

**VICARIOUS TRAUMA, BURNOUT AND COMPASSION FATIGUE AS THEY APPLY
TO AN EMERGENCY ROOM SOCIAL WORKER IN A MAJOR TRAUMA HOSPITAL**

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Vicarious Trauma, Burnout, and Compassion Fatigue as they Apply to an Emergency Room

Social Worker in a Major Trauma Hospital

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Abstract

This is a self-narrative account of a social worker who works in a trauma hospital emergency, as she reflects on her thoughts and feelings, and considers how they compare with the literature on vicarious trauma, compassion fatigue, and burnout. “Reflecting can be revealing and also painful, but from the learning we gain, we move forward humbler, wiser and hopefully with some degree of satisfaction” (Smith, 2014, p. 75).

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Dedication

This paper is dedicated to my parents, Aiti and Papa,
who raised me with *SISU* and kept me going when I was sure there was no way I could.

I. Introduction

In hospital emergency departments, social workers are required to respond to a wide range of situations, in an often fast paced and hectic environment (Maher & Maidment, 2013). Emergency department (ER) social workers regularly experience “high-volume and high-acuity caseloads, quick patient turnaround (leaving little time for intervention and planning), devaluation and challenging of social work within a medical model, and professional territory and responsibility disputes” (Badger, Royse, & Craig, 2008, p. 63). Hospital social workers are frequently exposed to patients who have experienced traumatic events or illnesses, such as accidents, catastrophic brain injuries, cardiac arrests, and assaults (Badger et al., 2008). The nature of hospital emergency work necessitates that social workers address their clients’ pain and trauma. They also need to deal with their own reactions and feelings (Badger et al., 2008). Badger et al. (2008) have identified that it is difficult to process one’s emotions in a hospital environment that allows little time for any type of personal reflection, and frequently excludes meeting basic personal needs because of the rapid pace of the work.

According to Saakvitne and Pearlman (1996) there is a developing understanding from research “that it is impossible to hear and bear witness to trauma survivors’ experiences and remain unchanged” (p. 17). Van Dernoot Lipsky and Burk (2009) similarly state, “a trauma exposure response may be defined as the transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet” (p. 41). The question being asked in this study is: How do vicarious trauma, compassion fatigue, and burnout relate to social work practice in the emergency room (ER) of a major trauma hospital? In this study, trauma is not viewed just as an event, as defined by the DSM 5 (American Psychiatric Association, 2013, p. 265), but also an on-going contextual reality (Briere & Scott, 2015). Vicarious traumatization

is presented from what Saakvitne and Pearlman (1996) described as “the transformation of the social worker’s inner experience” as a result of empathic engagement with the trauma stories of clients (p. 25). Kapoulitsas and Corcoran (2015) described compassion fatigue as a specific “term used to describe behaviour and emotions experienced by those who help people who have experienced trauma” (p. 86). Burnout was referred to by Wagaman, Gelger, Shockley and Segal (2015) as “overwhelming emotional exhaustion, depersonalization, and feelings of professional insufficiency” (p. 202). A social constructivist theoretical framework was used to guide this study. Narrative research theory was utilized to examine vicarious trauma, compassion fatigue and burnout for the social work professional working in an ER workplace context. The story of one ER social worker is used.

II. Literature Review

This literature review is organized to include both the findings and methods of various scholars who have considered the effects of vicarious trauma, compassion fatigue, and burnout on social workers, both in the ER and other frontline areas/professions where patient trauma is encountered. Prevalent themes, related to the numerous challenges faced by individuals who practice in the social work profession while striving to manage their interminable stress, are identified.

Social work involves helping people, families, and communities to upgrade their individual and aggregate health and prosperity. Social workers in emergency hospital settings are called upon to tend to clients who are struggling with oppression and trauma by caring for and responsibly guiding them through their experiences (van Dernoot Lipsky & Burk, 2009).

The social work profession can be very rewarding, yet stressful, due to the emotionally demanding nature of the work (Kapoulitsas & Corcoran, 2015). This stress can be compounded due to the complexities associated with promoting client well-being and managing personal emotions (Kapoulitsas & Corcoran, 2015). Social work values are devoted to the quest for social equity and the prosperity of mistreated and oppressed people based on such factors as bigotry, sexism, trauma, classism, and heterosexism, to name a few (Kapoulitsas & Corcoran, 2015). Kapoulitsas and Corcoran (2015) stated, “Social work is an expansive field that incorporates exercises from areas like social service administration, children and their families, social work policy analysis, social justice and diversity, traumatology, and the list goes on” (p. 93). The seemingly infinite issues that revolve around these wide subject areas increasingly require new knowledge and skills. The role of social work in many settings has become more rigorously scrutinized. In that measure, Joseph and Murphy (2013) contended that “trauma cuts across a

range of contexts and client groups and, as such, needs to be a core component of education and training in social work” (p. 1096).

A consensus appears to exist amongst social work professionals as to the core reason they select the vocation. This reason appears to be the desire to make a small difference in the world by helping those in need. This notion was best illuminated by Stamm (2002), who identified this satisfaction as “compassion satisfaction” (p. 108), which is the result of the overall feeling that one gets from doing a good job. Stamm (2002) referred to caregivers in general, but the idea can be extrapolated to include social workers, where compassion satisfaction can help reinforce the invigorating effects of caregiving. This social work professional can relate to Stamm’s (2002) findings regarding the satisfaction achieved from a successful work outcome with a patient.

This literature review explores vicarious trauma, compassion fatigue and burnout as they apply to the health care workers that provide services to those affected by trauma. The literature has been broken down into five topic areas, which include (a) differentiating the terms and symptoms; (b) self-care and vicarious trauma, compassion fatigue, and burnout; (c) spirituality, mindfulness, and meditation, and the role of empathy; (d) supervision; and (e) risk factors.

Differentiating the Terms and Symptoms

The terms vicarious trauma, compassion fatigue, and burnout were sometimes used interchangeably in the literature, depending on which author was gathering data. Their causes are commonly connected, stemming from or being defined as mental health professionals having some emotional distress via their patients’ accounts of severe incidents of traumatic events.

Diaconescu (2015) reported that the term vicarious trauma was first introduced by McCann and Pearlman (1990) and further developed by Pearlman and Saakvitne (1995). Saakvitne and Pearlman (1996) identified that “vicarious traumatization refers to the cumulative

transformative effect on the social work helper of working with survivors of traumatic life events” (p. 17). The combination of helping and listening empathetically can lead to having the condition of vicarious trauma (Saakvitne & Pearlman, 1996). Its trademark is a challenge to our belief system which may be reflected by an interruption in the social worker’s capacity to trust his or her own judgment. Saakvitne and Pearlman (1996) viewed “vicarious traumatization as an occupational hazard. It is not something clients do to us; it is a human consequence of knowing, caring and engaging the reality of trauma stories” (p. 25).

Joseph and Murphy (2013) reported, “Increasingly, it is recognized that social work operates at the interface of traumatic circumstances, the traumatized victims and their environment” (p. 1094). Diaconescu (2015) described the symptoms of vicarious trauma as: “Intrusive images, persistent avoidance of stimuli/persons/activities associative with hyperexcitability, depersonalization/derealisation/dissociative amnesia, faulty social and professional functioning etc.” (p. 60).

In her paper on burnout, Thomas (2013) informed readers that Freudenburg first coined the term in 1975, while he was studying how professionals become progressively less healthy. This condition can take various structures, from a basic unbending nature, in which the individual gets to be *shut* to any information, to uncontained outrage and eventual resignation. Diaconescu (2015) further identified symptoms of burnout as “chronic physical and emotional fatigue, the depletion of the empathetic resources and of compassion, boredom, cynicism, diminution of enthusiasm, temporary distress and depression symptoms which do not satisfy the criteria for manuals of mental disorders” (p. 57). Burnout was also noted to be associated with lower levels of job performance, higher than average sick time and earlier resignation in those affected with symptoms (Wagaman et al., 2015). Skovholt, Grier, and Hanson (2001) noted that

some of the incessant, yet basic, impacts of burnout were a lack of “supervision and mentorship, glamorized expectations . . . and intense execution tension” (p. 173). Van der Kolk and McFarlane (2012) noted that social workers who did not grasp the burnout condition until it was too late appeared to be left with no means to empower themselves to take legitimate measures to re-establish stability in their lives. Van der Kolk and McFarlane went on to say that in order to avoid such eventualities as burnout, social workers would benefit from seeking out the help or guidance from their supervisor or appropriate mental health professional at the first sign of feeling like they are overwhelmed.

Sansbury, Graves, and Scott (2015) asserted that “as many as 24 million or 8% of US residents will experience a traumatic stress response during their lives; but this rate is an estimated 15% to 50%, potentially nearly six times higher among mental health workers” (p. 114). This finding highlights the need to better understand the impact of trauma work on social work professionals.

Hearing about peoples disturbing experiences may predispose social workers to vicarious trauma, where flashbacks or ruminations linger and last, transforming into other symptoms of psycho-emotional strains (Wagaman et al., 2015, p. 202). Examples of psycho-emotional strains are “rumination, flashbacks, physiological responses, fear, dread, hypervigilance, nightmares, sleeplessness, agitation, and fatigue” (p. 203). Newell and MacNeil (2010) found excessively high caseloads, poor or no supervision, agency policies that are contradictory to social work values, and lack of on the job education contribute to burnout and workplace stress. Sansbury et al. (2015) suggested, “Organizations have enormous power to either mitigate or exacerbate trauma exposure responses, which highlights the need for a greater awareness of the concepts of trauma-informed approaches for service delivery at an organizational level” (p. 117).

Saakvitne, Gamble, Pearlman, and Lev (2000) characterized vicarious trauma as the total transformative impact on the counselor from working with survivors of traumatic life occasions. Working with trauma patients may extraordinarily influence the social worker. The impact on them must be addressed, while keeping in mind the end goal to guard both social worker and patient.

Pearlman and Saakvitne (1995) utilized a constructivist self-improvement hypothesis to determine that history or background tangibly shapes how one will experience, decipher, and adjust to traumatic or graphic information. Each social workers experience is unique (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Pearlman and Saakvitne (1995) summarized the importance of training in trauma therapy, which they identified would include information on understanding of the effects of doing such work, strong supervision utilizing assessment tools, attention to one's own self-care, and finally, strong supportive relationships with colleagues.

Vicarious trauma is a somewhat recent and modern concept that scholars have explored as part of trauma psychology (Barrington & Shakespeare-Finch, 2014; Sabin-Farrell & Turpin, 2003). It is not well understood in an ER department, where the incidents tend to be acute and trauma social workers are exposed to graphic client material.

Findings from Saakvitne et al. (2000) explained how vicarious trauma can negatively influence how trauma social workers identify with their own families, companions, and clients. Saakvitne et al. (2000) reported that the lingering stress factors from vicarious trauma can inhibit the social worker from constructive care for themselves, which can then compromise the care of their clients. These vicarious trauma symptoms can limit the capacity of the caregiver to competently and objectively empathize with their patient's experiences. This point was best illustrated by Stebnicki (as cited in Decker, Constantine, Brown, & Stiney-Ziskind, 2015), who

shared a Native American teaching that holds the following: “Each time you heal someone, you give away a piece of yourself until, at some point, you will require healing” (p. 28).

Diaconescu (2015) and Newell and MacNeil (2010) discovered that there is a lack of professional education in the social work field relating to the emotional and psychological risks attached to a social worker’s frame of mind while providing care to vulnerable populations. Diaconescu’s (2015) review, conducted over the last decade from data gathered from relevant literature on social work practices connected to burnout, compassion fatigue, and trauma, confirmed the aforementioned gap in the space between knowing a problem exists and how to get rid of it. He determined that burnout syndrome is a chronic problem throughout society, whereas vicarious trauma:

[For] social workers involved in the task of caring for others is little known, minimized or not recognized as a social problem and thus it does not benefit from access to the necessary resources for prevention, remedy and specific and long-term professional training. (p. 62)

Identifying the early symptoms of vicarious trauma, compassion fatigue, and burnout appears to be simpler than treatments to eliminate or reduce their significant after-effects on the mind of a social worker.

Self-Care and Vicarious Trauma, Compassion Fatigue, and Burnout

Social workers need to ensure they incorporate self-care techniques to forestall the anxiety of their work and its effects on them. Self-care techniques may include mindfulness and a balanced work-life ratio, referred to as equalization (Stebnicki, 2007; Thielemann & Cacciatore, 2014). The impact of vicarious trauma and compassion fatigue can be decreased when counselors maintain a balance of work, play, and rest (Pearlman, 1995). “This balance includes

socializing with friends and family, being involved in creative activities, and being physically active” (Trippany, Kress, & Wilcoxon, 2004, p. 36). Thomas (2013), in her research paper on personal distress with burnout, enforced the importance of being in touch with one’s feelings, “The ability of humans to regulate their own emotional responses in the face of another’s pain is necessary if they are to be optimally helpful to others who are distressed” (p. 375).

Newell and MacNeil (2010) advocated that social workers would be better served to have professional awareness of individual and organizational preventative measures to address stress conditions: “Professional self-care is the utilization of skills and strategies by workers to maintain their own personal familial, emotional, and spiritual needs while attending to the needs and demands of clients” (p. 62). Self-care strategies for burnout, as suggested by Newell and MacNeil (2010), include setting realistic goals with regards to workload and client care, utilizing coffee and lunch breaks, getting adequate rest and relaxation, and maintaining positive connections with close friends and family (p. 62).

Self-care for a social work practitioner, when viewed through the prism of developing coping strategies that relate to a biopsychosocial spiritual component, are essential, much in the same way that they perform their assessment of clients. Biological behaviours, such as looking after physical health, eating clean regular meals, and getting an adequate amount of sleep, exercise, or recreation can fend off stress or help manage it (Newell & MacNeil, 2010, p. 62). Positive forms of self-expression, such as drawing, painting, sculpting, cooking, or outdoor activities, all serve to fortify a social worker’s necessity for balance after the day’s work is done (Hesse, as cited in Newell & MacNeil, 2010).

Spirituality, Mindfulness, and Meditation

In her writings, Diaconescu (2015) suggested training in relaxation and meditation techniques, which if properly taught, would significantly reduce stress and enable social workers to teach themselves to be acutely aware of signals their body is giving off so they can better monitor their own anxiety levels. Wagaman et al. (2015) also confirmed that strategies such as mindfulness techniques and an emphasis on boundary setting are means that social workers can tap into to facilitate a process of sharing and increasing their self and other awareness. Wagaman et al. noted, “Some strategies include practicing self-talk or verbal cues, physically removing oneself from a situation to a more comfortable or familiar setting, and practicing effortful control of one’s physical or verbal reactions” (p. 204).

Diaconescu (2015) also provided the recommendation of peer debriefings/counseling with the purpose of *mental hygiene* in order to cope and contribute to the debriefing of traumatic situations. Social workers facing transference and counter transference reactions may require fundamental support from within their organization. Social workers often will not take the time to seek guidance unless they are nudged into it by a concerned peer or it is offered by their supervisor.

Spirituality is an important personal coping skill for managing stressful life events, such as health problems and grief over loss or death (McCormick, Holder, Wetsel, & Cawthon, 2001; Sowell et al., 2000). The presence of spirituality in people relates to positivity affecting their psychological well-being and physical health (Kendler et al., 2003). This premise rests upon three key factors that can provide the social worker with a defense mechanism against the tide of vicarious trauma, compassion fatigue, and burnout creeping into their psyche (McCormick et al., 2001; Sowell et al., 2000). The factors are that (a) spirituality can give a purposeful sense of

meaning or coherence in one's work, (b) a spiritual therapist is more likely to behave in a moral and balanced manner, and finally (c) an inner spirituality tends to invite more social support and collaborative dialogue with staff and patients alike (McCormick et al., 2001; Sowell et al., 2000). It is notable that distinctions can be made between religious beliefs and being spiritual, but both appear to encourage positivity through peace of mind (McCormick et al., 2001; Sowell et al., 2000).

No clear definition of spirituality was provided in the literature, but Griffith and Griffith (2002) stated, "Spirituality is a commitment to choose, as the primary context for understanding and acting, one's relatedness with all that is" (p. 15). Their focus was on relationships between self and others. Decker et al.'s (2015) focus was on the broader concept that practicing spirituality can take on various forms, including, but not limited to, prayer, meditation, breathing exercises, giving back, and mindfulness. Germer, Siegel, and Fulton (as cited in Decker et al., 2015) related mindfulness to social work practice as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally to the unfolding moment to moment" (p. 29).

Spiritual connection, whether through a church, meditation, yoga, philanthropic activities, and/or self-reflection, generally enhances self-care. These elements, if attended to, can prevent or help manage stress more effectively (Newell & MacNeil, 2010, p. 62). Along with self-care, supervision has also been shown to be a valuable resource to keep trauma workers healthy.

Previous studies have exalted the virtues of mindfulness as an intervention for caring professionals, in parallel with compassion satisfaction (Decker et al., 2015). Decker et al.'s (2015) study connected a correlation between mindfulness and compassion satisfaction; whether formally taught or informally trained, it improves the well-being of social work interns.

Unfortunately, it would appear that mindfulness training, like many spiritual or religious activities, is not readily available to social workers during their academic training (p. 29).

Wagaman et al. (2015) examined empathy as a combination of physiological and cognitive processes that may help to address burnout and secondary traumatic stress. Their study of 173 cases explored the relationship between the components of empathy, burnout, secondary traumatic stress, and having higher levels of empathy-reduced burnout.

According to Wagaman et al. (2015), empathy is a factor within a social worker's control that may prevent burnout and secondary traumatic stress and increase compassion satisfaction. Empathy and its components, particularly the cognitive aspects, can be taught and learned by social work practitioners. Such training does not have to solely occur in social work education; it can be conducted in practice settings. Additionally, "empathy has been discussed in the counseling and psychology literature for the last 125 years and has been conceptualized as a skill that can be both developed and learned if facilitated properly" (Stebnicki, 2007, p. 327).

Supervision

Trippany et al. (2004) reported in their findings that "agencies that employ counselors who provide services to clients with traumatic histories have a responsibility to help their clinicians decrease the effects or occurrence of such interventions" (p. 35). In addition, Trippany et al. (2004) found that "professional development resources should be available for trauma counselors, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education" (p. 36). Pearlman and Saakvitne (1995) further suggested that "provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload" (p. 157).

Being that social work is an occupation vulnerable to increased levels of stress, it is incumbent from an organizational team perspective for those who perform supervisory duties to exercise their influence constructively and supportively with their co-workers. This is best addressed during visible stress points, by a supervisor connecting to the trauma patient case directly in concert with his/her supervisee. It becomes an important reminder for supervisors, who have moved out of engagement with direct client contact, that they need to be mindful of and sensitive to the vulnerability of their supervisees developing secondary traumatic stress (Wagaman et al., 2015). Once again, from an organizational vantage, this may suggest a greater need for supervisors to maintain some portion of direct client work or engage in empathy-related training to better understand the experiences of their supervisees. Regular supervision can assist to identify staff who may be demonstrating risk factors of trauma-related illness.

Risk Factors

Newell and MacNeil (2010) noted from their study that it is vitally important that social workers providing services to vulnerable populations understand the risk factors and symptoms associated with vicarious trauma, compassion fatigue and burnout (p. 59). They noted three specific risk factors that they suggested may contribute to developing trauma symptoms. First, “It has been suggested that practitioners with a pre-existing anxiety disorder, mood disorder, or personal trauma, may be at greater risk of experiencing these conditions” (Newell & MacNeil, 2010, p. 60). Secondly, Newell and MacNeil (2010) noted that high caseloads of trauma-related situations carried by a social worker who has limited or no clinical experience practicing with trauma clients could result in the social worker becoming particularly vulnerable (p. 60). Under their third finding, they suggested that a social worker using “poor coping skills in response to their trauma work, such as suppression of emotions, distancing from clients, and re-enacting of

abuse dynamics, are identified warning signs for social workers impacted by these stressors” (p. 60). Understanding the differences in the conditions is critical, and one of the clear identifiers that separates compassion fatigue from burnout, is the empathetic role associated with compassion fatigue, whereas burnout is linked more to hopelessness and an overall inability to perform one’s duties competently (Newell & MacNeil, 2010; Tomas, 2013; Wagaman et al., 2015). Even though the phenomena can mimic one another through their symptoms, burnout is a process that occurs slowly over time, and compassion fatigue can manifest itself rather suddenly (Newell & MacNeil, 2010; Tomas, 2013; Wagaman et al., 2015). Both have been diagnosed as very disruptive psychologically and can result in severe professional consequences by debilitating one’s well-being (Newell & MacNeil, 2010; Tomas, 2013; Wagaman et al., 2015).

Organizational issues that contribute to risk factors include bureaucratic constraints, inadequate supervision, lack of availability of client resources, and far too often, a lack of support from professional colleagues (Newell & MacNeil, 2010; Tomas, 2013, Wagaman et al., 2015). An organization that cultivates a climate of accepting varying approaches to client care and one that is absent of rigid and dated practices can alleviate stigmas that trauma work inexorably presents (Newell & MacNeil, 2010; Tomas, 2013; Wagaman et al., 2015).

Gaps in Literature

Synthesis of the current literature on vicarious trauma, compassion fatigue, and burnout illustrated a need to understand how these factors relate to ER social workers in major trauma hospitals. The terms vicarious trauma and compassion fatigue were used interchangeably in literature at times but it is clear that scholars in the field have not “reached a consensus on the identification of a single descriptor that accurately reflects the uniqueness and range of responses to providing trauma therapy” (Kadambi & Ennis, 2004, p. 5).

From the literature reviewed for this study, there appeared to be a lack of clarity regarding descriptive terms for vicarious trauma, compassion fatigue and burnout. The literature findings indicated that the healthcare field is just beginning to recognize vicarious trauma and how it impacts the social work profession (Wagaman et al., 2015). The literature suggested that more inquiries are necessary in order to establish a comprehensive monitoring approach in guarding against the long-term effects of the depleting nature of stress-related conditions on the minds of persons who practice social work in a healthcare setting (Wagaman et al., 2015). Self-care is the preventative element that most authors suggested is an integral component of mitigating the mental issues incurred by the social worker stemming from the above discussed conditions. Wagaman et al. (2015) stated discarding the importance of self-care is a recipe for unmet social needs that may result in short circuiting a career.

Newell and MacNeil (2010) noted that there “is a substantial gap in the literature regarding practical methods of preventing and treating trauma conditions” (p. 64). The literature also noted that there is very little education on the warning signs and symptoms associated with vicarious trauma, compassion fatigue and burnout (Wagaman et al., 2015). Wagaman et al. (2015) suggested that education should be offered at the foundation level so students could be taught to understand the trauma exposure risk factors prior to going out to begin their field education: “Helping students to understand these organizational risk factors prior to them beginning their field education experiences may serve to decrease their vulnerability to professional burnout” (p. 64).

Conclusion

Overall, vicarious trauma, compassion fatigue, and burnout have been found to affect people in stressful job settings where workers are frequently addressing the traumatic problems

of patients. This literature review supports the investigation of the research question to determine how it is that social workers in a trauma hospital's ER setting experience these problems. From the literature reviewed, it was noted that only the work of Saakvitne and Pearlman (1996) proposed an explanatory theoretical framework for understanding vicarious trauma and compassion fatigue, and this framework is a social constructivist self-development theory. This same theoretical framework was used by the researcher and is described in the following section in some depth.

The literature revealed that stress-related conditions, such as feelings of being overwhelmed, crying to outburst of anger, anxiety, and lack of emotions such as flat affect and cynicism, are some of the conditions related to vicarious trauma, compassion fatigue, and burnout. These emotions are connected to the lives of most social workers who endeavour to heal the traumatized patient (Saakvitne & Pearlman, 1996; Wagam et al., 2015). As a symptom of compassion fatigue the literature suggests that social workers may feel less empathy for patients. Symptoms would include hopelessness, a decrease in experiences of pleasure, constant stress and anxiety, sleeplessness or nightmares, and a pervasive negative attitude. Burnout may also be experienced by the social worker. Symptoms of burnout include exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness, and also may have the dimension of frustration or cynicism, and as a result, reduced efficacy within the workplace. A social worker in the ER of a trauma hospital may experience all of these feelings based on the experiences that she or he has in the hospital.

The purpose of this review was to look at compassion fatigue, vicarious trauma, and burnout; what they are; and how they inform each other as they impact one professional frontline social worker. The study became a catalyst for further exploration into what the effects of these

conditions are (in particular to one frontline social worker in a high-stress context) by paralleling the connection with the data gathered from personal work-related experiences with clients over several shifts.

III. Theoretical Framework

This research was guided by a social constructionist approach, as Saakvitne and Pearlman (1995) described when explaining vicarious trauma. Social constructionism is a theoretical perspective where human experience meaning is internally created through interaction with the world and not discovered as something outside of ourselves. Moen (2006), writing from a narrative research perspective, described social constructivism as an alternative theory on the development of persons:

Although there are different versions of social constructivism, what they have in common is the belief that individuals learn and develop through participation in social activities in the world. (para. 4)

Prawat (1996) noted that what is often called the mind-world dualism problem disappears because narrative social constructivism connects the domains of individual mind and the context of individual experience. From a social work theory perspective, Payne (2005) referred to narrative social constructivism as human learning and development occurring in socially and culturally shaped contexts. These social contexts influence who people become. As one creates meaning, one develops one's own personal stories, or narrative, and begins to act and interact based on the created "moral" of our own story. Narrative social constructivism would seem to support that social workers become who they are, depending on what they experience in the social work practice contexts in which they work.

Larsson and Sjoblom (2010) presented that narrative social constructivism can apply as an intervention strategy in social work clinical practice and as a research tool when exploring social work practice. The social constructionist framework worked well with my narrative enquiry because it actively helped to describe several realities that emerged from my unique,

lived experience in the emergency department (Kapoulitsas & Corcoran, 2015). This framework was used to draw out my perspective as revealed in the telling of my story through the recording and then documentation of my personal experience as a social worker. Kapoulitsas and Corcoran (2015) stated that a “narrative theory forms a theoretical foundation in this research, as it looks at elements of one’s own experience specifically focusing on the structure, function and psychosocial implications of the narratives” (p. 90). My research question and methodology used will be described in the next chapter.

IV. Design and Methodology

The research question for this paper was: “How does vicarious trauma, compassion fatigue and burnout relate to Social Work practice in the ER of a major trauma hospital?” I used the narrative approach to relay my personal experiences. A more precise subsection of this narrative approach is the autoethnography methodology that assisted me in gathering the data required for addressing the themes and component topics of this research project. Maréchal (2010) described autoethnography as a form of self-reflection and writing that explores the researcher’s personal experience and connects the researcher’s autobiographical story to wider cultural, political, and social meanings and understandings” (p. 43). Maréchal posited that autoethnography is a vulnerable, self-reflective form of qualitative research that various disciplines use, including social work.

Autoethnography research permits for data collection and analysis by a single participant, who reflects on his or her own practice over a period of time. The emotions that invariably interplay in critical on-the-spot decision making during an assessment of all the dynamics involved in an emergency patient trauma situation can be consuming, especially where time is of the essence.

The narrative approach best articulates why something occurred or took place, in order to better facilitate a meaning or rendering of what one is feeling and why (Sandelowski, 1991, p. 163). Sandelowski (1991) explained how “the researcher is interested in cause in presenting an explanation of an end or outcome via locating those critical moments of human action and intention when the story could have ended differently” (p. 164). This kind of reasoning provides the clearest manner for exploring one’s own emotions with a what-if strategy. In large part, this kind of approach guards against unexpected or unforeseen events by using strategic thought

processes in charting a lower-risk path to a successful outcome. Following that process, one advances the data-gathering mechanism by expanding that capacity further through the journaling component and reflection on those assessment notes. This approach enables the researcher to conduct a thematic analysis that reveals a purposeful meaning to one's practice as related to vicarious trauma, secondary trauma, compassion fatigue, and burnout. In that measure, a thematic analysis was employed for identifying, analyzing, and reporting patterns from the detailed journaling that most appropriately related to the research question.

Data Collection and Analysis

The data for this study were gathered from oral journaling. An audio recorder was used to document the study participant's thoughts and reflections after seven 12-hour shifts, over a 3-month timeline. I have recorded my thoughts and feelings after working seven 12-hour periods from July 19, 2015 to October 7, 2015. Four shifts were during the day and three were nightshifts. It is relevant to mention more specifically that two dayshifts and one nightshift fell on week-ends, and two dayshifts were during the weekdays.

Audio recordings were automatically transcribed on a locked iPhone. Processing the autonomous data yielded overall vignettes of an ER social worker's feelings experiencing patient interaction as well as the general frame of mind while providing social work service in a dynamic ER environment.

From the seven shifts, I documented 24 patient stories as most meaningful to me. For the purpose of analysis, four salient and rich vignettes were chosen. All identifying information was removed from the vignettes, and some details edited or altered to protect confidentiality. The vignettes were analyzed for common factors that could contribute to vicarious trauma, compassion fatigue and/or burnout for a social worker.

The data was obtained from a major trauma emergency department. It has a total of 50 emergency beds. One social worker is available for duty in the emergency department at any given time. This entails the standard 12-hour shifts, 24-hours a day, seven days a week. The single ER social worker on a week day is responsible for coverage of a trauma room that has three beds, nine acute beds, eight cardiac beds, a minor treatment unit, ambulatory care room, outpatient antibiotic treatment area, four pediatrics beds, and an ambulatory holding area. Additionally, we receive transfers from many other area hospitals for cardiac, neuro surgery, and stroke protocol, and on average, the emergency department treats approximately 60,000 people a year. On nightshift from 1830 to 0645, the single ER social worker covers the entire hospital, which encompasses 450 beds, including a six-floor tower, pediatrics, maternity, neonatal intensive care unit, intensive care unit, high acuity unit, cardiac intensive care unit, surgery rooms, and recovery unit.

Ethical Considerations

Approval from University of the Fraser Valley Ethics Board was obtained February 11, 2015 (see Appendices A, B and C). Approval from Fraser Health Authority was obtained February 10, 2015 (see Appendices D and E). In order to adhere to professional protocol guidelines, the researcher contacted the Department of Evaluation and Research Services, Fraser Health Authority, and the University of Fraser Valley ethics board by email and phone to enquire if ethics approval may be a prerequisite to best conduct the research. At the outset, the researcher advised the board of her intent to conduct a study using herself as the research subject ($N = 1$) and to record her impressions through analysis after each shift, without naming the hospital or using any personal or identifying information of the patients in the recording. To protect patient and hospital privacy, all identifiers were to be removed from the translated vignette narratives.

Confidentiality of the information-gathering procedure is a basic principle of research ethics as governed by the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences, & Humanities Research Council of Canada, 2014) and, therefore, was in the forefront of the data collection.

V. Findings

These findings report on the researchers own experiences from working as a sole-charge social worker in an emergency department of a major trauma hospital as they relate to vicarious trauma, compassion fatigue or burn out. The researcher identified that working in a emergency trauma hospital setting as a social worker and being faced with high acuity cases, bearing witness to patients and family grief and suffering, with no clinical supervision or debriefings can result in vicarious trauma, compassion fatigue or burn out symptoms.

Demographic Summary

This research study has a single subject ($N = 1$), which refers to a 49-year-old female social worker who has practiced in the emergency department of a major trauma hospital for 4.5 years.

Themes

Over the seven shifts I encountered 24 impactful stories that were meaningful to me. I chose four vignettes that were analyzed for common factors that could contribute to vicarious trauma, compassion fatigue and/or burnout for a social worker.

From the vignettes chosen, three consistent themes were identified: (a) the high acuity of case load and the need to manage patient and family emotions during crisis intervention. (b) navigating self and processing own emotions while conducting crisis intervention, and (c) system navigation and victimization, due to lack of resources, supervision, staffing shortage and debrief.

Vignette 1: I went from rounds to an end-of-life discussion with a 70-year-old male who had throat cancer, which had metastasized virtually throughout his entire body. The patient had appeared to come to terms with his fate, as he had removed all his IVs and

feeding tubes himself while refusing any further medical care. The medical team had planned a family meeting with his wife, who did not agree with her husband's decision. The spouse confronted me sternly at the bedside, adamant that her husband did not have the mental capacity to lucidly disengage from his life support care. The spouse began uncontrollably screaming in my direction, she stated that her husband was not thinking clearly and therefore the medical staff should not be listening to him. It was plainly obvious in this hectic moment that she also believed that the medical staff and I were not listening to her needs or, better yet, her demands. From all of the chaotic activity, I was aware that I had a migraine coming on. Suddenly, my thoughts were that I had felt inconsequential, confined, and restricted; really and truly I arrived at a point where I no longer was a patient-family advocate, but closer to an adversary. In a way, I felt I was exacerbating a problem that I was mandated to alleviate. (Excerpt taken from Shift 1)

In this vignette, my role as the social worker was to advocate for the patient's wishes and provide support and comfort to both the patient and family. I had a reduced sense of personal accomplishment by way of feeling like I was inadequate in my therapeutic approach. In fact, anything I tried only seemed to anger the spouse. I attempted to empathise with the wife, as she was clearly upset over the imminent passing of her husband, but no intervention that was tried appeared to work. I was required to suppress my own emotions and found myself wanting to distance myself physically from the entire situation. Feeling overwhelmed and personal feelings of anger, apathy, self-doubt, hypervigilance, and empathy compassion were noted as I sat helplessly watching the situation unfold in front of me. These feelings are inline with vicarious trauma as they resulted from bearing witness to this severe grief reaction. Witnessing this near-death experience, with a strong grief reaction left me vulnerable for vicarious trauma. I was the

sole charge social worker on shift; there was no colleague or supervisor to debrief with in the building. Physically, I noted a migraine occurred, and I now recall an elevated heartbeat, sweaty palms, and the need to step out of the room to collect my thoughts and gain a feeling of safety.

Vignette 2: I was paged straight to a 4-year-old young boy who was just diagnosed with leukemia and his mother rightfully being so angry at everyone and the world it seems. It is difficult when you see someone so angry and not having the words or the capability to somehow find the soothing dialogue to temper her pain, which of course escapes me in the moment. Simultaneously, the boy's father was in constant denial, and my young patient was confused, asking why his father was crying to which I tried to provide an age-appropriate answer about tears meaning different things at different times. It's so difficult emotionally to wade through it, even though you know it is part of the grief cycle and yet you feel the anger is coming towards you, directed at you and while understanding that it needs to be directed at someone it still feels like a hard slap in the face. I struggle to please, an innate need in me to fix the tragic news they just heard. The child was most likely jaundiced for some time, my inside voice is screaming inside me asking why they could not have seen earlier how sick he was and especially over the last few weeks that they were on a camping trip. Feeling numb, yup pretty numb right now. Knowing that I need to somehow process it. In the process not sure how to, feeling so stressed. (Excerpt taken from Shift 1)

In this vignette, my role as the social worker was to provide support and assistance with system navigation to the patient and parents, as they had just received news that the patient had leukemia. Bearing witness to the intense feelings that these parents were going through as they attempted to come to terms with the new diagnosis was emotionally exhausting and left me

vulnerable to suffering from symptoms of vicarious trauma. I struggled with my own conflicting feelings about the situation, feeling anger towards the parents. I perceived that they had not sought medical attention in a timely fashion and then, on the other hand, feeling empathy for what they were going through as they visibly struggled with the new diagnosis. I noted the feelings of stress, numbness, and anger towards the parents. I noted being triggered as a mother and a health care worker. Physically, I feared of being struck by the mother. I also had an innate and overwhelming need to somehow fix the situation and change the tragic news that they had just heard. Additionally, there was no overlapping coverage with another social worker for debriefing the day's events due to staff shortage.

Vignette 3: I was paged to see a patient in labour and delivery that had miscarried at 15 weeks. We had no coverage overnight so the patient had been apparently holding the fetus in her lap since 2 a.m. It was now 8 a.m. I all of a sudden noted that I had the onset of ill feeling as I prepared myself to go up to the labour and delivery room [which] is not one of the areas I am comfortable working in. The staff had reported that they were unable to get the patient to part with her fetus. I went up to the bedside, and what struck me immediately was how small the dried up fetus was laying in the mother's palm. I noticed the fetus already had little human like features. The detail of the hands, little fingers even, and the face stuck in my mind. The patient appeared to be in shock, staring down at her tiny baby. The father appeared to be uncomfortable and relieved when I began talking to his wife and was able to take the fetus and hand it over to the nurse. I engaged both parents in small talk about their two-year-old toddler at home and what their immediate future would look like. Departing from the patient, I noticed a numbing of my emotions as I was called to attend to a morgue showing. (Excerpt taken from Shift 5)

In this vignette, I was paged to provide grief and bereavement support and system navigation to the patient and her spouse as well as support staff in managing the situation. I had to hide my own emotions over the shock and sadness of seeing the fetus, as I attempted to be empathic and emotionally supportive to the patient, spouse, and the medical team. Witnessing and acknowledging this families response to this traumatic loss left me open to the symptoms of vicarious trauma. There was no colleague or supervisor to debrief with, as I was sole charge social worker in the hospital, as it was a week-end dayshift. There also had been no overnight social worker coverage due to staff calling in sick, and no one was found to replace them.

Vignette 4: First trauma that came in was a patient that was in a motor vehicle accident where he had intentionally driven off the highway at a high rate of speed, resulting in him being ejected from his vehicle. Passerby witnessed the accident and came to help, and he reportedly told them that he wanted to be left to die. His family at the hospital reported that he has tried twice to hang himself in the last year, and it seems that there is no help. I found myself pondering once again the constant dilemma of patients with concurrent disorders and the problems they face receiving appropriate treatment. I heard the family speak about numerous times the patient had been in treatment facilities for substance miss use, with relapses concurring for what they believe is due to mental health issues not being met. I could only empathize with their frustration in a system that I see all too often failing the patients and families. I felt guilt when the family thanked me for my support, when in fact, what I all I offered was confirmation of a failed system. I only could promise that at least the patient would once again be seen by psychiatry, but unless they viewed him as a danger to himself or others, the likelihood of him being admitted after being medically cleared was unlikely.

In this vignette, my role as the social worker was to provide support to the patient and family and to support them to navigate the health care system and ICBC. I was also required to conduct a suicide risk assessment for the patient. I noted my own feelings of guilt and frustration from working in association to a system that does not have the capacity to manage both addiction and mental health. I also had to bear witness to and manage the family's frustration in regards to the system that they perceived to be ignoring the patient's and their cries for help. I was also the only social worker in the hospital, working as sole charge, and had no other colleagues with whom to review the case and process my feelings related to it.

Limitation of Findings

This study has a number of limitations. It was conducted with a small sample size of just one research subject; therefore, it cannot be generalized to the population of social workers working in any trauma hospital ER. As well, the findings were taken from one trauma hospital in one city and region, and therefore, the findings cannot be generalized to all hospitals in different geographical locations.

The findings also did not take into consideration the researcher's personal life experience prior to becoming a social worker, which could affect the interpretation of the work and the findings. Also, the researcher did not take into consideration how her current life circumstances could add to or diminish from the interpretation of the effect of trauma work, which would not likely be the same for another ER social worker.

Another limitation of the findings is that they were taken from a trauma hospital funded by a public health care system that delegates funding to each department, and these findings cannot be compared to a private health care system.

VI. Discussion

The main aim of this study was to relate my own experiences as a social worker in an ER trauma centre and to determine any common factors that could contribute to vicarious trauma, compassion fatigue, and/or burnout. I was guided by a social constructionist approach, where human experience and meaning were internally created through interaction with the world and not discovered as something outside of oneself, as documented by Saakvitne and Pearlman (1996). I selected four vignette from 24 stories recorded over a 3-month period. These short descriptions of contact with patients were chosen because they elicited or captured the most significant and memorable impact for me.

I conducted a thematic analysis of the findings and will discuss these themes in relation to vicarious trauma, compassion fatigue, and burnout. These findings are presented under the following three sub-headings: (a) the high acuity of the caseloads and the need to manage patient and family emotions during crisis intervention; (b) navigating self and processing own emotions while conducting crisis intervention; and (c) system navigation and victimization, due to lack of resources, supervision, staffing shortage, and debriefs.

The primary tasks that I identify with in my role as an ER social worker include, but are no way limited to, the following list: crisis management and counselling, psychosocial needs assessment, bereavement counselling and resources, substance abuse counselling, advocacy, education, linkage, placement, discharge planning, adjustment issues, financial assessment and assistance, location of next of kin, working with law enforcement officers, trauma patients, and family, interfacing with a multidiscipline staff on a constant basis. The prerequisite knowledge for all social workers is to be versed in or a resource for (a) information regarding legal medical patient issues; (b) adult guardianship legislation; (c) child protection issues; and (d) discharge

planning and community resources, including shelter and providing access for clients to a vast variety of transportation services, which are essential elements of daily procedure for a social worker. It must be made clear that an ER social worker's role is extremely fluid and ever changing, as no one specific case is the same or requires the same services. Often the roles overlap when involving complicated situations during acute trauma cases.

The over-arching concepts regarding the effects of trauma issues raised by researchers in the literature came out clearly in this finding. The literature findings noted the high acuity of caseloads involving patients who had experienced a critical or traumatic event, such as illness in Vignettes 1 and 2, death in Vignette 3, and a motor vehicle accident in Vignette 4, which may have been a suicide attempt due to a history of addiction and mental health issues. In all four vignettes, I was providing crisis intervention to patients and families while dealing with their emotions that involved frustration (Vignettes 1, 2, and 4) and denial, anger, and grief (Vignettes 1, 2, 3, and 4). In all four vignettes, while I was providing crisis intervention, I was bearing witness to immense patient and family pain and suffering. I also noted having conflicting feelings of empathy and compassion at times mixed with anger and frustration towards the family's (Vignettes 1 and 2) and in the system (Vignette 3 and 4). I reported feeling a numbing of emotions in Vignettes 2 and 3, and I also reported feelings of being overwhelmed, anger, apathy, self-doubt, and hypervigilance as themes throughout all four vignettes. In all four vignettes, I was the only social worker in the hospital working as sole charge; therefore, no supervision or colleague debriefings could occur with other social workers.

The High Acuity of the Caseloads and the Need to Manage Patient and Family Emotions during Crisis Intervention.

Having to bounce from multiple areas in acute care at a trauma hospital leaves one thinly spread emotionally as well as physically. All four vignettes described situations that involved death, dying, life-threatening medical diagnosis, and complex traumatic event. In Vignette 1, the patient's spouse was described as exhibiting "uncontrollable screaming," as she felt she was not being heard and her feelings were not being validated. In Vignette 2, I noted the "mother rightfully being so angry at everyone and the world." Simultaneously, the boy's father was in constant denial, and my young patient was confused, asking why his father was crying". In both these cases, I was presented with extremely strong emotions occurring simultaneously with the crisis situations. In Vignette 3, the sight of the drying-up fetus and entering the room, where both parents had been for six hours grieving their loss, still stands out. Providing support to families such as these is an everyday occurrence in the emergency department. "The complexities associated with promoting client well-being and managing personal emotions add to the stressful nature of practice" (Kapoulitsas & Corcoran, 2015, p. 87). It is the build-up of this stress for the social worker that can result in compassion fatigue symptoms, as will be identified in later discussion.

Navigating Self and Processing Own Emotions while Conducting Crisis Intervention

Vicarious trauma, compassion fatigue, and burnout can pose different risks within the psychology of a social worker's mind. In reference to my patient case load, I have come to realize that I experienced compassion fatigue, which Figley (1995) defined as the "cost of caring" (p. 7). I realize this is something I have incrementally suffered over time. From my finding, I described various cognitive, emotional, and behaviours symptoms, which are in line

with the literature review on compassion fatigue. Kapoulitsas and Corcoran (2015) described the following symptoms to describe compassion fatigue:

cognitive symptoms of lowered concentration, apathy, minimization, and preoccupation, emotional symptoms that an employee can feel include powerlessness, anger, guilt, depressed and behavioural indications are irritability, moodiness, and withdrawal to somatic symptoms of rapid heart rate, and dizziness. (p. 88)

I noted from the findings a constant “sense of emotional numbing,” as described in Vignettes 2 and 3, which pervaded my mind. This numbing was most probably associated with the severity of the trauma my client had endured in these segments of time at work. Connected to that was a tangible sense of fatigue or mental exhaustion, which was a running theme throughout each vignette.

I can see that the constant empathy I emit towards my clients going through egregious trauma has taken its toll in the form of emotional fatigue, transforming into sheer physical fatigue: in particular, when my desired outcome for a client appears unattainable. This is an example of moral distress from working in a system where social work values are compromised as seen in the following finding from Vignette 4: “I could only empathize with their frustration in a system that I see all too often failing the patients and families. I felt guilt when the family thanked me for my support, when in fact, all I offered was confirmation of a failed system.” This was seen also in Vignette 1, where I stated, “I arrived at a point where I no longer was a patient-family advocate, but closer to an adversary. In a way, I felt I was exacerbating a problem that I was mandated to alleviate.”

Diaconescu (2015) described the condition of burnout as “the physical and emotional fatigue that professionals can go through when they have low professional satisfaction and they

feel helpless and overwhelmed at their work place” (p. 60). Diaconescu noted that burnout can put an employee at a high risk for compassion fatigue, but unlike compassion fatigue, burnout can be quickly averted by a change of work place. From my findings in all four vignettes, compassion fatigue and burnout were both driven often by the sheer emotional exhaustion that these unique and challenging difficult cases presented. As outlined in the findings, feelings of “frustration, overwhelm, anger, apathy, self-doubt, and sadness” were prevalent throughout all four vignettes and in line with the findings from the literature review on compassion fatigue. Saakvitne and Pearlman (1996) described compassion fatigue symptoms of irritability, insomnia, a restricted sense of enjoyment, and physical exhaustion.

I also have noted that I suffer from symptoms of vicarious trauma as described by the literature, and from my findings, vicarious trauma has, at times, made me feel pessimistic and cynical towards my clients and the health care system. The process of constantly bearing witness and hearing stories of human suffering and being exposed to trauma patients has left me struggling with feelings of anger and frustration. In Vignette 2, I described an example of this: “My inside voice is screaming inside me asking why they could not have seen earlier how sick he was and especially over the last few weeks that they were on a camping trip?” This brief lack of empathy, if left unchecked, could lead to vicarious trauma, which then could affect my ability to be empathetic and provide compassion and hope to my clients and the often oppressed population that I am so dedicated to serve. For me, I often carry an emotional burden from the client’s ordeal or memories because of my profound sense of duty to aid the marginalized individual. This duty and passion for my work is what drives me to continue to do this work. This emotional burden is not unlike what all dedicated social workers feel about their work. Thus this is how social workers, in general, are at such high risk for vicarious trauma.

Although I have identified risks of compassion fatigue, I also need to mention that I find the work incredibly rewarding and enjoyable. I recognize that I undergo a regular cognitive reappraisal process, as I continually self-reflect on my feelings and emotions during my interaction with the patient and families. I believe this process helps me attempt to interpret and make meaning of my thoughts and feelings and assists in processing my emotions in regards to my role as a social worker, which helps me maintain a feeling of control, safety, and value in doing my work.

System Victimization, due to Lack of Resources, Supervision, Staffing Shortage, and Debriefs

In all four vignettes, it was noted that I was working as the sole charge social worker, with no other social workers in the hospital to engage or collaborate with. The literature and my findings indicated that having a colleague to speak with can, in some ways, alleviate the mounting stress of confronting terrible trauma cases. Wagaman et al. (2015) found that the longer social workers were in the profession, the more satisfaction they reported from their job. “This finding suggests that social work professionals can learn from strategies used by long-term social workers that prevent of burnout and maintain compassion satisfaction” (p. 205). The literature supported this notion that clinicians require empathetic support systems. In the findings, this researcher discovered that peer groups sharing concerns over a lunch break can assist a distressed colleague, as one can better recognize immediate symptoms or signs of vicarious trauma through less formal listening.

Due to the nature of working as the only social work in the ER and often in the hospital due to shift work, I have no supervision, as my findings indicated. Unless I seek out supervision on a week dayshift, I rarely see one. On an individual level, I know I am able to

compartmentalize the mental challenges of my work, but in totality, the organizational component in helping me further to effectively guard against vicarious trauma could be strengthened. At my institution, the role of the supervisor appears to be that of an administrative figurehead: that is, somebody you go to on procedural matters or perhaps information about conduct. This speaks more to the general inadequacies within the healthcare system as a whole, which include the lack of resources and funding cutbacks that all in health care communities must endure. The recent data suggest that both social worker and patient could do better with more impactful forms of intervention to guard against the stress of a traumatic experience. Wagaman et al. (2015) noted the importance for supervisors who are not actively engaged with the front line workers to “remain sensitive to the vulnerability of their supervisees to develop vicarious trauma” (p. 205). The simple fact is that I would function with greater competence if I could rely on some forms of dialogue with my supervisor on particularly difficult and sensitive cases.

I have rarely, if ever, discussed with my supervisor the nature of a patient trauma that has caused me to take a step back or alarmed me in some manner. Yet, there have been a good number of times such an exchange of thoughts and feelings would have benefited me immensely – as well as the next patient I looked after. That lack of communication is collectively detrimental to patient care, but, more specifically, it is counterproductive to curbing the negative effects of vicarious trauma. I sometimes find myself feeling desolate because the work load is so mentally strenuous, with little control of dividing the responsibility, coupled with unrealistic overreaching patient requests and minimal supervision. This makes for a fertile atmosphere of cynicism that can lead to distressing and degenerative situations if left unattended as indicated earlier in my findings.

The literature and findings indicate that being urged to plan breaks in the work day, balancing my case load, and having access to support from other social workers would work as preventative factors against symptoms of compassion fatigue. Kapoulitsas and Corcoran (2015) “suggest the need for a strong support system to be made available to staff allowing them to speak openly about their experiences in a safe environment” (p. 19).

In my experience, self-care has reinforced the need to be able to step back or take a timely break to afford me the respite I need from the increasing mental anxiety. In my view, these coping skills could allay my concerns about the long-term effects of vicarious trauma on me personally.

In relations to example of system victimization, I do not believe the experience of my trauma came only from witnessing or retelling of my patients’ stories. Feelings of trauma were noted to occur more from direct role conflict and system limitations. Through my analysis process, I found that the trauma was coming from the system limitation as opposed to the client. In Vignette 4, I described, “I felt guilt when the family thanked me for my support, when in fact all I offered was confirmation of a failed system.” In this way, the trauma is not vicarious, but rather due to direct experiences of a system that repetitively, and in its totality, has often left me feeling like I could not provide enough support through my therapeutic interactions. More obvious and consistent throughout were feelings of frustration due to the lack of resources and no sense of personal control as noted in Vignettes 3 and 4.

The literature also had many recommendations that suggested forms of meditation to combat the effects of burnout and vicarious trauma in two important areas. Based on perspectives from both an organizational and individual level, I was struck by the fact that I was at wits end to find the time to utilize the self-care tools suggested in the readings. These included

getting proper amounts of sleep (a constant shortfall working shifts), eating correctly, taking time off, exercising, and spending more time with friends and family: that is, in essence, insulating myself through a balance of my private life away from work-related issues (Saakvitne & Pearlman, 1996).

In embracing effective self-care steps, social work researchers have discovered that it can, in fact, reverse the maladies brought on by vicarious trauma and compassion fatigue. Implementing the practices of self-care, while increasing my awareness of these conditions through expanded research data, has given me hope in overcoming the inevitable effects they have had on me. From my work as a social worker, I have discovered that through trials and tribulations, and yes even my failures, I possess the competency to be successful in the critical moments. This is the human condition in one's life journey: the act of growing through experience, of being better, and of reforming one's ways with hope despite enduring painful conditions or setbacks. It is precisely something I have strived to impart to my patients as well.

The thematic nature of the literature review, as related to my own experience in dealing with compassion fatigue, vicarious trauma, and ultimately burnout, has echoed in my mind. Here, I have endeavoured to present my moment-to-moment inner thoughts in supporting a variety of trauma clients during a few work shifts. These vignettes have exposed, in some detail, segmented patient cases and their effects on my psyche and how I have approached my professional work duties as a social worker at a trauma hospital

VII. Implications for Policy, Practice, and Research

This autoethnographic research has provided an introspective vantage into important mental conditions that could concern the well-being of an ER trauma social worker practicing this rewarding discipline. The findings and the literature support that social workers in the emergency department are vulnerable to symptoms of vicarious trauma, compassion fatigue, and burnout. The social constructionist framework was used to draw out the researcher's own experiences as revealed in the narrative form.

The literature and findings indicated that the best defense against trauma "conditions is education about them, including a clear understanding of the phenomena themselves, their risk factors and symptoms" (Newell & MacNeil, 2010, p. 64). Newell and MacNeil (2010) noted,

[Emergency department] social workers should be made aware of the emotional and psychological risks involved with working and treating vulnerable populations, particularly victims of trauma, and should be encouraged to advocate for themselves for resources to address the consequences they face in providing potentially-traumatizing services to difficult populations. (p. 64)

Supervision was identified to be an important factor in this study and literature.

Supervision for sole charge social workers could provide a climate that would give permission for workers to process their feelings and perceptions related to client trauma. Leaning towards the assistance one can gather from an organizational perspective in mitigating these varying conditions, an avenue for dialogue should be in place for the social worker. In order to ensure the best possible protective care of frayed emotions, their supervisors could help provide data on matters pertaining to sensitive and difficult trauma patients.

Hospital health authorities may want to invest in strategies that prevent or mitigate workplace-related vicarious trauma, compassion fatigue, and burnout. Future policy changes recommended by the researcher would involve mandated training programs for social workers in identifying symptoms of vicarious trauma, compassion fatigue and burnout and strategies to cope with their feelings. Training in such skills as meditation, yoga and self-care interventions should be offered annually and considered to be mandatory. In addition policy should be put in place for mandated and regular clinical supervision by trauma informed and trained social work supervisors.

Further research could be conducted on models of shared governance, for example, empower social workers to have control over their practice in regards to their work load, to developing collaborative, supportive working relationships that should involve debriefings and reflective groups with each other and the interdisciplinary team. In addition, further research could be conducted on the effects of stress on social workers forced to work in a system that is under funded and has limited resources to provide for the many patients that are living in extreme poverty. Further more the high stress work environment, coupled with compassion fatigue should be studied to see how it may negatively impact the quality of care of clients and the turnover rate in health care social work.

Lastly, from a more professional approach to reversing the depleting effects of vicarious trauma (i.e., compassion fatigue and burnout), the positive implications for further ethnographic research cannot be overstated and is necessary. This pertains to insiders or those persons who have vast work experience and education in the social work profession, who could best access the critical data necessary to better define a cohesive analysis of how these important issues can be overcome.

VIII. Conclusions

Working in a trauma hospital emergency department as the only social worker who provides direct service to a vulnerable population is taxing, but rewarding work. The theme of this paper has been an introspective account of how one emergency department social worker's experience has been impacted by the elements of vicarious trauma, compassion fatigue, and burnout.

Vicarious traumatization is a significant concern for a social worker providing services to traumatized patients. The literature and findings supported that social workers' awareness of potential changes in their beliefs about self, others, and the world around them may have a preventative function regarding vicarious trauma, compassion fatigue, and burnout (Trippany et al., 2004). This awareness could help social workers in protecting themselves against the direct or indirect effects of helping patients with traumatic histories or who are going through a traumatic situation. An awareness of personal reactions to vicarious trauma, compassion fatigue, and burnout could allow social workers to implement self-care strategies to manage such effects, thus minimizing the potential personal and work problems that could arise from them.

Supervision was noted to be very important throughout the findings and literature in supporting social workers working with trauma clients. Supervisors should be aware of the impact of vicarious trauma, compassion fatigue, and burnout and, therefore, take on a proactive role in providing a supportive and trauma preventative environment by encouraging peer support and debriefings, educating social workers on the impact of providing trauma services, diversifying caseloads, encouraging social work's sense of spirituality and wellness, as well as providing support for those social workers identified to be at risk.

The findings revealed one must develop one's own self-awareness, preserve authenticity, as well as maintain a strong personal and professional support system. This would enable social workers to not only survive, but to also be able to thrive in such a setting.

The provision of services directed to the most vulnerable citizens in the communities is a noble undertaking. It is one that often goes unnoticed, and as such, it is imperative that social workers learn to advocate for themselves in order to erode the consequences of vicarious trauma and compassion fatigue and to eradicate the burnout that can cut short a society-benefiting career. This approach will best be realized through an expanded and continued education on this topic. Ultimately, the critical take away from the research was that a social worker in the ER department should learn to safeguard oneself from its invasive dangers, which is both an individual responsibility and that of the professional peer-group team.

In conclusion, this autoethnography can only offer one template for an emergency room social worker. The objective of this paper was to identify elements of my experience that might resonate with other social workers and, hence, assist them in their practice.

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Appendix A: University Fraser Valley Professor's Approval

From: "Leah Douglas" <email address>

To: "Heidi Ahlqvist" <email address>

Cc: "Glen Paddock" <email address >

Sent: Wednesday, 11 February, 2015 8:37:01 PM

Subject: RE: ethics approval for MSW research paper.

Hi Heidi,

Thank you again for following up on this.

Based on the response from Andrea and Susan below, I support you in moving forward with your research with no requirement for HREB approval.

However, I do suggest a few things:

1. That you keep this email, in e-copy and a printed form.
2. Include your process of deciding if ethics approval is needed or not as part of your next paper for SOWK 704 (and have this form part of your major paper as well).

Glen, do you agree? Warmly,

Leah

Leah Douglas, PhD, RSW

Assistant Professor, and Graduate Program Chair

School of Social Work & Human Services

University of the Fraser Valley

Appendix B: University of the Fraser Valley Ethics Approval, Initial Email

From: Heidi Ahlqvist [email address]

Sent: February 10, 2015 10:07 AM

To: Andrea Hughes

Subject: ethics approval for MSW research paper.

Hi Andrea

I am a social worker at Royal Columbia hospital in the emergency department and presently doing my Masters of social work at University of Fraser Valley. I am looking at doing a research paper on how I might make meaning of my own experiences as a hospital social worker in ER, in relation to vicarious trauma, compassion fatigue and burnout. This will be a critical reflection of my thoughts and feelings that I will audio record at home after 8- 12 hour nightshifts. I do not intend on naming the hospital or any personal identifying information about any patients.

It would be more that today I had a death, two child protection issues involving infants and parents with con-current disorder issues and a AGL case involving self-neglect. I felt overwhelmed and

Please let me know what your thoughts are. I have emailed the same question to Fraser Health Ethics committee as well.

With much appreciation,

Heidi Ahlqvist

Appendix C: University Fraser Valley Ethics Approval

From: “Andrea Hughes” <email address >

To: “Heidi Ahlqvist” <email address >

Sent: Tuesday, 10 February, 2015 11:12:17 PM

Subject: RE: ethics approval for MSW research paper.

Hi Heidi,

Thank you for your inquiry. It sounds like you deal with some very stressful cases. From what you have told me so far, I do not think you would need ethical approval for your paper. This is based on my interpretation that you will only be reflecting on your *own* personal experiences (as opposed to your patients). If your research paper is aimed at assessing only your experiences in response to your work, then you would not need review. However, if there is any possibility that the hospital or patients could be identified by your reflections then you would most definitely need ethical review.

I hope you find this helpful. If you need any clarification, or would like to discuss further, do not hesitate to ask.

Regards,

Andrea

Appendix D: Fraser Health Association Ethics Approval

From: Chunick, Susan [email address]

Sent: February 11, 2015 6:52 PM

To: 'Heidi Ahlqvist'

Cc: Leah Douglas; O'Shaughnessy, Sara

Subject: RE: ethics approval for MSW research paper.

That is fine by me, Heidi. All the best, Susan

From: Heidi Ahlqvist [mailto: email address]

Sent: Wednesday, February 11, 2015 8:09 AM

To: Chunick, Susan

Cc: Leah Douglas

Subject: Fwd: ethics approval for MSW research paper.

Hello Susan

Thank you for your quick response. I am forwarding you my response from the UFV ethics. This is a paper that will be interpreting and making meaning from my own experience and I will not be discussing or identifying the hospital or patients.

I will review with my readers and let you know if anything changes.

Thank you again, Heidi

Appendix E: Fraser Health Ethics Approval, Initial Correspondence

Hello Heidi,

Julie is no longer with FHA; so I am replying on her behalf. This certainly sounds like a very tough day! Research aside, I hope you will seek support from your department or from Workplace Health as this type of emotional demand sounds like it is really taking a toll on you personally.

That being said, if this type of critical reflection is actually deemed to be research by UFV and if you will be using a research methodology, then it would have to be reviewed by our REB. However, because you are the research 'subject', I'm not convinced it does need ethics review, as it could be considered a 'case study'. Please consult with UFV – meanwhile I'll review the Tri-council policy to see if this type of study would be considered research under their definition. I'll look forward to hearing from you.

All the best, Susan

Susan Chunick, B.Sc.(P.T.), M.Sc.
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