VICARIOUS TRAUMATIZATION: RELEVANCE AND IMPLICATIONS FOR PSYCHIATRIC MENTAL HEALTH NURSING.

by

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ABSTRACT

This research project is concerned with the risk of vicarious traumatization for psychiatric mental health nurses. Vicarious traumatization is an occupational hazard that is largely unrecognised and unaddressed in the profession. The paper explores the nature of vicarious traumatization, and its contemporary conceptualisation in the literature on helping-induced trauma. Findings from the literature search and understanding of the construct of vicarious traumatization are considered against the essence of psychiatric mental health nursing, the therapeutic relationship and use of self, and the nature of daily practice. After consideration of the potential risk of vicarious traumatization for the profession it is argued vicarious traumatization is a real risk and is likely to impact on all areas of psychiatric mental health nursing practice. Support for the position that vicarious traumatization is not well recognised and understood is offered. The paper concludes with recommendations that psychiatric mental health nurses and the profession take serious note of vicarious traumatization as a risk, and there is an ethical imperative for psychiatric mental health nurses to take measures to inform themselves of and engage in processes of risk management for nurses and clients.

ACKNOWLEDGEMENTS

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VICARIOUS TRAUMATIZATION: AN OCCUPATIONAL HAZARD?

Psychiatric mental health nurses and their clients are at risk of permanent damage from vicarious traumatisation. However, this hazard remains largely unrecognised and unaddressed within the profession. Vicarious traumatization is the deleterious effects on the health professional, working in trauma therapy that result from empathic engagement with trauma survivors and their trauma material. Psychiatric mental health nurses come into contact with trauma on a daily basis but without much awareness of the risk of helping-induced trauma. This paper identifies the basis of vicarious traumatization and its relevance to psychiatric mental health nursing, and that there is little recognition of this as an occupational hazard. It also examines the potential effects of vicarious traumatization and the implications for clients, nurses, and service providers.

My interest in vicarious traumatization arose through my longstanding concern that psychiatric mental health nurses in New Zealand have not given enough attention to their self-care as clinicians. In psychiatric mental health nursing a primary tool is the therapeutic use of self; and to remain effective as a clinician this requires constant attention to self-care. I believe that self-care is valuing oneself as a nurse and this includes attending to occupational hazards such as the negative effects of the therapeutic use of self, stress-related issues, and burnout. In my opinion, self-care as a nurse correlates to providing the best possible nursing care to clients. After more than twenty-five years of nursing my view is that vicarious traumatization should be recognised in psychiatric mental health nursing. Lack of knowledge and understanding of vicarious traumatization is potentially very harmful; and I hold the view that already vicarious traumatization has had significant implications for nurses and clients in mental health services. This paper is my contribution to raising awareness of the risk of helping-induced trauma in psychiatric mental health nursing.

There are a number of factors as to why and how vicarious traumatization can occur in psychiatric mental health nursing. Key factors include exposure to trauma, therapeutic use of self, client characteristics, and work context. In daily practice psychiatric mental health nurses often find themselves in the position of listening to unpleasant details of horrific incidents involving the clients with whom they work. These unpleasant details are often of trauma, where the client was a victim, witness or perpetrator. Psychiatric

mental health nurses are likely to be regularly exposed to hearing trauma material from the clients with whom they work.

The likelihood of exposure to trauma material for nurses is increased when the characteristics of the client groups are considered. Studies indicate a significant number of mental health clients have a background of sexual abuse or trauma (Gillette, 1996; Cleary & Warren, 1998, Horwood & Fergusson, 1998). In the field of psychotraumatology studies shows that those who work with trauma survivors are at significant risk of vicarious traumatization. The nature of the work in current mental health services in New Zealand, which treats the three percent of the population with major psychiatric disorders, is another factor that increases the risk of vicarious traumatization.

A key factor in the risk of vicarious traumatization is the therapeutic use of self. Psychiatric mental health nursing is primarily concerned with the therapeutic relationship and the therapeutic use of self, including empathy. In daily practice nurses are empathically engaged with clients and their experiences of trauma. Given the high incidence of trauma among mental health clients and the nurse's use of empathy in daily nursing practice, there would seem to be a very real risk of psychiatric mental health nurses experiencing vicarious traumatization.

Vicarious traumatization is deleterious, and is described as a transformation in the health professional's inner experience that results from empathic engagement with trauma survivors and their trauma material (Pearlman & Mac Ian, 1995). The effects are cumulative, across clients and extend into the health professional's personal and interpersonal world and are carried beyond the workplace. The deleterious effects impact on the health professional's view of self, others, and the world, and results in changes in behaviour. These changes within the health professional can impact negatively on the therapeutic relationship and on the client. Some sources suggest that overt signs of vicarious traumatization include emotional numbing, intrusive imagery, avoidance, social isolation, loss of self-esteem, cynicism, and despair (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995). There is no immunity to vicarious traumatization in working with trauma survivors and their trauma material. Health professionals who work with trauma need to be aware of the risk of vicarious traumatization and constantly attend to issues of self.

Risk management and self-care are growing imperatives for mental health clinicians, educators and administrators with regard to workforce development and retention. Helping-induced trauma is increasingly recognised as a risk for those who work with traumatized people (Pearlman, 1999; Stamm, 1999; Figley, 2002). Helping-induced trauma is not widely understood within psychiatric mental health nursing and it should be recognised as an occupational hazard. The relevance and implications of vicarious traumatization for psychiatric mental health nursing are the key issues examined in this paper.

Psychotraumatology and helping-induced trauma

The field of psychotraumatology is devoted to the study and treatment of psychologically and emotionally traumatised people. Developments in this field led to a number of specialist sub-fields of which trauma therapy is one. From trauma therapy the concept of helping-induced trauma has emerged. Vicarious traumatization is a particular type and construct of helping-induced trauma.

The concept of trauma has a very long history but it is only in recent decades that there has been significant progress in terms of study and research into traumatic stress (Watts & de L Horne, 1994). Initially the emphasis was on primary trauma in victims and over the past century the major wars have contributed to the common understanding of traumatic stress. For example, World War 1 gave us the concepts of 'shell shock' and 'war neurosis'; World War 2 showed us 'combat exhaustion' and 'survivor syndrome' and the Vietnam War produced the concept of 'post-traumatic stress disorder' (Valent, 1995).

The concept of helping-induced trauma has a shorter history although it has grown significantly over the past fifteen years. In working with traumatised people many writers speak of 'bearing witness' to the pain and suffering of the client and the impact of this on the helper (McCann & Pearlman, 1990b; Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 1999; Meichenbaum, 2000.) This phenomenon whereby those working with traumatised people were are at risk of becoming traumatised themselves began to be reported in the early nineteen-eighties in relation to emergency, disaster and military personnel (Stamm, 1997). Often this was in relation to large-scale events such as natural disasters, refugee exodus and major accidents such as plane crashes. By the

early nineties the literature was increasingly noting helping-induced trauma in personnel who worked with multiple victims across long periods of time. These helping personnel were mainly working with war veterans, refugees, rape and sexual abuse victims.

The concept of helping-induced trauma was variously described as burnout, countertransference and PTSD. For those who acknowledged the concept of helping-induced trauma there was no agreement on how it occurred or what it was named. Today the literature on helping-induced trauma is dominated by the constructs of vicarious traumatization (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995), and secondary traumatization (Stamm, 1999).

What distinguishes vicarious traumatization from other helping-induced trauma concepts is the framework of constructivist self-development theory (CSDT) upon which it is based. CSDT is a blend of psychoanalytic (self-psychology and object relations) theory with social cognition theories as a developmental framework for traumatic stress, which acknowledges individual adaptation to trauma in the context of social and cultural variables (McCann & Pearlman, 1990b). For psychiatric mental health nurses CSDT provides a holistic framework on which to understand the effect of trauma on the individual.

Over the past fifteen years psychotraumatology has made significant progress in understanding helping-induced trauma. Despite the lack of agreement regarding the aetiology, symptomatology and epidemiology of the disorder, there is a growing body of work including empirical research that demonstrates the relationship between trauma work and helping-induced trauma. As a construct of helping-induced trauma, vicarious traumatization, with its framework of CSDT, relates readily with psychiatric mental health nursing.

Vicarious traumatization and psychiatric mental health nursing
The relevance of vicarious traumatization to psychiatric mental health nursing can be seen in the parallels between trauma therapy and psychiatric mental health nursing. Further relevance becomes apparent in understanding the construct of vicarious traumatization, how it occurs and its effects.

Vicarious traumatization arises from the helper's participation in a therapeutic relationship encompassing therapeutic use of self and empathic engagement with the trauma survivor and trauma material (Pearlman & Saakvitne, 1995). The therapeutic relationship is central to psychiatric mental health nursing practice; and the use of self and empathy occur daily in multiple ways. The obvious parallel is that both the therapist and the nurse use the therapeutic relationship as their primary therapeutic tool. Therefore, both regularly employ the therapeutic use of self and empathy. A further parallel between trauma therapy and psychiatric mental health nursing is that of regular contact with trauma survivors and regular exposure to trauma material. The work context, client groups and self-care issues of both professions also have similarities. The parallels between trauma therapy and psychiatric mental health nursing will be explored in depth to illustrate how nurses are at risk of vicarious traumatization.

The relevance and implications of vicarious traumatization for psychiatric mental health nurses become clear by understanding how it occurs and its affects. The construct of vicarious traumatization is explored in some detail; understanding the construct and how it affects the practitioner is critical to its prevention. Vicarious traumatization itself is based on the further construct of CSDT, and both constructs are relevant to psychiatric mental health nurses in their self-care. The impact of vicarious traumatization extends beyond the individual nurse; it has significant implications for clients, the profession, and mental health service provision.

Structure of the paper

The paper has been structured in three sections to take the reader through a progression of the relevance and implications of vicarious traumatization for psychiatric mental health nursing.

Section One describes psychiatric mental health nursing and focuses on the therapeutic relationship. The centrality of the relationship and the significance of the therapeutic use of self and empathic engagement are discussed. These therapeutic tools are paralleled with therapists doing trauma therapy. Links are made between psychiatric mental health nursing, and trauma, and vicarious traumatization.

Section Two, the largest section of the paper, is devoted to discussion of vicarious traumatization. The first part looks at the background and development of vicarious

traumatization. CSDT is explained in the second part and is followed by a detailed description of vicarious traumatization including how it occurs, its effects, and what contributes to it. The significance of countertransference is discussed in this section, as is the place of hope as a therapeutic necessity. The description of vicarious traumatization also includes comparison with compassion fatigue and secondary traumatization. The differences between vicarious traumatization, burnout, and PTSD are also explained in this section. The links of vicarious traumatization to psychiatric mental health nursing are further described. The imperative for understanding vicarious traumatization in order to ameliorate its effects and for prevention is explained in the final part of this section.

Section Three extends the ideas developed in the previous sections to explore the relevance and implications of vicarious traumatization for psychiatric mental health nursing. A number of the effects of vicarious traumatization are highlighted along with suggestions of what the effects might look like in the nurse. The recognition of vicarious traumatization as an occupational hazard in psychiatric mental health nursing is discussed along with the implications for nurses if it remains largely unrecognised and unaddressed.

The paper is drawn to a conclusion by arguing the relevance of vicarious traumatization for psychiatric mental health nursing, and the consequences of not recognising and addressing vicarious traumatization, including its potential effects on the quality of nursing care, and nursing retention and recruitment. The implications of vicarious traumatization for clients are also discussed along with those for mental health service providers. Finally, recommendations are made for ameliorating the effects of and preventing vicarious traumatization in nurses.

Key sources

In exploring the relevance and implications of vicarious traumatization for psychiatric mental health nursing literature searches were conducted in CINAHL, Medline, and Psychlit databases. While there is an increasing amount of literature on vicarious traumatization the findings are mostly with regard to therapists, counsellors, psychologists, and social workers working in incest, sexual abuse, rape and domestic violence services. There is also a significant amount of literature on helping-induced trauma in personnel working in crisis, emergency, military, and disaster services.

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The key sources for vicarious traumatization are primarily the original works of McCann and Pearlman (1990a), Pearlman and Saakvitne (1995), and Saakvitne and Pearlman (1996). These authors identified, named, and researched vicarious traumatization as well as developing its theoretical base. The authors are recognised as experts of vicarious traumatization and their works provide the most comprehensive explanations and descriptions of the construct.

Other key sources for helping-induced trauma include Figley (1995), Kilbourn (1995), Stamm (1999), and Meichenbaum (2000). The psychotraumatology literature has also informed the discussion of the parallels between trauma therapy and psychiatric mental health nursing.

Definitions

For the purposes of this paper some of the key terms warrant definition. Vicarious traumatization is defined as a process that occurs in trauma therapy whereby "the therapist's identity and usual ways of understanding and experiencing herself and her world" (Pearlman & Saakvitne, 1995, p.xvi) are permanently altered as a result of empathically listening to the clients' trauma material. Moreover, the changes that occur are usually deleterious and extend beyond the therapist and her professional work into her personal life.

The use of the term psychiatric mental health nurse is to recognise the diverse nature of this nursing specialty. The term encompasses the psychiatric illness/disorder component of this nursing specialty and its link to psychiatry. Mental health refers to the wellness and prevention aspects of health as well as the recovery part of mental illness/disorder. For the sake of readability when the term nurse is used it refers to psychiatric mental health nurse; and likewise for the term nursing, it refers to psychiatric mental health nursing.

Helping-induced trauma has emerged as a generic term to describe the deleterious effects on any person in a helping role who works with trauma survivors and their trauma material. The helping role can include health professionals, therapists and counsellors, crisis and disaster workers, religious and missionary workers, military

personnel, and family members. Vicarious traumatization, compassion fatigue, and secondary traumatization are examples of helping-induced trauma.

Key terms and language

To provide clarity for the reader some of the key terms, language and nomenclature used in the paper are explained here. When health professional or clinician are used this indicates that the particular issue is multidisciplinary, and not restricted to nursing. The use of therapist generally refers to trauma therapist especially those working with incest and sexual abuse survivors. Therapists are more commonly in private practice whereas the majority of psychiatric mental health nurses work in publicly funded mental health services in New Zealand.

A person with a psychiatric or mental health need who accesses mental health services is variously described according to its context. Context includes historical period, geographical location, socio-political position, and place of treatment and care. In relation to current nursing practice in New Zealand the term client is used. The term patient is used in its common understanding and in regard to nursing it reflects the historical period of pre- nineteen-eighties. With respect to authors whose work is used I have tried to honour their use of language. For the purposes of this paper the term vicarious traumatization has kept to the American presentation.

The use of gender is to acknowledge female and male users of mental health services and the men and women who work in those services. There is however a greater representation of women among incest and sexual survivors and for this reason the female gender is used in relation to these survivors. Nursing is a female dominated profession so nurses are generally referred to in female terms.

The key terms noted here represent the experience and positioning of the writer as a psychiatric mental health nurse in the context of living and working in Aotearoa/New Zealand at this time. No one philosophical, political or cultural belief has any precedence over the other.

This introduction is intended to give the reader some background and context to the key points and issues presented in this paper. In particular to the argument that vicarious traumatization is a major risk to psychiatric mental health nurses and that as yet, it is not

a risk that is widely recognised. Psychotraumatology and helping-induced trauma are explained in relation to the connections to psychiatric mental health nursing. The Information about the structure of the paper, key sources, definitions and terminology have been given to provide a basis for reading the full paper. The next three sections will address the relevance and implications of vicarious traumatization for psychiatric mental health nursing.

SECTION ONE: PSYCHIATRIC MENTAL HEALTH NURSING

This section describes psychiatric mental health nursing and explores the parallels with trauma therapy. The parallels are drawn to show how psychiatric mental health nurses are potentially at risk of vicarious traumatization. The discussion focuses on the centrality of the therapeutic relationship and the therapeutic use of self in psychiatric mental health nursing, as these are key links with trauma therapy and vicarious traumatization. The particular functions of countertransference and empathy are explored and connected to the risks and vulnerabilities inherent in the therapeutic use of self. Further parallels are drawn between psychiatric mental health nursing and trauma therapy in relation to work context and client groups. It is also suggested that the nature of daily practice in mental health services might increase the potential risk of vicarious traumatization for nurses.

The discussion in this section on psychiatric mental health nursing and the centrality of the therapeutic relationship refers to literature by, and about, the American nurse and scholar, Hildegard Peplau, who is acknowledged as a very influential figure in the profession over the past fifty years. Further sources used are contemporary psychiatric mental health nursing texts and journals.

What is psychiatric mental health nursing?

Psychiatric mental health nursing is about relationships and communication. Specifically, the therapeutic nurse-patient relationship is considered the primary function, and the cornerstone or crux of psychiatric mental health nursing (Altschul, 1985; Forchuk, 1993; Wilson & Kneisel, 1996; Clinton & Nelson, 1999). The trust, empathy, and hope established in the therapeutic relationship creates the environment in which healing and recovery is possible for the client. Trauma therapy also has the therapeutic relationship as its main focus, and aspects of the relationship are viewed as key factors in the risk of helping-induced trauma (Cerney, 1995). The main parallels between trauma therapy and psychiatric mental health nursing are centred in the therapeutic relationship and this is where the potential risk of vicarious traumatization arises for nurses. The description of psychiatric mental health nursing situates the links with this potential risk.

Peplau's (1952) interpersonal relations theory with its therapeutic nurse-patient relationship is used as a key basis for psychiatric mental health nursing throughout the world (Altschul, 1985; Simpson, 1991; Forchuk, 1993; Clinton & Nelson, 1999), and contemporary nursing literature reflects her continued influence. For example, a Belgian paper reporting on a philosophical-ethical analysis of the work of Peplau acknowledges the singular contribution and impact of Peplau's theory and that it is still relevant today (Gastmans, 1998). In a new model for mental health nursing Barker (2001) states "the Tidal Model developed many of Peplau's assertions about the importance of interpersonal relationships for nursing practice …" (p.235). Exploring the epistemological issues of mental health nursing knowledge using a hermeneutic approach Geanellos (1995) concluded that many of the themes developed in the study reflected Peplau's conceptualisation of mental health nursing. Here in the South Pacific the relevance of Peplau's therapeutic nurse-patient relationship in current practice can be found in many articles in the *Australia and New Zealand Journal of Mental Health Nursing* (Crowe, 1998; Cleary, Edwards & Meehan, 1999; O'Brien, 1999).

Peplau's theory places the interpersonal processes and the therapeutic relationship between the nurse and the patient at the centre of psychiatric mental health nursing. The nurse and nursing are educative instruments. The interpersonal processes and therapeutic relationship are the mediums by which the nurse can assist the patient toward health, that is, toward intellectual and interpersonal growth and integration, maturity, and creative and constructive personal and community living (Peplau, 1952). The nurse does not solve the client's problems; rather the client is given the "opportunity to explore options and possibilities within the context of the relationship" (Forchuk, 1993, p.9).

The interpersonal processes include**:** the nurse-client relationship, communication, pattern integration, and the roles of the nurse (Forchuk, 1993). The therapeutic use of self especially the use of trust and empathy, are at the core of these interpersonal process. To be effective each of these processes requires the nurse to be self-reflective in addition to having knowledge, skills, and good interpersonal abilities. Self-reflection and self-knowledge is an ongoing process and a means of understanding how the nurse influences the therapeutic relationship (Crowe, 1998).

Peplau's conceptualisation of the therapeutic nurse-patient relationship was one of evolvement through overlapping phases and subphases in which particular processes and issues are addressed (Forchuk, 1993). Contemporary psychiatric mental health nursing texts describe the therapeutic relationship in three stages: introductory, working, and termination (Fontaine & Fletcher, 1995; Wilson & Kneisel, 1996). While Peplau's original work included a number of roles for the nurse she later stressed that the primary role of the psychiatric mental health nurse is that of counsellor (Forchuk, 1993). Peplau also identified a wide range of concepts that impacted on the practice of the nurse, the patient, and the therapeutic relationship. These included interpersonal factors, intrapersonal factors and specific clinical phenomena (Forchuk, 1993). In brief, the interpersonal and intrapersonal factors include verbal and non-verbal communication, patterns of behaviour in relation to others, cognitive processes, learning and developing self-understanding (insight). The specific clinical phenomena refer to the patient's symptomology; for example, hallucinations and behaviour such as isolation, and feelings, which might be anxiety and loneliness.

The interpersonal processes used by the nurse focus on the therapeutic use of self to establish trust and empathy in the relationship. Peplau was also very aware the nurse needed to understand the function and risks of countertransference in the therapeutic relationship (Forchuk, 1993). The nurse needs to develop good self-awareness and self-reflection to remain therapeutic in the relationship. However, the emphasis of self-awareness is to understand how the nurse affected the relationship, not how the nurse might be affected by the therapeutic processes. The concept of helping-induced trauma was in its infancy when Peplau's interpersonal nursing theory emerged.

The therapeutic relationship and the use of self are central to daily practice where the nurse works to create an environment where healing and recovery are possible for the client. Nurses are empathically engaged with clients in multiple ways with varying intensity throughout the day. In the reality of daily practice the therapeutic relationship is expressed in the nurse's daily caseload of multiple encounters with clients in busy, intense mental health services. The next part addresses the nature of the therapeutic relationship in its therapeutic value, and how this is expressed in contemporary daily practice.

Therapeutic relationship

The primary function of psychiatric mental health nursing continues to be developing the therapeutic relationship, and concepts such as those identified in Peplau's interpersonal nursing theory remains the basis of the relationship (Barker, 1997; O'Brien, 1999; McAllister et al, 2001). While the aim of the relationship is to be therapeutic for the client, the nature of contemporary practice is such that it can also have negative effects for the nurse. Today, the therapeutic relationship is a process that is highly contextual, situational, and dynamic (O'Brien, 1999).

In contemporary nursing practice the therapeutic relationship is viewed as an active partnership where the responsibility for healing and growth is shared. The relationship itself can have a healing effect. The sharing of thoughts, feelings and behaviours creates an atmosphere of therapeutic intimacy. The nurse assumes responsibility for ensuring the sharing nature of the relationship is used to positive effect. To establish and develop the relationship the nurse utilises therapeutic communication techniques and the therapeutic use of self. To this end the nurse's "most powerful healing capacity comes from who she is and how she relates to others" (Becks, Rawlins & Williams, 1988, p.25).

Vital components of the therapeutic relationship are to engage with the client and to establish rapport. Engagement requires the nurse to be open, genuine, and non-judgemental. Establishing rapport requires the nurse to convey warmth and positive regard to the client. The establishment of trust and the use of empathy are necessary to maintain rapport with the client and to bring into play the beneficial effects of the therapeutic relationship (Wilson & Kneisel, 1996). The nurse's stance of openness and caring is essential yet it is this very stance that presents a potential risk to the nurse of being personally affected by what the client might share.

Therapeutic use of self

The therapeutic use of self in the relationship refers to "the ability of nurses to use healthy aspects of their personalities to foster personal integration in others" (Geanellos, 1995, p.88). Therapeutic use of self is about the nurse's ability to be attentive, sensitive, responsive and empathetic with the client. In particular the use of empathy is essential to the interpersonal process of the therapeutic relationship. Wilson and Kneisel (1996) put it thus, "perhaps the most important function of empathic understanding is to help

the psychiatric mental health nurse give the client the very precious feeling of being understood and cared about" (p.12). When the nurse empathises with a client she momentarily relinquishes her personal self and relives the emotions and responses of the client. This exquisite inner comprehension by the nurse of a complex emotion of the client and the ability to convey this back to the client is how empathy is used as a therapeutic tool. The use of empathy is critical to the establishment of trust in the therapeutic relationship. Empathic engagement is the precursor to healing occurring for the client in the therapeutic relationship (McMahon & Pearson, 1991; Pearlman & Saakvitne, 1995).

Ironically, this empathic engagement can also be the means by which the nurse can be profoundly affected by what the client shares. Some commentators view these profound effects as related to the transference and countertransference dynamics found in the therapeutic relationship (Stamm, 1997; Friedman, 2000). Other nursing authors relate these profound effects to the development of burnout in psychiatric mental health nurses (Dhondea, 1995; Wilson & Kneisel, 1996). Countertransference in the therapeutic relationship is discussed here while burnout is discussed in the section on vicarious traumatization.

Countertransference

Countertransference is an important aspect of psychotherapy based therapies and counselling. In simple terms countertransference refers to the health professional's reactions to the client's transference and personality. Transference involves the client's reaction to the health professional. Countertransference and transference are normal phenomena that arise in the therapeutic relationship although countertransference can potentially have both beneficial and damaging effects for each of the participants in the relationship. The therapeutic use of countertransference is concerned with helping the client to understand unresolved childhood conflicts and how these are impacting on relationships in the present (Wilson & Kneisel, 1996). An understanding of countertransference is part of mental health nursing education and an important step in the nurse-patient relationship (Ens, 1998).

The concept of countertransference originated with Freud and was classically defined as the psychoanalyst's feelings toward a patient that arose from the analyst's unresolved inner conflicts. The concept later expanded to include the psychoanalyst's response to

the patient's transference. Still later the concept evolved to the view that it was a natural part of the therapeutic relationship and could be used for greater empathetic understanding of the patient. It was accepted that the clinician's emotions toward the patient were partly created by the patient's psychopathology (Ens, 1998).

Psychiatric mental health nurses generally understand countertransference as the nurse's powerful feelings, attitudes and fantasies in response to the client's transference and personality (Fontaine & Fletcher, 1995). Wilson and Kneisel (1996) state, "countertransference [occurs] when the nurse repeatedly assigns meaning to the nurse-client relationship that belongs to the nurse's other past relationships" (p.678). Nurses also understand that unrecognised countertransference on the part of the nurse can confuse the client and undermine therapeutic processes.

To use countertransference therapeutically is to understand that countertransference is a complex construct and process in contrast to the common definition of the clinician's conscious and unconscious emotional responses to a client. Self-knowledge, attunement, reflection and analysis are essential requirements for the clinician to use countertransference as a therapeutic tool in the understanding and healing of the client (Ens, 1998; Pearlman & Saakvitne, 1995).

Countertransference is a critical factor in the therapeutic relationship which unintended and unrecognised can be non-therapeutic. However, it can be used in an intentional and directed manner as a therapeutic strategy. Countertransference also has a significant role, albeit unintended, in the development of vicarious traumatization. The relationship of countertransference to vicarious traumatization is discussed more fully in Section Two.

Daily practice
The therapeutic relationship and the use of self are the primary tools employed by the psychiatric mental health nurse. Empathic engagement occurs in many ways and at differing levels of intensity in daily nursing practice. The nurse does not need to be engaged in deep one-to-one therapy with a client to employ these tools. Rather the work of the nurse is often merely being with the client during daily activities. Barker (1996) refers to this as therapy through daily relating. The being with the client during

daily activities is an important aspect of the nurse-client relationship. Fry (1998) describes it thus:

> Mental health nursing connects with clients by actively sharing experiences with them, such as planning a programme of care and implementing it, having a cup of tea and discussing things, providing information, administering medication, and participating in leisure activities. The mental health nurse may also promote the client's connectedness with nature through such as gardening and caring for the environment or by opening aesthetic windows for them, such as encouraging the appreciation of the beauty of natural world, art and music.
>
> (p.30).

There can be moments of connectedness in the sharing of daily activities during which the client may divulge very intimate experiences. The nurse is empathically engaged at such moments of connectedness and therefore very open to being profoundly affected by what the client relates.

For nurses there are multiple moments of empathic engagement in daily practice hence there are multiple occasions in daily practice where the nurse can be affected by what the client relates. The nature of psychiatric mental health nursing is such that nurses are exposed daily to the minutia of clients' innermost thoughts, emotions, and life and illness experiences. The daily work of the nurse in assessing and reviewing a client's mental status means the nurse aims to elicit the client's inner world. Because nursing is a twenty-four hour service nurses will assess and review clients more than any other discipline in mental health services. Therefore, nurses are empathically engaged with clients more often than other disciplines and thus, nurses have a higher exposure to what the client relates. There is also the suggestion that clients might be more comfortable with the nurse and therefore more likely to divulge experiences because of the closer contact across the twenty-four hours of the day.

Empathic engagement and exposure to a client's trauma experience and trauma material, across clients and across time, is how vicarious traumatization occurs (McCann & Pearlman, 1990a). The nurse does not have to be engaged in specific trauma or abuse therapy to be exposed to trauma material. There are many examples from my own experience in daily practice where the nurse is potentially exposed to a client's trauma experience and trauma material. Contributing factors include the nature

of the work, acute and crisis care, nurses increased contact with clients across the twenty-four hour period, client groups, and the presentation of mental disorder.

People's distress is often the first situation the nurse has to deal with in mental health services. Part of helping people with their distress is to create a safe space in which the client can verbalise or express the distress and the precipitating factors. In acute and crisis presentations there are often high degrees of distress, acuity of symptoms, and safety issues. Clients who are very distressed, disinhibited, dissociative, or psychotic may divulge traumatic feelings and experiences that they might ordinarily be more circumspect about verbalising. If the client requires care and containment it is nurses who will manage this situation. It is also nurses who will use calming and restraint techniques should it be necessary. Thus, it is the nurse who will be most likely to be exposed to the client's expression of emotion, thought, and memories of any traumatic experience.

The risk for the nurse to be exposed to the client's trauma experience is further increased by the nature of the client groups that use mental health services. New Zealand's mental health services are funded to provide services to the three percent of the population with severe mental illness (Ministry of Health, 1997). Research shows that there is a high incidence of sexual abuse trauma in this client population (Read & Fraser, 1998; Horwood & Fergusson, 1998). In New Zealand most nurses work in the public health sector (Nursing Council of New Zealand, 2000), and this combined with the nature of the client population suggests that nurses have a significantly higher potential for exposure to the client's trauma experience.

The potential for exposure to trauma in daily practice is not readily recognised in the nursing literature. Neither are the risks to nurses dealing with clients' experiences of trauma, the sequelae, and trauma material. Yet the risks to nurses of vicarious traumatization are potentiated by the nature of the client groups and the nature of daily practice. The risks to nurses need to be recognised and addressed by nurses themselves, managers, supervisors, and educators.

Conclusion

The centrality of the therapeutic relationship in psychiatric mental health nursing is the starting point for the nurse with regard to the potential risk of vicarious traumatization.

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The therapeutic use of self and empathic engagement in particular, are the means by which vicarious traumatization can occur. The increased potential of exposure to trauma due to the nature of daily practice and the client population compounds the risks to nurses of vicarious traumatization. This section has described psychiatric mental health nursing and established the relevance of vicarious traumatization for nurses. The next section addresses the phenomenon of vicarious traumatization and explores further its relevance for psychiatric mental health nurses.

SECTION TWO: VICARIOUS TRAUMATIZATION

Psychiatric mental health nurses are potentially at risk of vicarious traumatization because of the nature of their therapeutic work. The risk is compounded due to the daily contact with trauma, trauma survivors and their trauma material. A thorough understanding of vicarious traumatization is necessary to identify its causes and effects, to ameliorate its impact on the health professional, and to prevent its development.

The focus of this section is the understanding of vicarious traumatization. An understanding of the theoretical construction of vicarious traumatization is important as this informs how it occurs and what its effects are. Vicarious traumatization is based on constructivist self-development theory (CSDT), which provides a framework for understanding how the primary trauma impacts on emotional and psychological aspects of the victim. The same framework is used for understanding how the secondary, or vicarious, trauma occurs and its impact on the secondary victim. To understand the impact of the primary trauma is to understand the trauma in the secondary victim. This knowledge can then be linked to the risk of vicarious traumatization occurring in psychiatric mental health nurses.

Section Two is presented in several parts to assist in the understanding of vicarious traumatization. The first part describes the construct of vicarious traumatization, its origins and development, and theoretical basis. The second part of Section Two explores how vicarious traumatization occurs, what its effects are, and what contributes to its occurrence and effects. Part Three deals with other helping-induced trauma constructs and similar concepts. The discussion includes an exploration of secondary traumatic stress, and compassion fatigue. Vicarious traumatization is also contrasted against similar concepts including countertransference, post-traumatic stress disorder (PTSD), and burnout. The fourth part of this section discusses prevention and concludes with the connections between vicarious traumatization and psychiatric mental health nursing.

The work of Pearlman and Saakvitne (1995) is based on the empirical research they undertook which enabled them to further refine the construct and its effects. For these reasons that particular work has been used extensively in this section.

Part One: The construct of vicarious traumatization

Part one locates the emergence and development of vicarious traumatization in the helping-induced trauma field, the key figures, and their works. The background to the construct of vicarious traumatization includes its theoretical underpinnings, particularly that of constructivist self-development theory (CSDT). CSDT provides a framework for understanding trauma and its psychological and emotional impact in primary and secondary trauma victims. An understanding of CSDT is critical to understanding how vicarious traumatization occurs, its effects, and its prevention.

Background to vicarious traumatization

The background to vicarious traumatization is located in the field of psychotraumatology and the emergence of the concept of helping-induced trauma as a sub-specialty of the field. The development of vicarious traumatization and CSDT, have played seminal roles in the understanding of helping-induced trauma as a sub-specialty. The key figures and points of development in the concept of helping-induced trauma are discussed as background to the theory of vicarious traumatization.

Psychotraumatology emerged from the field of traumatology, that is, the study and treatment of traumatised people (Pearlman & Saakvitne, 1995). Historically, developments in the understanding of trauma have arisen alongside developments in stress research. The research and development of traumatic stress theory occurred largely in the separate arms of biological, psychological and social aspects of stress research, and it is only more recently that there has been concerted integration between these (Valent, 1995). In psychotraumatology, both traumatic stress theory and psychoanalytic theory have made major contributions to its development (Pearlman & Saakvitne, 1995; Valent, 1995). Frameworks for categorising traumatic stress reactions were developed in the field of psychotraumatology of which, post-traumatic stress disorder (PSTD) is the most widely known example to the general public.

Psychotraumatology was initially concerned with primary trauma in victims and it was some time before the effect on those who worked with the victims was recognised. In 1980 the literature began to talk about secondary trauma, that is, trauma that arose in the helpers who were caring for people with a primary trauma (Meichenbaum, 2000). Much of this early literature focussed on disaster workers and emergency services and military personnel (Stamm, 1997). The concept of helping-induced trauma was

developing by the end of that decade and a number of key forms and authors were emerging. Three forms of helping-induced trauma came to dominate the debate: vicarious traumatisation (McCann & Pearlman, 1990b); compassion fatigue (Figley, 1995); and secondary traumatic stress (Stamm, 1995). While there are similarities between the three, each form of helping-induced trauma has distinct differences.

The term, vicarious traumatization was first introduced in 1990 by McCann and Pearlman (1990b) in a paper that outlined a framework for therapists to understand the psychological effects of working with victims. The paper entitled 'Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists' was pivotal in the helping-induced trauma debate (Stamm, 1997). It challenged the construct of countertransference as too narrow to explain the life-changing effects on therapists engaged in trauma work. Countertransference was client and event specific whereas McCann and Pearlman's (1990b) research reported enduring effects on therapists across time and across multiple clients. The paper further suggested an alternative framework for understanding these effects on the therapist. The alternative construct of vicarious traumatization was based on constructivist self-development theory (CSDT), which provided a framework for understanding the psychological impact of trauma.

In 1991 Figley first used the term 'compassion fatigue' to describe the emotion draining effects of working with traumatized families. Figley (1995) notes that as early as 1983 he had referred to this phenomenon as "a form of burnout, a kind of 'secondary victimization' '' (p.2). Figley (2002) continues to describe compassion fatigue as one form of burnout and, a secondary traumatic stress disorder, which is nearly identical to PTSD. The obvious difference being that compassion fatigue relates to those emotionally affected by another's trauma. Compassion fatigue is based on the framework of PTSD and relates to the cognitive schema of the therapist, that is, the social and interpersonal perceptions or general morale of the therapist's professional and personal life (Figley, 1999, 2002).

In 1995 Stamm, published *Secondary Traumatic Stress* which brought together those who had made seminal contributions to the debate on helping-induced trauma. Stamm (1997, 1999) has noted that although there is considerable development in the area of helping-induced trauma there has been no agreement on what this phenomenon might

be named, nor it's theoretical basis and structure. Somewhat by default Stamm (1999) settled on the term 'secondary traumatic stress' as being the most palatable term and useful description for explaining helping-induced trauma, albeit with it's own limitations. Secondary traumatic stress is connected with PTSD as a means to describe the phenomenon and its effects. Stamm (1999) is clear that secondary traumatic stress "is not burnout, although burnout may be comorbid" (p.xx). Secondary traumatic stress also includes aspects of both vicarious traumatization and compassion fatigue.

The first half of the nineteen-nineties saw an explosion of field related literature and terminology in the exploration of helping-induced trauma. Much of this work was generated in the various centres that are devoted to the study of trauma and/or stress. The nomenclature for helping-induced trauma was varied and confusing. It has been used synonymously with countertransference, burnout and PTSD. Other terms found in the literature include indirect trauma, vicarious PTSD and traumatic countertransference. The Dissertation Abstracts International database shows multiple theses and dissertations on the phenomenon of helping-induced trauma since the mid-nineties particularly in North America. However, there is concern regarding the lack of empirical research into helping-induced trauma (Steed & Downing, 1998; Murphy, 2001). Nonetheless the literature shows many papers that have looked specifically at vicarious traumatization.

Vicarious traumatization as a term and as a construct of helping-induced trauma appealed to me as a psychiatric mental health nurse. The term vicarious traumatization is clearly descriptive and resonated with my own clinical experience. Within the helping-induced trauma literature vicarious traumatization is the only example that I found with a definitive theoretical basis. The CSDT framework provides a holistic view of the effects of trauma on the individual, and is the best framework I have found to date for understanding trauma. Understanding CSDT is crucial to understanding vicarious traumatization.

Vicarious traumatization and CSDT
In that first paper on vicarious traumatization McCann and Pearlman (1990b) offered a new framework for understanding the psychological effects on therapists of working with trauma victims. The new framework was based on constructivist self-development theory (CSDT), which the authors suggested was a better framework for understanding

trauma and its effects. CSDT is critical to understanding vicarious traumatization and some further background helps to contextualise its development.

The background to the development of vicarious traumatization arose from McCann and Pearlman's (1990b) professional work in the area of psychotherapy with adult survivors of childhood incest and sexual abuse. For that reason much of the earlier writing on this construct was done in that specific context. The description here of vicarious traumatization is within that specific context although it can be applied across a wider range of helping occupations and settings.

CSDT was the framework initially used by MacCann, Pearlman and others for understanding their work with clients, the clients' traumatic experiences and the impact the trauma had on the client. MacCann and Pearlman (1990b) observed that the negative impact of trauma work affected the therapist's view of self, other, and the world, in a similar manner to how the client had been affected by the primary trauma. There was a parallel in the psychotherapeutic relationship between the client's experience of trauma and its sequelae, and the impact on the therapist of their experience of hearing the trauma material. The authors suggested that the construct of countertransference traditionally used in psychotherapy was too narrow to describe the lasting and pervasive effects on the therapist of trauma work (MacCann & Pearlman, 1990a). While MacCann and Pearlman were clear that psychoanalytic theory underpinned their work of psychotherapy, they felt it did not explain the effects on the therapist engaged in trauma work. In seeking to address this little understood effect on the therapist, MacCann and Pearlman (1990a & 1990b) looked for a framework to assist therapists and realised that CSDT provided a very useful model. Later, Pearlman with her colleague, Saakvitne, further developed the construct of vicarious traumatization based upon the framework of CSDT.

CSDT gives clinicians a template or framework for trauma therapy that is useful to both clinician and client in understanding the effects of trauma. CSDT forms the theoretical underpinnings of vicarious traumatization and this framework is used to understand how clinicians are affected by working with trauma clients and their trauma material. A description of constructivist self-development theory (CSDT) states:

CSDT blends contemporary psychoanalytic theories (self-psychology and object relations theory) with social cognition theories to provide a developmental framework for understanding the experiences of survivors of traumatic life events. CSDT views individuals' adaptations to trauma as interactions between their own personalities (defensive styles, psychological needs, coping styles) and salient aspects of the traumatic events, all in the context of social and cultural variables that shape psychological responses

(Pearlman & Mac Ian, 1995, p.558).

The theory emphasises integration, meaning and adaptation, and as such, CSDT understands the individual's adaptation to trauma as an interaction between the person's personality, personal history, the trauma and its cultural and social context (Pearlman & Saakvitne, 1995). Thus, each person's experience of the trauma is unique to them, as are the effects of the trauma and the person's adaptation. The uniqueness arises in part from the person's personality, psychological and emotional make up and how these were shaped in childhood and developed further into adulthood. CSDT encompasses the individual's being in the world, that is, one's sense of self, identity and of others, and subsequent view of life. Within the CSDT framework, trauma is defined as a process definition of the individual's unique experience of the trauma and the impact of this on the self. In this context the trauma generally refers to incest or sexual abuse.

Components of self

The theory's framework for self is briefly explained so that the impact of trauma can be understood. CSDT has five components of self: frame of reference; self-capacities; ego resources; psychological needs and cognitive schemas; and memory and perception (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). The foundations of each of these five components of self are predominantly laid down in early childhood and are inter-related. The components of self are intrinsically connected with how a person relates with others in their world. Any disruption or damage to the formation of one of the components of self will affect the other components.

Within CSDT, the first component of self is one's frame of reference. This is an aspect of the self that relates to a person's framework for viewing and understanding oneself and the world. It is central to a person's perception and interpretation of life experiences. Frame of reference comprises worldview, self-identity, and spirituality, and combined these create the lens through which a person sees and interprets the world and their experiences (Saakvitne & Pearlman, 1996). Any disruption to frame of

reference is fundamentally disorienting and very stressful. According to Pearlman and Saakvitne (1995) trauma "virtually always affects the individual's frame of reference" (p.61).

The second component is self-capacities and this refers to the basic inner capacities that maintain a person's inner equilibrium, identity, interpersonal connections and self-esteem. Self-capacities are developed in early childhood through internalisation of interpersonal experiences of being held. CSDT identifies three specific self capacities which are critical to a person's experience of self and inner balance, specifically, "(a) to manage strong feelings, (b) to feel entitled to be alive and deserving of love, and (c) to hold onto an inner awareness of caring others" (Saakvitne & Pearlman, 1996, p.29).

Ego resources refer to the person's inner abilities to negotiate the world of their interpersonal relationships and to getting their psychological needs positively met. In the CSDT construct there are two sets of ego resources that are important. The first set concerns the person's abilities with regard to achievement, interpersonal relationships, and survival. These include self-awareness skills such as insight into one's own psychological needs, empathy, using willpower and initiative, and striving for personal growth. The second set of ego resources are concerned with a person's ability to protect oneself from harm within interpersonal relationships. The latter ego resources include one's ability to establish positive and mature relationships with healthy boundaries, foresee consequences, and make self-protective judgements (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996).

CSDT identifies five core psychological needs: safety, trust/dependency, esteem, intimacy, and control. These basic psychological needs are what motivate a person's behaviour and shapes their relationships, and are not necessarily conscious. Each of these needs is relevant to the self and in relation to others. Everyone has these needs (and others), and each need is specific to the person according to the individual's unique life story. CSDT views the five psychological needs as the most sensitive to the effects of psychological trauma (Pearlman & Saakvitne, 1995). An individual's psychological needs are inherently connected with their cognitive schemas.

Cognitive schemas refer to "the conscious and unconscious beliefs and expectations individuals have about self and others that are organised according to central

psychological need areas" (Pearlman & Saakvitne, 1995, p.68). The schemas of interest in CSDT are those that relate to the five basic psychological needs and to frame of reference. If a person's beliefs and expectations about their safety have been affected by trauma thereafter any new experiences related to safety and security are filtered through the affected schemas and either assimilated or accommodated to allow the person to make sense of their experience.

The final component of self that is impacted by psychological trauma is that of memory and perception. CSDT conceptualises memory as descriptive and understands that traumatic memory may be fragmented. Memory is inherently connected with experience (perception). Pearlman and Saakvitne (1995) identified five aspects of perception and thus, of traumatic memory, that they found clinically useful. These aspects were verbal (cognitive narrative), affect (emotion), imagery (pictures and visual images), somatic (bodily), and interpersonal (the past impacts on current relationships). The impact of trauma may be that the aspects of memory (and perception) are partial or fragmented and when this intrudes into one's consciousness it can be manifested as a panic attack or flashback.

The five components of self in CSDT relate to both the trauma survivor and to the trauma therapist. For example, a client with a background of incest may have a profoundly disrupted sense of their own safety and security in the world with poor self-soothing and coping mechanisms. The impact of the primary trauma on the client might manifest as suicidal and self-harming behaviours, drug and alcohol abuse, and little self-esteem. A therapist listening to multiple stories of incest and the aftermath can find their sense of safety and security disrupted. The impact of this vicarious traumatization on the therapist might manifest as an increase in alcohol use, poor sleep, and hypervigilance. A further consequence of the therapist's disrupted safety and security needs might be a decrease in clinical effectiveness.

The importance of CSDT is that it "offers a basis for understanding the psychological, interpersonal, and transpersonal impact of traumatic life events upon the adult survivor. Further, it provides the framework… for understanding the impact of trauma work upon the therapist" (Pearlman & Saakvitne, 1995, p.56). The long-term impact of trauma work on the therapist is vicarious traumatization. The same impact can affect psychiatric mental health nurses who are dealing with trauma and its aftermath on a

daily basis. With CSDT as the theoretical basis of vicarious traumatization the next part looks at how this phenomenon occurs.

Part Two: How vicarious traumatization occurs

How vicarious traumatization occurs requires not only knowledge of CSDT, but also an understanding of what vicarious traumatization is, its key features and processes. This part addresses the latter three issues of how vicarious traumatization occurs. How vicarious traumatization occurs then leads on to how it affects the health professional.

Vicarious traumatization is a process that occurs in trauma therapy whereby "the therapist's identity and usual ways of understanding and experiencing herself and her world" (Pearlman & Saakvitne, 1995, p.xvi) are permanently altered as a result of empathically listening to the clients' trauma material. Put simply this means that somehow listening to experiences of primary trauma begets further or secondary trauma in the listener. The trauma to the therapist occurs indirectly and is experienced second-hand in listening to the client's trauma material, that is, it occurs vicariously. MacCann and Pearlman (1990b) also observed that vicarious traumatization to the therapist occurred across time and across multiple clients, that is, it was accumulative and pervasive. They further noted that vicarious traumatization only occurred when the listener was empathically engaged with the speaker in, for example, a therapeutic or helping relationship. The traumatization that occurred vicariously had a lasting and deleterious impact on the therapist's life; it changed how they saw themselves and the world.

The key features of how vicarious traumatization occurs are the trauma therapy, the use of empathy, and repeated exposure to trauma material. In trauma therapy as in any therapeutic relationship, the therapist's capacity to connect empathically with the client experience is essential for healing to occur. This means the therapist must be open, genuine, emotionally, or affectively available. The client's experience is understood or sensed at a feeling level by the therapist. It is in this open and vulnerable state of empathic engagement that the therapist is exposed to the client's trauma experience, trauma material, and sequelae (Pearlman & Mac Ian, 1995). Trauma therapy has three aspects that contribute directly to vicarious traumatization: "exposure to graphic trauma material, exposure to the realities of peoples' cruelty to one another, and observation of and participation in traumatic re-enactments" (Pearlman & Saakvitne, 1995, p.298).

The transformation that occurs within the therapist (or other trauma worker) is understood using the CSDT framework and aspects of the self. Vicarious traumatization impacts on the therapist's frame of reference; self-capacities; ego resources; psychological needs and cognitive schemas; and memory and perception. It has an enduring and negative impact on the therapist leading to profound changes in how they view the self, others, and the world. Because vicarious traumatization occurs across time, across clients and through repeated exposure to trauma material it can be seen that "vicarious traumatization is a process not an event" (Pearlman & Saakvitne, 1995, p.32).

The critical factors of how vicarious traumatization occurs in the trauma therapist are paralleled in psychiatric mental health nursing. Nurses working in mental health services are exposed daily to clients' trauma experiences, trauma material and sequelae. The exposure occurs across time and across multiple clients. Psychiatric mental health nurses also use the therapeutic relationship as their primary therapeutic tool and hence are empathically engaged with clients on a regular basis. The key features of how vicarious traumatization occurs being trauma therapy (nursing), the use of empathy (therapeutic relationship), and repeated exposure to trauma material (daily practice) are clearly relevant to psychiatric mental health nurses.

The three aspects of trauma therapy that Pearlman and Saakvitne (1995) identified as contributing directly to vicarious traumatization are also replicated in psychiatric mental health nursing. The exposure to graphic trauma material occurs in daily practice as discussed above. Nurses are regularly exposed in daily practice to the realities of people's intentional cruelty to one another through their clients' narratives and histories of trauma and abuse. The third aspect of observation and participation in traumatic re-enactments is a reality of daily nursing practice. This is because mental health services deals with the client group with major mental health disorders as well as providing 24-hour crisis services. In my experience severely traumatized people with patterns of traumatic re-enactments are frequently clients of mental health services and it is nurses that deal with the traumatic re-enactments on a regular basis. These factors indicate that in daily practice nurses are directly exposed to each of the aspects contributing vicarious traumatization.

The nature of trauma therapy and of psychiatric mental health nursing contribute to the risk of vicarious traumatization. How vicarious traumatization occurs is a complex process that involves basic beliefs and functioning at the very core of the therapist or nurse. Understanding this process further requires knowing how vicarious traumatization impacts on and affects the health professional.

How vicarious traumatization affects the health professional

Understanding vicarious traumatization thus far has required knowledge of CSDT, the definition, the processes and key features of how it occurs. These factors set the scene for understanding how vicarious traumatization impacts on and affects the health professional. This further understanding is necessary to be able to identify and address the risk, management and prevention of vicarious traumatization. How vicarious traumatization affects the health professional is an extensive subject. The salient features only are explored here. The impact and effects of vicarious traumatization are profound, permanent and pervasive, and extend beyond professional boundaries into the personal life of the health professional. It changes how health professionals view themselves and how they see their world.

The changes wrought by vicarious traumatization colour or distort the health professional's experience, interpretation and perception of all of their life experiences. The transformation of the therapist's frame of reference that is, identity, world view and spirituality are consider by Pearlman and Saakvitne (1995) as the most disturbing and enduring impact of vicarious traumatization.

With vicarious traumatization the therapist's (and health professional's) sense of self or identity becomes disconnected leading to a sense of unrealness, emotional numbness and isolation from others. This alienation from one's usual sense of self leads to "rethinking one's basic beliefs about identity, role and self-worth" (Pearlman & Saakvitne, 1995, p.283). Making cynical and callous remarks in the clinical situation can be a sign of a therapist becoming alienated from one's normal sense of self. Also basic to one's identity is one's sense of body and bodily function and these too can be affected by vicarious traumatization. For example, the therapist may withdraw from any intimate contact as an unconscious way of protecting the self or dissociate from bodily experiences in clinical and personal situations.

Working with incest and sexual abuse survivors, therapists are frequently dealing with self-harming behaviour and suicidality as thoughts of death often serve a self-soothing function for the client. Managing this demanding, and at times frightening tension "exacts a toll from [the therapist]" (Pearlman & Saakvitne, 1995, p.285). The therapist is constantly exposed to the client's distress, grief and terror, and concerns of safety. This tension can lead to preoccupation with the client's safety to the extent that it intrudes on the therapist's home life and relationships. A therapist can become plagued by doubts regarding one's identity and value as a therapist. Pearlman and Saakvitne (1995) point out that often one's professional identity is a core component of one's overall identity and the aforementioned disruptions can be very distressing

Working with trauma survivors inevitably challenges the therapist's view of the world, existential beliefs, other people, one's values and way of life. Listening to multiple descriptions of intentional abuse and brutality can leave a therapist feeling overwhelmed, confused, saddened and angry. The trauma therapist's worldview can be profoundly disrupted to the extent they may feel hopeless and helpless themselves in the face of such pervasive abuse. Pearlman and Saakvitne (1995) expressed concern that "this change in world view defeats the therapist's greatest therapeutic gift, [one's] belief in the process and hope of healing" (p.285). Becoming inured to tales of extreme brutality can be a definite sign of a disrupted worldview in health professionals.

Disruption to the therapist's spirituality is viewed as the pathognomic sign or disease characteristic of vicarious traumatization. The term spirituality is used broadly to include "beliefs about non-material aspects of experience, about meaning and hope, about connection with something beyond oneself, and about awareness of all aspects of life" (Pearlman & Saakvitne, 1995, p.287). The therapist can feel lonely, distraught or numbed, and powerless when one's spirituality is profoundly disrupted and there is a danger of this spilling over into the therapy. The normal psychological defence mechanisms of emotional numbing, denial and affect withdrawal as responses to emotional pain such as outrage and horror, can also be signs of vicarious traumatization. These defences to emotional pain and spiritual disruption can lessen the therapist's insight, attunement and ability to empathise. Thus the therapist's therapeutic abilities and effectiveness becomes narrowed and diminished.

How vicarious traumatization affects the therapist or health professional goes beyond one's frame of reference into one's self-capacities, ego resources, basic psychological needs and cognitive schemas. Disruption to any of these aspects of self has serious implications for clinical and personal relationships. According to Pearlman and Saakvitne (1995), and Saakvitne and Pearlman (1996) ego resources which are sensitive to vicarious traumatization include insight, empathy, self-protective judgement, interpersonal boundaries, and awareness of one's psychological needs. Impaired ego resources in the therapist might be evidenced by overwork, preoccupation with therapeutic work, lack of sensitivity and interest in own needs and personal relationships, and difficulty making decisions. A therapist who has less insight and impaired cognitive and perspective taking abilities can become limited not only in their therapeutic focus but in therapeutic use of self. As Pearlman and Saakvitne (1995) point out "the loss of empathy with clients poses a profound danger to any therapy and can result in retraumatization of survivor clients" (p.289).

The above examples show how vicarious traumatization impacts on the self of the health professional within the CSDT framework. Using a medical model approach the effects of vicarious traumatization on the health professional can mirror those of the clients although at sub-clinical levels. These include signs and symptoms of PTSD such as emotional avoidant/numbing, recurrent and intrusive imagery, nightmares (Pearlman & Saakvitne, 1995), and hypervigilance and rage (Friedman, 1996). In addition, signs and symptoms of anxiety and depression are often present. Unsurprisingly the effects of vicarious traumatization can be mistaken for PTSD, burnout or depression and this is discussed later in the paper.

The effects of vicarious traumatization on the health professional have serious implications for the individual both personally and professionally. It can impact on personal and family relationships as well as one's professional identity. Unrecognised vicarious traumatization can lead to the individual resigning from their position and this represents a loss to the profession. The impact of vicarious traumatization on the therapeutic abilities and effectiveness of the health professional is dangerous for the clinician and the client. For these reasons it is imperative that nurses be made aware of the risks and effects of vicarious traumatization.

What contributes to vicarious traumatization

Vicarious traumatization refers to the cumulative effects of doing trauma work across time with multiple clients and its pervasive and negative impact on the self of the therapist. An understanding of the factors that contribute to vicarious traumatization will better address and lessen its effects. Pearlman and Saakvitne (1995) identified three critical factors that contribute to vicarious traumatization as: empathy; aspects of the work (including the nature of trauma therapy, the countertransference-vicarious traumatization cycle, and the client group); and aspects of the individual therapist (personality, qualities, personal, professional and institutional/organisational circumstances). This context can apply equally to psychiatric mental health nursing.

Trauma therapy

Pearlman and Saakvitne (1995) believe vicarious traumatization is unavoidable when engaged in therapeutic relationships with trauma survivors. They also posit that disrupted beliefs and intrusive imagery as a result of hearing clients' trauma material is both inevitable and normal. While they acknowledge that a therapist's own conflicts and vulnerabilities do contribute to vicarious traumatization they are clear that neither the therapist nor the client cause the trauma. Rather the traumatization arises as part of the reality and process of trauma therapy. However, there are identified a number of factors which contribute directly and indirectly to vicarious traumatization.

The most significant contributor directly to vicarious traumatization is the therapist's use of empathy. Empathy is a key tool of the therapist and it is critical to developing a therapeutic relationship. The therapeutic relationship and empathic engagement are essential to the client's recovery. Thus, Pearlman and Saakvitne (1995) described empathy as the therapist's asset and as a liability. The risk associated with the empathic engagement of the therapist with the client is increased by the nature of trauma therapy.

Three aspects of trauma therapy that contribute directly to vicarious traumatization were identified by Pearlman and Saakvitne (1995). These are: exposure to graphic trauma material; exposure to the realities of peoples' intentional cruelty to one another; and observation of and participation in traumatic re-enactments. As part of the healing process incest and sexual survivors often need to share graphic descriptions of the trauma they experienced including vivid imagery of bodily pain, sounds and smells. These graphic descriptions can shock or disgust the therapist and continue to haunt the

therapist long after the session. A normal response to the trauma material is to modulate one's emotions by a degree of withdrawal or numbing. Contrarily, emotional withdrawal or numbing by the therapist is counter-therapeutic for the client. Emotional numbing also diminishes the therapist's ability to be attuned to their own needs and self-protection.

Exposure to the realities of people's intentional cruelty to one another inevitably occurs in trauma therapy and impacts on the therapist's basic frame of reference and schemas (Pearlman & Saakvitne, 1995). Multiple occasions of listening to clients' stories that reveal this intentional cruelty overwhelm the therapist's defences leading to disruption of the frame of reference. As the authors point out it is very difficult to maintain a positive view of others as well-intentioned, families as loving, and childhood innocence in the face of the reality of intentional cruelty.

The third aspect of trauma therapy that contributes directly to vicarious traumatization is the observation of and participation in the client's trauma-related re-enactments. Pearlman and Saakvitne (1995) view these re-enactments of traumatic experiences as an inevitable aspect of psychotherapy with incest and sexual abuse survivors in the process of healing. For the therapist it can be particularly gruelling managing the client's transferences and projections within these re-enactments, as part of the psychotherapeutic process, across time, across therapy sessions, and across clients. It impacts greatly on the therapist's identity, basic schemas and cherished beliefs. The observation of and participation in re-enactments also refers to the therapist's various roles in the psychotherapy. These roles can include victim, perpetrator and bystander (helpless witness). These roles challenge the therapist's identity, ego ideal, and beliefs about self and others, and these challenges are in turn a step in the process of vicarious traumatization (Pearlman & Saakvitne, 1995).

Other specific aspects of trauma work that contributes to vicarious traumatization are the nature of the therapeutic process particularly with incest survivors, the nature of the client group, and the facts of childhood sexual abuse. These aspects all relate specifically to empathic engagement with the client's trauma material. The therapeutic relationship and the therapeutic process are often intense and intimate. The nature of the clientele, that is, trauma survivors and their adaptations also contribute to vicarious traumatization. Survivor clients' adaptations to the trauma and abuse frequently take

the form of chronic suicidality, chronic self-harming, mistrust, suspicion, narcissism, and persistent challenges to the therapist. The nature of trauma therapy including repeated exposure to trauma material in the context of empathic connection with the client is what creates vicarious traumatization in the therapist (Pearlman & Saakvitne, 1995).

A further aspect of trauma therapy that contributes to vicarious traumatization is a complex interaction between countertransference and vicarious traumatization, labelled the countertransference-vicarious traumatization cycle (Pearlman & Saakvitne, 1995). This also requires understanding for the therapeutic context and the countertransference-vicarious traumatization cycle is discussed in Part Three of this section.

Aspects of the therapist

According to Pearlman and Saakvitne (1995) the second major contributing factor to vicarious traumatization is the therapist themselves. They state:

> It is the interaction of both work, or situation, and therapist, or person, variables that is the key in the development of vicarious traumatization. Anything that compromises the therapist's ego resources, self capacities, or any unresolved personal issues, can set the stage for vicarious traumatization. Again, the specifics of what contributes to each therapist's vicarious traumatization will depend on the individual. [The authors] discuss the therapist's self or personality, personal history, current personal circumstances, and place in… professional development as they may contribute to vicarious traumatization
>
> (p. 306).

An aspect of the therapist that can contribute to the development of vicarious traumatization is illustrated by looking briefly at professional development. For example, if a therapist has not had appropriate training for trauma work then the lack of a theoretical framework is likely to present difficulties in managing boundary issues with the client. The lack of training may also lead to the therapist not seeking appropriate and adequate supervision which can be hazardous to both therapist and client.

Other contextual factors

There are both organisational and social contextual factors that contribute to vicarious traumatization. Pearlman and Saakvitne (1995) identified three general aspects of the

work context that are influential in a therapist's resistance or vulnerability to the effects of vicarious traumatization: organisational, professional and socio-political aspects. Organisational aspects include: the clinical work setting, (eg. long work hours; large caseloads; too many long-term trauma clients; consecutive sessions with trauma survivors), and inadequate supervision and ongoing training of trauma therapy. Professional aspects include: support for and understanding of trauma work; therapist isolation; access to services to refer clients for adjunctive treatments; and inadequate self-care interventions. Socio-political factors like gender bias, and victim-blaming can be influential. Funding factors can also be significant such as the cutting of funds for longer-term psychotherapy or programmes for survivor clients.

The multiple factors that contribute to vicarious traumatization in therapists engaged in trauma therapy are equally relevant to nurses working in mental health services. The relevance and implications of vicarious traumatization for psychiatric mental health nurses are more fully explored in Section Three.

The impact of trauma work has far-reaching and deleterious effects to the inner world and relationships of the therapist. Across time and across clients the impact accumulates and usually results in the vicarious traumatization of the therapist. Vicarious traumatization affects the very being of the therapist and impacts on the ability to conduct open, honest and beneficial relationships. This can lead to the dissolution of personal relationships, loss of friends, conflict with colleagues, and leaving the profession. Vicarious traumatization is hazardous to the therapeutic relationship and if the therapist's abilities are unwittingly impaired it can even be fatal to the client. The risk of vicarious traumatization increases significantly if it is not recognised and addressed. Self-care and self-protection by therapists and clinicians is crucial to the use of self in the therapeutic relationship.

The recognition and knowledge of vicarious traumatization are the beginning stages of clinician self-care. Clinicians also need to know the differences between vicarious traumatization and similar constructs such as PTSD and burnout. In addition, knowledge of the countertransference-vicarious traumatization cycle is necessary in ameliorating the effects of vicarious traumatization.

Part Three: Other aspects of vicarious traumatization

The discussion of vicarious traumatization thus far has looked at the CSDT framework, how vicarious traumatization occurs, how it affects the health professional and what contributes to it. There are other aspects of this phenomenon that play a significant part in the risks and impact of vicarious traumatization on the health professional. Of particular note are the countertransference-vicarious traumatization cycle and its impact on hope. For a complete understanding of vicarious traumatization it is necessary to discuss the likenesses and differences with similar constructs such as PTSD and burnout. Finally, it is also necessary to be aware of alternative modes through which helping-induced trauma can occur.

Countertransference-vicarious traumatization cycle

In the research on the impact of trauma therapy on the therapist it has been noted that vicarious traumatization and countertransference have a distinct relationship to one another. The dynamic between the two is labelled the countertransference-vicarious traumatization cycle (Pearlman & Saakvitne, 1995). The negative effects of the cycle on the therapeutic process are significant and can seriously diminish the hope of the therapist, which can potentially impact on the client.

The complex interaction between countertransference and vicarious traumatization, the countertransference-vicarious traumatization cycle, requires understanding for the therapeutic context as it has significant implications for the therapist and the client. It is acknowledged that while each is a separate and distinct construct and experience, they affect one another, and can create a cycle of reactivity between the two (Pearlman & Saakvitne, 1995). Countertransference is specific to: a particular client; an event in that therapeutic relationship; and its therapist-client dynamic. Whereas, vicarious traumatization is accumulative, across clients, and extends into the therapist's professional and personal lives. A further difference between the two is that "vicarious traumatization is permanently transformative, while countertransference is temporally and temporarily linked to a particular period, event, or issue in the therapy or in the therapist's inner or external life as it interacts with the therapy" (Saakvitne, & Pearlman, 1996, p. 47).

The cycle of reactivity between countertransference and vicarious traumatization occurs both within and across clients and treatments. Pearlman and Saakvitne (1995) use the

CSDT construct to explain how countertransference response set the stage for vicarious traumatization and vice versa. In brief, both constructs are concerned with the self of the therapist and the therapist's self-awareness. Saakvitne and Pearlman (1996) explain it thus: "Vicarious traumatization changes the self of the therapist, which is the context for all countertransference responses. Thus vicarious traumatization invariably shapes countertransference" (p.48).

'Countertransference affect' and psychological defences which are associated with countertransference can also set the stage for vicarious traumatization. Countertransference affect can be intense and when the therapist is immersed in a particular therapeutic moment or response the therapist's self-awareness can be reduced. In this state the therapist's cherished beliefs and values are vulnerable to erosion and vicarious traumatization. The intense countertransference affects also challenge a therapist's identity, personally and professionally, which can greatly distress the therapist and erode their therapeutic usefulness. If the therapist's countertransference affects are unacceptable to their self-identity then the defence mechanisms of denial and blocking may occur. This further lessens the self-awareness of the therapist making them more vulnerable to vicarious traumatization (Pearlman & Saakvitne, 1995).

Pearlman and Saakvitne (1995, p.318) also identified the risk of 'cumulative countertransference'. Cumulative countertransference occurs through the multiple intense countertransferences in sequential sessions of trauma therapy. In this state a therapist becomes tired and less self-protective, or overstimulated and less insightful and less alert to potential modes for vicarious traumatization.

Trauma work with incest and sexual abuse survivors will evoke a range of strong affective, spiritual and identity responses in the therapist. The therapist will experience these powerful countertransference motions in the context of their own self-capacities (Pearlman & Saakvitne, 1995). When the strong feelings cause unease or exceed affect tolerance then the therapist will draw upon their own familiar protective psychological defence mechanisms. The defence mechanisms disrupt the therapeutic use of self particularly the therapist's empathy, affective availability and genuineness with the client.

The countertransference-vicarious traumatization cycle impacts negatively on the therapist's self-awareness and the therapeutic use of self with serious implications for the therapeutic process. Unaddressed vicarious traumatization and unanalysed countertransference responses can lead to therapeutic errors and impasses as well as the loss of hope in the therapeutic process. The therapist's (and nurse's) hope is an essential element of the therapeutic relationship and is vulnerable to vicarious traumatization.

Hope

Damage to and loss of hope in the therapist is the most harmful aspect of vicarious traumatization and other helping-induced traumas. Saakvitne and Pearlman (1996) remark that "perhaps the most insidious impact of vicarious traumatization over time is its assault on [the therapist's] hope and idealism" (p.49). The harm can be found in the therapist's despair, cynicism, sadness, and disillusionment. The damage to and loss of hope incurred in helping-induced trauma is variously described in the literature: the 'cost of caring'(Figley, 1995, p.1); 'soul weariness' (Stamm, 1999, p.xix); and 'soul sadness' (Chessick as cited in Pearlman and Saakvitne, 1995, p.282). Pearlman and Saakvitne (1995, p.287 & p.308) wrote of 'existential isolation' and a 'spiritual crisis' associated with the loss of hope that results from unchecked vicarious traumatization.

Hope is vital to the therapeutic process and Saakvitne and Pearlman (1996) consider the there is an obligation to the client on the part of the health professional to ensure they are not damaged by the work they do. The authors believe "addressing vicarious traumatization is an ethical imperative" (p.49). Hope is also an essential element of psychiatric mental health nursing. Protecting hope and ameliorating the effects of vicarious traumatization is helped by knowledge and understanding of this phenomenon. This knowledge is furthered by the contrast to similar constructs such as PSTD and burnout.

PTSD

Post-traumatic stress disorder (PTSD) can be the result of a direct experience of a trauma. Its diagnosis is confirmed through the reported traumatic event with a strong emotional reaction, plus the presence of three clusters of symptoms: intrusion, avoidance and disordered arousal (Scott & Palmer, 2000). PTSD sufferers have persistent intrusive and distressing memories of the trauma during the day and

nightmares which disturb sleep; and cannot tolerate any reminders of the trauma. In addition, they develop avoidant/numbing symptoms to ward off the memories and painful emotions, and this can develop into dissociative symptoms and obsessional defences. Finally, PTSD sufferers experience autonomic arousal and are always on guard and mistrustful of others and the environment. The disturbed arousal is manifested in insomnia, irritability, agitation, exaggerated startle response, and hypervigilance (Friedman, 1996, 2000; Wylie, 1996).

Helping-induced trauma on the other hand arises from an indirect experience of trauma. However, there is a clear similarity in the signs and symptoms in both forms of trauma. Figley (1995) asserts "Secondary Traumatic Stress Disorder (STSD) is a syndrome of symptoms nearly identical to PTSD" (p.8). Pearlman and Saakvitne (1995) note that vicarious traumatization includes signs and symptoms of PTSD in addition to other symptoms of anxiety and depression. Stamm (1999) also notes that secondary traumatic stress (STS) and compassion fatigue may include features of complex PTSD, depression and substance abuse.

Vicarious traumatization differs from PTSD, STSD, and compassion fatigue specifically because it has its foundation in constructivist self development theory (CSDT) which emphasises meaning and adaptation. Whereas PTSD and STSD have their foundations in a symptom-based diagnosis and focus primarily on a constellation of symptoms (Pearlman and Saakvitne, 1995). Vicarious traumatization does have similarities with PTSD, depression and other helping-induced traumas. It also has a similarity with the signs and symptoms of burnout.

Burnout

Burnout is the second most cited concept in the literature that is contrasted against helping-induced trauma. The characteristic symptoms of burnout are physical, emotional, and mental exhaustion, depersonalisation, and reduced personal accomplishment as an employee. Burnout is perceived as a process which occurs across time and is associated with clients with a high degree of chronicity, acuity and complexity, where staff feel the clients needs are beyond the service's capabilities (Astin, 1997; Figley, 1999; Munroe, 1999).

Pearlman and Saakvitne (1995) are clear that burnout is different from vicarious traumatization. They commented that vicarious traumatization is more than emotional exhaustion and demoralisation. Figley (1995) made the distinction that burnout emerged gradually whereas secondary traumatic stress (STS) can emerge suddenly with little warning. He also noted that in addition to the rapid onset of STS that there is a sense of helplessness and confusion, and a sense of isolation from supporters in contrast to burnout. In Stamm's (1999) book a number of authors made a distinction between burnout and helping-induced trauma, or assumed this distinction including: Stamm herself, as well as Munroe (1999), Kassam-Adams (1999), Figley (1999), and Pearlman (1999). This distinction is also made between burnout and depression among 'wounded healers' (Rippere & Williams, 1985). While making the distinction that helping-induced trauma is different to burnout all of the authors acknowledged there is some overlap and even co-morbidity of the two. The similarities and co-morbidity can be misleading in the recognition of vicarious traumatization and other helping-induced traumas.

Alternative modes

The discussion on vicarious traumatization has identified the therapeutic relationship and one-to-one contact between the health professional and the client as the setting for the trauma to occur. The literature on helping-induced trauma also identifies alternative modes, or pathways, by which the trauma can occur. Other modes include reading clinical notes, research on trauma, and the debriefing and supervision of trauma, emergency, and disaster personnel (Saakvitne & Pearlman, 1996; Stamm, 1999; Figley, 2002; Meldrum, King & Spooner, 2002). These alternative modes for how vicarious traumatization can occur need to be taken into consideration by health professionals, educators and administrators.

Vicarious traumatization is a complex construct and needs to be understood in its component parts. The effects of vicarious traumatization on the health professional can be extremely damaging which in turn can impact negatively on the client. Therefore it is imperative that its complexities are laid out. The potential damage of the countertransference-vicarious traumatization cycle for therapist and client highlights the need for identification, intervention and prevention. Identification requires knowing what vicarious traumatization is not. It is not PSTD or burnout although the similarities

can be misleading. The theoretical basis of CSDT is what distinguishes vicarious traumatization from other helping-induced traumas and similar constructs.

What it is not and how vicarious traumatization occurs, and its effects, are relevant to psychiatric mental health nurses. To minimise the risks of vicarious traumatization and ameliorate its damage requires a thorough understanding of the phenomenon. Awareness of the alternative modes for helping-induced traumas is also necessary. The position of knowledge and understanding leads to the final part of this section, which addresses prevention.

Part Four: Prevention of vicarious traumatization

The potential risks of vicarious traumatization cannot be completely eliminated. The use of empathy and the nature of therapeutic work with trauma survivors preclude this. Rather prevention is concerned with risk minimisation and offsetting or ameliorating the negative effects. The interventions are the same for both minimisation and amelioration, that is, prevention.

The key features of prevention are: knowledge and understanding of vicarious traumatization; clinician self-care; and professional and organisational safeguards. These features are relevant for health professionals, supervisors, educators and managers, as well as consumers (Pearlman & Saakvitne, 1995). The need for understanding vicarious traumatization has been emphasised throughout this paper and the implications of lack of knowledge will be addressed later.

Clinician self-care is concerned with self-awareness, reflective practices and restorative activities, and has interweaving professional and personal aspects. The professional aspect encompasses individual responsibility for: appropriate training and ongoing education for trauma work; adequate and relevant supervision; support systems; and the acknowledgement of the rewards of therapeutic work. By way of example, in reducing the potential damage of the countertransference-vicarious traumatization cycle Pearlman and Saakvitne (1995) stress the importance of ongoing attention to the therapist's self-capacities. They recommend that it is helpful before and after a clinical session to notice one's emotional state and needs, particularly what was difficult in the session, as this information provides signals as to one's current vulnerabilities as well as self-care. This self-awareness can then be reflected upon in supervision and any further

interventions can be planned. These further interventions might include more theoretical knowledge, further personal development or ethical considerations.

The personal aspect of clinician self-care is concerned with the need for balance in one's personal and professional lives, and particularly attending to restorative activities of spirituality, self, and family. Leisure activities that distract from thoughts of work are an important part of personal self-care. The therapist whose identity is built upon their work is especially vulnerable to vicarious traumatization (Pearlman & Saakvitne, 1995).

The professional and organisational safeguards are the same as the professional aspects of individual self-care. Managers and clinical leaders also have a responsibility to ensure that clinicians are appropriately trained and supported for the work, have access to ongoing education and supervision, and acknowledging the successes and rewards of the work. Clinicians, clinical leaders and managers also to ensure adequate support systems including access to relevant professional and discipline specific colleagues and groups.

With regard to supervision and preventing vicarious traumatization is must be noted that there are particular components and special issues of trauma therapy supervision that need to be attended to. Health professionals, supervisors, educators and managers all have a responsibility for ensuring regular, adequate and appropriate supervision. For example, adequate support and supervision for new therapists needs to include weekly supervision as well as group supervision as a minimum to minimise the risks of vicarious traumatization (Pearlman & Saakvitne, 1995).

In offsetting or ameliorating the negative effects of vicarious traumatization Pearlman and Saakvitne (1995) stress the need to take the time to reflect on the rewards of the work and celebrating successes. As they point out trauma therapy does work and for the clients it "can resolve long-standing intrapsychic and interpersonal difficulties and discover meaning and hope in their lives" (p.400). They further suggest that time and success in therapeutic work can help heal some of the effects of vicarious traumatization.

The prevention of vicarious traumatization is relevant to psychiatric mental health nurses who face many of the same issues as trauma therapists. The features of prevention including clinician self-care, and professional and organisational safeguards are applicable to nurses and therapists.

Conclusion

Section Two has focussed on the discussion of vicarious traumatization and its complexities including its theoretical base, aetiology, and effects. The discussion has also considered the similarities and differences with other helping-induced traumas, PTSD and burnout. There has been an emphasis on needing to understand how vicarious traumatization occurs, how it affects the health professional and what contributes to it. Having considered the insidious, pervasive and negative effects, it can then be seen why a thorough understanding is critical to identifying vicarious traumatization, minimising its risks and ameliorating its damage. The effects of vicarious traumatization can also impact negatively on clients and hence there is a further imperative for addressing this phenomenon.

Throughout the discussion of vicarious traumatization an effort has been made to signal the relevance of and connections with psychiatric mental health nursing. The following section further explores vicarious traumatization and the relevance and implications for nurses. Suggestions are also made of what vicarious traumatization might look like in nurses.

SECTION THREE: RELEVANCE AND IMPLICATIONS OF VICARIOUS TRAUMATIZATION TO PSYCHIATRIC MENTAL HEALTH NURSES

Section Three further discusses the relevance and implications of vicarious traumatization for psychiatric mental health nurses. Parallels are drawn between psychiatric mental health nursing and trauma therapy, and between incest survivors and people with mental illness, to illustrate how vicarious traumatization occurs in nursing practice. Using the CSDT framework a number of the negative effects of vicarious traumatization are highlighted and suggestions made about what the effects might look like in the nurse. These effects will illustrate the implications for the therapeutic relationship, nurse and client. The recognition of vicarious traumatization as an occupational hazard is discussed in the light of what the literature is saying. The implications of unrecognised and unaddressed vicarious traumatization in nurses are examined. Finally, recommendations are made for ameliorating the effects of, and preventing, vicarious traumatization in psychiatric mental health nurses.

Vicarious traumatization as an occupational hazard

The relevance and implications of vicarious traumatization for psychiatric mental health nurses is discussed in two parts. The first part addresses the parallels between psychiatric mental health nursing and trauma therapy, and between incest survivors and people with mental illness. The parallels illustrate the process of how vicarious traumatization can occur in nurses. The second part focuses more on the implications and highlights some of the effects of vicarious traumatization. Suggestions are given of how the negative effects might be manifested in the nurse.

The relevance of vicarious traumatization for psychiatric mental health nurses begins with the client. Nurses have an ethical responsibility to do no harm to the clients they work with. Vicarious traumatization affects the person of the nurse and impacts on the therapeutic use of self and the therapeutic relationship. The therapeutic relationship is the point of connection between the nurse and the client and is the medium by which the client is offered healing and recovery. If this medium is impaired then the client is not offered the optimum opportunity toward wellness. In addition, a nurse affected by vicarious traumatization can unwittingly do harm to the client and to herself. Moreover, nurses have a professional responsibility to themselves individually, and to the profession in general, to be aware that vicarious traumatization can potentially cause

harm to both. The harm can occur either through the loss of the nurse who may leave the profession, or a public perspective that psychiatric mental health nurses are uncaring and non-therapeutic.

There are a number of parallels between psychiatric mental health nursing and trauma therapy, and between incest survivors and people with mental illness, with regard to vicarious traumatization. As discussed earlier the most obvious parallel between therapists and psychiatric mental health nurses is that they both work in therapeutic relationships with the associated issues of the use of self, empathy, transference and countertransference, and self-awareness. Both groups of clients have concerns regarding risk and safety for self and others, which must be managed within the therapeutic relationship. The therapist and the nurse are exposed to trauma material on a regular basis due to the nature of the client groups. These factors are all concerned with the risks of vicarious traumatization occurring in the health professional.

A further parallel between the nurse and the therapist, and between the two client groups is the social context in which all live and work. That is, the attitude of the world towards both incest and mental illness, including ignorance, victim-blaming, stigma and discrimination. The shame experienced by incest survivors and people with mental illness, and the secrecy and silence which surrounds both, present similar therapeutic issues to the therapist and the nurse. There is another parallel for the health professionals and both groups of clients with regard to the damage that can occur psychologically and emotionally to the client in response to the traumatic experience. The incest survivor's trauma responses and adaptations impact on all aspects of their life. A diagnosis of mental illness is traumatic in itself. Furthermore, the progress of a mental illness can affect the person's personal growth and development, relationships with family, friends and others, and view of the world. Mental illness can impact on a person's aspirations in life such as career, education, marriage, children and travel. Both groups of clients can have issues of trust, self-esteem, safety and control. Hence, nurses working with people with mental illness are faced with many of the same therapeutic issues as a therapist's working with incest survivors. These parallels reflect factors that contribute to the risk of vicarious traumatization for both nurses and therapists. The nature of psychiatric mental health nursing and the nature of the client group as factors that contribute to the risk of vicarious traumatization were discussed

earlier. At this juncture the relevance of those risk factors are revisited, and areas of potentially increased risk for nurses are highlighted.

Psychiatric mental health nurses can come in contact with people who have suffered any type of trauma, at any stage of recovery, and with a wide range of post-traumatic effects. Some of this contact is likely to occur in the context of enduring post-traumatic effects such as PTSD, depression, and suicidality. There can also be contact in the immediacy and crisis of the trauma, for example, rape or hit and run victims. There can be specific trauma groups such as refugees from war, famine and persecution. There is also a large group of clients with backgrounds of family violence, emotional abuse, and parental alcohol and drug abuse. However, the group that nurses are most likely to come into contact with regarding trauma are incest and sexual abuse survivors (Read & Fraser, 1998). The reason for the contact is likely to be about some aspect of the client's functioning or post-traumatic effects. People with mental illness who are experiencing acute exacerbations of the illness can also be traumatised or may behave in ways that are traumatising to others.

As nurses provide a 24 hour, seven day a week service particularly in crisis services, acute admissions and psychiatric intensive care facilities they are likely to come into daily contact with trauma. Exposure to trauma and to the risk of vicarious traumatization increases when clients are highly distressed, disinhibited, grossly thought disordered or acutely psychotic. In such states the risk can increase for such things as traumatic re-enactments with self-mutilation, self-harm and suicidality. The risk increases for clients to blurt out graphic and unpleasant details and/or accuse the nurse of being a perpetrator of violence. Incest and sexual abuse survivors can have multiple identity and dissociative disorders as a means of psychological protection. When the client is very distressed the nurse may have to deal with the dissociation and different alter personalities such as the homicidal and vengeful alter, the bewildered and frightened child, or the alter who endures the sexual abuse. When the nurse feels unable to help or is a silent witness to the sequelae of trauma the risk of vicarious traumatization increases.

Some clients have been very damaged by the trauma experience and/or mental illness with the result that they don't have the usual social skills and discernment, are unable to trust, and constantly challenge relationship boundaries. Constant challenges to the

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nurse's abilities, caring and trustworthiness can be extremely taxing. At times these clients may test the nurse and her abilities by deliberately telling the nurse of horrific acts the client has perpetrated, seen, or have endured themselves. These occasions can occur when the nurse is empathically engaged in helping the client and therefore has little self-protection. Again, the risk of vicarious traumatization is significantly increased in such a situation.

An unfortunate and potentially traumatising aspect of psychiatric mental health nursing is working with clients who may have perpetrated a horrific violent act when acutely psychotic, or the client who may have been very disinhibited and sexually promiscuous during a manic episode. Such occurrences are extremely traumatising to the client when their mental state is stabilised and the person realises what has happened. The nurse is exposed to not only the horror of what was perpetrated or occurred but also to the client's traumatization from their cognisance of their actions. Moreover, in situations such as this the nurse can be exposed to the family's traumatization.

In daily practice nurses are exposed not only to trauma material from survivors but are exposed to a client's descriptions of auditory and visual hallucinations, which can be of a violent and sadistic nature. These daily and accumulative exposures to trauma material and elements of violence place psychiatric mental health nurses at high risk of vicarious traumatization.

The instances outlined above all set the scene for, or contribute toward, vicarious traumatization in the psychiatric mental health nurse. It is the repeated exposure to trauma material or clients' trauma histories over time and across clients that leads to vicarious traumatization. A further instance where the nurse can be exposed to trauma and trauma material is by indirect contact through the client's clinical files, clinical meetings, judicial reviews or heard from a colleague in the shift handovers. Having addressed instances of where the nurse can be exposed to the client's trauma experience and trauma material the discussion now moves on to how and where vicarious traumatization can impact on the nurse.

Implications for practice
This part of Section Three considers a number of typical scenarios found in psychiatric mental health nursing, which illustrate how and where vicarious traumatization can

impact on the nurse, and how the effects of this might be manifested. The effects on the nurse follow the CSDT framework including: frame of reference; self-capacities; ego resources; basic psychological needs and cognitive schemas. The impact and effects of vicarious traumatization have significant implications for nurses and clients that become apparent in the scenarios.   In the nursing scenarios trust, risk and safety are consistent themes just as they are in trauma therapy. The suggestions regarding what vicarious traumatization might look like in the nurse are drawn from my own clinical experience although they are informed by helping-induced trauma literature.

In daily practice the nurse is constantly dealing with safety and risk in relation to the client's mental status and degree of wellness. Often this can mean dealing with a client's self-mutilating/harming behaviours, and suicidality. As for the therapist, managing this demanding and sometimes frightening tension is exacting on the nurse. The constant exposure and tension can lead to preoccupation with the client's safety to the extent that it intrudes into the nurse's home life and relationships. Worrying about the client's safety means the nurse can't give attention to her own relationships and needs at home. Or the nurse may have little energy left over for her personal relationships and feel that her partner's needs are too demanding or trivial in comparison to what she is dealing with at work. Waking suddenly in panic that you have overlooked some aspect of the client's safety, real or imagined, is greatly distressing to the nurse. The nurse struggling with such challenges to her sense of self and identity is at risk of vicarious traumatization.

The impossibility of keeping the client safe at all times can be overwhelming for the nurse. The nurse can respond by becoming over-vigilant, rigidly adhering to protocols and work routines, and prolonging the constant observation status of the client. By these actions the nurse conveys to the client the message that the client is not trustworthy, not capable or not in control. This state of affairs undermines the client's opportunity, ability and confidence to develop and utilise healthier and safer ways of managing their own safety. It also sets up the power struggle between the nurse and the client, which may replay the child and parent or authority figure scenario. Some clients will react to this dynamic by challenging the nurse's ability and authority, and the boundaries of the relationship. This client may respond with destructive behaviour to self, others or environment. This can in turn create even more attempts by the nurse to

control the client's behaviour and safety in what becomes a self-perpetuating cycle of damage to both the client and the nurse.

In addition, the truly awful extent of some clients' repeated self-harming and suicidal behaviours can become overwhelming for the nurse. The nurse can become fatalistic about the client and this loss of hope for the client is destructive to the therapeutic relationship. The nurse also has to deal with the fact that some people do commit suicide. This challenges the nurse's professional identity, sense of self and view of the world. Furthermore, the nurse's professional identity is a core component of her overall identity and any disruption can be very distressing.

In concert with the nurse's awareness of and struggle with the client's safety can be the knowledge of the earlier trauma perpetrated on the client. There is not just the horror of what the client may do to themself but there is the horror of what was done to the client. This can disrupt the nurse's world view to the extent of feeling confused, vulnerable, and hopeless and helpless in the face of such odds. The change in world view can defeat the nurse's greatest therapeutic gift, which is, the nurse's belief in the process and hope of healing (Pearlman & Saakvitne, 1995).

How might the disrupted world view of the nurse manifest itself? Becoming inured to tales of extreme brutality can be a sign. Other signs might be cynical remarks, the peculiarly jaded view of life that some nurses express, and discriminatory attitudes toward users of mental health services. Another sign might be some aspects of the black humour found among psychiatric mental health nurses. A disrupted world view can in turn affect the nurse's personal relationships and spirituality. These signs of vicarious traumatization are always harmful to the therapeutic relationship (Pearlman & Saakvitne, 1995).

Self-capacities and ego resources that are damaged and/or impaired can cloud cognitive processes and result in maladaptive or harmful behaviours. Ego resources that are sensitive to vicarious traumatization include: insight, empathy, self-protective judgement, interpersonal boundaries, and awareness of one's own psychological needs. Impaired ego resources in the nurse might be evidenced by overwork, preoccupation with therapeutic work, lack of sensitivity and interest in own needs and personal relationships. This might be the nurse who works much overtime, visits work on days

off, and seems to have constant marital or relationship difficulties? Compromised ego resources can lead to professional errors in boundaries, judgement and strategies or decision-making difficulties. This may be the nurse who overextends herself and becomes resentful, or seems unable to set appropriate limits, or dithers about treatment planning. A nurse with impaired ego resources can have less insight and with the loss of empathy with clients is unable to make effective therapeutic use of self. Pearlman and Saakvitne (1995) also stress that less self-awareness means less notice of transference and countertransference processes and this can result in further damage and retraumatization to the client.

According to Saakvitne and Pearlman (1996), a therapist's basic psychological needs and cognitive schemas are inevitably altered by working with trauma survivors. I would suggest that the psychological needs and cognitive schemas of psychiatric mental health nurses are also inevitably altered by their work. Disruptions in basic psychological needs translate into interpersonal difficulties (Pearlman & Saakvitne, 1995), which affect personal and professional relationships. Nurses will have changes in their safety and trust needs and cognitive schemas in particular. The nurse's beliefs about the safety of self and loved ones are challenged in the face of clients' stories of abuse and lack of safety. Clients who have also been perpetrators of violence and abuse in conjunction with a mental disorder can especially lead to the nurse having altered perceptions regarding safety and risk.

In clinical practice a disrupted sense of safety and security might be manifested in the nurse's constant concerns that clients do not know where the nurse lives or of the existence of the nurse's loved ones. While there can be very real risks of breaches of safety and security in nursing, especially in forensic services, I have observed nurses who have no actual experience of such a breach yet are constantly anxious and aroused by the possibility. A disrupted sense of safety can also translate into hypervigilance and fear of victimisation that can permeate beyond work into the nurse's home life. This can include increased security systems at home and fearfulness about letting the children play outside. At work this may be the nurse who is constantly conducting security checks, and wants to do the checks in pairs. In addition, nightmares which reflect disrupted safety needs have been reported by therapists (Pearlman & Saakvitne, 1995), and my own experience is consistent with these reports. Disrupted safety needs

can also impact on the nurse's personal life to the extent that the partner's sexual advances are rejected or the nurse avoids intimate contact.

Trust is another basic psychological need and cognitive schema that is affected by trauma. Saakvitne and Pearlman (1996) report that changes in "self-trust and trust in others are also common as [the therapist] is exposed to reports of dangers that couldn't be prevented and to the potential for betrayal by seemingly trustworthy people" (p.36). Psychiatric mental health nurses are similarly affected working with clients with incest and sexual abuse backgrounds especially if the perpetrator is still part of the client's life. In this situation the nurse has to trust her clinical judgement as to whether a client is mentally and emotionally stable enough to keep themselves safe. A nurse working in an inpatient facility with disrupted trust needs might for example, intervene directly by vetoing the client's leave from the unit rather than assessing the client and trusting one's clinical judgement.

Working with chronically suicidal clients challenges the health professional's trust in themself, their decisions, and assessments (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). Working with this client group regularly reminds the health professional of one's fallibility in judging and predicting others' behaviours. Chronically suicidal clients are often high users of mental health services and nurses in daily contact with these clients can have their self-trust and other trust needs excessively challenged. Because trust needs are intimately connected to our dependence and independence needs, any disruption can lead to rejection of external resources and supports. A nurse with vicarious traumatization might reject or question her colleagues' clinical judgements and therapeutic abilities, or lose confidence in her own clinical judgement and compensate by opting for the most restrictive intervention in an attempt to keep the client safe. This might be the crisis nurse who seems to always seek inpatient admission, or the acute unit nurse who insists the client be nursed in the intensive nursing care area and/or wants the client on a high level of constant observation for long periods.

Pearlman and Saakvitne (1995) were concerned to point out how pervasive and life-changing the disrupted trust needs in vicarious traumatization can be. The disruption of other trust needs can manifest in behaviours such as not socialising, preferring to be alone, avoiding friends. Perhaps the psychiatric mental health nurse with disrupted

other trust needs might prefer night shift, as this can minimise contact with clients, colleagues, friends and family.

Working with chronically suicidal and self-mutilating clients on a daily basis will challenge the nurse's beliefs and actions regarding control. As with disrupted other trust needs the nurse may respond by trying to control the client and the environment with restrictive interventions. Conversely, some nurses and therapists give up trying to control any aspect of their lives in the face of daily exposure to the limits of control (Saakvitne & Pearlman, 1996). Another possibility is that the nurse with disrupted other control needs may not advocate for the client in treatment planning or give up trying to work with the client's issues about control.

The disruptions to psychological needs and schemas that occur from vicarious traumatization can have profound affects on the health professional's relationships with loved ones, colleagues and clients. The loss of self-awareness, self-esteem and empathic connection with clients can be soul destroying for the worker and can ultimately impact negatively on the client's recovery. Pearlman and Saakvitne (1995) also identified other important signs of vicarious traumatization in the therapist's sensory systems including: intrusive imagery, nightmares, emotional numbing, avoidance of reminders, social withdrawal, and emotional flooding. Psychiatric mental health nurses can and do experience these signs of vicarious traumatization. It may manifest in the nurse as increasing alcohol and drug use/abuse, irritability, frequent sick leave, or even excessive hours on the computer.

Vicarious traumatization occurs through the health professional's repeated exposures to the client's trauma experience, sequelae, and trauma material. The nature of psychiatric mental health nursing, and the nature of the client groups clearly place nurses at high risk of vicarious traumatization. The impact and negative effects of vicarious traumatization have serious implications for nurses. The pervasive and life-changing effects of vicarious traumatization can impact on the lives of nurses professionally as well as personally. There are also serious implications for clients. Nurses affected by vicarious traumatization can unwittingly cause damage to the client's wellbeing and recovery. In turn this may lead to the social cost of a client remaining in need of health services for a much longer time. Implications for clinical leaders and managers arise in further social costs including the loss of nurses from mental health services and the

profession, the cost and high risk for service provision, and a limited ability to provide quality mental health services.

The implications of vicarious traumatization extend far beyond nurses, clients, and their families to clinical leaders and service providers, and then beyond to educators and supervisors, finally to regulatory bodies and policy makers. Given the relevance and implications of vicarious traumatization to nurses, clients and beyond, begs the question of whether it is recognised as an occupational hazard by mental health services and the psychiatric mental health nursing profession.

Is vicarious traumatization recognised? - Yes and no
Pearlman and Saakvitne (1995) have argued that anyone who engages empathically with people is at risk of vicarious traumatization. This ranges from religious ministers, to workers on suicide hotlines, to nurses, to psychologists and so on. The authors also comment that anyone who works with trauma survivors whether physical (natural events eg. earthquake), psychological, victims of torture, domestic violence, incest and sexual abuse are at risk of vicarious traumatisation. This includes emergency personnel, rape crisis workers, and psychiatric mental health nurses. The risks are associated with the nature of the client group, type of work, work situation, and training and supervision of the workers.

Having argued that psychiatric mental health nurses are at risk of vicarious traumatization, the ensuing issue is whether it is recognised as an occupational hazard to nurses. Helping-induced trauma as a risk to any nurse is not widely discussed in the nursing literature in general (Alexander & Atcheson, 1998). The literature does report on PTSD in psychiatric mental health nurses that has resulted from direct trauma such as assault by a patient (Caldwell, 1992; Buyssen, 1996). However, there is little reporting on vicarious traumatization or any helping-induced trauma among psychiatric mental health nurses (Clinton, Moyle, Weir, & Edwards, 1995). Although, in the trauma and stress literature there is a considerable body of work regarding vicarious traumatization in counsellors and therapists engaged in trauma therapy with incest, sex abuse and rape survivors. Compassion fatigue and/or secondary traumatic stress in helpers working with war veterans, refugees, and torture victims is also widely discussed. In addition, the literature addresses helping-induced trauma in those working with individuals, families, and communities affected by natural disasters, and man-made

events such as bombings and shootings. The helping-induce trauma literature does discuss risk and relevance for some mental health service personnel in certain settings or roles but nurses are not identified as an at risk worker group.

Since the mid-nineties a small number of papers on vicarious traumatization and/or work–induced trauma have been published in the psychiatric mental health nursing literature. The papers have usually had one of three themes: understanding vicarious traumatization in general; the risk of vicarious traumatization when working with specific client groups; and the risk of vicarious traumatization when working with certain client presentations and behaviours. The majority of these nursing papers have addressed the risk of vicarious traumatization when working with specific client groups. The groups identified include: incest and sexual abuse survivors (Weaver, Varvaro, Connors & Regan-Kubinski, 1994; Crothers, 1995; Evans, 2000); rape and sexual assault victims (Johnson & Hunter, 1997); domestic violence victims (Davies et al, 1996); and military personnel (Fillion, Clements, Averill, & Vigil, 2002). The risk of vicarious traumatization for nurses working with clients with certain presentations and behaviours focussed on borderline personality disorder and self-harming behaviours (O'Brien & Flote, 1997; Wilkins & Warner, 2001); and dissociative identity disorder (McAllister et al, 2001). Awareness and understanding of vicarious traumatization was the topic of the least number of papers found in the nursing literature (Blair & Ramones 1996; Clark & Gioro, 1998; Cosentino, 2000).

Only one paper was located that specifically addressed the risk of vicarious traumatization for nurses while noting that nurses are regularly exposed to clients' trauma experiences and trauma material (Tyra & Crocker, 1999). This paper also noted that the theoretical basis of vicarious traumatization offered nurses a solid framework for understanding trauma and it effects on survivors. Furthermore, Tyra and Crocker (1999) noted that responsibility for addressing the risk of vicarious traumatization went beyond the individual nurse to educators, administrators and clinical teams.

The response to the question posed: 'is vicarious traumatization recognised as an occupational hazard?' has to be yes, and no. Yes, it is acknowledged by a small number of nurses, and no, it is not widely recognised as a risk by psychiatric mental health nurses. This brings us to the position that vicarious traumatization is an occupational hazard due to nature of daily nursing practice, and is yet to be validated in the nursing

literature as such. In the meantime it is ethically imperative that the risks and the effects of vicarious traumatization be addressed, as ultimately the human cost to nurses, and to clients is too great.

Psychiatric mental health nurses need to know about vicarious traumatization because not only are there are implications for nurses but for clients, and for colleagues, supervisors, educators, managers, service providers and policy makers. These implications all pertain to the need for a healthy nursing workforce. A healthy nursing workforce will provide a quality service to clients and their families. To achieve this goal there are individual and collective responsibilities and actions for preventing vicarious trauma and ameliorating its impact and effects.

Nurses have individual and collective responsibilities for the prevention of vicarious traumatization. Actions include attending to: self care; supervision; ongoing trauma training and education; and raising awareness of this occupational hazard amongst nurses and their colleagues from other disciplines. Likewise supervisors, educators, and managers need to attend to their roles and responsibilities for these actions. For prevention there are evaluation tools, educative programmes, and other resources readily available online and in hard copy from the key authors and institutes.

Conclusion

In this section I have discussed the relevance and implications of vicarious traumatization for psychiatric mental health nurses. The parallels between psychiatric mental health nursing and trauma therapy, and between incest survivors and people with mental illness were used to illustrate the relevance. The implications for practice were highlighted in the discussion on how vicarious traumatization can occur in nurses and the impact and effects of this. The implications extend beyond the nurse to the client and on to educators and service providers. Small scenarios of what vicarious traumatization might look like in the nurse were used to illustrate the pervasive and insidious effects of this helping-induced trauma. The discussion concluded that vicarious traumatization is an occupational hazard for nurses due to the nature of daily practice and of the client groups. However, this risk is largely unrecognised and unaddressed in the profession and as such there is an ethical and professional imperative to act to remedy this situation.

CONCLUSION

This paper argues the relevance and implications of vicarious traumatization for psychiatric mental health nurses. The paper presents a case for why nurses need to know about helping-induced trauma, and the potential impact on clients and service delivery. The wider implications of vicarious traumatization, and professional responsibilities in relation to it are identified. The paper concludes with recommendations for short and long term strategies for the prevention and amelioration of the effects of vicarious traumatization.

Vicarious traumatization is the deleterious effects on the health professional, or helper, that results from empathic engagement with trauma survivors, their trauma experience, sequelae, and trauma material (Pearlman & Saakvitne, 1995). The intention of this paper was to: show that vicarious traumatization is relevant to psychiatric mental health nurses; that it can and does occur in nurses; and is an occupational hazard but that the risk is not widely known in the profession; and finally, that there are significant implications for nurses, clients, and service providers from the effects of vicarious traumatization.

Section One describes psychiatric mental health nursing and the centrality of the therapeutic relationship in order to make the link with therapists doing trauma therapy, and to illuminate the relevance of vicarious traumatization for nurses. The key factors in the risk of vicarious traumatization are shown to be present in daily nursing practice. Those factors include exposure to trauma and trauma material, the therapeutic use of self, the nature of the client groups, and the work context. What has became evident is the significant risk of and potential for exposure to trauma in daily practice. The risks and vulnerabilities inherent in the therapeutic use of self and empathic engagement are identified. The multiple and varied occasions of empathic engagement in daily nursing practice reinforces the significant risk for nurses. The risk of vicarious traumatization for nurses is also shown to increase in the light of the high number of mental health clients with backgrounds of sexual abuse. The risk further increases because of the nature of the work context, that is, of daily nursing practice. What is surprising is just how much nurses are at risk of vicarious traumatization in daily practice.

Section Two presents contemporary conceptualisations of vicarious traumatization: what it is, what it is not, how it occurs, and what contributes to it. The importance of understanding vicarious traumatization as a pre-requisite for preventing and ameliorating its impact and effects was made explicit. The relevance and implications of vicarious traumatization for nurses becomes evident in the discussion of the construct. The theoretical basis of CSDT is proposed as a holistic framework for nurses to use to gain insights into, and understanding of, trauma and its effects on clients and themselves. Section Two concludes with the prevention and amelioration of vicarious traumatization. It notes that the potential risks cannot be completely eliminated due to the nature of therapeutic work and nursing.

The final section extends the argument of the relevance and implications of vicarious traumatization for psychiatric mental health nurses. Further parallels between nursing and trauma therapy are drawn to illustrate the relevance for nurses, and likewise the parallels between the two groups of clients. The insidious and pervasive negative effects of vicarious traumatization on the health professional and its implications are discussed. Suggestions of how vicarious traumatization might look in the nurse are made to highlight the implications. It is identified that the implications extended further than the nurse, to the client, and beyond. The argument is made that vicarious traumatization is an occupational hazard for nurses, that it is not widely recognised, and that the profession is not addressing this with sufficient emphasis. The serious implications of this situation are discussed, and it is suggested that there is the wider issue of sustaining a healthy nursing workforce. The ethical imperative to remedy this occupational hazard is emphasised and prevention strategies and resources readily available are made known.

Recommendations

Psychiatric mental health nurses are at risk of permanent damage from unrecognised and unaddressed vicarious traumatization. Clients can be permanently damaged too as a result of vicarious traumatization in nurses. Nurses, clinical leaders, supervisors, educators and managers need to act promptly to remedy this situation. Increasing awareness of this occupational hazard and its effects need to be a priority now. The next priority must be that of training and education in assessing, preventing, and minimising the risks of vicarious traumatization. In the immediate future nurses need to attend more carefully to their self-care needs and ensure they have regular access to

appropriate supervision. Supervisors and managers need to ensure as soon as possible that nurses are able to attend to self-care and supervision needs. Mental health service providers must support clinicians and managers in prevention strategies. Educators need to begin now in educating themselves and nurses of the risks of helping-induced trauma. Each of these groups needs to initiate training programmes in clinical areas for nurses and others. Policy makers also need to be made aware of the risks of vicarious traumatization to nurses and to clients.

In the longer term, nurses, service providers and policy makers must work toward a healthy nursing workforce policy with prevention strategies at a national level. A national approach could help improve nursing recruitment and retention needs in this country. Educators need to include helping-induced trauma and prevention into the curricula of nursing programmes at undergraduate, specialty practice, and postgraduate levels. Supervisors also need to ensure that training includes helping-induced trauma so that appropriate supervision is offered to nurses. At the same time there is a pressing need for research into vicarious traumatization amongst psychiatric mental health nurses.

On a more personal note the process of writing this paper has been a challenging and rewarding journey. The extent of the risk of vicarious traumatization for psychiatric mental health nurses is alarming and has strengthened my resolve that nurses do need to be more proactive about their self-care as clinicians. Discovering the usefulness of the CSDT framework for nurses has been one of the rewards. The insights gained into vicarious traumatization will go with me in my practice, professional, and teaching roles. These insights have also encouraged me to pursue the issues in the future. I hope that this contribution to raising awareness of the risk of helping-induced trauma will be of use to nurses in carrying forward this important subject and work.

REFERENCES

Alexander, D., & Atcheson, S. (1998). Psychiatric aspects of trauma care: Survey of nurses and doctors. *Psychiatric Bulletin, 22,* 132-136.

Altschul, A. (Ed). (1985). *Psychiatric nursing.* Edinburgh: Churchill Livingstone.

Astin, M. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), *More than a mirror: How clients influence therapists' lives* (pp.101-109). Missouri-St Louis: Hogarth Press.

Barker, P. (1996). The logic of experience: Developing appropriate care through effective collaboration. *Australia and New Zealand Journal of Mental Health Nursing, 5*(1), 3-12.

Barker, P. (1997). *Assessment in psychiatric and mental health nursing: In search of the whole person.* Cheltenham,UK: Stanley Thorne (Publishers) Ltd.

Barker, P. (2001). The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of psychiatric and mental health nursing, 8*(3), 233-240.

Becks, C., Rawlins, R., & Williams, S. (1988). *Mental health- psychiatric nursing: A holistic life-cycle approach.* Missouri: C. V. Mosby.

Blair, D., & Ramones, V. (1996). Understanding vicarious traumatization. *Journal of Psychosocial Nursing and Mental Health Services, 34*(11), 24-30. Abstract retrieved September, 26, 2002 from http://tpdweb.umi.com/tpweb

Buyssen, H. (1996). *Traumatic experiences of nurses: When your profession becomes a nightmare.* London: Jessica Kingsley Publishers.

Caldwell, M. (1992). Incidence of PTSD among staff victims of patient violence. *Hospital and Community Psychiatry, 43*(8), 838-839.

Cerney, M. (1995). Treating the "heroic treaters". In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 131-149). New York: Brunner/Mazel.

Clark, M., & Gioro, S. (1998). Clinical scholarship: Nurses, indirect trauma and prevention. *Image: Journal of Nursing Scholarship, 30*(1), 85-87. Abstract retrieved September, 26, 2002 from http://tpdweb.umi.com/tpweb

Cleary, M., & Warren, R. (1998). An exploratory investigation into women's experiences in a mixed sex psychiatric admission unit. *Australia and New Zealand Journal of Mental Health Nursing,* 7(1), 33-40.

Cleary, M., Edwards, C., & Meehan, T. (1999). Factors influencing nurse-patient interaction in the acute psychiatric setting: An exploratory investigation. *Australia and New Zealand Journal of Mental Health Nursing,* 8(3), 109-116.

Clinton, M., Moyle, W., Weir, D., & Edwards, H. (1995). Perceptions of stressors and reported coping strategies in nurses caring for residents with Alzheimer's disease in a dementia unit. *Australia and New Zealand Journal of Mental Health Nursing,* 4(1), 5-13.

Clinton, M., & Nelson, S. (1999). *Advanced practice in mental health nursing.* Oxford: Blackwell Science.

Consentino, B. (2000). When helping hurts: Vicarious traumatization. *Nursing Spectrum,* 4(1), 10-11. Abstract retrieved September, 26, 2002 from http://tpdweb.umi.com/tpweb

Crothers, D. (1995). Vicarious traumatization in the work with survivors of childhood trauma. *Journal of Psychosocial Nursing and Mental Health Services,* 33(4), 9-13, 44-5. Abstract retrieved September, 26, 2002 from http://tpdweb.umi.com/tpweb

Crowe, M. (1998). Developing advanced mental nursing practice: A process of change. *Australia and New Zealand Journal of Mental Health Nursing,* 7(3), 86-94.

Davies, J., Harris, M., Roberts, G. Mannion, J., McCosker, H., & Anderson, D. (1996). Community health workers' response to violence against women. *Australia and New Zealand Journal of Mental Health Nursing,* 5(1), 20-31.

Dhondea, R. (1995). An ethnographic study of nurses in a forensic psychiatric setting: Education and training implications. *Australia and New Zealand Journal of Mental Health Nursing,* 4(2), 77-82.

Evans, B. (2000). "Opening a can of worms": Barriers to the assessment of clients with a history of sexual assault. *Book of Proceedings,* 26th International Conference of Australia and New Zealand College of Mental Health Nurses, Gold Coast, Australia, 75-80.

Ens, I. (1998). An analysis of the concept of countertransference. *Archives of Psychiatric Nursing,* X11(5), 273-281.

Figley, C. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Figley, C. (1999).Compassion fatigue: Toward a new understanding of the costs of caring. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Ed., pp. 3-28). Maryland, USA: Sidran Press.

Figley, C. (2002). *Treating compassion fatigue.* New York: Brunner-Routledge.

Fillion, J., Clements, P., Averill J., & Vigil, G. (2002). Talking as a primary method of peer defusing for military personnel exposed to combat trauma. *Journal of Psychosocial Nursing and Mental Health Services,* 40(8), 40-49.

Fontaine, K., & Fletcher, J. (1995). *Essentials of mental health nursing* (3rd Ed). California: Addison-Wesley .

Forchuk, C. (1993). *Hildegard E. Peplau: Interpersonal nursing theory.* Newbury Park, California: Sage

Friedman, M (2000). PTSD diagnosis and treatment for mental health clinicians. In J. Scott & S. Palmer (Eds.), *Trauma and post-traumatic stress disorder* (pp. 1-14). London: Cassell.

Friedman, M. (1996). PTSD diagnosis and treatment for mental health clinicians. *Community Mental Health Journal,* 32(2), 173-189.

Fry, A. (1998). Spirituality, communication and mental health nursing: The tacit interdiction. *Australia and New Zealand Journal of Mental Health Nursing,* 7(1), 25-32.

Gastmans, C. (1998). Interpersonal relations in nursing: a philosophical-ethical analysis of the work of Hildegard E. Peplau. *Journal of Advanced Nursing,* 28(6), 1312-1319.

Geanellos, R. (1995). Storytelling: What can it reveal about the knowledge of mental health nursing. *Australia and New Zealand Journal of Mental Health Nursing,* 4(2), 87-94.

Gillette, J. (1996). Child sexual abuse: Working with survivors. *Australia and New Zealand Journal of Mental Health Nursing, 5(2), 69-76.*

Horwood, L., & D Fergusson, D. (1998). *Psychiatric disorder and treatment seeking in a birth cohort of young adults* (Ministry report). Wellington, NZ: Ministry of Health.

Johnson, C., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. *Work & Stress,* 11(4), 319-328. Abstract retrieved September, 26, 2002, from http://tpdweb.umi.com/tpweb

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Ed., pp. 37-50). Maryland: Sidran Press.

Kilbourn, P. (Ed.). (1995). *Healing the children of war: A handbook for ministry to children who have suffered deep traumas.* California: MARC.

McAllister, M., Higson, D., McIntosh, W., O'Leary, S., Hargreaves, L., Murrell, et al. (2001). Dissociative identity disorder and the nurse-patient relationship in the acute care setting: An action research study. *Australia and New Zealand Journal of Mental Health Nursing,* 10(1), 20-32.

McCann, I., & Pearlman, L. (1990a). *Psychological trauma and the adult survivor: Theory, therapy, and transformation.* New York: Brunner/Mazel.

McCann, I., & Pearlman, L. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress,* 3(1).

McMahon, R., & Pearson, A. (Eds.). (1991). *Nursing as therapy.* London: Chapman & Hall.

Meichenbaum, D. (2000). Helping the helpers. In J. Scott & S. Palmer (Eds.), *Trauma and post-traumatic stress disorder* (pp. 117-121). London: Cassell.

Meldrum, L., King, R., & Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. In C. Figley (Ed.), *Treating compassion fatigue* (pp. 85-106). New York: Brunner-Routledge.

Ministry of Health, (1997). *Moving forward: The national mental health plan for more and better services.* Wellington, NZ: Author.

Munroe, J. (1999). Ethical issues associated with secondary trauma in therapists. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Ed., pp. 211-229). Maryland, USA: Sidran Press.

Murphy, S. (2001). Traumatic events: Individual and collective responses. In J. Fitzpatrick & P. Wilke (Eds.), *Psychiatric mental health nursing research digest* (pp. 230-233). New York: Springer Publishing Company.

Nursing Council of New Zealand. (2000). *New Zealand registered nurses, midwives and enrolled nurses workforce statistics.* Wellington, NZ: Author.

O'Brien, A. (1999). Negotiating the relationship: Mental health nurses' perceptions of their practice. *Australia and New Zealand Journal of Mental Health Nursing, 8*(4), 153-161.

O'Brien, L., & Flote, J. (1997). Providing nursing care for a patient with borderline personality disorder on an acute inpatient unit: A phenomenological study. *Australia and New Zealand Journal of Mental Health Nursing, 6*(4), 137-147.

Pearlman, L. (1999). Self care for trauma therapists: Ameliorating vicarious traumatization. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Ed., pp. 51-65). Maryland, USA: Sidran Press.

Pearlman, L., & Mac Ian, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6).

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Peplau, H. (1952/1988). *Interpersonal relations in nursing* (reissued). London: MacMillan.

Read, J., & Fraser, A. (1998). Staff response to abuse histories of psychiatric inpatients. *Australian and New Zealand Journal of Psychiatry, 32*, 206-213.

Rippere, V., & Williams, R. (Eds.). (1985). *Wounded healers: Mental health workers' experiences of depression.* Chichester, UK: John Wiley & Sons Ltd.

Saakvitne, K., & Pearlman, L. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: Norton.

Scott, J. & Palmer, S. (Eds.). (2000). *Trauma and post-traumatic stress disorder.* London: Cassell.

Simpson, H. (1991). *Peplau's model in action.* London: Macmillan.

Stamm, B. (1997). Work-related secondary traumatic stress. *PTDS Research Quarterly,* 3(2), 1-6.

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

Stamm, B. (Ed.). (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Ed). Maryland, USA: Sidran Press.

Steed, L. & Downing, R. (1998). A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies,* 2. Retrieved July, 21, 2001, from http://www.massey.edu/~trauma/issues

Tyra, P., & Crocker, K. (1999). The risk of vicarious traumatization. [Electronic version] *Massachusetts Nurse,* 69(6). Retrieved September, 26, 2002, from http://firstsearch.oclc.org/html/webscript.html

Valent, P. (1995). Survival strategies: A framework for understanding secondary traumatic stress and coping in helpers. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp.21-50). New York: Brunner/Mazel.

Watts, R., & de L Horne, D. (1994). *Coping with trauma: The victim and the helper.* Brisbane: Australian Academic Press.

Weaver, P., Varvaro, F., Connors, R., & Regan-Kubinski, M. (1994). Adult survivors of childhood sexual abuse: survivor's disclosure and nurse therapist's response. *Journal of Psychosocial Nursing and Mental Health Services,* 32(12), 19-25. Abstract retrieved September, 26, 2002 from http://tpdweb.umi.com/tpweb

Wilkins, T., & Warner, S. (2001). Women in special hospitals: Understanding the presenting behaviour of women diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing,* 8(4), 289-297.

Wilson, H., & Kneisel, C. (1996). *Psychiatric Nursing* (5th Ed). California: Addison-Wesley

Wylie, M. (1996). Researching PTSD: Going for the cure. *The Family Therapy Networker,* July/August, 21-37.