Review

Who cares for the caregivers? Application of vicarious trauma prevention research to prison healthcare professionals

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Vicarious trauma (VT), defined as disruption of an individual's important or fundamental beliefs about themselves, others or the world, is a complication of working with vulnerable patients. It affects the wellbeing of healthcare professionals, as well as their personal lives and ability to provide care. There is little literature on VT in prison healthcare professionals; however, vulnerable patient populations, empathy towards crime victims, the workplace environment and risk of assault place these individuals at risk. This study reviews the literature on preventing VT in high-risk healthcare professional groups, considering how findings could be applied to prison healthcare in the absence of group-specific research. Seven papers were included, covering VT prevention in social workers, rape crisis centre staff, obstetricians, intensive-care professionals and disaster workers. Successful interventions included both formal and informal workplace support, especially from senior staff, VT education and strategy teaching, and independent measures to build personal resilience. These interventions have potential application to prison healthcare. Group support appears especially appropriate, considering the complex environment and specific challenges. Future research looking into VT in prison healthcare is needed.

Introduction

Vicarious trauma (VT) is defined as disruption of an individual's important or fundamental beliefs about themselves, others, or the world, induced by prolonged exposure to patients' traumatic experiences.[1-3] This reduces the ability of healthcare workers to engage empathetically with patients and provide best care, having an impact on wellbeing. VT symptoms can mimic post-traumatic stress disorder and may include intrusive thoughts, depressed mood, tendency to withdraw, changes in world views, and negative impacts on self-esteem, feelings of safety and personal relationships.[1,3] If VT remains unidentified without intervention, it can develop into burnout, a state of emotional exhaustion and fatigue, to the detriment of professionals and institutions.[1,3]

Several factors within prison healthcare could promote VT. First, prisoners are vulnerable patients, with many having experienced difficult, traumatic lives, facing exclusion and social rejection. Prisoners are 13 times more likely to have been in care than the general population, up to half of female prisoners have experienced domestic abuse and one in three are thought to have experienced sexual abuse.[4] Furthermore, up to nine in ten have at least one mental health diagnosis, and risk of suicide is 3.7 times higher in the male prison population than the general male population.[4,5] As healthcare workers are trusted, patients may disclose past trauma. Consequently, over time, professionals accumulate secondary trauma from patients' experiences, creating a high-risk environment for VT.

Second, there is potential for empathy towards patients' victims, a unique prison healthcare factor derived from treating perpetrators rather than victims. Many professionals avoid details about patients' crimes; however, where details are known, there is potential for victim trauma to add to professionals' VT from dealing with prisoners, causing further secondary trauma.[3]

Third, prisons are noisy, overcrowded environments, often lacking facilities and resources to provide optimum healthcare. Noisier and harsher prison conditions correlate with poorer staff wellbeing, and increased smoking and drinking rates.[6] Reduced wellbeing could increase vulnerability to secondary trauma. Additionally, risk of inmate-on-staff assault is a potential stressor, especially if professionals have had previous incidents, increasing vulnerability to VT and burnout.[7]

There is limited literature describing VT risk in professionals with prolonged exposure to graphic descriptions of cruelty, abuse, assault and other traumatic events. However, there is little literature focused specifically on risk and prevalence of VT amongst prison healthcare professionals, and no interventions have been reported for the prevention of VT in prison staff. This study, therefore, reviews the evidence for VT prevention in other high-risk professionals, considering its application to prison healthcare professionals.

Methods

The online database Medline was searched (search date: 20 July 2018), identifying papers published between 2008 and 2018, using the search terms: "Vicarious Trauma" and "Prevention"; "Vicarious Trauma" and "Intervention". This provided 17 results. Inclusion criteria were English language, either 'prevention' or 'intervention' in the abstract, and discussing VT in healthcare professionals. Nine articles were excluded after abstract screening and, of the eight remaining articles, only four could be accessed. "Vicarious Trauma Prevention" was also searched on NICE Evidence (www.evidence.nhs.uk; accessed: 20 July 2018), giving 32 results, three of which met the inclusion criteria. Altogether, seven articles were included.

Results

The key findings from each of the articles included are summarised in **Table 1.** The main preventative measures were formal senior supervision, informal peer support (including support groups), education on VT and wellbeing techniques, improved working conditions, and individual measures to reinforce resilience.

Support was widely discussed, including both formal senior guidance and informal support from peers. Focus groups with oncology social workers highlighted the value of regular formal supervision sessions, tailored to seniority.[8] These groups gave opportunities for case discussions and reflection and supported professional development.[8] Several papers suggested younger professionals are at higher VT risk than more experienced colleagues, due to lack of experience or less-established coping mechanisms.[3,8,9] Therefore, senior supervision

should focus on younger professionals, tailing off as the professional becomes more experienced and senior. When surveying rape crisis centre staff, the protective role of supervision varied with seniority;[9] this is a factor to consider when designing support systems.[4]

The articles suggested that informal support from friends and family was useful,[10] but research focused on support from colleagues who understood workplace demands and trauma exposure. Informal support was valued, including discussions during breaks and within open-plan offices, and accessible open-door policies.[8] These gave social workers opportunities to discuss and debrief, helping minimise the emotional impact of work.[8] The National Society for the Prevention of Cruelty to Children's report on VT highlighted peer support in preventing isolation and promoting feelings of team working towards the same goal.[11] Case discussions and peer support was provided in monthly Balint groups for obstetrics and gynaecology doctors, which give clinicians space to discuss a patient that remains on their minds and recognise their emotional reactions to the case.[12] After 6 months, significantly lower levels of burnout and VT were reported and professionals found these groups so useful they were continued indefinitely.[12]

Institutions play a role in VT prevention through providing education and improving working environments. In one study in intensive care professionals, educational preventative measures were split into education about VT, awareness of symptoms and effects, and coping skills. Assessment of these preventative measures found that the most effective were person-directed interventions, such as relaxation, mindfulness, coping strategies and cognitive behavioural training.[13] Improvements in working environments, such as managerial awareness of caseload and ensuring even distribution of work between staff, also reduces the burden on individual professionals.[1,10] Provision of services, such as counselling, helps support employees by facilitating the processing of secondary trauma before it becomes problematic.[1,10] Using combined measures to support staff, institutions could reduce the risk of VT and subsequent burnout, benefiting both staff and patients.

Finally, independent measures to build up personal resilience were applied to disaster workers,[10] highlighting the importance of balancing professional, physical and emotional aspects of life by giving time to hobbies, relationships and emotional self-care.[10] Investing time into personal relationships was particularly important, creating a support network outside of work, further protecting against VT.[10]

Discussion

The VT risk from working with patients with traumatic backgrounds can be addressed by preventative measures. Staff support includes informal peer support, team building, socialising and case discussion. Combining formal and informal support, providing Balint and discussion groups for peer support, and one-on-one supervision may be options for incorporating support into prison healthcare. Barriers to the application of these interventions in prison healthcare include small teams and teams in which nurses, general practitioners and healthcare assistants are employed by different bodies. Alongside staff support, education on VT awareness, wellbeing, resilience and coping strategies can improve staff wellbeing and reduce the impact of secondary trauma. While training could be beneficial, time and resource pressures and dispersed teams make this more challenging within prison environments. Encouraging personal measures and hobbies may be more practical, encouraging work–life balance and self-care, alongside workplace support.

This review identified interventions to minimise VT risk in high-risk healthcare professionals. However, none of the studies included were conducted on prison healthcare professionals or in prison environments. Prison is a complex and unique workplace, so, although secondary trauma risk in prison staff is likely to be comparable with that in other healthcare professionals, key differences, such as potential empathy for patients' victims and chaotic, noisy workplaces, may limit intervention effectiveness. Furthermore, the studies included used small samples drawn from single institutions, and methodologies with limitations, such as cross-sectional studies or focus groups. Future research should focus specifically on prison healthcare professionals, using high quality study designs, such as randomised control trials, and large sample sizes, to increase confidence in intervention outcomes.

In conclusion, VT is a potentially serious complication of working within prison healthcare. A multifaceted preventative approach, strengthening an individual's coping mechanisms, alongside equal distribution of workload, informal and formal support provision and VT education, may help minimise VT risk.

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Table 1. Summary of results from articles included.

Authors, year [reference]	Cohort details	Type of article/study	Key relevant findings	Limitations
Joubert et al, 2013 [8]	Social workers based in an oncology department	'Exploratory study'. Quantitative data collected from four weekly focus groups assessing the impact of social work on their professional practice, personal lives and potential interventions. Quantitative data collected using scales (TSIBS and ProQOL), assessing positive and negative effects of helping clients who have suffered trauma	• The scales showed raised levels of intrusive thoughts, avoidance, numbing and heightened arousal in the group • The three main themes identified in the focus group were the 'professional role of social work', 'the uniqueness of oncology social work' and the 'role of supervision, professional development and wider organisational supports' • Regular supervision sessions were identified as an integral part of protection against VT, as these give opportunities for discussion, reflection and development • Significant importance was placed on informal support by peers, including meetings over tea breaks, open-door management policies and discussions within an open-plan office • Based on the focus group, a model was proposed for supervision of less experienced team members in oncology social work, with formal and informal aspects	• Small sample (n=16) • Results were collected in focus groups instead of individual interviews so risk of group opinion influencing individual's responses
Kanno and Giddings, 2017 [1]	Mental health professionals	Review	Defines the different types of secondary traumatic stress, including VT, and gives different preventative methods, including: • Regular supervisory meeting for processing traumatic cases • Peer support: informal or specific groups to form support networks • Equal distribution of case load • Education and training on self-care and coping mechanism • External supervision • Provision of formal counselling	• Acknowledges that few studies on preventing traumatic stress give strong empirical evidence • Does not look at the barriers to accessing preventative measures
Allen et al, 2017 [12]	Obstetric and gynaecology doctors	Assessment of effectiveness of an emotional wellbeing intervention (a monthly 'work-related emotional wellbeing intervention' [Balint group] for 6 months) using ProQOL score	• Scores significantly improved over the 6-month intervention (reduced burnout and secondary traumatic stress and increased compassion satisfaction) • The intervention was so successful that it has been continued indefinitely since termination of the study	• Small sample (n=22) • Lack of a control or comparison group
Dworkin et al, 2016 [9]	Rape crisis centre staff	Cross-sectional survey to assess secondary traumatic stress	• Found that younger staff are more prone to secondary traumatic stress • Lower caseloads and supervision were found to be protective against secondary traumatic stress, but the level of protection supervision offered may vary with seniority	• Unable to look at the impact of different interventions over time as results were gathered at one time using cross-sectional methodology
Palm et al, 2004 [10]	Disaster and trauma workers	Literature review looking at the effects of working in disaster environments on professionals, and potential measures to limit secondary trauma and VT	• Multiple professions are involved in disaster response; healthcare providers, emergency service workers and journalists are all exposed to slightly different risk factors, but are all placed at risk of VT through their work • Potential interventions to minimise VT risk can be categorised into individual factors (maintaining personal health, work–life balance, good social support and acceptance by colleagues) and organisational factors (provision of training, managing caseloads, improving work environment within limitations, supervision and support within the workplace)	• No comparison of interventions, or measures of effectiveness when put into practice
van Mol et al, 2015 [13]	ICU healthcare staff	Systematic review, measuring the prevalence of compassion fatigue and burnout in ICU healthcare professionals and investigating the preventative strategies that are successful in this group. Interventions in the studies included were differing work schedules, education on emotional distress, communication skills, coping and relaxation strategies and improving work environments	• The systematic review included 20 papers on interventions, testing the effectiveness or 11 interventions (grouped into organised-directed and person-directed interventions) • Communication strategy teaching, mindfulness sessions and discussion groups were all effective in reducing emotional distress amongst ICU professionals • Person-directed interventions (CBT, relaxation skills and counselling) were the most effective of the proposed interventions	• Lack of RCTs and vigorous studies on this topic, so a meta-analysis couldn't be performed
NSPCC, 2013 [11]	NSPCC staff	Literature review	• Managerial supervision and peer support are frequently identified as potential VT interventions in the literature, as they prevent isolation of staff, instead allowing them to share the burden of what they hear during their work • It is important to recognise VT within the workplace as a serious problem rather than 'just part of the job', and provide staff education around the risks of VT	• Conducted as part of an NSPCC report rather than a peer-reviewed paper. Lacks comparison or discussion of the suggested interventions

CBT, cognitive behavioural therapy; NSPCC, National Society for the Prevention of Cruelty to Children; ProQOL, Professional Quality of Life Scale; TSIBS, Traumatic Stress Institute Belief Scale.

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