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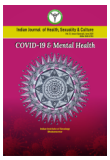

Commentary

Interventions for the management of vicarious trauma among mental health professionals during COVID-19

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Abstract

'Caring comes with a cost' is a phrase often used to describe the state of helping professionals. Experiences of vicarious trauma are commonly seen in various helping professionals, such as doctors, nurses, psychologists, social workers, lawyers, police, teachers, and public health workers, among many other helping professions. Vicarious trauma, also known as secondary trauma, by definition, is described as indirect exposure to a traumatic event through a first-hand account or narrative of that event. The outbreak of COVID-19 impacted the psychological and emotional well-being of the global community as a whole; apart from the fatal risk it posed to the physical health of many, it has impacted mental health professionals working in the frontline adversely. They are exposing themselves to people experiencing trauma, which impacts their emotional and mental health. This commentary focuses on the experience of vicarious trauma among mental health professionals and discusses targeted interventions to manage the traumatic experiences and implications for research and practice.

Keywords: Vicarious trauma, Mental health professionals, Interventions, COVID-19.

Introduction

Vicarious trauma (VT), also known as secondary trauma, is defined as indirect exposure to a traumatic event (Branson, 2019). VT experienced by mental health professionals resulting from empathic engagement with traumatized clients and their account of traumatic experiences. Vicarious trauma is an experience that has a long-lasting impact on the way how a clinician holds personal beliefs and their world view. The terminology 'vicarious trauma' was coined by Karen Saakvitne and Laurie Anne Pearlman (1995), who defined VT as 'the profound shift in world view that helps professionals when they work with individuals who have experienced trauma'. The term is also referred to as 'secondary traumatic stress (STS)' (Stamm, 2010),

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'secondary victimization' (Figley, 1982), or 'secondary traumatization' (ACA, 2018). The term 'compassion fatigue (CF) is also used to substitute VT. Vicarious trauma is experienced by helping professionals such as psychologists, lawyers, doctors, police officers, nurses, public health workers, social workers, teachers, among many others (APA, 2020).

VT's concept is closely associated with the phenomenon of burnout (Joshi & Sharma, 2020). Maslach defines burnout as a persistent state of exhaustion, cynicism, and inefficacy resulting from work-related stress (Maslach et al., 2001). It is inevitable that the world's fundamental beliefs held by helping professionals get altered due to working with individuals experiencing trauma regularly.

Vicarious trauma in mental health professionals

The study of vicarious trauma among mental health professionals meets a stopgap with maximum empirical evidence available among the nurse population. Individual theorists like Figley (1995), McCann and Pearlman (1990), and Stamm (1995) are pioneering contributors to the phenomena of secondary traumatization among mental health providers (Richards, 2014), however corroborative data and empirical literature is still nascent.

Mental health professionals are also exposed to secondary trauma by providing services to clients who share their trauma experiences (Baum, 2015). Mental health professionals working with populations subjected to trauma (marital conflicts, domestic violence, sexual abuse, military atrocity) are highly prone to develop secondary traumatic stress (Bride, 2004). While exposure to trauma is a natural consequence of providing mental health services, researchers have reported repeated exposure to secondary trauma increases the likelihood of secondary traumatic stress (Meadors et al., 2010; Baciu & Vîrga, 2018).

The prevalence of vicarious trauma is estimated between 19%-85% of helping professionals globally (Mathieu, 2012; Cieslak et al., 2013). Further, research has revealed that 10%-20% of health professionals also escalate to develop posttraumatic stress disorder (Yuan et al., 2021), though the exact prevalence of PTSD among mental health professionals remains understudied. However, the nature of the work of mental health professionals obviates the predisposition to the same. This is supported by DSM-5 (APA, 2013), which indicates that "experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" can be considered as potentially traumatic events. VT is also affected by the nature of emotional support available for the helping professions, the profession's risk, resilience among professionals, and the professional's self-care practices (Jordan, 2010).

Mental health professionals work with individuals who have experienced trauma (for instance, abuse, violence, assault, grief/bereavement, loss, trafficking, military combat, natural disasters, and terrorism) and thus are at specific risk of developing vicarious trauma. VT's development is eventual through repeated exposure and empathic engagement with patients' traumatic experiences, which is a core responsibility of their job (Kim, 2021). Pandemics are known to be experiences of collective trauma that affect everyone at a physical, emotional, biological, spiritual, and societal level- inducing overhauling changes as people adapt to systemic changes due to changing the fabric of communities. With COVID-19 being a traumatic stressor (Bridgland et al., 2021), the mental health burden grew more than 50%, experiences of trauma accelerated and further exacerbated

the experience of VT among mental health professionals. Coping with coronavirus disease is an important risk factor for healthcare workers' mental health distress (Vagni et al., 2020).

Impact of vicarious trauma

The impact of vicarious trauma among mental health professionals can be seen at multiple levels; however, the experience varies subjectively from professional to professional. The effects of vicarious trauma fall into the following five categories hampering functioning levels (Pearlman & Saakvitne, 1995);

- The emotional function can include feelings of grief, anxiety, irritability, anger, or sadness. Becoming distracted frequently, experiencing mood changes, increased feelings of being unsafe, and a reduced sense of humor are also reported.
- The behavioral function might include isolation, altered sleeping and eating patterns, agitation, and increased consumption of alcohol /substances. The chances of engaging in risky behaviors, avoiding people or important tasks may also surface along with an imbalance in work-life.
- A physiological function can appear in the various symptoms such as mild to moderate headaches, acidity, bloating, acne or rashes, ulcers, or heartburn, among others that affect the individual's physical well-being.
- Cognitive function may comprise the individual showing cynicism and negativity, difficulty concentrating, remembering, paying attention, and making routine diurnal decisions. A helping professional may find it challenging to disengage from work, and they may keep thinking about the trauma they experienced by patients under their care.
- Spiritual function encompasses hopelessness, a decreased sense of purpose/meaning, and feeling disconnected from others and the world, in general. Individuals are sometimes also likely to feel that they are unworthy of love.

Addressing VT among mental health professionals in low and middle-income countries

Vicarious trauma is a normatively expected response considering the nature of mental healthcare providers who work with traumatized people (Figley, 1995; Molnar et al., 2017). However, it is also true that these symptoms have the potential to result in a broad range of cognitive, emotional, and behavioral changes for mental health professionals (Bercier and Maynard, 2015). Gravely, service quality, decision making, judgment, and the ability to provide care also get hampered due to experiencing VT (Branson, 2019). Despite the alarming problem with VT, information is scarce concerning the development and implementation of VT interventions for mental health professionals. There has been a dearth of research literature in studying trauma-based intervention in addressing vicarious trauma among mental health professionals. The following section identifies interventions to address trauma (formulated in developed countries) that can be reasonably adopted by low-and-middle-income countries (LMICs) where there are a wider treatment gap and a paucity of mental health professionals trained in trauma.

Research so far shows that VT interventions can be divided broadly into four categories: psychoeducation, mindfulness intervention, art and recreational programs, and alternative

medicine therapy. A recent systematic review has delineated that apart from the above-mentioned trauma interventions, group psychological debriefings to self-help programs, structured workshops, and in-person and online training have been deployed to address STS among mental health professionals. However, psychoeducation and mindfulness continue to be the most prescribed means of addressing VT/STS. The majority of studies have adopted quantitative research or quantitatively focused mixed-method designs. Research outcomes reveal that though all the 4 VT interventions used so far are promising and helped address vicarious trauma's primary symptoms, they have not shown to be effective in their outcomes (Klein et al., 2017).

The following is a summary of existing efficacious interventions for addressing STS among mental health professionals:

1. **Health promotion and wellness:** The majority of the focus has remained on this aspect of care for STS. The oft-deployed techniques within this umbrella include supportive, self-directed, and non-therapeutic approaches in addressing STS from both standpoints, that of prevention and intervention for those displaying symptomatology. These self-care approaches include various techniques such as yoga, meditation, relaxation, physical activity, achieving parity between work and life, and attention to balanced eating, among others. This approach also helps negate the empathic engagement with persons with high stress/trauma symptoms. This approach is preventive.

2. **Clinician Experience and Reducing Trauma (CE-CERT):** CE-CERT is a clinical model that draws its core components from evidence-based trauma treatment. It proposes the clinician use these skills during treatment to address and maintain regulation of their emotions and modulate reactions to secondary traumatic experiences. The nature of these skills is rooted in emotional and cognitive regulation. It also encompasses building a healthier and affirmative narrative and allowing relaxation to occur, which is conducive to parasympathetic recovery. Experiential engagement and reduction of emotional labor are also parts of the training. (Miller and Sprang, 2016).

3. **Accelerated Recovery Programme (ARP):** ARP is a 5-step model for treating STS that involves developing resilience, self-management and self-care, interpersonal connections with others, acquiring skills of professional mastery, and healthy conflict resolution (internal and external). This paradigm of care is criticized for the inability to directly target symptoms of primary traumatic stress symptoms. The efficacy of ARP remains unstudied.

4. **Mindfulness:** Mindfulness-based stress reduction (MBSR) is one of the specific mindfulness-based interventions that are evidence-based and increasingly recommended to prevent and address STS (Thieleman and Cacciatore, 2014). Mindfulness interventions to address VT have also been carried out but with several variations in program components. There are interventions such as meditation, yoga, and body movement. Some programs also have psychoeducation as a component (Kim et al., 2021). Though proven, the efficacy of mindfulness has proven that the multiple methods of study pose a challenge in generalizing its outcomes.

5. **Professional skills training:** There is evidence supporting this model of care that suggests that individuals engaging in

evidence-based practice to address traumatic stress conditions had lower levels of STS. This training is two-fold, working on the preventive and treatment level for STS. The research literature reveals that self-efficacy results from a moderated relationship between appraising stress and maintaining the professional quality of life (including STS) (Prati et al., 2010). Thus, professional skills training embarks upon the concept of 'training as treatment' as the core of helping individuals understand and competently identify their own STS to better deal with it.

6 **Critical Incident Stress Management (CISM):** Multifarious disciplines insinuate CISM as an approach to prevent posttraumatic stress symptoms in the aftermath of a critical event. It is a group intervention with a significant component involving psychological debriefing among the group members as part of the seven-step psychotherapy process. Also, it has an education-based model (Tuckey and Scott, 2014). The studies on CISM have shown inconsistent results and thus, need more empirical support.

7. **Others:** Several interventions, primarily developed for the crisis and trauma fields, such as crisis intervention, crisis/stress debriefing, and psychological debriefing, have also been used to address CF, STS, and VT symptoms.

Implications for research and practice

There are diverse interventions that ameliorate trauma, from psychological first aid to therapies such as cognitive behavioral therapy, eye movement desensitized reprocessing (EMDR), and critical incident stress debriefing (CISD); however, none of them have been studied with addressing the VT experiences of mental health professionals. There is a minimal research-oriented outcome to support the efficacy of the interventions being developed or adapted for treating CF, STS, or VT with mental health professionals. Inadvertently, this calls for greater attention to the phenomenon of vicarious trauma and the consequential addressal of the same. A literature review done in 2015, had demonstrated a shortage of trauma-informed interventions for secondary traumatic stress (Bercier and Maynard, 2015). They examined 4,000 citations and 159 full-text reports but found none of the studies to meet the inclusion criteria for interventions to reduce the adverse effects of STS for mental health professionals.

The present status of literature brings to question why the lack of trauma-based interventions wielded to address VT among mental health professionals, having known the potential risk for PTSD. This also raises a question about the potential efficacy of trauma-based interventions that can plausibly reduce the burden of PTSD among mental health professionals. There is a need for accelerated research to address the gap of trauma-based interventions to address vicarious trauma among mental health professionals. This holds a promising future for mental health professionals, which is conducive to building resilience and preventing burnout while providing mental health care to those in need. The LMICs are to further benefit from the introduction of trauma-based interventions to address vicarious trauma given that the existing treatment gaps are significant, which have only further exacerbated with the pandemic around for a year now. Mechanisms to address vicarious trauma among mental health professionals is a step towards addressing the treatment gap at large, ensuring good health for our existing mental health professionals and greater resilience in dealing with situations like the current

pandemic, which has given rise to a mental health pandemic in consequence.

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References

American Counselling Association. (2018). Vicarious trauma, American Counselling Association, < https://www.counseling. org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf> [Last accessed on March 15, 2021]

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.

American Psychological Association. (2020). APA Dictionary of Psychology, American Psychological Association. https:// dictionary. apa.org/helping-professions [Last accessed on March 23, 2021]

Baciu, L. and Virga, D. (2018). The Prevalence of Secondary Traumatic Stress among Romanian Social Workers: A Replication Study. Social Work Review/Revista de Asistenta Sociala, 14(3): 151-164.

Baum, N. (2016). Secondary traumatization in mental health professionals: A systematic review of gender findings. Trauma, Violence, & Abuse, 17(2), 221-235.

Bercier, M.L. and Maynard, B.R. (2015). Interventions for secondary traumatic stress with mental health workers: A systematic review. Research on Social Work Practice, 25(1), 81-89.

Branson, D.C. (2019). Vicarious trauma, themes in research, and terminology: A review of literature. Traumatology, 25(1), .2.

Bride, B.E. (2004). The impact of providing psychosocial services to traumatized populations. Stress, Trauma, and Crisis, 7(1), 29-46.

Bridgland, V.M., Moeck, E.K., Green, D.M., Swain, T.L., Nayda, D.M., Matson, L.A., Hutchison, N.P. and Takarangi, M.K. (2021). Why the COVID-19 pandemic is a traumatic stressor. PloS one, 16(1), e0240146.

Cieslak, R., Anderson, V., Bock, J., Moore, B.A., Peterson, A.L. and Benight, C.C. (2013). Secondary traumatic stress among mental health providers working with the military: Prevalence and its work-and exposure-related correlates. The Journal of nervous and mental disease, 201(11), 917.

Figley, C.R. ed. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (No. 23). Psychology Press.

Hopkins, M. and Goss, S. (2013). The compassion fatigue workbook: creative tools for transforming compassion fatigue and vicarious traumatisation. British Journal of Guidance and Counselling, 41(3), 341-343.

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. Journal of Family Psychotherapy, 21(4), 225-237.

Joshi, G. and Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. Asian journal of psychiatry, 54, 102300

Kim, J., Chesworth, B., Franchino-Olsen, H. and Macy, R.J. (2021). A scoping review of vicarious trauma interventions for service providers working with people who have experienced traumatic events. Trauma, Violence, & Abuse, p.1524838021991310.

Klein, C.J., Riggenbach-Hays, J.J., Sollenberger, L.M., Harney, D.M. and McGarvey, J.S. (2018). Quality of life and compassion satisfaction in clinicians: a pilot intervention study for reducing compassion fatigue. American Journal of Hospice and Palliative Medicine, 35(6), 882-888.

Maslach, C., Schaufeli, W.B. and Leiter, M.P. (2001). Job burnout. Annual review of psychology, 52(1), 397-422.

Meadors, P., Lamson, A., Swanson, M., White, M. and Sira, N. (2010). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. OMEGA-Journal of Death and Dying, 60(2), 103-128.

Miller, B. and Sprang, G. (2017). A components-based practice and supervision model for reducing compassion fatigue by affecting clinician experience. Traumatology, 23(2), 153.

Molnar, B.E., Sprang, G., Killian, K.D., Gottfried, R., Emery, V. and Bride, B.E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. Traumatology, 23(2), 129.

Pearlman, L.A. and Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized, 23, 150-177.

Prati, G., Pietrantoni, L. and Cicognani, E. (2010). Self-efficacy moderates the relationship between stress appraisal and quality of life among rescue workers. Anxiety, Stress, & Coping, 23(4), 463-470.

Richards N. (2014). Vicarious Trauma: Research and History. Reunion, 2, 1-3.

Stamm, B. (1995). Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators. The Sidran Press.

Thieleman, K. and Cacciatore, J. (2014). Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. Social work, 59(1), 34-41.

Tuckey, M.R. and Scott, J.E. (2014). Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial. Anxiety, Stress & Coping, 27(1), 38-54.

Vagni, M., Maiorano, T., Giostra, V. and Pajardi, D. (2020). Coping with COVID-19: emergency stress, secondary trauma and self-efficacy in healthcare and emergency workers in Italy. Frontiers in Psychology, 11.

Yuan, K., Gong, Y.M., Liu, L., Sun, Y.K., Tian, S.S., Wang, Y.J., Zhong, Y., Zhang, A.Y., Su, S.Z., Liu, X.X. and Zhang, Y.X. (2021). Prevalence of posttraumatic stress disorder after infectious disease pandemics in the twenty-first century, including COVID-19: a meta-analysis and systematic review. Molecular Psychiatry, 1-17.