CHALLENGES ENCOUNTERED BY MENTAL HEALTH WORKERS IN KIGALI, RWANDA

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ABSTRACT

Being a mental health worker in Rwanda is very difficult as many endure traumatic stress as a result of working with trauma survivors and other psychiatric patients. This phenomenon has been described as Secondary Traumatic Stress (STS).

This study aimed to explore the mental health workers' experiences of STS when working with mental health clients in Kigalli, Rwanda. Using a qualitative approach with an exploratory design, mental health workers from four mental health services in Kigali City were invited to participate in the study. A total of 30 participants were interviewed and included nurse managers, medical doctors, social workers, trauma counsellors, psychologists and psychiatric nurses.

 Four categories emerged from the data, namely; feelings while experiencing STS; factors contributing to STS; strategies used to cope with STS; and support systems which limit STS. Mental health workers in Rwanda could experience immediate and long-term STS responses which might affect them emotionally and physically. Although there are a few positive aspects to working with traumatised clients in Rwanda, the effects of STS impact negatively on the professional functioning and interpersonal relationships of mental health workers in that country.

Mental health institutions should consider implementing protective strategies such as structured supervision and peer support groups to mitigate STS. Mental health professionals working with traumatised clients need to tend to their own self-care by examining within themselves any unresolved trauma issues of their own.

KEYWORDS: genocide in Rwanda, genocide survivors, mental health nursing, mental health workers, secondary traumatic stress

INTRODUCTION AND BACKGROUND INFORMATION

Being a mental health worker in Kigali, Rwanda, is difficult as many mental health workers experience traumatic stress as a result of working with trauma survivors and other psychiatric patients. This experience has been described as Secondary Traumatic Stress (STS) (Babbel, 2008), implying the normal subsequent behaviours and emotions resulting from information about a traumatic event experienced by a significant other. The literature reveals the use of different terms with similar meanings as STS, including compassion fatigue, counter-transference, burnout and vicarious traumatisation (Pearlman & McKay, 2008). As a result of STS, people are likely to adopt coping mechanisms and engage in self-protective defensive manoeuvres to create distance and reduce their own discomfort, anxiety and, in some circumstances, pain, to tolerable levels of STS (Babbel, 2008).

Rwanda is well-known for the 1994 genocide, when hundreds of thousands of people died in planned violence. Up to one million people were massacred during the 100-day genocide of the Tutsi, and the recovery process has presented huge national and personal challenges (Schaal & Elbert, 2006). The tangible costs of this genocide are still noticeable socially, emotionally, culturally, morally, politically and economically (Schaal & Elbert, 2006). During the genocide, Rwandan women were subjected to sexual violence on a massive scale, committed by elements of the notorious Hutu militia groups, known as the Interahamwe (Mukamana & Brysiewicz, 2008). Rape was extensive and many of the women were individually raped, gang-raped, raped with objects such as sharpened sticks or gun barrels, held in sexual slavery (either collectively or through forced marriage) or sexually injured (Schaal & Elbert, 2006).

Many mental health workers in Rwanda are survivors of the genocide and the way in which these mental health workers experience STS needs to be understood within the context of this unique work environment (Iyamuremye & Brysiewicz, 2010; Schaal & Elbert, 2006). A quantitative study carried out in Kigali, amongst mental health nurses, showed that most respondents' scores indicated very high or extremely high risks of suffering from post-traumatic stress (Iyamuremye & Brysiewicz, 2010). Given the important role that mental health workers play in Rwanda in providing care for trauma survivors and psychiatric patients, despite being victims themselves, it is vital to understand their perceptions of STS. This study aimed to explore the mental health workers' experiences of STS when working with mental health clients in Rwanda.

RESEARCH METHODS

A qualitative inquiry into the description of mental health workers' experiences of STS was carried out, which built on the findings of a preliminary study by Iyamuremye and Brysiewicz (2010). Guided by the Constructive Self-Development Theory (Pearlman,

2003) and using an action research approach, the study attempted to help develop an intervention model to help mental health workers in Rwanda to manage STS.

Individual interviews

Mental health workers from four mental health services in Kigali City were involved in this study. The institutions included a national referral hospital offering specialised psychiatric and mental health care, a leading institution in mental health care for out-patients, and two non-profit organisations that provided mental health services to survivors of the genocide. The researchers anticipated interviewing approximately 4 to 5 participants per research setting, but, due to the interest of mental health workers in the research, a total of 30 participants were interviewed over a period of three weeks (April–May 2010) when saturation was reached. The participants comprised nurse managers, medical doctors, social workers, trauma counsellors, psychologists and psychiatric nurses. Table 1 illustrates the characteristics of the participants.

Table 1: Characteristics of participants

Characteristic	Frequency	Category of healthcare professional	Frequency
Gender			
Male	10	Medical doctor	2
Female	20	Psychiatric nurse	7
Work experience		General nurse	12
1–5 year(s)	20	Psychologist	2
6–10 years	9	Social worker	3
More than 10 years	1	Trauma counsellor	4

Initial meetings were held with managers of the mental healthcare institutions in order to explain the aim of the study and to request access to the relevant staff members. Managers granted permission for interviews to take place while participants were on duty. Interviews were conducted by mixing each participant's mother language (Kinyarwanda) with English and French and each interview took between 45 and 60 minutes. All the interviews were audio-taped and transcribed (and translated where necessary) after the interview. The in-depth individual interviews consisted of four parts. The first part comprised a general introduction to the study and establishment of rapport. In the second part participants were requested to identify factors that caused stress during their activities with traumatised clients and/or psychiatric patients. The participants were then requested to explain the coping strategies they utilised to decrease and prevent workplace-related stress. They were also requested to explain the behaviours they had acquired to promote their own health. The fourth part was

the conclusion where each participant was thanked for his/her collaboration with the research team.

Trustworthiness

To confirm thoroughness of qualitative data, credibility, transferability, dependability and confirmability of the research should be demonstrated (Lincoln & Guba, 1985). Prolonged engagement was ensured as the interviewer was actively involved at the research site during the research period. Thick descriptions of the research process, including the sampling and context, were provided to enable a certain level of transferability. Dependability was assessed through the inquiry audit and field notes and a reflective diary was also kept. The research supervisor was consulted during the analysis of the data to verify the findings and participants were consulted to confirm the interpretation of the data. Data were analysed using the content analysis method as described by Kondracki and Wellman (2002).

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the University of KwaZulu-Natal, where the first author was a registered student, and permission to conduct the research was obtained from the authorities of the research settings. Participation in the study was voluntary and confidentiality and anonymity were maintained. Written informed consent was obtained from all the participants who were informed that they could withdraw from the study at any time. Should any participant have experienced stress due to the sensitive nature of the subject matter, the first author (a mental health nurse specialist) was available to either provide counselling or refer the participant to other appropriate services.

FINDINGS

Using content analysis, the following four categories emerged from the data: mental health workers' feelings while experiencing STS; factors contributing to STS; strategies used to cope with STS; and support systems which limit STS. A series of sub-categories emerged from each category (see table 2).

Table 2: Categories and sub-categories

Category	Sub-category
Feelings while experiencing STS	Feeling under-pressure and loss of control
	Feeling of anger and frustration
	Uncaring and dysfunctional relationships

Factors contributing to STS	Stressful work environment and work conditions
	Personal trauma history
	Lack of support
Strategies used to cope with STS	Verbalisation and letting go
	Internalisation and spiritualization
	Use of humour and personal hobbies
	Helping others
Support systems which limit STS	Informal support systems
	Organisational support system

Mental health workers' feelings while experiencing STS

This category contained three sub-categories as participants reported feelings of being under pressure and loss of control, feelings of anger and frustration and uncaring and dysfunctional relationships.

Feelings of being under pressure and loss of control

Participants explained that these feelings occurred when something did not go according to plan or when the work environment became so overwhelming that they could not handle the demands. One psychiatric nurse said:

> I think most that you experience STS when you don't have control over situations. There is something that you want to do but you can't for whatever reason. There are external factors that make it difficult. I feel [I am] working under pressure when there is a shortage of staff and no consultation with management or supervision occurs.

Another respondent said:

> I'm stressed all the time when I arrive at my work. My thing is not having enough time to spend with each patient. I think that is what gets me. And then when I get home, it's like, 'Did I do right by that patient?'

Many participants described that this resulted in feeling not only physically, but also mentally, fatigued. One psychiatric nurse said:

> After a particularly busy day I have felt stressed. I was exhausted, tired, and fatigued. There have been some nights where after I have worked all night in [the] acute ward of a psychiatric hospital and [when I] went home in the morning, I thought I just can't go back to that place.

Feelings of anger and frustration

Feelings of anger and frustration were common among the mental health workers as they described their experiences of being confronted with too many traumatised clients. Some of them felt that they occasionally allowed their feelings of anger and hostility to interfere with the care provided to their patients. One of the mental health workers said:

> At times, it makes you very angry and frustrated, very hostile, especially with your colleagues, some difficult patients; you may catch yourself not being as caring, friendly, or nice as you would have been if it had been a different circumstance.

Another participant, who was explaining that it was very difficult to provide compassionate care to patients who were hostile and aggressive, said:

> I get angry and frustrated because they [the patients] don't see the big picture – they don't realise how much we are doing trying to take care of them – they are nitpicking and it is very frustrating to me.

Uncaring and dysfunctional relationships

Participants expressed that work related stressors often resulted in uncaring behaviour and dysfunctional relationships among colleagues, as indicated by the following statements:

> It has affected me to the point where I don't care anymore. It's just a job. But that's not true for the people that really need to be there. My heart really aches for those people. I am not friendly – I am very blunt and to the point.

> It has made me very jaded. You are very insincere. Instead of seeing one patient as [and finding out] what's going on with that one, you kind of develop this mentality that everybody's a drug seeker or everybody's whining and complaining.

> Since I've worked in mental health service I've let quite a few friends go because … I've got nothing in common with them anymore. Yeah, my whole circle of friends apart from a few very close friends has changed quite considerably.

Factors contributing to STS

Three sub-categories emerged when participants identified factors contributing to STS, namely: a stressful work environment and working conditions; a personal trauma history; and lack of support.

Stressful work environment and working conditions

Participants complained about the stressful work environment that they encountered on a regular basis. One mental health worker said:

> Each day we are confronted with more realities in the workplace, all needing new solutions. It's too much; there are too many traumatised clients and psychiatric patients. I have lost hope that anything will change.

The lack of support from management and non-mental health workers also figured prominently in these discussions, as indicated by one participant who said:

> A lot of times it feels like you have nobody on your side. Nobody [is] going to bat for you.

Personal trauma history

While discussing a possible connection between personal trauma history and STS, participants explained that a history of personal trauma plays a major role in the occurrence of STS. One participant explained:

> I had experienced a traumatic event many years ago. I had done a lot of personal work and believed myself to be a strong mental health worker doing excellent intervention work with traumatised clients. I was working with a client who had a similar experience and the story really shook me up. I felt myself spiralling backward.

Lack of support

Many participants pointed out that the lack of support from management and colleagues was a common factor which contributed to STS, as illustrated by the following statements:

> The management staff is not in touch with what is going on, how we feel, or what we are up against. [There is] lack of support from colleagues … Managers that run this place think they know but they don't. And I think if they would come and see, it might open their eyes to see how we struggle because we're short staffed. I think they need to see what everybody goes through.

Strategies used to cope with STS

Four sub-categories emerged when discussing the strategies participants used to cope with STS, namely: verbalisation and letting go; internalisation and spiritualisation; use of humour and personal hobbies; and helping others.

Verbalisation and letting go

Most participants reported that, in order to cope, they discussed their stressful cases with colleagues, management, family or friends, by using statements such as:

> I think that verbalisation seems to work best for me. When it's all over with, if I can talk, then I can seem to let go of it. If I don't talk, then I hold on to it and it destroys the rest of my day even if the stressful part of the moment is over with.

> An hour of walking from work to home gives [me] the time to wind down and I can kind of review the work's events and discuss what could have been better or what could have been prevented. And that helps me a lot to just kind of vent my anger and my frustrations of the work's events. I try to have all of that cleared up by the time I get home.

> I think to myself that tomorrow is another day and that's just the way things are around here. I have to just try to get through it the best way I can.

Internalisation and spiritualisation

Some participants reported that when faced with a stressful situation at work, they sometimes removed themselves from the situation. This gave them the opportunity to think about and process what they had just endured and refresh themselves psychologically so that they would be ready to go back and face new challenges. One participant tried to explain:

> When it's really bad I just shut off completely from everything I do, I just kind of retreat into myself and I don't really feel anything. I don't socialise, I don't do anything, I just kind of sit and try and work through it on my own.

Many participants declared that spiritualisation was the coping strategy that helped them to get through STS in the short term, as stated by one:

> When I get up every morning, I just say a little prayer that my guardian angel is with me all day and that I have the ability to think and make [the] correct decision. I have done that since I started to work in [the] mental health service. So, that is how I start my day, and my guardian angel has not abandoned me yet.

Use of humour and personal hobbies

Some participants said they employed humorous comments and jokes to help them through a stressful situation or stressful day as humour and laughter provided a vent for work-related stress, especially with their huge workloads. One participant said:

> I have found that while working in mental health service I constantly have to take time in order to take care of myself. I do this by enjoying time with friends, watching kids play in the park. I also take the time out to play and have vacations from here. Without this balance, I think it would be very easy to develop STS.

Helping others

Many participants stated that being able to help others in their time of greatest need is what attracted them into the mental health profession. Participants stated:

> Knowing that the mental health care I provided was beneficial to the individual. Knowing that I saved somebody's life. That is the most rewarding thing in mental health care.

> To me it's not just the patients that you save but it's also the patients that you can be there to comfort.

> Feeling that you really made a difference in somebody's life and you really did something that was significant to save somebody's life, you have some reason for being happy to be in the mental health profession.

Support systems which limit STS

During the discussions, two sub-categories emerged with regard to the support systems which mental health workers believe help reduce the incidence of STS among themselves, namely: informal support systems; and organisational support systems.

Informal support systems

Some participants described how they would discuss particularly stressful days with their family members. Although their families did not necessarily understand the situation, just having them listen helped the respondents to cope with the situation.

> I am able to speak to my twin sister who will listen to me when I want to talk about my problem at work. My friends also will listen, comfort and encourage me when I am down and not feeling happy.

Some participants described how they would discuss particularly stressful days with their family members even though they could not understand; just having them listen helped a great deal:

> My daughter who is big will continue with the house hold duties if she see[s] I am tired [when] coming home.

Organisational support systems

Some participants reported that organisational support systems could help to reduce cases of STS among mental health care workers. They stated:

> A supportive organisation culture is one that not only allows for vacations, but also creates opportunities for mental health workers to vary their caseload and work activities, take time off for illness, participate in continuing education, and make time for other self-care activities. Mental health services might signal their commitment to staff by making staff self-care a part of the mission statement, understanding that ultimately it does affect client care.

> In my workplace they get on me if I have just a few hours of overtime. Sometimes I really wanted to stay, especially if I have made a good connection with a client. When I challenged this I was told that modelling good boundaries is good for staff and clients, that there is more to life than work and that it is easy to get into an overtime trap that leads to feeling overtired and overworked. I was kind of happy that management took this position.

DISCUSSION OF RESEARCH FINDINGS

Feelings of pressure and loss of control; feelings of anger and frustration; feelings of physical and emotional fatigue' and uncaring and dysfunctional relationships were experienced by the participating mental health workers in Rwanda. These symptoms were all consistent with those reported in previous studies. Anger and frustration have been recognised as the most common outcomes of ongoing emotional stress (Mouldern & Firestone, 2007). Marcora, Staiano and Manning (2009) also identified being overwhelmed, demoralised and withdrawing from friends and family members, and fearing and distrusting of others as symptoms of STS.

Participants identified a stressful work environment, personal trauma history and lack of support as factors contributing to STS. These factors were also consistent with previous studies' findings. When considering factors which contribute to STS, Killian (2008) stated that several factors, such as working long hours, time constraints and deadlines, large and professionally challenging client caseloads, limited or inadequate resources, low pay and safety concerns are important. Pearlman and McKay (2008) suggested that a history of personal trauma was the most powerful variable in determining the impact of STS.

 When considering strategies which mental health workers used to help them cope with STS, participants mentioned verbalisation and letting go, a sense of humour and personal hobbies. These strategies were also identified by various other studies. Verbalisation and letting go are considered the most readily available resources of

support for mental health professionals when dealing with traumatised clients (Osofsky, Putnam & Lederman, 2008; Moor, 2007). In support of this, Phelps, Lloyd, Creamer and Forbes (2009) found that the most helpful coping strategies for mental health workers were the use of peer support, clinical supervision, consultation and personal therapy. Russinova and Cash (2007) have also referred to spirituality and internalisation as significant coping strategies providing a sense of hope, connection and meaning when working with traumatised clients and mentally ill patients. Participants in this study reported some positive aspects of their work. They admitted that the experience of helping others and a sense of reward were gratifying features of mental health work. This has been also been acknowledged by Satkunanayagam, Tunariu and Tribe (2010). In addition, Engstrom, Hernandez and Gangsei (2008) found that, through a process of introspection, mental health workers could apply clients' resilience to their own lives, helping mental health workers to reframe and cope better with their personal difficulties and troubles.

Perez, Jones, Englert, and Sachau (2010) maintained that a lack of social support was linked to STS and this was endorsed by participants in this study who reported that informal support systems and organisational support systems were important factors limiting STS. Supportive social support was also associated with decreased STS in caregivers as it appeared that those who had more time to sustain relationships and engage in basic self-care, seemed to be at lower risk of experiencing the negative effects of their work-related stress (Badger, Royse & Craig, 2008).

CONCLUSIONS

The experience of STS among mental health workers is multifaceted and complex. The categories that emerged from this study indicate that STS experienced by mental health workers in Rwanda could lead to certain immediate and long-term responses and with emotional and physical effects. The results suggest a need for further interventions as few participants reported receiving adequate support.

RECOMMENDATIONS

Mental health professionals working with traumatised clients need to tend to their own self-care by addressing any unresolved personal trauma issues. Mental health institutions should implement protective strategies, such as structured supervision, peer support groups and regular attendance at workshops designed to mitigate STS. Educational programmes on STS, which identify triggers, symptoms and coping strategies, need to be developed for the mental health workers.

LIMITATIONS OF THE STUDY

The study was restricted to mental health services in Kigali, Rwanda. Mental health workers in the rural areas of Rwanda might experience different challenges. Another limitation was the fact that the first author was known to some of the participants, which might have influenced the participants' responses.

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