International Journal of Humanities and Social Science Invention (IJHSSI)
ISSN (Online): 2319 – 7722, ISSN (Print): 2319 – 7714
www.ijhssi.org ||Volume 11 Issue 3 Ser. II || March, 2022 || PP. 22-27

Secondary Traumatic Stress among Mental Health Professionals in India: Risk and Prevention

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ABSTRACT:*Indian Mental Health Professionals (MHPs) face endemic professional challenges including burgeoning rates of mental illness, shortage of trained professionals, chronic stigmatisation of mental illness, and the chaotic state of professional practice owing to the lack of a regulatory authority. Issues of burnout and secondary traumatic stress remain largely ignored in the face of these critical issues. Globally, an expanding body of research has reported that indirect or vicarious exposure to traumatic stressors can have a negative impact on mental health professionals. Such exposure, termed secondary traumatic stress, refers to the emotional distress that impacts helping professionals who are indirectly exposed to the graphic details of others' traumatic experiences. However, Indian research in secondary trauma among mental health professionals is sparse. Sources of interventions for organised self-care has also been neglected. It is therefore important to mobilise awareness, research, intervention and organised support towards amelioration of professional stress among mental health professionals. This paper will discuss the challenges faced by mental health professionals in India that might serve as risk factors for the development of secondary trauma. Lack of preventive management for mental health professionals and future direction for amelioration of professional stress will also be discussed.*

KEYWORDS:*secondary trauma, vicarious trauma, burnout, India, mental health professionals, stress*

Date of Submission: 15-03-2022 Date of Acceptance: 29-03-2022

I. INTRODUCTION

Work-related trauma exposure for helping professionals can be of a direct nature, characterized by experiencing or witnessing a traumatic event, or indirect exposure, characterized by empathic engagement withthe graphic narratives of traumatized people (Figley 1995; National Child Traumatic Stress Network, 2011). Such indirect exposure to accounts of human suffering is called secondary trauma, vicarious trauma, or compassion fatigue. While research in various countries is evolving to focus on the impact of professional stress exposure upon the professional, the issue in India remains largely ignored. This paper provides a critical overview of challenges faced by Indian mental health professionals, which could serve as potential risk factors for secondary trauma, juxtaposed against inadequate intervention and ameliorative care.

Understanding Secondary Trauma exposure

The terms 'secondary trauma', 'compassion fatigue, 'vicarious trauma' and 'burnout' have often been used synonymously by researchers to denote the impacts of professional stress.Secondary traumatic stress can be defined as *"the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person"* (Figley, 1995, p.10). STS is a natural response and if left untreated can lead to secondary traumatic stress disorder (STSD)with symptoms resemblingthose of posttraumatic stress disorder (PTSD), a form of direct trauma exposure (Figley & Kleber, 1995).With the publication of the Diagnostic Statistic Manual- 5 (APA, 2013), STS symptoms have now been re-examined based on the most updated PTSD models in the literature. Alarger body of research now finds a close resemblance between PTSD symptoms and secondary trauma symptoms characterized by intrusive imagery related to the client's trauma, avoidance, physiological arousal, distressing emotions, and functional impairment (Mordeno et al.,2017; Sprang et al., 2019)

The terms Compassion fatigue, vicarious trauma and burnout have also been used in the literature to describe professional stress.Figley proposed that *compassion fatigue* is similar as a construct to STS, but is a "friendlier" concept and, therefore can be used interchangeably with secondary traumatic stress to reduce the discomfort surrounding pathological labels (Figley, 1995). *Vicarious trauma* refers to changes in the inner experience of the therapist. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes following cumulative exposure to another person's traumatic material. (Pearlman &Saakvitne,

1995). *Burnout* is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general, occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically (NCTSN,2011)

Empirical findings on Secondary trauma

Research findings reveal that those closely working in the field of traumatic stress, including mental health workers deputed to sites of natural disaster (Creamer & Liddle, 2005; Dass-Brailsford & Thomley 2012); those working exclusively with child sexual abuse (Dagan et al.,2016; Vandeusen & Way, 2006), domestic violence (Baird & Jenkins, 2003; Kulkarni et al., 2013); sexual assaults and sexual violence (Kadambi & Truscott, 2004; Rizkalla et al., 2021) are most prone to secondary traumatization.

One of the most vital risk factors for the development of secondary trauma symptomsis a heavier trauma caseload, where the professional works with high percentages of trauma patients (Sartor, 2016; Sprang et al.,2007). Some studiesmention that increased age and professional experience serve as protective factors**,**althoughmore recent findings indicate that demographic factors havea negligible influence on developing STS (Hensel et al., 2015). Professionals with a personal trauma history are also at high risk for secondary trauma (Pearlman &Saakvitne 1995; Elwood et al., 2011).Other factors that can increase the risk of developing secondary trauma include lack of organizational support, inadequate professional supervision (Berger & Quiros,2014), and unavailability of trauma-specific training (Craig &Sprang, 2010).

Secondary traumatic stress symptoms may show up in physical signs including exhaustion, insomnia, and increased susceptibility to illness (Catherall, 1995; Figley, 2002). Behavioural signs of secondary trauma may include the use of alcohol and drugs, absenteeism, and compromised care of clients (Figley, 1995; Pearlman & MacIan, 1995). Psychological signs could include negative self-image, reduced ability to feel sympathy and empathy, dread of working with certain clients, heightened anxiety or irrational fears, intrusive imagery, failure to nurture non-work aspects of life, and a disrupted personal and sexual life (Figley,1995; Branson et al., 2014). Perhaps the most devastating cost of secondary traumatization for the therapist is the development of "cynicism" and reversal of hope leading clinicians to become excessively critical and judgmental, compromising ethics, thus diminishing their overall professional esteem (Pearlman &Saakvitne, 1995).

Challenges faced by mental health professionalsin India

While research in the West has spent a considerable part of the past two decades reporting the impact of indirect trauma on the helping professionals, there is a dearth of research and intervention with Indian mental health professionals. Helping professionals in India work in a cultural context replete with negative perceptions about mental health, poor help-seeking behaviours, and diversity issues which make the professional environment replete with challenges (Bedi et al., 2020; Lodha & De Sousa, 2018; Pereira & Rekha, 2017). However, the chaotic field of mental health in India struggles to correct larger national issues including an inadequate mental health budget, the rising rates of mental illnesses with an imbalanced demand-supply ratio of professionals, and the lack of regulatory authority for mental health practitioners. In such a scenario, unfortunately, yet inevitably, issues related to the mental well-being of mental health professionals becomes a lesser priority.

Outlined are some of the professional challenges faced by Mental health professionals in India which might set them at risk for development of secondary trauma.

1) *Treatment Gap:* According to the National Mental Health Survey of India, India's mental health care gap is 84.5%, with only two people out of ten affected reporting that they received any formal mental health care (Gautham et al., 2020). The shortage of professionals to address this gap has also been widely reported.There are only 898 trained clinical psychologists compared to the ideal requirement of 17,250. While global figures indicate 3 professionals per 100,000 in developing countries, there are just 0.3 psychiatrists, 0.07 psychologists, and 0.07 social workers per 100,000 people in India(Ministry of Health and Family Welfare, 2013).As the rates of mental illness burgeon in the country, the availability of adequate training resources, opportunities for professional advancement, as well as personal well-being of mental health professionals remain largely ignored.

2) *Scarcity of training***:** The only available psychotherapy training for Indian therapists are those that come from the West, most of which need to be tailored to suit the Indian client (Bhargava et al., 2017; Kumar & Gupta, 2012). Conversion of practice to theory is also not consistent in the field of counselling and therapy, which further contributes to lack of professional development in therapists. (Sriram, 2016; Yadav, 2017).

3) *Dearth of professional supervision*: Further complicating an already murky picture is that professional supervision in India is either minimal or absent altogether (Bhola et al., 2017). To reduce the stress coming from unsupervised casework, therapists may seek peer supervision from abroad. However, this can be expensive and restrictive, considering that foreign therapists have little idea of the indigenous environmental context (Aggarwal & Sriram, 2016; Sriram &Bhargava, 2016; Duggal & Rao, 2016).

4) *The absence of a central accrediting body*:The Mental Health Care Act (MHCA) 2017 has provided a regulation for clinical psychologists at a national level. However, the regulatory bodies have only focused on licensing Clinical Psychologists while the Counselling, Industrial and Social psychologists have not found any recognition. There is neither a governing body to regulate ethical standards and practices nor is there a check on private practitioners and/or their qualifications (Sriram & Nikam, 2016). The lack of a governing body leads to insecurity around professional identity, lackadaisical professional competency, poor grievance management, divisiveness, referral imbalance, and chaotic state of the field of mental health.

5) *Research Gap on Secondary trauma among MHPs in India*:While we know that Indian professionals might be predisposed to STS, there is a dearth of research examining this professional danger. Compassion fatigue and burnout in the medical fraternity have been explored in few studies (Eg: Amin et al., 2015; Langade et al., 2016), there is a paucity of similar studies among psychiatrists, clinical psychologists, psychotherapists and counselling psychologists.A few studies explore burnout among mental health professionals(Chakraborty et al., 2012; Manhas & Bakhshi, 2011; Mathew et al., 2013; Poojalakshmi& Ghosh, 2015; Raghuraman et al., 2019; Sarma, 2018; Suri et al., 2020). However merely two studies have been found exploring secondary trauma in Indian mental health professionals (Dar & Iqbal, 2020; Shah, Garland, & Katz, 2007). Burnout, as mentioned previously, is an indicator of overall occupational stress, and does not provide a description of specific traumatic stress experiences.

A similar research gap was seen among Indian MHPs during the COVID-19 Pandemic.Globally, the unprecedented workload and resulting stress on mental health professionals during the pandemic has been widely acknowledged**.** The American Psychological Association (APA) conducted two surveys to understand the pressures on the psychologists' workforce. Psychologists reported increased workloads, longer waitlists, and low capacity to take on new patients, which increased as the pandemic stretched (American Psychological Association, October 2021). In contrast, only a smattering of literature is available on burnout in MHPs in India during the Pandemic (Joshi &Sharma, 2020; Sandhu & Singh, 2021), and only one published article (Lodha, 2021) has shown up in a literature review on secondary trauma among mental health professionals during COVID-19. However, indications of the level of burnout and secondary trauma experienced by MHPs during the pandemic were evidenced by a fair number of grey literature in the form of blog articles and newspaper reports, indicating a presence of professional stress in the community which remained unconverted to empirical data (Bhatt, 2021; Biswas, 2021; Goecker,2020; Modi, 2022; Nair, 2021; Nigam, 2021).

6) *Lack of preventive management for mental health professionals**:***The focus on mental well-being among mental health professionals has yet to find adequate attention in India. The absence of care offered to the mental health community in India is reflected in the lack of guidance and supervision, inadequate training, few opportunities for professional advancement, and absence of organized self-care plans. Additionally, India's mental health professionals do not have a forum in which to raise these matters or a governing body to address them yet. Examples from the West indicate that the mental well-being of professional helpers has been given its due attention. Following the suicides of two psychologists in 2008, the American Psychological Association (APA) set up an ad hoc committee to investigate psychologists' stress. This led to the formation of the Advisory Committee on Colleague Assistance (ACCA) which aimed to prevent and ameliorate professional distress among psychologists, provide resources to state associations and consequently lead to better public health. Similarly, in the U.K., research by The British Psychological Society and New Savoy in 2015 revealed rising levels of depression, stress, burnout and bullying in the mental health field. This led to the launch of the *Psychological Professionals Wellbeing and Resilience Charter* to promote psychological well-being in the mental health field. The unavailability of such governing bodies and regulatory authorities that can meet the needs of practitioners is soon making India a fertile ground for burnout and traumatic stress in the mental health community.

II. IMPLICATIONS FOR RESEARCH, POLICYand PROFESSIONAL PRACTICE

Several preventive and protective factors can serve to mitigate the risk of STS. According to the National Child Traumatic Stress Network (2011), *"A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress"* (p.4). Organizations that establish clear boundaries and create a safe forum for expressing negative emotions, provide opportunities for supervision and training and promote employee wellness have been shown to reduce the risk of development of burnout and STS (Tullberg & Boothe, 2019; Wilson et al., 2013).Provision of sessions in trauma-informed care spearheaded by agencies and organization also serves as a mitigator to STS. These trainings would include continued professional development, learning of updated trauma-informed methods and specialized skills needed to respond to trauma victims, as well as self-care skills (Dierkhising &Kerig, 2018). Professionals who seek psychotherapy to reduce the impacts of STS, as well as to work through past trauma exposures, have lower levels of self-reported STS (Kanno 2017; Hargrave et al., 2006). Supervision has traditionally been considered a central component of professional practice (Berger & Quiros,2014) and is foundational as a prevention strategy for secondary trauma.

Providing regular supervisory meetings gives mental health workers an emotional outlet for processing trauma-specific work experiences. Availability of adequate supervision can normalize professionals' experiences when working with trauma populations, help them identify and work through transference and countertransference issues, and provide mentorship through the supervisory relationship (Slattery & Goodman, 2009).Promotion of self-care practices through peer encouragement, organizational supervision and individual mindfulness practices are also advisable.

Future direction for the amelioration of professional stress amongIndian MHPs

Despite the challenging nature of mental health work, few studies in India have examined the impact on professionals' emotional and psychological well-being or considered the protective factors that might reduce these difficulties. This section highlights recommendations for research and intervention in the prevention/amelioration of secondary trauma for mental health professionals in India.

Table 1:

Recommendations for prevention/amelioration of secondary traumatic stress

Protective/ameliorative factors	Availability in India	Recommendations
Resolution of STS symptoms through personal therapy.	Obstructions to availing psychotherapy include social stigma, professional boundaries, help-seeking hesitancy.	Increase accessibility of psychotherapy services within organizations. Include psychotherapy as part of both academic and professional training
Professional training in trauma-informed care.	Sparse availability	Increase affordable training in trauma-informed therapy with tie-ups from foreign/local trauma agencies. Create trauma-informed therapy curriculums adapted to the Indian environments.
Professional ongoing consultation and supervision	Sparse availability	Provide resources to organization to offer formal supervision. Increase training of clinical supervisors to offer paid, systematic supervision in trauma care.
Supportive systems of care	Offered in some organizations	Creating trauma-Informed organizations. Work-related support including caseload adjustment, mentoring, supervision
Associations to address stress in MHPs: Eg: ACCA (APA,USA)	Lack of a forum for guidance and supervision, grievance addressal and regulation of professional quality.	Regulatory authorities need to move beyond licensure and collection of Continuing Professional Education (CPE) creditstowards prioritizing mental well-being of professionals.

III. CONCLUSION:

Professional stress amelioration in mental health professionals is largely determined by a combination of larger, macro-systemendeavours, as well as individual effort. Systemic efforts include intervention for MHPs at an organization/agency level as well as within the professional statutory bodies that govern regulation. Some systemic changes might include mandatory psychological evaluation for the presence of trauma symptoms, planned self-care that can be self-administered by the therapist, support groups for therapists, professional case consultation and supervision, and mandatory individual therapy.

Investment in training and education to meet the needs of those with mental health issues should be on par with understanding the needs and risks for helping professionals. Adequatementorship,therapy and grievance addressal to prevent or treat secondary trauma enable helping professionals to continue to follow best practices with the populations they serve, while also caring for their well-being and mental health. It is equally important to have trauma-informed workspaces that promote optimal mental health in their workers. Most importantly, researchers need to conduct more qualitative studies to elucidate risk factors and effective coping strategies to prevent and manage secondary trauma among Indian mental health professionals.

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