

**VICARIOUS TRAUMATIZATION: THE IMPACT OF  
NURSING UPON NURSES**

**by**

**Lesley Davies**

**A thesis submitted to the Victoria University of Wellington in  
partial fulfilment of the requirements for the degree of Master of  
Nursing (Clinical)**

**Victoria University of Wellington**

**2009**

## Abstract

The aims of this research were to explore mental health nurses' knowledge and experience of vicarious traumatization (VT). Literature linking mental health nursing and VT is sparse. VT is an enduring trauma that affects those who engage empathically across time and with different patients. Mental health nurses form ongoing therapeutic relationships with patients to foster healing. This empathic engagement leaves nurses vulnerable to VT. This project is qualitatively designed using narrative enquiry with in-depth, semi-structured interviews of mental health nurses. Data gathered was thematically analysed and four main themes identified: the impact of VT; self-knowledge/self-awareness; self-care; and burnout. Participants in this study felt unprepared for the negative impact of mental health nursing and learned of VT 'on the job'. My recommendations include education on identifying VT, and self-care, including clinical supervision, to ameliorate the effects of VT. Further research is needed to explore the links between VT and mental health nursing.

Key words: nurse-patient relations – stress management – mental illness - narrative approach

## Acknowledgements

I should like to thank the Ashburn Clinic for its continued funding of my postgraduate education. I am appreciative of my supportive nursing colleagues in the clinic, in other local mental health services and in my university thesis class.

Thelma Puckey has been my academic supervisor for the thesis and has been a steady hand on the tiller even when I thought I was able to steer my own ship.

I have received essential technical support from Richard Davies, Peter Buckingham, Eryn Makinson, Kim and Antony Hamel, and the Victoria University of Wellington Library, Distance Service.

All my family have quietly endured my 'cone of silence' and have provided levity when needed. None more so than Richard, Ben and Mark.

Finally, a debt of gratitude to the participants in this study - without their courage in speaking about their experiences this research project would not have been possible.

## Table of Contents

	Page
Abstract	ii
Acknowledgements	iii
Table of contents	iv
<b>Chapter 1 Introduction to thesis</b>	
Background	1
Vicarious traumatization background	3
Vicarious traumatization and its relevance to mental health nurses	4
Constructivist self-development theory	5
Other caring induced traumas	6
Related constructs	7
The mental health nurses' knowledge of Vicarious traumatization	8
The nursing culture	10
The therapeutic relationship	11
Language	13
Structure of the thesis	13
Conclusion	14
<b>Chapter 2 The mental health nurse</b>	
Introduction	15
Historical context of mental health nursing	16
Modern nursing and the therapeutic relationship	17
Caring and the therapeutic relationship	19
The patients' experience of the therapeutic relationship	20
Nursing, the unconscious and the therapeutic relationship	22
The unconscious and vicarious traumatization	24
Other caring induced traumas	25
Why are mental health nurses at risk of vicarious traumatization?	26
Conclusion	29
<b>Chapter 3 Vicarious traumatization</b>	
Introduction	30
Vicarious traumatization, what is it?	30
Constructivist Self-Development theory	32
Vicarious traumatization and the mental health nurse	36
Trauma and its relationship to vicarious traumatization	38
Transference, counter-transference and the mental health nurse	39
Who may be more vulnerable?	41

What are the protective factors against vicarious traumatization?	42
Prevention of vicarious traumatization – is it possible?	44
Conclusion	46
 <b>Chapter 4 Literature review</b>	
Introduction	48
Search strategies	50
Vicarious traumatization	53
Compassion fatigue	57
Secondary traumatic Stress	58
Burnout	59
Mental health nursing and the therapeutic relationship	59
Conclusion	60
 <b>Chapter 5 Methodology</b>	
Introduction	62
Nursing research	63
Qualitative research	64
Narrative enquiry	65
Research design	68
Method of recruitment	70
Ethics approval	74
Research process	78
Data collection	78
Data management	83
Data analysis	83
Analysis process	85
Process reflections	86
Rigour bias	87
Conclusion	89
 <b>Chapter 6 Findings</b>	
Introduction	90
Description of participants	90
Decision on themes	91
Participant one	93
Participant two	98
Participant three	103
Participant four	110
Themes from the interview data	122
Theme one: The impact of vicarious traumatization	123
Theme two: Self-knowledge/self-awareness	126
Theme three: Self-care	129
Theme four: Burnout	135
Predisposing factors towards vicarious traumatization	137

Traumatic experiences as a novice nurse	139
Conclusion	141
<b>Chapter 7 Discussion and recommendations</b>	
Introduction	145
Discussion of findings	145
Personal and Professional effects of vicarious traumatization	147
Self-care – reducing the risks of vicarious traumatization	149
Reflections on this research	157
Recommendations	158
Conclusion	160
<b>Appendices</b>	
Appendix A Recruitment flyer	161
Appendix B Information for participants	162
Appendix C Informed consent form	163
Appendix D Ethics approval	164
Appendix E Bicultural liaison	165
Appendix F Interview questions	166
<b>References</b>	167

## **CHAPTER ONE: INTRODUCTION**

In the specialty of mental health nursing the relationship between mental health nurse and patient is a key factor in recovery and maintenance of hope (White, 2006). The closeness of the relationship between the nurse and patient has the potential for healing and the mental health nurse thus becomes the therapeutic tool. The often close and personal nature of this relationship can expose the nurse to secondary trauma due to continued exposure to the traumatic experiences of the patient. This continued exposure to the traumatic experiences of patients over time can lead to the development of vicarious traumatization in the nurse. Vicarious traumatization (VT) is a type of caring induced trauma that affects the nurse psychologically and emotionally (McCann & Pearlman, 1990). VT leads to a change in the nurse's frame of reference for how they view the world and the people in it, including the loss of trust, reduced esteem and power. Their effectiveness as the therapeutic tool in the therapeutic relationship is thus compromised. The impact of VT can be life changing and has implications for the mental health nursing workforce. There is a large body of literature on the impact of primary trauma on patients but little on those working to help them.

### **Background**

I am a Registered Nurse working in mental health within a psychotherapeutic community. In this setting the mental health nurse works with patients in psychodynamic groups, individually and with the families of patients. The mental health nurse is a therapeutic tool to help the patient move towards wellness and an improved way of relating to others. I have worked exclusively in mental health for nearly fifteen years. It was while working as a

new graduate that I had my own experiences of burnout and VT. At the time, however, I did not know the terms burnout or VT and only knew that I felt fatigued, worn out from work and withdrawn. Many years later while pursuing further nursing education I learnt there was a name for what I had experienced. Research linking VT and mental health nursing is limited. As a consequence it may be poorly understood or acknowledged in the mental health nursing profession. At the least it is very little talked about.

Literature describing the concept of mental health nursing and VT is sparse. VT falls under the umbrella term of 'caring induced trauma'. The term implies that by engaging empathically with others (in this context the mental health nurse with the patient) we may become traumatized through listening to our patients' trauma stories. There is a genuine gap in the literature exploring mental health nurses' experiences of this caring induced trauma through and using their own words to describe it.

I believe that mental health nurses may be at significant risk of developing VT as mental health nurses use themselves as the therapeutic tool to effect change in our patients. This close working relationship leaves nurses vulnerable in their profession to VT. Given the risk it is wise to raise awareness, identify risk factors and be attuned to ameliorating factors against VT. The theme of self-care is important in this latter objective.

The aims of this research project were to explore mental health nurses' knowledge and experience of VT. In-depth interviews with mental health nurses were undertaken and the content was thematically analysed. Themes include (1) the impact of VT; (2) self-knowledge/self-awareness; (3) self-care;



and (4) burnout. Further sub-themes emerged under each of these headings.

### **Vicarious traumatization background**

McCann and Pearlmann (1995), the key authors on VT, write mostly as observers of therapists exposed to VT. They argue, however, that the term can be applied to all who care for traumatized people. VT is the result of continued empathic engagement with those who have suffered trauma, McCann and Pearlmann (1990). This group of patients are particularly vulnerable over issues of control and trust in relationships. The authors also state that this type of trauma, VT, is a natural occurrence when one does engage empathically over a period of time with those who have experienced trauma. For mental health nurses the therapeutic relationship is at the heart of what we do and we work closely with patients within this relationship. Ongoing, empathic engagement places the mental health nurse in a vulnerable position to experience VT. It is this therapeutic use of self that enables recovery but also endangers the nurse.

The negative effects of VT can lead to nurses feeling they can no longer work in the job, and patients feeling dissatisfied with their nursing care. Due to the insidious nature of VT the nurse may be unaware of it but just feels tired, burnt out and withdraws from the patient relationship. This withdrawal from the therapeutic relationship is a threat to the recovery of patients. Clark and Gioro (1998) describe the insidious development of indirect trauma and that nurses are unaware it is happening. It is for this reason that my research is aimed at nurses' knowledge of VT and whether they have experienced this caring induced trauma.

## **VT and its relevance to mental health nurses**

VT represents enduring changes for a clinician who engages empathically with victims of trauma. VT, and mental health workers who treat traumatized patients, is explored by Canfield (2005). She states that literature related to caring induced traumas – VT, burnout, secondary traumatic stress – has greatly increased over the recent decade reflecting an interest and a raised awareness of the negative sequelae for those working with survivors of trauma. Crisis workers, including mental health nurses, are particularly vulnerable due to their regular exposure to traumatic events. The ‘John Wayne Syndrome’ (Beaton & Murphy, 1995), sees crisis workers using psychological defences such as repression to manage crises and avoid being overwhelmed. This is a protective mechanism which does not permit role conflict – John Wayne is always in control. It also allows the silence to continue about the dangers of working with traumatized patients. Canfield (2005) believes that clinicians working with traumatized patients are not made aware of the risks of such engagement. Figley (1995), states there is a “duty to inform mental health workers of risks of work” (p. 88).

What health professionals do with these traumatic events is a theme that Kleespies and Dettmer (2000) explore. Assimilation of traumatic events is defined as the changing or altering of events to fit into our already existing views on people or the world. Accommodation of traumatic events differs in that it requires to actually change our views of people or the world in order to manage the traumatic event and place it within our understanding. This places the mental health worker at risk for enduring and harmful changes due to assimilating and accommodating these events. The irony is that, according to Kleespies and Dettmer, those who are good at empathizing with patients are increasingly vulnerable to absorbing the patients’

trauma into their own psychological frame-work because they can enter the empathic space more readily with the patient.

### **Constructive Self Development Theory (CSDT)**

CSDT represents the philosophical and theoretical underpinning of VT. CSDT is a conceptual framework developed by McCann and Pearlmann (1990b) to not only understand the impact of trauma on the adult survivors of traumatic events, but to provide a theoretical framework to understand the impact of trauma on the therapist. CSDT identifies the patient in context of their individual experiences and avoids labelling patients as groups of symptoms. It sets out a framework for linking the impact of trauma work upon therapists/nurses (Pearlman & Saakvitne, 1995). CSDT is a psychological theory and framework for understanding and healing (Pearlmann , 1998).

CSDT identifies aspects of the self that are affected by trauma (Pearlman & Saakvitne, 1995). Our general frame of reference of the world and the people in it, and our beliefs through which we interpret our experiences are altered as we absorb trauma. Self-capacities, such as our ability to be consistent in ourselves across time and our tolerance of strong emotion or affect can be diminished and impact on our ability to stay in emotional connection with others. Our own psychological needs for safety, trust, esteem, intimacy and control can be threatened when in an empathic relationship with victims of trauma.

## **Other caring induced traumas**

Hudnall-Stamm states the importance of 1995 in producing key works on caring induced trauma. There are multiple terms used for caring induced traumas and these authors are leaders in the field of compassion fatigue (Figley, 1995), secondary traumatic stress (Hudnall-Stamm, 1995), and VT (Pearlman & Saakvitne, 1995). VT is specifically related to ongoing work with traumatized individuals and represents enduring changes to both personal and professional perceptions (Pearlman & Saakvitne, 1995). Compassion fatigue (CF) and secondary traumatic stress (STS) can be short-lived with some resolution occurring and a diminution of symptoms.

### *Secondary Traumatic Stress.*

In 1995 Hudnall-Stamm produced the first edition of *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*. Secondary traumatic stress (STS) is a caring induced trauma produced through hearing our patients' traumatic stories. Symptoms parallel those of Post-Traumatic Stress Disorder (PTSD) with numbing, emotional withdrawal and other emotionally avoidant symptoms but the transmission of the stress separates them.

### *Compassion Fatigue.*

Empathy is a major resource for those who work closely with the traumatized (Figley, 1995). Figley states that the terms STS and CF can be used interchangeably although he favours compassion fatigue. He (p. 15) describes this term as 'friendly' and that STS can carry a derogatory message whereas compassion fatigue reflects the stress and strain of providing of duty-related compassion. He notes that nurses often feel inclined to describe themselves as suffering from compassion fatigue as this somehow represents what their role is about.

## **Related Constructs**

I have included burnout as a related construct to tease out the differences between burnout, counter transference and VT as they can often be confused.

### *Burnout*

Burnout is a process and often the end result of ongoing caring induced trauma (Cherniss, 1995). Maslach, Jackson and Leiter (1996) defines it in three parts: (i) emotional exhaustion; (ii) depersonalisation; and (iii) reduced personal achievement. Emotional exhaustion occurs in response to what we may perceive as unreasonable demands from our work and that we feel unable to meet. Depersonalization is a way of preserving ourselves in the face of patient demands and blaming them for their own problems. Reduced personal achievement is often the result of the previous two categories, and is the feeling that we are not as effective in our clinical roles.

### *Countertransference.*

In the context of psychotherapy and mental health nursing, transference is the experience of the patient in relation to their clinician(s). In the same context counter-transference represents the feelings of the clinician(s) towards their patients. When Freud, in 1910, first introduced counter-transference it was thought to be something that needed to be overcome by the therapist. Jones (2005) identifies that nurses have the potential to invoke strong transference and counter-transference in their nursing relationships and if understood there is potential for benefit to both nurse and patient. He extends this theme to nurses becoming more aware of their own attachment styles in relationships and the impact that this may have on their nursing relationships and care giving processes. Herman (2001)

introduces us to the term traumatic counter-transference and talks of trauma as contagious, that in the role of witness to traumatic events the therapist/mental health nurse can be overwhelmed with the same rage, terror and despair experienced by the patient.

These constructs are similar in nature but do not adequately express the negative effects of empathic engagement across time and across different patients. VT allows for the permanent transformation of the clinician through the process of empathizing with traumatized patients. VT is specific to engagement with trauma in a clinical setting. STS, burnout and counter-transference can occur across a wide range of patients not just those who are traumatized.

#### *Vicarious resilience.*

Hernandez, Gansei and Engstrom (2008) introduces us to a new concept, that of vicarious resilience. It focuses on the patients' own stories of survival and the resilience developed to cope with traumatic experiences. These constructive coping mechanisms developed by the patients can foster vicarious resilience in the clinician. They are sustaining and empowering for both the patient and the clinician.

### **Mental health nurses' knowledge of VT**

To answer the question of whether mental health nurses are familiar with the term VT and/or have had experiences of it I chose a narrative approach with a semi-structured, in-depth interview for each participant. I believe that narrative methods mirror mental health nursing to some degree in that mental health nurses seek and value the stories of patients and that these stories emerge within the context of the therapeutic relationship. It is also part of our nursing culture that we value it with each other as

nurses, whether in debriefing, peer supervision or in end of shift handover. Participants in this study affirmed this view.

For mental health nurses to share the personal experiences of their work I felt it was important to create an atmosphere of trust and sensitivity to their stories. It is for this reason I chose the one-to-one, in-depth interviews. This method is, according to Fox (2006) consistent with the literature relating to the gathering of sensitive material.

There is wider literature available linking VT with allied health occupations especially social work and psychotherapy (Canfield, 2005; Kleespies & Dettmer, 2000; Ortlepp & Friedman, 2002; Pearlmann & Saakvitne, 1995). This gap in the literature for mental health nurses may mean we have difficulty in speaking of this caring induced trauma or simply that we do not know of its existence. The gap in the literature does not mean that vicarious traumatization is not experienced by mental health nurses. It is possible too that we simply assimilate it as part of the job (Kleespies & Dettmer, 2000). If a nurse is new to the field of mental health nursing they may not know what is usual or what is a sign of suffering from VT. This highlights the insidious nature of VT and its subtle but life-changing effects. It is essential that we reflect on our mental health nursing culture and ask if it contributes to nurses' experiences of VT.

The risk for mental health nurses of VT lies in our lack of awareness of its insidiousness (Clark & Gioro, 1998; Pearlman & Saakvitne, 1995). These authors are convinced that nurses who are informed about VT and lead a balanced personal and professional life are in the best position to guide themselves and their patients through the hazards of trauma work.

## **The Nursing Culture**

Mental health nursing is a caring profession. Historically the nursing culture incorporates notions of virtue, self-sacrifice and duty. The 'virtuous woman', a Victorian ideal of womanhood stemming from the Crimean War, and Florence Nightingale who established nursing as a respectable career for women (Adams, 2007). The 'soldier-on', another military metaphor, is familiar and observed anecdotally from colleagues and myself. Adams goes on to talk of the 'tyranny of niceness' whereby nurses are all-caring and nice to be around reflecting what others require of them. Employers need an unquestioning devotion to the organization, the patient needs a constant figure in their treatment whilst remaining uncognisant of the nurse's other demands. This environment may contribute to mental health nurses ignoring signs of vicarious traumatization and putting it down to 'just part of the job' – being encultured into trauma and silently accommodating it.

These demands may take a toll on the nursing population with a resultant paucity of nurses in the mental health field. It is important that we consider what messages are given to student nurses about the demands of this particular area of nursing and how we prepare new nurses for this challenging and rewarding profession (Evans, 2007; Clark & Gioro, 1998; Morrisette, 2004).

If mental health nurses believe that the empathic relationship between nurse and patient is the key to maintaining hope and promoting recovery, we are compelled to investigate anything that may impact upon this relationship. White (2006) asserts that if staff working in mental health cannot project this sense of hope and optimism then the service as a whole will be affected.



## **The Therapeutic Relationship**

Relationships as an agent of change is thematic throughout this thesis. The nature of the therapeutic relationship is important to define in the context of examining vicarious traumatisation. Pearlmann and Saakvitne (1995, p. 17) assert that “there is nothing that cannot be spoken and that events in the therapy and the therapeutic relationship itself are open to observation and discussion”. Patients may confide in nurses their most traumatic experiences.

VT is a permanently transformative process (Pearlman & Saakvitne, p. 33). This means that for those experiencing VT there may be changes in their frame of reference, such as their trust in others and whether they still view the world as benign as they once did. Pearlmann (1998) lays the foundation for considering the value of the therapeutic relationship and its healing potential. The therapeutic relationship is authentic and supports hope for patients whose experiences of relationships have been the opposite of real and offering hope. The rewards of working in this way can be great – a human and healing connection with another is profoundly effective for both. The risks can be equally as great, and it is this deep, empathic connection which places the mental health nurse in a vulnerable position.

For patients who have been abused, trust and control are of great importance in relationships. Once attached in relationship to another the experience for both patient and mental health nurse can be intense. Pearlmann (1998) emphasises the importance of the one to one therapeutic relationship for the patient so they can develop a sense of connection to a loving other. The loving other is an internalised object (therapist/mental health nurse) and is

transferential in nature. This transferential relationship is not 'stable' in the sense that it is formed and reformed within the therapeutic framework. For the mental health nurse it can be difficult being both idealized then denigrated as the patient struggles with their feelings of longing and disguises them with contempt. For the mental health nurse, exposure to this level of intensity can be challenging and, at times, overwhelming.

The mental health nurse and the patient must tolerate these feelings and it is known in Kleinian terms as the depressive position. Klein states that we must bear all our feelings and thoughts and not 'split' or 'project' them onto others – this is known as the paranoid-schizoid position (Segal, 2004). For the nurse and patient working in mental health the boundaries of the relationship in the emotional dimension are inter- and intra-psychically formed and maintained. Inter-psychically means between the nurse and patient and that boundaries such as self-disclosure and environment are used thoughtfully to build the working relationship. Intra-psychically relates to the nurse or patients own relationship or beliefs about themselves and their emotional, cognitive aspects. Each nurse and patient is unique and brings their own experiences to the therapeutic relationship.

Halton (1994) investigates the unconscious aspects of institutions from a psychoanalytic perspective. He sheds light on the function that staff may serve as 'containers' for the unconscious projections of patients. In a psychodynamic approach to treatment this is fostered and it is staff, including mental health nurses, who bear the unbearable feelings for our patients – they are projected onto us. We receive these projections, tolerate them and re-present them back to our patients as an interpretation. This is where the strength of the therapeutic relationship is tested with the potential for greater understanding of the patients' difficulties.

## **Language**

This section on language was included to offer greater clarity and consistency for the reader of the terms used in this thesis.

In the context of my work as a mental health nurse in a therapeutic community the term 'patient' is used almost exclusively. It is part of my working culture and is used throughout the thesis. When quoting or commenting from the research of others I have endeavoured to use the language they have chosen. This does not necessarily reflect my own views. In the findings section I have been faithful to the expressions used by participants. In the context of mental health nursing the therapeutic relationship is seen as an agent of change. Trauma includes physical, emotional and sexual trauma. Clinical supervision is a regular, formal meeting arrangement between supervisee and supervisor for the purpose of clinical reflection. Affect means emotion or feeling experienced. Psychodynamic nursing in this project reflects the in-depth focus of the therapeutic relationship and not taking things at face value alone.

## **Structure of the thesis**

Chapter one introduces the concepts of VT and the link to mental health nursing. In chapter two I focus on the mental health nurse and the therapeutic relationship which is at the centre of mental health nursing. I look at the impact vicarious traumatization might have on this healing relationship. Chapter three looks at the construct of VT and of CSDT which provides the theoretical underpinnings of this caring induced trauma. Chapter four summarises the extant literature on VT and its relationship to the mental health nurse, the therapeutic relationship and the patient. Chapter five focuses on the methods

chosen and why, and the ethical considerations contained within. Chapter six contains the findings and incorporates the analysis of the interviews and exploration of the nurses' stories themselves. Chapter seven is the discussion and recommendations section of the thesis. The discussion includes themes that emerged in the interview analysis and recommendations from the research will be put forward.

## **Conclusion**

This research focuses on VT as a caring induced trauma. I investigate whether mental health nurses know of VT and whether they have experienced it. The nursing culture within which mental health nursing sits is explored. VT is an enduring trauma and is often hard to recognize. VT has the potential to produce life-changing effects for the nurse and ultimately impacts on the care the nurse gives the patient.

The next chapter positions the nurse in the mental health context and makes links to nurses' vulnerability to VT in their role.

## **CHAPTER TWO: THE MENTAL HEALTH NURSE**

### **Introduction**

This chapter explores the context of mental health nursing and its interface with VT. The nature of the therapeutic relationship between the nurse and patient is explored including both nurse and patient perspectives. There is an overview of historical and modern influences on mental health nursing and I explore the unconscious and its links with nursing, VT and the therapeutic relationship. Other caring induced traumas relevant to mental health nursing are also described. It is important to link these subject areas to the role of mental health nursing as they may reveal the nurses' vulnerability to VT. The chapter concludes with an exploration of why mental health nurses may be at risk of VT.

The role of the mental health nurse is complex and changes with the setting. In some clinical areas of mental health the need for physical boundaries is important to maintain safety, in the community setting an assessment of daily function is more the focus. Regardless of the area the mental health nurse is working in he, or she, bring themselves to the role to form relationships with patients that are both therapeutic and recovery driven. It is important that if we value the therapeutic relationship and consider it as central to mental health nursing and the patient's recovery, then we should be mindful of what impacts on this relationship.

## **Historical Context of Mental Health Nursing**

Peplau (1952) was at the forefront of nursing theorists who questioned what mental health nursing practices are based on. She stated that nursing can be seen as both interpersonal and therapeutic (p. 5). Peplau proposed that if nurses know themselves, through observation, examination and monitoring of their own emotional and behavioural responses to others, that they may then take those experiences and use them in the therapeutic relationship with the patient, (Tomey & Alligood, 2002). Peplau trained as a nurse and specialized in psychiatric nursing, with wider education in psychology. Peplau's ideas on interpersonal relationships in nursing were insightful and refocussed psychiatric mental health nursing as a partnership between nurse and patient, versus the custodial style of nursing existent at that time. The empathy that Peplau alludes to in the forming of these therapeutic relationships is what puts mental health nurses at risk of developing vicarious traumatization (VT). Peplau says that without the mental health nurses' self-awareness we place our patients at risk of receiving, if indirectly, our own anxieties with the prospect of prolonging recovery for the patient.

Peplau attempted to de-stigmatize mental health nursing by her framework and emphasis on the interpersonal in therapeutic relationships, and to identify mental health nursing as a specialty in its own right (Tomey & Alligood, 2002). Peplau's theory is humanizing, in that it allows for the development of the nurse and the patient in relation to one another. Peplau asserts that the type of person a nurse became, would strongly influence what the patient learns while being nursed through illness (Peplau, 1952, p. 5).

A later contemporary of Peplau's was Joyce Travelbee, a psychiatric nurse, educator and writer (Tomey & Alligood,

2002). Travelbee's emphasis was to bring the nurse and patient together, put simply, the relationship was a partnership. Nurses and patients are uniquely human and from this basic position there is equality. She believed that the term 'patient' was a stereotype and that there are only individual human beings in need of care. Nurses have a special body of knowledge and can use it to care for other humans in need of assistance. This closing of the gap between nurse and patient is where the risk of VT comes in with such close quarter empathy. In today's nursing the therapeutic relationship remains the central theme.

### **Modern nursing and the therapeutic relationship**

Mental health nurses perceive the therapeutic relationship at the core of their practice. Although O'Brien also states that mental health nursing does not have exclusive ownership of the therapeutic relationship (O'Brien, 1999).

In recent times Barker's (2001) Tidal Model of nursing relationships has gained popularity. He uses the sea and the tide as a metaphor that reflects the constantly changing nature of a person's life. The Tidal Model assumes that each of us is on a journey on the ocean of experience. Experiences in illness and health are all part of this journey. Ideally we steer our own course across the ocean but at times we may founder, be boarded or need safe haven. Once repairs make us sea-worthy again we head out to sea once more. Barker attempts to reinvigorate the need for the mental health nurse whilst focussing on the patient's story – their lived experience. He feels that the experience of mental illness is inherently disempowering and has set out a model of care to ameliorate this disempowerment. By focussing on the patient's narrative, their experience of being unwell, the mental health nurse is in a unique position to assist the patient to

help themselves. In the Tidal Model, Barker assumes the mental health nurse needs to get close to the patient in order to explore the experience of health and illness together.

Silverstein (2006) expresses concern about an increasing trend towards more 'managed' health care, for the sake of economics, and advanced technologies have implications for the therapeutic relationships inherent within nursing. The conflicts that occur for nurses because of it, such as maintaining a therapeutic rapport with the patient in an ongoing way will affect the patients and their recovery. Silverstein (2006) strongly asserts "therapeutic interpersonal interactions as quintessential competencies for advanced psychiatric and mental health nursing and should be upheld, promoted and implemented to improve outcomes" (p. 40). However, I believe the danger for nurses is that working for too long in this conflicted environment may result in emotional exhaustion, depersonalisation and reduced personal achievement – that is burnout. Burnout and VT are threats to the mental health nurse profession which is an aging population that must regenerate to secure a future.

Participants in Rydon's (2005) study were clear that the clinician they most wanted a therapeutic relationship with was the mental health nurse. Families were reliant on nurses for support and information which fostered hope for recovery in their family member. Nurses who are experiencing VT may distance themselves from the patient and their family and rely on medication with limited availability to talk with patients (Cutcliffe, 2008). This, says Cutcliffe, has service users frustrated. The therapeutic relationship is not just an ideal, it is viewed as essential for recovery.



## **Caring and the therapeutic relationship**

Mental health nursing places caring and the therapeutic relationship with the patient at the centre of the nursing profession (Evans, 2007; Peplau, 1952; Silverstein, 2006). Yalom (1980) talks of the indestructible nature of this type of caring and that, as practice for relating to significant others in the patients' life, genuine relationships with clinicians are invaluable.

For the patient feeling cared for and trusting in the nurse is essential to facilitating trust and safety in order to disclose personal and often sensitive information about themselves to another – sometimes for the first time. Warelow and Edward (2007) argue that modern mental health nursing is more than care and caring. They include resilience and emotional intelligence and assert that these skills will assist in ameliorating the impact of negative experiences such as VT and further developing the skills of the nurse. Emotional intelligence refers to a nurse's ability to identify, express and recognize emotions and incorporate into thought. This helps build resilience in the nurse as they are then able to transcend negative experiences.

Nursing relationships with patients are rarely neutral. Mental health nurses work with patients who suffer severe and enduring mental illness. Nurses bring their own feelings to the relationship and assess those of the patient and formulate a clinical opinion. Because of this starting point we may encourage strong transference reactions from the patients we treat. This may be in both positive and negative transference. We may be the all-caring nurse/parent who alleviates anxiety, or we may be the uncaring nurse/parent that causes anxiety or even harm. If we can bear these extreme feelings and harness their potential for greater connection and understanding with the patient then we really do become the therapeutic tool that enables

hope and healing. Peplau (1952) described this as surrogate roles that nurses are cast into by the patient, a symbolic representation of a past relationship (p. 51).

### **The patients' experiences of the therapeutic relationship**

Research on patient experiences of mental health services reveals that the therapeutic relationship and talking therapies are highly valued (Cameron, Kapur & Campbell, 2005; Cutcliffe, 2008; Schattel, Starr & Thomas, 2007). If the relationship is compromised due to the nurse feeling traumatized then this affects the recovery prospects of the patient. Welch (2005) interviewed experienced psychiatric nurses to identify pivotal moments in the therapeutic relationship – in other words, what made them therapeutic. Emergent themes were: trust between patient and nurse; power sharing in the relationship; mutuality where both acknowledged the effect the relationship was having on them; self-disclosure from the nurse when appropriate; congruence in that the nurse displays attitudes consistent with their beliefs and values; and authenticity which was described as being as close as nurses could get to using their whole selves in the therapeutic relationship. The use of self is a mental health nurse trademark but it is also what places us at risk of VT.

Rydon (2005) views knowledge in New Zealand of the roles of mental health nurses as inadequate with a lack of consumer perspective. In focus groups she explored the perceptions of mental health users towards mental health nurses, their roles, and what was needed and valued in the therapeutic relationship. Six sub-categories emerged: being professional, conveying hope, working alongside, knowing and respecting the person, human quality and connection. These connections may be loosened or non-existent if the nurse has VT. Gordon (2006) is challenging

of nurses' own views of themselves and their profession, that we are cultured to regard ourselves in an almost religious and altruistic framework, perpetuating the role of nurses as self-sacrificing angels of mercy. This is a vulnerable position for mental health nurses to occupy. It could lead us to develop VT if we think we should be able to absorb the stress and trauma alone.

Another study of the perceptions of mental health service recipients on the therapeutic relationship was carried out by Shattell et al. (2007). Their research question was 'what is therapeutic about the therapeutic relationship?'. In qualitative interviews with mental health service recipients, participants were asked to comment on the experience of being understood and what made the difference in a relationship. Analysis was carried out to tease out components identifying a therapeutic relationship. Three themes were discovered as follows: 'relate to me'; 'know me as a person'; and 'get to the solution'. The use of touch, self-disclosure and blunt feedback were also articulated. An overall theme of 'knowing the whole person', versus as a user of mental health services, revealed itself. To achieve these empathic goals requires the mental health nurse to be 'present' with the patient in a close way. Anything that interferes with the nurse's sense of self is hazardous to the foundation of a therapeutic relationship. In VT, as an occupational hazard, a nurse may feel untrusting of others, unsafe and as a consequence withdraws from the patient (Pearlman & Saakvitne, 1995).

Cutcliffe (2008) stresses the importance that patients place on the interpersonal therapeutic relationship particularly with their mental health nurses. Their experience of 'natural and warm' relationships recognizes the patient's dignity and is respectful and supportive. This natural warmth is compromised when the nurse is experiencing VT.

Why are mental health nurses at risk of VT? Nurses provide the 'holding environment' as outlined by Winnicott (1965) a pioneer in the field of child psychotherapy. This 'holding environment' provides a safe space for patients to 'play' or experiment in while in a therapeutic relationship with mental health professionals. Nurses provide accessibility and continuity to a patient and offer the possibility of a secure and loving attachment. Through this attachment it is hoped that the patient's difficulties in relationships are worked through (Winnicott, 1965).

### **Nursing, the unconscious and the therapeutic relationship**

Although the two may never meet, the unconscious worlds of both the patient and the mental health nurse impact and interact with one another. Our unconscious motivations and ideas shape our conscious behaviour. In the unconscious, Freud (1915) proposed that we operate a series of defence mechanisms in order to manage the challenges of daily living. These defences serve the purpose of providing temporary relief from the conflict produced by these frustrations. The defences are part of our unconscious world and soothe our intrapsychic anxieties. They are revealed, according to Freud, in our dreams, behaviour, symptoms and relationships. This internal relationship with ourselves does affect others. Mental health nurses may work closely and empathically with traumatized patients. This psychodynamic work can change our frame of reference of the world and people in it, thus affecting all our relationships both personal and professional such is the impact of VT (Pearlman & Saakvitne, 1995).

In exploring the place of the unconscious in mental health nursing Crowe (2004) maintains that if mental health nurses are

aware of the function and importance of the unconscious in the patients' lives then this will arm the nurse with skills to kindle psychotherapeutic relationships that have longevity. Understanding unconscious processes in the patient will forge an understanding for the patient of their own processes, and make links in their conscious world. Raising to consciousness that which is hidden, barring behaviour and defences, is the start of conscious change and recovery. Peplau (1952) also recognized "the re-experiencing of older feelings in new situations" (p. 57) to facilitate personality growth.

Crowe (2004) believes that behaviour, without understanding what came before, is self-limiting and doomed to repetition. This repression of underlying feelings/processes in the patient can only last so long until the defensive adaptation to living in the world ceases to work. The psychotherapeutic relationship offers the patient a path to find meaning in their life that recognizes individual differences. Forging healthy, healing relationships with mental health nurses offers hope to patients. If the nurse is experiencing VT, however, this positive relationship is threatened.

Clarke (2008) believes that mental health nurses are at increasing risk of VT and recommends clinical supervision for the exploration of transference and counter-transference in trauma work. In Evans (2007) focus was placed on transference in the nurse-patient relationship in mental health. She is careful to draw out the difference between transference and dependency, the latter is often used pejoratively. The therapeutic relationship is a professional one where the nurse's use of self is central to communication. It is here that the transference can be taken up as part of this psychodynamic relationship between nurse and patient. Transference is the patient's experience or feelings that develop within the context of a therapeutic relationship. These

feelings are shaped by the patient's own lived experiences and relationships. The importance to the mental health nurse is that transference can provide the basis on which therapeutic work can be done. Counter-transference is the feelings developed by the nurse towards the patient. These feelings are drawn from the previous experiences of the nurse and within the framework of the therapeutic relationship. Counter-transference can be affected by the nurse's well-being. If affected by VT the nurse may develop negative feelings towards the patient. The skill is in recognizing whether VT is a factor or whether the nurse's responses are what he or she would expect given the particular patient they are working with.

### **The unconscious and VT**

I believe it is vital to look at factors that may protect those working closely with traumatized patients. Mental health nurses are among these workers given we are a large occupational group within mental health and form ongoing therapeutic relationships as part of our daily work. In a longitudinal, mixed method study Collins and Long (2003b) looked at the psychological effects of working with trauma. They demonstrated that compassion satisfaction was a possible protective factor and that those with high compassion satisfaction were less inclined to show high levels of compassion fatigue and burnout. In their qualitative data, team spirit and camaraderie, coupled with the satisfaction of patient recovery were viewed as the best aspects of working in a multi-disciplinary team and ameliorated the negative effects of trauma work. In an attempt to identify balancing factors against the negative effects of working with trauma survivors, Hernandez et al. (2007), formulated a new concept called vicarious resilience (VR). Their phenomenological approach was used to reveal descriptions of the effects on therapists of witnessing how

traumatized patients cope constructively with adversity. Through reflection on human beings' capacity to heal, incorporating spirituality as a valuable dimension in treatment and the fostering of hope and commitment, these authors feel VR is achievable. They conclude that VT and VR are both naturally occurring processes in the context of trauma work, and that VR offers a counter-balance to the negative effects of trauma work.

### **Other Caring Induced Traumas**

This broad term, caring induced trauma, is usually associated with working in professions where there are high human contact hours. Other caring induced traumas include compassion fatigue (CF), secondary traumatic stress (STS) and burnout. VT features across the different specialities of nursing, including emergency department nurses (Little, 2002), and those dealing with a high percentage of female patients such as nurses working in obstetrics and gynaecology (Gates & Gillespie, 2008). The risks in these areas are related to patients who are usually admitted for reasons other than psychological trauma but whose story emerges once they have been admitted into hospital. Nurses working in these areas may be unprepared for the extent of the emotional involvement sought in the one to one relationship.

Empathy is a major resource for those who work closely with the traumatized. Figley (1995) coined the term compassion fatigue which he believes reflects the stress and strain of providing of duty-related compassion. Hudnall-Stamm (1999, p. xx) quoted a colleague who thought that the term compassion fatigue sounded more "noble" since it is acquired through caring. This may have particular application to nurses who are often seen as noble and self-sacrificing, sublimating themselves to achieve the needs of others.

Maslach, Jackson and Leiter (1996) defined burnout in three parts: (i) emotional exhaustion; (ii) depersonalisation; and (iii) reduced personal achievement. Emotional exhaustion in response to what we may perceive as unreasonable demands from our work and that we feel unable to meet. Depersonalization as a way of preserving ourselves in the face of patient demands and blaming them for their own problems. Reduced personal achievement is often a result of emotional exhaustion and depersonalization, the feeling that we are not as effective in our clinical roles. These feelings are not unique to burnout and are noted by Pearlman and Saakvitne (1995) as consequences of VT. Mental health nursing requires us to be in relationship with the patient and this aspect of our practice is damaged by VT, burnout and other caring induced traumas.

### **Why are mental health nurses at risk of VT?**

Mental health nurses are at risk because empathic engagement is the basis for the therapeutic relationship between nurse and patient. They use themselves as the therapeutic tool which leaves us vulnerable to chronic exposure to the trauma stories of patients.

Nurses make up the majority in of the workforce of mental health. The therapeutic relationship is central in mental health nursing. The forging of real, caring relationships is highlighted as important in research that includes clinician as well as patient perspectives (Shattell et al., 2007). If, according to Yalom (1980) nurses are to maintain a sense of indestructible caring then they should, as mental health professionals with the highest human contact hours, make themselves aware of the risks for



caring induced traumas, and VT in particular, when they engage empathically with patients.

If mental health nurses become overburdened in their work they may withdraw from this empathic engagement. If left unchecked they may rely on depersonalization to bolster their flagging coping resources. Depersonalization may remove them from patients' experiences and rob patients of the chance to recover. It may also rob nurses of the possibility of a healing engagement with another person. Placing a false boundary between nurses and patients may give temporary relief when feeling beleaguered but this separation is detrimental to both. It may be stigmatizing for the patient as they may blame themselves for the nurses withdrawal. It is dehumanizing for the nurse as they may isolate themselves in response to VT and feeling overwhelmed.

Mental health nurses with a personal history of their own trauma are more at risk of VT (Clarke, 2008; Pearlman & Saakvitne, 1995; Warne & McAndrew, 2005). This raises two further issues. Firstly, are mental health nurses prepared to work in the area of trauma? Secondly, how can we promote our own mechanisms of self-care? Clarke (2008) feels that to value the mental health patient we must also value ourselves. She supports education on the risks of VT for nursing students, but also to be aware of our own responses generally towards those who are trauma survivors. A common reaction is to 'rescue' the patient, reinforcing the patient as a victim and disempowering them in the process. Another response is to disengage from the patient when feeling overwhelmed, as in the case of VT.

A risk factor for mental health nurses in developing VT is a lack of education and preparedness to working with trauma and its sequelae on the carer. Strong recommendations for the

education of mental health nurses come from Warne and McAndrew (2005). They believe that the environment within which education takes place needs to be as 'holding' as the environment we attempt to maintain for our patients. This environment would facilitate the working through of unresolved personal issues for the mental health nurse. Collins and Long (2003b) are also supporters of this type of therapeutic environment for those working with seriously traumatized people.

The inability to recognize and assess the experiences and consequences of VT and other caring induced traumas is a potential problem for the mental health nurse. Another risk is whether measurements for VT, CF and STS are accurate or sensitive enough (Sabo, 2006). She recommends further research to adequately capture the costs of caring and favours longitudinal studies to explore symptom development in relation to factors such as chronic exposure to traumatized patients, the impact of the nurse's own trauma experiences, their education level, and years of nursing experience. Long-term studies may give us important preventive strategies for VT in the mental health nursing workforce

Gordon (2006) asked an undergraduate class of nurses to describe their work and they struggled to define it, raising the question of what do nurses really do? Gordon challenges the notions of caring being a natural component of nursing rather than a learned skill and that generally nurses themselves are far too limiting of their role description. Intentionally or unintentionally, she feels that nurses, and some nursing organizations, reinforce traditional images of nursing as self-sacrificing and silent work. This may pose dangers to the mental health nurse. If nursing and caring is 'natural' then what if one feels unable to continue caring, as in the case of VT? The

potential to feel alienated within the nursing profession is a real threat to mental health nurses if VT continues to be unrecognized and those suffering it feel they do not belong with other nurses who are functioning without VT.

## **Conclusion**

Literature supports the notion of the therapeutic relationship being valued by both patients and nurses in offering hope and recovery. Peplau (1952) proposed that we know ourselves as nurses before we then seek to know our patients. Her theory of interpersonal relationships has provided a foundation for mental health nurses since 1952. Mental health nursing today must contend with advancing technologies whilst protecting the therapeutic relationship with patients. The therapeutic relationship is a vital part of recovery but VT is a threat to its healing potential. Engaging empathically and understanding what has gone before, both consciously and unconsciously, is a key component of psychodynamic nursing which can be negatively affected by this caring induced trauma.

VT is a risk for the mental health nurse due to our forming ongoing, empathic relationships with patients across time. It is under the spotlight of VT that we may experience enduring changes to our views of self, the world and those in it. VT is explored in the next chapter.

## **CHAPTER THREE: VICARIOUS TRAUMATIZATION**

### **Introduction**

This chapter discusses vicarious traumatization (VT) and the background to its development in the mental health area. It looks at the main authors of this phenomenon, the related research and the risks of this caring induced trauma. I also discuss trauma and its relation to VT and who might be more vulnerable to VT. Ameliorating factors are discussed along with whether it is possible to prevent VT from occurring.

The philosophical underpinnings of VT, constructivist self-development theory (CSDT), set it apart from other caring induced traumas. CSDT is an inclusive theory that encapsulates the effects of trauma on both patient and carer. It is less symptom driven than, for example PTSD, and represents a unifying personality theory across health and disorder (Pearlman & Saakvitne, 1995). CSDT outlines aspects of the self that are affected by VT. These include our frame of reference on the world, others and our spirituality; our self-capacities to tolerate strong affect and maintain a sense of connection with others; ego resources to meet our own needs and engage with others; psychological needs such as safety, trust, esteem, intimacy and control; and our memory can be affected by trauma with a disturbance in imagery and affect.

### **VT, what is it?**

Vicarious traumatization (VT) is a caring induced trauma that can occur when one engages empathically with a victim of trauma. The phenomenon that is VT had its genesis in 1990 when McCann and Pearlmann published their first work. They became

aware that the focus of trauma work was mostly with the client and did not encompass the impact that this work might have on those who treat trauma victims and, who as a consequence of that work may suffer enduring psychological sequelae. This can involve a change in the frame of reference, the treater's view of the world and those in it. Further effects on the treater may be felt specifically in the personal areas of safety, control, intimacy, trust and esteem.

McCann and Pearlmann (1990) elaborated on a previous model of theirs to understand the effects of psychological responses to trauma victims. This formed the basis of CSDT. Each trauma story is unique and it is not based on the treater's interpretation of it. Construction of meaning is formed and reformed as the individual experiences new events or takes in new information which are then incorporated into the individual's beliefs about themselves and others. From this we glean that each of us will respond differently to a traumatic event, given our background including culture and spirituality. Pearlmann (1998) suggests that this psychological theory is useful as a framework for both understanding and healing of trauma.

If trauma is contagious, as Herman (2001) states, the therapist/mental health nurse can become overwhelmed with the same rage, terror and despair experienced by the patient. She calls this VT or traumatic counter-transference. Herman believes that the core experiences of psychological trauma are disempowerment and disconnection from others. One could argue that that they are doubly disempowered, since Barker (2001) asserts that being mentally unwell is automatically disempowering with a subsequent loss of control. Recovery is based on empowerment and building new connections and that recovery cannot take place in isolation. The restoration of trust

and autonomy in relationships is a prime goal in psychodynamic therapy (Herman 2001). This leads to why the therapeutic relationships developed with mental health nurses is so important for the recovery of the traumatized patient, and why the mental health nurse is at risk from this traumatic contagion and might develop VT. Understanding the impact of trauma from both the patient and carer perspective is encompassed in the CSDT model.

### **Constructive Self Development Theory (CSDT)**

CSDT is a theoretical and philosophical framework around which a therapist can understand the patient's experience of trauma (McCann & Pearlman, 1990b). It also gives the therapist/nurse a framework for understanding the impact that it has on them as carers, that is, VT. CSDT identifies the patient in context of their experience and thus avoids labelling the client "as a collection of symptoms" (Pearlman & Saakvitne, 1995, p. 56). It sets out a template for linking the impact of trauma work upon therapists/nurses which results in vicarious traumatization.

In CSDT there is an emphasis on development at an early stage of the patient's life. There is an assumption that these experiences shape and guide our responses as adults. The premise of psychotherapy being a working through of developmental challenges by engaging in a therapeutic encounter. From these encounters comes hoped for personal growth and recovery (Pearlman & Saakvitne, 1995).

McCann and Pearlman (1990b) developed CSDT to address the complexity of the psychotherapeutic relationship and allow a guide that could be applied to the patient, the therapist and the relationship. The philosophical and theoretical underpinnings of CSDT, constructivism and the developmental perspective, are

described in the next sections. CSDT integrates psychoanalytic and cognitive theories (Pearlman and Saakvitne, 1995).

### *Constructivism.*

Constructivism is part of CSDT that offers a unifying personality theory (Pearlman & Saakvitne, 1995). Constructivism infers that individuals construct their own realities and that each is unique to that individual (Epstein, 1985). Working clinically with trauma survivors means that “the meaning of the traumatic event is in the survivor’s experience of it” (Pearlman & Saakvitne, 1995, p. 57). Each trauma will impact differently on the individual and as clinicians we must listen closely to ascertain this with each new patient. Meaning is constructed and reconstructed as new information and experiences are incorporated into an individual’s belief system and that adaptation is individualized. This construction and reconstruction occurs across subsequent developmental stages and is fundamental for therapeutic change for the patient (Pearlman & Saakvitne, 1995, p.57).

### *The Developmental Perspective.*

The developmental perspective is a central part of CSDT. It focuses on an individual’s early psychological and emotional development is crucial to their current way of experiencing and interacting with themselves and others (Pearlman & Saakvitne, p.58). CSDT identifies aspects of the self that are affected by trauma. Developmental tasks usually achieved by a certain age may be halted or incomplete if a person has been traumatized through violence in the home or sexual abuse from a young age. This gives a starting point in therapeutic work as to where the therapy tasks might lie for the patient and therapist. CSDT

reflects that meaning is constructed and reconstructed throughout our lives and this offers potential for growth when childhood sexual abuse survivors attend therapy as adults. Initially CSDT focussed on patients who were survivors of childhood sexual abuse but it is now inclusive across a range of traumatic experiences, not exclusively sexual abuse. The premise of psychotherapy being a working through of developmental challenges by engaging in a therapeutic encounter. From these encounters comes hoped for personal growth and recovery (Pearlman & Saakvitne, p. 58).

These aspects of the self are laid down in the first few years of life (Pearlman & Saakvitne, p. 61). Through our **frame of reference** we incorporate our beliefs through which we interpret our experiences: (i) world view, which comprises our broadest beliefs about the world, life, philosophy and moral principles; (ii) identity, holds our notion of self across time, situations and relationships and is reflective of our experience of ourselves; and (iii) spirituality, or how we ascribe meaning to ourselves, our lives and relationships in the larger world (Pearlman & Saakvitne, 1995, p. 62).

Our **Self Capacities** reflect our ability to maintain a relatively consistent self across time and include: (i) tolerating strong affect; (ii) maintaining a positive sense of self; and (iii) maintaining an inner sense of connection with others. These capacities are developed when young from a stable and loving parent/caregiver in our first few years of life (Pearlman & Saakvitne, 1995, p. 62).

**Ego Resources** are our abilities that enable us to meet psychological needs and relate to others, and are important to the therapy process. They include: (i) our intelligence and willpower to strive for personal growth; (ii) to foresee



consequences and be able to protect oneself from harm; (iii) and to establish mature relationships with others and maintain boundaries (Pearlman & Saakvitne, 1995, p. 62).

An individual is motivated, and their relationships shaped, by his/her **psychological needs and cognitive schemas** related to self and others and are central to meeting the psychological needs. They are: (i) Safety – to feel secure from harm; (ii) Trust – to have confidence in one's own perceptions; (iii) Esteem – to feel valued by oneself and others; (iv) Intimacy – the need to feel connected to oneself and others; and (v) Control – the ability to manage one's feelings and behaviours (Pearlman & Saakvitne, 1995, p. 62).

CSDT incorporates a descriptive concept of memory to reflect that traumatic memory is commonly fragmented and dissociated from the individual. Five aspects of the traumatic **memory system** are: (i) Verbal; (ii) Affect; (iii) Imagery; (iv) Somatic; and (v) Interpersonal (Pearlman & Saakvitne, 1995, p. 62).

Our intra-personal abilities allow us to keep a continuous, mostly positive sense of self and are important for self-soothing and affect tolerance (Pearlman & Saakvitne, 1995, p. 161). Continued exposure to trauma stories from our patients can profoundly and lastingly alter our sense of self and our frame of reference on the world.

CSDT is intricately connected with VT and was developed by the same authors (McCann & Pearlman, 1990a, 1990b). It is a model for working therapeutically with those who have experienced trauma in their lives. It provides the framework upon which to examine the effects of trauma work upon the patient and their therapists/mental health nurses with whom they form therapeutic relationships. It is the therapists/mental health

nurses who are at risk of developing VT from this type of empathic engagement.

### **VT and the mental health nurse**

Mental health nurses form the largest professional body within psychiatry. While the therapeutic relationship is not solely the domain of mental health nurses it is understood to be our 'raison d'être'. It is this close therapeutic relationship that places the mental health nurse at risk of VT.

Empathic engagement is a key ingredient of the therapeutic relationship and is one of the mental health nurses main tools. Among the strongest predictors of positive change for the patient is the quality of the therapeutic alliance that in itself creates therapeutic potential (Cameron et al., 2005). These same authors explore the notion of psychodynamic containment. Containment within a therapeutic relationship is important for trauma survivors in particular because personal boundaries have been violated in a most damaging way, especially for incest and sexual abuse survivors. This containment stems from childhood and is dependent on a consistent maternal figure (Winnicott, 1965) being able to be internalised by the child. In a noxious environment this process becomes maladaptive. As an adult these poorly held boundaries can result in an inability to tolerate strong affect in others and themselves. Relationships with others can feel out of control when the patient, or those around them, have strong feelings towards each other which are unbearable. Control is an important factor for those who have endured traumatic relationships. If the trauma survivor cannot tolerate these feelings they may then be split and projected into those around them.

The mental health nurse's role is one of caring. This position occupied by nurses increases their vulnerability to receiving the patient's unwanted, projected feelings. Without some knowledge of this process the nurse remains at risk of being on the receiving end of projected feelings and actions and is ill-equipped to engage effectively with the patient. If we do not have knowledge of the development of transference and counter-transference within the context of a therapeutic relationship we may blunder on unaware. We may experience the feelings that are disavowed by the patient that can lead to the nurse to feel confused, angry, and helpless. Without this awareness the nurse's default position is to react to these feelings rather than consider them. Hasty clinical decisions, retaliation or inadvertent re-enactment of the transference can occur as opposed to an emotionally corrective experience (Cameron et al., 2005). For example, if we remind the patient of their harsh mother we may respond like one because we have projected into us the feelings that the patient generates towards their real mother. The positioning of the mental health nurse at the edge of patient projections within the therapeutic relationship makes him/her more vulnerable to negative experience of the transference and possibly without the knowledge to incorporate it into the therapeutic relationship with the patient.

Warne and McAndrew (2005) explore mental health nurses preparedness for working with adult survivors of abuse. They assert that nurses often avoid discussing any issues of sexuality with the patient. This is partly in response to our own discomfort but that we may fear we do not possess the skills to engage with the patient. The authors also raise the issue of mental health nurses who may be survivors of sexual abuse and have entered the profession as much to understand themselves as assist their patients. Without being armed with self-awareness of their own sexuality, and the knowledge and skills to discuss the patients'

issues around sexuality, the nurse may be left vulnerable along with the patient.

The damage done by VT going unrecognised can be severe (Pearlman & Saakvitne, 1995). VT affects not only the clinician but the patient. The personal costs to the therapists can be depression, despair, cynicism, alienation from family and colleagues, professional impairment that often results in premature job changes.

### **Trauma and its relationship to VT**

VT is an inevitable and enduring trauma when one engages empathically with a victims of primary trauma (Pearlman & Saakvitne, 1995). Clarke (2008) explores the notion of trauma and locates it within mental health nursing. She positions early knowledge and understanding of trauma from the field of war, but that currently the notion of trauma has been embraced by the public as we seek to incorporate sexual abuse, violence, crime, war, torture and terrorist attacks. She states that within mental health nursing there is recognition of patients experiencing difficulties which may be beyond the usual range of human experience and that these difficulties overwhelm their capacities to deal with them. Enter the mental health nurse who through empathic sharing of the patients' helplessness may lead to intense feelings of incompetence and hopelessness. It is this empathic engagement that places the mental health nurse at risk of VT. In the role as witnesses for our patients to disasters or atrocities they have experienced we may become overwhelmed and experience to some degree the same rage and despair that the patient has lived with (Herman 1997, p140). This is VT, which can lead to the nurse withdrawing from the therapeutic relationship to protect

her/himself and leave the patient alone with their rage and despair.

Clarke and Flannagan (2003) found that mental health nurses utilized a range of avoidance [of patients] tactics, for the purpose, it would appear, of protecting their own mental stability. Implications for mental health nurses' practice may include a desire to rescue the patient from their victimization. While this may fend off any feelings of hopelessness in the nurse it is far from empowering for the patient and confirms their victim status. Disengagement from the therapeutic relationship is another possible outcome when feeling overwhelmed by the patient's trauma material. Despite her initial scepticism over the construct of VT, Clarke (2008) now believes that mental health nurses are at increasing risk of it. This intensity within the therapeutic relationship can foster the development of transference and counter-transference between the mental health nurse and patient. It is possible that the nurse's counter-transference response could be negatively influenced by her feelings of hopelessness and a sense of being overwhelmed.

### **Transference, counter-transference and the mental health nurse**

Transference and counter-transference may have some bearing on all relationships but it is in the mental health treatment setting that they are observed closely in order to assist the patient with their existing relationships (Jones, 2005). Transference refers to the feelings that are generated within the patient towards those they work closely with. In a treatment setting these transference relationships are useful in bringing to the surface previous relationship experiences and difficulties which can now be worked through with the mental health nurse. Counter-

transference refers to the feelings that the mental health nurse brings to the therapeutic relationship. These too are useful in identifying issues in past relationships not just for the patient but for the nurse and these can then be explored with the patient and in clinical supervision.

Counter-transference is our response to the transference, characterized by personal feelings and attitudes. Sometimes it is known as a reciprocal transference. In exploring transference, counter-transference and repetition in nursing, Jones (2005) puts the focus on interpersonal dynamics occurring between patients and colleagues. Put simply he sees transference as a way of revisiting past relationships particularly those which have some tension or difficulty within them. Understanding these concepts is an important aspect to ensure safe professional relationships across all nursing disciplines.

A feature of transference is its attribution to more than one person, regardless of gender, across different situations. Transference has the potential to be both positive and negative. Positive where the transference object [nurse] is viewed as loving, caring and giving, and negative where the object is critical, uncaring and unloving. In 1915, Freud developed this term and wanted to make clear the feelings of the therapist as separate from the patient. These processes of transference and counter-transference are largely unconscious. It is only within the realm of a therapeutic relationship that their potential can be recognized and understood for the gain of the patient and for the therapist/nurse in terms of increased self-awareness. Likewise with repetition or repetition-compulsion as described by Freud (1915). The compulsion to repeat ways of behaving in relationships either to put something right or make sense of something in that relationship, however faulty, or even dangerous.

An interesting aspect that Jones (2005) explores is that of career choice by some nurses may have been made through our own transference. He is clear that mental health nurses should not be viewed as deficient in some way because of their choice rather their unconscious choice may be helpful if they can bring it to the conscious arena. I agree that we must be careful not to pathologize mental health nurses' motives to enter the profession. However, there is evidence that if the nurse has a history of their own personal trauma that this increases the risk for VT (Baird & Kracen, 2006; Clarke, 2008; Collins & Long, 2003). Understanding our own personal attachment styles may be helpful in thinking about the impact we have on our patients and vice versa. It is wise to identify, if possible, other predisposing factors for mental health nurses to VT.

### **Who may be more vulnerable to VT?**

Helpers with a need for power and control are likely to be greatly impacted on by the powerlessness reported by the patient (McCann & Pearlmann, 1990). The mental health nurse who experiences this may feel the need to rescue the patient further confirming the victimhood status of the patient. It is much harder to tolerate the powerlessness with the patient just by listening to their story. If it is not understood the transference can lead us to make hasty clinical decisions as we are urged to action rather than understanding (Jones, 2005). The illusory nature of control is revealed and can result in helplessness in the helper and of feeling overwhelmed.

Loss of relationships is a risk with VT. Trust in others, our families or our colleagues, can be diminished or at least distorted to a view where few can be trusted and we expect the worse (Pearlman & Saakvitne, 1995). Intimacy and sharing is reserved

for a few close contacts which mimics the alienation patients often feel with their trauma stories. The resulting isolation can lead to the nurse feeling stigmatised or even the suggestion that they are gaining secondary treatment for themselves for their own unresolved trauma. Our basic frame of reference is damaged by a long and continuing association with the trauma stories of patients and this results in VT.

Munroe et al. (1995) described engagement and transmission of VT by the nurse absorbing the intensity of emotion from trauma survivors and may, as a protective instinct, shut down to avoid the feelings or even stop the patient from talking. This may reflect the earlier relationship of victim and perpetrator where secrets were encouraged.

### **What are the protective factors against vicarious traumatization?**

Professional supervision is given a priority by Pearlman and Saakvitne (1995) alongside maintaining a private life, a spiritual life and a balance between work and recreation. They do not talk of prevention but of addressing VT and ameliorating its impact. Pearlman and Saakvitne (1995) view VT as an inevitable part of empathic engagement with victims of trauma. Given the enduring nature of these changes related to VT, they assert the need to alert those working with, or planning to work with, trauma victims of the risks for suffering VT.

Two related concepts to working empathically are compassion satisfaction (Collins & Long, 2003a) and vicarious resilience (Hernandez et al., 2007). High compassion satisfaction can ameliorate the negative effects of trauma work. Collins and Long (2003) argue that trauma workers must be motivated to



help others and derive some satisfaction from it. They identify compassion satisfaction as a possible protective factor against compassion fatigue and burnout. Another positive factor was team spirit and camaraderie. Vicarious resilience (VR) was coined by Hernandez et al. (2007). Their focus was on therapists' interpretation of trauma victims' stories and witnessing how these survivors have coped constructively with adversity.

Resilience, as a feature of caring in nursing, is a skill explored by Warelow and Edward (2007). Nursing is often generalized as a caring profession when in fact it is far more complex in practice. Edward (2005) asked mental health crisis workers to describe their experience of resilience. The nurses interviewed thought that resilience developed in a caring environment within the team in which they worked. This allowed for a more flexible sense of self, better insights, self-care, faith, and hope – for themselves and the recovery of the patients in their care. These skills may be useful in combating the effects of VT on the mental health nurse where our basic frame of reference has been shaken.

Self-knowledge is a strong feature of the literature on caring induced traumas. If mental health nurses are the therapeutic tool then we should 'know' the tool and what it is capable of. Self-knowledge comes from self-reflection and making time for this professional necessity is paramount. Raising awareness of the risk for caring induced traumas such as VT is a recurring theme in the literature (Clarke, 2008; Clarke & Gioro, 1998; Collins & Long, 2003). Education on the risks for VT for undergraduate trainees prior to entry to the clinical arena is another theme (Clarke, 2008; Clarke & Gioro, 1998). This is a reasonable stance to take given other nursing disciplines do this as a matter of course, e.g. safe-handling of biohazardous material for instance, and that VT represents a real risk to the mental health

nurse. Education on compensatory factors such as strong family network and social support would be valuable.

The skills of empathy and compassion which make a clinician good at their job are the same skills that make them vulnerable to emotional distress which lingers after a critical incident (Kleespies & Dettmer, 2000). A further study by Kleespies, Penk and Forsyth (1993) looked at the relationship between year of training and the experience of a patient suicide. The earlier in training that the suicide occurred the greater the impact on the clinician with intrusive thoughts and images. They explore the notion of incorporating these traumatic thoughts and images into our minds. If one assimilates events it is the event that is altered to fit our existing concepts; if we accommodate them we must change our existing concepts to allow space for previously discrepant events. Over-accommodating carries the risk of increased cynicism or blaming the patient by way of explaining away the trauma. This is potentially damaging to patient and may leave the helper liable to experience VT.

### **Prevention of vicarious traumatization – is it possible?**

Pearlman and Saakvitne (1995) believe that VT is an inevitable consequence of empathically engaging with traumatized individuals. They do not talk of preventive strategies instead they use words like ‘addressing VT’ or ‘amelioration of effects’ of VT. Self-care and leading a balanced personal and professional life is cited as important in mitigating the effects of VT (Pearlman & Saakvitne, 1995). Clark and Gioro (1998) state that knowledge is the key and that prevention may not be a reasonable expectation given the premise that VT is an inevitable and enduring trauma. Clarke and Gioro (1998) focus on increasing self-awareness, a balanced self-evaluation and

appropriate seeking of corrective interventions, for example clinical supervision and/or post-event debriefing. They developed an acronym to sum up their views on the management of trauma – ACT (Acknowledge; Connect and Talk). They strongly recommend that education begin at an undergraduate level.

Collins and Long (2003b) conducted a literature review looking at the consequences of trauma on mental health care workers and question the exclusiveness of VT as it only focuses on the negative effects of contact with patients and their trauma material. They report that satisfaction in the job is a protective factor against this VT, as do Pearlman and Saakvitne (1995) and Clarke (2008). By contrast a personal history of trauma in the helper is a predisposing factor to VT (Clarke, 2008; Pearlman & Saakvitne, 1995).

The effects of VT on the helper's professional and private relationships may be profound. The helper may use defensive mechanisms such as distancing oneself from trauma survivors either consciously or unconsciously. The effect of this withdrawal is felt by the patient and is similar in terms of feeling emotionally isolated and detached. This withdrawal can affect relationships with family and friends as the trauma worker may feel socially isolated because they perceive no one understands their job and its ensuing distress. An alternative to withdrawal is an over-investment in taking responsibility for the patient with a side effect of feeling more in control from the helper's perspective, while disempowering the patient (Pearlman & Saakvitne, 1995).

Professional isolation may also be a feature if nurses feel they are the only one that is traumatized by their work. Feeling different from one's colleagues, positions the nurse in a lonely

place and away from supportive, collegial relationships with other nurses and may increase our risk of VT.

Clinical supervision should provide balance and an opportunity to work through personal difficulties while working empathically with traumatized patients. This type of reflection can bring about positive changes and arm the worker with increased self-capacities to tolerate working in this complex field and mitigate the effects of VT. Herman (2001) is clear that therapists cannot do trauma work alone which parallels the patient's experience who struggle to manage their trauma alone.

From these perspectives it does not appear possible to prevent VT from occurring, rather it is a case of alerting nurses to the risks of empathic engagement and minimizing its negative effects.

## **Conclusion**

VT is a caring induced trauma experienced through ongoing, empathic engagement with trauma victims. CSDT offers a theoretical framework for working with trauma and understanding its impact on the victim and the carer. Early experience of trauma can profoundly affect an individual. Transference and counter-transference provides a psychoanalytical view on the impact of these traumas. Mental health nurses are well placed to facilitate a therapeutic relationship through which to explore the patients' feelings. This close relationship places the nurse at risk for VT with negative consequences for nurse and patient.

Researchers in the area of VT suggest ameliorating its effects rather than prevention. Maintaining a life outside of work is seen

as crucial to mitigating the effects of VT. Other professional supports such as clinical supervision and team work, as opposed to working alone, are moderating influences against VT. If VT is an inevitable consequence of empathic engagement with traumatized individuals as Pearlman and Saakvitne (1995) assert then mental health nurses should know about it. As a profession, mental health nurses make up the largest professional group within mental health. We work closely and empathically with patients and form close, therapeutic relationships in an ongoing way. This relationship is important to the patient for their recovery, and for the mental health nurse it is at the core of our work.

Researchers have indicated that mental health nurses are mostly oblivious of VT and this is concerning as VT profoundly affects the nurse and secondarily the patient and their treatment. This is why it is important to research mental health nurses' knowledge and experience of VT.

Chapter Four contains the literature review for the project. It explores the literature related to the role of the mental health nurse, the therapeutic relationship between nurse and patient, VT and related caring induced traumas.

## **CHAPTER FOUR: LITERATURE REVIEW**

### **Introduction**

In this chapter I describe the search strategies I used for exploring the literature on VT. There are specific sections on VT and available research plus an overview of other caring induced trauma literature including burnout, STS and CF. These caring induced traumas were explored as related constructs to VT and to explore the clarity between these terms. This research has been to explore the mental health nurse's knowledge and experience of VT. The negative sequelae of VT can impact on the therapeutic relationship with patients and thus their recovery. I have searched the literature on the therapeutic relationship to capture the nature of the mental health nurse role and why nurses might be vulnerable to VT.

I started looking for VT and discovered there are many terms within the literature and this does make it confusing in terms of recognition.

There is little literature available looking directly at links between mental health nurses and VT. Most literature on VT was by the main authors McCann and Pearlman (1990), Pearlman and Saakvitne (1995), and Pearlman (1998). Their studies on VT can be used across different professions who work with victims of trauma but are not nursing specific. The use of the CSDT framework offers understanding of the effects this type of caring induced trauma can have on nurses, our view of the world, and those in it. The gap in the literature exists in exploring mental health nurses' knowledge and experiences of VT in their own words.

It is evident from the available literature that empathic engagement with victims of trauma can affect the carer (Canfield, 2005; Clark & Gioro, 1998; Figley, 1995; Hudnall-Stamm, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

If the carer, themselves, has a personal history of trauma their risk for VT increases (Pearlman & Saakvitne, 1995). If they have a high trauma patient workload their risk for VT also increases. Ameliorating factors for VT are clinical supervision, a balanced workload and maintaining a personal life is crucial to this balance (Pearlman & Saakvitne, 1995). Mental health nurses do not get any specific education or training in awareness or recognition of caring induced traumas and this leaves nurses vulnerable to signs going unnoticed. VT is a specific caring induced trauma that can affect the nurse's inner experience of themselves, the world and those in it. The effects of VT are insidious and enduring for the sufferer.

Other terms besides VT that fall under the category of caring induced trauma are compassion fatigue, secondary traumatic stress, burnout and VT. There are a number of other terms that I have discovered through my searching such as traumatic counter-transference, empathy fatigue and indirect trauma. I have concentrated searches on VT but have included compassion fatigue, secondary traumatic stress and burnout as comparable constructs. I also define counter-transference as I believe its position within the therapeutic relationship between mental health nurse and patient may be a flag to understanding the effect of working empathically with another.

## Search Strategies

Searches on the databases CINAHL and MEDLINE were suggestive of little research being done on VT as it relates to mental health nursing. There were no results in CINAHL for 'vicarious traumatization', 'vicarious traumatization and mental health nurses', or 'vicarious traumatization and compassion fatigue and mental health nurses' (match any words). Searching MEDLINE with the terms 'vicarious traumatization and psychiatric nurses' yielded no result and '(vt) and (psychiatric nurses)' resulted in one paper on psychoeducation for trauma survivors (Phoenix, 2007). I also utilized reference lists from papers and books that directly related to the concept of VT or other caring induced traumas.

Due to the paucity of literature relating VT to mental health nursing I broadened the search to websites including [www.therapeuticcommunities.org](http://www.therapeuticcommunities.org), [www.psychotherapy.com.au](http://www.psychotherapy.com.au), [www.bjp.uk](http://www.bjp.uk). The latter two are online journals of psychotherapy but yielded no response to searches with VT and mental health nursing as key words. The first website houses The Journal of Therapeutic Communities and all three of the sites are relevant for my own nursing context within a psychotherapeutic community. However, they yielded no results for VT and/or mental health nurse.

VT was first developed by McCann and Pearlman (1990). They recognized that there was a lot of literature about trauma survivors but very little about the effects on those that treated them and they set out to rectify this. Their observations stemmed from watching their psychotherapy colleagues become tired and world-weary from their work with trauma patients. They went on to develop Constructivist Self-Development Theory (CSDT), a conceptual framework specifically developed to not only



understand the impact of trauma on the adult survivors of these traumatic events, but to provide a theoretical framework to understand the impact of trauma on the therapist. It provides a framework for linking the negative impact of trauma work upon therapists/nurses – the impact being VT (Pearlman & Saakvitne, 1995). VT they define as a cumulative transformative effect upon the trauma therapist of working survivors of traumatic life events. The all encompassing effects of engaging empathically with clients was described by Pearlman and Saakvitne (1995) “Vicarious traumatization is the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material” (p. 31).

Trauma impacts on an individual’s frame of reference on the world, their own identity and beliefs. This perspective is crucial for us to understand our place in the world and how we interpret ourselves in relation to it.

I extended the CINAHL search for ‘caring induced trauma or STS or VT’ yielded thirty results but these were not specific to mental health nursing. The results included social workers (Bride, 2007); indirect trauma and suicide (Ting, Sanders & Jacobson, 2006); oncology social workers and VT (Woodward, Murrell & Bettler, 2005; Simon, Pryce, Roff, & Klemmack, 2005); volunteer workers in crises (Hargrave, Scott & McDowall, 2006); quantitative, validation studies on STS measurement scales (Ting, Jacobson, Sanders, Bride & Harrington, 2005; Bride, Robinson, Yegidis & Figley, 2004); 9/11 and PTSD (Suvak, Maguen, Litz, Silver and Holman, 2008); sexual assault nurse examiners (Gates & Gillespie, 2008; Townsend, 2005; Kataoka, Shitaya, Kano, & Ohtake, 2004); stress in paediatric intensive care units (McGibbon, 2004); child welfare workers (Bride, Jones & MacMaster, 2007); trans-generational trauma with children of holocaust survivors (Rowland-Klein & Dunlop,

1998). STS was the most common caring induced trauma to appear in these research titles. Clark and Gioro (1998) who explored the prevention of indirect trauma in nurses found that nurses who are informed of VT and balance their professional and personal life are better able to navigate trauma work. Baird and Kracen (2006) performed a research synthesis of terminology and compared VT and STS. White (2006) looked at the cost of VT, STS and compassion fatigue on nurses and implications for health care managers. Gates and Gillespie (2008) looked at STS in emergency nurses who care for traumatized, mostly female patients. Collins and Long (2003) looked at the effects of trauma for mental health care workers in a literature review. This search also revealed *The Journal of Traumatic Stress* as an option for further VT papers but on a closer examination there was nothing specific for VT and mental health nurses. Using 'job stress' as a broad search in CINAHL produced work by Cherniss (1995) who focuses on burnout in the human service professions, recovery from burnout and what helps.

In the next section caring induced traumas are discussed. I include CF, STS and burnout as they frequently appear in literature searches when broadening out the search term from VT. There are multiple terms used for caring induced traumas and McCann and Pearlman (1990), and Pearlman Saakvitne (1995), are leaders in the field of vicarious traumatization (VT). Figley (1995) coined compassion fatigue (CF) and Hudnall-Stamm (1995) prefers secondary traumatic stress (STS). VT is specifically related to ongoing work with traumatized individuals whereas CF and STS can occur across any group not just the traumatized. VT represents enduring changes to a persons' perceptions whereas CF and STS can be short-lived and incident specific.

## **Vicarious Traumatization**

VT is a particular risk for therapists working with traumatized people and in Pearlman and Saakvitne (1995) focus on adult survivors of childhood abuse and those professionals working with them. They chose this population because of their belief that childhood sexual abuse is widespread in the community and that therapists will work with adult survivors often. This work primarily addresses VT in therapists but Pearlman and Saakvitne allow its relevance across all who engage empathically with victims of trauma. This is the primary difference between VT and counter-transference, the latter occurring across all therapy populations.

Engaging empathically with traumatized individuals can predispose the mental health nurse to experiencing VT. McCann and Pearlman (1990) were the first authors to encapsulate this risk as VT and provide a theoretical framework, Constructive Self-Development Theory (CSDT), upon which to firstly understand and empathize with the trauma experiences of patients, and secondly to be aware of the impact that working with traumatized people can have on the helper.

Importantly McCann and Pearlman (1990) differentiate VT from existing terms. Burnout can occur while working with any population but VT refers specifically to working with victims of trauma. VT represents enduring effects of working closely with trauma victims whereas counter-transference is time-bound with a particular patient. STS is a symptom-rich description where VT provides a framework to understand how trauma impacts on both patient and helper. Pearlman (1998) went on to look closely at the impact of trauma on the self and using the CSDT framework as a healing model for the traumatized patient and those working with them.

There is confusion between the different terms for caring induced traumas. A research synthesis looked at conceptual clarity between VT, STS and related terms such as burnout and CF (Baird & Kracen, 2006). These authors state that a lack of clarity around these terms hinders their applicability to practice and education. They divided their findings in literature to those that provided persuasive evidence, reasonable evidence and some evidence for predictors of VT or STS. Their definition of persuasive evidence included whether studies were published in peer-reviewed scientific journals, whether there were any methodological weaknesses and if these weaknesses lead to their being unpublished. The themes identified were personal trauma history, perceived coping style, supervision experiences and exposure to trauma material. For VT they found persuasive evidence for having a personal history of trauma, reasonable evidence for perceived coping styles and some evidence for supervision experiences as important predictors of VT. Their views on clinical supervision are consistent with those of Pearlman and Saakvitne (1995) who see it as vital in maintaining a working balance. For those who have a history of trauma themselves, working in this field raises particular self-care issues and the need for peer support at work and a self-awareness of their vulnerability is essential. My own research findings in this project reflect some of these same issues for, example the need for clinical supervision especially when exposed to trauma stories.

Self-care is an important consideration while working with victims of trauma. Creating balance within the workplace setting itself, such as not having too full a caseload or breaking up the working day between clinical and educational work. Balance also applies to personal lives and, in particular, the continued exploration of our spirituality to refresh our hope and humanity.

This can be a moderating factor with VT (Pearlman & Saakvitne, 1995). Ortlepp and Friedman (2002) agree that a high trauma caseload can contribute to STS, but differ from Pearlman and Saakvitne in that they did not find a significant link between those that suffered STS and who had a personal history of trauma.

In a review of trauma terminology Sabo (2006) notes that is difficult to determine whether someone may be suffering VT, STS, burnout, PTSD or depression. This complicates recognition of VT as an occupational injury as it could go unidentified. Mental health nurses working with trauma survivors were researched by Clarke (2008). She looks at the notion of trauma in our culture as our awareness grows about the prevalence of childhood abuse and other traumatic events outside the norm of human experiences. She links this with mental health patients who have traumatic experiences which could be set beyond the usual range of human experience.

Due to the insidious nature of VT Clarke and Gioro (1998) felt that few nurses recognize it as such. They introduce the term indirect trauma to describe the same thing. Their assertion is that the first step to moderating the effects of VT/indirect trauma is recognizing that it exists. They agree with Pearlman and Saakvitne (1995) that nurses will eventually encounter patients who have been victimized and that we then become aware of the insidious but inevitable nature of VT.

In her literature review, Canfield (2005) tries to distinguish the terms STS and VT. She found that clinicians internally try to make sense of traumatic stories from patients and try to place these events within their own personal framework. VT damages our capacity to do this and can lead to enduring changes for the clinician. STS on the other hand is more a direct response to

hearing shocking stories from patients. How we incorporate these shocking stories was explored by Kleespies and Dettmer (2000). They warn against over-accommodating these events into our own framework, that we can just keep on tolerating further traumatic events in order to make sense of them without questioning its impact.

Collins and Long (2003b) state that VT is an inadequate capture of the effects of working with trauma as it focuses only on the negative effects. The expansion of VT to include vicarious resilience (VR) was developed by Hernandez et al. (2007). Hernandez et al. offer VR as a counterweight to the negative effects of VT. VR describes the effects on the carer of witnessing patients working constructively with adversity and overcoming it in their lives.

Collins and Long (2003b) are also inquiring of other factors that protect us from the effects of over-exposure to traumatic material and assert the imperative of clinical supervision. Clinical supervision promotes both personal and professional development and is a processing point for the emotional content we receive from patients. They advocate for self-knowledge of our unique thoughts and feelings as being a virtue rather than a weakness. Collins and Long (2003a) found that compassion satisfaction was a possible protective factor against compassion fatigue and burnout. In their study carers with increased compassion satisfaction were less likely to exhibit increased compassion fatigue and burnout. Working within a team was also noted as a positive support, with camaraderie and team spirit being valued, alongside seeing the recovery of patients. The lack of longitudinal studies robs us of information that would be useful in ascertaining the long-term effects of working with trauma and what can be done about it. It would be worthwhile

conducting further research into compassion satisfaction as a possible protective factor against compassion fatigue.

### **Compassion Fatigue (CF)**

Searching the literature, MEDLINE, on caring induced trauma reveals Figley as a leading researcher and proponent of CF, a term that he sees as interchangeable with STS. In fact CF arose when searching specifically for STS, caring induced trauma or VT. Figley (1995) defines compassion fatigue as “the natural behaviours and emotions that arise from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized person” (p. xiv).

The field of traumatic stress studies has expanded, linking to the growing awareness of long-term sequelae to trauma work (Figley, 1995). The American Psychiatric Association’s third edition of the Diagnostic and Statistics Manual of Mental Disorders (DSM-III) in 1980 is cited as an important marker and reflects the growing importance of recognizing the impact of primary and secondary traumatization, with the diagnosis of Post-traumatic Stress Disorder. In DSM-III’s description of a traumatic event there is clear acknowledgement that knowing of a traumatic event can be traumatizing. It is this type of secondary trauma that Figley describes as compassion fatigue (CF).

It is this helping relationship that puts the nurse most at risk of developing CF. Figley proposes that it is the most effective of therapists [nurses], that is, those capable of great empathy, who are more at risk of developing CF. The work of mental health nurses is premised on the relief of patients’ emotional suffering.

Through this absorption of another's pain and suffering we make ourselves vulnerable to absorbing the suffering itself.

A longitudinal study by Collins and Long (2003b) reported on the protective properties of compassion satisfaction that not all carers develop CF. Compassion satisfaction challenges the notion that trauma workers will only be affected negatively by trauma work.

### **Secondary Traumatic Stress**

STS is also a caring induced trauma produced through hearing patients' traumatic stories (Hudnall-Stamm, 1995). The symptoms parallel those of PTSD with numbing, emotional withdrawal and other emotionally avoidant symptoms. In comparison with the slower onset of burnout, STS can emerge suddenly and without warning. Hudnall-Stamm defines STS as behaviours and emotions that develop through helping a traumatized person and is similar to VT in this respect. STS is closely linked with PTSD in symptom similarities. Both are symptom rich descriptions and are listed in the DSM-IV manual. STS can be a temporary condition and is known as Secondary Traumatic Stress Response if lasting a month or less. If symptoms continue then it is known as Secondary Traumatic Stress Disorder. STS is reflective of the patient's experience of trauma but is less inclusive of the helper's experience (Collins & Long, 2003a). Canfield (2005) differentiates STS from other caring induced traumas as a secondary trauma resulting directly from hearing shocking material from patients.

Collins and Long (2003b) found there was a need for raising awareness that STS exists and can seriously affect the trauma worker. Recognition is the first step in moderating the influence



of STS. Collins and Long support a more balanced view of the risks and benefits of trauma work.

## **Burnout**

Maslach et al. (1996) define burnout as emotional exhaustion, depersonalisation and reduced personal accomplishment. They identify those most at risk of burnout are those who, through their professions, are in close working relationships with others, e.g. nurses, teachers, police. Maslach et al. identify the most pertinent of factors associated with burnout include client complexity, chronicity and acuity that are perceived as overwhelming to the service.

## **Mental health nursing and the therapeutic relationship**

Therapeutic relationships and empathic engagement with patients puts nurses at risk of VT and are important aspects to consider in this research project. In CINAHL ‘mental health nurse and therapeutic relationship’ was searched and narrowed, due to the plethora of research under this search term. I chose papers that focus on the psychodynamics of the therapeutic relationship and the place of the nurse and patient within this context as this is a significant part of my research.

Mental health nurses are in a pivotal position to establish therapeutic relationships that are valued by patients and that offer emotional containment and holding for difficult work (Cameron et al., 2005). Positive transference in the nurse-patient relationship was explored by Evans (2007) who sees the transferential purpose of the therapeutic relationship as being

able to offer a foundation for healing. The potential is for patients to be able to talk with a nurse in a way they cannot do with family and friends.

Welch (2005) explores the knowledge of experienced mental health nurses (via in-depth interviews) as to what constituents of a therapeutic relationship were essential. He highlights the intensely personal nature of mental health work. The nurses in the study stated that with experience in forming therapeutic relationships and reflections on these experiences they were in a better position within their practice. They identified aspects of the therapeutic relationship as key: identity, trust, power, mutuality, self-revelation, congruence and authenticity. These were identified as potential healing components within the therapeutic relationship. Some of these aspects are also noted by Pearlman and Saakvitne (1995) as parts of ourselves that can be affected by VT, that is trust, power or control, identity.

Warne and McAndrew (2005) parallels the distress of childhood sexual abuse with the distress nurses feel when addressing it, and ask have we been prepared to work with those who have been chronically abused? A question that Clarke (2008) also asks. The containment of the patient within the therapeutic relationship is assisted by the nurse's constancy but it is important that nurses too feel held and contained in their own anxieties while working with victims of trauma.

## **Conclusion**

There is limited literature specific to mental health nurses and the impact of VT. Most literature on VT comes from the leading authors on VT (McCann, Pearlman & Saakvitne) which is research based on the impact of VT on psychotherapists. These

authors provided the VT framework and its CSDT theoretical underpinnings for understanding the effect of trauma on both patient and treater. CF and STS were more easily located within the literature. Other terms, such as indirect trauma, exist but I did not search for these, they occurred as a by-product of my search for VT. This exposes the number of different terms that are used to describe similar experiences and can lead to confusion.

I was unable to locate research that explores mental health nurses' experience of VT in their own words. This guided my research design in selecting a narrative format as the most appropriate qualitative method. The method and research design is described in the next chapter.

## **CHAPTER FIVE: METHODOLOGY**

### **Introduction**

In this chapter I explain how I planned and carried out this research project to explore mental health nurses' knowledge and experience of VT. As the researcher, there are a number of considerations and responsibilities to attend to. The research process must be transparent and understood, the method and methodology must fit the research acquisition and the phenomenon under investigation. Ensuring validity and reliability is necessary to uphold the findings of the research but it is complex in qualitative research. In the context of qualitative research Riessman (1993) opts for 'trustworthiness' as a key validator versus 'truth'. She asserts that 'truth' implies an objective reality - if indeed that is possible given the possibility of multiple 'truths'. 'Trustworthiness' places the research narratives in the realm of social discourse (p. 65). Ethical considerations must be explained as well as pragmatic decision-making including project size, participant recruitment, facilities and equipment. A qualitative, descriptive research method was used in this study.

The first section of this chapter is dedicated to methodology and the second half to the research process. Methodology refers to the philosophical framework of a particular research perspective including its underlying assumptions and characteristics. Methodology is described as a plan of action, an overall strategy, and a guide to meet the goals or outcomes of a specific research project (Crotty, 1998). The particular methodological approach used in this project is that of narrative enquiry.

The chapter begins with a discussion of nursing research followed by qualitative research. The research design is explained including the methodological framework used, ethical considerations, research on sensitive topics, participant recruitment, the use of in-depth, semi-structured interviews. The actual research undertaken is then described in the second section of the chapter including data collection and management, the interview process and analysis and reflections on these processes. Rigour and bias in this research is addressed prior to the chapter conclusion.

## **Nursing research**

Nursing has been using research to develop its professional foundation since Florence Nightingale's time (Gillis & Jackson, 2002). Nursing research concerns those aspects over which nurses have control of the decision-making in their practice. It is vital to improving practice and providing a solid basis for nursing interventions and approaches. Nurses are now expected to provide evidence-based practice, that is, the use of the best clinical evidence in making patient care decisions (Polit & Beck, 2004). Research on nurses' knowledge, skills and experiences in practice contribute to the body of nursing knowledge and excellence in practice (Gillis & Jackson, 2002) which, in turn, can improve health outcomes.

There is no 'best way' or 'best design' when conducting nursing research. The research design and methodology must be based on the most appropriate design to answer the question posed or the aims of the research (Roberts & Taylor, 1998). However, qualitative research has been increasingly used in nursing as it facilitates the discovering, explaining and interpreting of nursing phenomena related to human care, health and well-being (Bailey & Tilley, 2002). The nursing phenomena

can relate to the patient, the family, the setting, to relationships and to the understanding and behaviour of the nurse. In this nursing research project a qualitative design has been used to explore mental health nurses' understanding and experience of VT.

### **Qualitative research**

Qualitative research is closely linked with naturalistic enquiry in the exploration of complex issues of what it is and feels like to be human (Polit & Hungler, 1997). Emphasis is placed upon this complexity of human existence and how we shape, reshape and create our own realities. The focus in qualitative and naturalistic enquiry is the lived experience obtained through careful collection and analysis of narrative and subjective materials (Polit & Hungler, 1997). According to Munhall (2007) qualitative research is suited to answering questions such as why? and how? This is because qualitative research methods can explore people's experiences of living and working and how it affects them.

According to Munhall (2007) qualitative research is about "discovery, the finding out about something otherwise not fully understood, is often the aim of qualitative research designs" (p. 518). There is a risk associated with this type of research given that discovery is its aim, which has the potential to raise anxiety in both researcher and participant.

This type of research is a reflexive process in that it includes the researcher as part of the research. "The researcher's communication is an explicit part of knowledge instead of ... an intervening variable" (Flick, 2006, p. 16). It is this reflexivity between researcher and participant in an interview setting that can reveal attitudes and norms within a specific culture or setting.

Flick states that qualitative research is suited to the exploration of social relations where the researcher and participant become collaborators and they each form a meaningful part of the research process. Bias is inevitable to some degree in qualitatively designed projects and should be incorporated into the findings (Morse, 2007). Bias can occur via myself as researcher and my own nursing experiences being embedded within this research project. The reflexive nature of qualitative research allows for the two-way process between researcher and narrator. It is an added dimension rather than a problem to be overcome (Foster et al., 2006). The research data is a co-created reality between them (p. 46).

Qualitative research is a method that values the ‘how?’ and ‘why?’ in an individual or group experience. It is for this reason that I selected narrative enquiry as the best way to explore nurses’ stories of VT. Riessman (1993) describes these stories as “essential meaning-making structures, narratives must be preserved ... by investigators, who must respect respondents’ ways of constructing meaning” (p. 4).

### **Narrative enquiry**

The methodological framework used for this research is narrative enquiry. The aim of narrative enquiry is to facilitate the telling of people’s experiences and stories of living – their lived experiences. I chose narrative enquiry as a method that would enable nurses to explore their experiences of vicarious trauma using their own words. Our desire to be understood “may be one of the most important desires and wants of human beings” (Munhall, 2007, p. 28). Narrative enquiry is respectful of experiences of participants and values their individuality.

As a discipline, narrative enquiry resonates with psychotherapy where narratives of personal experiences are used to change lives, retelling and constructing more fulfilling ones (Riessman, 1993, p. 2). In research Riessman suggests participants in research narratize to make sense of discrepancies between what is real and what is ideal (p. 3). In my study the nurses were confronted by traumatic experiences that they then had to come to terms with. It is this process that I am exploring and narrative enquiry offers a framework to do this in that it values the individual story or narrative of their experiences.

This form of enquiry is embedded in the field of education and educational research (Clandinnin & Connelly, 2000, p. 2). This links with the aims of this research to explore participants experiences of VT, and from there to offer recommendations for future practice and education. John Dewey (1938), a foremost thinker in education, highlighted the idea of experiences being both personal and social. That individuals cannot be understood alone but always in relation and in a social context. Dewey conceptualises experiences as a continual process that experiences grow out of other experiences, which lead to further experiences. We are on a continuum of experiences past, present and future.

Hence, narrative enquiry is used in this project is to capture mental health nurses' knowledge and experience of VT. Nursing, as a social construct (Barker, 2001) is experiential. Individual nurses relate with other nurses and within the context of the therapeutic relationships with our patients. The experience of VT in the past or present can impact on all of these relationships. By focussing this research on the experiences of mental health nurses of VT and using their own narratives to do so, we may be able to shed light as to how, and why, it develops in mental health nurses.



Clandinnin and Connelly (2000, p. 50) have developed their own terms for further defining narrative enquiry: personal and social (interaction); past, present and future (continuity); and place (situation). These three terms form their three-dimensional narrative enquiry space – a model for making meaning from experience. They assert that any research enquiry can be defined by these three boundaries. As researchers we address temporal, social and environment issues in equal measure. For nurses being interviewed in this project their experiences were in the past but they have impacted upon them in the present and will continue to influence their future. This parallels the development of VT which stems from ongoing experiences with trauma patients which translate into negative sequelae for the nurse.

Clandinnin and Connelly (2000) believe that narrative enquiry is “the best way of representing and understanding experience ... and a key way of writing and thinking about it [experience]. Thus narrative is both the phenomenon and the method of the social sciences”. (p. 18). Nurses’ experiences of caring induced traumas such as VT have been inadequately researched. Narrative enquiry gives an appropriate framework with which to explore these experiences.

Kelly and Howie (2007) believes that nursing stories offer potential to give rich insights into the meaning of nurses’ professional lives, their practice and what they are influenced by. This resonates well with conducting qualitative research with mental health nurses and valuing their stories. Foster, McAllister and O’Brien (2006) compare qualitative research enquiry with mental health nursing as both own a “purposeful use of self” which these authors believe is “synchronous to the role of the qualitative researcher who seeks to uncover the meaning of others’ experiences” (p. 1). This method is suited to exploring

VT, not just from the researcher's perspective, but from the emic perspective – that of the person within the culture being explored. Together the researcher and participant construct meaning from the research. The pitfall from this approach is that we may try and see what we want to see within the data gathered and this could impact on its validity (Morse & Mitcham, 2002) or the “trustworthiness” of the research (Riessman, 1993).

## **Research design**

This part of the methodology chapter discusses how I went about the project and the considerations and processes involved. I discuss the scope and size of the project, the participants with inclusion and exclusion criteria. The method of recruitment is explained with a focus on ethical considerations, research on sensitive issues. The gaining of ethics approval is in its own section that includes informed consent, confidentiality, risk and harm, bicultural and method considerations. The research process and details of data collection including the use of semi-structured interviews and reflexivity in research is described. Data management and analysis are explained along with my reasoning on member validation. The analysis process is reflected upon and rigour and bias is addressed prior to the conclusion.

### *The project.*

The aims of the project were to explore mental health nurses' knowledge and experience of VT. I had to decide who the participants would be, the method of recruitment, and the scope and size of the project. I also needed to consider the ethical implications of the project.

### *Scope and size.*

This research forms the thesis component of a master's degree. The scope and size of the project was formatted to be completed within one year. For these reasons and the decision to use narrative methodology I decided that between four and six participants would keep the project manageable. The research design was to conduct in-depth, semi-structured interviews of 60-90 minutes in length.

### *Participants.*

The research aims were to ascertain whether registered mental health nurses know of the term VT, and whether they had experience of it themselves. With these aims as my guide, I selected participants who were trained in New Zealand and working locally as registered nurses in mental health services.

Morse (2007) describes the process of deliberately selecting for those with anticipated experience in the research area, that it is purposeful and attracts those participants who are experienced in what we are studying. "When we purposefully select according to the best example, the characteristics of whatever we are studying are easier to identify than in situations that are muted with contextual factors." (p. 530). Horsefall, Cleary, Walter and Hunt (2007) concur that qualitative research is "explorative, in-depth and subjective [and] participants [are selected] for their knowledge or experience and ability to convey these to others" (p. S16).

### *Inclusion and exclusion criteria.*

The participant inclusion criteria are that they are New Zealand trained and registered mental health nurses with at least two years experience after graduation. These selection criteria were in order to assess the New Zealand context of VT and those who had at least two years of nursing practice would have relevant knowledge and experience with possibly more exposure to VT in their practice.

### **Method of recruitment**

Recruitment of participants was carried out using my own professional networks within mental health which is a 'snowballing' or networking method of recruitment where early participants recruit other participants (Polit & Hungler, 1997, p. 227). Recruitment flyers were distributed through these networks and interested participants contacted me via telephone and email. I first ascertained that they met the inclusion criteria and then emailed a copy of the Information for Participants (Appendix B) and the Informed Consent (Appendix C) prior to arranging the interview.

The recruitment process was stalled for some weeks as my initial method for accessing participants was to make contact with the unit managers and team leaders in mental health services, seeking their permission to place flyers on staff noticeboards. This route was complicated as the health service wanted to place conditions on the project such as someone else being the lead researcher. This was incompatible with my being a thesis student at Victoria University of Wellington. A change in recruitment strategy was initiated, to the more direct route of snowball recruitment via my own networks. This is an active

form of recruitment versus the volunteer strategy initially planned for. Permission was sought and given from the Human Ethics Committee at Victoria University of Wellington. Permission was also sought and gained from the New Zealand College of Mental Health Nurses and the local branch to post the recruitment flyer on their website.

#### *Ethical considerations.*

Ethical considerations when planning for this research included maintaining confidentiality for the participants within a small nursing community. I had to balance the needs of the project against the impact the research may have on the participants. This included the potential distress at reliving some traumatic experiences. I planned to contact the participants post-interview to review the process. The informed consent was emailed to them to view prior to the interview and I also took into consideration their working hours when scheduling an interview.

Three enduring principles of mental health research are described by Horsefall et al. (2007); (i) justice, (ii) beneficence, and (iii) respect, and that the burden of participation should not outweigh these principles. Horsefall et al. go on to support Asmundson, Norton and Stein (2002) and their ethical guidelines for keeping participants informed at every juncture from recruitment, to the actual interviews or other research methods used, and the interpretation and dissemination of information from the research after completion.

I was aware that the topic might provoke strong feeling for participants and that I would need to gain their trust over the course of the interview. I needed to gauge when was right to

pursue further questioning and when to allow the participant to move on. I wanted a safe and private environment for the interviews to enable greater disclosure. I had an interview room available but was flexible to meet participants when and where they preferred.

The emphasis in narrative research is on individuals as participants or collaborators as opposed to subjects. Nursing culture mirrors a deontological ethical approach in research – people are not to be used as a means to an end (Munhall, 2007). The therapeutic imperative in this project rests on beneficence for nurses despite the possibility of this research being emotionally provocative for participants. VT has the potential to be a sensitive topic as the changes from VT are profound and enduring and affect a helper's view of themselves, the world and those in it. These considerations were important in planning the research.

#### *Ethics in research on sensitive issues.*

Sensitive research may include stigmatising issues for participants (Morse, 2007). In this research the participant is being asked to reveal some personal aspects of themselves and their practice. It was for this reason that I chose to have fewer participants but longer, in-depth interviews to allow for trust to develop.

Alty and Rodham (1998) tackle the issue of sensitive issue research which, they say, can stir up such intensity of feeling that we would be negligent if we did not offer participants a reflective space for their concerns. In this project I contacted the participants a few days' after the interview to see if there were any outstanding issues they wished to talk about. All participants

found the experience satisfactory and wished me well with my study.

Sensitivity towards participants in qualitative research is pivotal in gaining their confidence and eliciting their experiences of VT. Horsefall et al. (2007) talk of balancing the need for a certain neutrality in research. All the while the interviewer is conscious of achieving the research objectives. Neutrality in narrative research is only a partial fit given the duality of the method between researcher and narrator. It is a balance between encouraging participants to talk, not putting words in their mouth, and to take note and attend to any feeling or distress that occurs.

Qualitative approaches leave room for interpretive skills, for example, what is the meaning of the silence, or a sudden change of pace in the conversation? It is the negotiating of the delicate balance between the participant and the sharing of their experiences for the purposes of the research that can be fraught for the researcher and participant. As a researcher one is not just guided by the aims of the project but must be mindful of the participant and how the process is affecting them. However, the continuing of an interview must not be so burdensome that it is damaging for the participant and this must be the guiding principle for qualitative researchers (Horsefall et al., 2007, Munhall, 2007).

Fox (2007) stresses the development of trust between interviewer and interviewee and that this level of intimacy is a privilege not a research right. The establishment and maintenance of trust is essential throughout each stage of the project – the entry, implementation and exit stages. The therapeutic imperative in this project rests on beneficence for

nurses despite the possibility of this research being emotionally provocative for research participants (Munhall, 2007).

### **Ethics approval**

I submitted an ethics application to the Human Ethics Committee at Victoria University of Wellington. I outlined my research plan to interview between four to six, New Zealand registered, local mental health nurses. I chose a narrative enquiry approach to explore mental health nurses' knowledge and/or experience of VT. I would conduct one-off, in-depth, semi-structured interviews of between 60-90 minutes. The application included a justification for my use of narrative enquiry as the most appropriate method for understanding nurses' experiences of VT. Formal ethics approval for the project was gained (Appendix D) plus a small amendment to the recruitment strategy was made later with the approval of the Human Ethics Committee.

### *Informed consent*

The Information sheet and Informed consent form clearly outlined to the participants what was entailed in the research, their right to withdraw from the project, and that the interview would cease immediately if requested.

### *Confidentiality*

Signed informed consent forms were kept separate from transcripts to diminish identifiability and stored in a locked desk at my home. Participants real names were not used on the transcripts and identifying features from interviews have not been included in the thesis itself.



Confidentiality was important given the small catchment area used for finding participants. This adds complexity to the task of representing participants faithfully from their interviews while maintaining their confidentiality.

#### *Risk and harm*

Risk and harm in this project included identifiability of participants and the sensitive nature of VT. Each participant was contacted after the interview process to see if there were any outstanding questions or issues that needed attending to.

Participants were asked about their understanding and experience of VT in their nursing practice. They were expressing how they felt about their work, the environment in which they work, and their relationships with their colleagues and patients. They were asked how they felt about themselves in relation to their work. This had the potential of re-exposing the nurse to the patients' trauma material which may potentially have been distressing for participants. Should the participants have felt unable to continue there was the option to reschedule the interview or withdraw from the project. If there was any further distress I would have encouraged them to utilize clinical supervision and/or access the Employee Assistance Programme within their workplace.

#### *Bicultural considerations*

Research in New Zealand requires attendance to the Treaty of Waitangi. The Treaty of Waitangi provides for Maori autonomy and the opportunity to form partnerships with equal participation. Health is seen as a taonga (a valuable gift) and equitable access to health enhancing programmes or research is protected in the

treaty. While this project is not Maori-centred research as defined by the Health Research Council of New Zealand, it is research that may involve nurses who identify as Maori.

I liaised with the Bicultural Advisor for my place of employment (Appendix E). We discussed my research from Ngai Tahu and Maori perspective and who might locally be approached as potential research participants. Potential benefit for Maori from research might be a raised awareness of VT as a seldom acknowledged caring induced trauma.

#### *Method considerations*

I chose to transcribe the interview data myself for several reasons. Firstly, I have the skills to be able to do this, secondly, it would cut down costs of employing a transcriber, and finally, it would enable a greater immersion in the participants' narratives.

#### *Member validation.*

A deliberate decision was made not to utilize member validation in this study. Member validation, or the returning of transcripts to interviewees, is a method used in qualitative research for data verification. In the first instance, my reasoning for non-member validation was based on Sandelowski (1993) comment on the potential for a 're-working' of the interview and attempting to change it if participants see themselves differently after participating in the process. This essentially would change the moment in which their stories took place and possibly skew findings – an unwanted influence in this project. Secondly, managing the tension and the delicate balance between researcher and participants: the researcher attempting to maintain a scholarly approach, the participant striving for an accurate representation of their experiences. The latter, however, has the

potential for constant revision as perceptions of self shift over time (Sandelowski, 1993).

Sandelowski (1993) contextualizes stories as “remembrances about the past in a fleeting present moment soon to be past” (p. 4). The telling and retelling of stories causes a natural revision or reshaping of events, and ‘reliving a moment’ has ethical implications. Participants consent to the process of an interview but not to go over events in an ongoing way that can be burdensome for the participant. If what they are describing is traumatic imagery then revisiting it has the potential to re-traumatize the participant.

The decision not to return transcripts to participants for validation also raises the issue of ownership of the research is discussed by Clandinnin and Connelly (2000, p. 176) and their preferred focus is on relational responsibilities within the research stories versus who owns them. For example, if a participant relates an experience that involves other staff, patients or family, relational responsibility would include all of them. They also acknowledge a certain inequality in the relationship relating to research interviews since they are driven by the interviewer (p. 110). The decision not to return transcripts to participants for validation is congruent with the idea of relational responsibility. It is not about who owns the data, or transcripts, but about the researcher accepting responsibility to maintain integrity and confidentiality within those relationships.

I concluded that the emphasis of this research rests with nurses’ experiences and their interpretation of those at the time the story was told in the interview. Munhall (2007) notes that interviews are time-bound and temporally set. If one is to

constantly review all research material it might lose its immediacy and be 'watered down'. Participants may see themselves quite differently from the researcher and look for themselves in the transcripts. However, the transcripts reflect what is actually said at the time, unaltered by myself or the participant, which is valuable in itself.

Participants were offered the option of a summary of findings and this provides a feedback opportunity.

Ethics in research is complex process of considering the potential benefits overall from the research and of improving nurses' knowledge of themselves and their practice. The overriding consideration, however, should be to 'do no harm' to the participant and the research aims should not take precedence over this.

### **Research process**

The second section of this chapter focuses on the research processes of data collection, management and analysis. The analysis process is described, along with rigour and potential biases of this project. I talk of the reflexive process between the researcher and participant that is embedded in the narrative enquiry method.

### **Data collection**

This section involves the collection of research data via the in-depth interviews with participants. Semi-structured interviews are defined and research questions included in the interviews are

noted. Methodological considerations such as the use of in-depth interviews over focus groups are addressed.

#### *The semi-structured interview.*

The in-depth interviews were conducted over a four week period. Semi-structured interviews are based on open-ended questions and are useful for gleaning attitudinal influences and for exploring some areas in-depth (Fox, 2006). The choice of the in-depth interview was to give time to the participants to explore their work and consider whether VT is a feature. Questions are kept to a minimum in semi-structured interviews to allow for the participants' stories to emerge as they wish. The structure of the questions centred around the nurse and whether they had heard of VT, whether they had experienced VT.

#### *Interview questions.*

Demographic data was obtained pertaining to age, training and education, years of experience, culture, length and type of mental health experience. Demographic data was collected to see if there were any links between levels of experience and education that might impact on a nurse's experience of VT. I relied on the participants' disclosure of their experiences but there were some questions (Appendix F) around VT which were used as prompts. Prompts are useful in case the interviews become 'stuck' at some point and can encourage the participants to share their experiences. I included some direct prompts on VT to ascertain the level of awareness of this term. More open ended prompts were used for greater freedom of response from participants.

#### *Methodological considerations.*

Fox (2006) supports the use of individual interviews over focus groups or telephone questionnaires when researching

sensitive issues. Individual interviews provide a more secure environment for disclosure of material that is personal and often complex in nature. This method, however, is time-consuming in nature and costly. This is countered with the potentially valuable and detailed information gleaned from participants about events and their meaning.

Focus groups were considered for this project but the disadvantage of focus group interviewing is that dominant personalities introduce a possible bias to the results (Jordan, Lynch, Moutray, O'Hagan, Orr, Peake et al., 2007). A lack of sensitivity by group members can also lead to restricting the disclosure of differing opinions within the group (Jordan et al., 2007). It is more comforting for groups to adopt a 'group think' jeopardizing the creativity within it (Gilstrap, 2007). It may be that a wider variance of nurses experiences in the domain of VT may be likely to appear in in-depth interviews where there is an opportunity to self-disclose in private. Ehigie and Ehigie's (2005) paper on applying qualitative methods in organizations is supportive of the semi-structured, in-depth interview. It allows a greater freedom within the interview setting to explain, elaborate or digress if assessed that this might be advantageous.

The interviewer is 'the tool' for the research (Horsefall et al., 2007). The researcher must rely on their skills as an interviewer whilst maintaining research standards, accurate records and guard against the introduction of bias. Narrative enquiry does not occupy a neutral space as we are asking participants to consider their identity and their culture within which they exist (Duffy, 2007). We must tolerate a certain ambiguity within the realm of qualitative research because we are asking the participant to think freely, especially in narrative enquiry, and not be bound by too many questions.

*Interview process.*

I have worked predominantly in a psychodynamic therapeutic community where relationships with both patients and staff are highly valued. I brought these experiences and expectations with me to the interviews and attempted to reassure participants of my research intent while being respectful of their nursing stories. Helping participants feel comfortable enough to share personal details lead me to share some of my own background and experiences with nursing and VT, and that this has prompted my current research.

The interviews were conducted at convenient locations nominated by the participants and at mutually agreed times. Refreshments were arranged if needed for the comfort of participants. Two participants preferred their own office space for the interviews to be conducted in and two offered no preference and we used an interview room at my disposal for the interview process.

I met with each participant at the agreed time and venue and after introducing myself I checked that they had received and read both the Informed Consent Form, and the Information for Participants sheet. I reiterated the research objectives, asked if there were any questions arising, if they were still willing to proceed with the interview, and had the time available. The Informed Consent form was then signed.

Participants were welcomed and thanked prior to the start of the interview and made comfortable. Parameters of the interview time were stated and both recorders were turned on. I described the process of a semi-structured interview and that while there were some questions, most of the interview will focus on their experiences in their words. I answered any questions that were asked.

I commenced with demographic data and once I had introduced myself and my project I asked if my description of VT sounded familiar. This led to participants talking of their experiences and nursing practice. As time progressed participants became more comfortable with self-disclosure. We moved from a sharing of general information such as times and places of work to disclosure of their challenging experiences in mental health nursing.

*Reflexivity as researcher.*

Reflexivity is a core thread in narrative methodology. It reflects the value placed on the 'backwards and forwards' nature of the narrative interview – that researcher and participant alike contribute to the story. Foster et al. (2006) say reflexivity promotes "dialogue rather than interrogation" (p. 47).

It is thought that "the credibility of qualitative research is enhanced when investigators describe and interpret their own behaviour and experiences as researchers in relation to the behaviour and experiences of subjects" (Sandelowski, 1986, p. 30). My role as researcher has been to investigate nurses' knowledge of VT. Managing the tension between the research aims and the participants' wellbeing; looking for themes to emerge versus 'seeing what I want to see', has been a challenge. I have utilized clinical supervision, academic supervision and maintained a reflective journal throughout the interview processes. Due to my own experiences of VT I needed to explicate my feelings from those of the participants. A 'working through' with multiple readings of the transcripts has helped contextualize these feelings.



## **Data management**

The interviews were audio-taped as this ensures an accurate account of what was said. I used two recording devices to minimize any recording problems and I transcribed the data myself. I maintained a reflective journal to assist interpretation of data and add my experience of the interviews. After the interviews the journal was helpful when linking with the case summaries of the interview data.

Transcripts were colour-filed individually for each participant and identified only as Participant One and so on. The individual transcripts, digital and tape recordings and the Informed consent forms were kept in a secure desk at my house. Access to data was restricted to myself and my thesis supervisor.

Ensuring the confidentiality and minimizing identifiability was made by masking the identity of the participants, and their place of work. Specific identifying features of place of work or of the participant were removed. I left out data that might be personally identifying while trying to present their narratives faithfully. Data from this research project will be destroyed within one year of submission of the thesis.

## **Data analysis**

This section discusses the use of thematic analysis and its theoretical positioning in qualitative research. I discuss the analysis process in this research project and identification of themes from the data. There are reflections on the process itself and I address rigour and bias in this research prior to concluding the chapter.

Braun and Clarke (2006) define thematic analysis as a method for identifying, analysing and reporting patterns or themes within the data. They argue for thematic analysis as a method in its own right. Braun and Clarke divide qualitative analytical methods into two camps. Firstly, those tied to a specific theoretical or epistemological position. Secondly, those that are largely independent of theory and can be applied to a range of other theoretical and epistemological approaches. They place thematic analysis in this second category (p. 78). This freedom allows for a rich and detailed account of the data. Braun and Clarke suggest that this rich description is especially pertinent for under-researched areas where knowledge and experiences are unknown. Vicarious traumatization as it affects mental health nurses falls into this category.

Fox (2007) talks of systematically identifying the main concepts that arise in the course of qualitative analysis and then categorize and develop them into common themes. For example, in this project participants spoke of the importance of exercise as a common theme under the main concept of self-care.

De Santis and Ugarizza (2000) state that there is no clear agreement on the definition of theme, and that they may be abstract and hard to identify. Thematic analysis is the search for and identification of common threads that extend throughout an interview or other data set (Morse & Field, 1995). This links to the idea of themes repeating themselves and recurring across different participants. Linking participants' interviews by theme may reveal the differences or similarities across their different clinical settings.

The emphasis in narrative research is on individuals as participants or collaborators as opposed to subjects. Thematic analysis was chosen for its fit with the experiences of the mental

health nurses in the semi-structured, in-depth interviews. It allows for meanings to emerge and be extracted as the transcripts are read and re-read. This process of re-reading is important and allows not only for the manifest content to be present but for latent themes to percolate (Sandelowski & Barroso, 2003).

### **Analysis process**

For the analysis process I was guided by Minichiello, Aroni and Hays' (2008, p. 280) guidelines for thematic analysis. These are built around the two main principles of first, reading each transcript to make sense of the interview, and then to read the interviews as a collective set to ascertain meaning as a group.

The interview audio recordings were transcribed by myself as the first step of analysis. I felt that by listening to the participants' stories and transcribing them I would become immersed in the data as the researcher and this would enhance the analysis. The second step of the analysis was the reading of the transcripts and using a highlighter to separate the voice of the participant from my own voice as researcher. I developed theme 'maps' that grouped related words or ideas together and the main themes were chosen to function as an overall description, e.g. self-care as the main theme and the importance of clinical supervision as a concept stated by all participants. Initial themes that emerged in this research were the impact of VT, self-knowledge/self-awareness, self-care and burnout and these were colour-coded on the transcripts.

Interviews were analysed for themes and resonance while tracing the emergence of differences between participants.

Interview data were compared for recurrence of a theme. For example exercise as self-care was a similarity for three participants, working as a team was noted by all participants as important in nursing. Some concepts raised fitted across two themes, e.g. clinical supervision was described as an important self-care professionally which also linked with raised self-knowledge/self-awareness.

I made case summaries of each participant's interview transcript and incorporated my own reflective journal observations within the summaries. From the transcripts and summaries, I made comparisons and linkages between the four participants, for example common experiences, similarities of experience, and education.

The transcripts have been read and re-read to make sense of each participant's data and to get a picture of the group as a whole.

### **Process reflections**

Nurses in this study were able to talk openly of their experiences and trust developed more deeply over the course of the interview. Participants were aware that mental health nursing could impact on them in negative ways, in terms of stress, being preoccupied with work and a lack of energy for life outside of work. They commented on having somewhere appropriate to talk about their more challenging work experiences. One person had not talked of her experiences of VT prior to the interview.

I contacted the participants a few days' after the interview itself to see how the experience had been and whether there were any outstanding issues they wished to talk about. All participants found the experience satisfactory and wished me well with my study.

### **Rigour and bias**

I believe the narrative enquiry method was an appropriate choice to glean nurses' knowledge and experiences of the topic of VT. There are limitations to a project of this size. Generalizing findings is not straightforward in qualitative research (Flick, 2006) the findings are concerned with what is represented by the qualitative data gathered between researcher and participants (p. 41). Foster et al. (2006) describe a 'reflexive orientation' (p. 46) where the researcher is aware of their own part in the research and the meaning constructed. This is a 'co-constructed' reality between researcher and narrator. Claims to objectivity cannot be made in this type of research (p. 46). This is a fundamental difference between quantitative and qualitative research. Rather than extinguishing variables, as in quantitative research, the differences are 'woven' in and become part of the research data in qualitative research. The awareness and acknowledgement of the active role the researcher plays is validated. The faithful rendition of the narrative data offers crucial validity to the research. Braun and Clarke (2006) talk of 'rich descriptions' (p. 83) and the layering of understanding.

Through the inclusion and exclusion criteria this study leaned toward those who already had experiences that they had put down as contributing to VT and who were reflective about it. This has given the study a retrospective lens to view findings. In

quantitative terms this could be described as a 'deliberate bias' or 'deliberate selection'. In this qualitative project, however, the gain was that participants will most likely have knowledge of VT and are prepared to share it. Validation may be a better 'fit' than rigour. Riessman (1993) asserts that validation is a key issue in interpreting narrative data. Riessman defines trust versus trustworthiness. She asserts the latter is more representative of qualitative research aims. The 'ringing true' of a described experience that readers can relate to. Riessman, however, does acknowledge that there are no set standards or rules that govern validity in qualitative research.

This is my first experience of a project of this size and my novice skills have been tested organizationally and academically. My strengths have lain in the field, meeting with the participants and gaining their trust.

I have attempted to keep the balance of my own thoughts and feelings from impacting on the findings. I have used the voice of participants in the findings chapter to balance any bias I may inject into the transcripts themselves and the project overall.

My own experiences of VT resonated with those of the participants, being new and inexperienced in mental health nursing which made me vulnerable to VT. The impact that personal interest and commitment may have in colouring research findings is discussed by Polit and Hungler (1997, p. 277). Anticipation of results is a potential bias when the researcher may steer the direction an interview takes. Our own emotions and attitudes and prejudices may interfere with research inferences. These biases cannot be completely eliminated.

## **Conclusion**

Significant topics covered in this methods chapter include the project design and the justification for use of narrative enquiry as the most appropriate qualitative method to explore nurses' experience of VT. The recruitment strategy focused on New Zealand registered mental health nurses with at least two years experience. Ethics approval for this project was gained from the Human Ethics Committee at Victoria University of Wellington with a focus on research of sensitive issues such as VT and my rationale on member validation of transcripts. The data collection through semi-structured interviews is described and the subsequent thematic analysis of transcripts is discussed. Key issues of rigour and bias are explored as they relate to use of participants stories in research and my own potential as researcher to influence findings. Detail of the data analysis and the findings are presented in the next chapter.

## **CHAPTER SIX: FINDINGS**

### **Introduction**

This chapter reveals the research findings and discusses them in relation to the known literature and the implications of the findings. The discussion includes a description of participants and my decisions regarding the themes from the interview data. There are also case summaries that include participant quotes. VT was an overall theme for the research and was embedded throughout the discussion with participants. There are some personal reflections on the research leading up to the conclusion of the chapter.

The analysis is described with four themes: impact of VT, self-knowledge/self-awareness, self-care and burnout plus associated sub-themes described in detail. Each participant has a section of their own and their words are in italics for emphasis and differentiation from other ‘voices’ in the study, including my own as researcher. There is a discussion on predisposing factors towards VT and the impact of trauma experienced as a novice nurse. The findings section is then summarized in the conclusion.

### **Description of Participants**

There were four participants in the study. The four participants were New Zealand Registered Nurses working in local mental health services with their work experience ranging from between five and twenty-nine years experience across inpatient and community services. Two were male and two were female. The ages ranged from mid-twenties to early fifties. All



participants identified as New Zealand European. Participants were employed in a range of practice areas including inpatient, community, emergency and education services. All of the participants have post-graduate qualifications. Two had new graduate entry to specialist practice qualifications; one had a Post Graduate Certificate and Diploma, and one completed a Master of Nursing.

### **Decision on themes**

Data gathered from participants revealed phrases, statements that developed into the overarching themes of impact of VT, self-knowledge/self-awareness, self-care and burnout. The impact of VT was a selected theme as it is the focus of this research and any reference to it in the interviews was potentially significant for this project. Self-knowledge/self-awareness was noted with all participants. Self-care was identified with regard to how nurses had coped if they had experienced VT, and some participants raised it spontaneously. Burnout was selected as an initial theme because it was a term used, or the feelings related to burnout described, by all participants. This research is exploring mental health nurses' familiarity with the term VT. It may be that they are more familiar with the term burnout which is marked by emotional exhaustion, depersonalisation and reduced personal achievement. It is possible that participants used the term burnout when they were experiencing VT. The difference between burnout and VT is that burnout can occur across different patient groups not just those who have been traumatized.

Analysis was done on each individual interview that revealed words particular to each participant and for the group as a whole. A repetition of words or phrases indicated an individual theme

with prominence for the participant, e.g. “*overwhelming sadness*”, “*there’s a lot of it [sexual abuse] out there*”. Case summaries were written for the four participants that enabled similarities and differences to be identified. These are useful to both expand and compress the data gathered from participants. Compressing data to a summary is helpful in seeing ‘stand out’ themes which lead to an expansion into other areas or sub-themes (Minichiello, Aroni, & Hays, 2008, p. 270).

Further reading and re-reading of the data transcripts was undertaken to tease out the manifest content, any latent themes, hidden meanings and symbolism inherent in the texts. Manifest content refers to that which is clearly seen from the data transcripts, e.g. “*overwhelming sadness*” expressed by one participant when thinking about the amount of sexual abuse he sees in his work. Latent themes are not always so obvious but must be interpreted through the language the participant uses (Braun & Clarke, 2006).

The theme of self-knowledge/self-awareness included the participants’ own views of themselves as people and as mental health nurses and how these two inter-related. Responses in the interviews included a knowing of how, with both life and professional experience, they are much better equipped to handle the stresses and strains of working as mental health nurses. One of the participants specifically related this to VT and that linking her knowledge of VT with her feelings and emotional responses, she now feels more able to observe for the signs of negative stress and VT in her life.

The self-care theme included issues such as team and, or, collegial support, clinical supervision, familial support outside of work, professional development and post-graduate education. One participant used the process of education to develop a job

description for himself that enabled him to feel that boundaries were in place and to not feel over-burdened with unrealistic expectations which had previously lead to him feeling overwhelmed and leaving his job. How participants managed to find a balance between work and play and that physical exercise played an important part of that for three of the participants.

Burnout emerged as a theme because it was a familiar term for participants and was used to describe difficulties experienced at work in a general way. I note burnout as a relational construct to VT, in that it is an occupational stress.

Identifying main themes is useful for compressing data and the sub-themes expand data into more detail. The following case summaries are included, firstly as a faithful representation of the participants' narrative and secondly to illustrate the themes identified.

### **Participant One**

Participant One is a male registered nurse with a Bachelor of Nursing Degree and a new graduate entry to specialist mental health nursing, Post-graduate Certificate. He has seven years experience working in mental health mostly in inpatient and community settings. He identified feeling burnt out in his second year after graduating while working in an inpatient unit. He describes that year as one of the most difficult he has ever worked in mental health and experienced times when he did not wish to return the next shift. Tension would build during the morning before an afternoon shift and he would feel anger rather than empathy towards his clients. He felt he managed a professional image but that some of his nursing practice was affected by these experiences. He said he had:

*Definitely lots of anger towards clients because it ... could be quite a violent place ... quite a restrictive environment ... with too much use of seclusion ... decisions were made from VT where you're feeling more angry ... like it's the client's fault ... you're just kind of not caring ... it was a tough year where I was having some levels of burnout.*

He was able to talk about these issues in supervision and recognize what was happening once he was “*away from the place ... I like nursing but it's the whole environment*”. He felt there was little time on the busy unit to talk and debrief with his colleagues but had good support with his partner. He identified that he became aware of “*the huge volume of people who come through the system who've been sexually abused or sexually and physically abused*”. Coupled with some personal issues this caused significant distress for the participant as he explained:

*So that was hard and it still carries through to this day. I don't know if I would call it burnout ... sort of a bit of cynicism or loss of faith in the world with another one that's been abused – it's a ridiculous amount of people [I just had] overwhelming sadness often about the people [and] the levels of it in our community ... I'm not to a point of the majority of people are abused or the majority of fathers are abusers or anything ... but there's a lot of it sometimes.*

This loss of hope, replaced by cynicism, can be directly related to VT. He clearly states that his frame of reference, his loss of faith in the world, has been altered.

Participant One was thoughtful about the difference environment made: *“working in the community ... you haven’t got it [the patient milieu] around you for eight hours a day ... you can kind of step back from it and look from the outside a little bit”* but in the context of a busy inpatient unit he felt that *“you were definitely in the thick of it”*. This seemed to relate to the difference in intensity experienced within the therapeutic relationship between mental health nurses working with their patients in the community versus in an inpatient unit. He also identified feeling hopeful and experiencing *“a good boost”* when someone whom he had cared for as an inpatient was doing well in the community.

Participant One further suggested that nurses need to move around the different clinical settings as in the inpatient setting nurses experience:

*“the same people coming in at their worst ... is there any hope? ... but in the community you see someone who is nearly at the end of their journey [treatment] just getting on with life really. In the inpatient units sometimes you can get a bit drowned in it ... the hopelessness and the overwhelming sadness He would sometimes close off a little bit to protect [himself] avoid that one to one [contact] not like to go into too much detail or depth [with patients].*

VT attacks our capacity to maintain hope for patients and we may become avoidant of engaging empathically to protect ourselves from further damage. At times he *“caught himself showing pity which I don’t think is helpful ... rather than trying to be empowering and empathetic”*. In the interview we

discussed the difference between feeling pity for a patient and feeling empathy for them. “ *pity is something I can put out there at any time, empathy is something I can do when I’m feeling better ... not sort of burnt out*”. The ability to empathize with our patients is at the heart of mental health nursing and requires us to be ‘with’ the patient. Pity does not require this closeness and may even place a distance between the nurse and the patient. This participant identifies empathy as a skill or attribute that he can muster when his personal resources are not low.

His development from novice to senior nurse included more life and work experience and he feels this has improved his interpersonal confidence with patients. This is especially with older women “*talking about abuse or any of their difficulties*”. As his self-knowledge and acceptance of himself grew he gained more confidence in the role as a mental health nurse. He realized that “*you can’t be like that nurse [comparing yourself to others] you have to be you and be ok ... we have our faults and strengths*”.

For a male nurse the issue of transference between female patients and the nurse can be difficult for both. This participant felt that being likened, consciously or subconsciously, to a patient’s abusive father rendered him somewhat ineffective in this job as a nurse. His feeling that maybe he was “*doing something wrong*” was followed up in supervision. He observed that continuing to “*hear difficult stories fills your head sometimes*”. Supervision allows for him to vent “*the big things that come up – ‘there’s so much abuse out there’ - that kind of thing*”. In his personal life there is a social limit where some things are unspeakable because you “*don’t want to bloody kill the evening or atmosphere ... so supervision is important ... and spending time with your colleagues going over that sort of stuff*”. His observation of the “*underbelly of the world*” that he sees in

his work places constraints upon where he can speak of it: *“God, if people could see what I see sometimes”*. The unspeakable things and where to speak of them is crucial for mental health nurses who work with trauma patients.

To balance the effects of work he utilizes exercise which he emphasised was *“important to me and [I] just kind of switch-off”*. In terms of work he enjoyed the *“non-clinical contact”* which enabled him to *“put things in an order sometimes”* related to paperwork and appointment times. By contrast he *“lov[ed] the unpredictability of [his] job”* and that this presented a challenge in his role. Another balancing factor was environment and whether there was a place to have his feelings. He thought that this was a *“key thing between inpatient and community ... [in the inpatient setting] you’ve got a little nurses station you can hide behind ... [but in the community] there’s nowhere to hide just to ‘blow out’ at times”*. He felt that inpatient units can be like *“a pressure cooker”*. Working in a team with *“humour and camaraderie is a very important thing amongst nurses, for nurses health and well-being”*. Especially *“in the context of feeling a little beaten down by the whole experience of being with the client ... if you can have a laugh ... it’s not as bad as it sounds sometimes”*. In VT the burdens of working empathically with trauma survivors outweighs the positive gains of engaging purposefully with another.

Currently he feels he is in a place within himself where he has perspective and optimism within his job and that overall he is an optimistic person.

*Every experience does change you ... but not always for the worse ... inherent qualities can remain in nurses or the health professions ... that comes down to your upbringing ... I’d like to think*

*in another seven years I'll still be an optimistic person. I think nurses as personalities bring themselves, you get told that in your training ... I think more and more we bring something to the relationship ... it could be what's happening in the nurses' own life that makes it difficult for them to process and take on board, and show empathy to other people.*

With hindsight he realizes that in his graduate and subsequent two or three years he took on too much responsibility. “... *as I've matured I've realized that a lot of responsibility lies with the client ... with the other nurses and the care team, I'm only a small bit and can only do so much*”. He does worry if his “*risk perception is getting dull*” or whether he is less anxious and able to tolerate a greater risk with patients? As mental health nurses he feels that “*we become so exposed to people taking overdoses ... hurt[ing] themselves ... long periods of psychotic breakdown and you can become a bit maybe blunted to it ... numb ... is that the beginning of cynicism?*”

This participant was able to identify his own cynicism at times and relate this to his experiencing burnout and VT in his nursing practice. He speaks of an overwhelming sadness when working with trauma survivors.

## **Participant Two**

Participant Two is a male registered nurse who has a wide range of nursing experience in mental health and general nursing. Early experiences in acute mental health services lead him to say “*I'd never go back to it ... just too busy and stressful ... as you*



*get older you get slightly different in how you assess things so you don't find it as stressful".*

This participant currently has high job satisfaction. He feels that he is in a good position to offer clinical expertise to the nurses in the acute setting where he works. He feels that experience is important and that the impact of mental health work on nurses and other professionals is "*undervalued*". He thinks that nurses leave the job:

*because they just can't manage it anymore, the stress, the type of people, their own needs – they just can't work here anymore ... as individuals they're very capable, competent people but ... they no longer have the capacity to accommodate the demands made on them by the patients they deal with.*

The environment this participant works in is a busy inpatient setting. They are often required to accommodate patients who exhibit "*... anti-social behaviour ... as a group they [can be] quite difficult ... often quite demanding and very entitled ... confrontational*". This can cause role conflict for nurses who are seen as "*controllers*". The conflict lies in balancing:

*having a responsibility to keep people safe [but] we're not really police ... nurses come into nursing because they're caring people. I think new staff struggle to accommodate all the demands ... the person puts on them ... often multiple and competing demands. They feel often let down that the caring is not reciprocated or not acknowledged or that you're held to blame even though you've worked your bum off.*

Young patients who are admitted with their first episode of mental illness, often present challenges not just for the patient and their families but for staff. This can lead to a loss of hope in the nurse as they support the patient and their family through the early stages of a life changing illness. *“Put yourself in their own shoes ... a young person ... all his life ahead of him ... you know that their life is just going to [change] from then on and that’s sometimes difficult”*.

Lack of progress in patients with severe and enduring mental illness is a frustrating challenge. He acknowledges that the staffs’ *“reference points”* for *“safety-wellness [are] completely at variance with the community because our perception of someone functioning well is ... distorted”*. This might be related to the setting within which he works but the theme of ‘distorted reference points’ for unwellness has been noted by other participants in this study. This referred to their working daily with people in some form of crisis and that this can affect how they view the population in general.

National and media expectations place demands on staff that are *“quite excessive ... it also needs a very good system in place to help assist staff [to manage the demands placed on them]”*. He emphasises the team approach and that *“it’s too much for an individual to do by themselves ... use the collective wisdom”*.

New staff often arrive well qualified but lack the experience or the ‘on-job’ familiarity. *“They [existing staff] forget what they were like when they first started and they were no different but they’ve forgotten ... they’ve forgotten that they had to deal with traumas and had to come to terms with it ... over time they’ve got the experience and the capacity to absorb trauma ... it takes time”*. This ‘forgetting’ may be related to unrealistic

expectations by existing staff. It is important to recognize the needs of newly graduated mental health nurses and how prepared they are for the demands made on them. He considered his own induction to mental health nursing in an acute unit: *“my first experience of mental health was very traumatic for me from an individual point of view. I didn’t know what I was doing, I didn’t know the patients”*. He described very little support forthcoming and that supervision was not in use then in the way that we know it is today. He feels things have changed considerably with the orientation provided to new staff today. *“You accommodate that after a while and you’d see things ... I worked there and a person killed themselves ... I found [the patient] hanging and there [was] no debriefing or post-incident analysis”*.

This participant thought that ‘newness’ in the profession may be a risk factor for burnout in nurses. He sees age and experience as ameliorating factors against this in terms of recognizing burnout in oneself. *“I think that’s one thing that people who are relatively new don’t recognize when they’re starting to unravel, they think that somehow they have to suck up the stress and demands placed on them”*. Nurses who have high self-expectations may be more at risk as seeing themselves as failures if they admit to finding the job stressful and overwhelming. Unit and, or, team culture was an environmental factor that impacts on mental health nurses. If the culture is too permissive and tolerates verbal abuse from patients to staff he worries that the effects may be cumulative; *“it sets a scene that this [verbal abuse] is ok and it’s not ok”*. I believe if a nurse is new to mental health nursing this may predispose them to VT if there is little or no awareness of the risks of working empathically with patients. A novice to the mental health nursing profession may be more vulnerable with a lack of experience to support their nursing challenges. How we are introduced to mental health nursing is important. Inexperience, coupled with being young, may be a

further risk factor, without life experiences and nursing experiences, to shape our resilience and tolerance. Or is the risk just being new to the nursing profession?

A particular stressor identified by this participant related to coercive treatment, especially those under compulsory treatment orders:

*You're having to do things to people ... make decisions for them ... having to hold them down and ... people don't come into nursing to do that. So you have to deal with those issues ... in two weeks time that person is going to be well leaving here [but] that doesn't take away the trauma or the distaste.*

An interesting aspect raised by Participant Two was why one person was traumatized but another wasn't, despite experience of the same, or similar, event. In this instance he was referring to patients who have experienced difficult childhoods. *"I think it comes down to individual personalities ... your individual capacity to absorb stress. I guess it's your upbringing ... it's your trust and faith in people"*. These ideas might also apply to mental health nurses and their capacities, strengths and vulnerabilities. He thinks that certain personality traits contribute to nurses feeling overwhelmed in the job and leaving: *"ones that have high expectations ... that are placed on themselves ... high achievers often undervalue their abilities"*. Our self-capacities, such as our inability to tolerate strong affect, are impacted upon by VT and this may contribute to our feeling unable to tolerate what we experience in relationship with the patient.

In terms of his own personality he feels *"comfortable with myself, know my faults, know my strengths [and has] good self-*

*awareness*". He felt, however, as a team leader he was more isolated in his current role and that professional progress and advancement in seniority, carries the downside of isolation in terms of support available: *"you become less of a group ... more down to you as an individual and less and less opportunities to discuss it"*. This may relate to his clinical supervision being 'informal' with other senior colleagues, rather than incorporated as a regular part of his working life.

Participant Two described a traumatic induction into mental health nursing resulting in a wish to never return. He also noted the lack of clinical supervision as we know it today. This participant thought colleagues left mental health when feeling overwhelmed with their work.

### **Participant Three**

Participant Three is a female registered nurse with a Masters qualification in mental health. She is currently working in education. This participant accepted early promotion as a unit manager two and a half years after graduation. This level of responsibility could be quite burdensome for a novice. She spent four years in an advanced practice role before being employed in her current role. It was in her advanced practice role that she became familiar with some of the concepts of caring induced trauma: *"I often thought about things like that [VT] when I was working [in her previous role] but had never heard of [VT]"*. Reading the recruitment flyer for this research reminded her of experiences in that role and it: *"brought back a lot of memories about some of the stuff ... working with people who had experienced trauma themselves"*. People, she said, who had been involved in motor vehicle accidents and lost loved ones,

some recently diagnosed with cancer, and those with chronic, unremitting pain and disease. She remarked:

*There was a significant amount of grief with each one of them and for me, I felt often it was very, very difficult to work with those people ... in terms of not seeing progress ... Feeling ... am I doing all I should be doing? ... Why aren't these people getting better? - and all that sort of stuff that goes with it in terms of your practice and feeling anxious about going to see these people ... I think you do experience [VT] working in mental health.*

She wondered if becoming a parent, had altered her perceptions. *"I'd ... had my own experiences through that time ... I don't know whether that changed how I view things and how I work with people and how much I took on board in comparison"*. She felt an identification with patients whether it was a client involved in a sudden car accident with the loss of a child or someone recently struck down with a terminal illness.

The isolation of that particular role contributed to significant stress for her. She had few nurses available for collegial support and needed more relevant supervision. *"I needed some help to see things from a different perspective ... my supervisor was quite sympathetic ... but [indicates more was needed]*. She would ask a colleague *"How do you cope with it? How do you cope and work with these people all the time and not walk away feeling like taking it all on board?* The response was *"you just get used to it"* which was of limited benefit. *"[I] felt quite distressed about not knowing if what I was doing was helpful in any way"*.

In this particular role there were:

*lots of people wanting support from you as well ...  
like the nurses ... they were saying the same things  
that I was saying ... what if we say the wrong  
thing? They also need advice about how to nurse  
people ... it was like I don't know! You feel like  
you're flying by the seat of your pants*

She remembers being very new in this role and unprepared for the strength of feeling aroused in herself through being with clients and their families:

*I was very new then ... I [remember] sitting there  
while he [patient's son] was talking to me about  
the accident and trying so hard not to cry because  
it was so sad. I really felt like I needed some  
support. I'd go [to visit colleagues] and I'd just go  
and sit ... I remember one time in particular I had  
a patient. Anyway he arrested and died before I  
got to see him and I got quite shocked by that so I  
went and sat [there]. But [they] don't fully  
understand ... because they're not working in that  
role so I just sat there and said something like 'oh,  
I've had a tough morning'. I did feel very isolated  
and didn't feel there was anyone to really talk to  
about it ... you'd discuss it as a team ... but I'd  
feel silly for bringing it up in a multi-disciplinary  
team meeting. I'd get assistance ... about the  
practical stuff but not the emotional stuff which  
was important to me ... it was very, very difficult  
... and partly the reason why I left.*

She found the clinical role “*exhausting ... I needed to take time out ... clinical stuff was very, very taxing without the support*”. This precipitated a change to her current role. Sometimes she would feel that she “*just need[ed] to be getting on with it*” and felt this message may have been, possibly unintentionally, reinforced by colleagues.

*It wasn't ... what she [colleague] said but how she is and what she does. I'd see that and think I should be doing the same thing [or] am I making a mountain out of a molehill? When I read your information sheet I thought well that's interesting that that's got a name and that other people experience probably similar things and that perhaps I wasn't just being ... woosy, you know?”*

Having few nursing colleagues in the team she compared herself unfavourably against another experienced clinician and felt inferior. She clearly acknowledged that her expectations of herself were very high “*that's the type of personality I am anyway ... probably doesn't help ... where you've got nothing to measure against*”.

This participant raised the issue of patient dependency on nurses and told the following story:

*I had quite a close relationship [with a patient] working with her I felt really good ... I know that she found it helpful [but] was I creating a dependency on me? Where's that fine line between creating a dependency on you but also being there for your client ... for them to be able to ring when they're feeling really anxious, because anxiety's a hell of a thing you know? I'd experienced anxiety*



*and I'd been there so I knew in a sense – could relate to what she [patient] needed ... because you've been there ... it makes you relate more to them and it becomes quite hard emotionally.*

In hindsight the timing of entering this advanced practice role was not optimal and she remembers “ *regularly feeling ... very, very anxious at work in those early days ... not knowing what I was meant to be doing not having much confidence*”. Although these issues were worked through over the time she spent in the role she did feel it contributed to her wish to change jobs to a non-clinical role. “*I think I really struggled with ... relating so closely with the client ... and that fear of seeing what they were being diagnosed with – like that could happen to me*”. The role of the mental health nurse is to forge empathic connections with patients, when we feel overwhelmed we remain as a ‘helpless witness’ to the patient’s traumatic stories. This effective loss of power and control diminishes our therapeutic agency and is an indicator of VT.

Postgraduate nursing education was helpful in the advanced practice role and gave her a practice framework upon which to base her nursing work:

*It gave me a lot of clarity in terms of confidence... all I really did was discover that I was doing ok and that I was doing what I should be doing in the role ... but it gave me a framework ... I was able to describe it and talk about it ... I think I developed ... I knew I needed to work through some stuff otherwise you don't grow, you don't learn from it do you?*

Esteem and confidence in oneself can be negatively affected by VT. For this participant postgraduate study had a spin-off in terms of esteem – in her role as a mental health nurse and personally: *“esteem was an issue ... I always found it difficult to measure whether I was doing an ok job”*. This research interview, was the first time she had spoken in any depth about her experiences which may reflect her reticence in acknowledging her difficulties or concern that she was the only one who was not coping with problems at work.

This participant thought that it was important in supervision to find *“the right supervisor”*. Informal discussions with nursing colleagues have provided some *“normality”* to her experiences within the advanced practice role and that she does not feel so different because of them.

*Other nurses experienced the same thing [lack of role clarity or conflict about whether they are doing a good enough job] particularly nurses that are empathetic and do care ... I mean if you were working in that role and you're a nurse that doesn't get emotionally involved or is emotionally withdrawn and detached then I think it would be very detrimental to the patient to see that.*

Participant Three found that off-loading at home was possible to some extent but:

*Trying to explain this stuff to somebody that's not a nurse ... you can tell them a funny story ... but when you start to talk about the other stuff it's like 'well, that's a bit much for me thanks'. It just ends up being more frustrating because they don't understand the depth of how you're feeling ... and*

*how it's affected you ... like it becomes trivial ...  
so it ends up frustrating.*

This raises the question of whether home is the place to 'debrief'? There may be little choice straight after a difficult shift. Being understood by those we live with may stop nurses feeling isolated in their nursing and that others can understand the impact of the work they do. Participant Three found sport played an important role in winding down after work in terms of managing her anxiety. Basics such as eating and sleeping enough were also noted "*all that stuff becomes really important*". However, she acknowledged that time for doing all of these was not always available in balancing a new job, study and a family.

*If I'd had a really stressful day I'd probably go  
out for a run in the evening ... I think it makes you  
feel good, makes you feel better ... that feeling  
afterwards of feeling physically tired is quite nice  
... with our work it's often emotional.*

Long term, the effects of cumulative stress concern her.

*I wonder if it catches up on you. Does it  
accumulate? I think that's why you change jobs  
... you work in an area like this it's quite low key I  
suppose ... I'll do the odd shift. I enjoy that ... I  
spoke with a colleague and [they] said to me that  
the idea of going back to clinical work just makes  
[them] feel sick. You know like why is that? Why  
do you get into a role like this? ... I still feel the  
same way ... I don't think I could go back to a  
clinical role for a while yet, but why is that? Why*

*can you not face the idea of not going back to clinical?*

I asked her if it depended on the type of contact nurses had with patients:

*Yeah, it brings up so many emotions within yourself and what do you do with that stuff? I think that's part of it ... I really felt isolated when I was in the [previous] job ... I felt powerless to change that, I didn't know how to change that when I was in the job ... I almost think that if I'd been able to afford paid supervision then that perhaps would have been ideal.*

This raises an issue for employers about level and cost of supervision and who should pay.

Participant Three said that further education had assisted her in gaining perspective and confidence in a new clinical role that made demands on her which she felt she could not meet at times. This contributed to significant stress. She made a decision to leave clinical work and moved to education. She does not feel ready to return to clinical work. However, clinical supervision was inadequate and contributed to a strong sense of loneliness in her job and a lack of team support.

#### **Participant Four**

Participant Four is a female nurse in with a Bachelor of Nursing and five years of working in mental health nursing. Following her graduation she completed a new graduate entry to specialist practice (Mental Health) programme. Her work

experience includes acute inpatient and crisis services. Her first encounter with the term VT was while researching on stress for a presentation to a volunteer community group. The presentation was to look at the impact of the group's crisis community work on themselves as a team. The links between this group of people and nurses she felt was obvious. *"What do you do when you find someone who is not in a very good way and potentially going to die and that sort of thing"*. After reading her research material she identified with it from her nursing perspective; *"oh, so that's what that, and that, and that is"* [indicating she had similar experiences]. She has pondered this in relation to her mental health colleagues. Her personal experience of VT, and being exposed to other people's abuse stories, has lead her to be more distrustful of people in general.

*You hear a lot of people's abuse and often it's people close to them – people that they thought they could trust. People don't believe them because everyone else around them trusts them [the abuser].*

In her personal life she wasn't aware of this lack of trust.

*I didn't really realize it was happening until I'd come across the term [VT] and it makes it a lot easier to kind of challenge yourself about that and say this isn't about my stuff, this is about having heard about this and this from all these different people and I've actually got no reason to distrust those people ... it makes it a lot easier to rationalize it all I guess. You do get a skewed view of reality I guess ... we see so many people that have been abused and I don't think it's representative of the general population.*

The subtle nature of VT can mean its presence goes undetected.

*You don't notice it creeping in ... until all of a sudden ... someone might say something and um, 'yeah, you're right I'm not really trusting you as I should' and it's not because of anything that they've done or that you've seen in their behaviour that makes you mistrust them ... you've all of a sudden realized that you've got this view that no one can be trusted.*

Given the insidious nature of VT this realization can take time. Meanwhile the enduring effects of VT continue.

*I probably didn't really notice until I started reading about VT and then it sort of dawned on me that I'm quite a different person now than to say how I was three years ago. I mean now that I'm aware of it, it's very obvious you know it's like 'oh, time to switch out of that' and into a more realistic view of the world.*

It is not something that she usually talks about at work but has in supervision: “usually when ... I've seen [a patient] whose kind of making me think along that line [VT] again”. She thinks that work is busy and she is focussed on the job and this is why she does not share it with her colleagues. “I'm just not aware of it happening at the time and I don't think that's really when it affects me at the time, it's usually a little bit after”.

We explored the issue of VT being experienced ‘a little bit after’:

*I think more because at work you ... trust what the client's saying, it's not like you can do a blood test to assess what they're saying ... if you don't trust them then you're just not going to get anywhere. It's more I think in personal relationships you know where you can pass judgements more on what people might be doing or saying. It's not so much people close to me it's people a little bit distant, more acquaintances. New people I find I'm a lot more wary of ... in the past I would kind of trust everyone until proven otherwise ... whereas now with new people ... I'm just wary of them ... trust has to be earned rather than just being given.*

She feels that these responses come as a direct result of her work: *"particularly in relationships with new boyfriends. That's where I've noticed it the most, it's like ... guys can't be trusted until they've proved it sort of thing".* This only shifts when she realizes it is occurring:

*It's about me realizing that at some point I'm basing my judgements of them on a skewed view of them that I've acquired through work rather than anything that they have or haven't done ... I make a conscious kind of choice to trust them just a little bit more ... before it was easy and natural whereas now I've got this awareness of it.*

This loss of trust in others and the world is indicative of VT. Participant Four felt this awareness is:

*disappointing, it kind of makes you feel a little bit hard ... but I enjoy the job and I like what I do and you know there's kind of risks in all jobs. Not insurmountable, it's manageable now that I'm aware of it ... would rather do without it, but it comes with the territory, and you kind of just have to manage that.*

We talked of what she does do to 'manage' and she responded:

*I can talk about it with my supervisor ... makes more sense because the things I take to supervision usually I've kind of thought about for the last two weeks ... things I talk about at work ... tend to be the more here and now type of things.*

This participant revealed that her frame of reference on the world and those in it had changed as a result of her nursing work. This change in frame of reference is a side-effect of VT. She said:

*Occasionally I mention it to my partner, if I'm just feeling wary and suspicious ... I call it cranky often that's what it's about, I'm just sort of feeling the world is not as nice a place as I'd like it to be ... at least if I'm feeling like that it links back to a specific [patient] story that I've heard recently ... if I hadn't heard of a specific story for a while it just kind of sits in the background and doesn't come up again until you hear the next story ... then you start thinking about all the different stories that you've heard in the last wee while but then you kind of rein yourself back in again ... it*



*comes and goes – and it's very traumatic ... I guess it's something that's triggered those kind of thoughts.*

In the context of discussing VT and hearing people's experience of abuse, participant four uses the term “*stories*”. I thought she was being careful about the language she used and she was uncomfortable at this point. I thought this might be significant in terms of how abuse stories are ‘carried’ by nurses in their minds.

*You look back through the notes and often you don't write every detail of all their difficult stuff but you remember it all and it's 'oh, that's right, that was what was happening with this person' ... so that might come up again even if that's not an issue for them at the moment.*

I asked if the things she was careful not to put into too much detail in the notes were traumatic aspects of the patients' stories.

*Yeah, I don't usually give a blow by blow account of things ... one person in particular ... she was really in a mess in terms of a relationship and some quite nasty stuff that happened ... and she was just kind of reliving it all at [the service], like wailing and very distressed and it's just all coming out you know, blow by blow what happened ... I think generally that stuff doesn't need to be in the notes all of it ... her description was very vivid and I don't think there's really anyway you'd forget it, you know kind of the way she'd talk it played out like a movie sort of thing.*

*She was kind of reliving it all ... yeah, you can't kind of say, stop I don't want to hear any more.*

She agreed she would like to ask that it stop sometimes “*but the reality is sometimes people want to talk about it*”.

Workplace supervision and debriefing were other supportive measures where she worked.

*I probably do vent about difficult stories that we do hear. You know you come back and it's 'oh, I can't believe what this person's been through you know – it's no wonder they're suicidal, I would be too' sort of thing.*

Colleagues share with her also but she finds this is different.

*It's interesting it never has the same impact when another nurse is with that person and hearing it from the person themselves. It doesn't seem to increase the load with them sharing in the office.*

I wondered if the difference was hearing it first hand from the client.

*Yeah, I guess there's no [obvious] emotional engagement when your workmates tell you the story that they've just heard. And they obviously don't feel it the same as what the patient did so they just come across differently.*

This type of emotional and empathic engagement is essential in the therapeutic relationship between mental health nurse and patient.

This participant's work environment is a busy one with most staff sharing one space. In order to get 'time out' in the moment at work:

*You might pop in [the manager's] office for a little bit and just write up ... you're still working, you're not sort of skiving ... but you're not kind of having to think the same and think with other people on the phone who might be distressed about something else. And that's usually enough to get you back on track for the rest of the [shift] ... I think just not having to deal with any more distress. For a little while. Until you've kind of got it all sorted in your head.*

Not everybody does this; "Probably the non-smokers, I think the smokers tend to take 15 minutes outside but ... ".

After a nursing shift she often uses physical activity as a way of ordering her thoughts.

*After a shift where something's ... happened, you have a run, think about it then, completely wear yourself out and usually get to feel like I'm pretty right after that ... yeah, if it's been a bad shift then ... I try to wear myself out ... until I'm absolutely exhausted.*

Social withdrawal is a downside of the job and Participant Four noted:

*If it's been a bit of a bad [time] I actually try and take myself away from friends as well, I'm just*

*sick of people! ... I don't want to talk to people, I don't want to hear about your problems ... you know call me in two days. That's probably the biggest impact it has on my personal life because that happens reasonably regularly that I just say 'right that's it – I've had enough of people' no Friday drinks this week.*

VT is known to affect areas such as safety and I raised this issue with the participant and she outlined her service's way of working. They work as a team rather than individuals and use the police service if they are concerned.

She feels the precautions she does takes personally are “*sensible*” rather than due to an increased wariness related to her work. This may be an important aspect as the effects of VT can be felt in one's personal as well as professional life.

I asked this participant when she first became aware of the negative impacts of VT in her mental health practice. “*Probably started developing later in my second year. There was a big, well big to me, incident ...*”. She described the incident where a patient hanged themselves and of finding the person:

*[The patient] was someone I'd worked with several times over the last year, year and a half and then to find her ... will never be forgotten. That did make me a lot more aware of the impact that work had on me at home. I used to think, the patient hung themselves in the shower, and for a long time after that, every time I was in the shower I was ...*

She made a noise/word that signified something unpleasant and from the look on her face she was still remembering this incident clearly. Recurrent and disturbing visual imagery are features of PTSD and VT. The effects of VT are enduring.

*The investigation wasn't particularly nasty or blaming ... it wasn't the first time I'd found [a person] with things tied around the neck, this time we found [the patient] too late ... but you're always thinking of what if we'd done that round just five minutes sooner. The team were all very supportive. Those of us that were on that shift actually all went back into work the next day and we were all on together for a couple of days ... I found that really helpful. I kind of decided that I wasn't taking time off work, because finding someone hanging in the shower had always been my biggest fear ... I didn't want to get to the position where I was scared to do my work, scared to do my round ... it was very important to me to go back that next shift I found it really helpful it was the same crew on ... we were all talking about it for weeks afterwards.*

I asked if she was more vigilant after this event. She replied: *"actually [I] tried not to be because it's quite sort of unsettling for the patients to have nurses kind of 'hi, how're you going' every five minutes".*

A few weeks after the suicide another patient was admitted who had some physical similarities to the patient who hanged themselves. This proved very alarming when this participant discovered the new patient had shut themselves in the toilet; *"I thought 'no not again' [throws hands up, leans back and closes*

eyes momentarily – her strongest reaction thus far] ... *you know the first time [previous suicide] that wasn't what my mind jumped to ... for a long time you're anxious about the toilets ...*". This raises the question of whether one can be 'encultured' into trauma in mental health nursing, and if so, does this raise nurses' vulnerabilities to VT? Six months later she left the inpatient unit for another service but only when she felt that:

*it had kind of passed ... I think that would have made it very hard work to go back ... when I guess the pain hadn't been quite dealt with and it wasn't sitting ok with us. I guess because the job does make you anxious, it's important to me to ... be one up on that, not to leave anything when I'm still feeling concerned about it ... otherwise I worry I would avoid those situations and that's not helpful. I don't think you can do the job if you're avoiding whole groups of people or 'x' situations or anything that looks like that situation.*

I reflected to her that this showed considerable courage and she laughed and said:

*[It's] more because I'm scared I'd run away and never go back to it ... to me it just kind of takes the power of that situation away. If you don't ... let it frighten you any longer than it has to ... or if it does ... continuing to go back to it till it doesn't.*

This last statement can be read in a number of different ways. To continue to go back to work to gain support from colleagues around a traumatic event, or until this type of event no longer affects you. I thought that this participant wanted to sort the traumatic event out in terms of her own thinking and what she

made of it, where it fitted in her own view of life. This may be around the assimilation or accommodation of discrepant events.

After changing jobs she returned to an inpatient service on a casual shift and met the patient who had gathered nursing help for her when the patient was found hanging. This patient asked if the suicide was the participant's reason for leaving the inpatient unit; *"it was quite good to be able to honestly say 'no that's not the reason I left' because she was another patient who used to, or still does, make serious suicide attempts"*. We considered together whether patients are often aware of the impact of the job on us as nurses. She thought this patient was certainly aware, in particular of how their self-harming behaviour might affect the nurses they work with. *"Sometimes when [the patient] was in a better frame of mind she could say 'look I know I do these horrible things to myself and that it's horrible to find me' ... 'but it's what I do – it's how I cope' type of scenario."*

Participant Four saw her change in work setting as a positive one, not based on any fear or a strong need to leave her job. Although she did own some frustration with seeing the same patients coming in and: *"feeling a little bit frustrated with developing this relationship with them, they're there for six weeks and then they're gone ... then they come back in six months later exactly the same as last time when they came in and you go through the whole process again and out they go and back in they come again"*. VT is characterized by its long-term effects across time and patients. The participant remarked:

*I think [VT] can have a huge impact on nurses more so if you're not aware of it. I think it is something that is quite manageable if you're aware of it and aware of what works for you in terms of putting it in its box and out of the way.*

I asked if she meant aware of VT as an occupational risk?

*Yeah, and I don't know that it's made obvious ... it was something that I found out about through my own research. I don't remember it being brought up [in nursing education] ... but you might not make the links before you've ... experienced it. I don't know if it's necessarily something you can be warned about. People try to warn you but I don't think it really carries any meaning unless you can kind of pin it on something ... see it in your own experiences ... it makes sense then. It's just very abstract – and you think 'oh, it's just a job' you'll be right, the old she'll be right attitude.*

These comments are reflective of VT being an inconspicuous but harmful transformation.

The four participants raised similar issues in their interviews. These were coded as main themes and sub-themes.

### **Themes from the Interview Data**

Four initial themes were identified from the data (1) the impact of VT; (2) self-knowledge/awareness; (3) self-care; and (4) burnout. The next sections deal with each theme and related sub-themes.



### **Theme one: The impact of VT**

All participants were familiar with the concept of caring induced trauma. Two participants knew the term ‘vicarious traumatization’ and what it described. Two participants knew the description after reading my recruitment flyer and then became familiar with the term VT after connecting the description to the term itself. One of the participants was researching stress and came across the term VT and related her own mental health nursing experiences matched the description.

Although there was knowledge that mental health nursing did expose nurses to caring induced trauma, and in this case VT, this was a process of self-discovery not from any nursing education or training. It was clear that no one had been prepared for it. One of the participants observed that in his long experience working in mental health that VT was an issue for retention of mental health nurses in the workforce. Three participants changed their jobs after feeling either traumatized and/or burnt out although they acknowledged it was some time later. One of the participants worked with a large team and noted that people left if they felt overwhelmed in their work roles. One of the participants had moved out of a clinical role.

A view expressed by participants related to the subtlety of effects of workplace trauma and VT. One participant noted that her trust of others in general was affected and it was only with some distance between her and her workplace did this become clear. This awareness has enabled her to challenge herself when she has similar experiences, that with previous knowledge of VT and its effects she is able to deal with it more effectively.

Two of the participants could clearly place themselves within the description of VT. The experience by one participant of

*“overwhelming sadness”* related to the regular hearing of stories of abuse. Pearlman and Saakvitne (1995, p. 31) talk of the VT effects of continual engagement with the trauma stories of our patients and that trust can be damaged. One of the participants was aware of her trust in others in her personal life had been affected. She was later able to connect this with VT. Others could identify it in their colleagues. It emerged through the interviews that some experiences could be put into the category of VT. For example, in reliving traumatic events, not wishing to go to work, not trusting people as one used to. Trust is a specific psychological need that Pearlman and Saakvitne (1995, p. 62) say can be damaged through experiencing VT. Trust encompasses the need to have confidence in our perceptions and judgements and to depend on others. Two of the participants expressed concern about whether they would know if they might be becoming blasé in their assessments of patients, or if they would know whether they themselves had accumulated too much stress and should not continue in clinical work.

The issue of trust in the therapeutic relationship, the heart of mental health nursing, is thought to be affected through the empathic engagement with traumatized patients. Mistrust was developed over time and across different patients. It is not the patients that were mistrusted *per se* but that their experiences changed/damaged the nurses’ view of the world and others in it. With trust in mind, Pearlman (1998) describes the three self-capacities that are embedded within the CSDT. These are the ability to maintain an inner sense of connection with others; the ability to tolerate and integrate strong affect; and the ability to maintain a sense of self as viable, benign and positive. It is the first capacity, that of connection with others, that permits the second two capacities. Canfield (2005) states that VT represents changes in the psychological working of mental health workers. It is across all relationships in both personal and professional life

and is permanently transformative. Participants in this study were aware of the impact that work had on their personal lives.

*Sub-themes related to knowledge and experience of VT.*

From the initial theme of VT there emerged sub-themes related to VT, those of trust, feeling “*peopled-out*”, “*overwhelming sadness*”, reduced esteem, personal and professional relationships being affected by lack of trust, a change in personal frame of reference with feeling the “*world is not as nice a place as I would like*” and “*there’s so much abuse out there*”. Trust was also affected in relationships outside of work. “*In the past I would trust everyone until proven otherwise ... now with new people ... I’m just wary of them ... particularly in relationships with new boyfriends ... that’s where I’ve noticed it the most*”.

The feeling that others outside of mental health nursing do not understand the impact of the job and it is hard to talk about socially without “*killing the evening*” – reinforcing that it is something not to talk about – “*that’s a bit much for me thanks*”. One of the participant’s enduring experience of VT was that she often wished to withdraw socially. “*That’s probably the biggest impact it has on my personal life ... happens regularly ... you don’t want to care*”. She found that work was consuming her life.

One participant stated that: “*This job has exposed me to the undercurrent of society and what can be down there in the depths ... whether that’s changed the way I see the world I don’t think so yet*”. I thought that he was experiencing enduring changes to his frame of reference. That he now sees the community within which he lives as hostile and damaging to others and himself by

association. This was a repeating theme as he spoke of “sometimes you see this underbelly of the world sometimes and you sort of think ‘God, if people could see what I see’ ”. There were times when he felt protective of himself: “you sort of close off a little bit ... you might avoid that one to one [with a patient] I’ve caught myself showing pity which I don’t think is helpful”. Avoidance is one way to manage intense thoughts and feelings and when we feel overwhelmed, as in the case of VT, we can frame it as self-protection. When our internal resources are stretched it is hard to find energy to balance a personal life that Pearlman and Saakvitne (1995) say is essential to ameliorating the effects of VT.

### **Theme two: Self-knowledge/self-awareness**

Participants in this study showed an ability to reflect on their nursing practice, its impact on their lives and the impact their personal lives had on their nursing. This reflective capacity developed with personal growth and experience in their jobs. One participant described it thus:

*I find that over the years I don’t sort of take it home as much ... the horrible stories you hear ... the hopelessness ... the terrible situations ... I feel like I can leave it at work a bit more. I don’t know whether it’s because of ... just maturing or feeling better in myself probably.*

The same participant thought that his increased experience of working in mental health had not only improved his communication skills but also his confidence and resilience. This personal growth is a positive experience in relation to his work

and balances the negative changes that can be experienced with VT.

*It goes along with your interpersonal confidence with people ... it's about being more comfortable with who you are ... we all have our faults and strengths ... but as I've matured I've realized that a lot of responsibility lies with the client ... the other nurses and the care team ... I'm only a small bit and can only do so much.*

One of the participants described his own personality in relation to his long experience in mental health nursing. *"I don't get too het up ... I'm comfortable with myself ... I know my faults ... my strengths"*. He currently puts his job satisfaction as high which contrasts with his initial and traumatic induction to mental health nursing. He feels that having had traumatic experiences and positive experiences of patients getting well and re-establishing their lives has provided balance and the knowledge that he can value their recovery and cope with the trauma: *" ... I've been through that ... worked through those things"*. Collins and Long (2003) noted that work satisfaction, or compassion satisfaction as they termed it, was a protective factor against VT. This type of satisfaction offered a balance against the negative experience of VT.

Fronting up to her worst fears was an important thread for one participant who discovered a patient hanging. She felt that: *"the job does make you anxious ... I don't think you can do the job if you're avoiding people"*. She felt that if she did not address her fears and anxieties in her work they would continue or worsen. Traumatic experiences over time and occurring with many patients can foster an unhealthy 'layering' of traumatic

experiences that affect the nurse's ability to work empathically and can result in VT.

*Sub-themes related to self-knowledge/self-awareness.*

Sub-themes related to self-knowledge/self-awareness included awareness by all participants of the effect the job could have on them and an awareness of its impact on their nursing practice and personal lives and vice versa. This awareness was something developed over time and experience in their nursing and private lives. Experience was expressed by one participant as an advantage in supporting his career longevity. The participants' capacity for self-reflection and supervision was cited as important in understanding themselves in relation to their work and to have a place to "vent" feelings - this word in particular was used by two of the participants. Feeling alone in a work role was identified by one of the participants as being a stressor in her life, coupled with inadequate supervision. One participant also described their own personality as quite driven with overly high expectations of themselves at work and their esteem suffered when these expectations were not achieved. The two male participants described themselves as optimistic people. Optimism may encourage resiliency in the mental health context according to Warelow and Edward (2007).

There was thoughtfulness about what the mental health nurse brings to the therapeutic relationship. One participant:

*I think nurses as personalities bring themselves [to the therapeutic relationship] ... I think that's really important to underline ... we can all work differently with people and that also comes down to how we cope with the job ... it could be what's*

*happening in the nurse's own life that makes it difficult for them to process and take on board, and show empathy to other people.*

Courage was in evidence as some of the participants continued nursing despite feeling traumatized by incidents particular to them. They wanted not to feel intimidated and frightened about their work, and not to avoid their own fears and anxieties post-trauma event. There was also consideration for the patients in their care and how they might be impacted upon by traumatic events on the ward, or secondarily by the impact it was having on the nurses who provide their care.

Ongoing education was identified by one participant as having a significant impact on her understanding of the effect of workplace stress on not only her occupation but her life overall. Some of the participants clearly identified that study/education had contributed to better understanding their work role, its stressors and risk of VT or other caring induced traumas.

The participants described how knowing themselves enabled them to understand the impact their work might have on them and what they brought to their nursing.

### **Theme three: Self-care**

The theme of self-care includes the participants' use of strategies to look after themselves in the context of their nursing and their personal lives. Self-care and its sub-themes of exercise, attendance to rest and relaxation etc. are discussed in relation to the literature on self-care issues for those working with victims of trauma.

Managing strong affect/emotion is important in this work and strategies for this include putting collegial support systems in place, drawing on our own sense of altruism, exercise and affective distancing – placing the patients’ strong emotions in the therapy context. Adaptive coping mechanisms such as these reduce the negative effects of trauma work (Canfield, 2005).

Self-care for those working empathically with traumatized patients is an important occupational need to ameliorate the effects of this type of work including VT. Self-care includes attending to both personal and professional aspects of our lives. Clinical supervision and collegial support are advocated by Pearlman and Saakvitne (1995). Humour and camaraderie was experienced as supportive. Restoring ourselves through social interaction and maintaining a personal life moderates the harmful effects of VT. One of the participants talked of “*being able to just ... switch off*” and “*being able to talk with [partner] at home*”.

All participants identified the importance of clinical supervision in their respective practice. Three participants attended formal clinical supervision but also informally amongst colleagues. It differs from debriefing which is incident-specific. One participant had mostly informal supervision with his peers if and when he felt he required but acknowledged that as he had taken up more senior nursing roles those opportunities diminished. Environment, including the physical environment and the team dynamics, played a factor in the extent to which one was able to debrief with colleagues. A busy inpatient unit was not seen as conducive to taking time out to consider events that occurred which were disturbing, to the point of encouraging a certain level of ‘staunchness’ about accommodating stressful events. One participant described this ‘staunchness’ as unhelpful



for himself as he felt on his own coping with challenging work situations.

How we attribute meaning and maintain our own sense of hope in life is an important aspect of self-care (Pearlman & Saakvitne, 1995). Three of the participants looked to balance their life outside of mental health nursing through physical exercise and cited its importance in providing a contrast to their working lives. After a stressful day one participant would “*go out for a run in the evening ... I think it makes you feel good, makes you feel better*”.

The use of extended family and friends, to balance out the work intensity, was mentioned by three of the participants and this provided a release and a contrast to a difficult day at work. The ability to be oneself that does not include being in the role of carer as in nursing, that is, to receive, or be part of reciprocal giving and receiving. However, three of the participants felt that discussing their work with their families could only go so far. This may reflect the taboo nature of sexual abuse and other traumas in society. There were times when participants felt they were “*sick of people*” and for one nurse, this happened on a regular basis “*just give me a book and a tree*”. Pearlman and Saakvitne (1995, p. 396) state that one’s spirituality is an early casualty of VT. Being involved with friends, family and enjoying sports offers a counter-balance to feeling that one is only experiencing negative parts of the world in which we live. These activities offer us hope, humour and an opportunity to maintain our spiritual health.

Socializing and home life provides a reality check from the negative effects of working closely with patients who had suffered abuse and the worrying belief that this abuse was becoming omnipresent. Canfield (2005), comments that a reality

check is especially relevant when working with traumatized children and how important it was to engage with healthy children. The need to have everyday experiences with healthy people in life when working closely with traumatized patients is a recurring theme in literature, (Collins and Long, 2003b; McCann and Pearlman, 1990; Pearlman & Saakvitne, 1995, p. 393). However, this social engagement becomes much harder when feeling “*peopled out*” as one participant noted. Without experiencing a balance between work with trauma victims and socializing with healthy people, there is the risk of feeling that everyone is suffering trauma. This negative change to our frame of reference provides a dim lens through which to view ourselves and others and contributes to our isolation. This is a particularly damaging aspect of VT.

A supportive home life was no substitute for clinical supervision, however. There are societal inhibitions that prohibit discussing taboo subjects like abuse in a social setting. There was worry that talking too much about working with traumatic incidents with patients would then be too much for their families and that one could only go so far. Confidentiality was an issue in terms of sharing work experiences in a small place. Mental health clinicians can also feel stigmatized along with our traumatized patients and feel that no one understands our work or its impact on us (Canfield, 2005).

One participant in this study felt that access to clinical supervision in a small mental health community was an issue for confidentiality which may result in not receiving supervision or it being of limited use. This raises the issue of nurses freedom to choose supervision outside the institution where they work, and who would pay for it.

The importance of team work was identified by all four participants in terms of sharing the workload, both mentally and physically. Isolation in their work role contributed to workplace stress for one of the participants who had few nurses or other clinicians around her to debrief or supervise with. Another aspect raised by participants was the idea of taking 'time-out'. Sometimes this was in the moment in practice when needing to remove oneself physically from feeling overburdened by work. Time out also included long-term suggestions such as changing clinical areas and moving to non-clinical work for a period of time. All participants had experienced not wanting to return to their work at some point in their career and attributed it to the difficulty or nature of their type of work.

One participant observed that maturity and life experience seemed a mitigating factor against VT and burnout. His experiences, of being able to manage traumatic situations and also be glad of a patient's progress, were enriching. Another participant also felt that with experience he has gained confidence in himself and his skills as a nurse. He felt able to look after himself personally and professionally, and to experience satisfaction from working with patients who got well.

Resiliency in mental health nurses is negatively affected by VT leading to a gradual wearing down of inner resources and a withdrawal from people, including patients. Resiliency was explored by Warelow and Edward (2007) in their paper on mental health nursing as a resilient practice. They argue for mental health nursing to extend its traditional skills of caring to include resilience which has the potential to assist with traumatic experiences and even change them. The two male participants described themselves as optimistic which is a feature of resiliency. The ability to maintain hope and faith in oneself and the recovery of the patients was another feature of resiliency.

### *Sub-themes related to self-care .*

Sub-themes related to self-care include taking care of oneself in activities of daily living, e.g. adequate sleep, food, rest. Exercise and keeping a balance between personal and professional life were identified. Team work and humour were noted by participants as important for morale.

Participants discussed their self-care approaches which included activities of daily living like making sure one is exercising, getting enough to eat and is resting adequately to refresh themselves. It raises educational issues for undergraduate nurses and those about to enter the field of mental health.

Exercise was cited by three of the participants as an important part of their coping and self-care strategies, something that takes their minds off their work or as one participant said *“to try and wear myself out”*. Another participant said, *“exercise was an important one for me in terms of that anxiety ... and getting enough sleep and eating enough, all that stuff was really important”*, attending to the basics of living. Equally when both home and work were hectic this participant found *“there wasn’t really time to wind down”*. One participant used the gym and running to *“switch off”*. He also thinks that *“humour and camaraderie is a very important thing amongst nurses for nurses’ health and well-being”*. He also valued having *“a good listener”* in his wife. The *“all-consuming”* nature of mental health work was noted, *“You’d think about it all the time without realizing”*. This emphasises the importance of having other activities and relationships in one’s life to balance the ‘all-consuming’ nature of this type of work. This is borne out by researchers such as Pearlman and Saakvitne (1995) who

identified self-care as paramount for those working with trauma survivors.

#### **Theme four: Burnout**

Burnout emerged in the first two interviews as descriptions that the participants used and were familiar with. Burnout is a problem of the social environment in which people work. Burnout is about high stress with low rewards in social services or helping jobs but does not incorporate the interaction with the individual, this latter being essential in defining VT (Pearlman & Saakvitne, 1995, p. 153). Effects can be cumulative but burnout can occur with any group of patients and not solely through hearing trauma stories as in the case of VT (Canfield, 2005; Maslach & Jackson, 1990). Maslach and Jackson (1990) identified three components of burnout as being: emotional exhaustion; depersonalisation; and reduced personal achievement. Treatment or assistance for burnout should be aimed at the organization not just the individual who can feel singled out and a failure (Pearlman & Saakvitne, 1995, p. 280).

##### *Sub-themes related to Burnout*

Sub-themes were stress and anger towards patients and a lack of empathy due to fatigue. Participant Two identified burnout as a common cause for staff attrition. It may be that the term burnout is used quite generally when in fact clinicians may be experiencing a secondary trauma such as VT. One participant experienced burnout and often did not want to go to work and avoided 'one to one' time with patients when feeling stressed. This participant could see cynicism and patient-blaming frequently, and in himself, and had felt anger rather than empathy towards patients. This cynicism and depersonalization (blaming

patients for their problems) is one of the three symptoms of burnout (Maslach & Jackson, 1990). This latter blaming is also a feature of VT and it may be difficult in distinguishing the two when experiencing them. Another participant described feeling “*peopled out*” and needing “*time out*” both in the moment when stressed at work and after work socially to wind down. There are similarities between burnout and VT such as fatigue, cynicism and withdrawal. Pearlman and Saakvitne (1995) note, however, that “VT is not specific to one client or therapeutic relationship” (p. 280) and the VT model is about “meaning and adaptation rather than symptoms” (p. 281).

### *Reflection on themes*

One of the participants identified that the biggest negative impact from her job was on her social life and feeling the need to withdraw from people. This was echoed by other participants. Three identified the need for self-care with things like nutrition, sleep and exercise. Clinical supervision was highlighted by participants and seen as essential to managing their nursing practice. None of the participants had felt prepared for the negative impacts of mental health nursing. And all had experienced difficulty, at times, in attending clinical work each day. The interview data revealed signs of VT in the participants with a change of frame of reference, a loss of trust and these impacted on personal and professional relationships. Knowing one’s own limits is important in terms of boundaries, safety and control in order to assist those we help (Pearlman & Saakvitne, 1995). These limitations are individual and identifying them is important as may hint at ways to mitigate the effects of VT or identify predisposing factors to VT.

## **Predisposing Factors towards VT**

The literature identifies predisposing factors towards VT and among these are a previous history of trauma, a need for control and experiencing one's own emotional difficulties while working. Trauma survivors have often found themselves in positions of powerlessness. Helpers with high needs for power and control are likely to be greatly impacted upon by the powerlessness reported by patients (McCann & Pearlman, 1990). Mental health nurses can feel powerless which parallels the patient's experience. This can lead the helper to feel despairing about the rapaciousness of human nature. If the helper has a previous history of trauma it can predispose them to VT (Pearlman & Saakvitne, 1995).

The four participants noted that inexperience was a predisposing factor to feeling overwhelmed in their nursing. Two participants talked of experiencing a traumatic event in their practice within two and half years of completing initial training. This raises an interesting question about the relationship between PTSD increasing vulnerability to VT. Two participants occupied positions of responsibility early after their initial graduation which may have increased their exposure to stress and trauma early in their career. Participants' 'newness' to the role of mental health nurse and lack of preparedness contributed to a sense of feeling overwhelmed in their work. An absence of self-confidence where we do not trust ourselves, our judgements and our abilities to cope can predispose one to developing VT (Pearlman, 1998).

Lack of clinical supervision, poor quality supervision, and minimal debriefing opportunities may predispose the mental health nurse the VT. Clinical supervision was cited by two participants as either non-existent or inadequate. This raises the

issue of the quality of supervision and its availability. There was acknowledgement from all that clinical supervision and opportunities for post-event debrief at the local level, with colleagues, was important in managing traumatic events. The downside to a busy workplace was that sometimes this debriefing, peer supervision with colleagues, was intermittent or even non-existent.

Barling (2001) identifies mental health nurses working in inpatient units as at a higher risk for burnout as they scored more highly on the depersonalisation and personal achievement scales (p. 49)..

One participant thought that role isolation had been a risk factor for burnout in her job. A lack of clear job description and responsibilities and lack of emotional support within the team can also contribute to burnout and VT as well as an isolated role with lack of professional support. This participant brought her own high expectations of herself as a person to her role as a mental health nurse. While this is not in itself a bad thing she experienced not being able to validate her work against an adequate description of her role and this caused her significant stress in the workplace.

Two participants reported that when they were having personal difficulties of their own this impacted on how they felt at work when identifying with patients which blurred the working boundary. This echoes the self-awareness or self-knowledge noted earlier as ameliorating factors against VT. One participant felt that lack of preparedness for a new role and the absence of a support structure aroused her anxiety further resulting in over-identification with the patients and predisposing her to burnout. This heightened anxiety may predispose nurses to



VT. The literature is unclear about what personality types are vulnerable to VT.

Lack of awareness of VT as a caring induced trauma was suggestive of a greater vulnerability to VT. One participant adopted a pragmatic stance in identifying VT as an occupational hazard, but one can only do this if one knows of VT. She accepted VT as part of her work and felt it was manageable now she knew it was there but prior to this had felt almost 'consumed' by it in her early nursing years. For this participant the impact on her social relationships was profound. Social avoidance was frequent and a distrust of male friends. These enduring features are indicative of VT. McCann and Pearlman (1995) state that VT is a natural occurrence when one engages empathically to this degree.

Participants thought that inexperienced nurses were vulnerable due to their being new to the profession with their skills untested or undeveloped. The powerlessness that patients can feel is paralleled by nurses who are overwhelmed by the demands of the job. One participant felt isolated in her role and this raised her anxieties to an intolerable degree.

### **Traumatic experiences as a novice nurse**

Does early career experience of trauma predispose one to VT or burnout? This was something I reflected on in this study as participants described their practice. It was a worthwhile consideration given participants' descriptions of their formative nursing years.

One participant's familiarization with VT came from research for a presentation to a group outside of nursing, but akin in its

observations of people in trauma. She found the link with mental health nursing “*quite obvious*”. In terms of primary trauma her “*worst nightmare*” occurred when she was two years out of her undergraduate training and discovered a patient hanging in the shower. This experience translated across her nursing, where she continued to work, and into her home life where she struggled to somehow incorporate this image into something less frightening. This image she describes as “*unforgettable*”.

How we remember or contain traumatic memories, images, and stories can have an ongoing impact on us personally and professionally. Traumatic memories provide heightened visual imagery triggering the physiological response experienced at the time. It is important to be aware of the links from witnessing traumatic events (primary trauma) and whether this predisposes us to caring induced (secondary) traumas such as VT. The question arises as to whether nurses can be en-cultured into trauma through early experiences of primary and secondary trauma in mental health nursing?

Negative experiences that occurred early in nurses’ careers have a long-lasting effect. Another participant described their initiation into acute inpatient nursing as a ‘sink or swim’ induction. He found a patient hanging in the grounds and at this time there was no formal clinical supervision or debriefing provided.

Two of the participants were concerned about the cumulative aspects of working with traumatized individuals in mental health nursing. One participant asked when she would know if her own personal threshold had been reached. The other was concerned he had been negatively changed because of his job. Working with the painful images of our patients means we may absorb them into our own memory system (McCann and Pearlman,

1990). The helper must enable themselves to give voice to these disturbing images or risk becoming numb and emotionally distant and damaging the potential of the therapeutic relationship.

## **Conclusion**

A common theme for all participants was the observation that mental health nurses operate within a distorted domain and mostly deal with patients who have severe and enduring mental illness. Patients are often at their most traumatized or in a crisis when they are admitted. Mental health nurses are there then to initiate a therapeutic relationship. Witnessing the effects of abuse on patients carries an ongoing burden for nurses to foster hope and wellness for the patient and for nurses as this study found.

VT occurs when the helper is engaging empathically with victims of trauma over long periods of time and with different patients. These intense therapeutic relationships are not easily forgotten according to the participants. One described the frequency of listening to “*difficult stuff*” and “*specific stories*” of abuse. The full story remained in the nurses mind even though at times she wished to say “*stop I don’t want to hear any more*” – but, of course, she never did.

One participant noted that the experience was different when colleagues debriefed with her and she was not directly engaging with the patient herself. This difference is relevant to the individual’s experience of VT and that although reading or hearing of traumatic events is contributory, it is firsthand, empathic engagement with the patient’s trauma material that poses the greater risk for VT.

Mental health nurses are the majority of workers in mental health. They form ongoing, close therapeutic relationships with patients in their care. This empathic engagement may come at a cost that of, VT. The ability to form therapeutic relationships can be damaged by VT and this can affect the patient's recovery (White, 2006).

VT is a consequence of ongoing, empathic engagement with traumatized individuals. Mental health nurses form close therapeutic relationships with their patients. The therapeutic encounter is what fosters hope and recovery and is sought after by patients (Cutcliffe, 2008). It is this close-quarter empathy that places the mental health nurse at risk for developing VT. They are the largest professional group of the mental health workforce and the only group who work 24/7 hence the most at risk of VT.

Participants experienced a loss of trust in relationships, both personal and professional and was indicative of VT. This lack of trust affected intimate relationships outside of work. A change in frame of reference on the world and those in it was noted by participants, feeling that others do not understand the stressors of mental health nursing and feeling compelled to not talk about work when out socially. Only one participant confidently said she knew VT, what it was, and that she had experienced it.

One participant felt that being new to the role of mental health nurse made them more vulnerable. There was concern that the stress nurses experienced was cumulative and what would indicate if they were becoming desensitized in their practice. The insidious nature of VT was noted by participants.

Increased self-knowledge/self-awareness regarding personal and professional issues was a capacity developed in all the participants. To reflect on the impact the job was having on them

and vice versa when strains were present at home and a raised awareness of how they were feeling in relation to work. Age and experience was noted as helpful in gaining a balanced view of work and having the skills required to cope, this included the transition from new graduate to senior nurse with developed skills and insight. Education played a part in supporting their nursing practice through difficulties and advancing their practice. Clinical supervision increased self-awareness in participants.

Self-care is an important aspect in maintaining a balance between work and home including sleep, nutrition, relaxation and exercise. This latter was especially important as a major stress reliever. Time with family and friends was valuable to support a balanced life, but not easy to do when feeling tired after work. Clinical supervision, debriefing with peers, teamwork, humour and camaraderie were all reported as assisting in gaining perspective at work. Nurses who are informed about VT and pursue an active personal and professional life are in a sound position to negotiate the difficulties of trauma work both for themselves and their patients (Clark & Gioro, 1998).

Some of the participants reported feeling ‘peopled out’, not wanting to be at work, avoidant of individual time with patients and that colleagues often left employment citing burnout. This often led to frustration, anger and depersonalization. New, inexperienced and under-prepared from nursing training to cope with the demands of mental health nursing leaves nurses unaware of the risks of working empathically and developing VT.

The next chapter contains the discussion and implications of the findings. The focus is on the issues raised through the research questions and what was found in the data. That is, are mental health nurses aware of VT; what are their experiences of it; and how have they managed it in their lives.

Recommendations are made from the findings and discussion of these issues.

## **CHAPTER SEVEN: DISCUSSION**

### **Introduction**

The discussion section brings together the research aims of this project and the participant findings. I summarize key points to form recommendations for the future.

This chapter summarises the themes that emerged in the findings and discusses them in the context of the known literature. Key components were the preparedness of nurses to work in mental health; the impact of work on their personal and professional lives, and maintaining a balance between work and home life. The insidious nature of VT is discussed along with the risks of empathic engagement with trauma survivors in the therapeutic relationship.

The research aims for this study centre around mental health nurses' familiarity with the term VT, and what their experiences might be of this caring induced trauma. The contribution of this research has been to highlight VT for mental health nurses and to identify the occupational risks for them and possible links with retention in the mental health workforce.

### **Discussion of findings**

Mental health nurses use themselves as a therapeutic tool to assist the patients' recovery. This therapeutic use of self can be threatened by anything that negatively affects the nurse. In turn these negative effects can flow on to the patient when the nurse struggles to be in relationship with the patient. VT is such a threat and is poorly acknowledged, or known, in mental health nursing.

At the heart of mental health nursing is the formation of therapeutic relationships. The therapeutic relationship is held important by patients using mental health services, (Cameron et al., 2005; Cutcliffe, 2008; Rydon, 2005). VT affects the formation of these healing encounters and the patient's recovery is put at risk, along with the health of the nurse. Nurses are not indestructible and the effects of VT can be enduring, threatening the nurse and the patient's recovery. Some participants discussed avoidance of emotional involvement with patients when feeling burnt out or overwhelmed which is symptomatic of VT and its impact on our relationships with others.

Sabo (2006) describes empathy as a double-edged sword for nurses. Empathy facilitates the caring nurses do and at the same times leaves them vulnerable to being wounded themselves. The therapeutic relationship is work of a most demanding and complex nature (Welch, 2005) and nurses should value it by being alert to anything which impacts on it. Mistrust is developed over time and across different patients. It is not the patients that are mistrusted. It is the re-telling of patients' traumatic experiences that change or damaged the nurses' view of the world and others in it.

CSDT is a useful theoretical framework for linking the impact of trauma work upon therapists/nurses (Pearlman & Saakvitne, 1995). Our intra-personal abilities allow us to keep a continuous, mostly positive sense of self and are important for self-soothing and affect tolerance (Pearlman & Saakvitne, 1995, p. 161). These capacities are negatively impacted upon by VT that inhibits the nurses' capacity to form therapeutic relationships with patients. Control is a capacity that Pearlman and Saakvitne (1995, p. 62) say comes under threat when experiencing VT.



Pearlman and Saakvitne (1995) name intimacy as a capacity that can be damaged by VT. The mental health nurse is a central component of recovery in the context of the therapeutic relationship. What affects the nurse can affect the care they provide for the patient and this needs to be highlighted when considering the effect of nursing and VT upon nurses.

### **Personal and professional impact of VT**

VT is insidious and can occur across time and with different patients who have been traumatized. VT will go undetected if we do not raise awareness of it. VT has been a process of self-discovery for some of the participants in this study, but this does not seem the best way to learn. Nurses are warned of the risks of needlestick injury, contamination and to use best practice guidelines to avoid or minimize risk. However, in mental health nursing there is an omission in warning of the risks of empathic engagement with our patients, and occupational hazards like VT. Caring induced trauma such as VT can cause nurses to leave the profession altogether as well as not understanding what has happened to them. This creates further shortages in the mental health nursing workforce (Silverstein, 2006).

Participants in this study thought that mental health nursing exposed nurses to VT, however, this was a process of self-discovery not from any education or training, no one had been prepared for it. VT is an issue for retention of mental health nurses in the workforce. Participants felt that the effects of workplace trauma and VT were subtle which fits with VT being insidious with its onset often going undetected.

Pearlman and Saakvitne (1995) state that our capacity to deal with strong affect/emotion may be diminished through empathic

engagement with traumatized patients and result in numbing and avoidant behaviour. Feeling numb can be a sign of secondary traumatic stress (STS) or compassion fatigue, (Figley, 1999, p. 12). Participant one felt he had experienced VT and observed it in his colleagues.

Canfield (2005) agrees that VT represents changes in the psychological working of mental health workers. It is across all relationships in both personal and professional life and is permanently transformative. VT produces a change in personal frame of reference and the feeling that others outside of mental health nursing do not understand the impact of the job. It is hard to talk about socially reinforcing that it is something not to talk about.

Pearlman and Saakvitne (1995, p. 163) talk about the effects of VT on interpersonal relationships and the prospect of social withdrawal, feeling different, when we know something others do not which is common to trauma survivors. The unique nature of the work can alienate nurses and patients. For one participant trust was an area affected in relationships outside of work and in particular with new boyfriends who were not trusted until they had earned it. This was a change from how she used to see people.

The process of having to confront one's worst fears was an important thread for one participant who discovered a patient hanging. One could argue that this would be a 'nightmare' for anyone to discover, but more likely in mental health nursing. For one participant working alone in a nursing role with lack of collegial support had a negative impact on her confidence with her nursing practice. There was thoughtfulness about what the mental health nurse brings to the therapeutic relationship. Some of the participants felt it was important to be aware of what was

happening in one's own life and the impact this might have on their nursing.

### **Self-care – reducing the risks of VT**

Self-care for those working empathically with traumatized patients is an important occupational need to ameliorate the effects of this type of work. Self-care includes attending to both personal and professional aspects of our lives (Pearlman & Saakvitne, 1995, p. 393). Managing strong affect is inherent in trauma work and is important in reducing its negative effects. Canfield's literature review noted that therapists managed this by developing "collegial support systems; drawing on a sense of altruism; regular exercise and affective distancing" (2005, p. 98). Canfield states that placing the patients' strong emotions in the therapy context are seen as useful strategies in keeping personal and professional perspective. Participants in this study identified the importance of clinical supervision in their respective practice areas. Debriefing with colleagues at work was cited as important but depended on the environment which made this type of debriefing variable in its availability. The use of humour and camaraderie with colleagues was also a good stress reliever. Feeling isolated in one's job and that no one quite understands the strains we are under while working with traumatized people is a feature of VT (Pearlman & Saakvitne, 1995). Collegial support has been identified as an essential support when working with trauma and that the absence of it can lead to professional isolation and loss of confidence. Pearlman and Saakvitne (1995) are clear that trauma workers cannot do this type of work alone.

How we attribute meaning and maintain our own sense of hope in life is an important aspect to self-care and can be an early casualty of VT (Pearlman & Saakvitne, 1995, p. 396). Three of

the participants balanced their lives outside of nursing through exercise and said it was important in providing a physical release and something to take their minds off work. The use of extended family and friends, to balance the intensity of the work, was mentioned by three of the participants. Socializing and home life provided a reality check from working closely with patients who had suffered abuse and the worrying belief that this abuse was becoming omnipresent. The ability to be part of reciprocal giving and receiving is a crucial restorative. The importance of maintaining a personal life when working closely with traumatized patients is a recurring theme in literature, (Collins & Long, 2003b; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995, p. 393). However, there were times when participants felt they were tired of being around people and that for one nurse, this happened on a reasonably regular basis and was the biggest, negative work impact on her personal life. The implications from this maybe that nurses cannot sustain themselves enough outside of work to keep working therapeutically. On a personal level they are denied the restorative of ordinary social contact.

Participants thought that 'time-out' was needed in the moment when feeling overloaded, but also that changing clinical areas and moving to non-clinical work for a period of time could be a more long-term option, and one of the participants in this study did that for herself.

Self-care raises education and development issues for mental health nurses, in particular to keep a balance between work and home. Attending to the basics of life such as eating, rest, sleeping etc was commented on as very important by one participant. However, when both home and work were hectic one participant found that getting time to wind down was impossible and the tension built up.

Burnout is a problem of the social environment in which people work but can occur with any group of patients and not solely through hearing trauma stories from patients as in the case of VT (Canfield, 2005). Participant two identified burnout as a common cause for staff attrition. It may be that the term burnout is used quite generally when in fact clinicians may be experiencing the secondary trauma of VT.

The issue of clinical supervision was remarked on by all participants in this research. White (2006) stresses to managers the importance of the availability of clinical supervision and advocates for a working environment that is accepting of the strong feelings in staff raised in their clinical work and to acknowledge the difficulty inherent within it.

In a small health organization that provides supervision for a number of mental health workers the selection of a supervisor can become problematic. This was especially noted by one of the participants who felt you had to have confidence in the relationship and not turn up to just anyone. Just how free are staff to choose their own supervisor within an organization, is external supervision an option, and if so who funds it?

Supervision may help temper the 'skewed reality' that all participants mentioned in their interviews. Bringing balance to the workplace experience is helpful in ameliorating the signs of stress for nurses. Working with patients we fear may harm or kill themselves raises our limits for tolerating being in a therapeutic relationship.

Balancing against the negative impact of VT on nurses' was the recovery of patients. The experience of patients' recovery supports resilience in the nurse (Collins and Long, 2003;

Hernandez et al., 2007; Hudnall-Stamm, 1999; Pearlman & Saakvitne, 1995).

Limiting contact hours with traumatized patients was found to reduce the likelihood of secondary traumatization (Ortlepp & Friedman, 2002). This reflects the suggestion of two of the participants in this study, who thought that mental health nurses should move around different clinical areas to ameliorate stress build-up.

### *Education and Preparation*

How do we prepare mental health nurses for the possibilities of experiencing a caring induced trauma such as VT? From the interviews the less experienced nurse seemed more vulnerable to VT. Nurses may not pass on enough of their knowledge to prepare mental health nurses for their roles. One of the participants was not sure if it is possible to fully prepare yourself for experiencing VT. She had the experience of trauma then made the links to VT but it was not obvious before. Providing psycho-education for those working with trauma is advocated by Phoenix (2007) as a way of minimizing VT for the helper and mitigating negative consequences for the patient.

Feeling unprepared for the rigours of mental health nursing was raised by all participants in this study. Morrisette (2004) focuses on student nurse preparation, well-being and whether they understand how they might absorb the trauma of their patients. This absorption can stem from the student's perceived inability to alleviate patient distress and result in a protective, emotional numbing and avoidance of thinking about traumatic events. This disempowerment felt by the student nurse parallels that of the traumatized patient.

Nurses who maintained a balanced personal and professional life and were informed about VT are in the best position to navigate trauma work with their patients (Clark & Gioro, 1998). They identified nurse characteristics affecting vulnerability to VT as amount of exposure time to patients with PTSD, level of self-efficacy, personal and professional support and spirituality.

The idea of preventing VT is a complex one if we accept the notion of it being an inevitable and natural consequence of empathic engagement with traumatized people (Figley, 1995; Pearlman & Saakvitne, 1995). Clark and Gioro (1998) think that raising awareness is key in mitigating the effects of indirect trauma. Acknowledging the existence of indirect trauma, its affect on nurses, and ultimately patients, is of primary importance in attenuating its effects.

### *Prevention*

The importance and meaning of trauma work can be spiritually restorative and foster hope for patient and nurse (Clark & Gioro, 1998). Being aware of the danger of VT, but also reminding ourselves of the therapeutic value of exposure to our patients' world and remembering the importance and meaning in working with victims of trauma, can further support our personal resources in this work. Maintaining professional connections is important in valuing ourselves and other working with mental trauma - having a safe environment to talk about intense thoughts and feelings.

There is a duty to inform trauma workers about the hazards of the work and to educate our students and supervisees about VT and that it is an inevitable part of the work, a natural response (Figley, 1995; Pearlman & Saakvitne, 1995). There must be validation, from nursing schools and employers, of the difficulty

of this type of work and encouragement for ongoing discussion of its effects. Canfield (2005) states that when prevention strategies are in place the negative cognitive changes of VT occur less frequently. The Bennett-Baker study (as cited in Canfield, 2005) identified resiliency as a protective factor against VT. Emergent themes from that study were: “VT was a normal reaction to trauma therapy; VT will change the therapist [nurse] both as a person and as a therapist [nurse]; therapists [nurses] gain a new awareness of the preciousness of relationships; as treatment continues therapists [nurses] learn to transform their VT into healing experiences for patients and themselves; and that spirituality is the bridge to healing” (p. 95). Canfield (2005) identifies self-care techniques when working with adult survivors of childhood abuse ranging from debriefing with colleagues, exercise, vacations and engaging with healthy children. She cautions against helpers feeling ‘unshockable’ after hearing repeated trauma stories. This pseudo-immunity is akin to PTSD symptoms of numbing and avoidance.

I agree with Figley (1995) and Pearlman and Saakvitne (1995) that we have an obligation to inform clinicians working in mental health that they are at risk for caring induced traumas. More specifically that if their work continues across time and with different patients who have been traumatized the risk for VT is increased.

In the literature it is evident that those who know of the risks of VT manage its impact on themselves and the patients more constructively. This is supported by the research data gathered in this project. This raises the issue of education of mental health nurses. Part of the emphasis in education needs to be on clinician’s owning their traumatic pasts as this can exacerbate the experience of VT. Clark and Gioro have challenged nursing schools to educate and explore with nursing students the



insidious nature of VT, given that many nurses will work with people who have been victimized. Preparedness is an issue also raised by Kleespies and Dettmer (2000) who doubt that those working with patients in crisis are educated in advance about constructive management and evaluation of patients in crisis.

White (2006) is explicit that managers in health care agencies need to be aware of the hidden costs of caring induced traumas. She notes that if the worker is unable to reflect to the patient a sense of optimism due to feeling hopeless then this will impact on the care that the patient receives. White advocates for raising awareness in educational workshops to arm workers with recognition skills of the negative impact of working with traumatized individuals (p. 345).

### *Education*

Education also rests with nursing schools and should begin at undergraduate level as novice nurses may be susceptible to VT. It is essential that all who choose mental health nursing as a specialty practice are aware of the risks to themselves from their career choice. Education and preparedness for new mental health nurses working with traumatized patients is essential (Clarke, 2008). Skills in training that need to be addressed include enhancing the nurses' resilience, psychological debriefing and assessment of whether students are equipped to deal with trauma, especially if they have a personal history of trauma themselves. Clarke is adamant that to value the mental health patient we must first value ourselves.

Warne and McAndrew (2005) argue for changes in nursing education and practice in respect of abuse and trauma. They suggest that useful strategies could include recognition of the real difficulties and pain that exist in the world we live in. There is

no undoing past traumatic events and the focus should be on the patient accepting their own experiences and the nurse validating them. The authors believe that this approach could balance the distress of trauma and abuse and the distress nurses experience in addressing it. The therapeutic relationship between mental health nurse and patient has a privileged position in being able to offer the patient a proper hearing of their personal story and experiences (Barker, 2001).

Warnings about VT are important but so too are ameliorating strategies of self-care. It is essential that mental health nurses maintain a personal life and engage with healthy people outside of work. Participants in this study identified how ‘all consuming’ the work can be and that the biggest impact of VT for some was loss of social engagement and enjoyment. Looking at ameliorating factors may increase our vision to the possibilities of benefits of trauma work, or VR. This concept incorporates the patient and how they have managed adversity constructively (Hernandez et al., 2007). VR may support mental health nurses working with trauma victims and acknowledge that they are doing an important job assisting patients to recover their health. Ironically, patients may suffer further if nurses do not make themselves aware of the risks for VT. Connection with others, including our patients, is stifled and damaged when we experience VT.

There is a cost to caring and responsibility rests with the employer to provide access to appropriate clinical supervision. There is an onus on the nurse to attend and explore their practice. This is a health and safety issue for nurses and their provision of care. The projection of hope for patients’ recovery often lies with the mental health nursing as the largest professional group in this area. Participants in this study support a teamwork

approach to managing trauma work and this is supported by literature.

McCann and Pearlman (1990, p. 136) state:

Whether these [VT] changes are ultimately destructive to the helper and to the therapeutic process depends, in large part, on the extent to which the therapist is able to engage in a parallel process to that of the victim client, the process of integrating and transforming these experiences of horror and violation.

The ability of nurses to integrate and transform these traumatic experiences may rest on raising awareness of VT as an occupational hazard.

### **Reflections on this research**

The impact that personal interest and commitment may have in colouring research findings is real (Polit & Hungler, 1997, p. 277). Anticipation of results is a potential bias when research aims steer the direction an interview takes. Our own emotions and attitudes and prejudices may interfere with research inferences. These biases cannot be completely eliminated.

My own experiences of VT and burnout are a potential research bias in this project and may have steered research findings in favour of VT. However, I worked to minimize bias through reflective practice activities. My reflective writings helped to clarify my thinking regarding participants' experiences and to separate my own experiences of VT. I have used clinical supervision for exploring any identification I may feel with

participants. Being able to maintain perspective on my own thoughts and feelings has been important to keep findings as free as possible of bias and open to emerging themes. The experiences of being new and inexperienced in mental health nursing which made me vulnerable to VT resonated with me. Whilst experiencing burnout and VT I learnt meditation and put some clinical boundaries in place. Since then I consider that maintaining my own health is a priority. I attend clinical supervision regularly, go to the gym, take time out with family and friends, have holidays, pursue further education and continue to meditate. Mental health nurses are a precious resource and I urge them to care for themselves as well as they care for their patients.

## **Recommendations**

The following are recommendations arrived at through the review of available literature linking mental health nursing with VT, and the data from the in-depth interviews with four mental health nurses. Recommendations include implications for nursing education, clinical support, employer and employee responsibility.

1. **Education:** Mental health nurses must be informed of the risk for experiencing VT through working with traumatized patients. Those who are more informed manage VT better. This education needs to take place at an under-graduate level and in an ongoing way for nurses once trained. Education may incorporate recognition skills for signs of VT, and the bolstering nurses' own strengths and resources through concepts such as vicarious resilience. Clinical supervision and education for nurses already working with trauma is paramount to maintain the workforce. An education

campaign could be supported by Ministry of Health or the New Zealand College of Mental Health Nurses.

2. **Self-care:** Raising awareness and knowledge of VT and its effects should be the first step in ameliorating its impact. Self-care and maintaining a life outside of work provides a restorative balance when working with trauma. Social and personal support networks will help nurses through difficult experiences and VT. Attending to the basics of life such as food, rest and exercise are important to maintaining a balance between work and home life.
3. **Clinical supervision:** Supervisors need to be trained in the identification of caring induced traumas such as VT. Access to appropriate supervision is a clinical imperative in ameliorating the effects of VT on nurses. There needs to be a raised awareness of VT as an occupational health risk for mental health nurses. It carries a risk to the nurse and the patient in terms of care offered by the nurse. For the nursing profession it may contribute to individuals leaving the job.
4. **Research:** Further research is urgently on mental health nurses and their experiences of VT or other caring induced traumas both in New Zealand and globally. Longitudinal studies are recommended looking at links between mental health nursing and VT to capture the long-term costs of this trauma.
5. **Funding:** There are funding implications for supervision, research and education. Support for these recommendations needs to be at a professional and employer level as well as governmental responsibility to fund initiatives.

## **Conclusion**

Mental health nurses are in a unique position to form healing therapeutic relationships. Therapeutic relationships form the foundation of mental health nursing and these therapeutic encounters are valued and wanted by patients. VT affects the nurse's capacity to form these healing relationships. VT brings profound, enduring changes into the life of the nurse that are not easily recognized. It is the insidious nature of VT that makes it a danger to nurses and ultimately the patients nursed by them.

The evidence for VT and other caring induced traumas is mounting and it is no longer acceptable to say 'we didn't know'. We do know of it, we do know of its effects. It is time to do something about it and care for our mental health nurses.

## REFERENCES

- ACC News September 2008, Issue 115. [www.acc.org.nz](http://www.acc.org.nz)
- Adams, V.M. (2007). Laughing it off: Uncovering the everyday work experiences of nurses. *International Journal of Qualitative Methods*, 6 (1) March, 1-26.
- Alty, A. and Rodham, K. (1998). The ouch! factor: Problems in conducting sensitive research. *Qualitative Health Research*, 8, 275-282.
- Asmundson, G., Norton, G.R. and Stein, M. (2002). *Clinical Research in Mental Health. A Practical Guide*. Thousand Oaks, CA: Sage.
- Bailey, P.H., & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of Advanced Nursing*, 38 (6), 584-583.
- Baird, K., & Kracen, A.C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly* June 19(2), 181-188.
- Barker, P. (2001). The tidal model: the lived-experience in person-centred mental health nursing care. *Nursing Philosophy*, 2, 213-223.
- Barker, P. (2001). The tidal model: Developing a person-centred approach to psychiatric and mental health nursing. *Perspectives in Psychiatric Care*, 37 (3), 79-87.
- Barling, J. (2001). Drowning not waving: burnout and mental health nursing. *Contemporary Nurse*, 11, 247-259.
- Beaton, R.D., & Murphy, S.A. (1995). Working with people in crisis: Research implications. In C.R. Figley (Ed), *Compassion fatigue: Coping with secondary traumatic stress disorder*. New York, N.Y., Brunner and Mazel.
- Bennett-Baker, A.A. (1999). *The resilient psychotherapist: An heuristic inquiry into vicarious traumatization*. Dissertation Abstracts International, 60, 1-B, 357. (University Microfilms No. AAM99916976).
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Bride, B.E. (2007). Prevalance of secondary traumatic stress among social workers. *Social Work Jan* 52(1), 63-70.
- Bride, B.E., Jones, J.L., & MacMaster, S.A. (2007). Correlates of secondary traumatic stress in child protective service workers. *Journal of Evidence-Based Social Work*, 4(3-4), 69-80.
- Bride, B.E., Robinson, M.M., Yegidis, B., & Figley, C.R. (2004). Development and

- validation of the secondary traumatic stress scale. *Research on Social Work Practice Jan 14(1)*, 27-35.
- Cameron, D., Kapur, R., & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse-patient relationship. *Journal of Psychiatric and mental health nursing*, 12, 64-74.
- Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work*, Vol. 75 (2), 81-101.
- Chenail, R.J, and Duffy, M. (2007). Locating qualitative research resources online. In: *Nursing Research: A Qualitative Perspective*. Patricia Munhall (Ed.), 569-575. Jones and Bartlett, Sudbury, Massachusetts.
- Cherniss, C. (1995). *Beyond burnout: helping teachers, nurse, therapists, and lawyers recover from stress and disillusionment*. Routledge, New York and London.
- Clandinin, D.J., & Connelly, F.M. (2000). *Narrative inquiry – Experience and story in qualitative research*. Jossey-Bass Publishers, San Francisco.
- Clark, M.L., & Gioro, S. (1998). Nurses, indirect trauma, and prevention. *Journal of Nursing Scholarship*, 30 (1), 85-87.
- Clarke, L., & Flannagan, T. (2003). *Institutional breakdown: Exploring mental health nursing practice in acute inpatient settings*. APS Publishing, Wiltshire.
- Clarke, V. (2008). Working with survivors of trauma. *Mental Health Practice*, April vol. 11 (7), 14-17.
- Crotty, M. (1998). *The foundations of social research*. Australia: Allen & Unwin.
- Crowe, M. (2004). The place of the unconscious in mental health nursing. *International Journal of Mental Health Nursing*, 13, 2-8.
- Collins, S., & Long, A. (2003a). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing*, 10, 77-27.
- Collins, S. & Long, A. (2003b). Working with the psychological effects of trauma: consequences for mental health-care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing*, 10, 417-424.
- Cutcliffe, J.R. (2008). The die has been cast? Rediscovering the essence of psychiatric nursing. *British Journal of Nursing*, vol. 17 (2), 88-92.
- DeSantis, L. & Ugarriza D.N. (2000). The Concept of Theme as Used in



- Qualitative Nursing Research. *Western Journal of Nursing Research*, 22, 351-372.
- Dewey, J. (1938). *Experience and Education*. New York: Collier Books.
- Duffy, M. (2007). Narrative inquiry: The method. In Patricia Munhall (Ed.). *Nursing Research: A qualitative perspective*. Jones and Bartlett, Sudbury, Massachusetts.
- Edwards, K.-L. (2005). The phenomenon of resilience in crisis care mental health clinicians. *International Journal of Mental Health Nursing*, 14, 142-148.
- Ehigie, B.J. & Ehigie, R.I. (2005). Applying qualitative methods in organizations: A note for industrial/organizational psychologists. *The Qualitative Report*, 10 (3), 621-638
- Epstein, S. (1985). The implications of cognitive-experiential self-theory for research in social psychology and personality. *Journal for the Theory of Social Behaviour*, 15, 283-310.
- Evans, A.M. (2005). Patient or Consumer? The colonization of the psychiatric clinic. *International Journal of Mental Health Nursing*, 14, 285-289.
- Evans, A.M. (2007). Transference in the nurse-patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 14, 189-195.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In Charles Figley (Ed). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (1-21). Brunner/Mazel, New York.
- Flick, U. (2006). An introduction to qualitative research. (3<sup>rd</sup> edn.) Sage Publications, London.
- Foster, K., McAllister, M., & O'Brien, L. (2006). Extending the boundaries: Autoethnography as an emergent method in mental health nursing research. *International Journal of Mental Health Nursing*, 15, 44-53.
- Fox, N. (2006). Using Interviews in a Research Project. Trent RDSU. [www.trentrdsu.org.uk](http://www.trentrdsu.org.uk)
- Freud, S. (1915). *The Unconscious*. London: Hogarth Print.
- Gates, D.M., & Gillespie, G.L. (2008). Secondary Traumatic Stress in Nurses Who Care for Traumatized Women. *Journal of Obstetric and Gynaecology Nursing*, 37, 243-249.
- Gillis A., & Jackson, W. (2002). *Research for nurses: Methods and interpretation*. Philadelphia: F.A. Davies Company.

- Gilstrap, D.L. (2007). Phenomenological reduction and emergent design: Complementary methods for leadership narrative interpretation and meta-narrative development. *International Journal of Qualitative Methods*, 6 (1), March, 95-113.
- Gordon, S. (2006). What Do Nurses Really Do? *Topics in Advanced Practice Nursing eJournal*, 6 (1). Retrieved 23/7/06.
- Halton, W. (1994). Some unconscious aspects of organizational life – contributions from psychoanalysis. In Anton Obholzer and Vega Zagier Roberts (Eds) *The Unconscious at Work*. Brunner Routledge, Hove and New York.
- Hargrave, P.A., Scott, K.M., McDowall, J. (2006). To resolve or not to resolve: past trauma and secondary traumatic stress in volunteer crisis workers. *Journal of Trauma Practice* 5(2), 37-55.
- Health Research Council of New Zealand [www.hrc.org.nz](http://www.hrc.org.nz)
- Herman, J.L. (2001). *Trauma and Recovery: from domestic abuse to political terror*. Pandora, London.
- Hernandez, P, Gangsei, D., & Engstrom D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process*, 46(2), 229-241.
- Horsefall, J. Cleary, M., Walter, G., & Hunt, G.E. (2007). Conducting mental health research: Key steps, practicalities, and issues for the early career researcher. *International Journal of Mental Health Nursing*, 16, S1-S20.
- Hudnall-Stamm, B. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. (2<sup>nd</sup> edn). Sidran Press, Lutherville, Maryland.
- Jones, A.C. (2005). Transference, counter-transference and repetition: some implications for nursing practice. *Journal of Clinical Nursing*, 1177-1184.
- Jordan, J., Lynch, U., Moutray, M., O'Hagan, M., Orr, J., Peake, S., et al. (2007). Using focus groups to research sensitive issues: Insights from group interviews on nursing in the Northern Ireland "Troubles". *International Journal of Qualitative Methods*, 6 (4), 1-19.
- Jung, C.J. (1966). *Psychology of the transference: The practice of psychotherapy*. (vol 16 Bollingen series) Princeton University Press, Princeton, N.J.
- Kataoka, Y., Shitaya, E., Kano, N., Ohtake. (2004). Nursing care of female victims of sexual assault and violence – a hospital-based questionnaire survey. *Journal of St. Luke's Society for Nursing Research Jun* 8(1), 1-10.
- Kelly, T., & Howie, L. (2007). Working with stories in nursing research: Procedures used in narrative analysis. *International Journal of Mental Health*

*Nursing, 16, 136-144.*

- Kleespies, P.M., & Dettmer, E.L. (2000). The stress of patient emergencies for the clinician: Incidence, impact, and means of coping. *Journal of Clinical Psychology, Vol. 56 (10)*, 1353-1369.
- Kleespies, P.M., Penk, W., & Forsyth, J. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 24(3)*, 293-303.
- Little, S. (2002). *An Exploration of Vicarious Traumatization in Emergency Nurses*. Masters Thesis, Victoria University of Wellington.
- Maslach, C. , Jackson, S.E., & Leiter, M.P. (1996). *The Maslach Burnout Inventory* (3<sup>rd</sup> ed). Palo Alto, CA: Consulting Psychologists Press.
- McCann, L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3(1)*, 131-149.
- McCann, L., & Pearlman, L.A. (1990a). Vicarious traumatization: A contextual model for understanding the effects of trauma on helpers. *Journal of Traumatic Stress, 3(1)*, 131-149.
- McCann, L., & Pearlman, L.A. (1990b). *Psychological trauma and the adult survivor. Theory, therapy, and transformation*. New York. Brunner/Mazel.
- MacGibbon, E.A. (2004). Reformulating the nature of stress in nurses' work in pediatric intensive care: An institutional ethnography. University of Toronto (Canada), Ph.D. (361p) (doctoral dissertation – research).
- Minichiello, V., Aroni, R., and Hays, T. (2008). *In-depth interviewing: principles, techniques, analysis*. (3<sup>rd</sup> ed). Pearson Education Australia.
- Morse, J.M. & Field, P.A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.
- Morse, J.M., & Mitcham, C. (2002). Exploring qualitatively-derived concepts: Inductive-deductive pitfalls. *International Journal of Qualitative Methods, 1 (4)*, 1-18.
- Morse, J.M. (2007). Strategies of intra-project sampling (529-539). In: *Nursing Research: A Qualitative Perspective*. In Patricia Munhall (Ed.). Jones and Bartlett, Sudbury, Massachusetts.
- Morrisette, P.J. (2004). Promoting psychiatric student nurse well-being. *Journal of Psychiatric and Mental Health Nursing, 11*, 534-540.
- Munhall, P.L. (2007). Ethical Considerations in Qualitative Research. In: *Nursing Research: A Qualitative Perspective*. In Patricia Munhall (Ed.). Jones and

Bartlett, Sudbury, Massachusetts.

- Munroe, J.F., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimmering, R. (1995). Preventing compassion fatigue: A team treatment model. In C.R. Figley (Ed). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (209-231). New York: Brunner/Mazel.
- O'Brien, A.J. (1999). Negotiating the therapeutic relationship: Mental health nurses perceptions of their practice. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 153-161.
- O'Brien, A.J. (2001). The Therapeutic relationship: historical development and contemporary significance. *Journal of Psychiatric and Mental Health Nursing*, 8, 129-137.
- Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in workplace lay trauma counselors. *Journal of Traumatic Stress*, 15 (3), 213-222.
- Pearlman, L.A. (1998). Trauma and the Self: A Theoretical and Clinical Perspective. *Journal of Emotional Abuse*, vol (1), 7-24.
- Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. W.W. Norton & Co., New York and London.
- Peplau, H. (1952). *Interpersonal Relations in Nursing. A conceptual frame of reference for psychodynamic nursing*. G.P. Putnam's Sons, New York.
- Phoenix, B.J. (2007). Psychoeducation for Survivors of Trauma. *Perspectives in Psychiatric care*, 43 (3), 123-131.
- Polit, D.E., & Hungler, B.P. (1997). *Nursing research: Methods, appraisal, and utilization* (4<sup>th</sup> edn). Lippincott, Philadelphia and New York.
- Polit, D.E., & Beck, C. (2004). *Nursing research: Principles and methods* (7<sup>th</sup> ed.). Philadelphia: Lippincott Williams & Wilkins.
- Riessman, C.K. (1993). *Narrative Analysis*. Qualitative Research Methods Vol. 60. Sage Publications.
- Roberts, K., & Taylor, B. (1998). *Nursing research process: An Australian perspective*. Melbourne: International Thomas.
- Rowland-Klein, D., & Dunlop, R. (1998). The transmission of trauma across generations: identification with parental trauma in children of Holocaust survivors. *Australian & New Zealand Journal of Psychiatry Jun* 32(3), 358-369.

- Rydon, S.E. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health services. *International Journal of Mental Health Nursing*, 14, 78-87.
- Sabo, R.M. (2006). Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work? *International Journal of Nursing Practice*, 12, 136-142.
- Segal, J. (2004). *Melanie Klein*. (2<sup>nd</sup> ed.). Sage Publications, London.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8 (3), 27-37.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16 (2), 1-8.
- Sandelowski, M., & Barosso, J. (2003) Classifying the Findings in Qualitative Studies. *Qual Health Res*, 13, 905-923.
- Shattell, M.M., Starr, S.S., & Thomas, S.P. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, 16, 274-284.
- Silverstein, C.M. (2006). Therapeutic Interpersonal Interactions: The Sacrificial Lamb? *Perspectives in Psychiatric Care*, vol. 42 (1), 33-41.
- Simon, C.E., Pryce, J.G., Roff, L.L., & Klemmack, D. (2005). Secondary traumatic stress and oncology social work: protecting compassion from fatigue and compromising the worker's worldview. *Journal of Psychosocial Oncology* 23(4), 1-14.
- Suvak, M., Maguen, S., Litz, B.T., Silver, R.C., & Holman, E.A. (2008). Indirect exposure to the September 11 terrorist attacks: does symptom structure resemble PTSD? *Journal of Traumatic Stress*, 21 (1), 30-39.
- Taylor, B., & Barling, J. (2004). Identifying sources and effects of carer fatigue and burnout for mental health nurses: a qualitative approach. *International Journal of Mental Health Nursing*, 13, 117-125.
- Ting, L., Jacobson, J.M., Sanders, S., Bride, B.E., & Harrington, D. (2005). The secondary traumatic stress scale (STSS) confirmatory factor analyses with a national sample of mental health social workers. *Journal of Human Behaviour in the Social Environment* 11(3/4), 177-194.
- Ting, L., Sanders, S., Jacobson, J.M., Power, J.R. (2006). Dealing with the aftermath: a qualitative analysis of mental health social workers' reactions after a client suicide. *Social Work Oct.* 51(4), 329-341.
- Tomey, A.M., & Alligood, M.R. (2002). *Nursing theorists and their work*. (5<sup>th</sup> Ed). Mosby.

- Townsend, S.M. (2005). Organizational correlates of secondary traumatic stress and burnout among sexual assault nurse examiners. University of Illinois at Chicago Ph.D. (152p) (doctoral dissertation – research).
- Warelow, P., & Edward, K. (2007) . Caring as a resilient practice in mental health nursing. *International Journal of Mental Health Nursing*, 16, 132-135.
- Warne, T., & McAndrew, S. (2005). The shackles of abuse: unprepared to work at the edges of reason. *Journal of Psychiatric and Mental Health Nursing*, 12, 679-686.
- Welch, M. (2005) Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing*, 14, 161-165.
- White, D. (2006). The hidden costs of caring: What managers need to know. *The Health Care Manager*, Vol 25 (4), 341-347.
- Winnicott, D.W. (1965). *The maturational process and the facilitating environment: Studies in the theory of emotional development*. New York: International Universities Press.
- Woodward, L.E., murrell, S.A., Bettler, R.F. (2005). Empathy and interpersonal style: a mediational ;model of secondary traumatic stress symptomatology following 9/11. *Journal of Aggression, Maltreatment & Trauma* 11(4), 1-27.
- Yalom, I.D. (1980). *Existential psychotherapy*. New York: Basic Books.



## Appendix F: Interview questions

### **Vicarious Traumatization: The Impact of Nursing Upon Nurses** **Masters Thesis by Lesley Davies**

#### Introduction

Before the interview starts I should like to gather some descriptive demographics of participants for the thesis which will be used as group data and are not identifying. They include age, gender, culture/ethnicity, qualification and where gained (hospital based training or polytechnic education) and length and type of mental health nursing experience.

I will introduce myself and talk about my area of interest and this project. I am a registered comprehensive nurse with twelve years experience working in the mental health area – mostly at Ashburn Clinic with a brief period at 1a, ODHB. I have a Postgraduate Certificate in Mental Health (Clinical) and now I am currently working towards completion of my Master of Nursing (Clinical).

My interest in the area of caring induced trauma was sparked by reviewing the Maslach Burnout Inventory. This is a tool developed by Christina Maslach (a former nurse) to measure the experiences of those working in helping professions and assessing its deleterious effects on those workers. Literature searches I conducted revealed the term vicarious traumatization (VT) and its links with burnout. I have been personally able to identify with both of these terms but only in retrospect – at the time I did not know there was a name for what I was experiencing. It is for these reasons my journey began with VT and burnout. My area of interest is caring induced trauma and in particular VT. The aims of this study are to ascertain whether nurses are familiar with the term VT and what their experiences are of this, and how they cope with it.

#### **Questions**

Can you tell me about yourself, your practice and nursing experience? What do you know about VT? Have you heard of VT? When were you first aware of the term VT or caring induced trauma?

Are you able to recall experiences similar to this?

Do you think you are affected by your work as a mental health nurse?

Can you recall an encounter where you were exposed to a situation that made you feel like that?

What was that like for you?

Do you ever talk with anyone about these feelings?

Do you think it is ok to talk about these feelings?

Do you think it is having an impact on you?

What do you think makes you vulnerable to VT?

How many of your patients might have a history of trauma (psychological/physical)?

After a 'hard day' how do you wind-down? Do you try not to think about it? Talk about it with other colleagues? Your clinical supervisor?



## ***Otepoti Consultancy***

### **Treaty of Waitangi Compliance Service**

2 March 2009

Hine Forsyth  
31 Orbell Street  
Dunedin  
Phone (03) 4730015  
Email [hine@earthlight.co.nz](mailto:hine@earthlight.co.nz)

Lesley Davies  
Ashburn Clinic  
Private Bag  
Dunedin

To whom it may concern

This is a letter of confirmation for Lesley Davies.

As the mandated local Runanga Representative and cultural advisor to Ashburn Clinic I met with Lesley last year to look at her work from a Ngai Tau and Maori perspective.

Her research was with local Mental Health Workers on "Vicarious traumatization"

We went through her research and I am pleased to have been asked to provide this letter of support.

Should you require any further information please do not hesitate in contacting me.

Hoei ano

Hine Forsyth



**MEMORANDUM**

Phone 04-463 5676  
Fax 04-463 5209  
Email [Allison.kirkman@vuw.ac.nz](mailto:Allison.kirkman@vuw.ac.nz)

TO	Lesley Davies
COPY TO	Thelma Puckey, Supervisor
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee
DATE	August 8, 2008
PAGES	1
SUBJECT	<b>Ethics Approval: No 15746, Vicarious traumatization: the impact of nursing upon nurses.</b>

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 30 June 2009. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman  
Convener



## Appendix C: Informed Consent Form

### **Vicarious Traumatization: The Impact of Nursing Upon Nurses**

Masters Thesis by Lesley Davies

Mental Health Nursing Research

Victoria University of Wellington

I have read the Information Sheet and had the details of the research explained to me. My questions have been answered to my satisfaction, and I understand I may ask further questions at any time. I understand that the length of the interview is approx. 60 minutes and agree to my interview being audiotaped for the purpose of the research project. I understand that this project has been approved by the Human Ethics Committee at Victoria University of Wellington.

I understand I have the right to:

- Decline to answer any particular question
- Withdraw from the project at any time up to the analysis phase of the project  
Which will be at least two weeks after my interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that my name will not be used and any other identifying data will be removed and pseudonyms used
- Provide information on the understanding that identifying features of clients/colleagues and place of work be removed
- Be given a summary of the research findings
- Ask for the audiotape to be turned off at any time during the interview

I would/would not like a summary of the research findings at the completion of the project.

I have read the Information Sheet and agree to participate in this study as outlined in the Information Sheet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name (printed): \_\_\_\_\_



## **Appendix B: Information for Participants**

### **Vicarious Traumatization: The impact of Nursing upon Nurses**

Masters Thesis by Lesley Davies

I am a mental health nurse working at The Ashburn Clinic and am currently doing a research project towards completion of my Master of Nursing (Clinical) at the Graduate School of Nursing, Midwifery and Health at Victoria University of Wellington (VUW). I work at The Ashburn Clinic and my area of interest is the experiences of mental health nurses who work with patients who have been traumatized.

For my project I wish to explore mental health nurses' stories and experiences of vicarious traumatization (VT). VT is a caring induced trauma an umbrella term to describe the responses/feelings clinicians may have in relation to working with patients who have been traumatized. VT describes a transformative process that nurses/clinicians may experience through engaging empathically with patients and their trauma experience. The relationship between nurse and patient is a key factor in recovery and maintenance of hope. The close and personal nature of this relationship can expose the nurse to developing VT due to a continued exposure to the patients' trauma stories. Researchers in the VT area explain that we all have our own individual view of the world, our place in it and that of others, and also of its benignness or otherwise. How do we as nurses integrate the patients suffering into these personal fields? How do we care for ourselves in this process?

Experiences of this type of trauma can be isolating and have long-lasting effects for the nurse and their families, their colleagues and ultimately the patient. In this research I wish to explore mental health nurses' stories and experiences of caring-induced trauma. I will conduct semi-structured interviews of mental health nurses working in local mental health services. The interviews will be audiotaped and transcribed lasting for approximately 60 minutes. Participants will be registered nurses who are New Zealand trained/educated with at least two years registration experience.

I am aiming to publish the research findings into a journal and anticipate presentation, in some form, at conferences. Participants in this study will remain confidential and identifying details removed and pseudonyms used. Participants will have the right of withdrawal from the project at any time. This project has been approved by the Human Ethics Committee at VUW. Please feel free to contact me should you have any further enquiries.

Lesley Davies  
Private Cell 021-162-8374  
e.mail: [lesleyd@ashburn.co.nz](mailto:lesleyd@ashburn.co.nz)  
or [r.davies@clear.net.nz](mailto:r.davies@clear.net.nz)

Thelma Puckey

[Thelma.puckey@vuw.ac.nz](mailto:Thelma.puckey@vuw.ac.nz)



## **Appendix A: Recruitment Flyer**

### **Vicarious Traumatization: The impact of Nursing upon Nurses**

Masters Thesis by Lesley Davies


I am currently doing a research project towards completion of my Master of Nursing (Clinical) at the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington (VUW). I am a mental health nurse working at The Ashburn Clinic and my area of interest is the experiences of mental health nurses who work with patients who have been traumatized.

For my project I wish to explore mental health nurses' stories and experiences of vicarious traumatization (VT). VT is a type of caring induced trauma, an umbrella term used to describe the responses/feelings clinicians may have in relation to working with patients who have been traumatized. Vicarious traumatization is a transformative process that nurses/clinicians may experience through engaging empathically with patients and their trauma experience. The relationship between nurse and patient is a key factor in recovery and maintenance of hope. The close and personal nature of this relationship can expose the nurse to developing VT due to a continued exposure to the patients' trauma stories.

I am seeking mental health nurses who are New Zealand trained/educated with at least two years registration experience currently working in local mental health services at to participate in my research. This involves a semi-structured interview which will be audiotaped and transcribed.

The project has the approval of the Human Ethics Committee at VUW and participants' confidentiality is assured, any identifying details will be removed and pseudonyms used. Participation is voluntary, with a participant information sheet and a consent form provided. It involves an interview at a time and place convenient to the participant.

If you are interested or would like more information please contact me by e.mail or telephone. If you have any queries about my project please contact me or my supervisor, Thelma Puckey. Contact details are below.



Lesley Davies  
Private Cell 021-162-8374  
e.mail: [lesleyd@ashburn.co.nz](mailto:lesleyd@ashburn.co.nz)  
or [r.davies@clear.net.nz](mailto:r.davies@clear.net.nz)

Thelma Puckey

[Thelma.puckey@vuw.ac.nz](mailto:Thelma.puckey@vuw.ac.nz)