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The development of a model for dealing with secondary traumatic stress in mental health workers in Rwanda

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ABSTRACT

Introduction: Mental health workers who listen to stories of fear, pain and distress of traumatised clients may develop deleterious emotional, cognitive and physical consequences (Cairns, 2007). This phenomenon has been called secondary traumatic stress (STS) (Perez, Jones, Englert, & Sachau, 2010). Rwanda is well-known for the 1994 genocide, with the death of hundreds of thousands of people in a planned campaign of violence. Numerous mental health workers operating in Rwanda were also victims of the violence and it has been suggested that there is a high level of STS in mental health workers in Rwanda (Iyamuremye & Brysiewicz, 2008).

Aim: To develop a comprehensive model to manage the effects of STS in mental health workers operating in Rwanda.

Method: An action research project was initiated to develop this model and data for the model was collected through individual interviews with mental health workers (nurses, doctors, psychologists, trauma counsellors and social workers) as well as a quantitative tool measuring secondary traumatic stress (Trauma Attachment Belief Scale) in these health workers.

Results: The Intervention Model to Manage Secondary Traumatic Stress (IMMSTS) was synthesised from these findings and includes preventive, evaluative and curative strategies to manage STS in mental health workers in Rwanda at the individual, social and organisational levels.

Conclusion: The model will offer mental health professionals an effective framework for addressing the issue of STS.

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1. Introduction

Rwanda is known throughout the world for the 1994 genocide where up to one million people were massacred during the 100-day genocide against the Tutsi. The recovery process has presented huge national and personal challenges for survivors (Schaal & Elbert, 2006). During the genocide, Rwandan women were subjected to sexual violence on a massive scale committed by elements of the notorious Hutu militia groups, well-known as the Interahamwe (Mukamana & Brysiewicz, 2008). Mental health workers who listen to these stories of fear, pain and distress of traumatised clients may develop their own deleterious emotional, cognitive and physical consequences (Cairns, 2007). This phenomenon has been called STS (Perez et al., 2010). Since numerous mental health workers operating in Rwanda are themselves victims of trauma, it is imperative to ensure that appropriate psychological support services are developed to help them deal with STS. A pilot study showed that there was a high level of STS in mental health workers in Rwanda which warranted further intervention (Iyamuremye & Brysiewicz, 2008).

The emotional consequences of working with traumatised individuals are visible in diverse ways, namely STS (Stoesen, 2007), compassion fatigue (Bride, Radey, & Figley, 2007) and vicarious traumatisation (Pearlman & McKay, 2008). Mental health workers may feel negative changes in their professional functioning, self and worldviews, sense of security, self-capacities and psychological needs as a result of indirect exposure to STS (Shah, Garland, & Katz, 2007). The impact of STS on mental health workers in Rwanda and the insufficient support system need to be investigated, as mental health workers who are overburdened with work, stress and their own traumas have few resources left to care for and comfort others (Iyamuremye & Brysiewicz, 2008). Unfortunately, most mental health workers are unaware of the nature and extent of STS, lack access to supportive resources and have little or no training about how to recognise symptoms in themselves and others, or how to respond to the resulting distress (Satkunanayagam, Tunariu, & Tribe, 2010).

Although attention has been paid to the process of healing primary victims of trauma (Bicknell-Hentges & Lynch, 2009), an enquiry into the therapeutic practice of mental health workers helping traumatised patients shows that very little has been done to manage the trauma of secondary victims. The aim of this study was to develop a comprehensive model which integrated primary, secondary and tertiary interventions in managing the effects of STS in mental health workers operating in Rwanda.

2. Development of the model

The Intervention Model to Manage Secondary Traumatic Stress (IMMSTS) was developed by using an action research design with mixed methodology. The researchers attempted to remain true to the mutually collaborative action research approach (Koshy, 2010) and ensured that health professionals were encouraged to be actively involved in the change process. At the beginning of the study, a research team consisting of experts in mental health care was established in keeping with the mutually collaborative action research approach. Inclusion criteria were that they had to hold either a qualification as a medical doctor, psychiatrist, psychologist, mental health nurse, social worker or trauma counsellor and expressed interest in being involved in the project. The research team members who guided the entire research process were involved in all aspects of the planning and implementation of the project. It was anticipated that once the research was completed, they would take a leading role in continuing the process of implementing the newly developed IMMSTS and leading the possible change in practice.

The research study comprised four cycles. Cycle 1 was the establishment of the research team and collection of quantitative descriptive data measuring the extent of STS using the Trauma Attachment Belief Scale (Pearlman, 2003). The results from this cycle then informed the questioning in Cycle 2 with the collection of qualitative data through individual interviews with mental health workers including nurses, doctors, psychologists, trauma counsellors and social workers regarding their experiences of STS (Iyamuremye & Brysiewicz, 2012). A summary of the main findings from these two cycles are presented in Box 1.

Cycle 3 was an amalgamation of the findings from Cycle 1 and 2, as well as relevant literature, to develop the IMMSTS (see Fig. 1); this process was guided by Taylor-Powell and Henert (2008). The key elements included in the IMMSTS were preventive, evaluative and curative strategies to manage STS in mental health workers in Rwanda. In the process of generating the model, the research team started by describing what the model was trying to represent and to identify and describe the concepts active in the domain of STS management and then analyse them in terms of the phenomenon of interest. The research team also attempted to develop a visual representation of the IMMSTS. They attempted to use the idea of an algorithm as a way of visually presenting the IMMSTS because in the mental health practice staff are familiar with the use of algorithms. Cycle 4 was the implementation of the IMMSTS. After each cycle the research team reflected on the data obtained in the previous cycle and planned and refined the following cycle.

Permission to carry out the study was obtained prior to the initiation of data collection from the authorities of mental health services in Rwanda and the research committee of the University of KwaZulu-Natal, South Africa (the researcher was a student). Written consent was given by the participants; anonymity and confidentiality were maintained. Owing to the sensitive nature of the subject matter being discussed, the researchers were aware of the need to provide psychological support should it be necessary, and they had the appropriate skills to do so. The issue of ownership of the data and the research team members' role in the study was negotiated at the beginning of the study.