

**Satkunanayagam, K., Tunariu, A. & Tribe R. (2010) A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture & Mental Health* 3,1, 43-51**

**A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka**

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Experiences of working with survivors of trauma in Sri Lanka (abbreviated title)

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**Abstract**

This study explored the struggles and rewards of trauma work and the notion that individuals are changed in some way by the work they do with survivors of traumatic events. Interpretative phenomenological analysis of interviews with twelve mental health professionals working in Sri Lanka has shown these changes to have both an accumulated negative emotional impact but also to simultaneously contain positive, growth-promoting and personally satisfying aspects. There is a bias prevalent in the trauma literature towards focusing on the many negative aspects of the impact of working with survivors of trauma or surveying the moderating factors for managing secondary trauma. The present research, instead, uses the paradigm of adversarial growth to demonstrate that when mental health professionals rebuild their assumptive world in light of their experiences of working with survivors of trauma there are valuable opportunities for personal, and by implication, professional growth. This study is of a qualitative nature

and explores phenomenologically grounded knowledge seeking to gain an understanding of the lived experiences reported by mental health professionals working with survivors of trauma, and the subjective and collective meanings that shape these experiences.

**Keywords:** survivors, trauma; secondary; health professionals, Sri Lanka;

## **A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka**

### **Background of Sri Lanka: conflict and natural disaster**

A civil conflict has ravaged Sri Lanka for over twenty five years broadly based on differences in language, religion and ethnic origin. As a result of the civil conflict many, including the participants in this study, have experienced and/or witnessed violence, torture, displacement, and the horrors of war. The psychological effects of the civil conflict in Sri Lanka have been commented on by de Silva, (1993) and Somasundaram, (1998). Somasundaram and Jamunanantha (2002) suggest that the widespread nature of traumatization due to the civil conflict has led to psychosocial reactions becoming accepted as a normal part of life, this is described in the literature as “collective trauma” (Somasundaram, 2007).

Disruption of identity and world-view continued with the Tsunami of December 24<sup>th</sup> 2004. Two thirds of Sri Lanka's coast line was affected. There were an estimated 35,000 deaths in Sri Lanka and the displacement of over 500,000 people (Miller, 2005). The tsunami accentuated rather than ameliorated the dynamics of the civil conflict within the country. In spite of initial hopes that the tsunami response would provide a space and an incentive to re-energise peace negotiations, it had the opposite effect (Goodhand & Klem, 2005).

Following the defeat of the Liberation Tigers of Tamil Eelam (LTTE) by the Sri Lankan Army in May 2009, Sri Lanka is now entering a new phase in its history. Effective interventions to deal with the social and psychological consequences of nearly thirty years of trauma will play a major role in promoting lasting peace and reconciliation.

### **The notion of Secondary Trauma**

“Secondary traumatization” is a relatively recent concept. There are several different terms within the literature on trauma that describe this phenomenon with “secondary trauma” being a term uniting various definitions. McCann and Pearlman (1990), for example, name its observable effects on mental health professionals as “vicarious traumatization”, while Figley (1995) uses the term “compassion fatigue”. Vicarious traumatization refers to the acquisition of trauma responses due to close association with traumatised individuals (Pearlman & Saakvitne, 1995). Figley (1995) defines compassion fatigue as the reduced capacity or interest in being empathic with subsequent behaviors and heightened, uncomfortable emotions resulting from knowing about a traumatic event experienced by a person.

It is theoretically possible to argue that the phenomenon of “secondary traumatization” is a culture-bound syndrome, for it is possible to see the notion of secondary trauma as a social construction whose reality is confined and sustained by the social practices of a particular Western view underpinned by normatively accepted psychotherapeutic principles. The experiences appropriately falling under the Western definition of secondary trauma may not be a consequence of working with survivors of trauma *per se*

but a result of the interaction of working with survivors of trauma within a particular belief system – that being the individualized, Judeo-Christian, post-modern culture of the Western world. As culture, with its dominant assumptions about normality and health, shapes expressions and perceptions of how to engage with and endure emotional stress. While discourses of secondary trauma – a set of professionally established normative formulations recognized by a comprehensive system of knowledge production – have instrumental clinical value, the impact of being in a caring and therapeutic relationship with a survivor of trauma may be expressed very differently and the coping strategies employed may also show great variation.

Most studies into secondary trauma have surveyed mental health professionals using questionnaires. The chief objective of these studies has been to assess the prevalence of secondary trauma among mental health workers and identify the caregivers that are most vulnerable and also those most protected against compassion fatigue (Figley, 1995).

### **The paradigm of growth through adversity**

Channeling research efforts into examining *negative* responses and cognitive processes has tended to obscure the benefits of systematically examining the *positive* aspects that individuals often experience as part of their engagement with traumatic exposures. A discernable body of empirical work is emerging within trauma studies highlighting that individuals are also able to process a traumatic exposure in ways that render new, helpful meaning out its unpleasantness and angst; post trauma growth as a possible outcome with

salutogenic effects of caring for distressed people being one example of this. (see Calhoun & Tedeschi, 2006).

The term adversarial growth refers to an individual's conflictual tension between new trauma-related information and pre-existing assumptive worlds and how the need to resolve this conflictual tension can serve as a springboard to positive change (Joseph & Williams, 2005). In application to secondary trauma and mental health professionals, the theory of adversarial growth suggested that those who nurture a habit of adopting a strategy of rebuilding their assumptive world in light of their experiences will have, in the long term, a more positive and growth-orientated experience of their work.

A traumatic experience is inherently one that overwhelms, in individualized ways, the psychological life-world of the experiencing individual. Preparedness in terms of engaging and enduring this kind of event is necessarily mediated by both the individual's prior experience and knowledge, including professional training. By this token, health professionals who have already cultivated a habit of flexibility in reshaping their assumptive worlds and associated strategies in the face of emotional distress are, arguably, more liable to identify growth-oriented positions within their experience of working with survivors of trauma. The present study sought to generate patterns of understandings carved directly from health professionals' experiences (within a certain context of working with trauma) that can contribute towards raising awareness and transferable participant-defined knowledge.

## **Methodology**

This study set out to engage in a qualitative exploration of mental health professionals' accounts about the struggles and rewards of trauma work in Sri Lanka with the intention that this exploration would also shed light onto the notion that individuals are changed in some way by the work they do with survivors of trauma. The interest was on exploring lived experiences in a way that allows mapping out subjective (variations) and collective (commonalities in) participant meanings rather than researcher imposed ones. As the focus was on participant's own descriptions and understanding of their experiences, a method of data collection which allows for individual articulation was required. One-to-one semi-structured open-ended interviews were conducted in English for consistency purposes across the data. All the participants used English regularly in their work or daily life and confirmed that they were happy to conduct the interview in English.

There were twelve participants in this study, five women and seven men with an age range of late twenties to early seventies. All the participants were native Sri Lankans, both Sinhalese and Tamil mental health professionals, who volunteered to share their recent experiences of working with survivors of trauma. They were all mental health professionals, mainly counsellors, psychologists, psychiatrists or medical officers working in mental health. Given the relatively small community from which this sample was selected, no other formal demographic data was collected so as to ensure that the participants' identities cannot be traced. Pseudonyms were also assigned to the participants in line with their ethnicity. Prior to data collection, this study's ethical

suitability was approved by both the University of Colombo and University of East London ethics committees.

The principles and practice of Interpretative Phenomenological Analysis (IPA) informed the processes of data collection and data analysis. IPA is a method of data analysis which explores the ways in which people construct knowledge about the world; more specifically how they make sense of their experience of situations at particular times and contexts (see e.g., Willig, 2001). It acknowledges that direct access into the participants lived experience is not possible and meaning is co-constructed through the interaction with researcher.

IPA involves conducting a systematic thematic analysis of the interview transcripts. Following the logic of inductive reasoning, the multiple reoccurrence of certain accounts, points of view and experiential narratives allows the researcher to arrive at a general conclusion – a master theme embedded firmly in the text. Four major themes emerged from the analysis of the interviews with these twelve health professionals; namely “emotional reactions to trauma work”, “managing emotional reactions to trauma work”, “approach to trauma work” and “process of trauma work”. The four themes are intricately related, and collectively, are outlining an ongoing experiential process grounded in current social, cultural, political and ideological contextual factors. For the purpose of this paper, only the “emotional reactions to trauma work” theme and its component sub themes are presented (see Satkunanayagam, 2008 for an exposition of the three remaining themes).



### **Emotional reactions to trauma work**

The following analysis aims to provide a phenomenological map of how it felt doing trauma work. The interpretative features of this theme encompasses the negative aspects of trauma work, the concept of secondary trauma, and the more positive and rewarding aspects. The analysis shows how the act of rendering certain aspects of trauma work as positive is a necessary aspect of preventing burn out and meaninglessness, and is routinely incorporated by these mental health professionals into their work with survivors of trauma.

### ***What it feels like doing trauma work***

All the participants acknowledged that hearing the trauma accounts of the people they work with had affected them. Many of the participants talked about experiencing feelings of sadness, sorrow, frustration and anger in doing trauma work.

Jegan expresses a sense of powerlessness which leads to a feeling of sadness and regret both for himself and the people he works with. With sadness he reflects on the vulnerability of finding oneself, client or health professional, stranded in a 'needless' socio-political stagnant state of affairs; and questions the pointlessness of the current community-wide suffering:

*"I feel so sorry to my clients and to me, because it's most of the time I feel it's unnecessary the so-called demon is unnecessarily produced by the factors. We can eliminate, eliminate but it's beyond my limit. It has to be arrived. It should*

*come from the so-called community leaders, politicians. I can't do anything so I feel sorry for myself as well as to my clients."*

Participants expressed frustration at the lack of change and called for transparency and coherence to address social injustice. As Mahesh states:

*"But doing it also made me frustrated, especially the things that are going on, and the fact that I could do very little to change it, and prevent injustices, et cetera and the injustices that are going on. So it just made me very frustrated and angry listening to the stories of some of these people."*

#### ***Participants' own understandings of the notion of "secondary trauma"***

All the participants were asked explicitly how they understood the notion of secondary trauma. Whilst sadness, frustration and a sense of relative powerlessness were a prevalent commonality across these participants' accounts, with regards to the concept of secondary trauma, there was a variety in responses. Some were familiar with the notion, while others had not come across the terminology to classify potent emotional nuances surrounding their trauma work.

Selvan speaks of how listening to the stories of trauma survivors triggered memories and dreams of his own experiences. This description does not fully overlap with the definition of secondary trauma but shows the potency of secondary traumatization. Listening to survivors of trauma can seep into practitioner's private life-world to reactivate one's own trauma memories:

*“I was in a bus going home the day the riots were happening in 1983 in Colombo and when I saw these shops being burned. And somebody got in the bus and asked if the Tamils are there and all that. And ... when talking to these people I do really have these memories back in my dreams ...These memories started to come back during some of the time when I was talking to these people and hearing their stories.” .*

Whether or not the term was employed, there was common recognition among these health professionals of a phenomenon akin to secondary trauma, and of how this could impact on them and the need to be diligent of maintaining clarity and a robust system of self-care.

### ***Positive aspects of trauma work***

The emotional expenditure of trauma work somehow seems to be counterbalanced by the reward which the participants were able to obtain. This reward seems to give strength in helping the participants transcend the overwhelming sense of powerlessness and sadness indicated earlier. Nalin is more explicit about the happiness he feels in providing relief to others:

*“I’ve really getting rewarded because I feel that by doing that I can give that person some kind of relief, and it makes me happy. I firmly believe that nobody does anything for nothing. I do this for me to be happy about it, be happy by*

*thinking that whatever the availability of myself to listen to that person has made that person, the burden even little things better.”*

Nalin describes a deliberate attitude of making purpose in his work, which many of the participants also share. For this meaning-making strategy to become an effective resource it needed to be actively tapped into, as it often co-existed with a strong sense of purposelessness and existential despair that many of the participants experienced.

The privilege and satisfaction of supporting people who are in distress was also made deeper by the sheer need for such support. For example Priya shares her experience of positive change in her work with children:

*“When I see children getting back to normal life, because I see sometimes children don’t go back to school, something traumatic takes place and then everyone thinks this child is no use. In Sinhalese they say this child is now like dead, no use. And then just for us to go in and to see that we made a change and that the child is back in school doing normal things, then I feel very rewarded.”*

There seems to be an explicit motivation to try and normalize the experience of trauma and invest in the hope that change is possible. For many of the participants seeing survivors of trauma improving was a huge motivating factor for their work and allowed them to resurrect a sense of hope, faith and goodness in humanity when all around them they were confronted with the evils of war and the apparent futility of the civil conflict.

### ***Personal growth through adversity***

These health professional's emotional reaction to trauma work in terms of reward and fulfillment was not just in seeing change and transformation in the clients they met. Rather for many of them there was also a sense of *personal* transformation in doing trauma work. As Amila tries to explain:

*“I think the change is that I have become less self-centered. It's a long way to coping with my ego. But in those days it would be more like, okay, just tell people how many clients I have seen and to be invited to various conferences to speak and feel important because but now, it's more like how much can I give to another person so that they will be happy, and that is much better than the first part. So in that sense I think it's changed me.”*

As illustrated by Amila's account, trauma work and the experiential re-engagement with and through core components of the human condition (e.g. life meaning, communion, hope, loss, despair) can deliver greater awareness of shared humanity and a reminder of the value of relating to clients in a deeper humanistic manner. This awareness becomes pivotal in working with survivors of trauma as it reorders priorities both professionally and personally (see also Folkman, 2008).

### **The costs and rewards of trauma work**

The construct of secondary trauma has been useful to describe the 'costs' of trauma work and as a framework for understanding these health professionals' struggles and ways of negotiating these, often to beneficial ends. The participants acknowledged the potential

negative impact that working with survivors can have. In a collective society like Sri Lanka where survivors of trauma are in the majority, it may be more useful to talk of secondary trauma in more collective terms rather than focusing just on the individual. Recovery from trauma cannot be seen as divorced from the social context which instigated it.

Similarly the paradigm of growth through adversity provides a useful conceptual framework to explore the 'rewards' of trauma work. In talking about these rewards the importance of social and environmental forces is acknowledged but the focus is still much centred on the individual. Many of the participants articulated how they had accommodated their experience of working with survivors of trauma in a positive, growth enhancing direction including an implicit alignment to personally held communal (as professionals) and social (as citizens) responsibility. It could be that collective traumas can promote positive social changes with extreme situations providing opportunities for collective action (Ai, Evans-Campbell, Santangelo, & Cascio, 2006). There is an acknowledgement that in addition to the collective negative impact of trauma there can be a collective sense of resilience and growth.

### **Awareness of the impact of trauma work**

The impact of being in a caring and therapeutic relationship with a survivor of trauma may be expressed very differently depending on defining, interacting features of a given context. Nevertheless, there is an underlying shared recognition that trauma work is difficult, challenging and frequently exhausting for those who undertake it. In order to

minimise the impact of trauma work and lessen one's potential vulnerability to secondary trauma practitioners need to keep monitoring feelings of frustration and hopelessness as well as feelings of accomplishment (Saakvitne & Pearlman, 1996). At a deeper psychological and existential level trauma workers need to try and ascertain how the work has touched their personal beliefs and expectations (see McCann & Pearlman, 1990). This awareness comes through training and reflective practice.

The importance of reflective practice, the opportunity to take time-out and process events and responses to these events, cannot be overstated in any therapeutic work, but it is even more crucial when working with survivors of trauma as was indicated by the participants' accounts. Many of the participants talked about the self-monitoring strategies they used and the self-awareness they cultivated through meditation. In Sri Lanka meditation is a culturally valued, even normative coping strategy and for many of the participants it formed the core of their reflective practice. The analysis has also highlighted the importance of self-care and supervision. In their own individualized ways, the participants were able to find and maintain a balance of work, rest and play. Peer supervision groups seemed to serve as valued resources for all of the participants.

## **Conclusion**

A prevalent idea to emerge from the analysis of these mental health professionals' accounts is the potential transformative nature of trauma work. All the participants spoke of the ways in which on a personal level they were changed by working with survivors of trauma. This aspect of their experiences mirrors an integrated framework of posttraumatic

adjustment that can encompass posttraumatic stress and posttraumatic growth for survivors of trauma (Joseph & Linley, 2008). Other researchers have shown how for mental health professionals these changes are both positive and negative and there is a belief that the rewards of trauma work can balance the painful effects of secondary trauma (e.g. Saakvitne & Pearlman, 1996). There is a need for greater preparedness in cultivating a habit of flexible reshaping of one's assumptive world, be it beliefs about what constitute clinical solutions and results to beliefs about the human condition and its strengths and vicissitudes. When the awareness of the impact of working with trauma can deliver these useful skills, then its profile within training agendas needs to remain high. Mental health professionals take seriously the impact of trauma in the lives of the individuals they serve, and are aware of the need to extend the same level of commitment and compassion to themselves (Saakvitne & Pearlman, 1996). This will not only limit the negative impact of trauma work but also enhance the growth-promoting and satisfying aspects of the work.

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