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Personal Trauma History and Incidence of Vicarious Trauma among Caregivers in Hospices

Phelista Marura Musili, Ph.D; Ann Merecia Sirera, Ph.D; & Beatrice Mwathi Kathungu, P.hD., Kenyatta University

Abstract

Hospice caregivers are constantly exposed to agonizing traumatic stories from patients and their families and this can trigger similar reactions within the caregiver as those experienced by the clients. Caregivers with personal trauma history are thought to be more prone to vicarious trauma, especially when there are similarities between their trauma and that experienced by their clients. Studies that have looked into the relationships between personal trauma history of caregivers and the risk of developing vicarious trauma have yielded equivocal results. The current study aimed at determining the relationship between personal trauma history, and occurrence of vicarious trauma among hospice caregivers. The study utilized a correlational research design. Random stratified sampling was used to select a total of ten hospices. The study sample comprised 70 members of staff in the sampled hospices. Data was collected using structured self-report tools and was analyzed using descriptive and inferential statistics. Pearson's correlation coefficient was used to analyze the data. Personal history of trauma had a significant positive relationship with the occurrence of vicarious trauma [r (70) =.275, p=.021]. The study recommended psychoeducation for caregivers to create awareness about the existence and possible risk factors of vicarious trauma. The study further recommended a need to develop appropriate assessment measures so that therapeutic interventions for caregivers with unresolved personal trauma can be advanced to help them.

Key words: Vicarious trauma, personal trauma history, hospice, hospice caregiver, chronic conditions, life threatening conditions, traumatic experiences

Introduction and Background

Exposure to trauma has become a common occurrence worldwide. Despite the variations in types and prevalence across countries, trauma is detrimental in many societies (Magruder, McLaughlin, & Borbon, 2017). The concept of vicarious trauma (VT) among care providers has been gaining attention in the recent past. The Constructivist Self-development theory by Pearlman and Saarkvitine (1995) defines vicarious trauma as the transformation of the inner

experiences of the caregivers as they engage with client traumatic material which may result in temporary or permanent disruption of their cognitive schemas. Studies have been conducted on the nature and toxic effects of VT particularly among caregivers working with traumatized clientele such as the chronically and terminally ill patients in hospice settings. Hospice care is a specialized and sensitive approach as it involves holistic care for persons who are terminally ill together with their families. The main goal of hospice care is to enhance the quality of life of the patients. Most of these patients suffer immense physical and psychological pain which can be overwhelming even for the caregiver. Literature highlights a number of risk factors that can be attributed to the occurrence of this phenomenon, including personal attributes such as history of individual trauma.

Hospice care givers may have experienced firsthand traumas in their own lives that may influence the way they perform their duties. For example, caregivers who have undergone similar trauma as their client likely to either over generalize their experiences or coping strategies to the clients (Figley, 1995). Personal trauma history entails the distinctive individual traumatic experiences of the caregivers (Pearlman & Saakvitne 1995a), which could include: physical violence (such as: robbery with violence); childhood abuse or trauma; serious injuries of self or others; death of a loved one; chronic and terminal conditions of self or significant others; experience of natural disasters (such as: landslides, floods or major earthquake); and or, man-made disasters such as motor vehicle or train crash, building collapse, fire among others (Jordan, 2010). Statistics show that majority of the global population have had exposure to at least one or more traumatic incidents. A study conducted in 24 low, middle, and high-income countries showed that 70.4% of the sample had been exposed to a traumatic event in their lifetime while 11.8% were exposed to life threatening illnesses (Kessler et al., 2017).

Historically, trauma is a phenomenon that has evolved over time. Many definitions in literature affirm that trauma involves the experience of a single- or multiple-traumatic events by an individual as emotionally threatening or overwhelming; and which has holistic and long-term effects (Goodman, Vesely, Letiecq, & Cleaveland, 2017). Numerous studies have sought to link unresolved personal trauma history with the occurrence of vicarious trauma and its deleterious effects. Over the years, studies conducted among trauma therapists found that majority of the therapists who had experienced personal trauma in their lives reported greater levels of VT and had more difficulties handling client material (Pearlman & MacIan

1995; Kassam-Adams 1995; Adams & Riggs, 2008; Radey & Figley, 2007; Bride, Jones & McMaster, 2007; Benoit, Veach & LeRoy, 2007). Many of these studies focused mainly on therapists and clinicians in health settings other than hospices. This study focused on all categories of staff in the hospice settings ranging from nurses, physicians, as well as other non-medics.

There has been minimal research on VT documented in Africa, particularly in Kenya. A study by Muli-Karugu (2006) on the prevalence of VT among caregivers in Kakuma refugee camp in Kenya found that 81% of the participants had a history of personal trauma with results also showing extremely high levels of VT specifically in subscales of safety, esteem and control recorded. The study concluded that caregivers with past unresolved traumas tend to have a deeper empathic response which may easily trigger traumas and the caregiver to re-live the experience. While Muli-Karugu (2006), in her study, mainly concentrated on VT prevalence; the study location was limited to a refugee camp; and the majority of the caregivers (73%) were non-medical participants; the current study sought to establish whether there was a relationship between personal trauma and VT among caregivers; was based on hospice settings in Kenya, and participants were drawn from across all cadres of hospice staff.

Alongside studies associating trauma history with VT, there has been recognition that having experienced personal trauma may not necessarily have a negative impact on some caregivers. Linley and Joseph (2007), observed that it is also very possible that a therapist's personal trauma history can be a protective factor in his or her personal growth potentially leading to an increased well-being. VanDeusen and Way (2006) conducted a study in USA to examine vicarious trauma effects in clinicians working with sexual abuse survivors and found no association between history of childhood abuse and VT outcomes. These findings concurred with those in a study by Knight (2010) which showed that trauma history did not correlate with adverse psychological impact. In addition, Hotchkiss (2018) found that hospice care providers who engaged in frequent self-care strategies had higher professional quality of life. Accordingly, if those caregivers with personal trauma histories have undergone therapy and recovered from their trauma, then they may be in a better position to initiate self-care techniques that prevent adverse effects such as VT. The results of these studies regarding personal trauma were contradictory and therefore not conclusive. Again, most of the related research conducted has focused typically on physical or sexual abuse, combat, and crises.

Furthermore, the implication in the reviewed studies is that the research findings on effects of personal history on occurrence of vicarious trauma is equivocal, hence the need for further research in this area. This study therefore, sought to find out the relationship between personal trauma history and incidence of vicarious trauma among hospice caregivers in Kenya.

Methodology

The study adopted a correlational approach. This design was chosen because the study sought to establish relationships between personal history of trauma and the incidence of vicarious trauma among hospice workers.

The study was carried out in selected hospices within Kenya. The target population of the study comprised 120 staff members employed within the hospices. The hospices were stratified into two subgroups: company owned free standing facilities (85.7%) and Faith-Based Organizations (FBOs) (14.3%). To ensure representativeness proportionate stratified sampling was used to select ten hospices. This guaranteed that participants from each subgroup were included in the final sample. The hospices were first stratified based on ownership criterion into two strata: the free-standing units which were privately owned and Faith-Based Organizations (FBOs) owned by faith or community-based organizations and which are mainly found in rural settings. A total of ten hospices were sampled. Since the hospices maintain a small workforce, the study included all the staff members comprising male and female personnel in the sampled institutions.
The study employed structured self-report tools to measure the variables. The demographic information of the participants was obtained using a brief questionnaire devised by the researcher. Personal trauma history was measured using a brief trauma history tool comprising 12 items adapted from the Trauma History Questionnaire (Green, 1996). Only items that were considered to be relevant to the hospice work like life threatening experiences were selected. For instance: *Have you ever had a serious or life-threatening illness?* The scale comprised ‘yes’ or ‘no’ responses. The lowest possible score was 0 while the highest possible score was 12. The items were then scored by adding up the scores of all the 12 items. A higher score meant higher level of trauma.

At analysis, the items were classified into six sources of personal trauma history. These

included: robbery by violence (to self), injury to self and others, terminal illness, death of loved ones, natural disasters, and man-made disasters. For each subscale a higher score meant higher level of trauma. The Vicarious Traumatization Scale (VTS) adapted from Middleton (2010) was used to measure VT among hospice workers. The questionnaires were administered face to face to individual respondents. Informed consent was sought from the participants before carrying out the study. The completed questionnaires were collected for safe storage. Ethical clearance was obtained from the Kenyatta University Ethics Review Committee (ERC) and the research permit was sought from the National Commission for Science, Technology and Innovation (NACOSTI). The researcher sought permission to access the hospices from the Kenya Hospice and Palliative Care Association (KEHPCA) Directorate as well as the administrators (CEOs) of individual hospices.

Data collected was analyzed using both descriptive and inferential statistics. Thus, means, percentages, frequencies and cross tabulations were used. Pearson correlation coefficient was applied to test the null hypothesis. The level of significance was set at $\alpha \leq 0.05$. Data obtained from the respondents was analyzed using the Statistical Package for Social Sciences (SPSS version 20).

Results

Majority of the participants rendering hospice care were female (77.1%) while their male counterparts comprised only 22.9%. The mean age of the participants was 40 years *(SD= 1.148)*. Many (65.7%) of the workers had certification beyond high school (tertiary and university education). Nursing was the main occupation which accounted for 48.6%. The support staff accounted for 27.1%. Regarding professional experience, majority of the participants (60%) indicated that they had worked for one to six years in hospice care.

Personal Trauma History of Respondents

Data on personal trauma history was first analyzed descriptively in order to give an overall picture. The mean score for history of personal trauma was 4.81 (*M=4.81, SD= 2.80*). The data on personal trauma scores was further analyzed to establish the scores of personal trauma history among the respondents.
The findings were presented in table 1.

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Table 1: General Scores of Personal Trauma History of Respondents

	Frequency	Percent
Low Scores on Personal Trauma History	26	37.1
Moderate Scores on Personal Trauma History	41	58.6
High Scores on Personal Trauma History	3	4.3
Total	70	100

Majority of the respondents recorded moderate to high scores of personal trauma history forming 62.9% of the total sampled population. Twelve items were used measure history of firsthand trauma but at analysis they were classified into six sources of personal trauma. Slightly more than half of the participants (58.8%) who had vicarious trauma had been exposed to robbery with violence. Nearly half of participants (47.1%) with vicarious trauma had been exposed to situations that involved serious injuries of self or others. Thirty percent of the participants who had vicarious trauma affirmed that they have had life threatening illness and 65% had family members, relative(s) or friend(s) who had life threatening conditions.

Correlation between Personal Trauma History and Overall Vicarious Trauma

To test the relationship between personal trauma history and overall vicarious trauma, Pearson product-moment correlation was computed, and its significance tested at an alpha (α) level of 0.05.

Table 2: Personal Trauma History and Vicarious Trauma

		Personal Trauma History	Occurrence of VT
Personal Trauma History	Pearson Correlation	1	.275*
	Sig. (2-tailed)		.021
	N	70	70
Occurrence of VT	Pearson Correlation	275*	1
	Sig. (2-tailed)	.021	
	N	70	70

*. Correlation is significant at the 0.05 level (2-tailed).

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The findings indicated that there was a significant positive relationship between personal trauma history and experience of VT [r=.275, p=.021] suggesting that the hospice workers who scored highly on personal trauma history were more likely to suffer vicarious trauma than those with low personal trauma history.

Predictor of Personal trauma on Vicarious Trauma

When all indicators of personal trauma were fitted into logistic regression, the model was statistically significant (χ^2 (6)=9.028, p=0.05); indicating that injury to self; terminal illness of self or others; and natural disasters were significant (p=0.008) as shown in Table 3.

Table 3: Logistic Regression of Personal Trauma History on Vicarious Trauma

Variable	B	S.E	Wald	df	Sig.	EXP(B)	95% C.I for EXP(B)	
							Lower	Upper
Injury of self	1.193	.681	3.073	1	.008	3.298	.869	1.193
Terminal illness of self and others	.819	.474	2.980	1	.008	2.268	.895	.819
Death of loved ones	.727	.698	1.084	1	.298	2.068	.527	.727
Robbery by violence to self	-.019	.672	.001	1	.977	.981	.263	-.019
Man-made disasters	1.267	.978	1.677	1	.195	3.551	.522	1.267
Natural disasters	-1.760	1.031	2.912	1	.008	.172	.023	-1.760
Constant	-5.519	1.837	9.028	1	.003	.004		

The findings in Table 3 imply that personal trauma such as injury to self and others; terminal illness in self or significant others as well as natural disasters experienced by caregivers could be significant pointers or predictors to vulnerability to vicarious trauma. These indicators of personal trauma in the current study are in line with those highlighted by Jordan (2010) which included traumas that happened in a caregiver's childhood or family of origin, serious injury or life-threatening illness of self or a loved one. Hospice staff may have experienced firsthand traumas in their own lives that may influence the incidence of vicarious trauma. Thus, a caregiver who suffers a chronic or terminal illness such cancer or has a loved one with such a condition is likely to get traumatized as he or she encounters client-based trauma that is similar to his or hers. In this case cancer of HIV related conditions are crucial as these are the main conditions that caregivers in Kenya are likely to be dealing with in the hospices.

It is possible that witnessing the disease process in clients could provoke anxiety and fear regarding one's own future or that of their loved ones.

Discussion

Every caregiver has a unique history of experiences that shapes the way he or she will interpret and react to traumatic events. History of personal trauma refers to the past as well as recent distinct experiences that an individual may have undergone which may impact how he or she responds to present traumatic situations. These personal experiences are unique in that they are subjective to the person, and they shape the way one views the world especially if they have not been resolved. Hospice staff may have undergone firsthand traumas in their own lives which may influence the way that they experience traumatic situations in their workplace as they offer their services. The findings of the study indicate that generally the care givers had high scores on personal trauma history. The analysis of data revealed that 50% of the respondents scored higher than the mean. In addition, 62.9% of the respondents reported moderate to high scores of personal trauma. This gives a general impression that many caregivers have had various exposures to traumatic events in their own lives. These findings corroborate the results of epidemiological surveys conducted by WHO World Mental Health (WHM) in low, middle and high income countries which found that 70.4% of the respondents reported experiencing lifetime trauma (Kessler et al., 2017).

In addition, these findings resonate with findings of a related study on Behavioural Health Clinicians in which a significant positive relationship was found between the personal trauma history and vicarious trauma symptoms (Adams & Riggs, 2008). Similarly, Pearlman and Mac Ian (1995) found that 60 % of clinicians who reported a personal history of trauma had significantly more vicarious trauma symptoms. The findings of this study also supported findings of other studies that found significant relationships between personal trauma and vicarious trauma (Graaf, 2011; Devilly & Varker, 2009; Dekel et al. 2007; Martin, 2006). It is possible that unresolved personal trauma can become an issue at work as alluded in a study by Cohen and Collens, (2013), where participants reported that their own personal trauma history was an issue for them in the work place. Accordingly, the experiences in the palliative care may serve as cues or trauma reminders that may lead to vicarious traumatization of the care givers. Arguably the emotional demands in relation to the work of care givers may rekindle the trauma memories leading to intense re-experiencing feelings of trauma thus

leading to poor health. According to Andrea, Saharma, Zelechoski and Spinazzola (2011), traumatization in early life confers exceptional risks for health burdens. In addition, patient care may be compromised because patients struggling with trauma histories are more likely to be anxious, depressed, distrustful, angry, and/or avoidant of trauma reminders, which may include medical settings and medical personnel

Another study on therapists' past traumatic experiences, compassion fatigue and work performance in Eldoret (Kenya), found that 31% of the participants had their duties affected by their past trauma histories (Kabunga Adinab, Disiye, Shikangad & Amapesae, 2015). Regardless of the fact that these studies were conducted among healthcare workers of varying cultures and in different locations, personal trauma history correlated with VT.

These findings imply that exposure to trauma could be a real issue among caregivers in Kenya. Consequently, a caregiver who either suffers a chronic or terminal condition such cancer is likely to get traumatized as he or she encounters client-based trauma that is similar to his or hers. Likewise, caring for a loved one with a terminal illness similar to his or her clients is more likely to trigger some emotions in the caregiver making him or her more vulnerable to vicarious trauma. In Kenya, cancer or HIV related conditions are the most common conditions that caregivers are likely to be dealing with in the hospices (Kenya Hospice and Palliative Care Association [KEHPCA], 2012). Therefore, a hospice worker who may have lost a loved one through related chronic conditions may suffer detrimental effects. As the caregivers witness their patients' painful conditions and listen to the agonising narratives, they are likely to get affected particularly if these conditions relate to their own.

Hospice patients suffer multiple complex symptoms ranging from pain, increased weakness, breathing problems, gastrointestinal problems, to decreased levels of consciousness (JBI, 2011). As the patients' conditions deteriorate, caregivers' painful experiences or unresolved traumas may be triggered. Additionally, as they process their own traumatic experiences, caregivers may begin to experience similar symptoms as their clients and in the process they become more vulnerable to vicarious trauma. It is possible that witnessing the disease progression and suffering in the clients could provoke anxiety and fear regarding the caregiver's own future or that of their loved ones. Moreover, death in hospice settings is common. Caregivers who have not resolved their personal experiences of the deaths of their loved ones could become more vulnerable to vicarious trauma. This is because the multiple

deaths of patients and grief experiences in hospices can put the caregiver in touch with their own losses. Wilson and Kirshbuam (2011) affirm that if personal experiences such as the death of a close relative or friend are unresolved or unaccepted, caregivers could be vulnerable when confronting the death of a patient. This may become more complex particularly if the patient's death had similar features to the one experienced by the caregiver.

The CSDT framework on which vicarious trauma is based, places emphasis on the self and how individuals construct their realities (Pearlman & McCann, 1995). The individual's sense of self begins with one's identity, which draws from the personal history of an individual. According to the constructivist theory, the self is ever evolving. The past histories (including childhood memories) are usually remembered and these shape the person's present and future development and growth of the self. The personal history of a caregiver therefore plays a role in the type of self (coherent or weak) that one constructs. In addition, CSDT posits that individuals are actively creating cognitive schemas or perceptions regarding their life experiences. Cognitive schemas are the conscious and unconscious beliefs and expectations which individuals have about the self and others. It is possible that these beliefs could have resulted due to the past experiences that a person has undergone over time. Therefore, when one faces a traumatic event, cognitive processes can be triggered which can result in either no change, positive change or negative change to previous schemas (Cohen & Collens, 2013).

Conclusion

Overall, the findings of the current study imply that personal trauma experience is a correlate of VT. What has emerged is that, the past life experiences and life events in the caregiver's life leave lifelong trajectories and marks on who a person is and how one interacts with the world around him or her. This in a way defines one's susceptibility to particular stresses (Best Start Resource Centre, 2012) and also determines how one reacts to traumatic events. Therefore, in trying to understand vicarious trauma, it is necessary to also target its correlates such as past history of individuals; and these need to be recognized and addressed. The study recommends a need to develop appropriate assessment measures so that therapeutic interventions for caregivers with unresolved trauma can be advanced to help them. The findings of the study may help create awareness of the risk factors for vicarious trauma among caregivers. This could prompt use of preventive measures and coping strategies

against the adverse effects of vicarious trauma. These measures could be incorporated in training as well as employee wellness programs. There is need to establish supportive programmes such as individual counseling and support groups in hospices to assist in reducing the risk of developing vicarious trauma.

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