many that can be used in the process of opening a cognitive communication between the conscious and subconscious minds. Guided visualization recalls familiar scenes and events and when the person is asked about related scenes and events, not consciously apparent to the person, that information has to come from deep in the subconscious mind. All five senses can be used to 'perceive' things consciously familiar and then recall information from the subconscious mind to fill in the blanks.

Guided visualization, also called guided imagery, is a variation of traditional meditation that can help to mitigate stress. When used as a relaxation technique, guided imagery involves imagining a scene in which the person feels at peace, free to let go of all tension and anxiety. Mental health workers could do this visualization exercise on their own, with a facilitator's help or using an audio recording and could picture whatever setting is most calming to them, whether it be a tropical beach, a favourite childhood spot or a quiet wooded glen.

The following example is part of a guided visualization session done during the research process as a demonstration to mental health workers:

*'Close your eyes and let your worries drift away. Imagine your restful place. Picture it as vividly as you can—everything you can see, hear, smell, and feel. See the sun setting over the water; hear the birds singing; Smell the pine trees; feel the cool water on your bare feet; taste the fresh, clean air'*

Guided visualization or guided imagery works best if it incorporates as many sensory details as possible. Its techniques have been helpful in treating general or specific anxiety, headaches, muscle tension and spasms, reducing or eliminating pain, and in the recovery from illnesses and injuries. Visualization and imagery techniques have also been used by athletes to help them achieve peak performance.

The basic premise behind visualization and imagery is that one's thoughts become reality. For example, if one thinks anxious thoughts, one will become tense. The principles behind visualization and imagery maintain that a person can use his or her imagination to be persuaded to feel a certain way or do anything that is physically possible to do. There are three basic types of visualization: programmed, receptive and guided visualization.

In programmed visualization, the person creates a vivid image which includes sight, taste, sound, and smell. The person then imagines a goal he or she wants to attain or some type of healing that is desired. In the visualization, the goal is achieved, or the healing occurs.

The idea underlying both receptive visualization and guided visualization is that the person is seeking an answer to a life question or resolution to an issue, and the answer or resolution is within the person, but is buried or inaccessible to him or her because of fear, doubt or anxiety. These techniques are similar to dream interpretation and free association techniques used in psychodynamic therapy. For example, a person wonders whether he/she should remain in his current position. A proponent of these techniques would maintain that "deep down," below the level of conscious thought or subconsciously, the person knows what he/she really wants to do, but is not allowing him/herself to listen to his desires or to act, as he is blocking the message his subconsciousness is sending him (Crampton, 2005).

The goal of these techniques is to facilitate relaxation and focus enough to receive the message of what needs to be done. In receptive visualization, the person creates a peaceful scene in his or her mind and then asks a question and waits for the answer. For example, the person might imagine being on a beach and asks the question, "Should I leave my job?" While continuing to relax and remain in the scene, he may "hear" an answer blowing in the breeze or "see" a boat sailing away, which may be symbolic of his wish to leave his job.

In guided visualization, the person creates a very vivid image, as in programmed visualization, but omits some important elements. The person then waits for the subconscious to supply the missing pieces. For example, a female computer programmer may wonder if she should stay in her present job or return to school for an advanced degree. By engaging in guided visualization, she may visualize her cubicle at work, the pictures on her desk, the feel of her desk chair, the sounds of people outside her cubicle typing and talking, but she will omit an element from the scene, such as her computer. She will then wait to see what her subconscious uses to replace her

computer. She may find in her visualization that her computer has been replaced by books, which represent her sub conscious desire to return to school.

Visualization and imagery exercises work best when a person is relaxed and are typically practiced two to three times a day for 10 to 20 minutes at a time. How quickly a person will see results can vary, but in many cases people report immediate symptom relief. However, the goals a person sets for him or herself, the power of a person's imagination and the willingness to practice can all influence how rapidly benefits can be obtained. It is recommended to tape record the sessions and replay detailed descriptions of what the mental health worker want to visualize or imagine.

Mental health workers who engage in the positive thinking processes that are associated with visualization and imagery can create a clearer image of what they want to accomplish. By repeating the images again and again, they come to believe that what they want will occur. As a result, they often begin to act in a way more consistent with accomplishing the goal.

### **Concept five: Feeling exercises**

One of the most important things for mental health workers dealing with secondary trauma is that they need to stay at a cognitive level and not let their feelings and memories of their personal trauma history overwhelm them. If they allow those feelings to overwhelm them, it becomes difficult for them to stay focused on patients' care. This is particularly important in Rwanda where most of mental health workers experienced the genocide and its aftermath. In order to stay at a cognitive level they should be encouraged to think about feelings rather than allow themselves to focus on their emotions.

The aim of feeling exercises is to invite mental health workers to notice and address feelings related to STS. These exercises are intended to elicit feelings and to make sense of them, and also to promote the integration of conflicting or distressing emotions. They are aimed at improving affect tolerance and helping mental health workers to examine their relationships with their own feelings by allowing them to see the benefits, as well as hardships, of experiencing certain feelings. The facilitator invites the mental health worker to notice and address feelings related to STS in order to bring forth feelings which will be integrated with healing imagery. During this exercise, mental health workers should work in pairs. Each mental health worker will be asked to “sculpt” their partner into a representative image of themselves. This exercise is useful for improving affect-tolerance and will help the mental health workers to examine their relationship to their own feelings and allow them to see the benefits as well as hardships of certain feelings.

#### **4.4.10 Providing STS risk assessment interventions**

Being in the mental health profession requires careful moment-to-moment self-monitoring. Symptoms of secondary traumatic stress can be the same as those experienced by the direct victims of trauma including increased fatigue or illness, social withdrawal, reduced productivity, feelings of hopelessness, despair, nightmares, feelings of re-experiencing of the event, having unwanted thoughts or images of traumatic events anxiety, excess vigilance, avoidance of people or activities, or persistent anger and sadness (Stoesen, 2007). The effects of secondary traumatic stress may also include changes in how individuals experiences themselves and others, such as changes in feelings of safety, increased cynicism, and disconnection from co-workers and/or loved ones (Rothschild, 2006).

In the workplace, STS has been associated with higher rates of physical illness, greater absenteeism, higher turnover, lower morale and lower productivity. Mental health workers may also experience difficulties in their personal or professional relationships, in managing boundaries and in dealing with their emotions. They may have difficulty in sleeping, overeat or turn to alcohol, become anxious about their own children and irritable towards their colleagues and family members.

#### **4.4.10.1 Process one: individual STS risk assessment**

Secondary traumatic stress affects mental health workers in different ways. The experience of STS can cause unusual and dysfunctional behaviour and contribute to poor physical and mental health. In extreme cases, STS may lead to psychological problems and be conducive to psychiatric disorders which might result in absence from work or preventing the mental health worker from being able to work again. When experiencing secondary traumatic stress, mental health workers may find it difficult to maintain a healthy balance between work and non-work life. They may also engage in unhealthy activities, such as smoking, drinking and drug abuse. Secondary traumatic stress may affect their immune systems, impairing their ability to fight infections. Understanding and accepting one's vulnerability to STS requires the practitioner to undertake a self-assessment.

Mental health workers bring a variety of ego resources, self-capacities and personal characteristics to their work which may include both strengths and vulnerabilities. Many people are drawn to this work because of their own life experiences, and those experiences may include a personal trauma history. It is important for them to understand how a personal trauma history

increases one's vulnerability to STS. Undertaking a self-assessment involves examining the way in which personal factors influence coping skills. There are three major categories of individual assessment for secondary trauma risk, namely; physical assessment, emotional assessment and behavioural assessment.

### **Concept One: Physical assessment**

The combination and interaction of the effects of traumatic stress on mental health workers can increase the risk of suffering from various negative physical health problems, such as cardiovascular disease, gastrointestinal problems, increased risk for cancer and immune system problems (Fisher & Anderson, 2002).

Aches and pains, raised blood pressure, heart disease, increased sweating, dizziness, blurred vision, skin problems, sleep disorders, exhaustion, nausea, appetite disturbance, weakened immune system with lowered resistance to minor illnesses are common physical symptoms associated with secondary traumatic stress. Those symptoms must be checked on regular basis when working in the mental health profession.

### **Concept two: Emotional assessment**

Mental health workers who experience secondary traumatic stress may also experience emotional symptoms such as depression, fear, anxiety, anger, sadness and horror, as well as cognitive symptoms such as dissociation, poor concentration and amnesia. If these feelings are not assessed, openly acknowledged and resolved, the mental health worker risks feeling numb or emotionally distant and, thus, become unable to maintain a warm, empathetic and responsive

stance with clients (Baird and Kracken, 2006). Those at risk of secondary traumatic stress, such as mental health workers, should have the following symptoms assessed: persistent or recurring moods, anger, irritability, frustration, detachment or withdrawal from others, worry or anxiety, depression, guilt or sadness. Those affected by secondary traumatic stress may have difficulty thinking logically and making decisions, and enjoy their work less and feel less committed to it

### **Concept three: Behavioral assessment**

Secondary traumatic stress can also affect the behaviour of mental health workers and it is recommended to review the presence of any of the following symptoms: difficulty concentrating, memory loss, an inability to “switch off”, poor judgment, loss of creativity, making more mistakes, checking things repeatedly, loss of interest in sex and an increased use/dependence on caffeine, alcohol or drugs.

#### **4.4.10.2 Process Two: organizational STS risk assessment**

Mental health institutions need to be aware that staff might be experiencing secondary traumatic stress and missing work due to work-related stress. Mental health workers should foster meaningful relationships in their personal lives and find a sense of meaning in life through their work. They should enjoy their work and like the clients whom they assist. The effects of secondary traumatic stress on the mental health services have been reported by several writers. If the large number of mental health workers is affected by secondary traumatic stress, this may challenge the health and the safety of the mental health workers and the healthiness of the mental health services. Managers should have a clear policy for the management of work related stress.

They could use an internal survey to keep regular stress records or use an external and credible survey provider to assess the risk of secondary trauma in their employees and organization.

There are four steps in assessing the level of secondary traumatic stress within the mental health service. Those are: evaluation of the level of work related stress; identifying work related stressors, including the main work related stressors affecting the staff now or in the recent past; evaluating the risk by identifying the most significant sources of stress for staff and describing these sources in detail; and the interventions to manage or to prevent the work related stress. When assessing the risk of secondary traumatic stress in mental health services, three major categories of symptoms should be taken into account, which are work performance assessment, interpersonal relationship assessment and staff attitude and behaviours.

### **Concept one: Work performance assessment**

Cunningham (2003) is of opinion that although traumatized individuals need to heal within an empathetic relationship, the mental health workers providing this therapeutic environment are at risk of developing secondary traumatic stress. Mental health workers who experience secondary traumatic stress are unable to maintain and sustain a therapeutic relationship with clients who are traumatized. Trippany et al (2004) maintain that mental health workers who do not adequately deal with their secondary trauma are likely to experience therapeutic impasses and prematurely terminate their clients' counselling. According to Trippany et al (2004) disruptions in cognitive schemas lead mental health workers to compromise therapeutic boundaries. They may resort to victim blaming when clients are perceived as threatening and manipulative. Some mental health

workers may lose objectivity because they found their clients' narratives so overwhelming and are, thus, unable to sustain a therapeutic relationship.

### **Concept two: Interpersonal relationships assessment**

Mental health workers and others working in the health care field are subject to secondary traumatic stress which places them at an increased risk of suffering from serious negative stress effects in the areas of interpersonal well-being. Interpersonal effects such as poor communication, boundary difficulties, withdrawal, aggression, mistrust, and defensiveness cause breakdowns in personal and workplace relationships (Fisher & Anderson, 2002). Relationships with colleagues can also be important hazards. Factors such as poor relationships with clients and conflicts between colleagues have been found to contribute to physical and mental ill health and absence among health care workers.

### **Concept three: Staff attitude and behaviour assessment.**

The following serve as examples of the various attitudes and behaviours commonly associated with secondary traumatic stress at the workplace which adversely affect mental health recruitment: poor timekeeping; loss of motivation or commitment; long working hours, but with decreasing effectiveness; increasing absenteeism; decreasing commitment to work; increasing staff turnover; impaired performance and productivity; increasing unsafe working practices and accidents rates; and increasing complaints from clients and customers.

#### **4.4.11 Providing curative care and STS management**

Providing curative care and secondary traumatic stress management is part of tertiary prevention of STS. When all efforts towards preventing STS and controlling anticipated risks have failed, managers within the mental health service need to act rapidly and correctly to deal with those who are being hurt by the experience of secondary traumatic stress. They will have to determine the problem and manage it appropriately. In caring for the mental health workers experiencing secondary traumatic stress two major interventions must be provided simultaneously. Those interventions are individual self-care/self management and therapeutic management.

##### **4.4.11.1 Process One: Improving self-care/ self-management.**

Self-care has often been a neglected topic in mental health care. However, the mental health profession has begun to recognize that self-care creates a balance in life that promotes good physical and mental health and leads to an enhanced quality of life (Shapiro, Brown and Biegel, 2007). Mental health workers have often been identified as being helpers to others who do not always take care of themselves to the extent they care for others. The self-care literature details a number of approaches and activities that can be of benefit to them (Williams-Nickelson, 2004). Shapiro, Brown and Biegel (2007) described the practice of self-care as involving both self-awareness and self-regulation in the service of balancing many factors including psychological, physical and spiritual needs; connection between self and others; and one's personal and professional lives.

Self care and self management illustrate the ability to refill and refuel oneself in healthy ways. It is quite common for mental health workers to find themselves anxious while working with

traumatized clients and, therefore, they should constantly perform activities of self-care or self management. Self care aims to ensure that both mental and physical health is in good shape. Mental health workers have a clear responsibility of providing quality care to the clients, but if they are not mentally and physically healthy, their ability to provide support to clients is limited. The single purpose of self care or self management for mental health workers is, therefore, ensuring that the daily work stress does not result in secondary traumatic stress (Rothschild, 2006).

Instead of developing a system of healthy practices for resolving their stress, many mental health workers find themselves redoubling their work efforts. Frequently this contracting cycle of working harder in an attempt to feel better creates a distorted sense of entitlement that can lead to a violation of personal and professional boundaries (Öst, 2008).

One of the most important aspects of this category of self-care of mental health workers has been the development and maintenance of a regular exercise regimen. In addition to physical exercise, good nutrition, artistic expression/discipline, meditation, outdoor recreation and spirituality all seem to be important ingredients of a good self-care plan (Adshead, 2005). Every mental health worker's self-care needs are different. Some will need to remain vigilant in the monitoring and execution of their self-care plan, while others will, seemingly, be able to maintain resiliency with minimal effort. However, it is strongly advised that mental health workers working with trauma survivors develop a comprehensive self-care plan that addresses and meets their individual needs. With this self-care plan in place, the mental health worker can practice with the assurance that they are maximizing resiliency toward prevention of the symptoms of secondary traumatic stress (Adshead, 2005). It should be noted that those mental health workers responding to a crisis

situation, such as those caused by the events of 1994 genocide against the Tutsi in Rwanda, may be limited in their ability to employ habitual self-care activities. While most trauma mental health workers are a hardy and resilient breed, they simply cannot sustain the rigors of this depleting and intensive work without intentional concern for their own health and welfare.

For self management of secondary traumatic stress, mental health workers need to learn how to nurture themselves. It is important to become their own best friends instead of their own worst enemies. Just as they teach their clients to care and help themselves, mental health workers also need to practice what they teach. They need to conduct a STS assessment and look at their physical, mental, emotional, social and spiritual situation. They should be able to make a treatment plan for themselves and carry it out. They must also perform the plan and then evaluate it. If it is not working, they should modify the plan and do it again. Self care activities for STS will be focused essentially on physical, psychological, emotional, spiritual and professional interventions.

### **Concept one: Physical Self-Care**

Physical fitness is considered as a general state of good physical health. Physical fitness concerns include attention to diet, exercise and preventive medical care. Major factors that have been shown to prevent the debilitating effects of disease are good nutrition and basic physical fitness (Berrigan, Dodd, Troiano, Krebs-Smith, & Barbash, 2003). Obesity and a sedentary life style, in particular, have been shown to increase the risk for a variety of problematic disorders, including cancer, respiratory diseases, gall bladder dysfunctions, diabetes and cardiovascular disease (Berrigan, et al., 2003). Regular exercise, a healthy diet, and regular medical checkups and health

maintenance enhance energy, combat depression and anxiety and provide a foundation for other positive health practices.

Several activities such as sleep, rest, exercise, good nutrition, , massages, hot tubs and sex are frequently mentioned as contributing to physical wellbeing. While each of these is important to physical self-care, exercise is crucial. According to Chamberlain and Miller (2009), stress, especially secondary traumatic stress, takes a toll on the body. Physical exercise protects the human body from physical diseases, mental disorders and a myriad other health risks. Research has shown that depressed individuals who exercised for thirty minutes, three times a week resolved their depression in a few months, without antidepressants (Craft, 2005). Additional benefits of exercise include improved sleep, less anxiety, and improved sexual performance and sexual pleasure (Vazquez, Jordan, Kuper, Hernandez, Galmarini, and Ferraro, 2010).

Mental health professionals should find innovative ways to exercise at work, such as taking the stairs or a brisk thirty-minute walk at lunch. They can also make a habit of parking their cars at a distance from their office buildings to increase the distance they walk. The mental health service should help the staff by allowing them to use a large room for a thirty-minute aerobics session at the end of the workday. It is recommended that mental health workers join health clubs and make exercise appointments on their calendars to ensure that they go. Doing exercise in a group helps them to sustain the practice (Vazquez, et al., 2010).

### **Concept two: Psychological and Emotional Self-Care**

This is a state of emotional and psychological well-being in which individuals are able to use their cognitive and emotional capabilities, function in society and meet the ordinary demands of

everyday life (Kearney, Weininger & Vachon, 2009). A person with good psychological and emotional health has the ability to express all emotions appropriately, and to maintain a balance of emotions so that negative emotions such as depression, stress, anxiety, fear and anger are not dominant. Emotional self-care also involves self-reflection and has intrapersonal and interpersonal aspects as well. Each mental health professional can assess how the work is affecting them emotionally. Periodically taking the STS risk assessment is one way to monitor the ways in which they may be affected. In the times that are most difficult, mental health professionals benefit from having someone to talk with, whether that is a colleague or supervisor. It may also be necessary to seek professional counselling when intrusive thoughts, rumination and an inability to leave the work at the workplace become the rule rather than the exception. Mental health workers can support each other in seeking help when they recognize intrusive thoughts and rumination in each other.

Interpersonal aspects of emotional self-care involve being intimately connected to significant others and friends (Leary, Tate, Allen, Adams & Hancock, 2007). This involves having an emotional life outside of work and not allowing work to intrude into personal time. Staying present with family and friends and being close to others is pertinent to maintaining a balanced worldview, as are having hobbies and engaging in activities that bring renewal of spirit and soul. Emotional self-care is an equally important aspect of healthy functioning. Research has established clear links between the ability to recognize and express emotions and positive health (Geller, Norcross and Orlinsky, 2005). If mental health workers do not recognize and address the impact of their emotions and deny them instead, this may result in anxiety, depression and negative physical consequences (Cohen, Doyle, Turner, Alper, & Skoner, 2003). In addition to

issues in their personal lives, some of these emotional stressors may result from the pressures of psychological practice in a variety of work settings from clinics to hospitals to private practice to universities, etc. (Baker, 2003). Dealing with the emotional problems of others may create emotional stress in the psychologist. Long-term or acute experience of client/patient trauma may vicariously traumatize the mental health worker (Pearlman and McKay, 2008). Mental health workers can benefit from developing appropriate networks or venues to process their emotional reactions to their work. These may include peer consultation groups, personal psychotherapy, and informal sharing with friends and colleagues. Other suggested outlets include physical activity, recreation and creative outlets such as playing music, artwork or cooking.

According to Huggard (2003), psychological strategies to limit secondary trauma in mental health workers can be summarised as follows:

- Identifying and making sense of disrupted schemas
- Striking an appropriate work-life balance
- Undertaking personal psychotherapy
- Identifying healing activities
- Attending to spiritual needs

### **Concept three: Spiritual Self-Care**

Spiritual self-care can be an additional aspect of emotional health. Spirituality may be connected to religion or it may manifest itself through connections to nature or other beliefs in human purpose (Satkunanayagam, Tunariu and Tribe, 2010). Spiritual self-care can be described as developing a personal understanding about the purpose of life and its meaning. Research has

demonstrated that a healthy spiritual life is associated with greater self-esteem, personal happiness and life satisfaction, and less depression (Geller, Norcross & Orlinsky, 2005). Spiritual self-care activities may include meditation, participation in a religious group, joining a spiritual community, visiting places of great natural beauty or attending a cultural or artistic performance. While a personal choice, involvement with a group may provide not only spiritual care but also support in community and comfort in meaningful rituals. For someone with a background that includes an emphasis on religion and communality, involvement in a religious organization may also contain a strong and positive tie to family.

Research suggests that spiritual coping strategies, involving relationships with self, others, God or nature, were found to help individuals to cope with their stress. This may be because of finding meaning, purpose and hope, which may nurture individuals in their suffering. Spirituality is often referred by literature as being synonymous with religiosity. Thus, the use of spiritual coping strategies is restricted to individuals who hold religious beliefs. However, the definition of spirituality indicates that this concept is broader than religiosity (Rusinova & Cash, 2007).

Interestingly, spiritual beliefs play an integral part in the life experiences of most mental health workers in Rwanda. According to Rakoczy (2009), spirituality is often described as reinforcing that each therapist's work has meaning.

If the word "spirituality" doesn't fit in the organization, McSherry (2006) highly recommends that mental health services allow their staff a personal cathartic releasing of traumatic material and help therapists to improve their capacity to integrate the traumatic material into their lives. The key is for managers to be flexible enough to allow mental health workers catharsis as

needed, not being so focused on efficiency that leaders forget what is good and sacrifice it for what they perceive as right.

Maintaining a spiritual life is another essential practice for mental health workers to cope professionally with secondary traumatic stress. As Miller and Kelley (2006) pointed out, a person's spiritual nature produces qualities such as compassion, forgiveness, love, faith, hope, trust, generosity and kindness. These characteristics are affected by evil, which produces suffering and leads to the stifling or destruction of some aspect of the spirit. According to Lee & Waters (2003), spirituality has also been shown to lower traumatic stress. These researchers found that spirituality was strongly correlated with a decline in trauma symptoms. They found that as spirituality increased, trauma symptoms decreased. Lee and Waters (2003) concluded that spirituality is a protective buffer for cumulative traumatic experiences. Maintaining a spiritual life helps practitioners keep their worldview balanced and their belief system intact in a world of good and evil and helps them remember that there are happy, stable, healthy people and professionals who are cared for and who care for each other.

#### **Concept four: Professional Self-Care**

Although professional self-care has not been fully examined or addressed within the mental health profession in the Rwandan context, it is an essential foundation of the mental health profession. The need for professional self-care has significance to all mental health workers within the service in which they practice. Two things are crucial for professional self care of mental health workers in order to deal with secondary traumatic stress when working with traumatized clients. Those are professional development and activism. Professional development

consists of two focused activities (Wicks, 2006). The first activity is getting quality feedback on individual performance, reflecting on it, and gauging individual practice and professional growth. The second is a process of continual education. For example, a person can pursue formal education, attend seminars, collaborate with colleagues and/or create a personalized professional development plan. Activism involves mental health workers getting involved in some aspect of mental health care that is not their normal work, thus giving them an opportunity to proactively address the challenges of work from a different perspective (Wicks, 2006).

Activism may involve collaborating with colleagues to organize a self-help group to address STS in the workplace. It may involve volunteering with one of the community programmes that assist children from a different perspective. As Rothschild, (2006) pointed out, social action can take many forms, from concrete engagement with particular individuals to abstract intellectual pursuits. For mental health workers to cope professionally with secondary traumatic stress, firstly and foremost, STS must be acknowledged as an occupational hazard in mental health work that can result in an occupational stress injury. Secondly, certain activities can help the practitioner maintain a balanced worldview (Bride, Radey & Figley, 2007).

The most helpful activity for professional self care is to start the day with a list of work to be achieved, prioritize it, and then try to organize it so that emotionally draining tasks are not piled together. Another useful activity which helps mental health workers to cope with secondary trauma is communication. This is especially pertinent when asked to take on a non-essential task. If mental health workers answer, "Let me think about that" it gives them time to evaluate whether or not this additional task needs to be taken on at all.

Colleagues are also an important part of professional self-care (Rothschild, 2006). They understand the work, and they are essential to professional social support. Mental health workers can talk to each other about their clients (within reasonable bounds of confidentiality) and how they are affected by the work and what they are doing about it. It would be helpful for managers to validate the experiences of novice workers, especially around their natural apprehension and anxiety. Expertise and practice wisdom should be shared (Wicks, 2006). Cohesion among colleagues can help in the worst of times and can buffer the sometimes grinding ambiguity of the work. Colleagues can help each other to recognize their successes with clients and to appreciate what they have done. Colleagues can help each other to maximize the use of problem-solving coping by thinking the problem through and acting on the conclusion rather than the use of avoidance to cope. Colleagues also understand each others' sense of humour and the need to debrief and talk about the frustrations of the stressful work environment (Morgan, 2004).

In their professional role, mental health workers must maintain clear consistent boundaries that are permeable enough to allow them to be deeply touched by others' reality, without ever losing their own perspective. They should maintain a trusting belief in the general goodness of people, which endures, even though their work involves empathic engagement with clients who have suffered greatly from acts of human cruelty, and who have come to believe that people are generally bad, dangerous or untrustworthy, as is often the case in Rwandan context. They should develop the ability to be consistently trustworthy and patient with their clients, knowing that such attitudes will be helpful to them as they continue in their work. Holding onto belief in their ability to heal and moving forward, helps to understand clients' worldviews and maintains a sense of being connected with them (Kearney, Weininger & Vachon, 2009).

Mental health workers should view their clients as more than the products of the bad things that have happened to them, such as the 1994 genocide, and not believe they are capable of "contaminating" them. In these ways, they maintain clear, consistent boundaries and a loving core.

In addition to their daily tasks in their organization, mental workers should find other activities within the service to allow them to have some variety. They should also seek out opportunities for further training and professional development and get permission to read at work in order to keep up to date in the field.

Given the inherent difficulties in working with traumatized clients, taking care of themselves is absolutely essential to mental health workers. Without self-care, mental health workers, their patients, the service and their families all suffer. Secondary traumatic stress can impair the professional judgment of mental health workers as well as their personal mental health. Rothschild (2006) describes how clinicians may find themselves trapped in a vicious cycle of increasing symptoms, and increasing ineffectiveness with clients, which leads them to plunge themselves further into their work.

The first step in breaking such a cycle is to recognize that there are unique hazards associated with working with traumatized clients and other psychiatric patients. This may necessitate mental health workers to recognize their own vulnerability and acknowledge, perhaps for the first time, their own history of trauma. This history can eventually make them more effective in their work, but it also brings with it an increased vulnerability. Once they recognize their

vulnerability, it is then necessary to take specific steps to counter it. Rothschild (2006) proposes some ideas to help mental health workers in this regard.

According to Rothschild (2006), mental health work is often a solitary activity especially when counselling trauma survivors. Mental health workers need to acknowledge that some patients require the care of more than one practitioner. Having regular supervision and peer support is also important as they work with challenging clients. A team approach also works well in this regard. They should make relationships with family and friends a priority, and nurture these relationships.

Rothschild (2006) also recommends mental health workers to limit their involvement when working with traumatized clients. An important type of self-care is learning not to carry patients' concerns once they leave work. Mental health workers must keep firm boundaries between their work and home life. Another strategy is to limit the number of trauma cases that they see and try to balance out their caseload with less severely affected patients.

According to Huggard (2003) professional self care strategies include the following activities:

- Undertaking regular professional supervision with an experienced senior colleague where patients can be discussed and the clinician's own responses to them examined without embarrassment and fear of censure
- Engaging in appropriate self-care practices
- Developing and maintaining professional networks
- Having a realistic tolerance of failure
- Being aware of work and personal goals

#### **4.4.11.2 Process two: Offering STS therapeutic management**

The literature contains a number of suggestions for reducing the effects of secondary traumatic stress, including: adherence to a therapy contract with clear goals, rules and boundaries, specialized training to raise awareness and recognition of secondary traumatic stress, support which allows mental health workers to address the effects of secondary traumatic stress without fear of judgment, personal therapy and various therapies such as narrative therapy, cognitive and behavioural therapy.(Way et al., 2004).

##### **Concept one: Narrative therapy**

Narrative therapy involves telling and retelling the story of a trauma in order to better understand it, and work through the problems associated with it. Many researchers and writers have identified the creation of a chronological verbal and/or graphic narrative as an important ingredient in the healing of traumatic stress, especially intrusive symptoms (Kaminer, 2006). A time-line narrative of a care giving career that identifies the experiences and the clients from which the mental health worker developed primary and secondary traumatic stress is invaluable in the resolution of secondary traumatic stress symptoms, especially those associated with secondary traumatic stress. The mental health worker must tell the story from the beginning of the first experiences that led him/her toward mental health profession, until the present. A video camera can be used to record this narrative and the mental health worker should watch it later that same day, taking care to identify the experiences that have led to any primary and secondary traumatic stress (intrusive symptoms) by constructing a graphic time-line. Role play can also be

utilized in which two participants each take a one-hour block of time to verbalize their narrative while the other practices non-anxious bearing witness of this narrative.

Narrative practices offer linguistic resources with which to understand problems while co-creating, re-telling and thickening alternative stories. According to Taylor, Durant and Boje (2007), the narrative therapy process includes externalizing conversations, re-remembering, therapeutic letter writing and use of rituals, leagues and reflecting teams. Naming the problem is recognized as an important first step in narrative therapy. This step does not involve diagnostic evaluation, where therapist is required to identify and label the presenting symptom. Rather, in narrative therapy it is important that the name of the problem is an experience near name in that it fits the experience of the person (White, 2008). Narrative therapists therefore pick up on people's own words or names for problems and phrase them in a way that clearly situates the problem outside of the person and the person's identity.

In narrative therapy, naming the problem should involve a co-creative process and the name chosen should allow for the experience to be examined in that the powerful position that it may have assumed in a person's life. It is important to fully appreciate the impact of the dominant problem story on a person's life and to acknowledge the distress or worry it might have caused, so that the person can feel listened to and understood. Often the first step of naming will be combined with the second step of externalizing the problem. Muntigl (2004) summarizes the process of externalizing as a narrative therapy practice that establishes a context where people experience themselves as separate from the problem in their lives. Externalizing practices focus on the relationship between the person and the problems instead of on a problem-person.

Once the problem has been externalized it becomes possible to identify unique outcomes. These are the times and ways in which the person has resisted the influence of the problem. A unique outcome could be anything that does not fit with the dominant problem-saturated story (Payne, 2006). However, it is important that the person perceives an incident as a unique outcome. Unique outcomes are often stored when an invitation is extended to the person to evaluate the effects of problems.

After naming and externalizing the problem, dominant problem narratives can be thickened and richly described through various maps of re-telling in a re-authoring process. Maps of re-telling may be therapeutic documents and letters, remembering conversation, building a wider audience through the use of witnesses, communities of concern and definitions of ceremonies and reflection. Letters and other forms of documentation can be used, both to summarize developments that unfold in conversation, and to engage other people who may contribute to preferred development in the person's life. Narrative therapy stresses the importance of continually consulting people about how the reinterpretation and expressions of their experiences is affecting the shape of their lives, and about what they understand to be the limitations and possibilities associated with the conversations.

### **Concept two: Emotional focused therapeutic approach**

Emotion-focused Therapy (EFT) is an empirically-based approach, based on methods designed to help people accept, express, regulate, make sense of and transform emotion (Johnson & Greenman, 2006). Most fundamentally, emotions tell us what is important to us in a situation and thus act as a guide to what we need or want. This, in turn, helps us to figure out what actions are

appropriate. Emotions are basically adaptive and guide attachment as well as the tendency toward growth. Emotion focused therapy focuses on helping people become aware of and express their emotions, learn to tolerate and regulate them, reflect on them to make sense of them and transform them. Learning about emotions is not enough; instead, what is needed is for mental health workers experiencing STS to acknowledge those emotions as they arise in a safe therapeutic way, where they can discover for themselves the value of greater awareness and more flexible management of emotions. Emotion-focused therapy systematically, but flexibly helps people to become aware of and make productive use of their emotions (Johnson & Greenman, 2006).

The basic philosophical assumption of emotion focused therapy is that to change, people cannot leave a place until they have arrived. Mental health workers, therefore, need to reclaim disowned experience before they can be changed by or change that experience. In this process, it is not that mental health workers discover things they did not know, but rather that they become aware of and experience aspects of themselves they have not consciously felt or may have previously rejected, dismissed or pushed away.

Based on emotion, attachment and growth theory, EFT facilitates people to recognize which of their feelings they can trust and rely on as adaptive guides and which of their feelings are reminders of hurting memories that have become maladaptive to the person's current context and need to be changed. With the assistance of the facilitator's empathic understanding and the use of experiential methods, mental health workers are trained how to make healthy contact with feelings, memories, thoughts and physical sensations that have been ignored, feared or avoided (Pos and Greenberg, 2007). By recognising adaptive emotions such as healthy grief, empowering

anger and compassion, mental health workers will be able to use these as resources to change maladaptive feelings such as fear, sadness of abandonment and shame of inadequacy that have developed from past negative learning or traumatic experiences when working with traumatized clients or psychiatric patients (Johnson and Greenman, 2006).

According to Greenberg (2006), emotion is seen as foundational in the structure of the self and is a key determinant of self-organization. As well as simply having feeling, people also live in a constant process of making sense of their emotions. Personal meaning emerges by the self-organization and explication of one's own emotional experience, and optimal adaptation involves an integration of reason and emotion. In emotional focused therapy, the differences between diverse types of feeling provide mental health workers with a map for differential intervention. Facilitators in emotional focused therapy are viewed as emotion coaches who help mental health workers become conscious of, recognize and make sense of their emotional experience. According to Greenberg (2006), the four major empirically supported principles of emotion awareness; emotion regulation; emotion transformation; and reflection on emotion guide emotion coaching and serve as the goals of treatment.

Emotion focused therapy session is based on two phases, namely, arriving and leaving (Greenberg, 2006). The first phase of arriving involves four steps. These steps are focused on awareness and acceptance of one's emotions. The first step aims to help mental health workers to be aware of their emotions. In the second, mental health workers are coached to welcome their emotional experience and allow it. In this step, they are also coached in skills of regulation if needed to help them tolerate their emotions. In the third step, mental health workers are helped to describe their feelings in words in order to assist them in solving problems. In the fourth step of

the arriving phase, mental health workers are helped to become aware of whether their emotional reactions are their primary feelings in this situation. If not, the facilitator will help them in discovering what their primary feelings are (Greenberg, 2006).

The second phase of emotion focused therapy emphasizes emotion utilization or transformation to promote leaving the place arrived at. This phase involves moving on or transforming core feelings (Greenberg 2006). The second phase also comprise four steps, namely fifth, sixth, seventh and eighth. In the fifth step, the mental health workers and facilitator carry out an evaluation to see if the emotion is a healthy or unhealthy response to the current situation. If it is healthy, it should be used as a guide to action. However if the emotion is unhealthy then it needs to be changed. In the sixth step of the leaving phase, if the primary emotion was found unhealthy, the mental health workers will be helped to identify the negative voice associated with these emotions. In seventh step, the mental health workers are helped to find and rely on alternative healthy emotional responses and needs. Finally, in the eighth step, mental health workers are coached to challenge the destructive thoughts in their unhealthy emotions from a new inner voice based on their healthy primary emotions and needs, and to learn to regulate when necessary(Greenberg 2006).

### **Concept three: Cognitive behavioural therapies**

Cognitive behavioural therapy (CBT) comes from the idea that people are characterized by how they think about the world, and that the way they think and interpret events leads to emotional responses (Hembree et al., 2004). The goal of CBT in the context of secondary traumatic stress is to teach the mental health worker to identify and change irrational or dysfunctional thoughts

about their experience that are causing negative emotions and reactions (Hembree et al., 2004). It is also aimed to help mental health workers to achieve an objective and undistorted appraisal of their role in the secondary traumatic stress experience.

Cognitive therapy, which usually includes behavioural exposure therapy as a part of the treatment, is one of the evidence-based therapies considered most effective for treatment of secondary traumatic stress in mental health workers. Cognitive therapy emphasizes identification and testing of beliefs associated with secondary traumatic stress. Thus, cognitive therapists use exposure methods (both in vivo and in vitro) to identify and test key beliefs rather than simply as a method for desensitization. A cognitive therapist would also include this type of exposure in therapy. However, such exposure exercises would be linked to cognitive therapy by identifying and testing beliefs thought to be maintaining the current secondary traumatic stress

Research suggests that the origins of PTSD lie not simply in the occurrence of trauma, but in the nature of the trauma memory and the cognitive appraisals of the trauma and its sequelae (Ehlers & Clark, 2000). That is, particular cognitive factors are correlated with whether someone recovers naturally from a secondary traumatic stress.

Cognitive behavioural therapy has three phases, namely; assessment, debriefing or imaginary exposure exercises, and formal cognitive therapy, which involves separate procedures for correcting thinking errors that lead to faulty conclusions associated with secondary traumatic stress (Öst, 2008). The thinking errors are addressed in the context of four separate, semi-structured procedures for teaching mental health workers to distinguish what they knew then from what they know now, and for reappraising perceptions of justification, responsibility and

wrongdoing (in light of beliefs held and knowledge possessed when the secondary traumatic stress occurred). Space limitations here preclude an elaboration of the phases and procedures of cognitive therapy (Öst, 2008). Mental health workers interested in implementing Cognitive Therapy are encouraged to examine these other sources.

#### **Concept four: Group therapy**

Group therapy is a form of psychotherapy in which one or more therapists treat several clients together as a group (Kanas, 2006). The term can legitimately refer to any form of psychotherapy when delivered in a group format, but it is usually applied to psychodynamic group therapy where the group context and group process is explicitly utilized as a mechanism of change by developing, exploring and examining interpersonal relationships within the group. The broader concept of group therapy can be taken to include any helping process that takes place in a group, including support groups, skills training groups and psycho-education groups (Nasim, 2007). The differences between psychodynamic groups, activity groups, support groups, problem-solving groups and psycho-educational groups are discussed by (Kanas, 2006). Other, more specialized forms of group therapy would include non-verbal expressive therapies such as dance therapy or music therapy.

Group psychotherapy, like individual psychotherapy in the context of secondary traumatic stress, is intended to help people such as mental health workers who would like to improve their ability to cope with difficulties and problems in their lives. But, while in individual therapy the person meets with only one person (the therapist), in group therapy the meeting is with a whole group

and one or two therapists. Group therapy focuses on interpersonal interactions, so relationship problems are addressed well in groups.

The aim of group psychotherapy in the context of secondary traumatic stress is to help mental health workers with solving the emotional difficulties and to encourage their personal development in the group. The facilitator chooses people who can benefit from this kind of therapy and those who may have a useful influence on other members in the group as participants for the group (Evanand Marad, 2004).

Members of the group share with others personal issues which they are facing. Participants can talk about events they were involved in during the week, their responses to those events and problems they had tackled, etc. Participants can share their feelings and thoughts about what had happened in previous sessions, and relate to issues raised by other members or to the facilitator's words. Participants can react to each other, give feedback, encourage, give support or criticism, or share their thoughts and feelings. The subjects for discussion are not determined by the facilitator, but rise spontaneously from the group. Members in the group feel that they are not alone with their problem and that there are others who feel the same. The group can become a source of support and strength in times of stress for participants. The feedback they get from others on their behaviour in the group can make them become aware of maladaptive patterns of behaviour, change their points of view and help them adopt more constructive and effective reactions (Kanas, 2006). Frequently, the participants in the group represent others in their past or current life with which they have difficulty. In group therapy participants have the opportunity to work through these situations.

Group psychotherapy is suitable for a large variety of problems and difficulties, beginning with participants who would like to develop their interpersonal skills and ending with participants with emotional problems like anxiety, depression, etc (Nasim, 2007). There are support groups for people in the same situation or crisis, but usually the recommendation for the therapeutic group is to be as heterogeneous as possible and represent a micro-cosmos. The group is especially effective for people with interpersonal difficulties and problems in relationships. Participants can benefit whether these difficulties are social, working, couple or even sexual relationships.

Groups are ideally suited to people who are struggling with relationship issues like intimacy, trust or self-esteem. The group interactions help the participants to identify get feedback and change the patterns that are sabotaging the relations. The great advantage of group psychotherapy is working on these patterns in the "here and now" in a group situation more similar to reality and close to the interpersonal events (Kanas, 2006). This seems to be suitable for mental health workers in Rwanda during the annual commemoration period of the 1994 genocide, when mental health workers are supposed to be on standby all the time in order to intervene in the cases of emotional crisis which might arise during the commemoration ceremonies.

According to Nasim (2007) there are many types of group-psychotherapies. The techniques used in group therapy can be verbal, expressive, psycho-dramatic etc. The approaches in the context of secondary traumatic stress in mental health workers can vary from psychodynamic to behavioural, gestalt or personal developmental groups. Groups vary from classic psychotherapy groups, where process is emphasized, to psycho-educational, which are closer to a class. Psycho-

educational groups usually focus on the most common areas of concern, notably relationships, anger, stress-management etc. They are frequently more time-limited (10 to 15 sessions) and, thus, very appealing in a managed care environment. Each approach has its advantages and disadvantages, and the participant should consult the expert which technique matches her/his unique personality (Evanand Marad, 2004).

Participants in the group are expected to be present each time and arrive on time. It is required that the information brought up by members of the group and their names be kept confidential by all the group members. In some groups, participants are asked to commit for a specified length of time at the beginning of the group. The usual commitment is between 3 to 6 months. This facilitates getting a sense of how the group works. When participating in a group, they will not be required to talk, or reveal intimate issues if they do not want to. However, it is clear that the more they participate, be open and talk about themselves, their feelings and thoughts, the more they can gain from the experience (Kanas, 2006).

Usually, there are between 8 and 12 members in the group. Above 15 members, it is impossible to create a therapeutic atmosphere and have enough time for each member to work personally. The length of every session can be from an hour and a half to three hours. The frequency for mental health workers can be once to twice a month. The duration of the group depends on many components such as the severity of the problems and the targets sought. It can be from a few months to a few years. They should allow 4 to 6 months to pass in order to feel the effect of the group.

#### **4.4.12 Model validation workshop**

Due to the research methodology being used, namely action research, I wanted to ensure the validation of the developed model and the collaboration of the research team and other interested mental health professionals. I arranged a workshop with the research team members and participants from the four mental health institutions participating in the study. I met them in the staff meeting room of the Ndera Psychiatric Hospital.

After thanking the participants for agreeing to the meeting, I requested permission to tape the discussion and then went through the proposed model to manage secondary traumatic stress in mental health workers in Rwanda. Initially developed by the research team and checked by the research supervisor, a very basic, simplified model was formulated from the data collected from the participants during the preceding cycles 1 and 2, and from the literature review. The description of the model and its diagram was projected in PowerPoint as a starting point to trigger discussion to validate the model. I had to actively encourage the participants to get involved as some of them had not been involved in the model development cycle. Even though I had a good relationship with all the participants and had known them for a number of years, they were a little uncomfortable about making comments on the developed model. Most of the participants in the workshop were quick to hand the ownership of the research to the research team, even though it was stressed to them at all the times that they were actively involved in the process and that the change being planned would directly affect them. After the workshop, all participants were happy with the developed model presented by the research team and it was decided to implement it in one of mental health services. The Ndera Psychiatric Hospital was chosen by the participants as the site to implement the model.

## **4.5 Cycle 4: Model implementation**

The implementation cycle of the present study was carried out in one mental health service namely Ndera Psychiatric Hospital. This was chosen by research team and participants in the implementation workshop because it is the only referral in-patient mental health service where the majority of mental health workers operate in Rwanda. All mental health workers and managers from this hospital were involved in this cycle. The data in this cycle was collected from the implementation workshop as well as during regular contacts with mental health workers using field notes.

### **4.5.1 Model implementation process**

Before the implementation started, I arranged a time to meet with mental health workers and managers from the mental health service where the model was being implemented in a workshop. The objective of the implementation workshop and subsequent meetings was to explain the model being implemented and to discuss any potential obstacles and concerns. During the implementation workshop, time was spent discussing the proposed model which had been developed. I attempted to create a conducive environment to encourage active participation from participants at all times. Refreshment time was also provided which then allowed the participants more time to talk freely to each other and during this time there was much sharing of ideas and experiences on the model being implemented. The participants were enthusiastic about the model.

The aim of this model was to assist mental health workers in preventing, assessing and managing STS. It was anticipated that the model would assist mental health workers to become aware of their thoughts, actions and feelings in order to intensify their self-awareness and enhance their connection with themselves, colleagues and their clients. The intervention model focused on the use of personal resources and other resources in order to reduce the negative effects of STS and to promote the ability to cope effectively with trauma-related stressors in the mental health services.

A participatory approach was used to implement the developed model. All mental health workers from Ndera Psychiatric Hospital were involved in the implementation of the model. The implementation was done in six weeks in the participating mental health service and evaluation of the implementation was being done simultaneously. Regular contacts was kept with the mental health workers in the mental health service where the model was being implemented in order to monitor the progress of the implementation of the model and to be aware of any problems or difficulties experienced during the period of implementation. During the implementation process, arrangements were then made to hold meetings with mental health workers and managers on duty in order to hear their experiences of implementation and hear about any changes being suggested to the model.

The model endeavoured to transform mental health workers' views of self-awareness and mitigating the effects of secondary traumatic stress. By sharing their experiences mental health workers deepened their own awareness and decreased their sense of isolation. This ensured that they could begin to break down the barriers of isolation and silence. I emphasized the fact that

the model should not be seen as complete and all mental health workers using the model should feel free to suggest any changes they felt could improve it.

Prior to starting with the implementation of the model I asked the participants if they thought that the model may be helpful in managing secondary traumatic stress. The majority of the participants answered that it definitely would and some stated that the model would also help the mental health services to develop their own guidelines in addressing secondary traumatic stress. The participants appreciated the fact that that the model was simple and easy to use, as well as being very comprehensive and containing all the necessary information about secondary traumatic stress management. Other participants said that the model will improve the mental health care to traumatized and other psychiatric clients

While the development of the model was based on finding from cycle one and two of the present study as well as literature, the emerging implementation of the present developed model was unique and mixed in the sense that it was based on the strengths of both the developmental process, and the competence.

#### **4.5.2 Action planning and reflecting for change**

During the implementation cycle of the developed model, I asked the participants (mental health workers and managers of the chosen service) if there was any input I could provide to assist with the implementation. . It was suggested that I provide a resource folder of relevant literature on the different aspects of secondary traumatic stress in mental health professionals and how to manage it. I was also asked to arrange a time to discuss this literature with the participants. This was done every Thursday afternoon as this is the time reserved at this institution for training for

all clinicians operating in the hospital and allied mental health services. During these Thursday sessions I spent many hours talking to the mental health workers and managers. I usually visited them on duty and spend about four hours with them on each occasion. Due to spending all this time with them I came to know them all quite well and many of the individual staff members confided in me about various problems they had in both their personal and professional lives.

During this time it became apparent to me that mental health workers in Rwanda need a great deal of psychological support, from management and colleagues, as well as from outside of their work environment. When this support is not available or the supportive relationship is threatened for any reason, they find it difficult to care for their clients. This particular point was often mentioned during my meetings with the participants during the model implementation. All the participants told me that they wanted to know more about what they could do to improve their interaction with their clients, both for themselves and their clients.

My presence appeared to facilitate some change in the participants. At the end of the model implementation phase, the mental health workers appeared better able to express their concerns, reflect on their own problems and find solutions. On many occasions their solutions to a particular problem were implemented and this they said left them feeling better. If on the other hand, their suggestions were not implemented they said that they felt better for having voiced their concerns and knowing that their problem was now “out in the open”. The mental health workers in the institution where the implementation was being carried out seemed to see me as being supportive.

Occasionally some mental health workers worked against the research process by refusing to perform the some activities. Their attitudes and behaviors sometimes influenced others within the institution and I had to work extremely hard to re-establish relationship and maintain their interest in the research process though pointing out what a difference they were already making with regards to secondary traumatic stress management in mental health workers and through acknowledging that change is not easy.

#### **4.5.3 Reflecting on facilitation of change**

Burke (2008) states factors such as power and influence are important factors to facilitate change in an organisation. This author states that influence is the process where one person modifies the attitudes or behaviour of another, whereas power is the ability or resource which enables him to do so. Power can be charismatic, resource, legitimate, expert and negative (Burke, 2008).

Physical or charismatic power comes from within the person. Resource power refers to the person's ability to grant desired rewards, whereas legitimate power refers to the person's position or role in organization and is usually dependent on either physical or resource power. Expert power is different from other powers. It can be very potent and refers to the power given to an individual because of their acknowledged expertise. It is also the most socially acceptable type of power, however it is relative, and is usually only established by a small differential of knowledge or skill. Negative power on the other hand, is used by all individuals, especially in time of frustration and stress to disrupt, block and distort (Burke, 2008)

Higgs and Rowland (2005) also mention that compliance, identification and internalization play an important psychological role in the manner in which an individual adjusts to influence.

Compliance usually results in the person doing something grudgingly. Identification with or admiration of a person can result in change, however the person and therefore the change, usually remains dependent on the continued presence and influence of the charismatic resource (Higgs & Rowland 2005). Internalization, where the person adopts ideas as their own and internalizes it, is self-sustaining and occurs independently of any source of influence however it is the most lasting but also takes the longest to achieve (Landau, 2007).

Mental health workers in the institution where the model was being implemented vacillated between all of these methods adjusting to change initially. However the majority of them seemed to have internalized their need to change towards the end of the study.

Cognitive dissonance and group pressure are two of the most powerful mechanisms of attitude change. Wagner and Kegan (2006) explain that people are social beings and are dependent on others for knowledge about themselves and the world. Pressures exist within the groups which cause people to behave, feel and think alike. Higgs and Rowland (2005) agree with this and suggests that in order to facilitate change, information should be presented to participants. This will supply the motivation to change and will keep them committed to proposed solutions which have been derived from consensus and group discussion. Following By's (2005) suggestions of allowing the practitioners to decide on what they wanted to change and encouraging their participation in the process, the research team members were able to develop and control the change process. The fact that the majority of mental health workers felt that the change was relevant and essential for STS management contributed to the success of the change process.

Higgs and Rowland (2005) declare that there are several principles which can serve as a practical guide to individuals involved in the projects attempting to initiate change. The collection of clear

and unbiased data is critical as in the perception of the need to change by the mental health workers involved in the study. This point was achieved in that the data was collected without my knowing what factor(s) the mental health workers would identify as being desirable to change. They also were aware of the situation and the conditions under which I collected the data and were able to act as check and balance regarding the accuracy of data presented to them. I feel that if the data was not accurately presented, they would not have identified a need to change their attitude toward secondary traumatic stress management.

If the mental health workers are involved in implementing the model, it helps them to realize why change is necessary. Initially, all mental health seemed to have different ideas about the study, however after a feedback sessions they moved towards a shared view of what should be changed in managing secondary traumatic stress in mental health workers. According to Higgs and Rowland (2005) the staff should be a part of the problem solving process. This point was also achieved, in that the mental health workers and managers participated actively in discussions held to resolve various issues in the ways that the model would suit in the service. They also tried to use different interventions stipulated in the model and discussed the practicability of these interventions in the services.

I was also sensitive to the fact that change makes large demands emotionally, physically and socially on all the mental health workers in the process and was careful to allow the change to take place slowly and at the mental health workers' own speed. My continuous contact with mental health workers and managers allowed me to experience and appreciate the difficulties involved with being innovative and in implementing these new ideas in the institution.

It is suggested that positive reinforcement in the form of praise or rewards, be given as frequently as possible (Landau, 2007). I did not reassure or praise the mental health workers in the process as often as they would have liked me to and this did hamper the research process to quite a large extent, especially in the implementation cycle.

I feel that the fact that our discussions were conducted in “on duty” time, benefited the change process. I was to be accommodating and whenever our discussions were interrupted or had to be cancelled for any reason, the mental health workers were always apologetic. I do not think that as many mental health workers would have participated in the model implementation cycle if the discussion had been held during their “off duty” time.

I also think that I acted as a catalyst for the change process. This catalyst role was facilitated by my being available comprehensively for the mental health workers, the laying down of ground rules, being perceived as an expert and several external factors. As this study was using action research approach, I was able to build relationships with all people concerned and gave the mental health workers opportunities to discuss various issues relating to the model being implemented and the change process such as fears, anxiety and insecurities as suggested by By (2005). By (2005) suggests that it is essential that the person wishing to introduce change show an interest in the staff. My genuine interest in the mental health workers and my willingness to help them with secondary traumatic stress management also aided the process. According to By (2005) the facilitator of the change requires knowledge, tact, commitment and perseverance. Higgs and Rowland (2005) mention that facilitator needs to be patient and persistent in supporting the staff in their efforts to overcome difficulties. When the mental health workers

realized that they could criticize me and ask for more support or clarifications of the process, they found that they could trust me.

At the beginning of the implementation cycle, I laid down basic group ground rules, in that I stipulated that whatever was said by participants would not be discussed with no one else and that whatever said in our discussion would be confidential. Although some of the mental health workers were not convinced that this was necessary at the first, they realized how important it was later during the implementation cycle. It seems to be essential to lay down the ground rules early on before there are any problem since this contributes to being accepted by participants (By, 2005).

During my time working with the staff on implementation of the developed model, I felt that I had expert power. The authorities of the institution in which the model was being implemented had informed all mental health workers on my entering the service that I was ongoing my PhD degree and that they knew that I worked at Psychosocial Service as in charge before. The management of the institution and all mental health workers had also sanctioned the research and appeared to be interested in the process and were supportive and encouraging. These factors contributed to my being seen as expert, particularly in the initial stage of the implementation cycle. My provision of the report of my master's research and other documents and articles on secondary traumatic stress for the mental health workers to read contributed also to this perception.

External factors which acted as a catalyst for change were the training on secondary traumatic stress that all staff attended during the research period. Another factor that contributed to change

process was that no overt pressure was placed on the staff for change to occur (By, 2005). I emphasized the point that they are there to see if it would occur. The mental health workers were encouraged to continue trying new interventions when they saw how beneficial minor changes were. Ultimately, they believed in the process of implementation of the intervention model to manage secondary traumatic stress in mental health workers, even it was difficult at the times, because they had made decision on what needed to be changed.

#### **4.5.4 Spin-off spirals**

McNiff and Whitehead (2002) point out that action research should offer the capacity to deal with a number of problems at the same time by allowing the spirals to develop spin-off spirals, just as in reality one problem will be symptomatic of many underlying problems. These spirals are planning, acting, observing, reflecting and re-planning. The spirals allowed me to explore other problems as and when they arise, without losing sight of the main focus of enquiry.

The divergent themes of coping with other stressors from outside the work such as difficult relatives, economic issues are an example of spin-off spirals observed in this study. These problems were dealt with the some degree, in discussion with mental health workers regarding the different support systems used to dealing with stressful event. The issue of critical incident debriefing had been also arose in this study, a job I was also able to fulfil during the process of implementation cycle at Ndera Psychiatric Hospital and which the mental health workers found to be useful.

#### **4.5.5 Feedback loops on the model implementation process**

After a number of days during the implementation the mental health workers involved in the implementation cycle of the study, seemed to be feeling more confident when we discussed various issues arisen in the implementation cycle. I told them that I was looking to see whether any change had occurred in their attitude and the management of their own secondary traumatic stress and reminded them that I was not looking at any specific individuals. I pointed out too, that from our discussion during the throughout the implementation cycle it was very apparent that some change had occurred, but the research process required the collection of a further set of data.

#### **4.6 Cycle 5: Evaluation of the model implementation**

The purpose of evaluation research is to seek answers to particular questions and the goal of evaluation research is to evaluate the success of effectiveness of a particular phenomenon. According to Denzin and Lincoln (2007) the results of evaluation should provide practical knowledge, which has been empirically justified, about the worth of a particular phenomenon. For the purpose of the current study, the implementation of the developed model in one mental health site was evaluated.

##### **4.6.1 Evaluation procedures**

According to Sidney, Rosemary and Mary (2009) action research is a process in which the practitioners were included as evaluators. After the implementation cycle the participants from the one implementation site were asked to evaluate the implementation of the model according to

the objectives of the study. The data was collected in a workshop held with mental health workers, managers and research team members. This workshop was held in the mental health service where the model had been six weeks ago. I had also collected some data (observation and field notes) during the regular contacts I had with the with mental health workers throughout the implementation process.

Verbal feedbacks from mental health workers were also obtained. No formal interview schedule was used and the notes were taken as people talked. Mental health workers and managers were asked whether they felt the research had been worthwhile, how they had felt about my presence in their service, whether they felt that there had been any change in their attitude. This enabled me to clarify and expand on some issues that were not addressed in meeting on evaluation of the implementation of the model.

The results of the evaluation of implementation of the model to manage secondary traumatic stress in mental health workers in Rwanda in the participating mental health service were discussed with research team, managers and mental health workers by examining the outcomes of the implementation cycle.

According to managers and research team members, it seems that most mental health workers benefited from the model implementation, in particular from the exercises that addressed STS and integrating emotional experiences. During the workshop on evaluation of the implementation process of the model, the participants went through flexible spiral processes. Ideas which participants were written on the flip charts, they were then examined critically one by one until the participants developed the objectives based on the assumptions that mental health workers benefited from the implementation of the model.

Participants during the workshop reflected on what they had done in the implementation cycle and presented the measures for the mental health institution participating in the implementation cycle. After the presentation, participants systematically critiqued what they had done during implementation cycle in their institution. The process of reflecting gave an opportunity for the participant to re-plan, forming a basis for the future. Dick (2006) indicates that in each cycle there is action and critical reflection. During reflection people first examined what happened previously, they reviewed, they then decided what to do next they planned.

The participants were asked to reflect of the following question during the discussion:

- After the implementation of this model have there been any changes in the way in which mental health workers and the mental health services manage the secondary traumatic stress? If so what are these changes?
- When considering the intervention model to manage secondary traumatic stress in mental health workers in Rwanda do you think that it may or may not be useful for mental health workers and services?

#### **4.6.2 Results of evaluation of the model implementation**

The participants stated that following the implementation of the model they had a clear understanding of STS learnt new strategies to cope with work-related stressors and that they could identify signs and symptoms of STS. Some of the mental health workers stated that they could make a commitment to the mental health service, to their profession and to their self care. They also felt that they could develop a personal resource plan, could identify any needs that are disrupted by STS, and commit themselves to address and manage STS. Many of the mental health workers indicated that they had become aware of their own resources of wisdom, spiritual

restoration, and that they could now become aware of their inner resources by evoking feelings which they integrated during the meditation exercise.

The participants reported that being involved in the research and helping in developing the model had changed their practice in general. One of the participants reported that having the model to manage secondary traumatic stress helped mental health workers and clients.

Many of the participants said that they would like to continue being involved in this research as it had made them more aware of things that they previously had taken for granted; “We learned much” said one of the participants.

No changes were suggested to the model after the period of implementation, although the research team members and managers stated that they would continue to use the model and evaluate it to see if they will discover any changes that need to be made in the future. After each meeting on evaluation of the implementation of the model, participants thanked me for the research although I reminded them that it was, in fact their research. I asked them if they were not able to recognize their own contributions to the model and they all acknowledged that they were able to recognize this. The research team also emphasized that they needed to use the model when managing secondary traumatic stress in mental health workers and they would then be in more of a position to evaluate and suggest changes.

One nurse working in acute ward of psychiatric hospital said that this research had made her very aware of how difficult it is to change one’s attitudes and behavior. She stated that she had found the experience quite uncomfortable at times because it involved examining her own feelings and actions. She also mentioned that she felt that she had personally benefited from being actively

involved in the process. One counselor said that being involved in the research process had encouraged her to analyze her feelings towards traumatized survivors and that she tried to become more empathetic towards them.

One unit manager and psychiatric nurse said that there had been a marked behavioral change among mental health workers in the unit, especially in the way that they coped with traumatized patients. She said that “the research reminded the mental health workers not to judge patients based only on the information available to them”. She further stated that “we are brought up to believe that it is not an acceptable way of coping with something unless the client has what we deem to be an acceptable excuse”. Nevertheless, she now felt comfortable when patients expressed their anger or choose not to communicate. She said that she often told patients that she understood that their behaviors were normal considering the circumstance they found themselves in, but that there were other ways of dealing with their problem. She stated that she now felt that her care for traumatized patients and others psychiatric patients was more effective than it had been before the research process.

One psychologist reported that the research had forced them to look at an issue that ‘might have remained hidden behind the door’. He said that he thought all the mental health staff had become more aware of all their patients and the care given to them. He mentioned that in particular he had become aware of traumatized patients as individuals and felt that he was more empathetic towards them. He reported that the research process had helped them identify a problem area and had made them realize that they would have to address it and change their actions. He said also that it had been a big hurdle, but that he felt comfortable with the outcome.

## **4.7 Conclusion**

The chapter four discussed the data analysis and findings of the five cycles of the present study. The findings were also discussed with reference to the literature reviewed. The five cycles of the study were described in detail. Cycle 1 was concerned with exploring secondary traumatic stress in mental health workers in Rwanda. This cycle helped me to establish if there was a need for the research and if mental health workers would be interested in developing the model to manage secondary traumatic stress in mental health workers in Rwanda. The second cycle aimed to explore the experiences of secondary traumatic stress in mental health workers. The third cycle involved the development of the model (based on the findings from cycle 1 and 2) and during the fourth cycle the model was implemented. The fifth cycle was involved in evaluating the implementation of the model.

## **CHAPTER 5: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS**

### **5.1 Introduction**

The current study was carried out to explore the existence of STS, to develop and implement an intervention model to address STS in mental health workers in Rwanda, and to evaluate the implementation of the model. Research process and findings were summarized and making recommendations for mental health institutions, mental health workers, education and future studies and briefly discussing limitations. I used quantitative and qualitative data to explore secondary traumatic stress among mental health workers in Rwanda. Action research approach was used in all stages of the research process to develop the model, implement and evaluate the implementation of a model to manage STS. This study provided information that is important to mental health services and mental health workers. The cycle one and two of the study provided information regarding secondary traumatic stress and the experiences of mental health workers in Rwanda. The cycles three, four and five of the study provided an account of reflective process which participants went through in developing an intervention model to manage secondary traumatic stress in mental health workers in Rwanda, implementation and evaluation of the implementation of the model. The summary of the findings was based on the objectives of the present study.

#### **5.1.1 Explore secondary traumatic stress in mental health workers providing mental health care in Rwanda.**

Using Trauma and Attachment Belief Scale (TABS) to measure disruptions in the psychological need areas of safety, esteem, trust, intimacy and control, the mean of the total scores was 77.04

with a standard deviation of 1.154. The total scores were high in all areas of beliefs. This can indicate that there is a disruption in the cognitive schema of the mental health workers operating in Rwanda. The mean scores of most respondents ranged from very high to extremely high in all areas of cognitive beliefs

### **5.1.2 Describe the work–related aspects that contribute to secondary traumatic stress in mental health workers in Rwanda**

Stressful work environment, inadequate work conditions, personal trauma history and lack of support were perceived by some mental health workers as major risk factors contributing to development of secondary traumatic stress. Describing work-related aspects that contribute to secondary traumatic stress, participants focused mostly on the workload and lack of support.

### **5.1.3 Describe the available support system for mental health workers in Rwanda**

Only 30% of the participants in this study indicated that support system is available for mental health workers in Rwanda. Some participants mentioned that they received informal psychological support such as talking to friends and family; and organisational support systems, such as counselling service and debriefing sessions after having experienced a stressful case.

### **5.1.4 Develop an intervention model to manage the secondary traumatic stress experienced by mental health workers in Rwanda**

A diagrammatical model to manage secondary traumatic stress was developed by mental health professionals. The key elements to include in the model were based on preventive, evaluative and curative strategies to manage secondary traumatic stress in mental health workers in

Rwanda. The developed model will serve as a framework reference for mental health professionals to mitigate secondary traumatic stress in individuals and the mental health service as a whole

#### **5.1.5 Implement this model in one mental health service in Kigali, Rwanda.**

The implementation of the developed model was carried out in Ndera Psychiatric Hospital chosen by research team because it is the only referral in-patient mental health service which comprises the largest number of mental health workers operating in Rwanda. All mental health workers and managers from this hospital were involved in the implementation process within a period of six weeks.

#### **5.1.6 Evaluate the implementation of the model to manage the secondary traumatic stress in mental health workers in Rwanda**

Evaluation of the implementation of the model was carried out after six weeks of implementation. During the evaluation of the implementation, it emerged that participants noticed a change in coping strategies when facing the stressful incident in the practice. The participants stated that they had a clear understanding of STS learnt new strategies to cope with work-related stressors and that they could identify signs and symptoms of STS. They also reported that the developed model will be helpful and it will change positively their practice in general.

## **5.2 Outcomes of the study in terms of change**

The majority of the mental health workers in the mental health institution in which the model was implemented appeared to be more empathetic towards traumatized clients at the end of the implementation period. At the beginning of the research when asked the mental health workers how they manage secondary traumatic stress in their services, a wide variety of descriptions were given. A large number of mental health workers participating in the study they didn't know what to do and often they would rather avoid the client with trauma history of traumatic stress and leave to another mental health worker. When discussing managing secondary traumatic stress in mental health services, most of mental health workers said that it is too time consuming and this limited the care they provided to traumatized clients.

By the end of the study a number of mental health workers would come up to me to initiate discussions regarding secondary traumatic stress in mental health professionals and ask for more reading about secondary traumatic stress management. The mental health workers seemed to be open for discussion and to talk about STS and what they could do when experiencing secondary traumatic stress. I have been told very proudly by some of research team members about how mental health workers followed the model and that it worked. Those mental health workers seemed very enthusiastic and excited about the fact they had the concrete model to manage secondary traumatic stress. They also said that the research changed them and they were aware that preventing, evaluating and treating secondary traumatic stress is important for them when working with traumatized clients and psychiatric patients.

### **5.3 Outcomes of the study in terms of production of knowledge**

Burke (2008) point out that knowledge derived from action research is grounded in actual practice situations. The author further suggests that it is a valuable method of generating knowledge and for discovering the limits of knowledge applicable in practice. In this study, a model was developed to guide mental health professional managing secondary traumatic stress in mental health services in Rwanda. This model was developed from the data obtained from the mental health workers who are currently working in various mental health services in Rwanda. The research team members who guided the process of the research were themselves mental health workers currently working in the services, and they ensured that the model developed was relevant and appropriate for the situation. Following the evaluation of the implementation cycle no changes were deemed necessary to the model. The research team members had asked the mental health workers where the model was implemented for their comments and feedback was positive.

Noar and Zimmerman (2005) stated that not only is the theory relevant to practice but also practice relevant to theory and both relevant to research. Being involved in this research prepared mental health workers to function in scientific way. Action research with its reflective spirals encourages participants to be critical of their own practice and to determine ways of improving it in a supportive environment. It can be said that critical thinking and comments engendered by action research creates a base for building new knowledge (Alligood and Marriner-Tomey, 2002).

Many mental health workers in Rwanda are knowledgeable about many things involving their practice, but often they are unable to articulate and therefore use this information. Although this research did not look at this aspect, the action research process through describing what mental health workers in Rwanda are doing facilitates the documentation of current knowledge which is gleaned by observing mental health practice. This helped mental health workers in Rwanda develop a new common understanding of secondary traumatic stress and the problem which were identified and their causes. It is suggested that further research be carried out to determine whether, when discussing ways to solve these problems, they will become more aware of and will articulate their own ideas and suggestions which are based on previous experiences or readings. Actions implemented in this research were beneficial of both mental health workers and patients and therefore from this perspective it can be said that the research process was successful as well as relevant and useful.

### **5.3.1 Theoretical assumptions underpinning the model**

A theory is a set of interrelated concepts, which structure a systematic view of phenomena for the purpose of explaining or predicting. A theory is like a blueprint, a guide for modelling a structure (Streubert-Speziale & Carpenter, 2003). A blueprint depicts the elements of a structure and the relation of each element to the other, just as a theory depicts the concepts, which compose it and the relation of concepts with each other. Chinn and Kramer (2007) define a theory as an expression of knowledge, a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena. According to Chinn and Kramer (2007) a theory is a set of interpretative assumptions, principles, or propositions that help explain or guide action.

The theories used by members of a profession clarify basic assumptions and values shared by its members and define the nature, outcome, and purpose of practice (Alligood & Tomey, 2002). Use of the model also promotes rational and systematic practice by challenging and validating intuition. It is widely believed that use of theory offers structure and organization to professional knowledge and provides a systematic means of collecting data to describe, explain, and predict professional practice

It is important to remember that the theoretical underpinning of action research is concerned with social intervention (Traynor and Wade, 2008). In the present research the research team members acted as facilitators for change by guiding and providing information for the participants which enabled them to self-reflect and identify problems, their possible causes and probable solutions. Their knowledge bases were enhanced and a change in the attitudes, skills and relationships was observed. These criteria described by Trautmann, Maher & Motley (2007) were identified as being essential for the process of change to be self-sustaining. This self-reflection and the participants increased understanding of the problems identified, both of which are essential should enable the mental health workers to continue using the model to manage secondary traumatic stress once I leave the setting.

The resulting new and common understanding of the identified problems and their causes, which is referred to as local theory, and the subsequent discussions as to how the change should be implemented ensures that the changes that are implemented tend to last.

Smith and Liehr (2008) differentiate between four levels of theoretical thinking namely; meta-theory, grand theory, middle-range theory and micro range theory. Meta-theory is most abstract

and universal level of theoretical thinking, and is the theory of inquiry. Grand theories are formal, highly abstract theoretical systems that frame our disciplinary knowledge within the principles of practice, and their concepts and propositions transcend specific events (Smith & Liehr, 2008). Grand theories are said to describe and explain large segment of the human experience (Marriner-Tomey & Alligood, 2006). Middle-range theory is similar to grand theories in that it explains the empirical world of practice but is more specific and less formal. Micro-range theory is the least formal level of theoretical thinking and restrictive in terms of time and scope or application (Higgins & Moore, 2000).

Chinn and Kramer (2007) described how the need for practice linked theory resulted in the development of middle-range theories. Chinn and Kramer (2007) highlighted the need for professionals to develop a substantive theory which provided specific guidance in regards to specific practice concepts. Middle-range theories are described by Chinn and Kramer (2007) as substantive theory that tends to cluster around a concept of interest to nursing. A middle-range theory has a narrower focus and more concrete than a grand theory in its level of abstraction. It is more precise and focuses on answering a specific practice question. It contains information indicating the situation of the health condition, the patient population or age, the location or the area of practice and the actions of the practitioner or the necessary interventions (Marriner-Tomey, and Alligood, 2006). Chinn and Kramer (2007) suggest that clinicians need middle-range theories. This intervention model to manage secondary traumatic stress in mental health workers in Rwanda is a middle-range theory that is very action oriented, as research team members and mental health workers participating in this research were practitioners who needed

and wanted something concrete that could understand and successfully implemented in the clinical situation.

#### **5.4 Evaluation of middle-range theory**

The intervention model to manage secondary traumatic stress in mental health workers in Rwanda can be evaluated using five broad analysis criteria described by (Marriner-Tomey, and Alligood, 2006). These criteria are clarity, simplicity, generality, and empirical precision and derivable consequences.

##### **5.4.1 Clarity**

Clarity involves the examination of the major concepts, sub-concepts and their definitions in order to evaluate how clear the model is. The words used in the model to manage secondary traumatic stress were carefully and specifically defined and these were related to the framework from which they were derived, namely secondary traumatic stress. The definition of the concepts was based on the quantitative and qualitative data collected from the mental health workers in Rwanda. The model developed logically and the assumptions are consistent with the model's purpose. Three major interventions of managing secondary traumatic stress in mental health workers are clearly described as are the role to be carried out by the mental health workers and mental health services.

The theory also needs to be oriented to outcomes that are important for the clients and the theory should not just describe what mental health workers do. The secondary traumatic stress management model has attempted to take into account the views of mental health workers as

well as the managers. The conceptual linkages of the theory have also been provided in diagrammed model.

#### **5.4.2 Simplicity**

The intervention model to manage secondary traumatic stress in mental health workers is a simple theory. This is true because it is sufficiently comprehensive to include the vast amount of information available regarding secondary traumatic stress and its management but this is provided in a way that appears very simple and easy to follow (Marriner-Tomey, and Alligood, 2006).

#### **5.4.3 Generality**

To determine the generality of the theory one needs to consider the scope of the concepts and goals within the theory. The more limited the concepts and goals, the less general the theory (Marriner-Tomey, and Alligood, 2006). The intervention model to manage secondary traumatic stress could be applied to many different situations where mental health workers are expected to deal with traumatized patients. The research team members were also of opinion that this model can be successfully used to manage secondary traumatic stress in others settings such as emergence departments and Intensive care units of general hospitals when dealing with physical trauma.

#### **5.4.4 Empirical precision**

This aspect of evaluation is concerned with the testability and ultimate use of the theory (Marriner-Tomey, and Alligood, 2006). The intervention model to manage secondary traumatic

stress in mental health workers is based on reality and the relationship between the theory and the empirical data is available to researchers to validate and verify. This model has not been tested, but its propositions are clear and can be tested. Specific instruments might need to be developed to measure some of the variables (providing curative care for mental health affected by secondary traumatic stress).

#### **5.4.5 Derivable consequences**

This criterion is concerned with reviewing how important the theory is. The intervention model to manage secondary traumatic stress in mental health workers in Rwanda provides important and practical guidelines for mental health workers in order to prevent, to assess and treat secondary traumatic stress. These guidelines can be used to provide therapeutic management of the secondary traumatic stress experienced by mental health workers or any other professionals when dealing with traumatized clients. I do believe that this model can make a significant contribution to the mental health profession and to the nursing knowledge base.

#### **5.5 The contribution of the research**

This intervention model to manage secondary traumatic stress in mental health workers in Rwanda will serve as a frame of reference to facilitate and assist mental health workers who experience secondary traumatic stress. This model is a unique contribution to the body of mental health knowledge nationally as well as internationally, and will hopefully increase awareness in the mental health practice of the implication of secondary traumatic stress. I believe that this knowledge will enable mental health workers in Rwanda to reduce or prevent the effects of secondary traumatic stress, which, at times, may leave them burned out, personally disintegrated

and devastated. The description and implementation of the model serve as clear understandable foundation for any mental health worker to prevent and manage secondary traumatic stress in him/her or their colleagues when experiencing secondary traumatic stress.

### **5.5.1 Contribution to the body of knowledge and mental health profession**

This research has made the contribution to the mental health profession and body of knowledge within the profession. The research has achieved its goals of providing information about the nature of extent of secondary traumatic stress among mental health workers in Rwanda. A comprehensive report on the matter has been compiled together with an account of the procedures and methods adopted. The research process allowed the voice of the participants to be heard so that their needs and experiences could be articulated.

Because the focus was on mental health workers in Rwanda it has value for the mental health profession. My background as well as my knowledge of mental health care enabled me to articulate a link between the experience of mental health professionals in Rwanda and the findings emanating from research within the collaborative and participatory approach. This is a contribution to the theoretical knowledge base of mental health workers using the action research approach.

O’Leary (2005) suggests that research can produce data that can be a catalyst for change on a number of levels. The author conceptualises these levels as a pyramid. The base of the pyramid is professional development. The next tier is practice, followed by programmes. The next level is policy. Change at all these levels may influence the culture of the organisation. At the level of professional development, O’Leary (2005) suggests that research has an impact on the researcher

and that personal growth is inherent to conducting research. Moving up the hierarchy, research may impact practice. It may provide data and allows individuals, organizations or communities to reflect on what they do. At this level the research may take the form of a needs assessment, evaluate new practices or try out new ideas. At the level of programmes, the emphasis of the research is to change the projects, procedures and strategies in a systematic way. Finally, research may influence policy, that is, the guiding principles and directions of the organization or community. At the level of practice, this research has taken the form of evaluation and providing an overview of the situation pertaining to mental health workers in Rwanda with a view to determining the need for intervention model to manage secondary traumatic stress. The need for such model has been demonstrated throughout this research project. Recommendations about how the need may be met have been provided. The research can impact programmes for change. The present research has provided data on the extent of the problem that indicates that the situation warrants attention. Data on the effects of secondary traumatic stress involves that mental health workers' ability to care for traumatized clients and other psychiatric patients may be hindered by their personal trauma history has been provided. Literature review indicates that personal development is required to practice mental health profession, irrespective of theoretical orientation adopted.

These concerns suggest that low throughput may be partially addressed by finding ways of assisting mental health workers to overcome the destructive effects of secondary traumatic stress when dealing with traumatized clients. This would further be the goals of both the mental health workers and their organizations. It would also further be the goals of the profession by increasing the number of mental health workers to meet growing needs. O'Leary (2005) suggests that action

research can facilitate the personal development of the researcher. In this study, the researcher is practicing mental health profession in Rwanda. His knowledge and understanding of secondary traumatic stress in mental health workers were expanded. His communication skills were enhanced. His ability to think critically about the literature and existing knowledge expanded. He was able to acquire new research skills. He was able to produce new knowledge in the field of mental health profession, he was also able to search the literature, integrate it with research findings and engage in evidence-based decision making when writing recommendations. This research will be used to make a contribution to the well-being of mental health workers in Rwanda as well as traumatized clients and other mental health ill persons consulting different mental health services in Rwanda.

## **5.6 Recommendations**

Based on the findings, the research team makes the recommendations to mental health workers, to mental health services for education and training and future research. Recommendation to mental health workers focused on what the individual can do to recognize, reduce, or prevent secondary traumatic stress effects. Recommendations to mental health services focused on what mental health institutions can do to minimize secondary traumatic stress in their mental health workers.

### **5.6.1 Recommendations to mental health workers in Rwanda**

Research team was in agreement with Northwood (2008) who stated that when therapist experience secondary traumatic stress, they need to become aware of over-identification with

clients and take responsibility for their self care. The following recommendations are aimed at helping mental health worker to assess systematically and reduce secondary traumatic stressors.

Mental health professionals working with traumatized clients need to tend to their own self-care. They should examine within themselves any unresolved trauma issues of their own. It is also essential that they develop an understanding of the characteristics of their client population.

Mental health professionals should also be alert to the symptoms of secondary traumatic stress. They need to be aware of their feelings and mood states and recognize when additional support or relief may be needed. Support can come in the form of talking to colleague professionals as well as asking for suggestions, advises, and/or consultations from their professional team. Working in isolation tends to augment the risks of secondary traumatic stress and is contraindicated when working with traumatized clients.

Mental health professionals should also implement realistic objectives and limits in their work. Additional training and education can be obtain to be updated on the evolving literature related to understanding secondary traumatic stress and treating traumatized clients. Such professional development can also motivate new ideas and interests in their professional development.

Mental health professionals should be encouraged to use existing support services to help them deal with their own as well as patients' trauma.

Mental health professionals should have a balanced life between professional and personal activities that provides opportunities for self-growth and revitalization. Some of the STS management strategies involve personal lifestyle changes such as eating regularly, getting

sufficient exercise and sleep, taking more time for themselves, and developing outside interests. Strategies for psychological, emotional, and spiritual self-care are also suggested for mental health workers.

### **5.6.2 Recommendations to mental health services in Rwanda**

Mental health institutions may consider implementing protective strategies such as structured supervision, peer support groups, or required regular attendance at workshops designed to mitigate STS. One of ways to address this question effectively is to bring in a supervisor from another institution once a month to debrief mental health workers. Supervision should be aimed at providing task-oriented prescriptions for healthy change, rather than focusing on individual errors and mistakes.

Managers are expected to act as change agents in mental health services. It is suggested that action research would be an extremely useful method for them to employ when embarking on such venture. It is recommended that action research be taught to all unit managers in mental health services so that they have a tool which they can use in a meaningful, appropriate and responsible way to facilitate change for managing secondary traumatic stress in mental health workers.

The most important factors that improve mental health service's ability to cope with secondary traumatic stress is the amount of support, should be built into the structures of the organization itself. It is also important that mental health services inform and protect their staff against the possibility of secondary traumatic stress and offer the necessary support.

Facilities such as a room with a few comfortable chairs and with tea making facilities need to be available in all trauma counseling units where a member of staff experiencing a traumatic event can be comforted and supported away from the activities of the unit and surrounding areas.

It is strongly recommended that a counselling program to be implemented for all mental health workers dealing with traumatized clients because of the nature of work they are engaged in. It is suggested that the staff from this unit might be available to conduct a critical incident stress debriefing when it is needed.

Supervision should be made obligatory for all mental health workers working in mental health service in Rwanda, especially those who treat the traumatized patients.

Inexperienced mental health workers who are recruited to work in mental health services should be informed of the possible risk of developing symptoms related to secondary traumatic stress and supported by having open channels of communication with the supervisor.

Caring for the staff should be included in the organizations strategic plan as a key focus area in order that their most valuable asset, their human resources, are retained and feel valued.

The physical environment must be improved. Ensure that there is a room that is conducive for the mental health workers to spend their break times. Mental health workers must be encouraged to take a break during their duty time.

### **5.6.3 Recommendations for Training and education**

Educational programmes on secondary traumatic stress need to be developed for the mental health workers, identifying triggers, symptoms and coping strategies. Regular case discussions

should be seen as a valuable training session, supportive measures should be included in the program for the staff to provide direct care to traumatized clients.

Opportunities for further studies should be created and mental health workers should be encouraged to subscribe to the concept of lifelong learning.

Ongoing training for mental health workers is needed, to enable them to work effectively with traumatized clients.

New mental health workers should be included in an introduction program to be able to share new ideas or knowledge in order to clarify the unknown.

Mental health workers should be encouraged to attend personal development courses such as stress management, time management and conflict resolution courses to acquire the skills needed to deal with challenges in life.

#### **5.6.4. Recommendations for future research**

There is need to validate this intervention model to manage secondary traumatic stress in mental health workers in Rwanda with a view to replicating the study on a large scale within the country and in the East African region.

For future research it would be more beneficial to increase the time-lapse of implementation of the model in order to ensure that mental health workers develop all the necessary strategies required to cope with STS over time.

Research on coping strategies for STS should also be investigated in more detail to ensure that the mental health workers in Rwanda develop the necessary coping skills required to overcome STS.

The present findings suggest that a more comprehensive model is necessary to mitigate STS in mental health workers in Rwanda. Additional individual variables likely moderate the effect of coping skills on symptom levels. Self-efficacy is an example of one such variable. In addition, work environment variables may also have a large impact on the development of STS. For instance, co-worker support and cohesion, well-defined job roles, physical safety, financial security, and clear physical boundaries between worker and client space likely all impact risk of STS. These variables and more need to be examined across samples of mental health workers.

## **5.7 Conclusion**

The findings from this study showed that there were different roles which were needed to be undertaken by different stakeholders for management of STS in mental health workers in Rwanda. The intervention model to manage secondary traumatic stress is an essential component in rendering effective mental health care to the traumatized clients and other psychiatric patients. The model offered mental health professionals an effective framework for addressing the issue of secondary traumatic stress. Changing the organizational culture towards secondary traumatic stress in mental health workers needs a commitment by all role players in the mental health sector operating in the mental health system in Rwanda.

Action research approach used in this study is a relatively new method in the health profession in Rwanda. It does have inherent problems which have become clear in this study, such as the

enormous demands in terms of time. However, from this research it can be seen that it can play an important role in both theory and practice and it should continue to receive support.

I carried out this action research project with mental health workers working in mental health services in Rwanda in order to foster a change in practice by involving mental health professionals with a view to manage the secondary traumatic stress . I approached the mental health professionals working in Ndera Psychiatric Hospital, Psychosocial consultation services, AVEGA and ARCT-RUHUKA in Rwanda if there was any support for the idea of developing a model to manage secondary traumatic stress in mental health workers in Rwanda.

The present model outlined different ways to cope with STS at the individual, professional and organizational levels. There is a need to translate these interventions into active ongoing coping activities to be conducted at the individual, group and organizational levels. Organizational responses, such as creating an organizational culture that acknowledges the potential for secondary traumatic stress, may help mental health workers to deal with secondary traumatic stress. Simply naming the stress of the work may help mental health workers feel supported and give them permission to seek personal solutions for whatever stress they may experience. In the end, these responses are likely to lead to a healthier environment for both mental health workers and their clients and a higher and more consistent quality of service.

### **5.8 Limitations of the study**

According to Burns and Grove (2007), limitations of a study are restrictions in a study that may decrease the generalizability of the findings. The restrictions are either theoretical or methodological. This study has a number of limitations that should be considered in the

interpretation of the results. In this study, the limitations were on generalisability, in that the study was only done in mental health services situated in Kigali City. This restriction was due to financial constraints. In view of the restriction, the data which was generated may apply to the Kigali City in Rwanda. For practical and logistical reasons and for the purposes of this research it was not possible to involve larger number of mental health services.

The fact that the model was implemented in one mental health service in six week period of time may also have restricted the impact of the model. More time of implementation of the model would be beneficial; as it should be considered that the negative impact of secondary traumatic stress on the mental health workers was the result of a long period of exposure to work-related stressors. It could therefore be expected that this condition could not be altered over a short period of time. For future studies larger number of mental health services would be more beneficial. The time period could be extended in order to gain more significant indications concerning the success of an intervention model as well as to reduce the effects of STS on mental health workers. In spite of these limitations, this research indicated the importance for more research on intervention models that address STS for secondary traumatic stress experienced by mental health workers especially in the context of Rwanda.

Another limitation was the fact that I was known to some of the participants, which may have influenced the participants' responses. The assumption was, however that, due to the precautions taken with the ethical requirements and the assurance of confidentiality, and the use for which the study was intended, the information which was provided by the participants was valid. To overcome these limitations this study adopted a mixed methods with action research approach in

order to complement each other and make a stronger research design with more valid and reliable findings.

An additional potential limitation in this study was the difficulty insuring confidentiality and open responding. Participants may have felt uncomfortable answering such private questions about themselves, especially given that their managers would receive feedback about the staff as a whole. Though efforts were made to diminish this anxiety by providing information on managers' feedback reports ahead of time to demonstrate the safeguards to confidentiality.

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## Appendices

### Appendix 1

#### THE DEVELOPMENT OF A MODEL TO MANAGE SECONDARY TRAUMATIC STRESS IN MENTAL HEALTH WORKERS RWANDA

##### Section A: Demographic data

Gender

Female	Male

Age in years

25 years and less	26-35 years	36-45 years	46 years and more

Number of years' service as mental health worker

0-5 years	6-10 years	11-20 years	More than 20 years

Number of years' service in the current mental health service

0-5 years	6-10 years	11-20 years	More than 20 years

Qualification of participants

Psychiatrist	Medical doctor	psychologist	Mental health nurse	Social worker	counselor

Marital status

Single	Married	Widow	Separated

**Section B: Personal traumatic history**

You can tick more than one box

7. Have you personally experienced the following events

Genocide	Emotional/psychological abuse	Physical abuse as child	Accidental disasters( e.g., car accident fires	Natural disaster (e.g., flood, earthquake)

**Section C: Working conditions**

8. How many time per week do you spend doing counseling?

10 hours and less	10-20 hours	20-30 hours	30 hours and more

9. How many hours per week do you spend in counseling for trauma victims?

10 hours and less	10-20 hours	20-30 hours	30 hours and more

10. How many time do you spend in counseling for new case?

0-10 minutes	20-30 minutes	40-50 minutes	1 hour

11. Is support system available in your service?

Available	Not available	Do not know

12. Which kind of support system do you use?

Family member	Significant others	Friends	Colleagues	Therapist	supervisor

13. Do you think psychological debriefing in mental health is?

Helpful	Not helpful	Unsure

14. Which one of the following support systems do you think is better to limit or to prevent STS?

Better salary	Better working conditions	Support with transport	Supervision/ Debriefing	Sensitivity by non mental health colleagues and managers

15. Who is the most appropriate to provide supervision or debriefing to mental health workers in Rwanda?

Psychiatrist	Psychologist	Psychiatric nurse	Counselor/ social worker	Clergy

## **Appendix 2: INTERVIEW GUIDE**

1. How do you define STS and how it affects mental health workers?
2. Describe your recent stressful situation with your clients and how it affected you?
3. How do you cope with work related stress?
4. What kind of stressors did you encountered and what are contributing factors to STS in you service?
5. Describe support systems received to limit STS in your institution?
6. What are gratifying features in mental health profession?

## Appendix 3: Ethical approval



University of KwaZulu-Natal  
Research Office  
Govan Mbeki Centre  
Westville Campus  
University Road  
Westville  
4000  
South Africa  
Tel No: +27 31 260 3587  
Fax No: +27 31 260 4609

25 FEBRUARY 2010

Mr. JD Iyamuremye  
School of Nursing  
HOWARD COLLEGE CAMPUS

Dear Mr. Iyamuremye

**ETHICAL APPROVAL NUMBER: HSS/0094/10D**

**PROJECT TITLE: "The development of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda"**

In response to your application dated 23 February 2010, Student Number: **206519315** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through the amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study.

**PLEASE NOTE:** Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....  
Professor Steve Collings (Chair)  
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor (Dr. P Brysiewicz)  
cc. Mr. S Reddy

Founding Campuses:    ■ Edgewood    ■ Howard College    ■ Medical School    ■ Pietermaritzburg    ■ Westville

## Appendix 4: Permission from Ndera Psychiatric Hospital



**HOPITAL NEURO-PSYCHIATRIQUE CARAES NDERA**  
**FRERES DE LA CHARITE**  
B.P.423 Kigali; Cellulaire 0788307932  
E - mail : cnkubili@yahoo.fr



23<sup>th</sup> December 2009

Jean Damascene IYAMUREMYE  
PhD Mental health student  
University of KwaZulu Natal  
Howard College Campus  
4041, Durban  
South Africa

30<sup>th</sup> December 2009

### RE: PERMISSION TO CONDUCT A STUDY

Dear Jean Damascene,

Reference is made to your request for permission to conduct a study at Ndera Neuro-Psychiatric Hospital on your research topic which is: **"The development of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda"**.  
I am pleased to inform you that the permission has been granted to conduct your research on the above mentioned topic. We have found the topic very interesting and we are confident that your findings will help mental health workers working in our hospital to prevent and manage their own secondary stress when working with traumatized and psychiatric clients.

Thank you very much for choosing Ndera Neuro-Psychiatric Hospital as your research setting and we wish you success.

Sincerely

Br. Charles NKUBILI  
Director General  
Ndera Neuro-Psychiatric Hospital



CC:  
Chief of Nursing, Ndera Neuro-Psychiatric Hospital

## Appendix 5: Permission from Psychosocial Consultation Service

REPUBLICQUE DU RWANDA

 Service de Consultations Psychosociales 

MINISTERE DE LA SANTE  
TEL. 577910  
B.P. 84 KIGALI

S.C.P.S.  
TEL. 571937  
B.P. : 1811 KIGALI

---

January 8, 2010

Jean Damascene IYAMUREMYE  
PhD Mental Health student  
University of KwaZulu Natal  
Howard College Campus

**RE: PERMISSION TO CONDUCT RESEARCH**

Dear Jean Damascene

It was a pleasure talking with you last time regarding your very interesting research on *“The development of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda”*. We believe that the work will be important to the mental health workers working with traumatized and psychiatric patients in our service and we will help where we can.

As discussed, we will be happy to provide you with access to key people in our service, which will include contact information for all service program and activities. Please let us know if there is any other way we can be of service

Good Luck

Kindest regards

Nancy Misago  
Acting Coordinator  
Psychosocial Consultation service



---

B.P. 1811 KIGALI      Email : [minisantescps@yahoo.fr](mailto:minisantescps@yahoo.fr)      Tél. 571937

## Appendix 6: Permission from AVEGA



*Que les cris de nos martyrs empêchent le silence et l'oubli*

**« AVEGA »**

**ASSOCIATION DES VEUVES DU GENOCIDE AGAHOZO**

REF: ... 6.2.31.12.6.6.1.3.5.1.2010

December, 28<sup>th</sup> 2009

**Jean Damascène Iyamuremye**  
University of KwaZULU Natal  
Howard College Campus  
Faculty of health Sciences  
Mental health Program  
School of Nursing  
4041 ,Durban  
South Africa  
Email: Iyadamas@yahoo.fr

**Subject:** Permission to conduct a study

Mrs. Iyamuremyi J. Damascène,

We confirm our agreement to gathering information relating with your study "The development of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda"

We hope that your contribution to the department and to the institution will be of great value and at the end of your program; you will be requested to share your report with AVEGA

Kindest regards

UMURUNGI Assumpta  
Executive Secretary of AVEGA



Kigali office : B.P. 1535 KIGALI TEL : (250) 08520122, 55107545 et 55101086. Email. [avega@rwanda1.com](mailto:avega@rwanda1.com)  
Compte bancaire : B.C.R. N° 0010-12945-01-20 FRW 0010-12945-02-21USD

## Appendix 7: Permission from ARCT

**ARCT – RUHUKA**  
**Association Rwandaise des Conseillers en Traumatisme**  
B.P.717 Kigali  
E-mail : [arct@rwanda1.com](mailto:arct@rwanda1.com)



Tél : (+250) 55 11 71 95

24<sup>th</sup> January, 2010

To Mr. IYAMUREMYE Damascene  
University of KwaZulu Natal  
Howard College Campus  
Faculty of Health Sciences  
Mental Health Program  
School of Nursing  
4041, Durban  
South Africa  
E-mail : [iyadamas@yahoo.fr](mailto:iyadamas@yahoo.fr)

Dear Sir,

**Re : Your request of permission to conduct a Study**

We acknowledge receipt of your letter asking for permission to conduct a study here at ARCT-RUHUKA.

We would like to inform you that your request is favorably agreed and inform you that counselors are available to give you any information you would be needing.

Yours faithfully,

ABATONI Jane GATETE

Executive Secretary



N° DE COMPTE :

ARCT- RUHUKA

010-0026973-03-52BCR

## **Appendix 8: INFORMATION DOCUMENT**

**Study title:** “The development of an intervention model to manage secondary traumatic stress in mental health workers in Rwanda”.

Dear Mental health worker,

My name is Jean Damascene IYAMUREMYE and I’m a PhD student at the University of KwaZulu Natal. As part of the requirements for my course I am required to undertake a research project. I therefore wish to invite to you participate in my study, which focuses on the development of a model to manage secondary traumatic stress in mental health workers in Rwanda.

Your participation in this study will be more important in accomplishment of my research. Your contribution in this study is voluntary. The data received from this study will be kept confidential. You will be free to withdraw from the study whenever there is need to without fear for any consequences.

This research poses no risk to the respondents as it involves giving responses to the posed questions.

I will be available to answer any questions that you may have.

You may contact me on **+27731017140** or **+250788400068** or at **[iyadamas@gmail.com](mailto:iyadamas@gmail.com)** at any time if you have questions about the research. You may also contact my supervisor, Dr. Petra Brysiewicz on 031 260 1281 or at **[brysiewicz@ukzn.ac.za](mailto:brysiewicz@ukzn.ac.za)**

Thank you for taking interest in my research.

Yours sincerely

Jean Damascene IYAMUREMYE

## Appendix 9: CONSENT DOCUMENT

### Consent to Participate in Research

**Study title:** “The development of a model to manage secondary traumatic stress in mental health workers in Rwanda”.

You have been asked to participate in a research study. You have been informed about the study by Jean Damascene IYAMUREMYE; a PhD student at University of KwaZulu Natal having read the information document which has the details of the study. You may contact me on **+27731017140** or **+250788400068** or at **iyadamas@gmail.com** at any time if you have questions about the research or if you are injured as a result of the research. You may also contact my supervisor, Dr. Petra Brysiewicz on 031 260 1281 or at **brysiewicz@ukzn.ac.za**

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. If you agree to participate in this study, you will sign this document below in the space provided as a show of your acceptance of participation.

#### Consent

The research study, including the above information, has been explained to me. I understand what is expected of me in this study and I voluntarily agree to a participant.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

## **Appendix 11: interview sample**

**Interviewer:** Today is 12/04/2010. You are a psychiatric nurse. Albright. The first thing I like to know is how many years have you been working as mental health worker in this institution.

**Interviewee:** This is my 6<sup>th</sup> year

**Interviewer:** Well, just before I start asking you things and that I want to make sure that you are clear about the purpose of the study, Uh, as I said to you when I was talking to all of you the other day that we are researching on secondary traumatic stress with all the things that were happen in our country in 1994. And I am just looking if there is any influence on mental health workers on daily basis. So that's basically what I am looking for. and just to make sure that you understand that you know, it is quite an emotional sort of questions and things we are talking about, so if you feel uncomfortable at any time and you feel you can't carry on this, it is quite fine, it is your right. I am using ID numbers so that no one will ever know what it was you said, it is all private and confidential, although you might see it written up as an article, it won't be able to be traced back to you and all typed will be destroyed afterwards, ok, Uhm, anything you want to ask me or are you quite clear?

**Interviewee:** I will ask as we go along

**Interviewer:** The title of my research is all about secondary traumatic stress. I am trying to develop a model to develop secondary traumatic stress in mental health workers. At this stage I am going to focus on experiences of people working with traumatized clients and who are exposed to secondary trauma, so it is like having no directly, not direct experiences in that kind of things. So, it is hearing about stories of the traumatized clients.

**Interviewee:** Okay, as in that it hasn't happened to me?

**Interviewer:** Yeah, but we are constantly, obviously bombarded with all these stories all the time, what horrific things happen. So, I am interested in how people cope with being of constantly exposed to that kind of level of story, on daily basis, but it becomes part of their life, that how they sort of cope with that and just deal with having that as a part of their life, that kind of traumatic experiences around them. So, I am interested in that and what people think about and well, in this case, what you think about feel when you hear stories and things like that, just focusing on your reactions to, your coping styles, and that kind of things to secondary trauma. Well trauma, I am really saying that are traumatized, just the exposure of sort of horrific things that we are sort of exposed to. Can you remember stories like that in your work?

**Interviewee:** Obviously, I remember hearing such stories

**Interviewer:** Can you describe your recent stressful situation with your clients and how it affected you? I just would like you to tell me a stressful story that you can remember, you know, a particular patients that came in

**Interviewee:** you know, there is so many that is hard to pin point, you know

**Interviewer:** Okay, when you hear about a traumatic story from you patient, what you would say are your thoughts and feelings.

**Interviewee:** hearing story like that, my first thought is whether it is emotionally charged, it make me worried about my family members. The other thing is that I think about me on how I would oh, well, you know, how it would be if I was involved in a situation like this. I think it is the fear of what happened and what is going to happen and your fears are to such a high degree that the reality of the situation probably is vastly different. But you know my first fear is always about my family members. And about me being in the same situation as my clients.

**Interviewer:** And now you talked about what you think about and you worry about, but what sort of feeling do you have what do you feel when you hear stories like that or....

**Interviewee:** you fear that you are going to be the next. You are anticipating, it is a fear, you are living in fear. You are constantly living in fear that is going to happen to me it is not matter of if, it is a matter of when. And no matter what you do no matter you try to do to dispel it, and I presume you obviously going to get on to ways and means of how you sort of block it out or deal with it, but it is always there and the constant reminder of it simply draws it more and more to your attention. I don't know, really, how to describe it more than that. In terms of, I mean, emotionally.

**Interviewer:** like, for instance, if you hear that story, what would your first feelings reactions be, instead of thinking, like, how would you feel?

**Interviewee:** First of all, thank God it wasn't me. I know that sound terrible but actually that story particularly is that it's coming more and closer to me.

**Interviewer:** especially the family context in that.

**Interviewee:** What I get worried about is that I am feeling much more claustrophobic is not the right description; it is becoming more intrusive because it is coming closer and closer to me. I think that what is my biggest concern is that now I tend to be cautious to the point of being paranoid, just so that it is not you.

**Interviewer:** that was actually

**Interviewee:** yeah, that is what I find to be the most disturbing about all these stories, is that it is now, it become so pervasive that you can't escape it anywhere, there is no escaping it. You are going to be traumatized, if you don't it is a question of time. And I think the thing that disturbing me the most about these traumatic stories particularly. The reality of it, I think, is vastly different. I think the reality of it and the way. I don't know if you want me to go onto this right now.

**Interviewer:** No, it is fine

**Interviewee:** the reality of what I do sometimes to consciously cope with it or to deal with it is, to realize that if you look on it. There a huge amount of traumatized people in Rwanda. But the reality I think is that or at least I try to convince myself, is that don't blow it out of proportion, consciously think about it in a logical way. but , yeah, the only mechanism I try to cope with it is to, A, block it out and not to think about it because to think about it just cause me to get very, very depressed, but to try and rationalize it to say, well, in so far as statistically concerned, statistically you aren't not going to be traumatized.

**Interviewer:** are there any other ways. I mean, you said don't really talk about these kinds of things much but would you say that's just sort of avoiding it and blocking it out. When you hear stories like that, do you tend to think about it again or do you feel like you just sort of will hear about it and that will just, you will try an just.....?

**Interviewee:** I try to block it out

**Interviewer:** Block it out so it doesn't bother you.

**Interviewee:** I found that more you talk about it the more and more you hear stories. I try not to because thinking about it just causes me to get very morbid and morose about the situation that there is, or hopeless situation. You feel that there's nothing that can be done and there is nothing that is being done to help mental health workers who get traumatized because of the stories of their patients. So consequently, you are just biding your time, waiting until inevitable. So yeah, I try to avoid it, I try to avoid talking about it with people. I find that sometimes I can talk to my wife. I think that part of the reason a traumatic events happen is that people, I don't say take the attitude that it can't happen to me, that are just simply vigilant. But that again comes back to my point, that unfortunately becomes almost paranoiac reaction and you worry about worrying, that if I let my guard down for a single

moment, then that is the moment it is going to happen. But no I try to not focus on it. I distract myself with something else, watch a movie, and sometimes very pointedly distract myself, other thing depending on the level of the story. And at some point, I find that it is kind of almost routine, oh, well, you know.

**Interviewer:** You mentioned feeling a bit of a sense of hopelessness

**Interviewee:** Yeah, I do I feel very angry to being with and then just eventually it generates into hopelessness, oh, well, what are we going to do? There is nothing you can do, it doesn't seem like that anyone is paying the slightest attention to it. It is also frustrating .but I feel that, yeah, it is, it is a sense of hopelessness that I end up feeling when I hear those traumatic stories, and that , really , is what I try to avoid because I don't want to focus on that. The longer and longer I dwell on it, the more and more depressed and more upset I end up becoming because no matter what you seem to do, no matter what steps seem to be taken, they are just ignored

**Interviewer:** What are contributing factors to your experiences and to your feelings?

**Interviewee:** one of the contributing factors to the experience of stress in mental health workers here is that, Managers that run this place think they know but they don't. And I think if they would come and see, it might open their eyes to see how we struggle because we're short staffed. I think they need to see what everybody goes through.

**Interviewer:** What do you notice about the manner in which your clients talk about those stories?

**Interviewee:** the commonality that I find is, firstly, that clients do sensationalize it themselves, that they will elaborate and clearly exaggerate certain details for sensational benefits in the social context in which they find themselves for very obvious reasons. That is the one commonality I find is as it were, of negativity, if I can call it that. But it feeds upon itself, it literally does, it swells to the point of where you

actually feel uncomfortable because it is making you feel helpless, and I think is a combination of the two that really just frustrates me, feeling that you are afraid to do anything, that you are afraid to take a decision, afraid to do anything, to go certain places, which you shouldn't be, but at the same time, knowing that the fear is somehow prudent but not being able to do anything about it.

**Interviewer:** what, just generally, and overall do you think has been the toll on you personally as mental health worker?

**Interviewee:** Now I've become anxious, I've noticed that it is very pointedly in the two last years. I was never terrified or petrified of doing things, I was never particularly fearful. I now find myself being very fearful, I find myself afraid for, I'll be honest, for my family members and for myself. But the personal effect that I have find is that I am fearful and I have noticed others who were not fearful.

**Interviewer:** You say that you are now fearful that before. What make to be afraid?

**Interviewee:** I found myself to be, is I found myself to be more untrusting, I don't trust people as much I did once upon a time. I'm far less likely to place any reliance on anyone to do anything in order to prevent such things in this job. I have a greater degree of pessimism that anything will be done to support mental health worker who are dealing with traumatic stories on their daily basis.

**Interviewer:** what do you do personally to cope with those stressful stories?

**Interviewee:** in order to cope with such stories we hear every day, I think that verbalization and some time letting go seems to work best for me. When it's all over with, if I can talk, then I can seem to let go of it. For example with this interview I am feel well. If I don't talk, then I hold on to it and it destroys the rest of my day even if the stressful part of the moment is over with.

**Interviewer:** Did you receive any support systems from your institution to cope with STS?

**Interviewee:** I don't think so. It just sort of comes when you least expect it, you'll suddenly start thinking [about an event... and all of the thoughts and feelings that you had at that time...] If we say we would like counselling, you know, I feel we should get it within a week of asking. Not two to three months down the line, and it has gone when we dealt with it. It is like supposed to be getting heard two weeks ago and we are still waiting. We don't need it now. I don't think we do, but we, most of us we feel we don't need it now. We want it when we ask for it.

**Interviewer:** According to you, what are rewarding features in mental health profession?

**Interviewee:** Yeah, I think there are too many rewarding things in mental health. You know. Let me say for example. Knowing that the mental health care I provided were beneficial to the individual. Knowing that I saved somebody's life. That is the most rewarding thing in mental health care. Helping others is good you know. One day I was in staff office and I saw a patient coming in accompanied by the family members walk through and she was very depressed with physical symptoms as she refused to eat since a week ago. I took her in one of the private rooms and immediately I started an IV infusion. After the IV infusion I called the doctor to examine her and prescribed the medication. The following two days I was off duty. When I come back to the service I was surprised to see the patient sitting and talking. After one month of hospitalization under antidepressant treatment she was healthier and discharged. The delay in treatment of the patient would lead her to commit suicide. She is alive and she has been back to visit us numerous times to thank us. We really made a difference in that patient life. That's the most gratifying thing I remember. Feeling that you really made a difference in somebody's life and you really did something that was significance to save somebody's life, you have some reason for being happy to be in mental health profession.

**Interviewer:** is there anything else you would like to add?

**Interviewee:** No.

**Interviewer:** Okay, thank you very much, I really appreciate

November 10, 2010

Jean Damascene IYAMUREMYE  
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Re: Trauma and Attachment Scale (TABS)

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