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Spirituality and Vicarious Trauma Among Trauma Clinicians: A Qualitative Study

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ABSTRACT

Background: There has been a lack of research so far on spirituality and trauma. There has been some indication that religion and spirituality are resources in protection against burnout.

Objective: The aim of this study was to understand the phenomenon of spirituality in the context of vicarious trauma among trauma clinicians.

Methods: This was a qualitative study based on hermeneutic phenomenological methodology. Individual interviews were conducted with 36 physicians, nurse practitioners, and physician assistants on the relationship between their spirituality and trauma work.

Results: Participants were recruited from a large Midwest metropolitan Level I trauma center and attendees at the 2018 Eastern Association for the Surgery of Trauma annual conference. Four patterns emerged from the interviews that transcended religious or spiritual affiliation and medical specialty. These included (1) the world of trauma; (2) religious or spiritual beliefs guiding their work; (3) the need for support systems; and (4) the importance of coping mechanisms.

Conclusion: Religion or spirituality plays a role in underlying meaning making and, in the moment, coping for trauma professionals.

Key Words

Religion, Spirituality, Traumatology, Vicarious trauma

BACKGROUND

Trauma and Stressor-Related Disorders

In the current *Diagnostic and Statistical Manual of Mental Disorders* 5th ed. (DSM-5), there is a new category, "Trauma and Stressor Related Disorders." One of the criteria A items for posttraumatic stress disorder (PTSD) is "experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)" (American Psychiatric Association, 2013, p. 271). This is the first time vicarious trauma has been recognized as a psychological disorder. Health care professionals working with trauma patients are at risk of developing a trauma-related disorder, including dissociative symptoms, one of which is depersonalization, "persistent or recurrent experiences of feeling detached from and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly)" (p. 272).

There are several terms in the research literature that are used to describe this overall phenomenon, including "burnout," "compassion fatigue," "secondary trauma," and "vicarious trauma." At times these terms are used interchangeably or have different definitions associated with them, adding to the complexity. This study used the term "vicarious trauma," which refers to a process that evolves over time with an accumulative effect (Aparicio et al., 2013).

Vicarious Trauma

Vicarious trauma can impact one's worldview and all aspects of one's functioning (Branson, 2019; Edelkott et al., 2016; Tabor, 2011), including physical (Hayes, 2013), neurological (Shepard, 2013; Tyler, 2012), emotional (Sansbury et al., 2015), mental (Mairean & Turliuc, 2013), cognitive (Aparicio et al., 2013), sexual (Branson et al., 2014), and spiritual (Dombo & Gray, 2013). Vicarious trauma can result in collateral damage to peers, families, and friends (Tabor, 2011).

Prevalence

Research indicates that the nature of a clinical relationship with a victim of trauma creates a vulnerable situation for the medical professional to develop vicarious trauma (Aparicio et al., 2013), with some researchers viewing this as inevitable, natural, and normal (Sansbury et al., 2015). In a qualitative study looking at the impact of vicarious trauma on trauma researchers, the results indicated that simply listening to traumatic stories (even in the context of research) can contribute to vicarious trauma (van der Merwe & Hunt, 2019). Research shows that it is important to view this phenomenon not as an individual problem

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but rather as an occupational phenomenon that puts health care workers on the frontline of caring for trauma patients at greater risk (Kelly, 2020). According to Mathieu (2012), between 40% and 85% of "helping professionals" develop vicarious trauma, compassion fatigue, or high rates of traumatic symptoms.

Much of the literature on trauma-related disorders in health care professionals use the term "burnout" and the Maslach Burnout Inventory to measure the presence and extent of symptoms (Maslach et al., 2016). The Maslach Burnout Inventory measures three key areas: emotional exhaustion, depersonalization, and low personal achievement. Several studies have been conducted to explore the rate of burnout in physicians (Gribben et al., 2019; Peckham, 2019), including international studies (Durand et al., 2019; McKinley et al., 2020). Studies examining the rate of burnout in nurses have also been conducted (Hinderer et al., 2014), including international studies (Adriaenssens et al., 2015; Bock et al., 2020; Kim & Yeo, 2020).

Vicarious Growth

Although trauma health care workers are at a greater risk for negative outcomes from working with trauma survivors, there is a growing body of research related to vicarious growth, sometimes referred to as vicarious resilience. The term "vicarious growth" was originally developed by Tedeschi and Calhoun (1996). They created the Posttraumatic Growth Inventory, which originally consisted of five dimensions: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. The inventory was subsequently revised to reflect the diversity of spiritual and existential experiences of persons across cultures (Tedeschi et al., 2017).

Research has been conducted to assess the relationship between vicarious trauma and vicarious growth to assess whether the relationship is linear or curvilinear (Dar & Iqbal, 2020; Yaakubov et al., 2020). Results vary, suggesting that the relationship between the two is complex but that research needs to appreciate the potential presence of each. However, there are indications that prevention efforts that utilize elements of vicarious growth can be an effective means of guarding frontline trauma health care workers against vicarious trauma (Sansbury et al., 2015).

Spirituality

Spirituality is defined as "that which allows a person to experience transcendent meaning in life, often expressed as a relationship with God, but can also be about nature, art, music, family, or community—whatever beliefs and values give a person a sense of meaning and purpose in life" (Puchalski & Romer, 2000, p. 129). This study emphasized spirituality in a broad sense, including persons who may or may not be religious (including atheists), with the understanding that some persons choose to express their spirituality through religion. The terms "religion" and "spirituality" are used together with this underlying foundation.

Health care professionals working with trauma survivors may experience spiritual distress due to a lack of meaning in their work or hopelessness, thereby increasing their risk for vicarious trauma (Dombo & Gray, 2013). One study of physicians found that "engaging in prayer or meditation was associated with higher compassion fatigue scores" (Gribben et al., 2018, p. 738). The researchers suspect that the physicians who were more stressed turned to prayer or meditation as a form of coping; yet, more research is needed to explore this relationship. Spirituality has also been associated with preventing or mitigating vicarious trauma and promoting vicarious growth. A continuing education course on mindfulness was shown to decrease levels of burnout and improve the well-being of health care professionals (Goodman & Schorling, 2012). Prayer, meditation, mindfulness, and talking with a chaplain have been shown to improve compassion satisfaction and manage burnout (Gribben et al., 2019; Hinderer et al., 2014). Many physicians correlate compassionate patient care with compassion, which they link with underlying spiritual values, thus approaching medicine as a spiritual discipline (Anandarajah & Roseman, 2014). Attending to one's spiritual health and sense of calling may provide trauma health care professionals with the ability to find purpose and meaning in their work, thus combatting vicarious trauma and promoting vicarious growth (Dombo & Gray, 2013).

OBJECTIVE

The aim of this study was to expand the understanding of spirituality and vicarious trauma and vicarious growth by examining the lived experiences of frontline health care providers (physicians, nurse practitioners, or physician assistants) dealing with trauma patients.

METHODS

Methodology

This was a qualitative study utilizing hermeneutical phenomenology. Phenomenology itself is complex in that it refers to a philosophical tradition as well as a methodology. As a philosophical tradition, phenomenology undergirds most qualitative research. Regarding methodology, phenomenology is an umbrella term that encompasses different schools of thought that overlap yet offers distinctions. This project utilized the philosophical principles of Martin Heidegger as a foundation for hermeneutic phenomenology. Heidegger emphasized the concept of the person, of which there are five key facets, including:

1. Persons as having a world;
2. The person as a being for whom things have significance and value;

3. The person as self-interpreting;
4. The person as embodied; and
5. The person in time. (Leonard, 1994, pp. 43–63)

Heidegger's philosophy was heavily influenced by his experiences with and understanding of theology. Many Christian theologians, including his colleague, Paul Tillich, have been influenced by his work. One of the fundamental aspects of Heideggerian phenomenological methodology is its focus on essences or themes that emerge from studying the lived experiences of persons and thus give subsequent meaning to a particular phenomenon. This methodology seeks to reveal meanings associated with practical knowledge that is left hidden in empirical research approaches. Heidegger's phenomenology is concerned with ontology: in the case of this study, how does spirituality influence and is influenced by being a trauma worker who cares for those in the aftermath of traumatic experiences. This approach was appropriate for this study, given that the world of health care trauma was being studied and how trauma personnel interpret and make meaning out of their experiences in the context of their spirituality.

Participants

Participants were physicians (trauma surgeons and others) and extenders (nurse practitioners and physician assistants) who provide care to persons who have experienced trauma. They were recruited in person from two sources: from a large metro Level I trauma center in the Midwest and at the 2018 annual Eastern Association for the Surgery of Trauma convention. Participants from both groups were also asked to recommend other colleagues (snowball sample). Participants were unaware of the research or the researcher before being approached.

Interviews

Interviews began with demographic questions, including gender, race, medical specialty, and religious preference. Participants were asked open-ended questions designed to solicit discussion around their experience working with trauma patients and their personal understanding of spirituality, which for some included religion (see Table 1 for interview questions). Participants were interviewed one time in person or over the phone. Interviews lasted between 45 and 75 min. Interviews were held in private areas to ensure confidentiality. No additional persons were present during the interviews. Participants signed written consents or, in the case of phone interviews, faxed them. Interviews were recorded and transcribed verbatim. Pseudonyms were given before sending interviews to the transcription company. The only identifiable data were the consent forms.

A trauma surgeon in charge of trauma research at the Midwest Level I trauma center and who has a background in religious studies was involved in testing the research questions, thereby becoming Participant 1. Once a codebook was developed, Participant 1 provided feedback on patterns and themes to ensure academic rigor. The project received approval from the Ascension St. Vincent Indiana Institutional Review Board office on February 26, 2017, and expedited review status was granted (Project #R20160016).

Data Analysis

Deidentified demographic data were uploaded in Microsoft Excel to track participants' gender, race or ethnicity, medical specialty, and religion or spirituality. Transcribed interviews were uploaded into the qualitative data analysis software program Atlas.ti. 8 Windows (Atlas.ti, 2019). Analysis was driven by the data themselves. Interviews were analyzed for patterns that were present in all interviews, as well as the way those patterns manifested themselves in themes. Patterns and themes were analyzed using Heidegger's five concepts of the person. The author coded the interviews.

RESULTS

Forty-seven health professionals were approached, five declined, and six agreed but did not respond to requests to schedule an interview, resulting in 36 interviews (response rate 76.6%).

Sample Characteristics

Two thirds (n = 24) of participants came from the Midwest Level I trauma hospital, and one third (n = 12) were recruited from the trauma conference. Participants were predominantly White and Christian and represented various medical specialties (see Table 2). The participant cohort included health care professionals with experience in active military duty, high school shootings, and child or adult sexual abuse, assault, and trauma.

Phenomenological Patterns and Themes

Four patterns emerged from the interviews: (1) the world of trauma; (2) religious or spiritual beliefs as guiding their work; (3) the need for support systems; and (4) the importance of coping mechanisms. These patterns manifested in various themes (see Table 3).

The World of Trauma

Participants described the experience of being "thrown" into the world of trauma. With little to no warning, they were responding to awful circumstances and stories. The world of trauma is fast-paced and requires members of the trauma team to make quick decisions and rapidly move from one case to the next. There is an expectation that the trauma team members keep moving and do not need or have the luxury to let the work get to them. Participants

TABLE 1 Interview Questions

Overarching Question	Follow-Up Questions
How did you make the decision to work with Level I trauma patients?	What factors did you consider when making this career choice? What is it about this type of work that attracts you? What is the best part about working with trauma patients? What is the worst part about working with trauma patients?
Tell me about a trauma patient that you will never forget.	What was it about that patient that was significant to you? How did that patient impact you spiritually?
What is the organizational culture of your hospital regarding trauma patients?	What is the general perception by providers about people who have experienced trauma? Does this vary depending on type of trauma? i.e., accidental, violent, self-inflicted. What is the general perception of trauma health care providers? How are your colleagues or coworkers treated if they experience vicarious trauma or compassion fatigue? How does your organization view spirituality?
Talk a bit about your individual spiritual beliefs.	Where do you find meaning? Where do you find connection? How do you live out your beliefs? What sustains you given the work you do?
In what ways have your spiritual beliefs been altered as a result of working with trauma patients?	How has your worldview been altered by witnessing the aftermath of trauma? In the context of your spiritual beliefs, how do you understand the role of suffering? In what ways has trauma work strengthened your spiritual beliefs? In what ways has trauma work challenged your spiritual beliefs? What impact do your altered spiritual beliefs have on your care of patients? What impact do your altered spiritual beliefs have on your personal life?
How do you care for your own spirit during the critical moments of treating or caring for a trauma patient?	What do you usually do after you leave work? What opportunities do you have to debrief? If you had the opportunity to debrief after caring for a person who experienced trauma, would you participate? (What are your reasons for thinking you might or might not?) What impact does your work with trauma patients have on your personal life and relationships?
If you noticed that one of your coworkers was troubled after caring for a trauma patient, how would you perceive that person? What if any action would you take?	
Is there anything you have experienced spiritually in regard to trauma that I have not asked you?	

talked about their difficulty shifting from the world of trauma to the world of their families and personal lives.

Participants talked about vicarious trauma in terms of the cumulative toll it takes on them to witness the aftermath of trauma. Children may not think Mom or Dad cares because they do not react to blood or even a broken bone. Others talked about seeing potential traumatic accidents everywhere and being hypervigilant about safety. The flip side to vicarious trauma is vicarious growth. Many participants highlighted the positive aspect of working with trauma patients as they felt they had become better people.

TABLE 2 Demographics of Participants

	Participants (N = 36)
Gender	
Female	16
Male	20
Race	
White	29
Black	2
Other[a]	5
Medical specialty	
Trauma surgery MD	13
Trauma orthosurgery MD	5
Neurosurgery MD	1
Critical care, pulmonology MD	3
Emergency MD	5
Trauma extender NP, PA	8
Surgical RN, educator	1
Religious identification	
Protestant Christian	16
Roman Catholic	7
Other[b]	3
No religious identification	10

Note. NP = nurse practitioner; PA = physician assistant; RN = registered nurse.

[a]*Three mixed race, one Asian, and one Indian.*

[b]*One Jew, one Muslim, and one Hindu.*

Religious or Spiritual Beliefs as Guiding Work

Regardless of religious affiliation or nonaffiliation, all participants talked about their religious or spiritual beliefs as guiding their work with trauma patients. This pattern manifested itself in three key themes: faith in God or higher power; a desire to make a significant difference in the lives of others; and a belief that all persons are sacred.

Several participants shared that their faith in God or a higher power guides their work. Another strong spiritual theme was a desire to make a significant difference in the lives of others. Participants did not use the language of "calling," but they spoke to a sense of being called to care for their fellow human beings as people experienced horrific circumstances.

Many participants shared a belief that all persons are sacred and deserved their "A" game regardless of what brought the patients to the hospital. After hearing this theme repeatedly, participants were asked whether this belief system was simply a function of being a medical professional. The overwhelming response was to dispute the idea stating that trauma work attracts professionals who believe all persons deserve exemplary care. Participants shared stories of colleagues who had boundaries of who they would take as patients, believing that some and not all were deserving of their care.

The Need for Support Systems

Having a strong support system is vitally important for trauma professionals. This pattern manifested itself in the themes of needing support from spouse or significant other, religious community, and colleagues. Participants shared that they talked with their spouse or significant other after difficult shifts. They found this helpful because their spouse or significant other knows them personally on an intimate level. Participants also sought support from clergy, members of a Bible study group, or military chaplains. This support allowed them to process their experiences in conjunction with making meaning related to their faith or other worldviews. One participant with extensive military experience whose religious affiliation was "none" spoke of confiding in his wife's Catholic priest and the military chaplain after his colleague was brutally killed in a military attack. The participant found these encounters meaningful to safely and confidentially process his experiences.

Support from colleagues was important and included processing experiences, covering shifts so someone could sleep in after a string of difficult shifts, or taking turns working out in the hospital gym and covering the pager. Participants find it helpful to process with colleagues on an individual basis, in the moment or immediately following their shift. They want to share with trusted confidants who "get" what it is like to respond to horrific events. Trauma extenders (nurse practitioners or physician assistants) find it helpful to text or call each other after a difficult shift. Physicians appreciate having other physicians within their practice who they can call. Depending on the hospital design, it is effective to have surgeons' offices next door to each other, so they have easy access to pop in and debrief a tough case in the moment. Physicians and extenders whose offices are next to each other spoke of greater support from colleagues than those whose offices were spread throughout their hospital. Physical proximity makes it easier to process in the moment. The success of these informal debriefing sessions is in creating an organizational culture where vicarious trauma is perceived as a normal reaction.

Being part of a supportive community helps increase longevity and combat vicarious trauma. The orthopedic trauma team at the Midwest hospital includes surgeons who have worked there on average more than 16 years. Their offices are in a shared space. Their practice annually works together at a Habitat for Humanity house to form connections and do community service. Half of the

TABLE 3 Patterns and Themes

Patterns and Corresponding Heideggarian Principle	Themes	Illustrative Quote
World of Trauma (The Person as Having a World)	World Description	"I think probably though our ER culture, our trauma culture, I mean we work nights. We work weekends. We work holidays, so I think there very much is a suck it up, buttercup kind of attitude. The attitude in the ER is that you don't call in sick unless you are a patient in the ER. I think that's a suck it up mentality." (Male, MD, Roman Catholic)
	Shifting Between World of Trauma and Personal World	"I had the realization that when I'm at work, when I say give that patient a liter of fluid, boom, it happens. A verbal order and it's done and I sign the order later, and it happens. I remember looking at my kids one day, and I'm like pick up the socks, that's a verbal order. Do it. They'll look at me like, okay. I realized that it's so different at work." (Female, MD, Protestant Christian)
	Vicarious Trauma	"My son would probably tell you that his mom did not want to see him in sporting events because I see every possible accident that could happen at any sporting event at all times. He would say I want to go to a roller skating party and I thought well, there's a traumatic brain injury waiting to happen or broken extremity…. It would keep me from going to certain things that I know would cause me anxiety just to watch them…. When I'm driving in the car, I can see car accidents. I can see this type of injury. It really kind of takes its toll on me." (Female, PhD, RN, Protestant Christian)
	Vicarious Growth	"I think in terms of making me more empathetic and compassionate" (Male, MD, none)
		"I think more patient. I think when I say everybody deserves mercy, I think that I'm more able to step back and see them as a human." (Male, MD, Roman Catholic)
Religious or Spiritual Beliefs Guide Work (The Person as a Being for Whom Things Have Significance and Value)	Faith in God or Higher Power	"Servants of God are those who are serving people … everything I do, it can be basically a prayer by itself." (Male, MD, Muslim)
		"You have to think about the patient as a machine that's broken but has potential. It's my job to get that person functioning to live out God's purpose for them." (Male, MD, Hindu)
		"I'm not really religious but I think I've always believed that God had ultimate control and that what I do is through God. So, I think that guides me even though I don't think about it all the time. I think that just guides me." (Female, MD, Protestant Christian)
	Desire to Make a Difference	"It has to be about helping others and being part of a community and helping other people." (Female, MD, Protestant Christian)
		"I feel like my gift is that I can make a difference at the bedside." (Female, NP, none)
		"My personal spiritual journey at this point is just trying to help and improve things for other human beings that I run into along the way. And do what I can to improve things for as many people as I can." (Male, MD, none)
	Sacredness of All Persons	"For me it was … taking care of everyone the same. When a trauma patient comes in it's not an elective surgery, it's not somebody is better or different than somebody else but taking care of everyone and priding yourself on giving the same care to anyone who rolls in the door. You're not picking and choosing your patients. So taking care of patients that nobody else necessarily wants to take care of." (Female, NP, Protestant Christian)
		"Even though this person may not be a good person by our standards, they are still made by God. In the image of God and there's some good in them even if I don't see it. I can't see it. I trust there is some." (Male, MD, Roman Catholic)

(*continues*)

TABLE 3 Patterns and Themes (*Continued*)

Patterns and Corresponding Heideggarian Principle	Themes	Illustrative Quote
Need for Support Systems (The Person as a Being for Whom Things Have Significance and Value)	Spouse or Significant Other	"I think my wife helps. That's probably one of the benefits to having a sounding board outside medicine. I'll tell her something that happened, and she'd be like, "Oh, that's horrible. That poor person." And that's not necessarily what we thought about at work. We're thinking about other things and forgetting the person and she grounds me in that. I think helping me remember that on the other side of the blue drapes is an actual person with family and kids." (Male, MD, none)
	Colleagues	"We have eight fellowship trained traumatologists, who do all of the trauma here for orthopedics…. I can't imagine how the 8 of us could be any closer, not socially but professionally. Within this medical environment, providing trauma care, if I was getting overwhelmed, there's not one of those seven partners I couldn't call, and they would come in on their day off to come and help me. We've got a standing rule that if anybody's getting slammed on call, if you get called, and you're sober, you get in the car, and you drive in, it doesn't matter what's going on." (Male, MD, Roman Catholic)
	Church, Clergy, Chaplain	"Chaplain and I still communicate every once in a while. When the nurse from the deployment and I get together and go down to pay our respects to (friend who was killed in war), every year, the prayer that I bring along is the one that Chaplain wrote for me." (Male, MD, none)
Coping Mechanisms (The Person as Self Interpreting)	Prayer	"I think prayers, the regular and daily prayers play a major role because by default even if it's a hard day or patients that I really have a hard time to forget even what happened in the day then prayers is almost always a savior when it comes to that point." (Male, MD, Muslim)
		"Sometimes I'll start praying during surgery. And usually it's the 23rd Psalm. Many times it's Hail, Mary, Help Us." (Male, MD, Roman Catholic)
		"I prayed a lot, a lot for patience, a lot of patience because he was very difficult." (Female, NP, Protestant Christian)
	Physical Exercise	"Running is very therapeutic. It helps me a lot. Meditation centers me." (Male, MD, Roman Catholic)
	Compartmentalization	"I try to just be like there's a certain order…. There was a role for every single person in that room." (Female, NP, Protestant Christian)
		"There's a standoffishness as well that you have, which is somewhat self-protecting. If you get too emotionally wrapped up, then you can't do this job for very long." (Male, MD, Protestant Christian)
	Negative Impact of Compartmentalization or Depersonalization	"It wasn't until recently that I've become more spiritually open, aware of all the exposures of trauma that I've seen. I left for Iraq with a year-old, in my husband's hands, and he took care of him…. In order to survive, I really didn't have a lot of emotional attachments to patients, and that impacted my home life with my husband too, because … I don't think you can shut it off, and I didn't even miss my son…. I felt bad, but I did not get emotionally attached, because there were ten other folks that I had to take care of, … So, I was really very, very tunnel visioned about my job and what I had to be, and I didn't really realize until I started seeing a therapist about just my inability to deal with home situations, that I really realized how far gone I had been, in terms of shutting myself out." (Female, MD, Protestant Christian)

team participated in this study, and each emphasized the importance of their strong team.

The flip side to the need for support is that when trauma professionals experience difficulties with their personal support systems, fall out with friends, divorce, death, and so on, they experience a greater sense of isolation and hopelessness, making it harder to cope with the aftermath of other's trauma. One participant shared that

as she went through a painful divorce, difficult medical cases got to her more, and she had a harder time letting them go. Another participant experienced a painful romantic breakup and dysfunctional dynamics within her church Bible study, which left her feeling more isolated as she tried to simultaneously cope with the heaviness of her job.

Participants had strong reactions to questions about formal debriefing sessions, including scoffing, rolling their eyes, and shifting their body language. They highlighted several difficulties with these formal debriefing sessions. Sessions are usually held several days to a week later, and by that time, trauma professionals have shifted their focus to several other patients in the interim. There is a great deal of pressure for trauma surgeons to be the "captain of the ship." The result is that they do not want to share their vulnerabilities for fear that it will impact how subordinates perceive them. The other problem with formal debriefing sessions is that what triggers one physician or nurse may not impact another.

The Importance of Coping Mechanisms

Coping mechanisms included a wide range of things, with the three most prominent being prayer, physical exercise, and compartmentalization, detachment, or depersonalization. Several respondents mentioned praying prior to a difficult case, during surgery, or afterward to provide compassionate care to difficult patients. One Roman Catholic surgeon said he has a statue of the Virgin Mary in his backyard. If he knows he has a difficult case coming up, he lights a candle by the statue and says a prayer. Many participants spoke of physical exercise and specifically running as a means for coping with stress. Several participants spoke of running more than 10 miles to and from work. Participants spoke of caring for their spirits while in the trauma bay by compartmentalizing. They could cope by focusing on protocols, procedures, and viewing the body as a machine that needed repair.

DISCUSSION

The aim of this study was to expand the understanding of spirituality and vicarious trauma and vicarious growth by examining the lived experiences of frontline health care providers (physicians, nurse practitioners, or physician assistants) dealing with trauma patients. This project contributes to a previous gap in the research on vicarious trauma by looking at the role spirituality plays in understanding this phenomenon. The patterns identified contribute to this understanding.

The pattern of religious or spiritual beliefs guiding the work of trauma health care professionals is in keeping with research that explored medicine as a calling (Ada et al., 2021; Anandarajah & Roseman, 2014; Thomas et al., 2019). Findings from this study take medicine as calling farther in that respondents spoke of the medical specialty of traumatology as attracting persons who share certain beliefs, that is, all persons are sacred and deserve exemplary care. Park (2013) discusses the Meaning-Making Model regarding religion or spirituality as a general framework for the ways people make meaning out of life's experiences. Global meaning includes beliefs, goals, and emotions. Many participants shared a belief in God or a higher power. Likewise, several spoke directly of the goal to make a significant difference in the lives of others. Seeing this goal come to fruition gives trauma health care providers a sense of purpose and meaning. Viewing health care as calling has been associated with "less burnout and intention to leave, and more job satisfaction, employee engagement and organizational commitment" (Ada et al., 2021, p. 442) as well as an increase in compassion (Thomas et al., 2019).

A few respondents shared that personal difficulties (divorce, relationships ending, death in family) compounded their ability to deal with the trauma of others. These struggles are in keeping with research demonstrating that health care workers with a history of trauma were more susceptible to developing vicarious trauma (Roden-Foreman et al., 2017). It may be that the cumulative effect of dealing with their own and others' trauma puts too much strain on their meaning-making system and their ability to process discrepancies between beliefs and life experience (Park, 2013).

The need for support systems of varying types was seen throughout the interviews in this study. Respondents spoke of the importance of support systems in mitigating stress, which is consistent with research showing that talking with colleagues and positive coworker relationships were significant predictors of higher compassion satisfaction (Gribben et al., 2019; Hinderer et al., 2014). Talking with a family member as a means for self-care is associated with significantly lower burnout scores (Gribben et al., 2018). Kim and Yeo (2020) found that "social support was a predictor of PTSD in trauma nurses; the lower the social support, the higher the PTSD symptoms" (p. 55). Conversely, this may explain why health care providers experiencing challenges in their personal relationships are at a higher risk for vicarious trauma. Study participants did not embrace formal debriefing sessions but rather one-on-one sharing and processing with trusted others. A few participants talked about clergy or chaplains as members of their support systems. Having a chaplain who understands traumatology and is seen as a trusted colleague may be an additional means for individual processing and support. As a result of participating in this study, one surgeon reached out to the author as a chaplain to discuss personal issues causing him stress as she had inadvertently become a trusted other by understanding the culture of traumatology. Other participants said that participating in the interview was a valuable means for helping them process thoughts and emotions previously set aside.

All respondents spoke of the importance of coping mechanisms. Some modes of coping were individualized, such as listening to music. Participants were not directly asked about exercise; yet, several spoke specifically about running and distance running as a means for meditating and eliminating stress. The role of exercise is an area that warrants continued research. Compartmentalizing in the middle of the trauma bay can be a healthy way to focus on the job at hand and care for the patient's physical needs. However, compartmentalizing can accumulate to the point of depersonalization without other coping mechanisms and support systems in place. For one participant, her depersonalization was viewed in the context of spiritual distress. Both religious and nonreligious participants described prayer as a means for coping in the moment or on the day of difficult cases. Prayer provided them comfort, knowing that God was in the thick of it with them providing them guidance.

Study Strengths

Focusing on health care professionals who work directly with trauma patients helped narrow the scope and understanding of the role of spirituality in the context of vicarious trauma and vicarious growth. Recruiting attendees at the trauma conference proved to be an effective means for broadening the scope of the study and its participants. Participants at the trauma conference expressed the same patterns as those from the Midwest trauma hospital, therefore offering no new patterns, which helped ensure data saturation. There has been limited research on religion or spirituality and vicarious trauma in trauma health providers. This study provides an important initial look at the subject.

Study Limitations

Regarding study limitations, selection bias is a concern as it may be that the persons willing to participate were more spiritual than those who declined. Persons experiencing high levels of spiritual distress may have chosen not to participate for fear of opening Pandora's box. Some people view spirituality as a very private matter and may not have felt comfortable talking about it. Efforts were made to have diverse participants, but the participants were predominantly White and Christian. Because of a limited budget and a lack of qualitative researchers, the author was the only coder. Even though steps were taken to review the interview questions and patterns with Participant 1, it is customary to have more than one researcher code the data.

Future Research

Future research is needed with representative samples to further explore the role of spiritual distress in burnout. Spirituality is measured as part of the Posttraumatic Growth Inventory, recognizing the important role spirituality plays in making meaning out of trauma in ways that promote growth (Tedeschi et al., 2017). However, the Maslach Burnout Inventory does not include spirituality as one of the areas contributing to burnout (Maslach et al., 2016). Therefore, research that combines the Maslach Burnout Inventory with instruments measuring spiritual distress is needed to understand the role of spirituality and distress in burnout. At present, no research measures the prevalence of spiritual distress in trauma health care providers. Research is needed that approaches spirituality in terms of underlying global meaning making and its role in coping in the moment as these are two distinct areas of spirituality. More research is suggested that examines the spirituality of trauma workers from ethnically and religiously diverse backgrounds.

CONCLUSION

In the era of COVID-19, health care leaders are increasingly mindful of the stress medical personnel are under. This cultural shift has implications for the field of trauma. Trauma departments need to focus on a culture of care that includes medical personnel and is not limited to patients. Wholistic care of staff, caring for their spirits, is vitally important to combat vicarious trauma and promote vicarious growth. The field of spiritual care is exponentially expanding care beyond traditional patients and families to caring for health care colleagues. Chaplains are trained to conduct spiritual assessments and provide care to persons of all faith traditions and nonfaith. Chaplains with their specialized training and experience are well suited to aid trauma personnel who want spiritual support in processing their personal stressors and making meaning out of their work experiences on an individual basis. Hospitals and medical groups would be wise to have a specialized chaplain designated to support trauma personnel.

Trauma departments (teams) would do well to have offices in a shared area to allow for colleagues to debrief with one another conveniently, in the moment, as issues arise. Without the ease of convenience, personnel may not prioritize debriefing, leading to the cumulative negative impact of working with trauma patients. Providing opportunities for collegial support is vital to combatting vicarious trauma. Having opportunities to process, make meaning, and reconnect with their sense of purpose can aid trauma workers in developing vicarious growth. Supporting colleagues experiencing personal hardships is essential to avoid the cumulative harmful impact of personal and professional stress.

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KEY POINTS

- Traumatology is a spiritual practice.
- Spiritual distress contributes to vicarious trauma.
- Spiritual well-being contributes to vicarious growth.

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