CASE REPORTS

SECONDARY TRAUMATIZATION IN THE CAREGIVERS – UNIQUE CASE OF COMPASSION FATIGUE IN A RELIEF WORKER

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INTRODUCTION

An earthquake, measuring 7.6 on the Richter scale struck Pakistan on the 8th of October 2005, epicentre in Azad Jammu and Kashmir. There were more than 80,000 dead, 3.5 million rendered homeless and more than 2.5 million injured.

In order to understand the concept of "Secondary Trauma", we need to map out the disaster zone. Different kinds of helpers working in the disaster area including medical personnel and paramedics, Armed forces personnel, search and rescue workers, fire safety workers, transport drivers, workers of national and foreign NGOs, security investigators, mental health and social service personnel, volunteers from elsewhere who staff shelters, provide mass care, and assess and repair the infrastructure. All these helpers are working in the affected area in the capacity of "carers".

Survivors as well as carers are at risk of suffering from traumatic effects of disaster. Alexander [1] has emphasized an important point, namely, that there is no single traumatic event, which is guaranteed to cause psychopathology in all those exposed to it; resilience rather than psychopathology is the norm. On the other hand, we need to be aware of the risk that, however experienced and/or well trained are relief workers and other carers, some individuals might be adversely affected by their work

A critical incident is defined by Mitchell and Everly (1995) as "Any event which has a stressful impact sufficient to overwhelm the usually effective coping skills of either an individual or a group". Usually such events are powerful, sudden and out of the range of ordinary human experience. In health-care domain, however, one group most likely to be confronted regularly by such incidents are ambulance personnel who provide an accident and emergency service, and staff of trauma units [2].

Professional stress and dissatisfaction is a growing problem, and it is only a step from disengagement from the emotional element of the doctor-patient relationships, another way of describing burnout, the most sad and preventable consequence of failing to provide care for the carers [5].

CASE REPORT

The patient is a 31 year old married male, a resident of Rawalpindi, a military doctor by profession who had no previous psychiatric or medical condition prior to the Earthquake of October 2005.

On the afternoon of 8th October 2005 he came to his hospital to offer his services to help the staff on duty. He was instructed by the medical authorities to move to the helipad in a local air base, in an emergency state without any preparation or arrangements. In his medical kit he received a few dozen tablets of pain killers and some bandages. He did not receive any briefing on the nature of the task ahead or on his role in that disaster area.

This doctor, who arrived in the disaster struck area with inadequate preparation, became a part of a major crisis. He continued

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to work with same spirits over the next two weeks. He worked day in and day out with the wounded, mutilated, broken bodies of humans, dead and alive. He helped in the rescue efforts by digging out dead bodies, helped in their burial and helped in tending the wounded.

Over the next few days, maintaining the same routine, he started to develop physical fatigue and tiredness, and had difficulty in going to sleep. He became fearful of the after shocks which continued to rock the ground. Outbursts of anger became a constant feature of his routine, and as a result he also became quarrelsome with his colleagues.

All these complaints made him unable to perform his duties. In face of such adversity from nature, he himself was trapped in a persistent state of physical and emotional fatigue.

He was constantly finding himself troubled by moral and ethical dilemmas. Then, there was the issue of food – available to some but not to others. Logistic support was not available, and there were inadequate shelter arrangements.

It was in this unbearable state of mind and physical exhaustion that, suddenly, the ordeal for him ended and he was instructed to report back to base hospital in Rawalpindi.

This doctor joined his workplace the next day without any debriefing session, and he starting looking after the hospitalized casualties in different wards over the next two weeks. But by then his mind and body had suffered enough and could not cope any more. His sleep was disturbed by nightmares, and he had outbursts of anger. His relations with colleagues deteriorated. He could not cope with the demands of his job that had been previously routine for him.

His family was worried, his colleagues were concerned, and the senior staff noticed the change in his behaviour. One senior colleague asked him to seek consultation with a psychiatrist.

At his first psychiatric interview, he reported chronic fatigue, multiple somatic complaints, disturbed biological functions, strong guilt and self blame against a background of a "pervasively depressed mood". He had lost compassion – he had lost trust of colleagues and seniors – he indulged himself in medication with benzodiazepines, and he had isolated himself socially.

Psychiatric examination revealed that he was depressed, distressed and was preoccupied with overwhelming guilt of having not done enough, and was burdened by an unrealistic set of expectations and poor coping mechanisms to handle stress. He did not show any psychotic features, and his cognitive functions were mildly impaired.

Based on a detailed history and psychiatric assessment he was diagnosed as suffering from "Secondary Trauma".

MANAGEMENT

He was managed without medication. Instead, a series of counselling sessions were organized leading to relaxation training, mobilisation of adaptive coping methods, repeated sharing of his experiences in Bagh with his family and friends, an acceptance of negative emotions and working through his feelings of anger, despair, guilt and depression. He was also encouraged to use self-care tips and ensure adequate nutrition, sleep, and regular exercise, and, above all, maintain contact with the psychiatric services at Military Hospital, Rawalpindi.

Outcome

The patient is today a healthy colleague. He has resumed his duties and is performing well. He is coping successfully with his work, his family life has returned to normal, and is not on any medication.

Comments

Emergency workers, including urban fire fighters and paramedics, must cope with a variety of duty-related stressors including traumatic incident exposures. Rescuing, aiding survivors, and the tasks of body

recovery, identification, and transport, are but a few of the stressors that contribute to high levels of emotional distress among disaster workers.

The survey [2] also confirmed that burnout was associated with longer service, less recovery time (between critical incidents) and more frequent exposure to such incidents Managing Secondary Trauma at the organizational level requires awareness and recognition of Secondary Trauma – that the organization for which the carer is working must be aware of the fact that he is himself vulnerable to the traumatic effects of the disaster.

Managing stress in the work-place, ensuring regular scheduling, time off and rotation are recognized as policy issues and not as a carers' option.

Carers working in the disaster zone need to appreciate the significance of team work. They should preferably work in pairs and be able to communicate freely and openly with other co-workers. Open dialogue should be encouraged, and team members should engage in frequent discussions of the problems facing them and their individual challenges. All conflicts within the team should be resolved.

At the level of the individual – the carer is usually managed by biological interventions, emotional catharsis and by mobilizing adaptive coping techniques, depending upon the degree and severity of the trauma. Emotional catharsis includes talking about the experience. The principle that it is acceptable to share emotions voluntarily needs to be inculcated among the caring professions. Finding a shoulder to cry on – finding a partner to share the daily experiences, and using the "buddy support system" is imperative for the caring professions.

CONCLUSIONS

Emergency workers are required to cope with a variety of duty-related stressors including the exposure to traumatic incidents. Disasters workers have a deep commitment to working long hours without breaks and may quickly dismiss suggestions about using time to relax. Understanding the stressors associated with rescue work and the rescue work culture can facilitate alliance building.

Emergency workers often have a high capacity for trust among each other, but they tend to be cautious about the competencies of individuals perceived as outsiders. Rescue workers may demonstrate mental and emotional resilience during an operation, but they may have intense emotional reactions afterwards because of their sensitivity to the suffering of survivors and their families. If mental health workers tactfully acknowledge these polarities, it would help to achieve the confidence of rescue workers while increasing their willingness to disclose feelings of vulnerability or self-criticism, and to accept emotional support.

RECOMMENDATIONS

Based on more than 6 months of experience of working in the disaster struck area, the following recommendations are made to address the subject of caring for those medical staff deputed to perform relief work in disaster areas. These include the following.

- Timely rotation of caregivers.
- Focused briefing on the role of the caregiver.
- Proper logistic support ensured by the managers of the project.
- Debriefing session of the care giver.
- A spell of leave for the care giver or at least relaxed duties after completion of their duties.
- Expressions of "appreciation" from the management.

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