Professional Caregivers:
Stress and Coping in the Face of Loss and Trauma

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Abstract

Professional caregivers who work with the trauma and suffering of others, such as doctors, nurses and psychologists, may face significant challenges along with the risk of adverse, long-term mental and physical health problems. Caregivers with responsibility for dependants outside their professional work reported more stress. This finding is of particular relevance in respect of caregivers in under-developed countries such as Zimbabwe, where many households have taken in additional children who have been orphaned, whose parents are ill, or whose parents have temporarily gone elsewhere in search of work. For the purposes of the study, a qualitative phenomenological research design was selected as appropriate to the focus on human experience. An interpretative approach was adopted to explore and explicate the lived experiences of the participants and the meaning they attached to them. The major sources of stress for professional caregivers emerged as being resource constraints, interpersonal issues, and personal issues. Factors found to promote coping include the caregiver's meaning making perspective, making a difference, and constructing a sense of personal control.

Introduction

Professional caregivers who work with the trauma and suffering of others, such as psychologists, doctors and nurses, may face significant challenges along with the risk of adverse, long-term mental and physical health problems (Rothschild & Rand, 2006). Despite the value and significance of their work, they are likely to suffer burnout, resulting in poor motivation and high turnover, which will affect the quality of service given to their clients (Schaufeli & Buunk, 2003). Figley (1995) identified stress, burnout and compassion fatigue as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Other comparable definitions have identified stress and burnout as common and even expected at times for professionals who help others through providing care and empathy (Becvar, 2003; Figley, 2002a, 2002b; Rourke, 2007).

Other factors have been associated with higher levels of professional burnout. Caregivers with more responsibility for dependants outside their professional work reported more stress (Kash et al., 2000). This finding is particularly relevant in respect of caregivers in underdeveloped countries, where numerous households have taken in additional children who have been orphaned, whose parents are ill, or whose parents have temporarily gone elsewhere in search of work (Sprang, Clark, & Whitt-Woosley, 2007). Research findings indicate that these concurrent stressors, which can parallel the experiences of their patients, can have a cumulative effect on caregivers, inhibiting how effective they may otherwise be within their profession (Ablett & Jones, 2007; Kuerer et al., 1997; Maslach, 1982; Meadors & Lamson, 2008; Vachon, 2004; West et al., 2006).

A number of studies have identified coping mechanisms and strategies to help avoid or ameliorate caregiver stress, including:

(1) Organizational strategies such as systems for staff support (Figley, 2002a; Meadors & Lamson, 2008; Papadatou, Bellali, Papazoglou, & Petraki, 2002; Vachon, 2007);

(2) Professional strategies including the development and maintenance of clear professional boundaries (Ablett & Jones, 2007; Becvar, 2003; Davies et al., 1996; Meadors & Lamson, 2008; Pearlman & Saakvitne, 1995; Rourke, 2007); and

(3) Personal strategies including ways to nourish one-self, behaviours that support physical, emotional, and spiritual health (Ablett & Jones, 2007; Becvar, 2003; Figley, 2002a; Holland & Niemeyer, 2005; Joinson, 1992; Meadors & Lamson, 2008), and personal strategies that foster the development of self-awareness (Harrison & Westwood, 2009; Shapiro, Astin, Bishop, & Cordova, 2005).

However, the vast majority of research to date has been conducted in North America and Europe. In western cultures such as these, there is a dominant orientation towards individualism and autonomy, whereas in non-western countries, including Africa, and specifically Zimbabwe, the dominant orientation is rather towards collectivism and the extended family and community (Nyamukapa & Gregson, 2005). It is not known whether this sense of community is a factor that increases coping, offering a "we're all in this together" approach, or whether it decreases coping because of the high level of shared exhaustion, and hence fewer resources for supporting each other. An understanding of caregivers' experience of chronic stress is necessary for designing culturally appropriate support structures for professional caregivers (Marimbe, Cowan, Kajawu, Muchirahondo, & Lund, 2016). If, for example, community were found to act as a resource, building in mutual staff support in work settings could play an important role in promoting resilience.

The recent hyperinflation and subsequent economic downturn in Zimbabwe have imposed loss and stress on the population. Professional caregivers, often responsible for the well-being of others, have faced an additional burden that puts them at risk for compassion fatigue and burnout (Marimbe et al., 2016). Caregivers are exposed to situations where they have minimal control over the conditions conducing the suffering of their clients. The challenges confronting them include the impact generally of the economic collapse, the poorly resourced health care system, the widespread problem of HIV/AIDS with limited care facilities and medications, poverty, and death in extended families and/or communities (Rothschild & Rand, 2006; Schaufeli & Buunk, 2003).

The focus of the study reported here was to explore the experiences of professional caregivers who provide care to support the well-being of others, and the strategies they use to cope with these challenges. A culturally specific understanding of these stresses and strategies is necessary in order to develop training and resources geared towards the promotion of coping in difficult times.

Research Design

A qualitative phenomenological research design, which is experiential in nature, was selected for the study. Qualitative research helps researchers understand people and the social and cultural contexts within which they live (Myers, 2009, p. 5). Such studies allow the complexities and differences of worlds-under-study to be explored and represented (Philip, 1998, p. 267). For the purposes of the present study, an interpretative, experiential approach was adopted to explore the lived experiences of the participants and the meaning that they themselves attached to their experiences (Denzin & Lincoln, 2003).

Population and Sample

A total of twelve participants was selected for the study, comprising physicians (3), nurses (4, including one psychiatric nurse and one nurse counsellor), mental health professionals (3), and lawyers (2). Six of the participants were male and six were female. Because of their ready accessibility, the researchers targeted individuals from within a single organization whose mission is to provide care to people coping with illness, loss and trauma. This provided a relatively homogeneous sample, which supported efforts to achieve a deeper level of analysis with an interpretative focus, whilst also offering the opportunity to explore the range of views across care professionals and genders.

Data Collection

Individual interviews were conducted, in preference to focus group discussions, to explore participants' in-depth experiences of caregiver stress and coping. It was felt that individual interviews would give the participants privacy, allowing them to express themselves without feeling constrained by the presence of others whose experiences potentially differed from their own.

All the interviews were audio-recorded and transcribed verbatim. All conversations conducted in Shona were transcribed in Shona and then translated into English by the bilingual transcriber. Translations were then reviewed by an independent coder for accuracy in accordance with recommended practice (Temple & Young, 2004).

Data Analysis

Each interview transcript was coded independently by two researchers for categories of information that arose in each interview and group. The research pairs then met to compare categories identified by each. The categories of information generated by the pairs of researchers were then shared with the full team of researchers and consensus was reached. The team aimed to develop themes that were abstract enough to capture a shared experience among participants while remaining grounded in the ideography of the individual's experience. Determination of the importance of the respective themes was based on the number of individuals and groups that had discussed a particular theme, and the amount of interest the theme generated in the discussion. These factors were examined across groups, as well as between the first and second meetings of the groups.

Results

The researchers identified sources of stress for caregivers and factors that promote coping and resilience. Sources of stress emerged as resource constraints, interpersonal issues, and personal issues. Factors found to promote coping included meaning making perspective, making a difference, constructing a sense of personal control, spirituality, interpersonal engagement and organisational support, recognition/feedback, maintaining boundaries, and enhancing capacity.

Sources of Stress

Resource Constraints

The issue of shortages of resources was an over-arching theme for caregivers in Zimbabwe, and played a role in the experience of the other stresses identified. This theme was discussed repeatedly in each group in both phases. These constraints have a direct bearing on the stress experienced due to the nature of the work. Specifically, caregivers talked about the distress they felt when they experienced the suffering of someone who was ill or dying, complications in illnesses, or deaths that they believe would have been preventable had basic resources been available to patients and families.

Participants narrated the ways in which the resource shortages impacted not only the patients, but also themselves. The following description was given by one of the participants regarding a group of community nurses in a rural area to whom they consult:

> When mentoring in Kwekwe you go to nurses that haven't been paid since 2009, and I was just looking at them and saying, "How are you surviving?" There is no BP machine, there is no thermometer, there is no scale and I asked, "So what are you doing?" "We just see people."

> "So how many hours do you work?" "We work the whole day" "So how do you survive?" "We don't know. And all that we know is that it's hard."

National shortages of government economic resources have impacted most human service organizations. There is little in the way of third party payment or government funding, and many organizations are reliant on funding from grants and donations from the international community. With challenges to the global economy and the chronic nature of the financial need, money has become less available, and many organizations have either closed or markedly reduced the size of their staff, leaving those remaining facing overwhelming workloads, while still not being able to offer care to the many others that they know are in need. As stated by one of the participants who is a hospice nurse:

> But as you are going along, you realize that there are moments where you feel like you are being drowned by the workload, these boulders and everything else that is in there, and these boulders are some of the challenges that we come across. But we bury those boulders and we keep on going on.

Additionally, there are often shortages of supplies with which to treat patients, which has further implications in particular for home-based caregivers. Frequently mentioned was the fact that, since the constraints on finances in organizations had increased, they have lacked common supplies such as gloves, placing caregivers at risk due to the nature of their work with patients with infectious diseases. Many participants articulated their sense of personal vulnerability.

> Maybe I might work without proper tools and maybe someone needs to be bathed. I cannot leave that person, so I may have to bathe that person with my bare hands – but at that time I'm supposed to have gloves, but at that time I don't have them, but I cannot leave that person like that, so it will be 50/50. Right there I may be infected.

Stress was experienced by many caregivers when they could not meet their own expectations in the care they gave, due to not having the resources – for example, lack of pain medication or even food – to alleviate suffering they felt they should be able to address. Alternatively, due to an absence of referral sources, with many NGOs having closed their doors, professional caregivers often expressed their sense that they should be able to address issues that were outside their area of expertise, simply because there was no-one else to do so. This kind of unrealistic self-expectation further elevated the stress experienced.

Interpersonal Challenges

The findings suggested that, in Zimbabwe, there are some cultural values or social beliefs that clash at times with the requirements of care provision or that constrain caregivers as they try to manage their stress. Sometimes this was due to gender issues that played a role in how people allow themselves to interact with others, or how they perceive the rules or expectations of others.

> *Being a member of family it can be difficult to talk about what's worrying you. Maybe if I can use the African perspective, being a man, it can be difficult to keep on talking about things worrying you. It can be seen as being weak, or somebody not fighting hard with things that are worrying you. But with hospice you can be open with four or five people.*

For the male social worker quoted above, as with other participants, the notion of needing to talk about his worries or distress seemed in conflict with his beliefs about what was expected in his social world due to his gender. Therefore, he can turn only to colleagues, rather than to his social or personal relationships for support around many of the stresses he experiences. Another participant was acutely aware of having failed to meet a perceived need of a patient specifically because of her gender:

> *But he wanted to take off his trousers so I can see the pus coming out of his sores. But he is male and I am female. So it's hard, that thing whereby I feel their pain but I have to follow instructions.*

Additionally, in Zimbabwe there has historically been no role for professional counselling. Relatives like aunts and uncles handled problems. Today, however, due to urbanization and westernization, the impact of the HIV pandemic, poverty and other factors, many of the traditional support systems have changed. Participants also reported a lack of value placed on counselling (as opposed to tangible things) with the idea of counselling as a valuable service regarded with scepticism.

> *So there were a lot of questions we faced in the community like if we would go for a visit they would say, "You have come to visit me, what do you have to give me?" and you say, "Nothing. I have just come to visit you and discuss and offer some counselling to you". It was a very big challenge, as some of them would turn us away as an organization.*

In keeping with some of the challenges created between cultural and social expectations, the chronic shortages of resources, and the both physical and emotional needs of ill patients and their families, professional caregivers experience a range of stresses in the course of their work. Some family members were thought to react to the stigma, discrimination, myths and judgments surrounding HIV, which still persist. This resulted in problems within families when caring for an ill member, or between family members and the professional caregiver. Problems described by caregivers include family members not providing care for patients; not following advice about needed care provided by the caregiver; anger or rejection by patients/families at times when they perceive the caregiver as having little to offer, or are suspicious of the intent of the caregiver.

Personal Challenges

The final group of themes involved the personal make-up of the participants, their current and past experiences, and the ways in which these influenced their work experience. A number of the participants talked about the impact on their work of their "personal baggage", which included stresses occurring currently in their personal life that paralleled the experiences of their patients or clients, as well as past experiences that were triggered by a current experience of a client and re-experienced by the caregiver. When talking about the ways in which stress at home impacted on them when at work, one person said:

> *Sometimes we bring our own baggage from home. There are certain things which may be stressing us from home, and we come to work; but sometimes it will be very difficult to draw a line to say this is hospice, this is home, because I am expected to be here. I won't function as I'm supposed to do.*

Participants also talked about the ways in which the struggles or pain of their clients will at times affect them beyond their time at work. Generally, they saw this happen when a client's experience triggered the reliving of past experiences of their own. When this happened, they found that their stress levels went up and could affect them for some time to come.

> *Sometimes the session would have even touched on a personal experience of that counsellor; there is some kind of trigger that happens, where you relive that experience that once happened to you or to someone close to you.*

Coping Themes

On responding to the question of what it is that kept them going, many participants pointed out their core beliefs and the meaning they attach to their work. As highlighted by one: *"[This] job is a calling, knowing you are uniquely made to help, to serve. This realization pulls you together when you are falling apart"*. This informed their motivation to keep going, to overcome the odds:

I'm the one who chose to do this so I should do this. I am meant to do this. That keeps you going.

Others cited the personal positive experiences attached to their caregiving service:

That wonderful warm feeling that you get at the end of the case from knowing that you've helped them through their loss, that is fulfilling. And when people say to us "How do you manage to do your work?" "How do you manage to do your job?", it's because of that isn't it? That wonderful joy and fulfilment of knowing that you have helped someone.

Meaning Making Perspective

Some participants value the impact that the challenges of their work have on their personal life. Reflecting on other people's suffering helps them to take a step back and take an inventory of their own lives.

I think working with hospice you see a lot of pain and suffering and it helps you put your life in perspective. It really does. And I think that helps me in my personal life, my personal stress. This helps me attach easily, feel the pain for a short time, but it's not affecting me that you go through that experience, detach. So when it's in your personal life it helps you to cope better.

Making a Difference

The idea of making a difference in other people's lives was a strong driver for most of the participants. They expressed how they found fulfilment in making use of self to improve the lives of others.

For me there are some caregivers whom I came with here whom I have cared for when they were sick and they came back as caregivers. So that encourages me – when I see someone I once cared for become a caregiver, doing the same thing I do, it means this gives life.

Or, as stated by another who used the image of ducks to symbolize the joy she feels in being there for others,

The community [members] that are bedridden, we encourage them to take medication, we offer psycho-social support. We are encouraged that a person who was bedridden is out and about.

One of the few male caregivers said:

What inspires me is that the work we're doing in the community is helping my community. At the same time, as men in this organization we can show that men are also doing good things in the community.

Discussion

Our findings reveal that there are certain factors that cause professional caregivers stress, such as resource constraints, interpersonal issues, and personal issues. Our findings also reveal a number of coping strategies that professional caregivers have adopted, including meaning making perspectives, making a difference, and constructing a sense of personal control. The stressful effect of inadequate resources was an overarching theme. A surprising finding was the criticism that volunteer caregivers received from the community, raising the question as to whether the concept of volunteering was foreign, and if so, whether this issue might be addressed through public education.

The findings showed that one of the most important factors to cause stress among caregivers is resource constraints. This is a factor that has also been reported by Marimbe et al. (2016), whose study indicated that resource constraints may impact both emotionally and psychologically on the mental health of caregivers. Stress may be experienced as a result of burnout, as was described by one of the participants in the present study. Rourke (2007) reported that burnout is considered a common possible outcome for professional caregivers. Kash et al. (2000) observed that caregivers with more responsibilities outside their professional work are more prone to burnout than caregivers without such additional responsibility. This was confirmed in the present study, as most of the caregivers were also mothers and wives, which increased their responsibilities, given the cultural expectations of women in the Zimbabwean context.

Although most studies on caregiver stress and coping had been conducted in North America and Europe, the findings of the present study are in many respects consistent with such studies. The research participants used similar coping strategies, such as meaning making perspective and constructing a sense of personal control, which factors have been reported by Ablett and Jones (2007), Becvar (2003), Davies et al. (1996), Meadors and Lamson (2008), Pearlman and Saakvitne (1995), and Rourke (2007). The dependence on such coping strategies may differ because of the cultural differences and expectations, and this confirms what was reported by Marimbe et al. (2016) and Nyamukapa and Gregson (2005).

One of the most important findings of this study is the emphasis on the impact of the economic situation in Zimbabwe on the quality of care given by professional caregivers. Given the stress they face and the kind of coping mechanisms that they try to engage, they still face the extra burden of a collapsing economy that puts a severe strain on the healthcare delivery system. The widespread challenges of HIV and AIDS, along with limited medical facilities and poverty make the situation particularly dire, which findings were also reported by

Rothschild and Rand (2006) and Schaufeli and Buunk (2003).

Despite the challenges faced by these professional caregivers, there is still hope regarding how to manage the crisis. The demand for education is Zimbabwe is still high, which means that mitigating the impact of stress and burnout can be achieved through training of more professional caregivers. What has made the experiences and coping strategies of the caregivers in this study similar to the findings of studies conducted in North America and Europe could be the type of education that most of the practitioners received, which was mostly European. There is definitely a need to incorporate more indigenous knowledge and practices into mainstream professional practice. It would also be beneficial to the health care organizations to recognize the value of inter-personal relationships and encourage social activities among their employees. They may even go further by facilitating chatting time. Finally, the degree to which the research served as a beneficial intervention gives an insight into how individuals and organizations can cost-effectively enhance caregiver coping by facilitating self-awareness programmes.

Conclusion

Professional caregivers in Zimbabwe require support from health care organizations to help them deal with stress and cope with caring for their clients with minimal adverse impact on their own mental health. The findings of this study are useful for policy formulation to re-design or resuscitate appropriate mental health intervention strategies for professional caregivers in Zimbabwe.

Referencing Format

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