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Direct and Secondary trauma: re thinking occupational trauma

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Background

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- Healthcare is experiencing a series of interconnected challenges
- Whilst approaches to managing each of these challenges are demarcated and fragmented it is vital to the healthily future of healthcare that we acknowledge and adopt an integrated approach to responding to them, that prioritises developing a healthier workforce

Staff wellbeing / occupational distress

Funding constraints

Financialization

Challenges to professionalism

Quality and performance

Recruitment and retention

Occupational Distress: Dominant theoretical Frameworks

- Secondary or vicarious trauma (STS) is one of the dominant frameworks used to describe occupational distress in Forensic settings

- 'The natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other'' (Figley, 1995)
  - Cumulative impact of engaging empathically with [traumatic] patient material (Perlman & Saakvitne, 1995)

- Significant body of evidence suggests that STS is both present (5-15% of MH professionals) and impactful,
  - **Cognitive:** Intrusive thoughts and imagery, mistrust, increased beliefs relating to vulnerability
  - **Affective:** Anger, sadness, anxiety, helplessness, detachment
  - **Somatic:** Sleep disturbance, Nightmares, numbing
  - **Behavioural:** Avoidance, compulsive and addictive behaviours, impaired functioning
  - **Interpersonal:** Problems in relationships and social withdrawal, problems with intimacy
  - **Service impact:** Impaired decision making / judgements, non empathic distancing, non completion of therapy.

Occupational Distress: Direct trauma exposure

- However, the lack of academic rigour of STS studies, especially interventions for STS, which hampers developing a accurate understanding of its contributions to understanding occupational distress.

Key limitation in the literature

- Specifically, STS has largely been investigated, exclusive of the exposure and impact, of direct exposure to trauma in the workplace.

- This is problematic as HCP's in forensic / prison settings are exposed to behaviours that are potentially traumatising (criterion A of PTSD and CPTSD)
  - Verbal Aggression
  - Physical aggression
  - Sexual aggression
  - Self harm, including life threatening levels
  - Suicidal behaviours and completion

- Recent data from large NHS study (N=12,965; Williamson et al., 2023) reported 25% of HCPs met the criteria for probable PTSD (based on symptoms, not functioning), Looking at symptoms, exclusive of functional impact may inflate the presence of psychopathology. This and other similar studies didn't look at CPTSD.

- International systematic review of pooled prevalence rates of PTSD in HCP's reported a prevalence rate of 21.5% (range: 2.9% to 49.5%) (Li et al., 2021).

Key limitation in the literature

- CPTSD, new diagnosis in ICD-11 is also worthy of consideration, but has not been readily explored in relation to HCPs.
  - **Core PTSD criterion**: (i) Intrusions, (ii) Avoidance, (iii) Vigilance to threat
  - **Disorganised Self Organisation**: (i) Problems with relationships, (ii) Negative self concept and (iii) Affect regulation

Key limitation in the literature

- HCPs do not live in a 'vacuum' and may experience exposure to potentially traumatic events outside of the workplace, the impact of which we also need to consider alongside occupational exposure, both direct and secondary.
    - Significant minority of referrals to staff trauma service in a forensic setting related to non work related traumas that were highly impactful (Morris et al., 2023)
- Our current understanding of occupational distress, specifically 'fear / anxiety based' models is therefore fragmented an incomplete if we don't investigate STS alongside direct exposure
- We need to understand the integrated impact of these experiences (secondary and direct)
- Important to ensure that we have the correct paradigms, inclusive of consideration of the impact of work and non work experiences, to underpin interventions to tackle occupational distress

The current study

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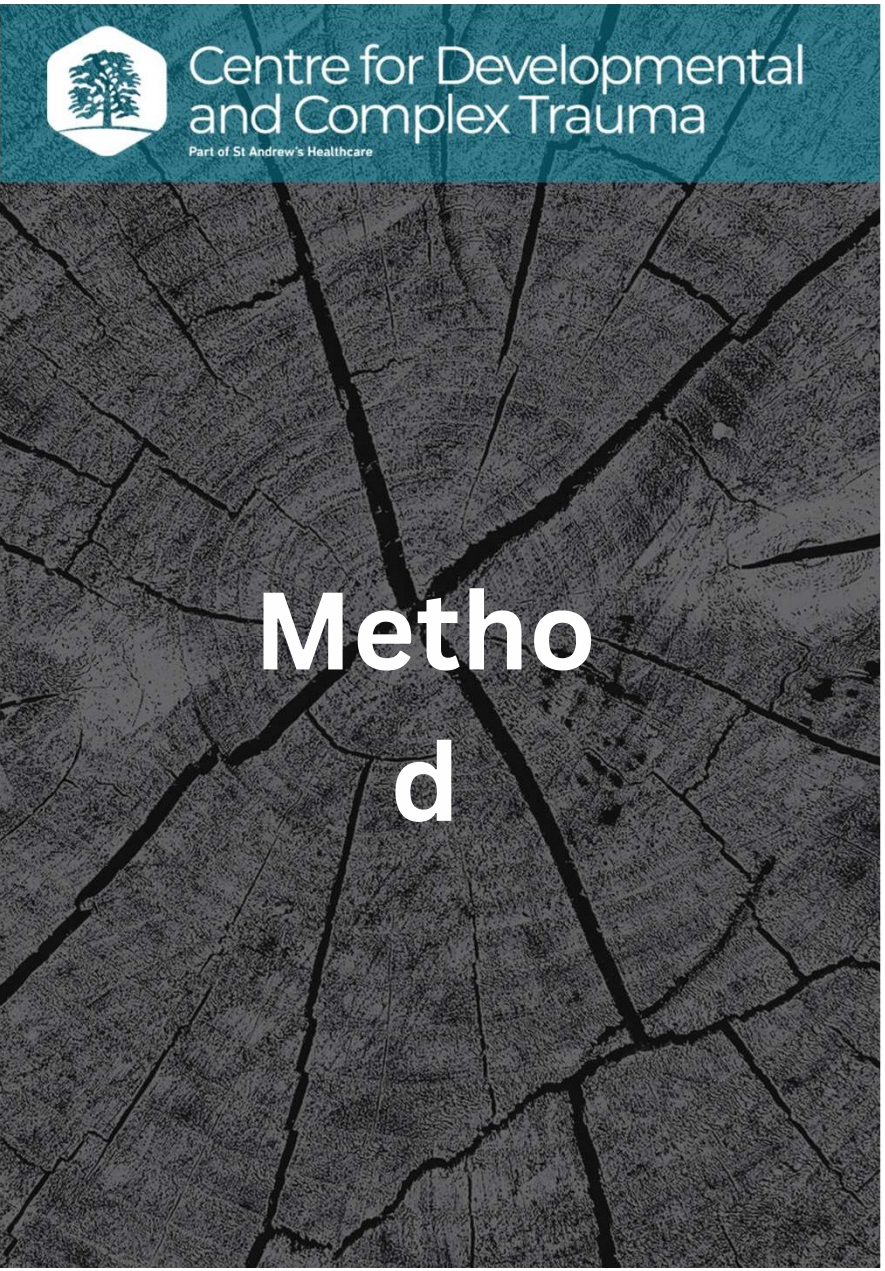
1. What are the levels of Secondary Traumatic Stress (STS) in Healthcare Professionals (HCPs) in a forensic service?
2. What is the impact of STS on functioning?

3. What are the prevalence of PTSD and CPTSD (symptoms and diagnostic thresholds) in HPCs in a forensic service?
4. What are the impacts of PTSD and CPTSD on functioning?
5. What is the prevalence of non occupational and occupational (currently impactful) sources of trauma?

6. What is the relationship between direct and secondary trauma, and functioning?



Design

Online survey, convenience sample

Participants

- Clinical and non-clinical staff within a large mental healthcare provider (charity sector), with at least 6 months experience

Measures

- International Trauma Questionnaire (ITQ) -PTSD & CPTSD
- Work and Social Adjustment Scale (WSAS) - Functioning
- Professional Quality of Life Scale (ProQoL) - Secondary Trauma (e.g., *'I feel as though I am experiencing the trauma of someone I have helped'*).

Procedure

Survey administered online via Microsoft Forms and paper copies distributed to ward

Participant characteristics

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	91	229
AGE	47.58 (23-66)	42.98 (20-67)
	White British 55 (60.4%) African 9 (9.9%) White European 7 (7.7%) Mixed Ethic Group 6 (6.6%) Black / Blck British 5 (5.5%) White Irish 4 (4.4%) Asian / Asian British 3 (3.3)	White British 182 (79.5%) African 6 (2.6%) White European 7 (3.1%) Mixed Ethic Group 5 (2.2%) Black / Black British 15 (6.5%) White Irish 3 (1.3%) Asian / Asian British 10 (4.4%)
	Clinical role = 66 (72.5%) (HCA, 30; Nurse, 15; MDT 21) Non-clinical role = 25 (27.5%)	Clinical role = 150 (65.5%) (HCA, 53; Nurse, 34; MDT, 62) Non Clinical Role = 68 (29.7%)
	Social support = 89%	Social support = 92.6%

Q1: Secondary traumatic stress profiles

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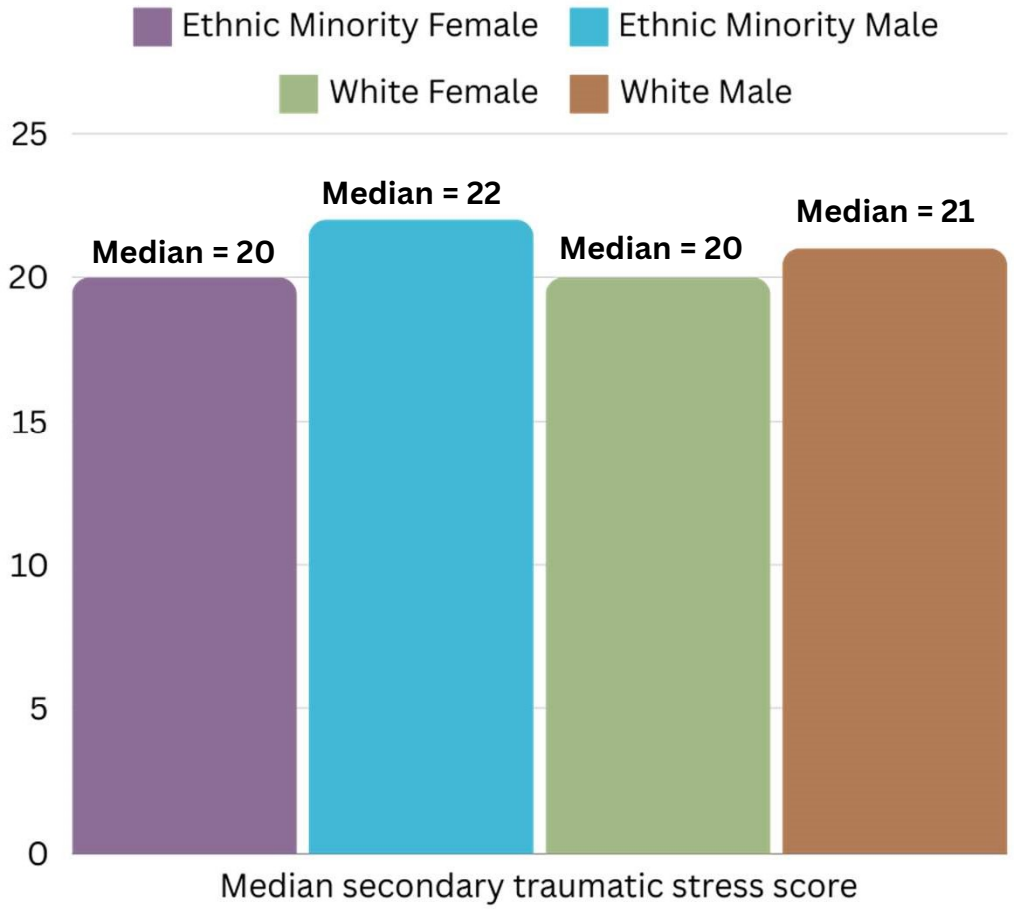

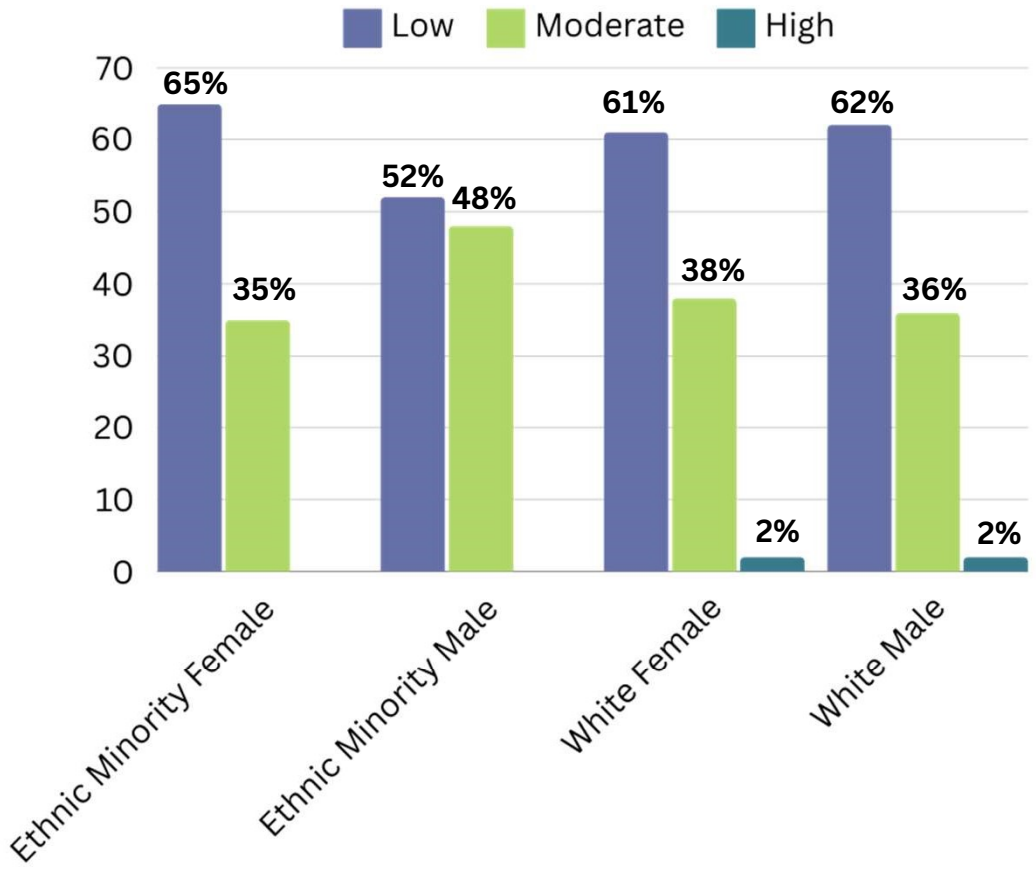

PTSD & CPTSD profiles

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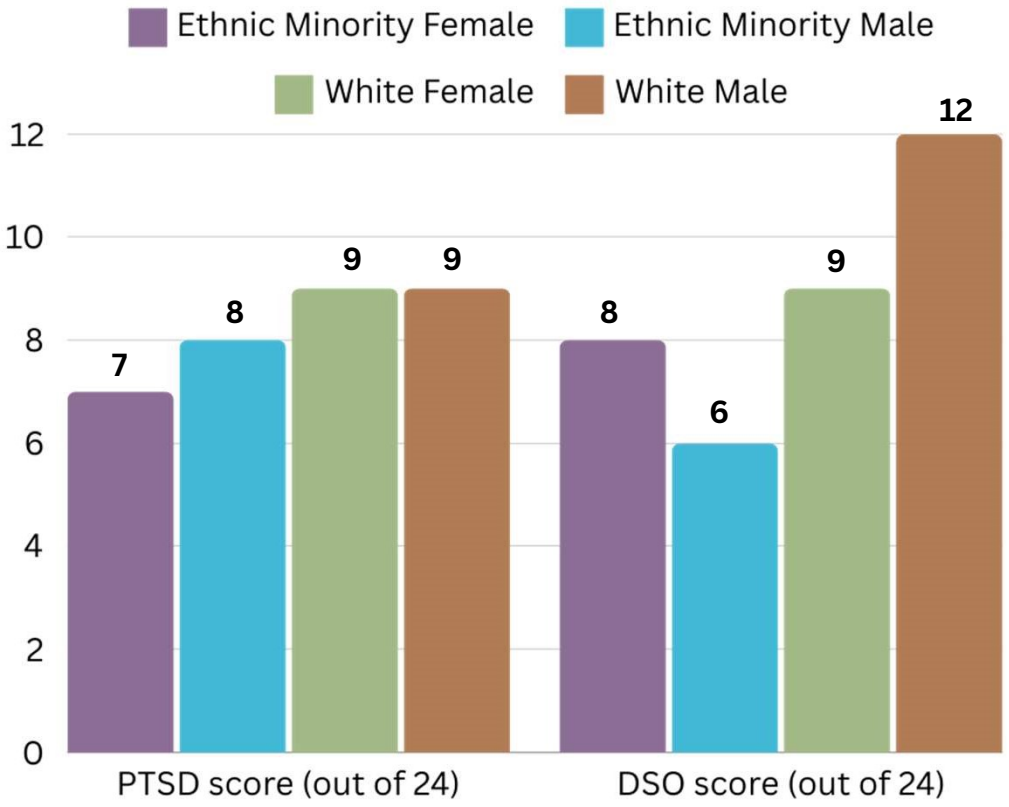
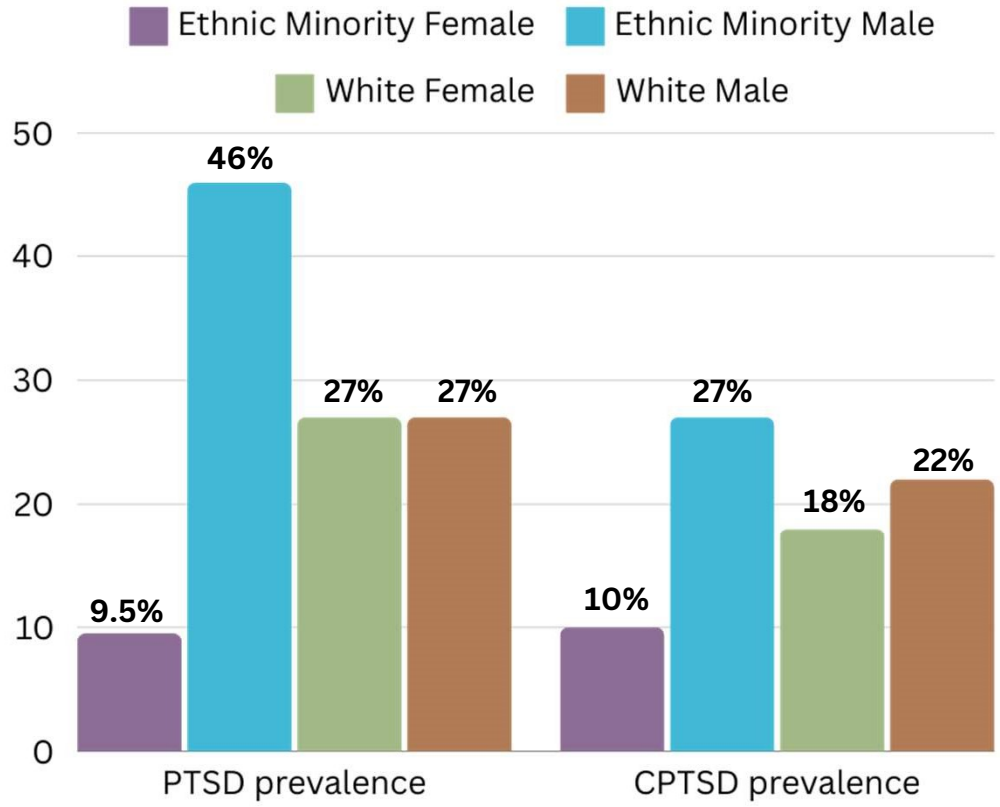
- Overall, the prevalence of PTSD and CPTSD in the whole sample was 25.9% and 18.5%, respectively.





Comorbidity between PTSD, CPTSD and STS

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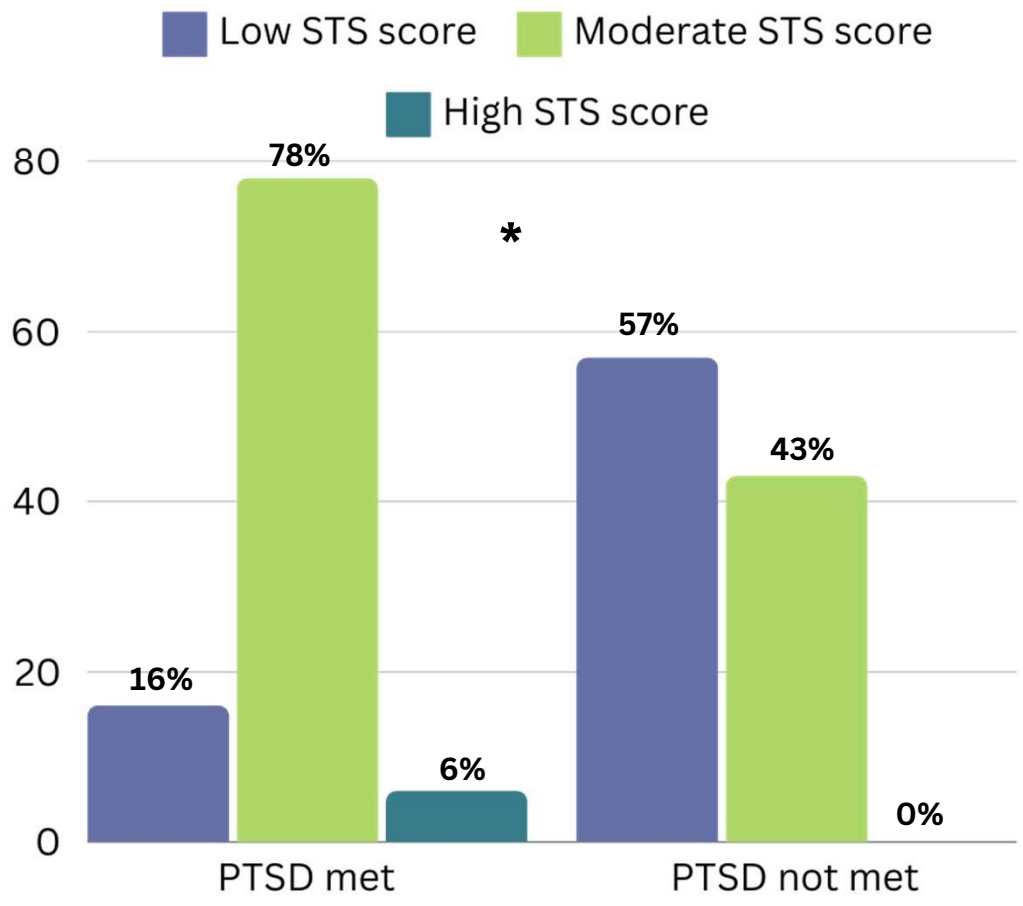

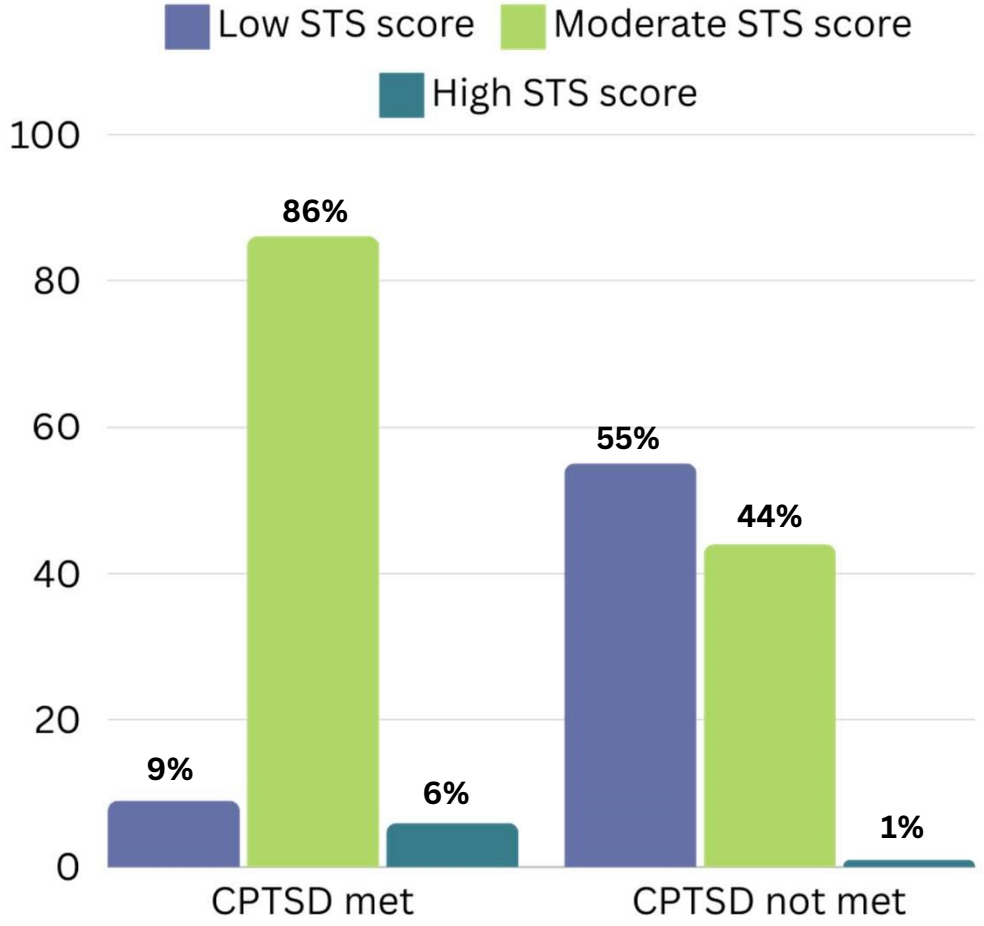

Associations of direct and indirect trauma with functional impairment

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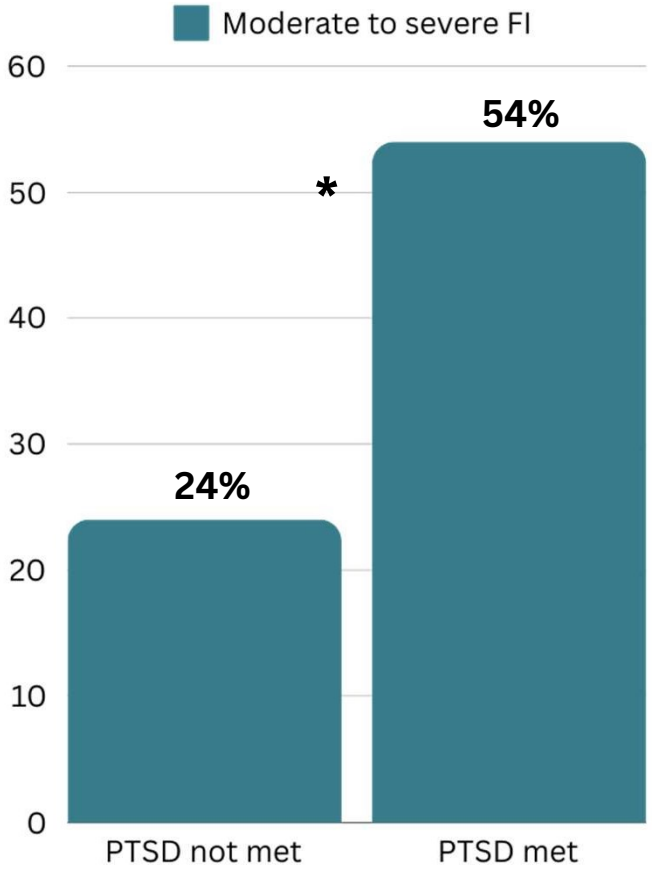

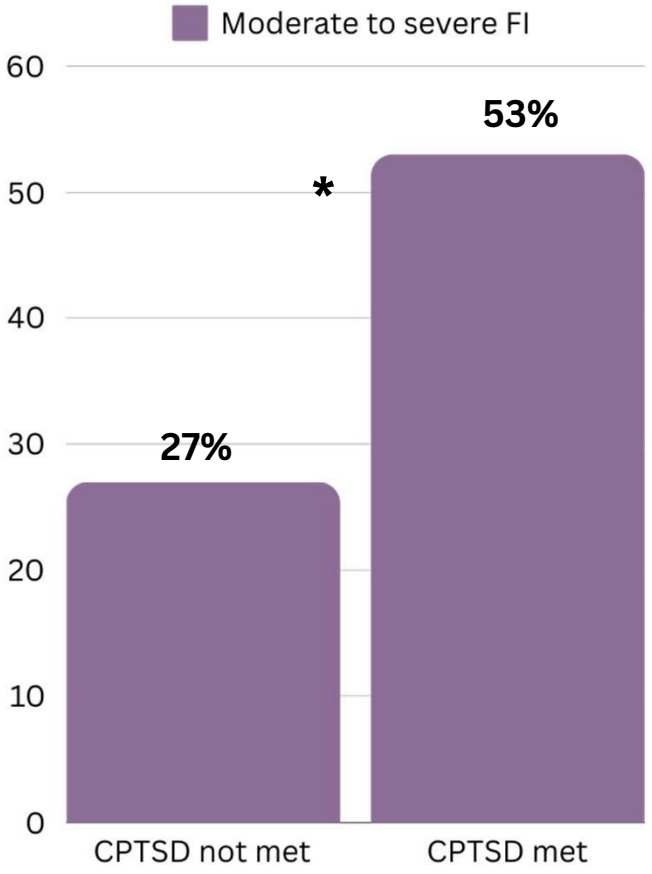

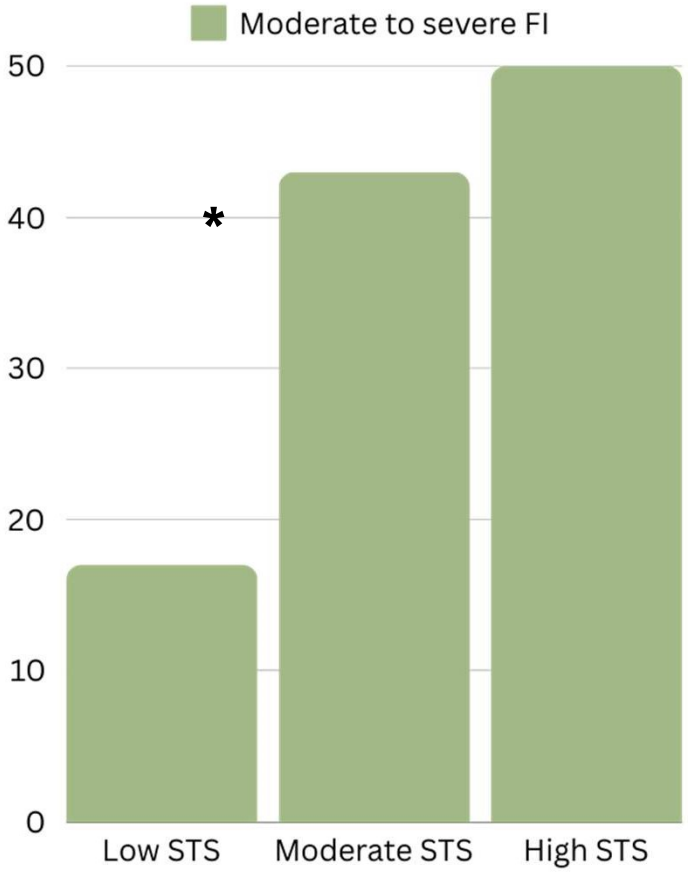

Direct vs. indirect trauma

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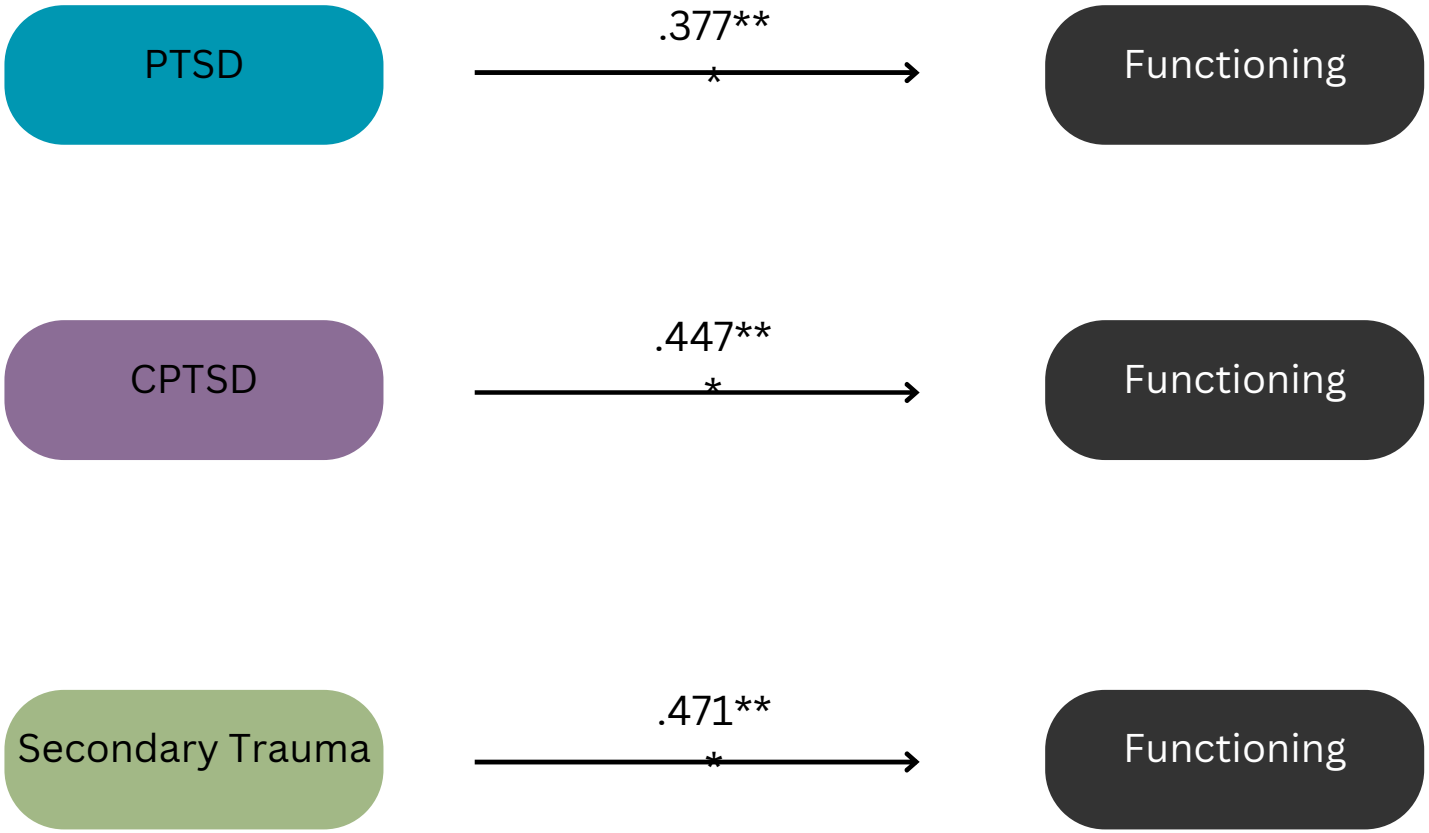

Direct vs. indirect trauma

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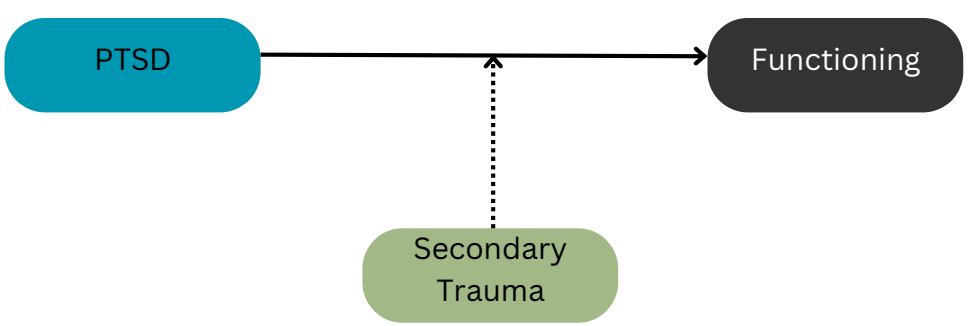
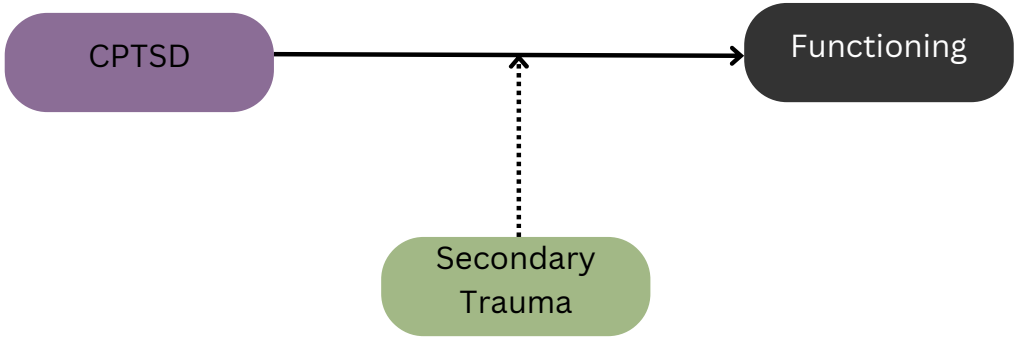
- Moderation analyses indicated that the predictive effects of PTSD and CPTSD symptoms on functional impairment were not moderated by secondary traumatic stress
- In model 1, both PTSD and secondary traumatic stress remained significant predictors, though no significant interacting effect between the concepts was found
- Similarly, in model 2, both CPTSD and secondary traumatic stress remained significant predictors of FI, with no significant interacting effect
- This indicates that treating one type of trauma does not negate the effect of the other - in other words, they have independent effects on functional impairment.





Prevalence of trauma types

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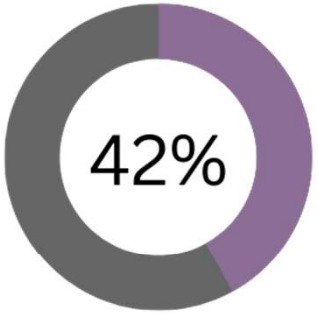
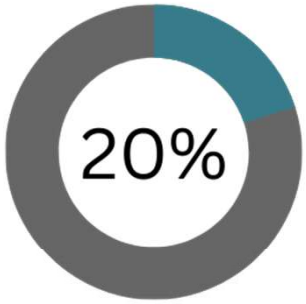
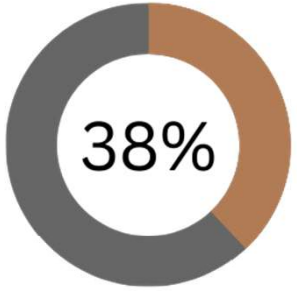


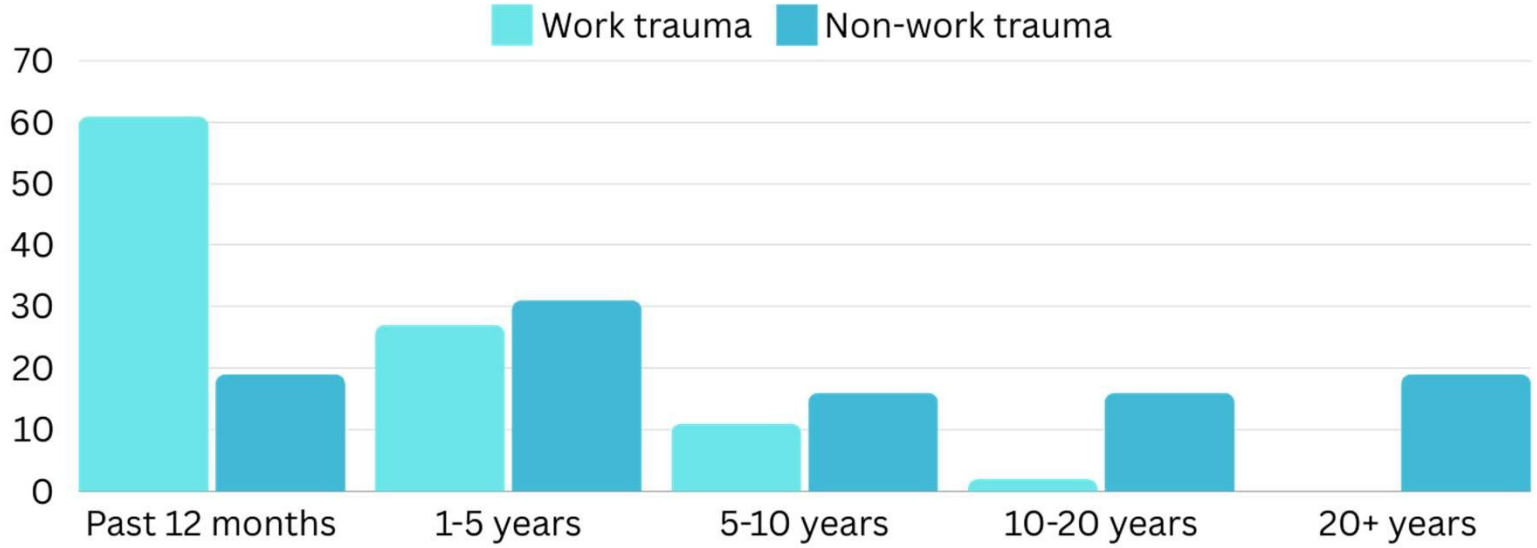
did **not** experience a trauma that still impacted them



experienced a work-based trauma that still impacted them



experienced a non-work trauma that still impacted them



- Work traumas occurred more recently, primarily in the prior 12 months
- Non-work traumas occurred less recently, primarily over 5+ years ago

PTSD and CPTSD profiles by trauma type

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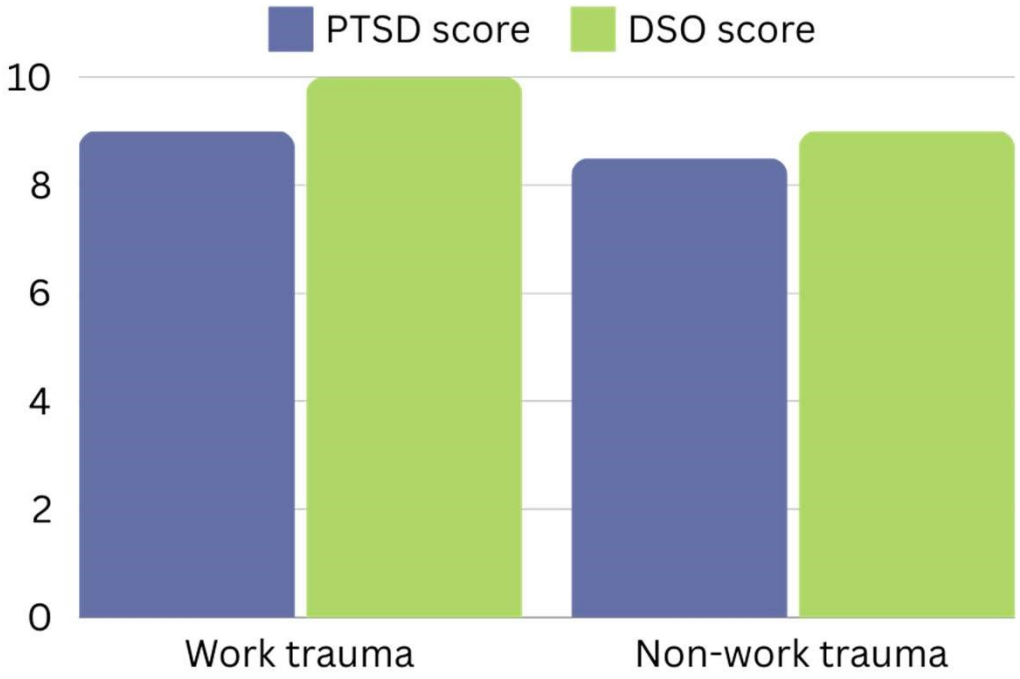
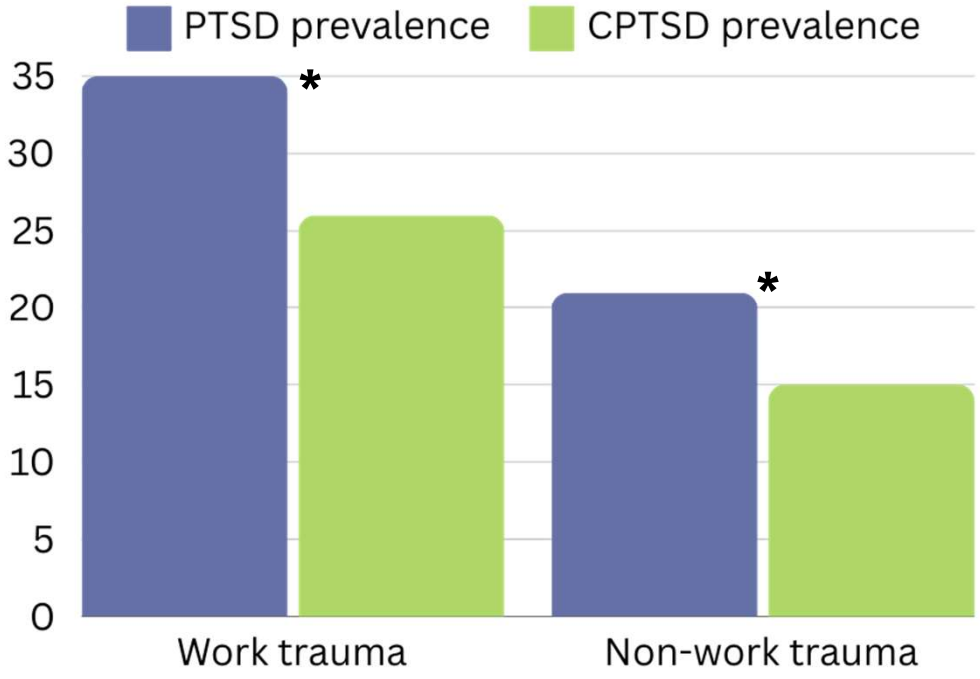
- The prevalence of PTSD was significantly higher in the 'work trauma' group (p=.03); this group had twice the odds of meeting the PTSD diagnosis, compared to people most impacted by a non-work trauma. This was not found for CPTSD

- PTSD and DSO symptom scores and CPTSD prevalence rates were comparable between the groups.





Secondary trauma profiles by trauma type

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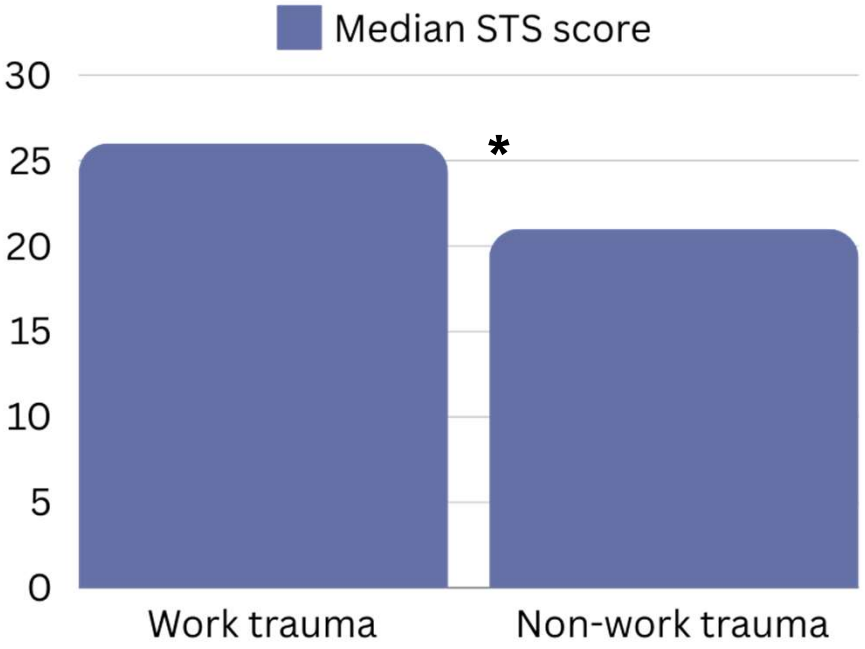
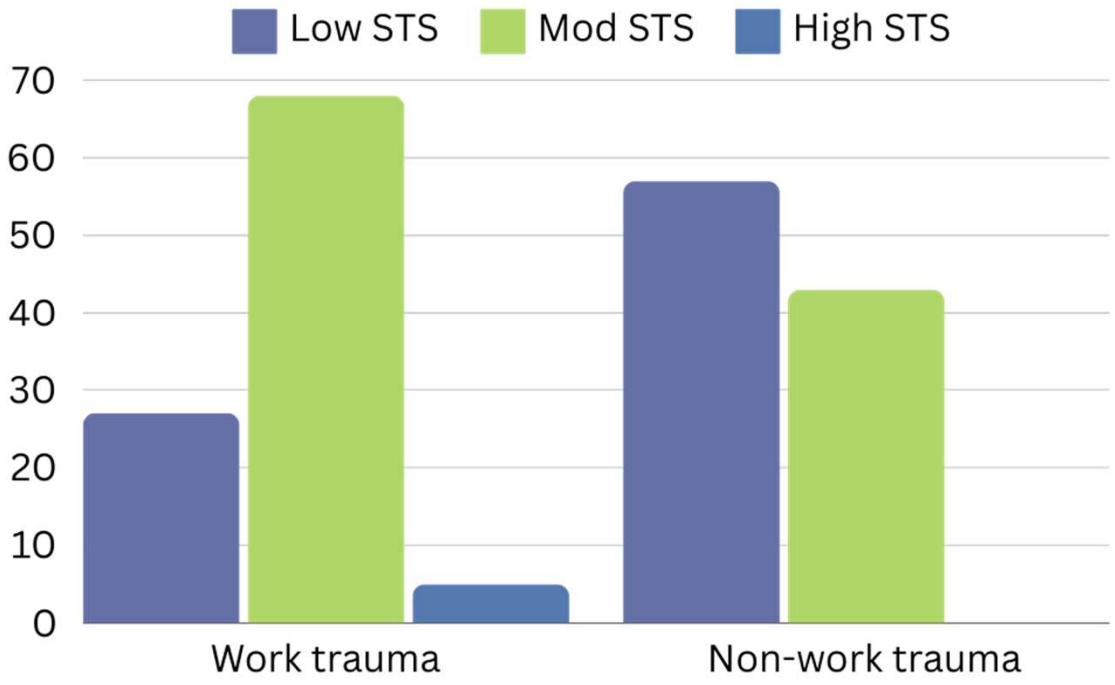
- Staff most impacted by a work trauma had significantly higher STS scores compared to the 'non-work trauma' group (p<.001).
- Due to insufficient cell counts, associations between trauma type and STS categories could not be explored.





Summary of results

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- Moderate or high levels of secondary trauma were endorsed by 40% of respondent's and associated with impairments in functioning Impact was not consistent across different intersections, with males from minority ethnic groups particularly impacted.

- 58% of respondents reported that they had experienced a traumatic event that continued to impact on them, mostly non work related incidents (65% of those reporting a currently impactful trauma)

- Probable PTSD, at a diagnostic level, was endorsed by 26% of respondents
  - Men from minority ethnic groups were more likely to meet criterion for PTSD, compared to other gendered ethnic groups
    - of the 91 men in the sample 32% met criteria for PTSD compared to 24% of females.

- Probable CPTSD, at a diagnostic level, was endorsed by 19% of respondents
  - Gendered ethnic differences were not observed for CPTSD

- Whilst non work related traumas were the most commonly reported by HCPs that continued to impact, respondents who reported work place traumas had twice the odds of meeting PTSD criteria than those reporting non work related traumatic experiences.

- Staff meeting criteria for PTSD or CPTSD reported significantly higher levels of STS. All staff reporting high levels of STS also met criteria for PTSD or CPTSD

- Moderation analyses suggested that direct traumas and STS are independent predictors of overall functioning

Policy and Practice implications & conclusions

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- Moderate levels of secondary trauma are relatively common in HCP's working in forensic settings - although we need to gain a better understanding of intersectional differences, especially as these may not be reflected in the demographics of staff seeking support

- PTSD and CPTSD rates are elevated compared to the general population, although lower than reported in NHS and in systematic reviews. Also important to acknowledge that despite ongoing exposure to adversity in the workplace, the most prominent position was not to meet criteria for PTSD or CPTSD.

- Current focus on designing staff support services that are modelled or promote 'wellbeing' rather than those that can treat diagnostic thresholds of mental health needs may not be as impactful as needed.

- Findings suggest that the provision of services to meet diagnostic thresholds of trauma symptomatology in HCPs are indicated

- Services seeking to support HCPs need to be able to assess, detect and respond to direct and indirect sources of potentially traumatic events

- Wider implications for how we support staff with historical traumas that still impact, given they are exposed to potentially re traumatising events in the work place, on an ongoing basis, both directly and vicariously.

- Need to have a better understanding of the (potential) impact of re traumatisation for staff of secure environments their impact on trauma needs

Contact Details

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