# UNIVERSITY OF KWAZULU NATAL

*EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN MENTAL HEALTH SERVICE IN RWANDA*

2008

By

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# EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN MENTAL HEALTH SERVCE IN RWANDA.

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**Dissertation submitted in partial fulfillment of the requirements for the degree of Masters in Nursing (Mental Health), School of Nursing**
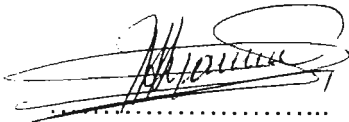
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# DECLARATION

I, Jean Damascene IYAMUREMYE declare that this dissertation entitled "**EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN MENTAL HEALTH SERVICE IN RWANDA**" is my own work and has not been submitted for any other degree or examination in other University other than the University of KwaZulu Natal. I have given complete acknowledgement to the resources referred to in this study.

**Signature (J.D. Iyamuremye)**            Date 12 | 03 | 2009

**Signature (Dr P. Brysiewicz)**            Date 12 | 3 | 2009

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# 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 for the study.

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Anyone who has ever been through the process of conducting research and writing a thesis knows what a difficult process it can be.

There are nights when you can't sleep because of the racing thoughts about various concepts, times when you don't leave the confines of your room for days because you are busy trying to write something brilliant and days where you just are unable to see the end of completing this last task for your degree.

The material within this document represents the end of that process and while it was a hard journey at times, it was one which I did not complete alone.

I would like to express my sincerest thanks to the following individuals who gave their support, insight, enthusiasm and encouragement throughout this research.

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# ABSTRACT

It has been suggested that a unique feature of some mental health nurses' work is exposure through their role as therapists to clients' descriptions of, and reactions to, trauma, and that these experiences may actually indirectly cause distress and traumatization to the nurse. This proposed phenomenon has been termed "secondary traumatic stress" and is the focus of the current study.

**Aim:** The aim of this study was to explore secondary traumatic stress experienced by nurses working in mental health services in Rwanda.

**Methods:** The research was conducted in Ndera Psychiatric Hospital. The questionnaire consisted of items of the Trauma Attachment Belief Scale (TABS), demographic characteristics of participants, personal trauma history, work related aspects and support systems. A convenient sampling of 50 nurses who provide a mental health care to trauma survivors and mentally ill patients in the Ndera Psychiatric Hospital was adopted.

**Results:** Results of the study indicate that there is belief disruption in the respondents. The mean scores of most of the respondents were high in all areas of cognitive believe. Of the respondents, 98% (n=49) had T-score of 80 for other-safety which was extremely high. The nurses identified the psychiatric nurses and a psychiatrist as their main support systems in dealing with secondary traumatic stress and generally believed in the usefulness of supervision.

**Conclusion:** In summary, this study expanded on knowledge into the effects of secondary traumatization, particularly with concern to mental health clinicians, a population often ignored. This study was considered to be a contribution to trauma literature as it provides much needed empirical evidence.

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# CHAPTER ONE: INTRODUCTION

## 1.1 INTRODUCTION

Traumatic events occur and affect people during their lifetime. Traumatic stress may be a result of physical events such as violence, for example physical abuse. It can also be of a phsychological nature, for example, learning that one has terminal disease such as cancer.

Nurses working in mental health services generally have compassion for the traumatised people because of the nature of their work (Schwam, 1998). They assist their patients to function within the working environment (Figley, 2003).

Most research, to date, has focused on the effects of traumatic stress on the primary victims and not on the secondary victims (those who provide care and support) (Galea, et al., 2003). Due to the fact that secondary victims are not directly involved in the traumatic event, their distress often goes undetected (Brady, Guy, Peolstra and Brokaw, 1999).

According to McCann and Pearlman's (1990) Constructivist Self-Development Theory, (CSDT), nurses will give meaning to traumatic events according to how they experience them.

A shift in this approach is necessary, as these secondary victims need to be assisted in their role as helpers so that they can continue to help the primary victims cope with their traumatic stress.

## 1.2 BACKGROUND TO THE STUDY

Nurses working in mental health care hear tales of extreme human suffering and observe the emotions of fear, helplessness and horror registered by these trauma survivors on a regular basis. The vivid recounting of trauma by the survivor and the clinician's subsequent cognitive or emotional representation of that event may result in a set of symptoms and reactions that parallel Post Traumatic Stress Disorder (PTSD) (e.g., re-experiencing the event, avoidance and hyperarousal) (Zimmering et al. 2003).

Recent research demonstrates that these occupational duties may cause psychological symptoms in the clinicians who bear witness to the survivors' accounts of trauma. This is called secondary traumatic stress (STS) (Zimmering, Munroe and Bird-Culler, 2003).

Secondary traumatic stress is defined as indirect exposure to trauma through a firsthand account or narrative of a traumatic event (Zimmering et al. 2003). Secondary traumatic stress is also referred to as compassion fatigue (Figley, 1995) and vicarious traumatization (Pearlman and Saakvitne, 1995).

Saakvitne (1998:p.1) stated that "working with trauma survivors changes us profoundly." This author states that clinicians whose work involves an empathic connection with individuals who have experienced traumatic life experiences suffer a significantly adverse impact on their personal well-being.

More attention has recently been given to the literature regarding the phenomenon of "secondary victimization." and this phenomenon concerns the fact that professionals, who listen to clients' stories of fear, pain and suffering, may also feel symptoms of fear, pain and suffering because they care (Thomas, and Wilson, 2004).

It is now fourteen years since Rwanda experienced genocide during the period from April to July 1994. During this time approximately 800,000 people were killed by the Interahamwe militia using clubs and machetes at an average of 8,000 people per day. This killing rate was more than that of the Nazi death camps (Des Forges, 1999). The Rwandan Genocide was the systematic murder of the Rwanda's Tutsi minority and the moderates of its Hutu majority.

This was both the bloodiest period of the Rwandan Civil War and one of the worst genocides in history (Mamdani, 2001).

In addition to the killings, rape and other forms of physical and psychological violence and torture were committed. Most of the victims were killed in their villages or towns, often by their neighbours and fellow villagers. The militia members typically murdered

their victims by hacking them with machetes, although some army units used rifles. The victims were often massacred by the militia members while hiding in churches and school buildings. Ordinary citizens were called upon by local officials and government-sponsored radio to kill their neighbours, and those who refused to kill were often killed themselves. People who tried to escape were hacked down with machetes or shot (Hannington, 2004).

Nurses form the largest group of health workers in Rwanda (Ministry of Health, 2006) and nurses working in mental health services there are the first contact for traumatized patients and often bear witness to severe physical and emotional trauma. They provide the main connection with patients, act as their advocates with other care providers, have the most direct one-to-one contact with them, give them physical care and give emotional support to both them and their families (Leiter, Harvie and Frizzell, 1998).

This intensive caring can lead to the experience of secondary traumatic stress which is a short-term reaction to dealing with the traumatic material of their patients. It can cause a long-term alteration in the nurses' own cognitive schemas, beliefs, expectations and their assumptions about the self and others. (Allen and Mellor, 2002; Sabin-Farrell and Turpin, 2003).

Dealing with the trauma of others may result in emotional overload in nurses. This causes chronic stress in them and can result in secondary traumatic stress. Nurses suffering from this condition often appear to function relatively well in their work and

personal life, thus the symptoms of secondary traumatic stress can often go undetected (Lerias and Byrne, 2003).

Nurses working in mental health services in Rwanda, however, are sometimes characterized as being unmotivated and insensitive towards patients, thus exacerbating other problems such as the lack of resources and understaffing faced by the psychiatric services. These behaviours, however, are more typical of burnout and are often a consequence of the above adverse conditions (Figley, 2002).

Mental health nurses in Rwanda are not equipped or trained to manage the demands made on their own mental health. The shortage of nurses, also, does not correspond with the excessive demands made on them by the high volume of trauma they have to handle (Ndera Psychiatric Hospital, 2007).

## 1. 3 PROBLEM STATEMENT

Secondary traumatic stress is an important occupational hazard in the mental health nursing profession as the effects accumulate and may change the way in which the nurses view themselves and their world (Zimmering et al., 2003).

The effects of secondary traumatic stress experienced by nurses in the workplace and their inadequate support system need to be investigated, as nurses, who are overburdened with work, stress and their own trauma, have few resources left to care for and comfort others (Zimmering et al., 2003).

The Rwandan genocide, one of the biggest in human history, not only led to unimaginable personal loss and grief, but also to the disappearance of all kinds of human resources, experiences, talents and staffing needed for the efficient functioning of a whole society (Des Forges, 1999).

Fourteen years later, the consequences of this genocide are still noticeable in a very tangible way on various levels, ie: social, psychological, cultural, moral, political and economic (Schaal and Elbert, 2006).

Most of the nurses and trauma counsellors working with trauma survivors in Rwanda are themselves survivors of the genocide and the effects of secondary traumatic stress experienced by these nurses need to be understood in the context of that unique work environment.

As many of the nurses who render a service to traumatized individuals in Rwanda are victims of trauma themselves, it is imperative to ensure that adequate psychological support services are developed to assist them, and other mental health professionals, to deal with their own secondary traumatic stress.

No current formal studies could be found on nurses, working in mental health in Rwanda, who are exposed to secondary traumatic stress. It follows, therefore, that authorities do not currently recognize the adverse effects of secondary traumatic stress on nurses who have to deal with trauma profiles.

Given the strategic role of mental health nurses in Rwanda regarding the care they provide for trauma survivors, it is vital to understand secondary traumatic stress and its impact on the mental health of these nurses.

## 1. 4 AIM OF THE STUDY

The overall aim of the study is to explore the effects of secondary traumatic stress experienced by the nurses providing mental health care at a mental health service in Rwanda, Kigali.

## 1. 5 OBJECTIVES OF THE STUDY

The objectives of this study are to:

- To explore traumatic stress in nurses providing mental health care in mental health service in Rwanda.

- To explore traumatic events in the nurses' personal history associated to the Secondary Traumatic Stress.

- To describe the work–related aspect that fosters secondary traumatic stress in nurses working with victims of trauma in Rwanda.

- To describe the available support system for nurses who work in mental health care service in Rwanda.

## 1. 6 RESEARCH QUESTIONS

To achieve the aim, the study wishes to answer the following research questions:

- What is the extent of secondary traumatic stress among nurses providing mental health nursing in Rwanda?
- What are the traumatic events in the nurses' personal history associated to STS?
- What work-related aspects trigger secondary traumatic stress in nurses working in mental health service in Rwanda?
- What support systems are provided for nurses who work in mental health care services in Rwanda?

## 1. 7 SIGNIFICANCE OF THE STUDY

The significance of this study is that it would document secondary traumatic stress in nurses who provide mental health care service in Rwanda. Furthermore, it should establish whether secondary traumatic stress is associated with the nurses' own personal trauma history.

This study may inform the Ministry of Health in Rwanda and the authorities of the mental health system regarding the psychological needs of nurses working in mental health in order to prevent the adverse effects of psychological trauma. In addition, it could create an awareness of the shortcomings in the support system of nurses in the clinical field.

The findings could facilitate future planning of additional support, which could be rendered to nurses in areas where they work with violence in the community.

## 1.8 DEFINITION OF THE TERMS

### 1. 8.1 Secondary traumatic stress

Secondary traumatic stress is the psychological consequence resulting from repeated exposure to a patient's traumatic experience (Schauben and Frazier (1995). Pearlman and Maclan (1995), define secondary traumatic stress as disruption to a therapist's inner experience services, as a result of repeated exposure to the client's trauma narratives.

In this study, secondary traumatic stress is the emotional disturbance to nurses' inner experiences, as a result of repeated exposure to their clients' traumatic narratives. According to the CSDT, these psychological disruptions affect the way in which the nurses' view themselves and their world.

### 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 an outpatient basis.

In this study, a mental health service relates to the services rendered by nurses 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 that 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 nurses 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 Nurse

A nurse is defined as a person who has graduated from an accredited nursing program, has passed the state examination for licensure and is licensed to practice by a state authority. (http://dictionary.webmd.com/terms/registered-nurse.xml).

For this study the term nurse is used to define a mental health clinician qualified in nursing care, with additional training in mental health care or in trauma counselling

## 1.9 THEORETICAL FRAMEWORK

McCann and Pearlman's (1990) Constructive Self-Development Theory, (CSDT), served as theoretical framework foundation for this study. The CSDT is a developmental interpersonal theory that provides an understanding of the psychological, interpersonal and adaptation effects that traumatic events have on the individual who counsels victims of trauma.

Individuals construct their own reality through developing cognitive structures known as schemas. These schemas include beliefs, assumptions and expectations of the self and the world.

The CSDT suggests that the changes to helpers' cognitive schemas are pervasive (potentially affecting all areas of their lives) and cumulative (potentially permanent because each traumatized client the nurse encounters reinforces these changes) (McCann and Pearlman, 1990).

Every individual responds differently to trauma because each one is unique in their life experiences, personal trauma histories personalities and the meanings they attach to trauma (Pearlman and Saakvitne, 1995). Their early development shapes the way they experience life and the way they interact with the self and others.

A trauma such as childhood sexual abuse can arrest an individual's potential development (Pearlman and Saakvitne, 1995).

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.

## 1.9.1 Frame of reference

Frame of reference refers to the individuals' framework for viewing themselves and the world. Frame of reference is important as it refers to how each individual perceives and interprets their life experiences (Pearlman and Saakvitne, 1995). According to McCann and Pearlman (1990), a meaningful frame of reference for human experience is a fundamental human need. Frame of reference encompasses an individual's world-view, identity and spirituality.

World-view refers to beliefs about the world which include attitudes about others and the worth, intentions and role of others in the individual's life (Pearlman and Saakvitne, 1995).

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 and Saakvitne, 1995).

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 a higher power (Pearlman and Saakvitne, 1995).

### 1.9.2 Self-capacities

Self-capacities refer to the inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive esteem (Pearlman, 1998; Pearlman and Saakvitne, 1995). These self-capacities allow individuals to manage emotions, maintain interpersonal relationships and sustain positive feelings about themselves.

When a nurse experiences secondary traumatic stress, these self-capacities are disrupted and the nurse may experience loss of identity, interpersonal difficulties, difficulty in controlling negative emotions or self-doubt in meeting the needs of their significant others ( Trippany, White Kress and Wilcoxon, 2004).

### 1.9.3 Ego resources

Ego resources are inner faculties that an individual uses to navigate the interpersonal world and meet his/her psychological needs (Pearlman and Saakvitne, 1995).

There are two types of resources:

- Resources important to the counselling process, namely; intelligence, willpower and initiative, awareness of psychological needs, striving for personal growth,

- Resources for protecting oneself from harm which include the ability to conceive consequence, the ability to set boundaries and the ability to self-protect (Pearlman and Saakvitne, 1995).

A disruption of these resources may promote perfectionism and the inability to be empathetic (Trippany, White Kress and Wilcoxon, 2004).

## 1.9.4 Psychological needs and cognitive schemas

Cognitive manifestations of the psychological needs such as safety, trust, esteem, intimacy and control are known as schemas (McCann and Pearlman, 1990).

Safety is the need to feel safe from harm by oneself and others (Pearlman and Saakvitne 1995).

Trust includes self trust and the trust of others. The need to trust own perceptions and beliefs, as well as the ability to depend on others (Pearlman and Saakvitne 1995; Trippany et al 2004).

Esteem is the need to feel valued by oneself and to value others. It also includes the need to perceive others as worthy of respect (McCann and Pearlman 1990; Pearlman and Saakvitne 1995).

Intimacy is the need to feel connected to oneself and others (Pearlman and Saakvitne 1995).

Control is the need to self-manage as well as to manage others in interpersonal situations (McCann and Pearlman 1990).

The CSDT views the responses of nurses to their clients' traumatic narratives as being shaped by the nurses' 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, each need area can be affected to a lesser or greater degree in each individual. It follows therefore, that if a nurse has disrupted safety needs, there would be an increased feeling of insecurity when working with trauma victims (Pearlman and Saakvitne 1995).

### 1.9.5 Memory system and perception

Within the CSDT framework, traumatic memory is descriptive. Pearlman and Saakvitne (1995) identify 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).

Each aspect of memory can represent a fragment of a traumatic event when a person experiences trauma. 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 memory of traumatic narratives remains with a nurse after a counselling session has ended.

Nurses treating victims of trauma can experience intrusive thoughts, flashbacks and dreams that have no meaning. Because imagery is a part of the nurses' memory system these traumatic memories can become permanently entrenched within them (McCann and Pearlman, 1990).

Some nurses use defence mechanisms such as numbing, avoidance or denial to cope with secondary traumatic stress, but these only offer temporary relief.

Hattingh (2001) alludes to the profound psychic numbing that occurs in health care professionals who are exposed to extreme, longstanding or repeated trauma.

Ortlepp (1998) states that some people alter their state of consciousness, enabling them to distance themselves from the state of unbearable arousal associated with trauma.

In her study on emergency services' professionals, Hattingh (2001) found that some respondents were reluctant to admit that traumatic situations affected them, stating rather, that they were used to coping with trauma.

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┌─────────────────────────────────────────┐
│ CRITICAL INCIDENTS                        │
│                                           │
│    •  TRAUMATIC EVENTS                     │
│                                           │
│    •  CLIENTS' TRAUMATIC                   │
│       NARRATIVES                           │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────────────────┐
│ CSDT COMPONENTS OF SELF IN ADAPTATION                 │
│                                                       │
│    •  FRAME OF REFERENCE                               │
│                                                       │
│    •  SELF CAPACITIES                                  │
│                                                       │
│    •  EGO RESOURCES                                    │
│                                                       │
│    •  PSYCHOLOGICAL NEEDS AND COGNITIVE                │
│       SCHEMAS                                          │
│                                                       │
│    •  MEMORIES AND PERCEPTION                          │
└─────────────────────────────────────────────────────┘
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Rational CSDT                                    Irrational CSDT

Components of self

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┌───────────────────────────┐      ┌───────────────────────┐
│ SUCCESSFUL ADAPTATION      │      │ RISK OF SECONDARY      │
│                           │      │ TRAUMA                 │
└───────────────────────────┘      └───────────────────────┘
                                              │
                                              ▼
                            ┌──────────────────────────────────┐
                            │ SUPPORT TO NURSES                 │
                            │                                   │
                            │ SUPERVISION, CONSULTATION,        │
                            │ EDUCATION, DEBRIEFING             │
                            └──────────────────────────────────┘
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**Figure 2.1 Secondary traumatic stress adaptation: Adapted from Baird and Jenkins (2003).**

According to the Conceptual Model of Secondary Stress Adaptation, (Figure, 2.1), nurses exposure to the details of their patients' narratives and re-enactments cause them to question their concepts of meaning, purpose and hope.

The nurses then try to cope by applying the five CSDT components referred to in fig.2.1..

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 nurse adapts successfully.

When the nurses are overwhelmed by the critical incident, they cannot comfortably handle the emotions and questioning evoked by their clients' stories. In this instance, they will need support through supervision, consultation, education or psychological debriefing.

## 1.10 CONCLUSION

This chapter provided an introduction to the study, the background of the study, the problem statement, research questions, and the aim, objectives and significance of the study.

The researcher defined the key terms, discussed the basic assumptions and presented the theoretical framework.

Chapter 2 discusses the literature review on the effects of secondary traumatic stress on professionals working with traumatized clients.

# CHAPTER TWO: LITERATURE REVIEW

## 2.1 INTRODUCTION

According to Polit and Hungler (1999), a literature review is necessary for comparing results of earlier findings in order to explore what further research would be necessary.

As this study will be linked to other similar research, the findings will be understood within the existing base of knowledge about secondary traumatic stress and its effects on nurses working in mental health services.

The researcher conducted a literature review of the empirical and theoretical sources on the effects of secondary traumatic stress experienced by nurses working in mental health services and counsellors working with victims of violence.

In order to put this study in perspective, the researcher searched for data on aspects of secondary traumatic stress globally.

The literature search included the following computer-assistance data-based bibliographies namely; MEDILINE (Medical Literature Online), Academic Search Premier, Nexus and CINAHL (Cumulative Index to Nursing and Allied Health Literature). It also includes concepts such as secondary traumatic stress (Stamm, 1997) vicarious traumatisation (McCann and Pearlman, 1990), compassion fatigue (Figley, 1995), burnout, counter-transference and post-traumatic stress disorder (American

Psychiatric Association, 2004). All these terms are associated with the effects nurses experience when working in mental health services.


## 2.2 CONCEPTUALISING SECONDARY TRAUMATIC STRESS AND RELATED CONCEPTS.

Figley (1995) uses the terms compassion fatigue, compassion stress and secondary traumatic stress synonymously. He argues that either compassion stress or compassion fatigue can be used interchangeably for those who feel uncomfortable with the term secondary traumatic stress, as the latter is often perceived offensive in that it appears to indicate some sort of pathology (Figley, 1995).

Furthermore, other specialists in the field of trauma often use the terms secondary traumatic stress, vicarious traumatisation and compassion fatigue interchangeably with reference to their studies and theories (Figley, 1995).

McCann and Pearlman (1990), however, are clear that vicarious traumatisation differs conceptually from compassion fatigue and secondary traumatic stress in their emphasis, context and focus. They argue that secondary traumatic stress and compassion fatigue are based on a conceptualisation of PTSD, and are therefore mainly concerned with symptoms, thereby giving context and etiology less attention. Despite the fact that Pearlman maintains that there is a distinct difference between compassion fatigue, and

vicarious traumatisation, other research indicates a link between these concepts (Figley, 1995).

Steed and Bicknell (2001), state that vicarious traumatisation is a more holistic approach to the individual and incorporates more than just symptoms of trauma but also individual's cognitive world

Figley (1995) claims that compassion fatigue is related to the cognitive schema (social and interpersonal perceptions or morale) of the counselor and therefore related to vicarious traumatisation (Figley, 1995).

Figley (2003), also states that there is a significant correlation between measures of cognitive schemas and measures of compassion fatigue.(Figley, 2003).

Furthermore the notions of compassion fatigue and vicarious traumatisation all point to the impact of trauma work on counselors. Moreover, vicarious traumatisation overlaps with compassion fatigue and both are used interchangeably with secondary traumatic stress as they are all a result of working with victims of trauma.

Therefore, when all concepts are combined they provide material for in-depth analysis of traumatic stress reactions in trauma workers as it provides a more holistic view of the trauma worker (McCann and Pearlman, 1990).

Stamm (1997) states, however, that secondary traumatic stress is a better term to use as it is more broad, and that vicarious traumatisation and compassion fatigue are actually specific types of secondary traumatic stress (Ortlepp, 1998).

Given the commonalities of these terms, the link between secondary traumatic stress and PTSD, and the fact that secondary traumatic stress is often used by other authors when referring to compassion fatigue and/or vicarious traumatisation (McCann and Pearlman, 1990; Stamm, 1997; Ortlepp, 1998), the current study will use the term secondary traumatic stress.

Although not directly relevant to this study it is important to highlight the term 'burnout', as it is often confused with, and/or used interchangeably with, compassion fatigue and vicarious traumatisation (Figley, 1995; Salston and Figley, 2003; Adams et al, 2001).

Burnout is a state of emotional, mental and physical exhaustion characterized by the decreased ability to cope with one's environment (Figley, 1995). It is associated with the stress and hassles involved in an individual's work. It is cumulative and relatively predictable. It can often be resolved by simply taking a break or experiencing a change in scenery. (Figely, 1995).

In addition, McCann and Pearlman (1990) state that, although the burnout literature is relevant to working with some victims, the effects of working with trauma victims are distinct from other populations because the trauma worker is exposed to shocking emotional images of suffering and horror (McCann and Pearlman, 1990).

Salston and Figley (2003) have observed that secondary trauma and job burnout overlap to some degree as they are both characterised by the emotionally exhausting nature of working with trauma clients (Adams et al, 2004).

They do argue, however, that the concept of burnout is too vague to be valuable in understanding and helping those who work with victims of crime (Salston and Figley, 2003).

## 2.3 SECONDARY TRAUMATIC STRESS AND MENTAL HEALTH

### CLINICIANS

Secondary trauma or secondary traumatic stress refers to a set of symptoms that parallel those of posttraumatic stress disorder (PTSD) or acute stress disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2004).

The effect of traumatic events on mental health professionals has been referred to as secondary traumatic stress, (STS). It is conceptualized as a reaction to the emotional demands on these professionals, as well as an exposure to trauma survivors, who have experienced terrifying, horrifying, and intrusive traumatic memories (Sexton, 1999). This may cause a disruption in the therapist's view of self, others, and the world in general (Sabin-Farrell and Turpin, 2003).

Consequently, articles and books in scholarly and professional literature seek to understand and explain these experiences and to determine means for reducing distress among trauma therapists.

Mental health nurses are providing services which focus more and more on traumatic memory and traumatic symptomatology. Because of the realization that this focus does not come without cost to the individual therapist, the more current literature focuses on the costs of caring for therapists themselves.

Terms used to describe their condition are varied, but the most common include secondary traumatic stress and vicarious trauma (Arvay, 2001).

Several quantitative studies point to elevated rates in psychological trauma among counsellors and therapists working with traumatized individuals. Nevertheless, whereas these studies support the notion that trauma counsellors endorse items on questionnaires consistent with secondary traumatic stress and vicarious trauma, symptoms generally do not reach a clinically significant level or one in which symptoms markedly interfered with functioning (Ortlepp and Friedman, 2002).

A study of 70 human rights workers in Kosovo, who were responsible for collecting data on human rights violations, revealed elevated levels of anxiety in 17.1%, depression in 8.6%, and PTSD symptoms in 7.1% (Holtz, Salama, Cardoza, and Gotway, 2002).

Among lay trauma counsellors, who had been trained to assist bank employees following bank robberies in South Africa, only 10% reported secondary traumatic stress symptoms in the high or extremely high range (Ortlepp and Friedman, 2002).

Conversely, in a study of 173 child welfare workers, exposed both to traumatic imagery through the stories of clients, and direct exposure to trauma such as violence and threats directed at them, 46.7% reported traumatic stress symptoms in the severe range (Regehr, Chau, Leslie, and Howe, 2002a).

Qualitative studies and anecdotal reports have described the experiences of trauma therapists in more detail. Similar to traumatic stress, symptoms of vicarious trauma can include immediate reactions such as intrusive imagery, nightmares, increased fears for the safety of oneself and loved ones, avoidance of violent stimuli in the media, difficulty listening to clients' accounts of events, irritability and emotional numbing.

Longer term reactions can include emotional and physical depletion, a sense of hopelessness and a changed world view in which others are viewed with suspicion and cynicism (Iliffe and Steed, 2000; Ortlepp and Friedman, 2002).

Factors that influence symptom levels include the number or percentage of trauma cases on a therapist's caseload, the availability of social support (Ortlepp and Friedman, 2002) and personal histories of trauma and abuse (Wall, 2001). The perception that they have had adequate training to effectively assist victims can help reduce the sense of hopelessness that may accompany this work (Ortlepp and Friedman, 2002).

Theorists in the area of secondary or vicarious trauma recommend a variety of strategies for reducing the levels of symptoms and disruption. Several authors point to the

importance of maintaining a balance between work and personal life (Hesse, 2002). Seeking psychotherapeutic treatment to assist with countertransference issues related to unresolved events in ones' personal history and their effects on secondary trauma are recommended (Hesse, 2002). Peer consultation, supervision, and professional training to reduce the sense of isolation and increase feelings of efficacy are suggested (Dane, 2000). Finally, stemming from the association between exposure and symptoms, reducing the number of trauma cases is frequently suggested (Hesse, 2002).

These strategies are mirrored by therapists participating in qualitative studies and in anecdotal reports by therapists whose suggestions include peer support, physical activity and self-care, reading, watching TV shows or movies that are non-violent and by limiting political activism as well as their trauma counselling workload (Iliffe and Steed, 2000).

## 2.4 HOW DOES SECONDARY TRAUMATIC STRESS OCCUR?

Although, symptoms and reports on the stress experienced by nurses working in mental health service have been documented, the most fundamental question remains a mystery. How is it that the traumatic stress found in one person, a survivor, is also found among those who attend to the survivor, ie, the counsellors? (Salston and Figley, 2003)

One explanation is that the trauma counsellor, in an effort to generate an understanding of the traumatized person, identifies with the survivor's suffering (Gilliland and James, 1998). During this process, the trauma counsellor may experience emotions that are strikingly similar to those of the survivor (Gilliland and James, 1998).

These may include visual images (flashbacks), sleeping problems, depression, and other symptoms that are a direct result of visualizing the survivor's traumatic experiences, of being exposed to the symptoms of the survivor or both (Gilliland and James, 1998).

Mental health clinicians may have little control over contextual issues that may lead to traumatized individuals being re-traumatized, such as when bank robberies occur several times at one particular branch (Galloucis, Silveram, and Francek, 2000).

In addition to addressing the client's experiences, Ortlepp (1998) and Arvay (2001) suggest that the nature of the trauma itself may also have an impact on the mental health clinician.

According to Gilliland and James (1998), the severity of the trauma experienced by survivors can wear down the optimism and motivation of any health clinician.

By being exposed to the concept of trauma, mental health clinicians not only become aware of their clients' pain, but also come to the realization that such an event is possible, perhaps even in their own lives or in the lives of their loved ones (Gilliland and James, 1998). The thought of losing control, losing a sense of connection with

others, being pushed beyond one's perceived ability to cope, having one's frame of reference (i.e., sense of identity, world view, moral principles, life philosophy, and spirituality) change is a shocking possibility(Galloucis, Silveram, and Francek, 2000). According to Pearlman and Saakvitne (1995), the presence of a survivor client is an inescapable reminder of the mental health clinician's own personal vulnerability to traumatic stress.

## 2.5 FACTORS ASSOCIATED WITH STS IN MENTAL HEALTH CLINICIANS

### 2.5.1 Factors related to the mental health clinician

### 2.5.1.1 Personality characteristics

According to Friedman and Ortlepp (2001), STS in mental health clinicians working with trauma survivors has been associated with the tendency to be altruistic and over-committed in the service of others to the detriment of self. This combination leaves the individual vulnerable to exhaustion. An idealistic mental health clinician may view his or her job as calling, and feel compelled to assist everyone who calls on him or her for help (Friedman and Ortlepp, 2001).

This idealistic outlook could lead to over-involvement and over-identification with the client (Koeske and Koeske, 2000).

As the mental health clinician becomes enmeshed in the helping relationship, the strong need to be accepted and liked makes it increasingly harder to say no to a client's demands. At this point, the mental health clinician has to take on responsibility for the client (Gilliland and James, 1998). This over-involvement with the client may manifest itself in a variety of ways.

### 2.5.1.2 Empathic ability

Empathic ability, defined as the ability to see things from another's point of view (Du Toit,Grobler, Schenck, (2003), is frequently the characteristic that leads people to choose the role of mental health clinician ( Friedman and Ortlepp, 2001). Ironically, it is this ability that may cause the mental health clinician to be vulnerable to clients' traumatic material (Pearlman and Saakvitne, 1995).

As elucidated by Collins and Long (2003), "trauma workers who listen to clients stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care." Collins and Long (2003), point to the special challenges of mental health clinicians working with trauma survivors, since some of them may even feel that they have taken over the pathology.

### 2.5.1.3 Lack of assertiveness

Gillespie (2000) discusses how, by not setting limits, the mental health clinician can become susceptible to STS. By failing to say no, within reason, to the demands of their

clients, and by failing to educate their clients to accept their limitations, they, in turn, set the stage for their own incompetence and burnout (Gillespie, 2000).

### 2.5.1.4 Cognitive thoughts that engender burnout

It has been suggested that unrealistic self-expectations may also foster adverse reactions in mental health clinician (Gilliland and James, 1998).

For example, the superhuman notion that one should be able to save the world can become a psychological burden (Baird and Jenkins, 2002). In the extreme, this attitude, may lead to burnout and paralysis.

### 2.5.1.5 Demographic characteristics

According to Gillespie (2000), the demographic variables that have been associated with STS in mental health clinicians include age, education, marital status and family status,

Although inconclusive, Collins and Long (2003) report, that in some cases, it has been found that younger mental health clinicians working with trauma survivors are more susceptible to STS than their older counterparts, possibly because of their lack of experience.

Single and divorced trauma counsellors seem to be at greater risk for burnout than married counsellors (Gilliland and James, 1998). This is probably because they lack the supportive aspect of having a partner to confide in.

Collins, and Long (2003) explain that interpersonal support systems can operate as protective buffers against work stress.

According to Koeske and Koeske (2000), education without practical experience tends to create the greatest discrepancies between idealistic expectations of service and the realities of counselling, which may leave the mental health clinician most vulnerable.

It seems that the experience of STS affects both men and women – in other words, there do not appear to be gender discrepancies (Koeske and Koeske, 2000).

**2.5.1.6 Personal trauma history**

In some cases, mental health clinicians may have experienced some sort of traumatic experience in their own lives. They may still harbour unresolved feelings in this regard (Ortlepp, 1998).

It is also possible that they will work with people who may have experienced events that were similar to those experienced themselves (Gilliland and James, 1998). There is a danger that any unresolved trauma of the mental health clinician could be activated by similar trauma in the client (Collins and Long, 2003).

### 2.5.2 Factors related to the service organization

#### 2.5.2.1 Resources

In mental health care, the human services organisation is dependent on resources to maintain service delivery, and, if these are inadequate to meet the requirements or demands of clients, mental health clinicians may develop symptoms of stress and burnout (McKendrick, 1998). According to Ortlepp (1998), STS has been shown to be related to work overload.

#### 2.5.2.2 Structure

The structure of the organization determines the relationships between mental health clinicians and clients and also mental health clinicians and their supervisors. If the structure lacks the flexibility to meet the unique, and sometimes changing needs of its staff and clients, mental health clinicians can become vulnerable to burnout (Gillespie, 2000).

Gillespie (2000) suggests that the more bureaucratic the organization, the lower the level of autonomy felt by mental health clinicians. Professional self-esteem is seen as a subjective evaluation regarding prestige, worth and self-fulfillment, as well as the quality of service to other people provided by the profession (Gillespie, 2000). Additionally, it is hypothesized that an increase in work autonomy and variety were negatively associated with STS (Koeske and Koeske, 2000).

According to Koeske and Koeske (2000), mental health clinicians can become unmotivated if they are not given the flexibility, recognition and support they require.

### 2.5.2.3 Role of mental health clinician in mental health service

Mental health clinicians may work for organizations that expect them to fulfil a variety of roles over and above counselling work. They may, for example, be expected to perform heavy administration tasks, which could result in unnecessary stress (Koeske and Koeske, 2000).

Even in private practice, the role of being an independent business person means being completely responsible for maintaining the practice, where long hours and difficult work periods are the rule rather than the exception (Gilliland and James, 1998).

Because most of their patients work during regular hours, private practitioners devote many evenings and weekends to their work and may start to feel isolated from others in their field.

According to Gilliland and James (1998), because so little is said about STS, they may attribute their negative experiences to personal inadequacy.

### 2.5.3 Factors related to the nature of work

Traumatic events vary considerably, and this variation may hold important implications for the understanding of the nature, severity, duration and amenability to intervention,

not only for the primary cause, but also for the secondary, post-traumatic reactions (Creamer and Liddle, 2005).

Some of the variables which may influence the degree to which a trauma counsellor becomes affected include:

- Level of unpredictability of traumatic events (e.g. mental health clinician's expectation of encountering traumatic material) (Gillespie, 1999).

- Source of the traumatic experience (Dalenberg, 2000).

- Extent to which the trauma violates assumptions about the world or others (Inbar and Ganor 2003).

- Level of death threat involved (Collins, and Long 2003).

- Level of intimacy of the traumatic experience (e.g. sexual versus nonsexual) (Dalenberg, 2000).

- Whether the mental health provider himself or herself has survived or witnessed a prior traumatic event (Creamer and Liddle, 2005).

Research is needed to consider STS reactions as a function of the nature and degree of exposure material (Creamer and Liddle, 2005).

### 2.5.4 Factors related to the care-recipients' profile

### 2.5.4.1 Clients' behaviours

Clients, who display traits such as severe anger, anxiety, hostility, or despair, may challenge the capacity of mental health clinician (Gillespie, 1999).

Gillespie (1999) believes, that while it may be possible for the care providers to cope with one recipient who displays negative feelings, their coping strategies become depleted by the cumulative effect of an entire caseload of recipients with similar negative feedback (Gillespie, 1999).

### 2.5.4.2 Demographic characteristics of clients

If the patients are either very young or very old, a greater variety of resources and attention from trauma counsellors may be required (Maytum, Bielski, Heinman and Garwick 2004).

A mental health clinician may feel an additional responsibility to help a child or fragile geriatric because of their vulnerability, but at the same time may neglect themselves, thus adding to potential energy depletion (Maytum et al., 2004).

Trauma counsellors report that they are most vulnerable to compassion fatigue when dealing with the pain of children (Maytum et al., 2004).

It has been suggested that trauma counsellors find it more difficult to help clients who are under educated or poor, and these social issues compound recovery and have been linked to recidivism, thus furher taxing the competencies and resources of the trauma counsellor(Patti, 2000).

### 2.5.4.3 Chronicity

In cases where clients have chronic, unsolvable problems, mental health clinicians may question their efforts (Gilliland and James, 1998). Studies have found high STS rates among trauma counsellors working with victims of child abuse, mentally retarded clients and chronically ill psychiatric patients (Maytum et al., 2004). Mental health clinicians may also feel a sense of despair at being unable to resolve these problems.

### 2.5.4.4 Acuity

Acuity, or the immediacy and intensity of problems presented by clients, may also contribute to secondary traumatic stress (Maytum et al., 2004) because of the intensity of assistance required.

## 2.6 THE EFFECTS OF TRAUMATIC STRESS

### 2.6.1 The effects of traumatic stress on an individual

A review of the traumatology literature reveals that, until recently, most of the reports focus on those who were directly traumatized, the survivors, rather than on those who were traumatized indirectly or secondarily. Yet descriptions of what constitutes a traumatic event outline in category A in DSM-IV clearly suggest that the mere knowledge of another's traumatic experiences can be traumatizing (APA, 2004). People can be traumatized indirectly and without being physically harmed or threatened with harm. They can be traumatized simply by learning about a traumatic event and this experience has been labelled as STS (Salston and Figley, 2003). Not only are nurses and other health clinicians vulnerable to STS, but so too are the family and friends of survivors.

### 2.6.2 Secondary traumatic stress reaction

According to Salston and Figley (2003), discussion of STS reactions or vicarious victimization among mental health professionals is beginning to appear in the literature. However, there are only a few reports documenting its prevalence and, to date, treatment of this issue has been largely theoretical or anecdotal.

The terms, traumatic counter-transference, contact victimization, burnout and compassion fatigue have also been used to describe reactions similar to STS (Salston and Figley, 2003).

The writer will use the term STS throughout for consistency, but any one of the above mentioned terms could also have been used to describe the stress resulting from helping or wanting to help a traumatized person.

Although some researchers argue the distinctions between STS reactions versus disorders, based on the extent of the reaction, this writer questions the value of distinguishing between different reactions (Cunningham, 2003). Prolonged recovery among trauma workers, as with direct survivors of traumatic events, may be influenced by individual characteristics such as biological vulnerability, prior trauma and cultural differences (Baird and Jenkins, 2002).

Therefore, caution should be taken before premature classification of stress reactions as disorders is made, both in health professionals (secondary traumatic stress) or survivors (post-traumatic stress disorder) (Cunningham, 2003).

It seems that STS is inevitable among mental health providers, especially in trauma counselling and may develop regardless of race, age, gender, or level of training (Arvay, 2001; Baird and Jenkins, 2002).

Other factors include type of clients dealt with, caseload, frequency of supervision, satisfaction with supervision, and feeling of bureaucratic development (Steed and Bicknell, 2001). These STS reactions, though normal, can affect a nurse's health and productivity.

Paton and Violanti (1999) highlight the reality that rescuers are also vulnerable to the horror of human suffering. They state that psychological aftershock can emerge days, weeks or even months after the event and can seriously affect a person's performance as rescue worker.

As a means of formal categorization, STS reactions have been described in three areas: firstly, as indicators of psychological distress or dysfunction, secondly, as in cognitive schema and thirdly, as relational disturbances (Salston and Figley, 2003). This categorization is parallel to that of post traumatic stress (PTS) reactions. According to Salston and Figley (2003), "it seems reasonable to assume that the process of secondary trauma is similar to that of primary trauma and that existing theoretical models can shed light on that process."

The descriptive model detailed below is a useful framework for identifying the symptoms of STS.

## 2.7 SYMPTOMS OF PSYCHOLOGICAL DISTRESS IN MENTAL HEALTH

## CLINICIANS

Researchers have found that those suffering from STS have symptoms nearly identical to those suffering from PTSD (Courtois, 2004).

Secondary traumatic stress symptoms can be identified in four categories ie.: physical, psychological, relational and behavioral symptoms.

### 2.7.1 Distressing emotions

Sadness, depression, anxiety, dread, horror, fear, rage or shame are just some examples of psychological distress experienced by mental health professionals working in trauma counselling (Arvay, 2001). Feeling helpless - "the helplessness of humanity"- has also been described as a distressing reaction (Cunningham, 2003).

### 2.7.2 Intrusion

Arnold, Calhoun, Tedeschi, Cann, (2005), reported that images of clients' traumatic experiences can become intrusive for the health provider. These intrusions could take the form of nightmares, flooding and flashbacks of images generated during the client's narration of traumatic events.

### 2.7.3 Avoidance

Arnold et al. (2005) suggest that psychic numbing, dissociation or the reluctance to listen to traumatic stories are examples of avoidance tendencies.

In an attempt to block out or avoid intrusive traumatic images, addictive or compulsive behaviours such as substance abuse, workholism, and compulsive eating have been reported (Arnold et al., 2005).

### 2.7.4 Somatic complaints

Salston and Figley, (2003) mentioned headaches, gastrointestinal distress, heart palpitations, excessive fatigue, sleep disturbances, nightmares, vomiting and diarrhea as symptoms of psychological distress.

### 2.7.5 Physiological arousal

Examples of physiological arousal include angry outbursts, anxiety, irritability, restlessness, moodiness and lack of concentration (Arvay, 2001).

### 2.7.6 Impairment of day-to-day functioning in social and personal roles.

According to Baird and Jenkins (2002), mental health providers may start to avoid appointments, use less supervision, always be late and neglect self-care behaviours. Baird and Jenkins (2002) also mention overwhelming feelings of isolation, alienation, or lack of appreciation as being common. In their interventions with survivors of armed

hold-ups, they reported feelings, thoughts, and behaviours which have been cited in the literature as indicators of "burnout". These symptoms included exhaustion which was manifested in feelings of confusion, tearfulness, a sense of uselessness, and rigid thinking.

### 2.7.7 Cognitive changes in beliefs, expectations and assumptions.

Most people have theories or assumptions about the world, which provide a framework from which they conduct "normal" living (Berg and Janoff-Bulman, 1998). Mental health providers may start to question personal beliefs such as "it won't happen to me" or "bad things only happen to bad people" (Berg and Janoff-Bulman, 2000). They could also start to feel incredibly vulnerable and helpless.

Other examples cited are, chronic suspicion and lack of trust, bitterness or cynicism about others, alienation, client blame and disorientation (Friedman and Ortlepp, 2002).

Disorientation is often manifested in trauma counsellors as confusion about practical issues such as what day or month it is or what they are supposed to be doing.

According to Salston and Figley (2003), novice trauma counsellors may feel guilty when a survivor re-experiences the trauma as a result of the necessary procedures, such as encouraging the client to tell and re-tell the exact details of the event. He further describes a type of client blame that may result when a health provider begins to feel

victimized by clients whom he or she perceives as threatening, manipulative, or exploitative.

### 2.7.8 Relational disturbances

According to Salston and Figley (2003), the personal relationships of mental health providers may suffer, due to stress or anxiety over trust and intimacy. Working with trauma survivors, especially when the traumatic event involves exploitation, abuse, or intentional violence, may increase the sensibilities of the counsellors to those same dynamics in their own personal relationships (Steed and Bicknell, 2001). Other dynamics could be the trauma counsellor's over-identification with, or detachment from, the survivors. Detachment may involve judging, labelling, or pathologising the traumatic reaction (Steed and Bicknell, 2001).

It is important to note that all of the above may be regarded as normal responses to the stress of working with survivors of trauma (Baird and Jenkins, 2002). It is only when they become chronic or prolonged, or if they interfere with the functioning of the counsellor, that they can be termed 'abnormal' (Gilliland and James, 1998).

## 2.8 POSITIVE EFFECTS OF WORKING WITH TRAUMA SURVIVORS

The crisis helping relationship, which is described as reciprocal, is thought to lead to a process with the potential for constructive change, not only for the client but also for the

mental health provider (Gilliland and James, 1998). Gilliland and James posit that positive change is not merely the sense of achievement in successfully helping a client negotiate a crisis, but also the incorporation of the survivor's experience into the mental health provider's own life which leads to a more holistic and enabling outlook. The assumption is that the mental health provider, through his or her connection and identification with the client, can be transformed (Calhoun and Tedeschi, 1998).

Just as a trauma counsellor may be vulnerable through his or her empathic openness to negative emotional and spiritual effects of vicarious traumatization, perhaps he or she can benefit positively, too, through the client's processing of the experience (Pearlman and Saakvitne, 1995).

Some people suffering from the shock of highly stressful events have been transformed from sadness, depression, and desperation, to hope, joy, and a renewed sense of purpose and meaning of life (Calhoun and Tedeschi, 1998).

Can such a transformation be equally possible for mental health providers who recognize that they themselves are suffering from STS?

According to Gilliland and James (1998), STS can lead to personal and professional growth, as well as to despair and trauma.

Pearlman and Saakvitne (1995) report that it is possible for trauma counsellors to experience profound shifts in their identity and world-views. In the process of helping a

client to find meaning from his/her experience, a trauma counsellor may start to feel a connection and experience a spiritual awakening similar to that of the survivor. Arvay (2001) reported that emergency workers frequently coped with disastrous events by using cognitive strategies akin to searching for meaning or attempting to achieve mastery of the situation.

## 2.9 STRATEGIES TO PREVENT AND DEAL WITH STS

A variety of strategies are recommended in the literature to both prevent and deal with secondary traumatic stress.

### 2.9.1 Self-care strategies for the individual

'Self-care' refers to proactive strategies or routines that clinicians use to offset the negative aspects of working with trauma victims and to promote their own wellbeing. Self-care is distinguished from 'coping', which is said to refer to reactions that may or may not be chosen consciously and "the notion of self care is predicated on the assumption that working with trauma victims can be emotionally strenuous for service providers." (Wasco and Campbell, 2002).

The impact of STS can be decreased when the clinician maintains a balance of work, play, and rest (Bell, Kulkarni, and Dalton, 2003). This balance includes socializing with friends and family, being involved in creative activities and being physically active.

Participation in the aforementioned activities may work towards preserving a sense of personal identity.

Because of their restorative nature, rest and leisure activities (e.g., taking vacations) are important in decreasing the effects of STS (Iliffe and Steed, 2000).

Because STS may affect the mental health clinicians' ability to trust others,, a strong social support network can help to prevent STS and may also help to calm STS reactions. In addition, participation in activities that increase personal tolerance levels, such as keeping a journal, personal counselling, meditation, and obtaining emotional support from significant others, allows reconnection to emotions (Wasco and Campbell, 2002).

### 2.9.2 Organisational strategies to prevent and address vicarious trauma

Organizational support can be the key to help employees vent their feelings, process, or get debriefed about traumatic material (Wasco and Campbell, 2002). On the other hand, however, unsupportive administration, low salaries and difficulties encountered in providing services are all predictive of higher burnout rates and stress for mental health clinicians (Bell, Kulkarni, and Dalton, 2003).

### 2.9.2.1 Ensuring appropriate and diverse caseloads

Given that the level of exposure to trauma is a predictor of secondary traumatic stress levels, the number of cases clinicians see within a given time period need to be appropriate. It is also important that clinicians do not feel pressure to see more than this

because of 'waiting lists' (if waiting lists are a problem, more clinicians need to be funded).

In relation to mental health services where caseloads are not applicable, exposure to traumatic material or traumatised clients needs to be recognised as difficult and challenging work, with appropriate supports put in place. More diverse caseloads are associated with decreased secondary traumatic stress (Bell, Kulkarni, and Dalton, 2003). Diverse caseloads can be achieved by ensuring a variety of clients rather than only traumatised clients.

For those working in a specialist field (for example, trauma counsellors, and acute units) more diverse caseloads can be achieved by seeing different client types: i.e both male and female, children as well as adults (if the service sees both children and adults) or adult survivors of child abuse as well as adults recently abused.

Another strategy for diversifying caseloads is for a mental health clinician to work at multiple levels in psychosocial rehabilitation and prevention. For example, engaging in individual counselling, group work, training, research, communication, advocacy and community education/social change work (Annscheutz, 1999).

### 2.9.2.2 Providing effective supervision for all mental health clinicians

Effective supervision is said to be an essential component of the prevention and healing of secondary traumatic stress (Bell, Kulkarni, and Dalton, 2003). Responsible supervision creates a relationship in which a clinician feels safe to express their fears, concerns and feelings of inadequacy.

Sometimes staff supervision will be combined with ensuring organizational accountability and staff evaluation. This can create a tension in that a clinician's concern about the evaluation of their work may make him or her reluctant to bring up something relevant to work related secondary traumatic stress. Because of this, some authors recommend that supervision and evaluation remain separate functions (Bell, Kulkarni, and Dalton, 2003). In mental health services where this is not possible, the use of an external mental health specialist for specific supervision is recommended.

Certainly, all supervisory relationships need to be characterized by trust and transparency and fostered within a supportive workplace culture.

It is also worth noting that supervisors themselves need to be able to access effective supervisory support.

### 2.9.2.3 Access to debriefing

Debriefing and peer support were identified in the literature as the most important strategies for dealing with the after-effects of a difficult counselling session (Iliffe and Steed, 2000). Mental health clinicians dealing with trauma need to have access to regular debriefing. 'Critical incident debriefing' is a formalized method for processing specific traumatic events, and is an important component of organizational support.

Ongoing support for managing repetitive or chronic traumatic material also needs to be available and indeed, it has been suggested that talking in a semi structured setting may be an integral part of dealing with crisis work. Therefore, a key way in which mental institutions can support their clinicians is by providing them the opportunities to

verbalise 'work-related pain' in the company of supportive listeners, as the clinicians may find this difficult to arrange in other areas of their lives.

### 2.9.2.4 Staff and peer support system

The literature on secondary traumatic stress and vicarious traumatisation emphasises the importance of social support within the organization.

Bell et al. (2003) state that staff opportunities to debrief informally, and process traumatic material with supervisors and peers can be helpful. Group support can be formal or informal, take a variety of forms and be peer or professionally led. It may involve case conferences, clinical seminars or even reading groups. Time for social interaction between clinicians (for example, celebrating birthdays and specific achievements, team-building activities, staff retreats) can increase feelings of support.

### 2.9.2.5 Safety and comfort in the work environment

Some work places in mental health services are so dangerous that clinicians experience primary trauma, including physical and sexual violence, abuse, stalking and threats of violence, rather than only vicarious trauma. They may also experience bullying and harassment. Research has found that being threatened by a client or any other person at work is strongly correlated with compassion fatigue or secondary traumatic stress (Morrissette, 2004).

Obviously, protecting the physical and psychological safety of the staff must be of primary concern when creating a supportive work environment. Certain measures must exist in the workplace that clearly and urgently prioritize a mental health clinician's

physical and psychological safety. Such measures must prevent the occurrence of any direct physical or psychological harm, and must respond swiftly and effectively to any safety violations that might occur.

As well as safety issues, comfort is also important. Research has suggested that clinicians need to have personally meaningful items in their workplace (Pearlman and Saakvitne, 1995), in the form of inspiring posters or pictures (Bell, Kulkarni, and Dalton, 2003). A comfortable staff room is also important, perhaps, with provisions for comfort such as refreshments and music.

### 2.9.2.6 Workplace culture

According to Bell et al. (2003), the values and culture of an organization set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers should experience trauma and deal with it, both professionally and personally. An organizational culture that normalizes the effects of working with traumatized clients and other psychiatric clients can be a start to providing a supportive environment for workers to address those effects in their work and wider lives. It may also give rencouragement for clinicians to take care of themselves (Morrissette, 2004). Part of acknowledging the impact of secondary traumatic stress would include providing education about the condition, and ideally, this education would start at the beginning of a professional's career and be ongoing.

There are other aspects of a supportive organization that can be recommended to prevent secondary traumatic stress which are allowing for holidays, flexible working

hours, taking time off for illness, participating in continuing education and not explicitly or implicitly expecting or encouraging staff to work overtime. Ideally, people working in this field would have additional leave to deal with vicarious trauma issues or to simply be allowed to take a break when necessary (Bell et al., 2003).

## 2.10 CONCLUSION

This chapter discussed the literature review conducted to gain insight into the effects of secondary traumatic stress that nurses and other health clinicians experience by working in mental health services. It also discussed the strategies recommended to prevent and deal with the condition. The concept of secondary traumatic stress was explored with reference to the CSDT. Local and international literature was reviewed. Chapter Three discusses the research design and methodology used in the study.

# CHAPTER THREE: METHODOLOGY

## 3.1 INTRODUCTION

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.

The researcher describes the research design and methodology used in the study which includes population, data collection procedure, validity and reliability, and ethical considerations.

The aim of the study is to explore and describe the effects of secondary traumatic stress experienced by nurses working in mental health services in Rwanda. The research methodology facilitates the attainment of the research objectives.

## 3.2 RESEARCH DESIGN

A research design is an overall plan for collecting and analyzing data, including specifications for enhancing the internal and external validity of the study (Polit and Hungler, 1999; De Vos, 2001).

For this study a non-experimental design was adopted. The research approach was quantitative in nature, with an exploratory and descriptive design in order to understand the phenomenon under investigation.

The researcher explored the effects of secondary traumatic stress and personal trauma history experienced by nurses and the underlying process of integration, meaning and adaptation alluded to in the CSDT. The aspects of secondary traumatic stress, namely the work situation and support systems, were described within the context of nurses working in mental health in Rwanda.

## 3.3 RESEARCH SETTING

This study was carried out at NDERA Psychiatric Hospital in Rwanda. 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 prevention and specialized psychiatric and mental health care, training, supervising the mental services in district hospitals and providing technical support in mental health care to referral and district hospitals.

Ndera Psychiatric Hospital is located at Gasabo district in Kigali City, the Capital of Rwanda. The staff includes 67 nurses (3 registered nurses with honours degrees, 42 registered nurses, and 22 enrolled nurses), 4 medical doctors, 2 psychiatrists, 1 neurologist, 9 social workers and 2 psychologists.

The hospital has 177 beds divided into 5 wards – male and female acute, male and female rehabilitation, the children's ward and the chronic ward. 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 several laboratories.

## 3.4 POPULATION

The target population for this study was all the nurses (N=67), male and female, working at Ndera Psychiatric Hospital in Rwanda.

## 3.5 SAMPLE AND SAMPLING

In this study, a sample of all nurses who provide a mental health service within the Ndera Psychiatric Hospital was selected, according to the following inclusion criteria:

- Respondents must be nurses who have completed their initial nurse training and have additional training in psychiatric nursing or trauma counselling, currently working at Ndera Psychiatric Hospital.
- Participants must have at least 6 months experience working at Ndera Psychiatric Hospital.
- Participants must be employed on a full time basis.

- Participants must be directly involved in counselling the victims of psychological trauma and other psychiatric patients.

For this study the researcher adopted a non-probability sampling approach. Using a convenience approach, all the nurses working at Ndera Psychiatric Hospital during the data collection period and who met the inclusion criteria were included.

## 3.6 DATA COLLECTION INSTRUMENT

In this study, the researcher developed a questionnaire which contained four sections. These sections include: Section A: demographic data; Section B: personal trauma history; Section C: work related experiences and support systems and Section D: Trauma and Attachment Belief Scale (TABS). 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). 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 and Saakvitne, 1995a: 408). Measures beliefs are related to the five needs areas that are sensitive to the effects of traumatic experiences (safety, trust, esteem, intimacy, and control) (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 specific items which shape the ten subscales are made up as follow: Self-Safety (13 items 1, 11, 17, 27, 32, 38, 43, 47, 54, 60, 65, 71, 81), Other-Safety (8 items: 6, 16, 24,

29, 37, 63, 72, 80), Self-Trust (7 items: 7, 19, 34, 49, 58, 67, 77), Other-Trust (8 items: 2, 12, 26, 31, 41, 52, 61, 70), Self-Esteem (9 items:3, 13, 21, 30, 42, 51, 64, 73, 83), Other-Esteem (8 items: 8, 18, 28, 39, 44, 57, 68, 76) , Self-Intimacy (7 items: 9, 23, 40, 53, 62, 75, 84) , Other-Intimacy (8 items: 4, 14, 20, 35, 48, 55, 74, 82), Self-Control (9 items: 5, 15, 25, 36, 45, 50, 56, 69, 79) and Other-Control (7 items: 10, 22, 33, 46, 59, 66, 78).

Permission to use this instrument was obtained by Western Psychological Service (WPS) (see Appendix 4).

The questionnaire was translated into French by the researcher and checked by the Department of Language of University of KwaZulu Natal (see Appendix 7).

## 3.7 VALIDITY AND RELIABILITY

According to Polit and Beck (2004) validity is defined as a degree to which an instrument measures what is supposed to measure.

Polit, Beck and Hungler (2001) describe reliability as the consistency with which an instrument measures the attributes.

The TABS which was used as section D of the current questionnaire has demonstrated validity and reliability as it has been used in previous studies (Pearlman and Saakvitne, 1995; Pearlman, 2001; Lerias and Byne, 2003).

The validity and reliability of 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) (Pearlman and Saakvitne, 1995).

The overall reported reliability (Cronbach's alpha) of the TSI is 0.98 (Pearlman, 1998).

Other questions were developed by the researcher, himself, using the research objectives and research questions as a point of departure. The research supervisors assisted with formulating these questions and the research supervisor evaluated the questionnaire.

A pilot study was carried out on ten mental health nurses in Rwanda who did not participate in the final project. This was done to check that the respondents were able to understand the questions and fill it in correctly.

Content validity refers to the extent in which the questionnaire includes all the major elements relative to the concepts being measured (Burns and Grove, 2001) (Refer to Table 3.1 below).

**Table 3.1 Content validity**

| Objectives | Theoretical framework | Questionnaire |
|---|---|---|
| To explore the effects secondary traumatic stress in nurses who provide a psychological care to victims of trauma in Rwanda | Frame of reference<br><br>Self capacities | **SectionD**:1,4,9,15,19,24, 25,27,31,32,34,35,36,39, 40, 44,47,50,55,56,64,65,66, 6870,74,80,84 |
| To describe the work–related aspect that creates secondary traumatic stress in nurses working with victim of trauma in Rwanda. | Ego resources | **SectionD**:2,3,5-8,22,23,26, 29,30,33,54,57-61, 83<br><br>**Section B**: 8- 10. |
| To investigate traumatic events in nurses' personal history associated to STS | Psychological needs and cognitive schemas | **Section D**:10-14,37,41-43, 45,61-63,71,72,81<br><br>**Section B**: 7 |
| To describe the support system for nurses who work in mental health care service in Rwanda. | Memories and perception | **Section D**: 16-18,20-21,46,49,51-53,73,75-79,82<br><br>**Section C**: 11-15 |

## 3.8 DATA COLLECTION PROCEDURE

Permission was obtained from the authorities of Ndera Psychiatric Hospital in Rwanda prior to data collection (see Appendix 3).

Before commencing data collection, an introductory and informative session was held with the nurses and managers of Ndera Psychiatric Hospital to explain the purpose of the investigation and to negotiate when it would be convenient to collect data.

After the introductory and informative session, the researcher made appointments with the nurses as to when they would be on duty.

Each participant was seen individually by the researcher and the questionnaire was delivered by hand to each participant. A covering letter, explaining the information about the study and the consent form were included. Clear and concise instructions for completing the questionnaire were also included.

Due to the sensitive nature of the questions asked, the researcher (a trained psychiatric nurse) was available to provide psychological support should the need arise

## 3.9 DATA ANALYSIS

The questionnaires were numbered and coded to facilitate data capturing and the auditing of captured data. All variables were analyzed using the SPSS version 15.0

program. Descriptive statistics were used to describe and synthesize data. Frequencies and basic statistics were calculated and presented in tables and graphs.

## 3.10 ETHICAL CONSIDERATIONS

Ethical considerations are vital to any study because of the influence the researcher has to acquire and retain respondents (Polit and Hungler, 1999). Burns and Grove (2001) suggest that in order to maintain a high standard of research, the conduct of nursing research not only requires expertise and attentiveness, but also honesty and integrity.

Prior to data collection, ethical approval was obtained from the ethics committee of the University of KwaZulu Natal and permission to conduct research was obtained from the authorities of Ndera Psychiatric Hospital in Rwanda (see Appendix 2 and 3).

Ethical issues always need to be considered when dealing with a sensitive issue such as trauma and, during the course of this research, strict ethical standards and procedures were adhered to. Confidentiality and anonymity were maintained by ensuring that the questionnaires were anonymous and the data collected could not be traced back to individuals.

Written informed consent (Appendix 5) was obtained from all the respondents and participation in the study was voluntary. The respondents were informed that they could withdraw from the study at any stage.

Every effort was made to clarify the questions and to ensure that the respondents did not have unrealistic expectations of the project.

Based on scientific honesty, the researcher acknowledged all the ideas and works from others that he used in this study. For this purpose, permission for using the TABS was obtained from the author (Dr. Laurie Anne Pearlman) and from Western Psychological Services (WPS).

## 3.10.1 DATA MANAGEMENT

The data were stored by the researcher in a secure place only accessible to himself and his supervisor. The researcher 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. 11 CONCLUSION

This chapter discussed the research design and methodology in detail, including the research instrument and the method of distributing and collecting the questionnaires to ensure a high return rate. It also discussed validity, reliability, ethical considerations and data management. Chapter Four discusses the data analysis and findings and includes discussion relating to the literature reviewed.

# CHAPTER FOUR: DATA ANALYSIS

## 4.1. INTRODUCTION

The questionnaire used in this study was carefully analyzed to ensure that the data gathered were presented clearly. Tables, percentages and graphs, were used, where possible.

The overall aim of this study was to explore the secondary traumatic stress experienced by nurses providing mental health care in mental health services in Rwanda.

Work-related aspects were also analysed and presented, bearing in mind that the mental health nurses not only treat victims of trauma, but also care for patients with major psychiatric illnesses.

Initially, the total population of 67 nurses working at Ndera Psychiatric Hospital was identified to participate in the study. Some of the nurses, however, were unavailable to complete the questionnaire, resulting in only a total of 50 questionnaires being distributed with a response rate of 100% (n=50).

The data were entered into a computer. This information was protected by secret password, to which only the researcher had access.

## 4.2. DEMOGRAPHIC DATA

In this study demographic data covered the gender, age, marital status, professional qualifications, years of experience as nurse and years of experience in mental health service.

### 4.2.1 Demographic characteristics of the respondents

According to Table 4.1, 64% (n=32) of respondents rendering a mental health service at Ndera Psychiatric Hospital were female and 36% (n=18) were male.

This is consistent with Cunningham's (2003) finding that 82% of social work clinicians rendering services to victims of trauma were females. Furthermore, in Trippany et al's (2004) study on factors influencing secondary traumatic stress, the sample consisted of 144 self identified female therapists. These findings suggest that females serve predominantly as nurses in mental health service in Rwanda.

Brady et al. (1999) is of the opinion that females generally assume the "caring" role and therefore work in the helping professions of nurses, social workers and teachers. Although we cannot address the gender differences in this study, given the small size, gender differences merit further study.

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, and Saar, 2006 ) and in a study of psychotherapists, who were treating

sexual trauma survivors, Kassam-Adams (1999) noted that female therapists reported greater PTSD symptoms than male therapists.

Of the respondents, 80% (n=40) were in the age group 26 – 35 years and 10% (n=5) were in the age groups of less than 25 years; 6% (n=3) were in the age groups 36-45 years and 4% (n=2) were in the age groups of more than 45 years.

These finding indicate that the ages of the majority of the nurses ranged between 26 and 35 years.

Of the respondents 64% (n=32) were single and 36 % (n=18) were married.

The severity of secondary traumatic stress symptoms may be mitigated by various factors, including the perceived availability of, and satisfaction from, social support (Hyman, 2005). The majority of the nurses working in the Ndera Psychiatric Hospital were single and, perhaps, did not have much social support.

Of the respondents, 60% (n=30) were registered nurses (with an advanced diploma in nursing and/or training in mental health), 34% (n=17) were enrolled nurses with secondary education in nursing; 6% (n=3) had an honours degree in nursing with mental health training and none (0%, n=0) had a masters degree.

These findings suggest that nurses working in mental health services in Rwanda have a wide range of qualifications.

The researcher is of the opinion that these qualifications assist the nurses in their daily work as they are able to work independently. It is of concern, however, that none of the

respondents had master's degree although this can be attributed to the fact that there is currently no training being offered for nurses at a master's level in Rwanda.

Educational levels, length of career and increased contact with clients have been positively correlated with the severity of STS symptoms (Baird and Jenkins, 2003). Trippany et al (2003) found that all their respondents had either a master's or doctoral degree and corresponding high scores relating to secondary traumatic stress.

**Table 4.1 Demographic characteristics of the respondents**

| Demographic characteristics | | Frequency | Percentage |
|---|---|---|---|
| **Gender** | Female | 32 | 64 |
| | Male | 18 | 36 |
| **Age** | 25 years and less | 5 | 10 |
| | 26 – 35 years | 40 | 80 |
| | 36 – 45 years | 3 | 6 |
| | 45 years and more | 2 | 4 |
| **Marital status** | Single | 32 | 64 |
| | Married | 18 | 36 |
| | Separated | 0 | 0 |
| | Widow | 0 | 0 |
| **Qualification** | Enrolled nurse | 17 | 34 |
| | Registered nurse | 30 | 60 |
| | Honors | 3 | 6 |
| | Masters | 0 | 0 |

### 4.2.2 Experience in service as a nurse

Of the respondents, 46% (n=23) had 6 - 10 years experience as nurses; 36. % (n=18) had 0 - 5 years experience; 10% (n=5) had 11- 20 years experience; 8 % (n=4) had more than 20 years experience.  This is illustrated in Figure 4.1.

These findings suggest that the nurses currently working in Ndera Psychiatric Hospital in Rwanda have limited years of experience.

While length of experience may also be relevant in predicting secondary traumatic stress, existing research on this is contradictory.

Although providing treatment to survivors over a shorter length of time has been found to predict greater 'intrusive' symptoms in clinicians, it is also been suggested that clinicians most affected by trauma may leave the field prematurely (Way et al. 2004).

On the other hand, working in the field for a longer period of time has been associated with having more disruptive beliefs regarding intimacy with others (Bober and Regehr, 2006).

These researchers suggest that degree of exposure has an impact on intrusion and avoidance symptoms, but that altered beliefs do not appear to occur in the short term. Iliffe and Steed (2000), suggest that symptoms may also be recognised to a lesser extent over time, becoming 'normalised', and so, less noticed.
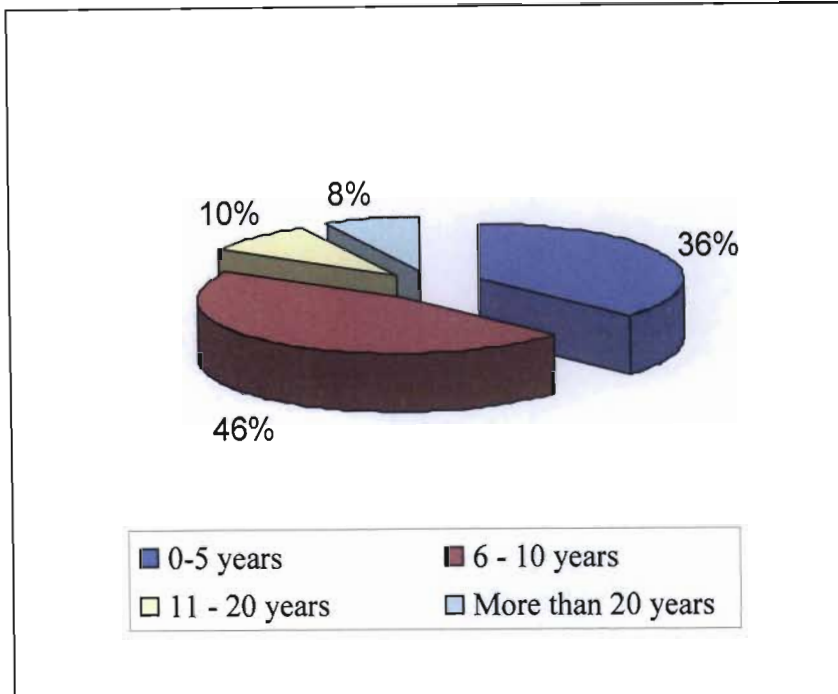
**Figure 4. 1. Years of nursing experience**

### 4.2.3 Experience in mental health service

Of the respondents, 64% (n=32) had 0-5 years experience in mental health service; 30% (n=15) had 6-10 years experience and 6% (n=3) had 11-20 years experience.

As shown by Figure 4.2, new and inexperienced nurses accounted for most (64%) of the respondents.

Conningham (2003) found that new and inexperienced staffs were most likely to experience secondary traumatic stress. Furthermore, Steed and Bicknell (2001) concurred and reported that therapists, who are new, are more susceptible to developing STS symptoms.

Previous research, however, showed that close and long-term contact with an emotionally disturbed person may cause chronic stress in the persons providing help which, in time, can lead to various emotional problems. These include higher levels of depressive symptoms, anxiety, lack of concentration, emotional exhaustion, pain syndromes and sleeping problems (Dekel et al., 2005).

Arvay (2001), Birck (2002), and Pearlman and MacIan (1995) all reported that secondary traumatic effects increased with the number of years in trauma work.

A few studies reported that length of experience did not buffer the effects of exposure to trauma material.
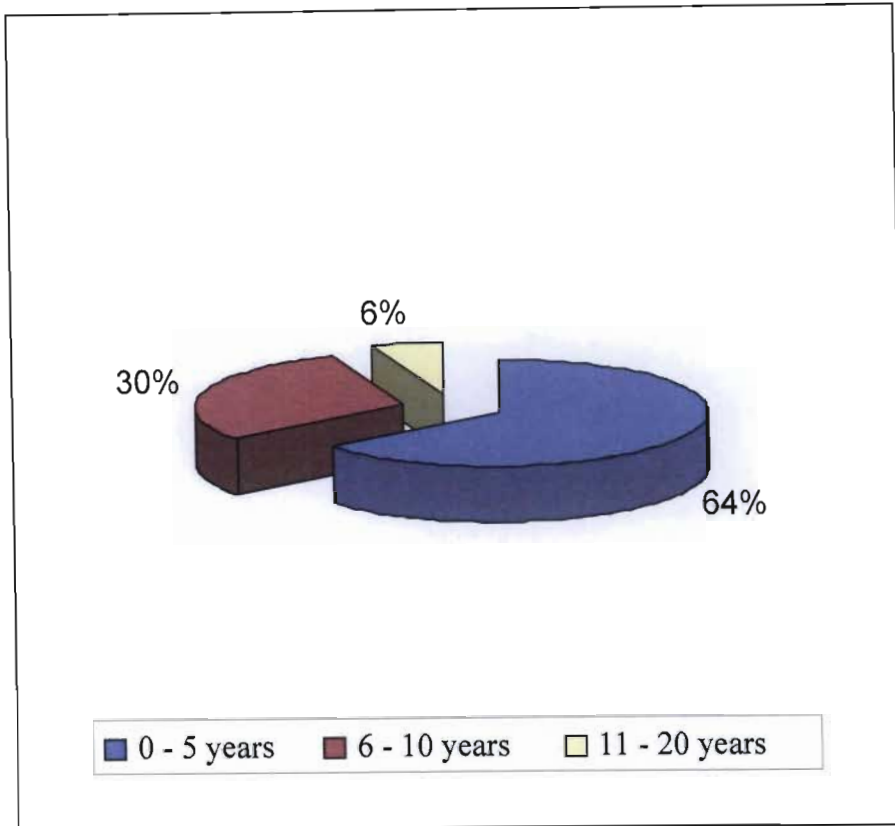
**Figure 4.2: Nurses' experience in mental health services**

## 4.3 Personal trauma history.

Personal trauma history includes any psychological trauma experienced by the respondents, their family or friends. Also included were questions relating to intervention they received to deal with the trauma. Refer to Figure 4.3 below.

Of the respondents, 76% (n=38) had personally experienced genocide, 10% (n=5) had experienced accidental disaster, 8% (n=4) had experienced emotional or psychological

abuse and 7% (n=3) reported that they had experienced some form of natural disaster (e.g. a flood or earthquake).

It became evident that most of the respondents had personally experienced trauma due to the Rwandan genocide and these findings reflect the impact it has had on the people living and working in Rwanda.

A previous personal history of trauma is another factor that is contentious in research findings to date.

Schauben and Frazier (1995) reported that a personal history of trauma was not a factor influencing levels of STS symptoms, whereas, on the other hand, Ghahramanlou and Brodbeck (2000) and Pearlman and MacIan (1995) reported that a personal history of past trauma was a risk factor in the development of secondary trauma.

Salston and Figley (2003); Arvay, (2001); Pearlman and Saakvitne, (1995) suggested that the personal trauma history of trauma therapists requires further study.
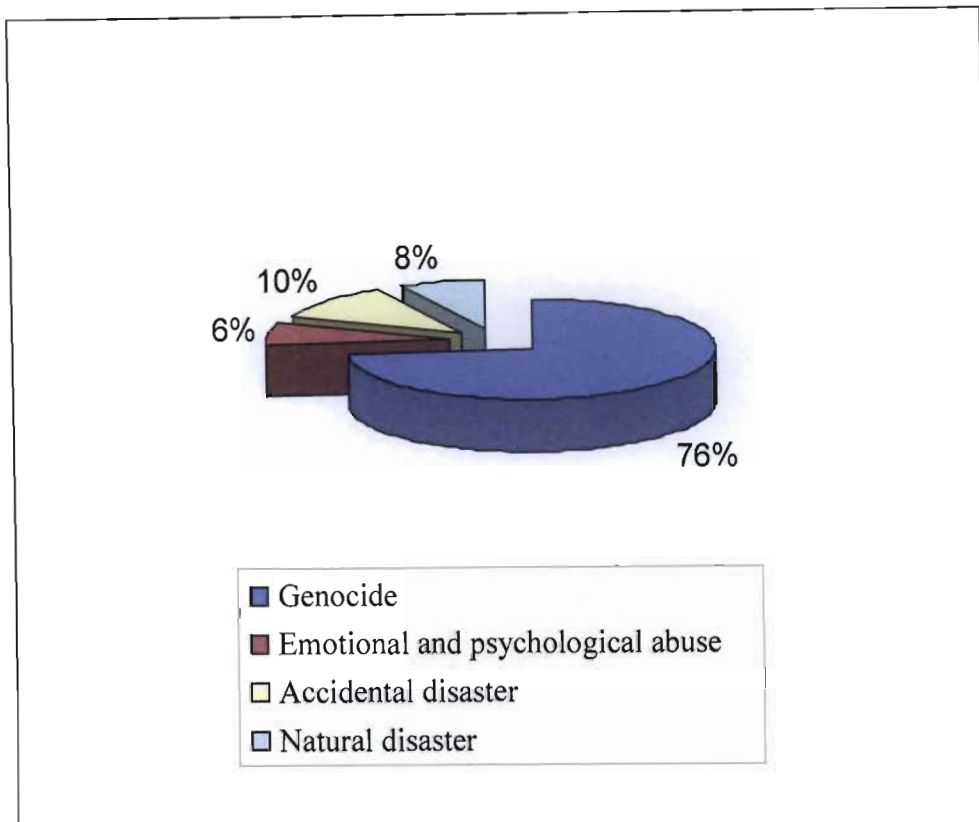
**Figure 4.3: The respondents' personal trauma history**

## 4.4 General counselling time

As shown in Table 4.2, 50% (n=25) of the respondents spend 10hours or less per week in counselling service, 42 %( n=21) spend 10-20 hours per week in counselling service while only 8 %( n=4) of the respondents spend 30 hours and more per week in counselling service

According to Bober and Regehr (2006), time spent counseling a client is the best predictor of secondary traumatic stress among counselors. This can have implications for preventing or addressing STS.

**Table 4.2 Number of hours per week spent in counselling service**

| Number of hours in counselling | Frequency | Percent |
|---|---|---|
| 10 hours and less | 25 | 50 |
| 10-20 hours | 21 | 42 |
| 20 – 30 hours | 0 | 0 |
| 30 hours and more | 4 | 8 |
| **Total** | **50** | **100.0** |

**4.5 Number of hours per week spent in trauma counselling**

As shown in Table 4.3, 52% (n=26) of the respondents spent 10 hours or less per week counselling trauma victims, 32% (n=16) spent 10-20 hours per week, 10% (n=5) spent 20-30 hours per week and 6% (n=3) spent 30 hours or more per week. Schauben and Frazier (1995), in their study, have found that counselors with a higher percentage of trauma patients in their caseload reported more disrupted beliefs, more PTSD symptoms, and more self-reported secondary traumatic stress.

**Table 4.3 Number of hours per week spent in counselling for trauma victims**

| Number of hours per week | Frequency | Percent |
|---|---|---|
| 10 hours and less | 26 | 52 |
| 10-20 hours | 16 | 32 |
| 20-30 hours | 5 | 10 |
| 30 hours and more | 3 | 6 |
| **Total** | **50** | **100.0** |

## 4.6 Counselling time for new cases

Figure 4.4 depicts the average time the respondents spent counselling new trauma victims.

According to Figure 4.4, 44% (n=22) of the respondents spent 40-50 minutes counselling a new mental health case; 28% (n=14) spent 1 hour; 24% (n=12) spent 20-30 minutes, and 4% (n=2) spent 10 minutes or less.

This statement is consistent with Halloran (2003), who states that 50 minute counselling sessions are necessary to deal with distressing events, such as trauma, in an individual's life.
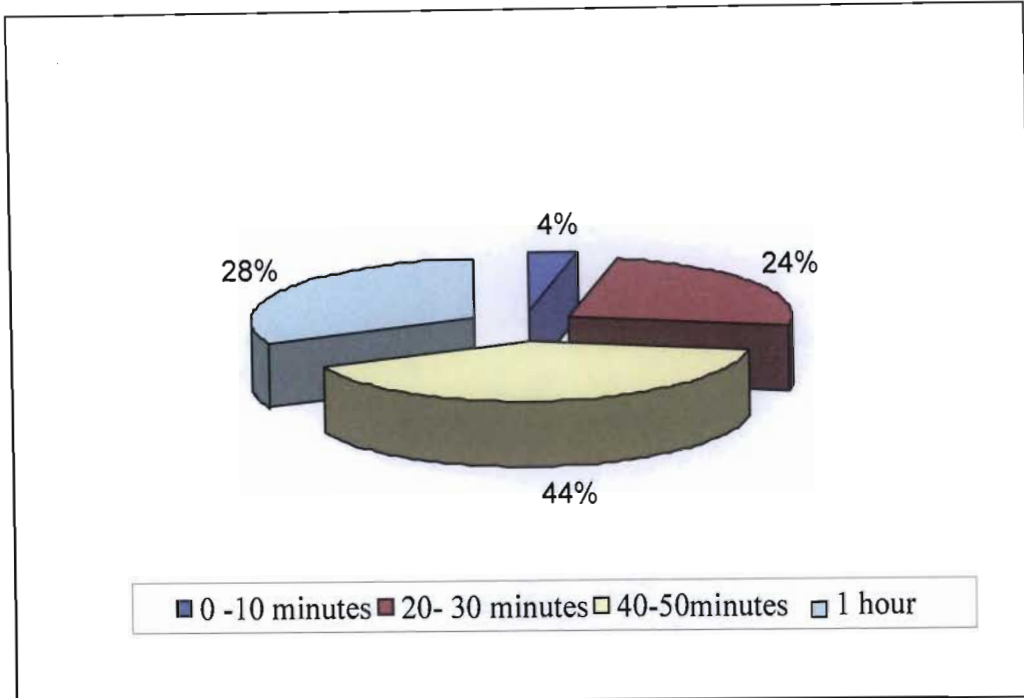
**Figure 4.4 Counselling time of new cases by nurses.**

## 4.7 Availability of a support system

Figure 4.5 depicts the availability of psychological support in the workplace, as reported by the respondents.

Of the respondents, 46% (n=23) indicated that there was no psychological support system for nurses working in the mental health services in Rwanda, 30% (n=15) indicated that there was a psychological support system and 24% (n=12) did not know if such a system existed or not.

This indicates that only 30% say that a support system is available.

Hattingh (2001) found that staff were often unaware of the support services provided by their organization and that, in many cases, such support systems, that were available for staff were not being used.
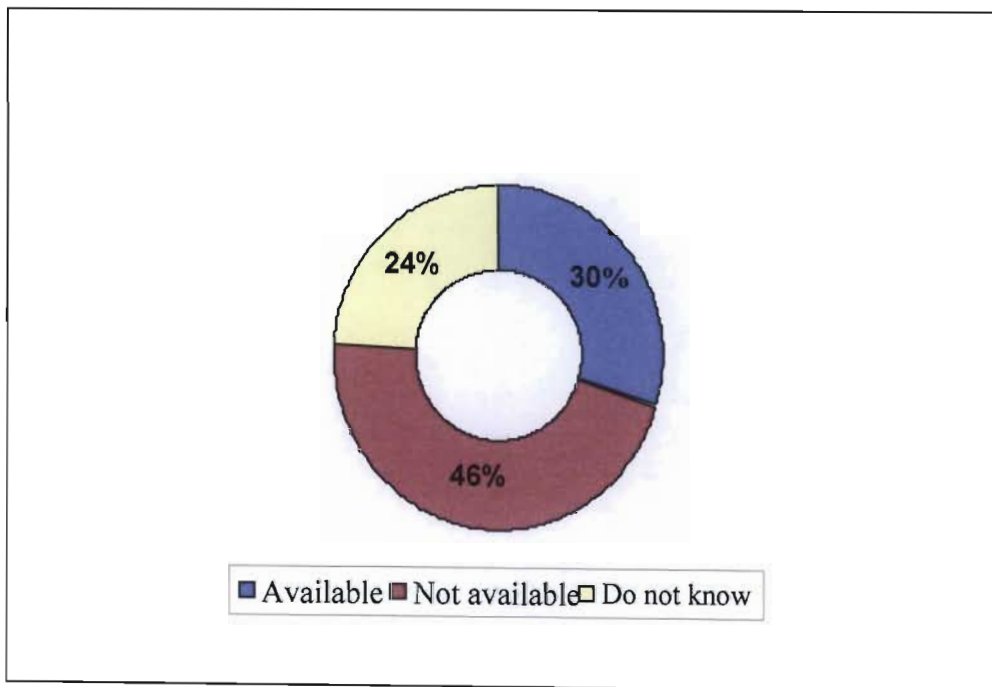


**Figure 4.5 Availability of support system**

## 4.8 Types of support systems used by mental health nurses

With reference to Figure 4.6 which indicates types of support systems used by mental health nurses, 30% (n=15) of the respondents indicated that support was provided by a peer supervision group; 26% (n=13) indicated that support was provided by talking to friends or family; 24% (n=12) indicated that psychological support was provided by psychiatrists or psychologists working in mental health system ; 12% (n=6) indicated that the psychological support was provided by psychiatric nurses working in the same service; 8% (n=4) reported structured workplace system, provided sufficient support

Hattingh (2001) emphasizes that the support of family and significant others is important for the individual to maintain a healthy physical, psychological and social life. Furthermore, the absence of this support creates feelings of alienation and loneliness in the individual.
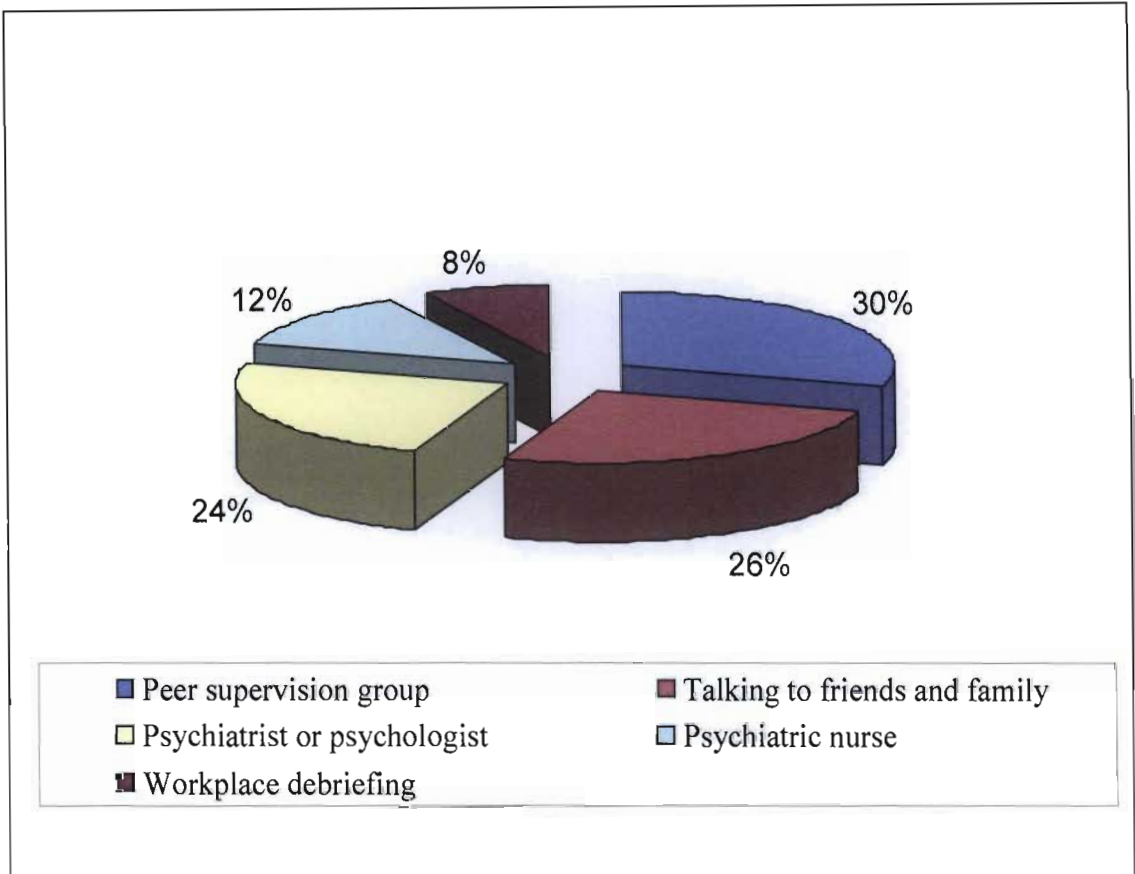
**Figure 4.6 Types of support systems used by mental health nurses**

## 4.9 PSYCHOLOGICAL DEBRIEFING IN MENTAL HEALTH

### 4.9.1 Benefits of psychological debriefing

The respondents were asked to indicate whether psychological debriefing to mental health nurses was helpful. All respondents (100% n=50) reported that psychological debriefing is helpful when working as a nurse in mental health services.

However, Geyer (2001), 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.

## 4.10 SUPPORT SYSTEMS TO LIMIT OR PREVENT STS IN WORKPLACE

Figure 4.7 reflects the respondents' views on what support systems could be applied to limit, or prevent, psychological trauma in nurses working in mental health services. Of the respondents, 36 % (n=18) reported that better working conditions would assist the nurses, 24% (n=12) reported that sensitivity shown by their non-mental health colleagues and management would assist them, 20%(n=10) reported that supervision or debriefing are the best ways to limit secondary traumatic stress, 12% (n=6) reported a better salary would help and 8%(n=4) suggested that help with transport would be of benefit.

Ka Mzolo (2004) found that the extra workload that nurses carry because of staff shortages results in them experiencing high levels of stress.

Geyer (2001) is of the opinion that management and the employer have a responsibility to ensure that the workplace remains a healthy and supportive environment.

Furthermore, Birck (2002) states that decreased job satisfaction is a by-product of the traumatic stress that individuals experience because they do not have support systems they can rely on to help them deal with their problems.
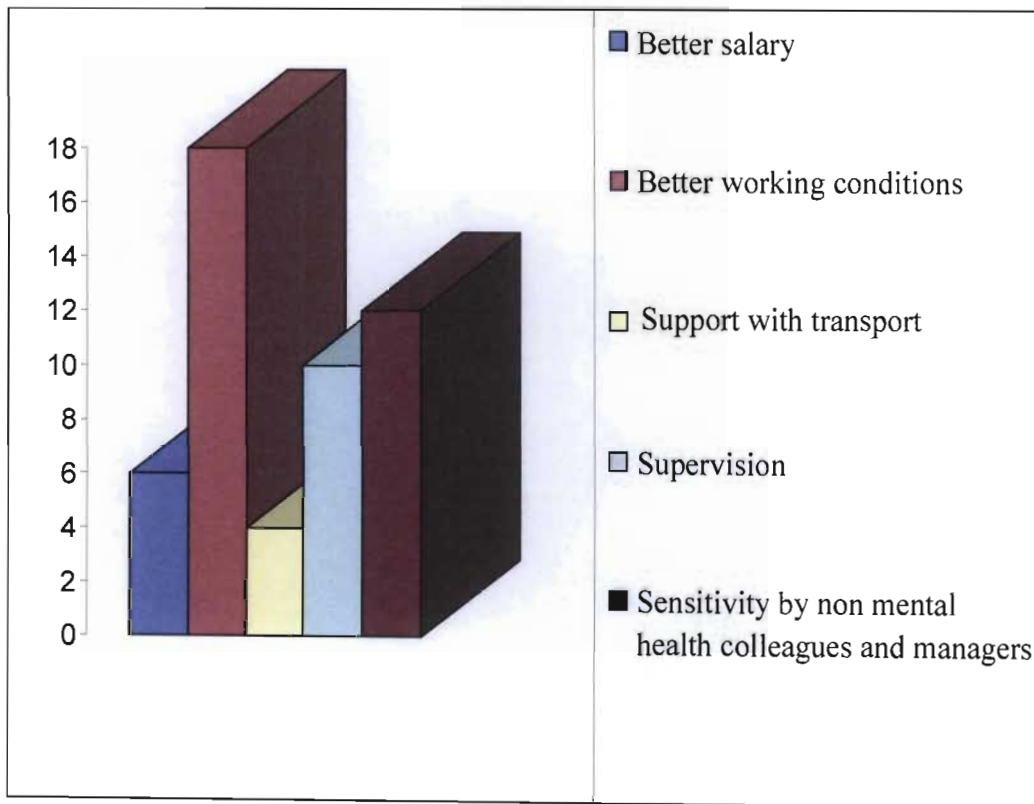


**Figure 4.7 Support system to limit or prevent secondary traumatic stress in**

**workplace**

## 4.11 The most appropriate professional to provide support to nurses working in mental health services

Figure 4.8 reflects the respondents' views on who should be appointed to render psychological supervision.

Of the respondents, 44% (n=22) were of the opinion that supervision should be provided by a psychiatric nurse; 32% (n=16) felt that supervision should be provided by a psychiatrist, 18% (n=9) felt that a psychologist should do it; and 6 %( n=3) indicated the clergy.

Mitchell and Everly (1994) found that nurses were more accepting of nurses as supervisors than psychiatrists, psychologists or clergy. These findings may be attributed to the fact that the respondents were themselves mental health nurses and were knowledgeable about the role of psychiatric nurses in psychological support.
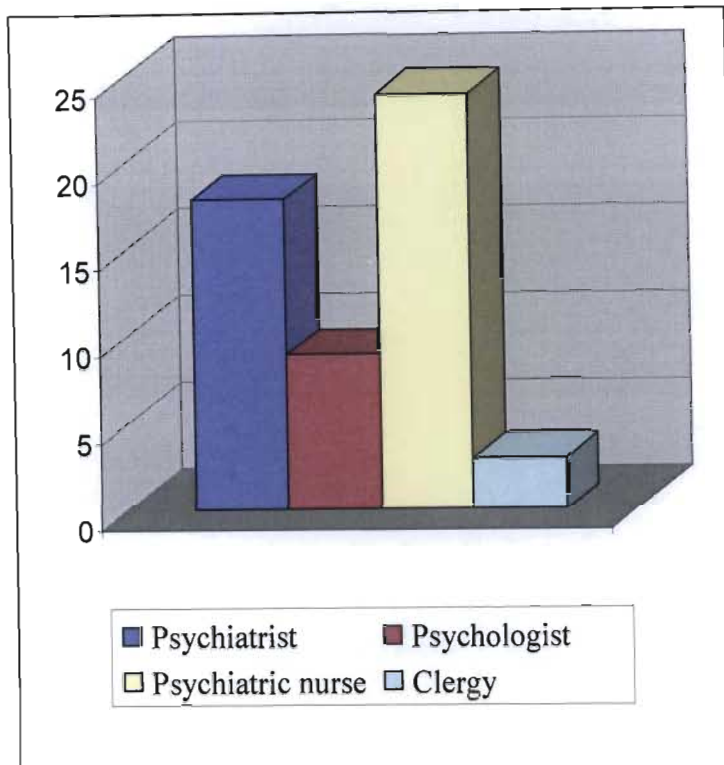
**Figure 4.8 The most appropriate professional to provide supervision to nurses working in mental health service**

## 4.12 TRAUMA AND ATTACHMENT BELIEF SCALE

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, 1998).

The TABS has shown strong reliability and validity in previous studies.

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 some items in this scale include: "I find myself worrying a lot about my safety" and "You can't trust anyone."

As depicted in table 4.4, the subscales had varying means since they consisted of a different numbers of questions.

As shown in Table 4.4, all respondent (n= 50) answered the 84 questions that were asked for the 10 subscales. The subscale other-safety had the highest mean at 79.58 whilst self-trust had the lowest at 63.74. The mean score for the total score of the sample was 79.06 which is extremely high.

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

70 or more = extremely high risk (substantial disruption).

The higher the scores the greater risk factor for secondary traumatic stress. It is suggested that the cut-off point for secondary traumatic stress is 50, above which moderate or severe disruptions are indicated.

The standard deviations also varied, indicating more or less symmetrical distributions.

**Table 4.4 Respondents' views of their Trauma and Attachment Belief Scale**

**Descriptive Statistics**

|  | N | Mean | Std. Deviation |
|---|---|---|---|
| Self – Safety | 50 | 69.88 | 3.001 |
| Other – Safety | 50 | 79.58 | 2.970 |
| Self – Trust | 50 | 63.74 | 5.138 |
| Other – Trust | 50 | 65.16 | 4.808 |
| Self – Esteem | 50 | 72.46 | 3.660 |
| Other – Esteem | 50 | 71.52 | 4.829 |
| Self – Intimacy | 50 | 67.04 | 4.602 |
| Other – Intimacy | 50 | 72.20 | 4.499 |
| Self – Control | 50 | 78.90 | 2.628 |
| Other – Control | 50 | 77.00 | 5.838 |
| T- Score of scale | 50 | 79.06 | 2.152 |
| **Valid N (listwise)** | **50** | | |

## 4.12.1 Pair-wise correlation between the T-scores of the ten subscales

To investigate the relationship between the subscales, pair-wise correlation coefficients were computed.

According to Polit and Hungler (1999), Pearson's product-movement correlation coefficient ( Pearson's r) is the most commonly used correlation index that is computed to measure variables on an interval scale, as was the case with the ten subscales.

Table 4.5 depicts the pair-wise correlations between the values of the ten subscales of TABS. There are three values in each cell:

(1) The Pearson product moment correlation coefficient

(2) The p-value for the hypothesis test HO p=0

(3) The sample size

The correlations other-safety vs. self-esteem(r =. 294), other-safety vs. other-esteem (r = .285) were found significantly correlated at 05% and other-safety vs. other control (r = .396) was significantly correlated at 01% of level of significance. According to Pearlman (2003), other-safety reflects the need to feel that cherished others are reasonably protected from harm inflicted by oneself or others. People with an elevated other-safety score are concerned about the safety of their significant others. Most people

who have been traumatized or who have treated traumatized individuals come to worry about the safety of their loved ones.

Self-esteem reflects the need to feel valued and respected. Pearlman (2003) states that experiences that inhibit the development of positive self-esteem are characterized by defilement, degradation, humiliation, rejection, or devaluation. These experiences can also create a sense in the survivors that others are bad, evil, or unworthy. People with the elevated self-esteem scores are significantly disrupted in their sense of self-worth, and may believe that what happened to them was their fault and what they deserved. Other-control reflects the need to manage interpersonal situations. The individuals for whom the other-control scores are elevated feel uncomfortable when they are not in charge. They are often in conflict with others, especially those who value or demand their own autonomy

**Table 4.5 Pair-wise correlation between the T-scores of the ten subscales**

| | | SS | OS | ST | OT | SE | OE | SI | OI | SC | OC |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **SS** | Pearson | 1 | 0.235 | 0.075 | 0.216 | 0.239 | 0.002 | 0.067 | 0.227 | 0.032 | 0.165 |
| | Sig. (2- | | 0.101 | 0.606 | 0.131 | 0.094 | 0.991 | 0.645 | 0.113 | 0.825 | 0.251 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **OS** | Pearson | 0.235 | 1 | -0.092 | 0.125 | .294(*) | .285(* | 0.189 | 0.135 | -0.005 | .396(** |
| | Sig. (2- | 0.101 | | 0.527 | 0.388 | 0.038 | 0.045 | 0.188 | 0.351 | 0.970 | 0.004 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **ST** | Pearson | 0.075 | -0.092 | 1 | -0.206 | 0.079 | 0.022 | -0.101 | -0.072 | 0.149 | -0.184 |
| | Sig. (2- | 0.606 | 0.527 | | 0.152 | 0.585 | 0.879 | 0.487 | 0.620 | 0.301 | 0.200 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **OT** | Pearson | 0.216 | 0.125 | -0.206 | 1 | 0.113 | 0.024 | 0.013 | 0.123 | 0.032 | 0.035 |
| | Sig. (2- | 0.131 | 0.388 | 0.152 | | 0.435 | 0.871 | 0.931 | 0.395 | 0.826 | 0.810 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **SE** | Pearson | 0.239 | .294(* | 0.079 | 0.113 | 1 | -0.201 | 0.021 | -0.028 | 0.153 | 0.053 |
| | Sig. (2- | 0.094 | 0.038 | 0.585 | 0.435 | | 0.162 | 0.887 | 0.847 | 0.288 | 0.712 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **OE** | Pearson | 0.002 | .285(* | 0.022 | 0.024 | -0.201 | 1 | -0.130 | 0.016 | 0.044 | 0.168 |
| | Sig. (2- | 0.991 | 0.045 | 0.879 | 0.871 | 0.162 | | 0.370 | 0.913 | 0.760 | 0.244 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **SI** | Pearson | 0.067 | 0.189 | -0.101 | 0.013 | 0.021 | -0.130 | 1 | -0.063 | -0.194 | 0.104 |
| | Sig. (2- | 0.645 | 0.188 | 0.487 | 0.931 | 0.887 | 0.370 | | 0.661 | 0.178 | 0.472 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **OI** | Pearson | 0.227 | 0.135 | -0.072 | 0.123 | -0.028 | 0.016 | -0.063 | 1 | 0.050 | 0.226 |
| | Sig. (2- | 0.113 | 0.351 | 0.620 | 0.395 | 0.847 | 0.913 | 0.661 | | 0.730 | 0.114 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **SC** | Pearson | 0.032 | -0.005 | 0.149 | 0.032 | 0.153 | 0.044 | -0.194 | 0.050 | 1 | 0.019 |
| | Sig. (2- | 0.825 | 0.970 | 0.301 | 0.826 | 0.288 | 0.760 | 0.178 | 0.730 | | 0.898 |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| **OC** | Pearson | 0.165 | .396(* | -0.184 | 0.035 | 0.053 | 0.168 | 0.104 | 0.226 | 0.019 | 1 |
| | Sig. (2- | 0.251 | 0.004 | 0.200 | 0.810 | 0.712 | 0.244 | 0.472 | 0.114 | 0.898 | |
| | N | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

The scatter plot (Figure 4.9) gives a visual representation of the relationship between variables, for example self-intimacy vs. other – control. Pairs of scores for the ten subscales are plotted on a graph by placing dots to indicate where each pair of variables relating to the subscales intersects.

Inspection of the scatter plot denotes that other-safety has a strong linear relationship with other subscales. As previously mentioned, other-safety reflects the need to feel that cherished others are reasonably protected from harm inflicted by oneself or others (Pearlman, 2003). Often a trauma survivor's other-safety concerns come from a heightened sensitivity to both past losses and current circumstances which the survivor feels might pose a threat of danger to loved ones. These results can be explained by the fact that most of the nurses in Rwanda are themselves survivors and have lost loved ones during the genocide.
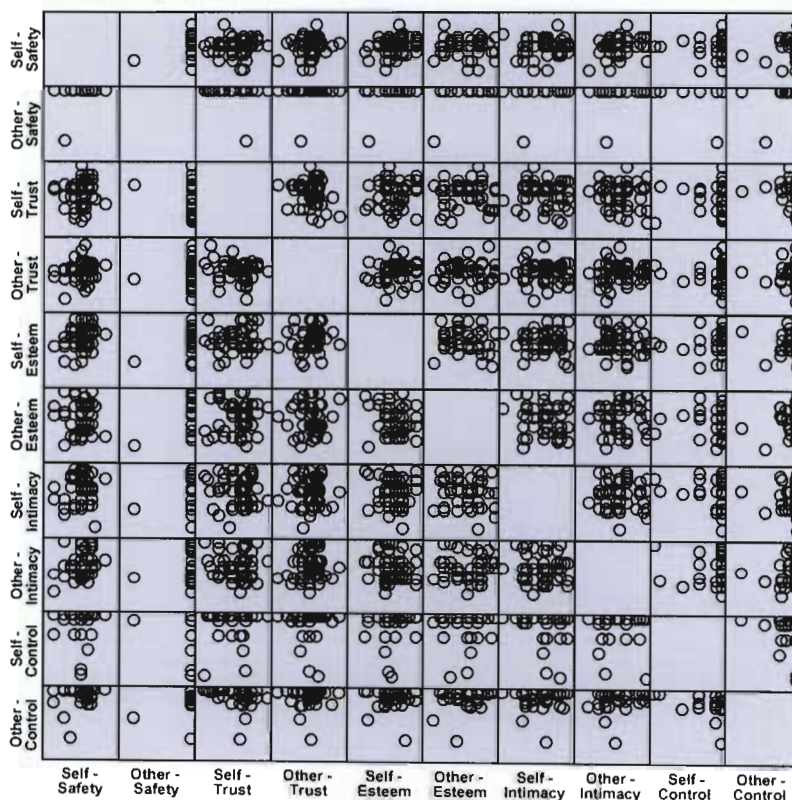


**Figure 4.9 Pair-wise scatter plots of the ten subscales**

### 4.12.2 Relationship between personal trauma history and TABS ten subscales.

To explore a relationship between personal trauma and the Trauma Attachment Belief Scale on ten subscales, a plot was used. According to Burns and Grove (2005), a plot of relationship is a common way to illustrate the relationship between variables graphically. Figure 4.10 and Figure 4.11 display the relationship between the personal trauma history of the respondent and the ten subscales.

As shown by Figure 4.10 and Figure 4.11, the majority of the respondents who reported a personal trauma history in their lives were located on the top of the box plot between the T-score of 60 and 80.

According to Polit and Hungler (1999), for variables of a psychological nature, an r of .70 is high, meaning that the relationship between the variables has a strong positive correlation. Pearlman (2003), states that a T-score of more than 70 is extremely high and indicates a disruption in a given area. When TABS scores are in average T-score range and lower, this may signal an area of relative strength for a respondent, which can be a point of departure for addressing needs disruptions. However, a score in the low average range or lower can reflect a respondent's reluctance to give self revealing answers, or may also indicate limited awareness of respondent's beliefs in the given area (Pearlman, 2003).

**Personal traumatic history of participants**
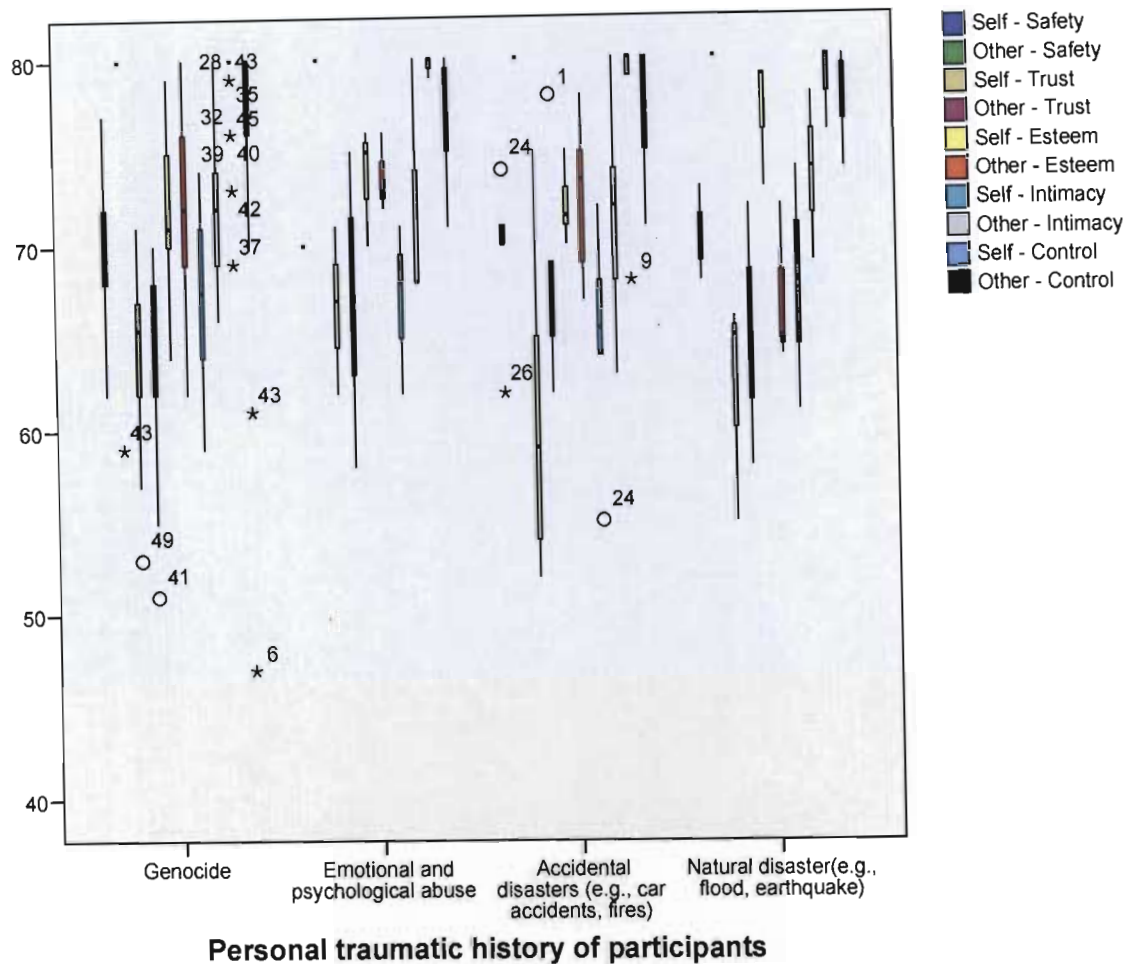
**Figure 4.10 Relationship between ten subscales and respondent's personal**

**trauma history**

A composite box plot further denotes the descriptive statistics of the sample. As depicted in Figure 4.11, the distribution of the respondents on the TABS according to their personal trauma history looks abnormal. The majority of respondents' scores are situated between T-score of 60 and 80 which are considered as very high or extremely

high risk. 98% (n=99) of respondents were scored 80 or above for others-safety. This score is extremely high and may indicate a strong disruption in areas of other-safety.
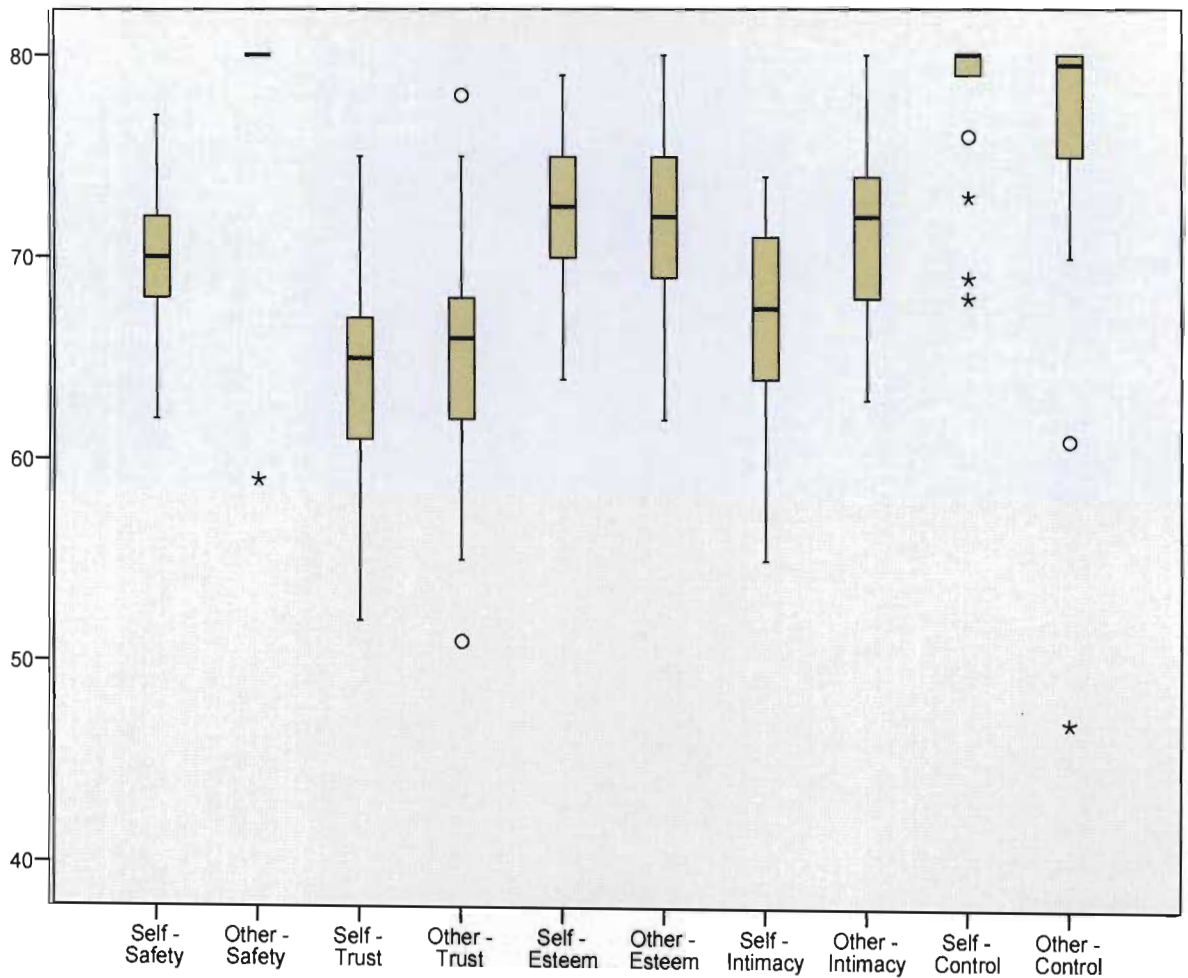


**Figure 4.11 Composite box-plot of ten subscales and Personal trauma history on the TABS**

### 4.12.3 Relationship between hours of counseling time and ten subscales

To explore relationship between variable hours spent in counseling service and the ten subscales, a Kruskal-Wallis Test was used.

According to Burns and Grove (2005), Kruskal-Wallis Test is the most powerful non-parametric test (distribution-free) used to compare three or more independent groups of sampled data. Unlike the parametric independent group ANOVA (one way ANOVA), this non-parametric test makes no assumptions about the distribution of the data (e.g., normality). This test is an alternative to the independent group ANOVA, when the assumption of normality or equality of variance is not met. This, like many non-parametric tests, uses the ranks of the data rather than their raw values to calculate the statistic (Burns and Grove 2005).

As shown by the Kruskal-Wallis test in Table 4.6 and test Statistic in Table 4.7, the means rank for hours spent in counselling service did not differ significantly for the ten subscales. There was a relationship between counselling time and secondary trauma in nurses working in mental health services in Rwanda.

Time spent counselling trauma victims is the best predictor of trauma scores among counsellors (Bober and Regehr, 2006).

Schauben and Frazier (1995) have also found that counsellors with a higher percentage of trauma survivors in their caseload reported more disrupted beliefs, more STS symptoms and more self-reported secondary traumatization .

**Table 4.6 Kruskal-Wallis Test**

| | Number of hours per week spent in counseling service | N | Mean Rank |
|---|---|---|---|
| **Self - Safety** | 10 hours and less | 27 | 25.56 |
| | 10-20 hours | 20 | 26.78 |
| | 30 hours and more | 3 | 16.50 |
| | Total | 50 | |
| **Other - Safety** | 10 hours and less | 27 | 25.07 |
| | 10-20 hours | 20 | 26.00 |
| | 30 hours and more | 3 | 26.00 |
| | Total | 50 | |
| **Self - Trust** | 10 hours and less | 27 | 29.26 |
| | 10-20 hours | 20 | 19.50 |
| | 30 hours and more | 3 | 31.67 |
| | Total | 50 | |
| **Other - Trust** | 10 hours and less | 27 | 24.11 |
| | 10-20 hours | 20 | 29.10 |
| | 30 hours and more | 3 | 14.00 |
| | Total | 50 | |
| **Self - Esteem** | 10 hours and less | 27 | 27.94 |
| | 10-20 hours | 20 | 23.05 |
| | 30 hours and more | 3 | 19.83 |
| | Total | 50 | |
| **Other - Esteem** | 10 hours and less | 27 | 24.43 |
| | 10-20 hours | 20 | 26.85 |
| | 30 hours and more | 3 | 26.17 |
| | Total | 50 | |
| **Self - Intimacy** | 10 hours and less | 27 | 23.94 |
| | 10-20 hours | 20 | 28.38 |
| | 30 hours and more | 3 | 20.33 |
| | Total | 50 | |
| **Other - Intimacy** | 10 hours and less | 27 | 24.69 |
| | 10-20 hours | 20 | 27.70 |
| | 30 hours and more | 3 | 18.17 |
| | Total | 50 | |
| **Self - Control** | 10 hours and less | 27 | 26.67 |

| | | | |
|---|---|---:|---:|
| | 10-20 hours | 20 | 24.00 |
| | 30 hours and more | 3 | 25.00 |
| | Total | 50 | |
| **Other - Control** | 10 hours and less | 27 | 25.80 |
| | 10-20 hours | 20 | 26.75 |
| | 30 hours and more | 3 | 14.50 |
| | Total | 50 | |

Grouping Variable: Number of hours per week spent in counseling service

| | Self - Safety | Other- Safety | Self - Trust | Other - Trust | Self - Esteem | Other - Esteem | Self - Intimacy | Other - Intimacy | Self - Control | Other – Control |
|---|---|---|---|---|---|---|---|---|---|---|
| Chi-Square | 1.3383 | 0.852 | 5.7984 | 3.3714 | 1.8105 | 0.32953 | 1.4841 | 1.3225 | 0.6547 | 2.15411 |
| Df | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Asymp. Sig. | 0.5121 | 0.653 | 0.0551 | 0.1853 | 0.4044 | 0.84809 | 0.4761 | 0.5162 | 0.7208 | 0.3406 |

## 4.13 CONCLUSION

This chapter discussed the data analysis and findings, using tables, percentages and graphs where possible. The findings were also discussed with reference to the literature reviewed.

Chapter 5 concludes the study, briefly discusses its limitations and makes recommendations for practice and further research.

# CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

## 5.1 INTRODUCTION

This chapter concludes the study by summarizing the research process and findings, briefly discussing its limitations, and making recommendations for future studies

According to the literature reviewed, secondary traumatic stress is an occupational hazard for those who treat the traumatized. The overall aim of this study was to describe the effects, namely secondary traumatic stress, experienced by nurses who render mental health care to trauma victims and other mental patients in Rwanda. The study was carried out at Ndera Psychiatric Hospital in Rwanda.

This study falls into the category of applied research, as the knowledge generated could directly affect the quality of support received by nurses to limit secondary traumatic stress. The purpose of applied research is to solve problems, make decisions or control outcomes in real-life situations (Polit et al 2001).

The study contributes to identifying the effects of secondary traumatic stress with reference to the subscales identified in the CSDT. Predictor variables, such as personal trauma history, workload, and length of career were correlated with the ten subscales of the Trauma and Attachment Belief Scale for secondary traumatic stress.

## 5.2 SUMMARY OF THE RESULTS

The researcher's conclusions were based on the objectives and research questions.

### 5.2.1 What is the extent of secondary traumatic stress among nurses providing mental health nursing in Rwanda?

Ten subscales were created from the Trauma and Attachment Belief Scale to measure disruptions in the psychological need areas of safety, esteem, trust, intimacy and control. The distributions appeared to be abnormal for these subscales. The total scores were high in all areas of beliefs. This can indicate that there is a disruption in the cognitive schema of the nurses providing mental health services in Rwanda. The mean scores of most respondents ranged from very high to extremely high in all areas of cognitive beliefs

Of the respondents 98% (n=49) had a T-score of 80 for other-safety, which was extremely high. Pearlman (2003) indicates that a T-score of 70 or more is deemed extremely high and indicates a substantial disruption in cognitive schema. She further stated that individuals who experienced a traumatic event worry about the safety of their loved ones (Pearlman, 2003). This can indicate that the respondents are often concerned about their loved ones.

### 5.2.2 Is personal trauma history associated with secondary traumatic stress?

Of the respondents, 76% (n=38) had personally experienced genocide, 10% (n=5) had experienced accidental disaster in their past, 8% (n=4) had experienced emotional and psychological abuse and 7% (n=3) reported that they had experienced some form of natural disaster (e.g. flood, earthquake etc...). The composite box-plot showed that there

was relationship between the respondent's personal trauma history and secondary traumatic stress as measured by the Trauma Attachment Belief Scale.

### 5.2.3 What work-related aspects create secondary traumatic stress in nurses?

The mean rank for hours spent in counselling doesn't differ significantly for the ten subscales. As measured by the Kruskal-Wallis test and test Statistic (see Table 4.5 and Table 4.6), the means for hours spent in counselling service did not differ significantly for the ten subscales.

There was a relationship between workload and secondary trauma in nurses working in mental health service in Rwanda.

### 5.2.4 What support systems are there for nurses who work in mental health services in Rwanda?

Of the 50 respondents who answered the question, 30% (n=15) indicated that the psychological support is provided by a peer supervision group; 26% (n=13) indicated that the psychological support was provided by talking to friend or relative; 24% (n=12) indicated that the psychological support was provided by a psychiatrist or a psychologist working in mental health system ; 12% (n=6) indicated that the psychological support was provided by psychiatric nurses working in the same service; 8% (n=4) reported the workplace system.

Furthermore, 46% (n=23) of the 50 respondents indicated that there were no psychological support systems for nurses working in mental health in Rwanda, 30%

(n=15) indicated that there were psychological support systems and 24% (n=12) did not know if such a psychological support system existed or not.

In addition, 36 % (n=18) of respondents reported better working conditions would assist them in limiting or preventing psychological trauma in their workplace, 24% (n=12) suggested that sensitivity shown towards them by their non-mental health colleagues and management would help,, 20% (n=10) reported that supervision and debriefing were the best ways to limit secondary traumatic stress, 12% (n=6) reported a better salary could be of benefit, and lastly, 8% (n=4) reported that support with their transport would help..

## 5.3. RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for organizational support, self-care and future research.

### 5.3.1. Organizational support

- Supervision should be made compulsory for all nurses working in mental health service in Rwanda, especially who treat the traumatized patients.

- Young inexperienced nurses who are recruited to work in mental health services should be oriented and be supported by having open channels of communication with the supervisor..

- Buddy systems between nurses should be implemented whereby nurses have telephonic or personal contact with colleagues for support.

- Team building exercises are vital to improve communication between the various categories of staff working in the mental health system in Rwanda.

- Staff shortages should be addressed promptly as this has negative implications for working conditions.

- Nurses recruited to work in mental health should be informed of the potential risk of developing symptoms related to secondary traumatic stress.

- Educational programmes on secondary traumatic stress need to be developed for the nurses, identifying triggers, symptoms and coping strategies.

- Opportunities for further studies should be created and nurses should be encouraged to subscribe to the concept of lifelong learning.

- The employer needs to take cognizance of the fact that secondary traumatic stress is a potential work hazard for nurses who work with traumatized patients.

- 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.

## 5.3.2. Self-care

- Nurses should be encouraged to use existing support services to help them deal with their own and their patients' trauma.

- Nurses should know their own "triggers" and vulnerable areas and learn to defuse or avoid them.

- Nurses should allow themselves to grieve when bad things happen to others.

- There should be a balance between professional and personal activities that provides opportunities for self-growth.

- Nurses 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.

- Exercise, hobbies and the regular taking of leave should be encouraged to promote physical and emotional well being.

### 5.3.3. Future research

Given the evidence provided by previous studies on secondary traumatization among mental health professionals and the varying factors presented by the researcher in this study, there is ample cause for further investigation.

Arvay, (2001) and Birck, (2002) have stressed that more research is needed to understand the factors that contribute to the development of STS and its prevalence among mental health professionals.

Further research should be conducted on the following topics or areas:

- The relationship between the positive and negative effects of working with the traumatized.

- The refinement of instruments used to measure secondary traumatic stress in Rwanda, so they capture the effects of secondary traumatic stress and not the

perception of secondary traumatic stress as appears to be the case in the Trauma Attachment and Belief Scale.

- A study on nurses who work in the Intensive Care Units and emergency departments in the general hospitals, to establish whether treating patients with physical injuries has the same psychological effects as counselling trauma victims.

- How working with the families of traumatized patients influences nurses' experiences of secondary traumatic stress.

- A qualitative study on the internal process related to understanding the cognitive effects that nurses experience when working with traumatized individuals.

- The prevalence and impact of secondary traumatic stress among other professionals such as journalists, lawyers, policemen and the military need to be established.

- Exploration of systemic traumatic stress and its impact on social development in post conflict societies like Rwanda.

## 5.4 LIMITATIONS OF THE STUDY

Secondary traumatisation is a sensitive issue. Although great attention was paid to the content, literature, methodology and statistical analyses of this study a number of limitations may be identified. One limitation focuses on the title, which is at the centre of this study.

The major limitations of this study, however, relate to methodological issues. These can be classified in the following categories: sample and sampling, data collection, instruments and data analysis.

For this study, the sample was selected on the basis of convenience and consisted of nurses working at Ndera Psychiatric Hospital who volunteered to participate in the study. Non-probability sampling was employed as the sampling method. In non-probability sampling the probability that any person from a specific population will be selected is not known, therefore generalisability may be reduced. Its main weakness is the subjectivity involved in the sample selection. The subjective nature of the process adds uncertainty when the sample is used to represent the whole population (Welman and Kruger, 2001).

A further limitation of the current study is its sample size. Although the sample size was adequate for the statistical procedures used in the current study, its size may have introduced problems with the statistical analyses. Sample size affects the power of a test, the smaller the sample, the lower the power of the test. Due to this limitation, caution was used in the interpretation of data. In future, studies on a larger sample size would be more ideal.

Questionnaires used to gather data consisted solely of self-report measures TABS. The subjective responses of respondents, although essential and relevant for this research, may also be problematic. The problem with this type of approach concerns the accuracy and honesty of responses. It is impossible to determine, or control, the honesty of the answers and the seriousness with which the questionnaires were completed (Gillham, 2000; Welman and Kruger, 2001).

Answers received may also be reconstructions of respondent's experiences, influenced by the demands of the research. Furthermore, respondents often tend to answer questions in what they consider to be a socially desirable manner.

In addition, questionnaires were only administered in French and later converted to English. This may have posed a problem to second language speakers as they may have had trouble understanding certain questions and/or statements. Questionnaires as a method of data collection are often criticized due to the lack of in depth information in areas of concern. Data collection methods such as interviews could have been utilised to supplement and verify self-report measures (Welman and Kruger, 2001).

In general, it was found that there was a lack of willingness and motivation for completing the questionnaire. This may be due to three reasons. Firstly, time constraints as respondents may have had work they considered to be more important to complete, especially if they were nurses working in the hospital and had other duties in the wards. Secondly, the questionnaire may have had no personal relevance to the participant.

Lastly, respondents may have been afraid of what would happen to the data or whether the study may impact them negatively.

Despite the limitations illustrated above, self-report instruments were felt to be the most viable option after other options (eg. interviews) were considered and debated.

One of the main reasons was that it could be administered to a relatively large, demographically diverse sample and it is considered to be less invasive, which has been shown to encourage participant's disclosure (Gillham, 2000).

The amount of instruments that made up the questionnaire was essential as each variable needed to be measured in order to ensure the feasibility of the study. This necessity, however, made the study lengthy which in turn may have led to boredom and tiredness and may have contributed to the low response rate.

In the field of secondary traumatic stress, the most widely used instrument is the Trauma Attachment Belief Scale

The questionnaire comprised of likert type scales. This method often introduces central tendency bias, which is the tendency of individuals to select the middle response of the rating scale, rather than using the extremes. However, this method was used as it is a widely used format and it appears that, with this method, respondents are more likely to feel greater freedom of expression. They also generally find them more enjoyable than other formats (Gillham, 2000).

Despite these limitations, good reliabilities of the scale obtained in this study suggested that the respondents responded with some consistency and appeared to find the measures comprehensible.

The majority of the results found in the current study were derived from correlational and comparison analyses therefore, although the findings that emerged from the study contribute to the field of trauma, causality cannot be inferred (Welman and Kruger, 2001).

Despite all these limitations, they did not overshadow the strengths of the study. The major strength of this study is that it provides research into areas which have been severely limited and neglected. Although these results may not benefit the actual subjects, the findings make a helpful contribution to the field of trauma in Rwanda. In addition they help validate previous literature and studies in this area, therefore allowing a better conceptualization of secondary traumatic stress and its components in mental health clinicians working in mental health services in Rwanda.

## 5.5. CONCLUSION

There is general recognition in the literature and in the field that the intensity of working with traumatized individuals in mental health services negatively impacts the well-being of therapists. This negative impact includes both immediate effects in terms of disruptions in cognitive beliefs generally associated with posttraumatic stress and longer term effects in terms of altered belief systems. This study explored and described the effects nurses experienced when working with traumatized patients in Rwanda, namely secondary traumatic stress. In this study of 50 nurses providing mental health services in Rwanda, those individuals who spent more time per week counselling individuals who were victims of trauma reported higher levels of traumatic stress symptoms. A relationship was

found between secondary traumatic stress and the predictor variables of personal trauma history and workload. There was a relationship between secondary traumatic stress and length of career. Support systems were reported to be helpful by respondents and respondents generally believed in the usefulness of supervision. The findings of this study were supported by others researchers (Brady et al., 1999).

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# APPENDICES

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**APPENDIX 1: QUESTIONNAIRE**

# EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN MENTAL HEALTH SERVICE IN RWANDA

## QUESTIONNAIRE

## SECTION A: BIOGRAPHICAL INFORMATION

**Please tick the appropriate block**

**1. Gender:**

| Female | Male |
|--------|------|
| 1 | 2 |

**2. Age in years**

| 25 years and less | 26-35 years | 36 -45 years | 46year and more |
|-------------------|-------------|--------------|-----------------|
| 1 | 2 | 3 | 4 |

**3. Number of year's service as a nurse**

| 0-5 years | 6-10 years | 11-20 years | More than 20 years |
|-----------|------------|-------------|--------------------|
| 1 | 2 | 3 | 4 |

**4. Number of year's service in mental health care**

| 0-5 years | 6-10 years | 11-20 years | More than 20 years |
|-----------|------------|-------------|--------------------|
| 1 | 2 | 3 | 4 |

## 5. Highest qualification achieved:

| Enrolled nurse | Registered nurse | Honors in nursing | Masters in nursing |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

## 6. Marital status:

| Single | Married | Widow | Separated |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

## SECTION B: PERSONAL TRAUMA HISTORY:

**You can tick more than one box**

## 7. Have you personally experienced the following events?

| Genocide | Emotional/ psychological abuse | Physical abuse as a child | Accidental disasters (e.g., car accidents, fires) | Natural disaster (e.g., flood, earthquake) |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

## SECTION C: COUNSELING TIME AND SUPPORT SYSTEM

## 8. How many hours per week do you spend doing counseling?

| 10 hours and less | 10-20 hours | 20-30 hours | 30 hours and more |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**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 |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**10. How may time do you spend in counselling for a new case?**

| 0-10minutes | 20-30 minutes | 40-50 minutes | 1 hour |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**11. Is support system available in your service?**

| Available | Not available | Do not know |
|---|---|---|
| 1 | 2 | 3 |

**12. If available, which kind of support system is?**

| Peer supervision groups | Talking to friends and family | Psychiatrist/ Psychologist | Psychiatric nurse | Workplace debriefing |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**13. Do you think Psychological debriefing in mental health is?**

| Helpful | Not helpful | Unsure |
|---|---|---|
| 1 | 2 | 3 |

**14. Support system to limit or prevent psychological trauma in workplace:**

| Better salary | Better working conditions | Support with transport | Supervision / Debriefing | Sensitivity by non mental health colleagues and managers |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**15. Who is the most appropriate to provide supervision or debriefing to nurses working in mental health?**

| Psychiatrist | Psychologist | Psychiatric nurse | Counselor / social worker | Clergy |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**APPENDIX 2: ETHICAL CLEARANCE**

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL  : ximbap@ukzn.ac.za____

22 SEPTEMBER 2008

MR. JD IYAMUREMYE  (206519315)
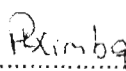SCHOOL OF NURSING

Dear Mr   Iyamuremye

## ETHICAL CLEARANCE APPROVAL NUMBER:  HSS/0388/08M

I wish to confirm that ethical clearance has been approved for the following project:

*"Exploring secondary traumatic stress experienced by nurses working at Kigali Mental Health Centre in Rwanda"*

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

**MS. PHUMELELE  XIMBA**

cc.   Supervisor (Dr. P Brysiewicz)
cc.   Mr. S Reddy

**APPENDIX 3: PERMISSION FOR DATA COLLECTION**

17th June 2008
**Jean Damascene IYAMUREMYE**
**Master Student Mental Health**
University of Kwazulu Natal
South Africa

## RE: PERMISSION TO COLLECT DATA

Reference is made to your request for permission to collect data for your research project, with the topic: **Exploring secondary traumatic stress experienced by nurses working in mental health services in Rwanda.**
I am happy to inform you that your permission has been approved. Your topic is very interesting and I am sure that your findings will help the mental health clinicians in Rwanda to improve the quality of care.

Good luck

Jean Michel IYAMUREMYE
**Director of Nursing**
Ndera Psychiatric Hospital
RWANDA

**APPENDIX 4: PERMISSION FOR INTRUMENT USE**

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October 3, 2008

Jean Damascene Iyamuremye
University of KwaZulu Natal
Howard College Campus
Mental Health Nursing
4041, Durban
South Africa

Re: *Trauma and Attachment Belief Scale*

Dear Mr. Iyamuremye —

This confirms receipt of your license fee for use of the above-referenced material. Under separate cover by mail you will soon receive a paid-in-full invoice, which will serve as your license to create and use a TABS French research translation, and to administer the translated scale up to fifty (50) times total. Our authorization is subject to the terms and provisions of my letter to you of August 18, extending to sole use in your registered graduate research study – examining secondary traumatic stress experienced by nurses working at Kigali Mental Health Centre in Rwanda – with no authorization for continued or commercial use, for any purpose, without the prior, written approval of WPS.

In keeping with the terms of our August 18 letter (ref. condition 4), the following is the reprint notice that must appear in English and in French on each photocopy you make for application of the TABS translation in your project:

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Thank you for your research interest in this instrument, and for your consideration of our copyright. We look forward to receiving a copy of the translation (ref. condition 5), and to learning in due course of the results of your study. Please feel free to contact me if you have any follow-up comments or questions.

Sincerely yours,

SusanW
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SDW:se

August 18, 2008

Jean Damascene Iyamuremye
University of Kwazulu Natal
Howard College Campus
Mental Health Nursing
4041, Durban
South Africa

Re: *Trauma and Attachment Belief Scale*

Dear Mr.. Iyamuremye —

This letter serves to provide our terms of permission for you to undertake a French research translation of the TABS for use in your graduate research project, examining secondary traumatic stress experienced by nurses working at Kigali Mental Health Centre in Rwanda.

On your signature to this agreement, Western Psychological Services will authorize you to create a research translation of the TABS protocol, and to reproduce the translation for paper-based administration with hand-scoring -- for the sole purpose of conducting the above-noted study and not for continued or commercial use -- with the following conditions:

(1) Use is strictly limited to the specified research. Participants on the research team must be advised that:

    (a) The TABS French translation is in a prepublication state that does not have adequate documentation at this time, and that – in consultation with the authors – WPS has determined that it is not professionally proper to release the translations, in any language, for routine clinical use in this condition. Consequently, no permission will be granted for any additional use of the translated materials – whether in whole or in part, including but not limited to reprinting copyrighted content in journals, lists or reports – other than in formal, qualified research projects under the direct supervision of individuals who have been trained by the authors or those approved by the author for these research purposes. The TABS French translation must remain in this restricted state until a qualified, regional publisher can be located who is willing to undertake and secure WPS-licensed, formal publication in French.

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and

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Upon receipt of the fees (see condition #2), WPS will issue your license and send it to you with the required copyright notice (see #4).

NOTE: For the items and scoring needed to support proper construction and use of the research translation, please refer to your TABS manual.

WPS appreciates your interest in the TABS as well as your consideration for its copyright. I look forward to your reply.

Sincerely yours,

**SusanW**

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**APPENDIX 5: INFORMATION DOCUMENT**

# INFORMATION DOCUMENT

**Title**: EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN KIGALI MENTAL HEALTH SERVICE IN RWANDA.

Dear nurse,

I am a student in Masters Program of Psychiatry and mental health at University of KwaZulu Natal. I am currently conducting thesis research to **EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN KIGALI MENTAL HEALTH SERVICE IN RWANDA.** I would very much appreciate your participation in this study.

We do not ask for your name so the information you provide will be anonymous and confidential. The findings from this study will be used to increase understanding the effect of secondary traumatic stress on nurses. Enclosed you will find a questionnaire that will take approximately 20-30 minutes for you to complete. The questionnaire consists of a series of questions. You are asked to mark the response that best describes how you feel. Participation in this study is strictly voluntary, and you may refuse to participate or you may withdraw from the study at any time without consequence. Your consent to participate in this study will be confirmed by completing the questionnaires. If you have any questions or concerns regarding this research project, please feel free to contact me at iyadamas@gmail.com , or you may contact my supervisor, Dr.Petra Brysiewicz at brysiewiczp@ukzn.ac.za

Thank you for your time and co-operation.

Sincerely,

**APPENDIX 6: INFORMED CONSENT AND DECLARATION OF CONSENT**

## INFORMED CONSENT

### *Consent to Participate in Research*

**Study title: EXPLORING SECONDARY TRAUMATIC STRESS EXPERIENCED BY NURSES WORKING IN KIGALI MENTAL HEALTH SERVICE IN RWANDA.**

Dear Nurse

You have been asked to participate in a research study. You have been informed about the study by Jean Damascene IYAMUREMYE having read the information document which has the details of the study .You may contact on +250 08400068, +27733737755, email: iyadamas@gmail.com at any time if you have questions about the research You may also contact my supervisor on: tel: 031 260- 1281, e-mail: brysiewiczp@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 below this document in the space provided as a show of your declaration of consent.

### DECLARATION OF CONSENT

I........................................................................................ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.


SIGNATURE OF PARTICIPANT                                    DATE

...........................................................................................................................

**APPENDIX 7: PROOF OF TRANSLATION**

**From:**        Ninon Larche
**To:**          Jean Iyamuremye
**Date:**        10/5/2008 11:08 PM
**Subject:**     Re: Help on translating questionaire for research
**Attachments:** Translated Questionnaire.doc

I have looked at both the French and the English. You will see my corrections: all additions are in black; I have crossed through the words and sections which need to be eliminated.

I am satisfied that if you make the corrections carefully and think carefully about the details, the text will suit very appropriately the purpose for which it was designed.

Regards


Ninon Larché
French Studies,
School of Language, Literature and Linguistics
UKZN, Pmb Campus
ph: (+33) 260 5541
fax: (+33) 260 6213
>>> Jean Iyamuremye 09/19/08 7:07 PM >>>
Dear

I am Jean IYAMUREMYE, masters student in mental health nursing conducting a research project on effects of secondary trauamatic stress on nurses working in mental health service in Rwanda. Because my research population is french speakers, I need to translate my tools from English to French. I came to see you in your office and you promised me to help for the translation.
I tried to translate myself but because English and French are not my first languages, I send the attached document for checking and editing. The French is in Red colo.

Thank you

Jean

**APPENDIX 8: PROOF OF EDITING**

Dear Jean

Thank you for sending your dissertation to me for editing. I have completed the task and attach the following for your attention:

2 different copies of the main body of your discussion, the first being the edited version which highlights all the alterations for you to see and the second which can be used as a final draft,

1 copy of the Declaration, Abstract and Table of Contents. These have been corrected grammatically and adjusted to reflect the correct page numbers.There is no version, however, highlighting the changes, so I would recommend that you check it and change it should you wish.

The receipt of your payment - thank you.

A few comments

In the edited section (the body) you will see I have suggested the following:
grammar corrections
spelling corrections
spacing changes to make your discussion easier to read
in some instance I changed the order slightly to give more impact to your argument.
in some instances I changed words which I thought would be more suitable to the context of the sentence and in a few instances I altered entire sentences to avoid ambiguity

Please note that these are merely suggestions and you should rearrange anything that is not to your liking.

There are a couple of small spacing problems I have not been able to address because of time restraints:
1. In the table of contents there is a discrepancy in the spacing between 2.9.2 and 2.10 which I don't seem to be able to adjust.
2.I have also struggled to adjust the spacing of tables and figures as I didn't want to interfere with them too much and a couple of them are not quite right. Please will you check them and adjust page numbers if necessary. Table 4.6 on pg95 and Fig 49 on pg90

3. Your document contains some blue text which needs altering.

I have not had a chance to reread your discussion as a whole, but will do so in the morning and if I find anything that I'm unhappy with I'll give you a ring.
If you have any problems you can contact me on 0833099130.

I hope you will be happy with the final result.
I wish you a safe trip back to Rwanda and a Happy Christmas with your family

Regards
Margaret