

Vicarious Traumatization among Professional Caregivers and Support Staff in Selected Hospices in Kenya

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Abstract: - Hospice workers are constantly exposed to the trauma experienced by the clients they interact with daily in their work settings. The purpose of the current study was to determine the prevalence of vicarious trauma (VT) among the hospice caregivers in selected hospices in Kenya. A tool adapted from Vicarious Trauma Scale was utilized to assess prevalence and levels of vicarious trauma among the participants. A brief questionnaire was also used to obtain demographic information of the participants. A total of 70 male and female staff in the various occupations and positions within the hospices were included in the study. Data was then analyzed using descriptive statistics. The study findings revealed a VT prevalence rate of 67% among hospice workers. The findings showed that vicarious trauma is a real threat to care givers working in hospices. The study recommended that there is need to educate caregivers about the existence and possible risk factors of vicarious trauma. These findings offer valuable information for developing staff competencies in the workplace and ensure appropriate intervention as well as practitioner support programs.

Keywords: vicarious trauma, hospice staff.

INTRODUCTION

Hospice staff members provide specialized care to terminally ill patients. This type of care focuses on prevention and relief of suffering of patients and their families facing difficulties associated with life threatening illnesses (World Health Organization [WHO], 2006). It is estimated that over 70% of people with advanced cancer or Acquired Immunodeficiency Syndrome (AIDS) are in need of this kind of care (WHO, 2010). Existing literature on traumatology suggests that, persons caring for clients suffering trauma associated with hospice care are at risk for vicarious traumatization (VT). The patients' agony, fears or distrust infect the caregiver resulting in changes in their worldview as well as profound disruptions of their cognitive schemas. Thus, the caregivers tend to exhibit similar symptoms as those of their clients. McCann and Pearlman (1990) used the term vicarious trauma to describe the profound transformations that occur in a caregiver's inner experience resulting from empathic engagement with traumatized clients.

Related Concepts

VT concept has been associated with constructs such as: secondary traumatic stress and compassion fatigue (Bride, Radey & Figley 2007). However, there are noteworthy differences between these concepts depending on context (Newell & MacNeil, 2010). Figley (2002) defined compassion fatigue as the behavioral and emotional effects that result from a traumatizing event experienced by a significant other or from caring for a distressed person. On the other hand, secondary traumatic stress has been used to refer to the stress resulting from indirect exposure to trauma such as helping or wanting to help a traumatized person, with the emphasis being more on the outward rather than intrinsic changes (Figley, 1995).

Hospice Work and Vicarious Trauma

Hospice staff members are directly and indirectly exposed to the trauma experienced by the clients they constantly interact with. This is because life threatening illnesses cause agony to patients in that, they not only affect the physical aspects of the patient, but permeate all other psychosocial and spiritual aspects of the individual which heavily weighs them down. Hospice work involves caring to improve both the physical, social and psychological discomforts of terminal illness and dying. The continuous emotional engagements with terminally ill patients; plus repeated exposure to numerous losses of lives of some patients can vicariously affect the caregivers, rendering them vulnerable to VT.

In the Sub-Saharan Africa (Kenya included), approximately 80% of patients who seek hospice services present with advanced disease (WHO, 2012). Therefore majority of the patients come with various complications. Physically, patients suffer a myriad of symptoms including intense pain, weight loss, diarrhea and breathlessness. As the disease progresses, patients' bodies may develop gaunt appearances and multiple disabilities. Consequently, these patients are psychologically and emotionally vulnerable. Many of them suffer chronic stress, existential distress, hopelessness and a sense of helplessness. Hence staff-client

communication is often emotionally charged (Way, 2010). For some, a diagnosis of a terminal illness means a death sentence which may result in an existential crisis (Onyeka, 2010). They grieve as they count their losses and worry about their families. Their disfigured bodies may evoke shame, guilt or helplessness in the patients as well as the caregivers, which could easily generate into psychological trauma. Some patients suffer psychological disturbances. Thus, some hospice members of staff could be traumatized, especially if they are ill equipped to deal with such complex disorders.

Death is common in hospices. The hospice workers watch some of their patients as they deteriorate until they die. They witness parents grieving the death of their children and vice versa. They are thus forced to face their own mortality which could make them experience a sense of futility. Some workers avoid seeing their patients to escape these feelings. National Cancer Institute (NCI, 2012) asserts that clinicians avoid discussing death with their patients for fear that it may signify loss of hope. Avoidance could be a sign of VT.

Literature shows that hospice care is relatively new in Sub-Saharan Africa. Hospice work in Kenya began in 1990 (Kenya Hospice and Palliative Care Association [KEHPCA], 2012) with the opening of the Nairobi Hospice. Subsequently, other hospices were opened up in other parts of the country. Usually, the staff members visit patients in hospitals, homes (for the bedridden) and also offer daycare services where patients and their caregivers converge to share their experiences. It is worth noting that most African countries lack the developed hospice model with a complete multidisciplinary team (Cameron, Viola, Lynch & Polomano, 2008). Therefore, many of these hospices operate with very limited number of staff as well as inadequate resources. The few available personnel perform multiple roles. For instance, nurses serve as clinicians, pharmacists, social workers, counsellors and also play other roles where practitioners are unavailable (Kinyanjui, 2006, Nyakundi, 2013). Many caregivers are ill prepared for these diverse roles which require empathic engagement with the client. Consequently, these members of staff may be exposed to the risk of developing VT particularly when they are unable to maintain empathic boundary or if their competence is threatened.

Hospice support staff members also play a crucial role in the smooth running of hospices (Swinney, Lee, Rubin, & Anderson, 2006). Their jobs involve administration, psychosocial support, and personal care for patients or general cleanliness. They too develop substantial interactions with the terminally ill patients. Since nearly 77% of hospice workers are involved in direct patient care (National Hospice and Palliative Care Organization [NHPCO], 2007), these workers are likely to experience some negative effects. This is especially so because at the heart of hospice care is the staff-client relationship, which makes empathic engagement critical. It is against this background that hospice staff form close relationships with their clients. Chronic empathy could pose a risk for vicarious trauma especially if the workers fail to sustain healthy empathic boundaries.

Symptoms and Prevalence of Vicarious Trauma

Vicarious trauma can adversely affect the caregiver, the hospice and ultimately the clients if it is not adequately addressed. A study conducted in USA revealed that 12% of palliative care physicians reported depressive symptoms, anxiety and sleep disturbances (Vachon & Mueller, 2009). Another study carried out in Botswana found that workers caring for cancer patients had elevated levels of disruption in self-trust, self-control, safety and intimacy (Majuta, 2010). Similarly, nurses providing HIV care in Uganda showed that their ability for compassionate care ebbed as their personal reserves diminished (Harrowing, 2011). Thus, there is need to recognize and address this phenomenon due to its deleterious consequences. Symptoms of vicarious trauma include: invasive imagery such as flashbacks or nightmares, avoidance, increased arousal, irritability and disruptions of cognitive schemas including diminished capacity for intimacy and trust (Bride & Figley, 2007; McCann & Pearlman, 1990a). These effects can be short- or long term, as well as permanent. Vicarious trauma is an occupational risk as it permeates the personhood of the caregiver impairing the quality of their personal and professional lives.

In terms of personal effects, the continuous witnessing of the patients' deteriorating conditions, multiple deaths within a short period, as well as listening to their trauma narratives, can possibly infiltrate the caregivers' worldview which can drain their psychological resources. The cumulative effect could result in temporary or permanent disruptions of the caregivers' cognitive schemas. According to McCann and Pearlman, (1990a) this may degenerate into profound changes in the caregivers' core beliefs about themselves, others and the world. Their psychological needs namely: safety, trust, esteem, intimacy and control are thus deeply affected. The caregivers then begin to filter their beliefs through the affected schemas, seeing their world as unsafe, experiencing intrusive imageries, loss of control as well as emotional numbing. An affected caregiver may be unable to connect empathically with the patients, an aspect that is the very heart of hospice care. Consequently, the caregivers' job performance is affected in that they may deliver sub-quality services to clients.

Vicarious trauma continues to be prevalent among caregivers although the rates vary. Reviewed studies showed vicarious trauma rates as ranging from as low as 26% to as high as 90% across various clinical settings. Dunkley & Whelan (2006) conducted a study in Australia among telephone Behavioural Health Clinicians (BHCs) counsellors. The findings indicated a VT prevalence rate of 26%. A study by Abendroth & Flannery (2006) in USA found that 78% of hospice nurses were prone to compassion

fatigue. Additionally, Middleton (2011) carried out a study in USA among child welfare professionals on the relationship between VT and job retention. Results indicated that about 26% - 35% of participants experienced core aspects of VT. Similarly Komachi, Kamibeppu, Nishi, Matsuoka (2012) in their study among nurses in Japanese hospitals found a secondary trauma prevalence of 90.3%. This underscores this study's concern about the levels of VT among caregivers in many hospice settings in Kenya whose main clientele are cancer patients. In addition, most of the studies reviewed tended to focus almost exclusively on one group of staff such as medical professionals and therapists leaving out the support staff within the same work settings who are also directly involved with traumatized clientele and are therefore exposed to VT. Furthermore, there is limited local research on VT to guide our understanding and intervention of this phenomenon with regard to hospice workers. It is yet to be conclusively demonstrated that hospice staff across various disciplines within hospices exhibit significant levels of VT, a gap that this study intended to fill.

This study was guided by the Constructivist Self-Development Theory (CSDT) propounded by McCann & Pearlman, (1990). CSDT combines Self-Psychology, Object Relations, Social Learning and Cognitive Theories (Kohut, 1977; Mahler, Pine & Bergman, 1975; Rotter, 1954; Mahoney, 1981; Piaget, 1971 cited in McCann & Pearlman, 1990). The major assumption of the CSDT includes the understanding that the self is the center of a person's identity and inner life and it has four interrelated features: self-capacities which promote the development and maintenance of positive self-esteem; the ego resources that aid in relating with others; psychological needs that motivate behavior; and the cognitive schemas that are the cognitive manifestations of the psychological needs (McCann & Pearlman, 1990). All these aspects mediate in vicarious trauma.

The theory assumes that the meaning of trauma is subjective to the survivor in that, individuals are capable of constructing their own perceptions of reality and to alter these perceptions if need arises (McCann and Pearlman, 1990). A caregiver, whose ego resources have been impacted negatively, may lack the ability to activate the self-protective skills thus placing him or her at risk for VT. Hospice workers whose psychological resources are weak

may find themselves emotionally overwhelmed by issues that would not normally impact on them. In spite of all this, it is rare to find VT included in training programmes or even discussed during supervision (Knight, 2010; Nuttman-Shwartz & Dekel, 2008; Radey & Figley, 2007). According to McCann and Pearlman (1990), even when caregivers are extensively trained, they may not be fully prepared for the agonizing images or emotions that can be elicited in the course of interacting with suffering clients. A hospice staff may get distressed just by witnessing clients' difficult experiences or due to the empathic bonding with them.

Aim of the study

The main objective of the study was to establish the prevalence of vicarious trauma in both professional and non-professional staff working in hospices in Kenya.

METHOD

Design

The study used an exploratory survey in order to establish the prevalence and levels of VT among staff working in the hospices. The Vicarious Trauma Scale (VTS) which was adapted from Middleton (2011) was used to assess VT among respondents. The scale was modified to suit the context of the respondents. Data on VT scores was analyzed descriptively in order to establish the VT scores of the participants.

Participants

The sample was drawn from the twenty one hospices across Kenya. The researchers utilized two sampling techniques: stratified random sampling as well as purposive sampling. To ensure representativeness proportionate stratified sampling was used to select ten hospices.

This guaranteed that participants from each subgroup were included in the final sample. The hospices were first stratified based on ownership criterion into two strata: free standing units which were owned by companies; and faith-based or community-based organizations (FBOs) owned by faith or community based organization and which are mainly found in rural settings. The free standing units comprised eighteen hospices forming 85.7% of the total number of hospices; while faith or community-based ones consisted of three units which formed 14.3% of the hospices in Kenya. A total of eight hospices were selected from the stratum of free standing units and two hospices from the stratum of FBO facilities yielding a total of ten hospices. This was obtained by dividing the proportion of units in each stratum by the total number of the institutions and multiplying it by the desired sample size.

Since the hospices in Kenya maintained a small workforce, the study included all the staff members comprising male and female personnel in the sampled institutions. Thus a total sample size of 77 staff members from the ten (10) hospices was included in the study. This sample represented 64.2% of the total number of hospice staff in Kenya. This was more than 30% of the total number of the targeted population. According to Borg and Gall, (2003) and Mugenda and Mugenda, (2003), at least 30% of the total population is representative.

Instrumentation

The Vicarious Traumatization Scale (VTS) developed by Middleton (2011) was used to measure vicarious trauma among hospice workers. This was adapted to suit the context of the present study sample. The 34-item scale was designed to measure the changes within the caregivers' self as well as disruptions in the cognitive schemas of caregiver's identity and belief system (Pearlman & Saakvitne, 1995). Higher scores on this scale represented greater vicarious trauma. The scale is brief and has good psychometric properties. The tool was designed on the basis of detailed theoretical review and research (Middleton, 2011). A brief questionnaire on demographic information devised by the researchers was also used.

Data Collection Procedures

Data collection commenced after the research permit was granted from the National Commission for Science, Technology and Innovation (NACOSTI) after approval by the Kenyatta University Graduate School; and ethical clearance from the Kenyatta University Ethics Review Committee (ERC). The researcher obtained a written permission to access the hospices from the KEHPCA Directorate.

RESULTS

Demographics

Data was collected on demographic characteristics of participants namely: gender, age, level of education, occupation and years of professional experience. Based on the demographic analysis, the study showed that there were more female staff (77.1%) than males (22.9%) with a mean age of 40 years. The findings regarding the level of education showed that 38.6% of the workers had acquired tertiary education, with very few (2.9%) having only primary education. Thus, the bulk of the staff in hospices had some form of certification beyond high school. In terms of occupation, the findings showed that nursing was the main occupation which accounted for 48.6% (nurses and nurse aids). Physicians formed the minority accounting for only 4.3%. There were no counsellors or psychologists in any of the sampled hospices. These roles were played by the nurses who mainly run these institutions. Regarding professional experience, majority of the participants (60%) indicated that they had worked for one to six years in hospice care.

Prevalence of Vicarious Trauma among Respondents

The findings of this section were guided by the objective of the study which sought to find out the prevalence of VT among hospice staff in Kenya. The aim was first; to establish whether hospice staff in Kenya experience VT and secondly; to determine the levels of vicarious trauma where it was present. Analysis of data on the general prevalence of VT revealed that, a substantial proportion of the caregivers (67%) experienced VT while 33% did not suffer VT as shown in figure 1.

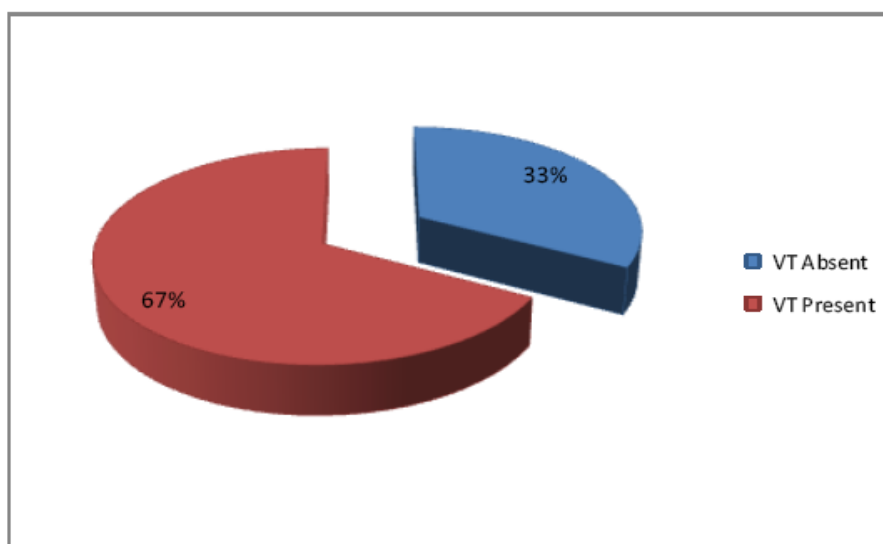


Figure 1. Prevalence of Vicarious Trauma among Respondents

However, majority of those affected (83%) had low levels of VT which means that many participants experienced mild vicarious trauma; while a few staff members (17%) experienced moderate to high levels, meaning that the effect was significant and required action. This is presented in table 1.

Table 1. Levels of Vicarious Trauma among Respondents

Level of Vicarious Trauma	Frequency	Percent
Low Vicarious Trauma	39	83.0
Moderate Vicarious Trauma	7	14.9
High Vicarious Trauma	1	2.1
Total	47	100.0

Vicarious Trauma Scores among Respondents

Cross tabulations were carried out on the various demographic variables and occurrence of vicarious trauma. The findings indicated that vicarious trauma affected both professional and support staff. The results showed that 77.3% of the support staff and 62.5% of the professionals suffered vicarious trauma. A higher proportion of the female participants (74.5%) suffered vicarious trauma compared to their male counterparts. Regarding age, the study showed that a total of 80% of those who suffered vicarious trauma were aged between 31-40 years. A large proportion of the caregivers aged 61 years and above (66.7%) had no vicarious trauma. In addition, approximately 86% of the respondents who had worked in hospices for 7 to 11 years experienced vicarious trauma, as presented in table 2.

Table 2. Demographics and Vicarious Trauma

Demographics		VT Absent		VT Present	
		Freq.	%	Freq.	%
Gender and Vicarious Trauma	Male	04	25	12	75
	Female	19	35.2	35	64.8
Age and Occurrence of Vicarious Trauma	61+	2	66.7	1	33.3
	51-60	4	57.1	3	42.9
	41-50	8	30.8	18	69.2
	31-40	3	20.0	12	80.0
	21-30	6	33.3	12	66.7
	< 20	0	0	1	100
Level of Education and Occurrence of Vicarious Trauma	No response	0	0	1	100
	University	8	42.1	11	57.9
	Tertiary	8	29.6	19	70.4
	Secondary	6	30.0	14	70.0
	Primary	1	33.3	2	66.7
Occupation and Vicarious Trauma	Support staff	5	22.7	17	77.3
	Professional caregivers	18	37.5	30	62.5
Years of experience and vicarious trauma	Over 11	3	33.3	6	66.7
	7-11	1	14.3	6	85.7
	1-6	15	35.7	27	64.3
	<1 year	4	33.3	8	66.7

DISCUSSIONS

Demographic Information of Staff in Hospices

The purpose of this study was to establish the prevalence of VT among professional and support staff in the hospices in Kenya. Based on the demographic analysis, various observations were made. With regards to gender, the results of the study indicated that there were more female staff (77.1%) in hospices than males.

This shows an imbalance which seems to suggest that hospice work is primarily a female profession. This pattern mirrors previous studies which showed that caregiving largely rested on the female population. Graaf (2011), in a study among caregivers of HIV/AIDS patients in South Africa, found that 86.4% of the participants were women. Similarly, Middleton, (2011), Unroe, Cagle, Dennis, Lane, Callahan and Miller (2014), reported more female caregivers accounting for 92% and 93% respectively. The findings of the current study confirmed the general trend in the Kenyan health sector whereby, majority of the healthcare workers are women (WHO, 2013). This probably means that caring is a role that females assume more easily than males, making most of them join the helping professions. The trend may be attributed to gender role socialization. Depending on the culture where one lives, the roles of men and women are culturally defined. Though the trend may be slowly changing globally, the predominant trend in many societies has been that girls and women are socialized to take caregiving and nurturing roles which hospice work entails, as their societal gender roles.

With regard to age, generally, the findings show that in Kenya, hospice workers' ages range mainly from 20 years to 60 years. Those over 60 years were also relatively few (4.3%). The mean age of the respondents was 40 years. These findings are consistent with Kaladow's (2010) findings that caregivers' ages ranged between 25 to 70 with a mean age of 48.7%. Likewise, in another study on the determinants of grief among workers who cared for terminal cancer patients in Taiwan, the age of respondents ranged between 18.7 to 62.1 years with a mean of 42.9 years (Chiu, Huang, Yin, Huang, Chien, & Chuang, 2010). The findings in the current study showed that there were many staff members aged between 41 and 50 years. This could be attributed to the fact that on average, majority of workers in Kenya are at the peak of their careers within this age group.

On the other hand, the few staff under the age of 20 years may be due to the fact that the education system in Kenya is organized in such a way that after secondary education, students join the tertiary institutions, at about the age of 18 and complete their college education at about age 21 to 25. Since hospice work requires that one goes through some training after secondary education, it follows therefore that many young people of this age are generally still in colleges. Additionally, the low numbers of staff aged 60 and above could be explained by the fact that, workers are supposed to retire at the age of 60 years according to the Government of Kenya (Rakoum, 2010). There is a possibility that these few workers who are still offering services in hospices at such an advanced age possess specialized training, experience as well as expertise required to meet the needs of hospice care.

With respect to the level of education, 38.6% of the workers have tertiary education. The bulk of the staff in hospices have secondary education and at least some form of certification beyond high school. These findings are similar to Graaf's (2011) findings that majority (77%) of the participants had post primary education. This trend is expected in Kenya because it is in line with the health sector requirements that health care personnel should be trained beyond secondary education. Thus training is a key determinant of health care market (Scheffler, Bruckner & Spetz, 2012). In addition, the constitution of Kenya places emphasis on provision of high quality health care services for all Kenyans (Kiambati, Kiio, & Toweett, 2013) which calls for further training after secondary school. The results seem to suggest that because hospice care is a very specialized kind of care, it requires qualified or well trained personnel. Palliative care education in Kenya is being delivered at certificate or diploma level (KEHPCA, 2013). So it follows that for a person to work in hospice he or she has to undergo some specialized training in palliative care. Thus, many workers join hospice care after they have undertaken training. This explains why most hospices are served by members of staff who have received training after secondary education to care for patients and their families.

In spite of this, the results of the current study show that there are also a few members of staff (2.9%) that have primary education. It is not uncommon to find that most of these are probably support staff who are mainly drivers or persons doing manual labour such as cleaning. According to the National Hospice and Palliative Care Organization (NHPCO, 2007) nearly 77% of hospice staff are involved in one way or another in caring for the patients. These workers also play an important role in that, even though they are not in the medical team treating the patients, they are sometimes called upon to assist in various aspects of caring for the patients. For example, they are called upon to offer a helping hand like lifting, carrying or bathing patients among other services that may arise. This means that they also interact with the patients' suffering and trauma. They are thus exposed to the risk of VT.

It is therefore safe to suggest that there is need to accord some form of training in palliative care for the few staff (2.9%) that only have primary education. This may be necessary because, all are involved in care giving in one way or another.

In terms of occupation, majority of the professional staff members (48.6%) in the hospices are nurses. These findings resonate with findings of a study by Unroe, et al., (2014) whereby majority of participants in hospice care were nurses. From these findings, the pattern shows that a number of hospices in Kenya have few employees and therefore they may not have complete multidisciplinary teams that are recommended in hospice care to effectively offer holistic care (Ministry of Health [MoH] national palliative care guidelines, 2013).

The holistic care approach is essential because hospice care involves caring for persons who are mainly terminally ill patients, many of who suffer immense physical, emotional as well as psychological pain. As the disease advances, many of them suffer anxiety, grief and depression as they worry about the progression of their conditions as well as the welfare of their families. Therefore an interdisciplinary team is essential to take care of these concerns (Ministry of Health national palliative care guidelines, 2013). A multidisciplinary team is a group of health practitioners with specialized training in different fields who offer a variety of services which amount to holistic care of the patient (Abdulrahman, 2011). The absence of such a team implies that the same personnel take up the various roles where staff are lacking. When the same caregivers are left to care for all the issues of dying patients and their grieving families, there is a risk of prolonged exposure to trauma which increases staff risk to VT. All these issues together with the workload of the staff can be overwhelming for the caregiver.

Many of the hospices maintain limited numbers of professionals (Kinyanjui, 2006, & Nyakundi, 2013) and therefore, they fall short of the comprehensive teams. The few staff members are thus expected to perform multiple roles to fill in any gaps in terms of personnel. For example, nurses in most of these hospices assess, diagnose and prescribe medicine for patients. Furthermore, they take on the roles of physicians, social workers, pharmacists, counsellors and administrators as well as other roles that need to be filled. This could lead to workload stress which increases the risk for VT. In addition, some roles and responsibilities may not be clear to the caregiver which may cause feelings of inadequacy or a sense of futility. Such feelings of helplessness in a caregiver could gradually generate into deep psychological turmoil including VT.

Another possible outcome of taking on multiple roles is the issue of dual relationship, where the same caregiver plays several roles with the same client. A caregiver who plays all these roles may find difficulties in maintaining healthy boundaries with patients and their families, exposing him or her to the effects of trauma. It is also possible that some caregivers are not adequately prepared to take up these heavy roles and responsibilities. A hospice worker in such a situation is likely to experience role strain, whereby one senses that he or she is incapable of fulfilling the role expectations (Feldman, 2011) thus increasing the risk of developing VT. The role strain coupled with work overload may drain the staff emotionally increasing the risk for the onset of VT. By limiting staff, the hospice administrators may be exposing their own employees to adverse effects of trauma. This may affect the psychological wellbeing of caregivers making them vulnerable to vicarious trauma.

The study findings showed that there were no counsellors in most of the sampled hospices. In most cases nurses played the roles of counsellors and psychologists, designations that require intensive and extensive training and supervision. According to Ellington, Reblin, Clayton, Berry & Mooney, (2012), hospice nurses have extensive skills especially in assessment of patients, symptom management as well as communication to assess the holistic needs of clients.

The nursing curricula, including hospice nursing are principally geared towards direct physical care. Although the nurse practitioners are expected to conduct counselling for their clients, the work overload, unclear roles and inconsistent expectations (Kim, Yoo, Lee & Kim, 2014) seem to make it difficult for effective counseling to take place. In addition, some may not be adequately prepared to offer counseling services effectively. This is a major concern as psychological and emotional needs of patients require a psychologist or counselor

who is specially trained to take care of deep emotional needs of clients. Thus a staff member, who is not soundly trained in this highly specialized area, may not adequately address the psychological issues of patients and their families. Effective counselling is essential for both the patients and their families to help them cope with the emotional and psychological issues that arise as a result of the terminal illness. In addition, some of the emotional issues are heavy and may impact negatively on a worker who is not adequately trained. When the caregivers begin to feel inadequate, their ego resources may be drained, rendering them vulnerable to vicarious trauma.

There was evidence that many hospices relied on volunteers to fill in the roles where caregivers were lacking. This boosts the incomplete multidisciplinary teams in these facilities. However, the use of volunteers may have implications in terms of services offered. Where the volunteer fails to turn up, it could possibly cause anxiety or frustration on the part of the employed staff, which then forces the already overworked caregiver to step in and take over the role. This can be stressing therefore increasing the risk of vicarious trauma for the caregiver.

With regards to the staff years' of experience, the bulk (60%) of the caregivers have professional experience of between 1-6 years. Another significant proportion (12.9%) had a long working experience of more than 11 years. This resonates with findings of a study by Abendroth and Flannery, (2006), who found that hospice nurses in a US community-based hospice had worked in hospice nursing for between 6-13 years. The main reason cited by the participants was that they were not hired but 'called' to the profession. This possibly suggests that many of the staff consider their jobs a lifetime vocation characterized by selflessness and altruism. This can be a positive attribute on one hand as it gives one a sense of satisfaction in serving. However, on the other hand, it could result in adverse consequences where staff are constantly offering emotional support to patients and their families but they are not getting emotionally nourished themselves, leaving them emotionally drained.

The finding that some employees have worked for several years in hospices (over 7 years) implies that there could be continuity in the facilities. This could mean that the said personnel have acquired relevant skills and experience in hospice care and may therefore be an asset to the hospices. These caregivers learn to make meaning out of the suffering and death of the patients they interact with; which motivates them to keep working in hospices. These can be very helpful in mentoring the young caregivers who may be joining the facilities especially in the field of self-care in order to reduce or curb the adverse effects of vicarious trauma.

Prevalence of Vicarious Trauma among Hospice Staff

The study sought to find out the prevalence of Vicarious Trauma among hospice workers in Kenya. Analysis of data on prevalence of vicarious trauma revealed that, a substantial proportion of the caregivers (67%) experienced VT. However, majority of those affected had low levels of VT, while a few staff members (2.13%) experienced high levels of VT. Hospice care which involves continuous intensive emotional involvement with patients who are terminally ill as well as their significant others can be quite straining, depending on a caregiver's personal characteristics and coping. Studies carried out in other parts of the world have found relatively high prevalence rates among caregivers such as: Branson (2011) and Bride (2007) who reported rates of 61.3% and 70% respectively. This shows that healthcare workers across the globe experience similar effects in their work places where they constantly interact with traumatized clientele.

The relatively high prevalence of vicarious trauma could be attributed to the human tendency to react in certain ways in the face of suffering. The work of caring for the dying in hospices involves constant exposure to individuals who suffer trauma and anguish. The continuous witnessing of the patients' deteriorating conditions, multiple deaths within a short period, as well as listening to their trauma narratives, can possibly infiltrate the caregivers' worldview which can drain their psychological resources. The cumulative effect could result in temporary or permanent disruptions of the caregivers' cognitive schemas rendering them vulnerable to VT.

Vicarious traumatization results in profound changes in the core beliefs of the caregivers regarding themselves, others and the world. Their psychological needs namely: safety, trust, esteem, intimacy and control are thus deeply affected. The affected caregivers then begin to filter their beliefs through the affected schemas, seeing their world as unsafe, experiencing intrusive imageries, loss of control as well as emotional numbing. An affected caregiver may be unable to connect empathically with patients, an aspect that is the very heart of hospice care. McCann and Pearlman, (1990) describe the resulting changes of VT to be pervasive, cumulative, and permanent. Moreover, VT could possibly result due to the caregivers' inability to disentangle themselves emotionally from the clients they serve or if the caregiver fails to employ self-care strategies. In addition, VT could occur where supportive measures such as regular supervision and other trauma management practices are lacking.

Although all caregivers are exposed to a potentially traumatizing environment, not all get adversely affected. The findings in the current study imply that there are variations in the way caregivers experience vicarious trauma. According to CSDT, the self is the seat of the person's identity and inner life (McCann & Pearlman, 1990). This means that individuals are self-regulatory. The self is capable of maintaining a balance of wellness through its protective boundaries and coping patterns. This could explain the findings that a proportion of the workforce (33%) has not been impacted on by VT.

The Constructivist Self-development Theory (CSDT) proposes that the meaning of trauma is subjective. The theory further posits that individuals actively construct their realities through development of cognitive perceptions that facilitate the understanding of their trauma experiences (Pearlman & Saakvitne, 1995). This means that every caregiver is unique and therefore each one constructs personal realities and meanings as he or she interacts with patients. Changes in the caregivers' perceived realities may occur due to the patients' trauma stories and caregivers' individual characteristics. The theory further denotes that humans have self-capacities or inner capabilities which allow them to maintain a coherent sense of identity, positive self-esteem and manage strong emotions. It follows that, a hospice worker who has a strong cohesive self can in fact be protected from the adverse effects of VT. It is also possible that some caregivers have developed resilience over time as they interact with patients. Another probable explanation could be that, the caregivers are involved in trauma management programs that help moderate the trauma effects.

In addition, it is important to note that vicarious resilience and other positive outcomes such as posttraumatic growth (PTG) could also result in the midst of traumatic experiences. PTG means that a caregiver is positively transformed by his or her experience of trauma beyond adjustment (Tedeschi & Calhoun, 1996, as cited in Hernandez, 2010). Hospice workers could experience positive changes as a result of exposure to trauma, such as resilience or post traumatic growth. Besides, it is possible that caregivers can be affected positively by their clients and they develop vicarious resilience, that is, they experience similar strength,

personal control and other coping mechanisms as their clients. The clients' suffering and success stories of how they have managed to cope with their conditions can vicariously influence the caregivers into building their own resilience. This may explain why some caregivers have served for very long in hospices yet they are not adversely affected.

The fact that majority of hospice workers are affected by VT could imply that the positive outcomes such as PTG or vicarious resilience are yet to be experienced by many of the workers. The current study has shown that VT prevalence is relatively high among caregivers in hospices. Well over half of the respondents had VT. If this condition is not recognized, acknowledged and treated it may affect service delivery to clients as well as the organization. There is need for the stakeholders to recognize and acknowledge that vicarious trauma is a real occupational risk; and address it appropriately through formulation of policies that target relevant and practical intervention strategies. It is crucial that all hospice staff, professional as well as support are actively supported to reduce the risks of VT.

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