The Cancer Professionals Podcast

Episode 5 (May 2024) – The Weight of Empathy: Understanding Vicarious Trauma in Cancer Care (Part 1)

(Intro music)

00:00:08 Lydia

Have you ever paused to think about the emotional weight you carry as a professional in cancer care?

00:00:14 Karen

One of the major crisis points was- we had a little container that had cards in it, and we put a card in there for every person that had died and the contact details so that we would send out a bereavement card, a year's anniversary, and there was just one day I was looking at it and I thought, I don't know if I can do this any longer.

00:00:39 Carly

Hello, I'm Carly and my pronouns are she/her

00:00:42 Lydia

And I'm Lydia and I go by she/her. Welcome to the Cancer Professionals Podcast, a podcast from Macmillan. In this series, we chat to a wide range of guests, including health and social care professionals, to lift the lid on current issues faced by the cancer workforce.

00:00:58 Carly

This is part one of our first ever two-part episode, where we're joined by Lisa Nel, practising therapist, clinical supervisor and independent trainer, and Dr Karen Campbell, President of the UK Oncology Nursing Society and Associate Professor in cancer nursing. They talk to us about vicarious trauma, how to recognise it, and how you can best support yourselves and others.

00:01:22 Lydia

This episode contains conversations about emotional trauma, which you may find upsetting or triggering. Listener discretion is advised.

00:01:30 Carly

Hello, Karen and Lisa, and welcome to the Cancer Professionals Podcast. So shall we start by you both telling us a little bit about you, introducing yourselves, Karen, should we start with you?

00:01:43 Karen

Hi, I'm Karen Campbell. I'm an Associate Professor at Edinburgh Napier University and currently the President of the UK Oncology Nursing Society. Actually, I really got interested in the topic while I was working at Macmillan and it was in between COVID and we were trying to reach out to lots of professionals, because we knew that they would be finding the situation very, very difficult. So my interest has been maintained since then and I'm really interested in different areas of vicarious trauma, say with students, with staff, with just understanding vicarious trauma because it's not a thing that everybody will understand at this point in time.

00:02:29 Lisa

Hi everybody. It's lovely to be here. I am working currently as a therapist and a trainer and my interest in Vicarious trauma actually came about from a colleague, Mark, who had completed his masters in the impact on male therapists of working with women who had survived childhood sexual abuse. Actually, he invited me to go to get together and create a training for people because he learned about the impact of that work through his research. And so we put together a workshop which has been running for 10 years now and which Macmillan invited us to come and run for frontline Professionals across the UK at the beginning of the pandemic.

00:03:12 Carly

Thank you so much, So this episode, as we've mentioned, is about Vicarious trauma, raising awareness of it, how to recognise it, So can we start by talking a bit about what vicarious trauma is? So how we might define that, particularly in the context of health and social care? So what is vicarious trauma?

00:03:33 Lisa

So I'll kick off. So Vicarious trauma is something that we've only really spoken about since the 70s, and lots of the original research was in the States by a woman called Laurie Ann Perlman, then there are a number of other people, like Karen Saakvitne and Lisa McKay, who joined her in doing research in places like A&E departments, war zones, looking at the impact on frontline staff of connecting with other people's either emotional or physical trauma over time, and that is one of the defining features of vicarious trauma, is that it's something that builds up in the nervous system of people who are regularly supporting those who are suffering. And the key to it really is that empathic connection, because that's how our nervous system is impacted over time so what we're going to be looking at, I know is the difference between vicarious trauma and other kinds of impact. One of the defining features of VT is some of this easy to call it VT is that it can really over time, not just affect our psychological well-being and our physical well-being but also our spiritual wellbeing, it'll change the way we actually look at the world, look at ourselves at our work and create a real feeling of hopelessness.

00:04:56 Karen

I think that it's really interesting, Lisa and I, as I said, I only really became, I only got a snapshot of it you know, in 2020, but I would definitely say in my career, but there are so many labels of burnout, compassionate fatigue, moral distress, that actually, I think for the cancer nursing community and wider probably feel that, but they don't know what it is and what the difference of that is. So it's a feeling rather than a conscious knowing what the context or the, I don't want to say label as such, but it is a kind of umbrella term, isn't it? For a different way of feeling.

00:05:42 Lisa

Yes, I think that's true. And I think that in, in our experience, you know, Mark and I, we've found that so often people put everything under the umbrella of burnout and often that's felt as a- what's wrong with me? Which is part of what we want to sort of counteract by spreading the word about this is that it's people think it's just me and it isn't. It's actually the impact of the work. In fact, in a number of trainings that come to mind where people have actually made that connection and thought, oh my goodness, I realise now that it was vicarious trauma they felt a real relief from recognising that it wasn't just them.

00:06:23 Lydia

Do you think that perhaps using the label of burnout is diminishing what people are experiencing? Maybe slightly?

00:06:30 Lisa

I mean I think it's misleading and I think it is such a catch-all phrase and I mean, we would say that actually burnout, although it can have huge impact on your sort of mental health. Actually if you get enough of a break, you can come back from that. Whereas the thing about the impact of VT over time is it actually changes the nervous system and we can come back from it but if we're not sure what it is, then we're not going to do the right things to come back.

00:07:00 Carly

So I think this comes on quite nicely into the next question I was gonna ask around signs and symptoms in terms of- what are those signs and symptoms that we can spot in ourselves if we think this might be something that we're experiencing, or even in that of others, how might we notice that this is happening to us.

00:07:20 Lisa

I mean, I think one of the reasons that we have chosen to continue to use the term vicarious traumatisation rather than compassion fatigue, which is often used

interchangeably with VT Is because actually so many of the indicators the symptoms of VT are similar to post traumatic stress injury. It is more like the impact of trauma and somehow, compassion fatigue, it sort of softens it in a way that it feels like we can more easily ignore it so it's things like, feeling exhausted, feeling that you no longer are any good at what you do, feeling increasingly disconnected from people, so kind of pulling back, shutting down. It can be things like intrusive thoughts and dreams, and not being able to stop thinking about somebody that you're working with or on the other hand, really wanting to avoid them and overall, the kind of key things that people start to feel much more anxious and unsafe in the world, So the whole nervous system is sort of heightened. So one client that that I've worked with had a lot of support. She had worked for many years in sex trafficking and she said I've got lots of support, she said. I know that this is VT. I just want to know what I can do about like restoring my nervous system to health again, which is that I know for example, when we go out for a walk with the dog, I'm just thinking the dog's gonna get run over or for a cycling, you know, gonna get flattened by a juggernaut. Or so she's just like anxious a lot of the time, which is very similar to PTSD or post-traumatic stress injury.

00:09:13 Carly

You mentioned compassion fatigue, and I wondered whether if you wouldn't mind explaining that and actually what the difference between vicarious trauma is and compassion fatigue.

00:09:24 Lisa

I mean I would say that they are used interchangeably. I know that you know certain trauma therapists like Babette Rothschild, she uses compassion fatigue where others will say vicarious trauma. I mean, certainly it describes something whereby, you know, you actually have got nothing left in the tank, to connect with people empathically anymore and that might be one of the things that we experience in VT but doesn't necessarily convey the kind of trauma impact.

00:09:55 Karen

Yeah, I think that that to me is the key difference. It's the difference in caring for somebody and being fatigued by it. So you've done it too much as it were. But the trauma aspect of vicarious trauma for me is about, you know, you sometimes you probably don't realise that it's trauma in your own life, that resonates with what you're doing as a caring role do you know? So I think it's that for me it's it has to be about the awareness of traumatic events in your own life as you're going into the profession. And that's not to stop you going into the professional roles. It's just about being aware of it rather than it becoming a problem.

00:10:41 Lisa

Yeah, that really makes sense to me. I mean, so many people who come in to helping roles, we do so because we've experienced support ourselves and then want to offer that back. But without that kind of awareness of, you know, our own history and what might be triggered, we can be much more at risk of VT and the impact of supporting others definitely, yeah.

00:11:06 Karen

I mean, I think if you actually sat on the first day of induction of a healthcare programme and you were asking everybody, why is it that you've come into this profession, they will all say- I've been looking after my granny or I've been doing this or I've been doing that and you know that it's fantastic intentions, but you also know that at some point they may come across other things that will tip that just a wee bit and remind them.

00:11:39 Lisa

Yeah, that's true. I mean, one of the other terms that people sometimes say, so what's the difference between secondary trauma and vicarious trauma? It's something that we've thought about quite a lot and actually had examples of. So like an obvious example of Secondary trauma is if you witnessed something horrible like a car crash, so you end up with kind of trauma from witnessing somebody else's trauma, and what's interesting and sort of I think links Karen to what you were just saying is as a therapist, for example, if I've experienced something horrible in my past and then somebody tells me a story that connects with that. I think in that moment I might experience secondary trauma and that is distinct from the VT that builds up in my system over time.

00:12:32 Carly

I'm interested to know, are certain people more likely to develop vicarious trauma? As in, are there perhaps some people who are more naturally predisposed to developing it than others?

00:12:47 Karen

I would just follow on from what I said before where it's kind of, it's a wee bit evolutionary in a way because we self-select, we actually self-select people in healthcare because they can be empathetic. And I think that's the it's not a difficulty and we should never stop doing that because it's essential. But I think we've already pre-selected a group of people that may well be at risk. I'm not saying are at risk may well be at risk.

00:13:18 Lisa

Yeah, and I agree. I think you know people who come into these roles, we are sort of naturally empathic in the way we connect with other people. And that's kind of on a spectrum, isn't it, I mean, there is evidence to show that we're all born with empathy, but

that there are kind of levels of it and sometimes in the discussions in, in the trainings, you know we ask that question. So what is empathy? What you know, how does it play out in your work? Is it essential to your work? Is it essential to how you see yourself and people say, yeah, you know, definitely. And you can see some people are saying. Yeah, no, I kind of, I know where I kind of draw the line. I feel it, and then I kind of, I keep one foot in and one foot out and other people are saying I find that really hard. You know, it feels like I'm right in there down in the pit with somebody and I mean it's something that I mean Mark quite often says in the training is to remember our role in the relationship. If we can keep that little bit of awareness, that's a protective factor, because otherwise the risk is that we can kind of end up being over invested in the outcome for that person, and that can put us more at risk.

00:14:26 Karen

I think you know, we all come with our baggage. We all come with our different characteristics and you know, so there's complexity there in the human beings that are entering into the profession anyway. So it would be really difficult to say that somebody specifically at risk, it's just to watch out if you're accruing probably the risk factors I suppose, is what I would say.

00:14:51 Lisa

Yeah, I mean, you know, in the research around VT there are there's a whole list of kind of risk factors. I mean, in addition, I think, Karen, you've hit the nail on the head about the big thing is like that empathic connection. But then there are things within the workplace that can make us more at risk, like excessive workload, like maybe a lack of training to do the job that we're doing so that we're not kind of able to kind of protect ourselves and monitor how much we're doing. Feeling isolated, and something that we've ended up talking a lot more about in recent years, just as the services have become more and more depleted, you know, funding is harder to come by and everything is the sort of moral injury aspect to it that's seen now to be kind of a risk factor like where we can't get the outcomes for people that we would like to because of the lack of resources and more places to kind of look for additional support.

00:15:51 Karen

Yeah, it all adds to the trauma, doesn't it?

00:15:54 Lydia

And I think what you said there about the moral injury is something that really resonates with me in terms of, you know, you do go into nursing or healthcarem social care to help people and when you can't do that, and perhaps somebody is telling you that you are not giving them what they need or what they want, having to go home with that burden, that

that is a lot and it does build up over time. So yeah, I can totally see that in my past clinical career.

00:16:25 Lisa

I've seen it so much and, I was in a school just a couple of weeks ago, doing a whole day for all the staff, really forward thinking school. And you know you can see, I mean, and this school is a nursery school used to be a children's centre where they had lots of other professionals that they could actually refer in to, you know, children and families for additional services that have just gone. And you know, I think the impact on people has just mounted overtime.

00:16:56 Carly

And you highlight in there some of the work you've been doing, as you've said with teachers in schools, although this podcast episode is for health and social care professionals, actually what that indicates is it goes wider than that. We see this not just in the context of healthcare, but other places as well sounds like people who are of course, in supporting roles who are dealing with people who are perhaps vulnerable, where else might we see this?

00:17:24 Karen

Everywhere. Absolutely everywhere. I was just thinking that when you were talking is to, you know, the whole, the whole of society right now is probably getting traumatised, you know, because we have a lack of resources and everything else don't we. And I think the difficulty I have is that it's not necessarily it' goes back to what you said, Lisa, about the training do you know and aspects of support? Because I think we've got to remember as we're trying to change cancer services, do you know and we're trying to take what we're calling, do you know that burden of clinical nurse specialist advanced nurse practitioners to do the kind of non-clinical outcomes for patients and yet, we're putting these people at risk because they've not had the training, they've not gone through that kind of three-year potential training that at least buffers it a little, but they are also being self-selected for their empathy as well. So you know at the first hurdle they are at risk. So I think that for me is about, we need to think very carefully about how we're changing cancer services and are we just shifting the vicarious trauma onto those that don't have the training behind them?

00:18:49 Lisa

Yeah, and which therefore may make them more at risk. It's so interesting to see the people who can be affected because if it's true that empathically connecting with anybody's suffering is going to actually build up over time, then we're looking at lawyers, they may not all be empathetic, but, you know, we're looking at anybody. I remember a

Rape Crisis centre again, very forward thinking, they made sure that their admin staff, who were often not, they weren't doing frontline work, but they were actually reading stories that that was impacting them as well. So I mean right across all three sectors, sort of the public sector, charity sector, private sector, mental health first aiders in in corporate.

00:19:35 Karen

And I and I think we talked about this before, but I also think the way that we train people is very much to try and use patient stories. We're trying to use, do you know that real life situation and actually in doing that because we feel that it gets into the empathy part of the person that you're training that actually we might already be kind of partly traumatising. I'm not saying that that's what happens. But to think, sometimes we need to think a little bit more carefully about how we're immersing people in situations as we're going forward with training as well, especially the virtual training, which can be very, very realistic.

00:20:27 Lisa

I mean, that's. Yeah, that makes so much sense, Karen thinking about how sometimes when you're reading something as well, because you're actually supplying the images from your own mind, that can be really powerful as well. And linking back to something you were saying before or about where people have experienced things, things, some things themselves, that could connect with those experiences too.

00:20:51 Carly

And actually that what that really highlights is how wide reaching this is that there are so many people in lots of different roles, lots of areas, sectors who were perhaps feeling these feelings, but they don't know what it is. They don't know what it's called. They don't know what to do about it. And that's really tricky, isn't it, to help themselves or support others if they see it in others. So I was interested to know about any, perhaps misconceptions or any stigmas that people might feel that surround Vicarious trauma?

00:21:25 Karen

Yeah. So I think I think the difficulty probably with looking at it that it's just vicarious trauma is I think probably the umbrella of resilience, burnout, compassionate fatigue. In fact, I think it's easier to say you're burnt out because then people will give you time out. Whereas recognising the other ones you might not want to approach people, you might not want to say, it's like any human being. You might not actually want to say what's going on with you because that appears like you're weak. You know you're not resilient, although I don't like that word. You know, so in a profession that asks a lot of you, and you step up to that ask, it's not always seen as something positive if you're not coping. And maybe that's just an internal thing.

00:22:28 Lydia

And do you think this is something that you experienced during your clinical work, Karen?

00:22:32 Karen

I would say in my middle of my career I had a very young family and I decided to go from a job which was looking after the worried well, so it wasn't tapping into my empathy, it wasn't, it wasn't something then that I was finding satisfying on a on a daily basis. And I decided that after my daughter was born that I would actually take a role which was closer to home, but was actually a community palliative care nurse, so really throwing myself into the deep end and in respect of the patient type clientele. But actually it's one of the things I always aspired to in my cancer nursing career was to become a clinical nurse specialist in palliative care, so that was where I wanted to be and that's where I never had felt that death and dying was a problem before. And so I became this community palliative care nurse and actually, really, it only took less than a year to become quite a traumatic event for me, and I do think it's probably because I had a young family and you've already alluded to that a wee bit, Lisa, from the perspective of, then I was beginning to see danger everywhere. You know, I was getting very anxious about the kids. You know, were they well, were they not well. So that, and every mother probably goes through that. But I think this compounded it. And one of the major crisis points was we had a little container that had cards in it, and we put a card in there for every person that had died and the contact details so that we would send out a bereavement, at a year's anniversary and there was just one day I was looking at it and I thought I, I don't know if I can do this any longer. And it was also associated with not just the care of the palliative care patient but the bereavement care of the relatives afterwards. And so we would either be attending funerals or we would also, when you went round to the house, you would actually be sitting near enough in the chair that the person always used to sit in, so there was all that grief and trauma sitting around that. My father died when I was relatively young and I think one of the other pivotal moments was going to a funeral in that same scenario. you can see the build up over that year, but it was a very quick build up for me, but I didn't know that that's what it was. I had no clue as to what that was. I just thought it was bringing back feelings of my past, but it was actually my partner who was beginning to put other job adverts under my nose, saying that I hadn't, I wasn't connecting anymore. I was just in a bubble and I wasn't there for them and the family. So that's the kind of connection bit that you seem to be talking about Lisa. And I did have help. We had a clinical supervisor that saw us on a regular basis. And eventually in working with me, she just kind of said, I don't think this is the job for you right now. And actually, that's what helped me move forward. But actually thinking about it, it's also kind of something that's directed me into the career that I'm in do you know. So from there, I went to education and I've never really come back out of that. I do have again. I've got that empathetic feeling when students come to me, do

you know having suffered bereavements etcetera? You know it's that kind of, you know, people will be traumatised by these events and it's very difficult cause that job was a very isolated job. You were in your car, you were going to see patients, you didn't really at the end of the day discuss that with anybody. So there was a lot of key risk factors there, but I didn't have a clue what that was. And I actually it's only really until I met up with you and Mark over COVID that actually I began to go actually that was just the blip, but it wasn't my fault, you know? It wasn't it all coming back for me. It was actually a point in time where it was brought back, as it were.

00:26:58 Lisa

Oh wow gosh Karen. I think really the heart of why I think both Mark and I are passionate about doing this because actually if we can make sense of something that we've lived and that's been hard, it can be really freeing. I'm just glad. And actually, almost all the times that we we start we we start by asking people who's heard of vicarious trauma. And generally it's only just a handful of people who have even come across the term or the concept that we can be impacted by the work that we're doing over time. In a way that is different from burnout, you know which everybody, as you say gets, you know, everybody talks about burnout.

00:27:46 Karen

Yeah, or post-traumatic stress syndrome, I think because it's a common terminology. Do you know when people recognise it? And I think it's it, but it is that associated with trauma. And I think that that is really important to get over to people, the difference in that

00:28:07 Lydia

Lisa, listening to what you know, Karen has shared about in terms of her story are those sort of quite common things that you see in your work?

00:28:16 Lisa

Yeah, all the time, you know. And it's actually, we always say that at the start of the training- look after yourselves because you might not know that you will connect with things in what we're sharing, and there might be a bit of an aha moment which can be a little bit overwhelming to say the least. So and I think and as you were saying Karen earlier, it's like the thing is then what it's important that you know what we can then do about it so that we can holding that sense of hope and that we can do something about it, which is why I did the second part of the training is always and once we've moved on from like being able to recognise the signs is actually what we can do about it proactively.

00:28:58 Karen

I think it's also really important, and especially in palliative care, because there is a lot of people that stay for a very long time, you know, and that is their career and you look when I came into that and I thought- why is everybody else coping and I'm not, do you know what I mean? So you do kind of, I mean, they might not have been, but that was my assumption that they were and they obviously weren't. If there was an in-house clinical supervisor, clinical psychologist, to think she was actually, do you know, she was there for a reason. But I think that's the thing is we all tend to look like we're coping when actually inside it's, do you know a hornet's nest that we're building up

00:29:44 Lisa

Yeah, I mean, which links with the whole drive to kind of normalise being able to talk about mental health and you know the high profile people who have done more of that in recent years and how important that is. And then really shifting the culture around mental health in the workplace so that there isn't shame connected with it and also that they're, you know, if it can be done at that kind of like taking responsibility for myself, like really noticing my colleagues you know, with that compassion and also from an organisational level, real recognition, then the whole thing changes. But what we're looking at is a paradigm shift really in terms of, you know, changing the culture around mental health. You know, people who come into helping roles and also organisations and organisations made-up of people are themselves helpers. And there's that thing of actually we get our feel-good hits from doing for others, and often that can be at a complete you know, to ignore what we need ourselves. So it's that kind of focusing inwards can actually feel quite challenge for for us, if we are in helping roles.

00:30:55 Lydia

So Karen, I wonder during the time when you were sort of working as a palliative care nurse, you mentioned that you had some clinical supervision. Is there any other support that you accessed at that time or perhaps have accessed since to help?

00:31:09 Karen

Actually, no. When we were given the clinical supervision, that was part and parcel of the role, so they obviously knew that, you know, it could have an effect. I've never accessed any counselling since then or felt that the only next time that I've probably felt that is during my Clinical Doctorate, when of course I wanted to get back out, talk to patients and it was a palliative care and I was trying to talk to them about death and dying. So there was a hint of it then. But other than that, I haven't really. How would you say, I haven't really exposed myself to the same client group or and dealing with nurses, emotions and trauma seems to be less on my system than actual patients, and I think that probably does go back to my past experience, I have to say and and maybe it makes sense. Actually, as I'm talking because I didn't go into nursing until later on. So my dad had already passed away by that

time, and actually during my training, I had to have counselling because I went exactly the same way. I began to be a bit disconnected, but of course I just thought that that was the grieving process and there was a fantastic counsellor at St. Georges in Tooting, where I did my training and that really bolstered me for quite a while, but I have to say I probably went into the cancer nursing because that wasn't what my dad died of. So it didn't remind me in any shape or form. And I think it's only as I've got through to that kind of more concentrated death and dying part for me, that was probably that kind of key inflammatory factor, if I would say that, you know kind of spiralled me a little bit more.

00:33:19 Lisa

Yeah, I really want to just echo what you're saying, Karen, about any connection with our own experience. I mean, the session I had with somebody who was describing how both of her elderly parents went into hospital with COVID and mum died. And the trauma of not being able to say goodbye to her, and then the impact on the daughter and her Vicarious Trauma of continually connecting empathically with him and the link is that my father died of cancer, and actually my first encounter with Macmillan Cancer Support was we had Macmillan nurse who came for the last couple of months to support my mum and I who were nursing my father. And so I think that I connected to that person from my own experience of losing my father to cancer so. Although COVID and cancer are not the same thing, but you know the brain makes those connections, we're looking for kind of links all the time so.

00:34:23 Lydia

And I think you know, just you sharing that Lisa, it just shows that we are all so susceptible to it, aren't we? And I suppose, you know, you don't know when it's going to happen. So I suppose it's about sort of helping yourself when that does happen. And and Lisa, I wonder if you have any advice to perhaps somebody who's listening, who sort of resonated with Karen's story, and is thinking that maybe they are, they are experiencing vicarious trauma at the moment. What advice would you have for them in terms of how they can access support now and what they can do sort of in the moment while they're experiencing that vicarious trauma?

00:35:02 Lisa

I mean, I think the first thing is always to reach out for support that feels safe because it's all about feeling safe with whoever we might be talking to. And Karen, you were talking about clinical supervision. You know, our experience even in the 10 years we've been running this is that more and more places that do offer what's called clinical supervision, it can vary so much, so if it's only about the caseload and how effectively you're doing your work, then it's not including the practitioner. It's like Karen says, like we all have this impression that everyone else has got their life sorted, that they're all fine. In fact, we've

got an acronym. I don't know if you've come across it before, which is FINE stands for something really rude, starting with insecure, neurotic and emotional, you know? And it's like we all go around going. I'm fine, you know? And that's the first sign of, like, are you? So yeah, to to reach out for support and you know, ideally somebody who understands the impact of VT. And the other thing is to actually, and I know that we're going to be talking about this perhaps a little bit later looking at the things that we can ourselves do because the same things that help build resilience in the nervous system actually help us come back into, you know, sort of health or resilient nervous system again so.

00:36:25 Carly

One thing that struck me what one thing you were saying earlier, Karen, and talking about your own experiences around feeling that perhaps you're not coping, but why am I not coping? And it seems like other people are when, perhaps, as you acknowledged and recognised, maybe they weren't, and I was interested to know, looking back, what difference would it have made if you would have talked to your colleagues about that, reached out to them. What do you think might have happened and what difference do you think that had made had you done that?

00:37:01 Karen

Yeah. And I do actually think it would have made a big difference because I'll describe this scenario as you would all come in at the end of the evening having done all your visits, but everybody would be organising equipment for their patients, or phoning GP's or whatever, so there was no time, there was no space to talk about, you know yourself in that context and I think probably looking back, everybody just kept busy to not potentially talk about it. You know, so it kind of perpetuated itself and I have to say, we did get a swap over of manager. Unfortunately for me towards you know, I had already kind of proceeded to thinking about another career, but there was a stark difference between somebody who was a good palliative care nurse that had nursed in a lot of different environments and that she could act, she supported us far better. So I do think it's it is, as Lisa said, you know it's difficult because your supervisors or your line managers are the people that you have, but they themselves might not have the necessary skill to deal with the level that you're at at that point. But they do need to know you're feeling it. But I do think, I mean, I suppose that's one thing I would argue for that we need more services for people to just walk in and go- I'm having a bad day here. Because one of my regrets really is, that I kind of came out of that career. Do you know what I mean? I had to just come out of it to heal and and get over it, you know, and maybe it might have been different if there had been a different set of support structures in there or even just transferring me from a community aspect of that. Because you were out in people's homes. You were seeing what was happening. To maybe being in the inpatient side of the Hospice, do you know so it's it's these things and I never

talked about any of them. I just decided that I had to change my job. So that was quite drastic.

00:39:22 Lisa

Yeah, that makes so much sense. And I mean some of the recent trauma research that's emerging is that the sooner we can process something that is stressful or difficult to have heard or held or witnessed, then it will enable it to kind of dissipate. So it's the build up over time of holding all of that in ourselves, so if there's an immediate opportunity to talk to somebody, perhaps it's something that within a team, you know, there is always the opportunity to offload, like you say, if you've had a bad day, then you don't have to carry it with you and that helps prevent that build up.

00:39:57 Karen

One of the key things I think I also noticed when I took the next job was, it was a longer commuting distance and actually this short commuting distance it was only something like 10 minutes in the car to my home wasn't enough. Wasn't enough for me to offload everything before I got in the house before I was then dealing with young children, etcetera, etcetera. And it was one of the things is that you, you do need to put space between you, and I think that that also came about in COVID because we do back-to-back Teams, we do back-to-back clinical consultations. Do you know and where do we find that space to actually kind of go "uff, that was a difficult one" and kind of offload it. I think that that, that's one of the key factors I think is space, space between you and your daily sharing of empathy.

00:40:58 Lisa

Yeah. No, that makes again. That makes so much sense because it's about having that space to process things. If you haven't got space to process things, there's no buffer. And when people were doing back-to-back and then actually turning off at the end of the day and, you know, going to their children or whatever other things that they were going to do, there wasn't any of that. In fact, it reminds me of a story that came up in Mark's research where one of the therapists he interviewed said that the one of the ways he actually helped himself was to actually park his car further away from the counselling room and he would have that chance to kind of walk and connect with fresh air. And the other thing that may listeners may be interested in on that front is walking is incredibly powerful, in terms of, it's the left right movement which actually enables the prefrontal cortex to stay online, which helps us to process something. So Francine Shapiro, who was the originator of eye movement desensitization reprocessing therapy, EMDR, which is kind of one of the trauma therapies. She was processing something traumatic herself and went out for a walk and then when she came back she realised that actually she'd processed quite a lot of it and the whole, all the research came about from that original incident as sort of iconic sort

of moment where she went OK, so you know. And so hence you get the kind of bilateral movement and the different ways that we can stimulate in order to kind of process the trauma so.

00:42:29 Karen

So can I ask Lisa then what specifically happens to your nervous system, then when all this is going on?

00:42:40 Lisa

Wow. I mean, in the way we've come to understand more and more and it's emerging all the time about how trauma impacts the nervous system is that if we, so either have a moment of trauma or repeated traumas so complex trauma that builds up overtime and chronic stress can do the same, because any of those things can ping us into our fight or flight. So we're getting an adrenaline rush and then we're getting cortisol on the back of that. What happens is that instead of flexing healthily between you know, being in our kind of feeling safe into if there is a real danger, we go into fight or flight in order to kind of first run from the danger or if we can't run from it, we'll fight it. And if we can't do either of those, we'll kind of go into that collapse place where we kind of go into what we think of as the Blue Zone, you know, the sort of collapse playing possum like a zebra would stand stock still, so the lioness doesn't see it on the edge of the herd until the dangers pass. If we can't, if we're carrying trauma, what happens is rather than being able to respond appropriately to the risk in the environment, we stay stuck in perceiving danger kind of more of the time even where there isn't danger. So it's like the ANS, the autonomic nervous system gets stuck in the kind of red zone. So that's why people feel hyper vigilant when they're carrying vicarious trauma or trauma. And it's not being able to flex appropriately according to the actual risk or lack of it in the environment.

00:44:22 Karen

I can. I can really associate with that zebra. That's what I do an awful lot. If I'm if I'm in a in, if I'm in a stressful situation, I call it floating. But actually it is that kind of. I'm just. I've just got to be still. I can't. I can't do anything other than that. But I also recognise the hyper vigilant as well and that's it's actually quite again it's that's quite reassuring to know that these are two states that you can get into because I would have just said that's my character. Do you know what I mean now? And. And and actually, it's probably been been brought about over a long period of time.

00:45:02 Lisa

No, I was just gonna say so. I mean, if if it helps people remember, it's just like it's like the nervous system gets stuck in the red zone. It's like we say the nervous system is a bit wonky. And you know by doing the things that actually reconnect us with our kind of what

we would say, window of tolerance, our Green Zone, more of the time actually we can live in that Green Zone more of the time we kind of bring it back into being able to flex appropriately in in relation to whether there is a real threat or there isn't. And that's the hopeful thing is like, the nervous system is adaptable. It changes according to you know, if we've experienced trauma or we're carrying vicarious trauma or chronic stress, but equally by doing certain things we can bring it back again.

00:45:52 Lydia

So back to what you said about in terms of the hyper vigilance, I think that's something that I can relate to as well in terms of working in a chemotherapy unit, we had a real string of really bad allergic reactions to chemotherapy. And that really puts you on edge then every single day in your career. And I think that's probably what led to me leaving chemotherapy and getting a new job because you are just on that high alert, and it can be exhausting. Absolutely exhausting. But you know, you explaining through how that sort of affects your nervous system and things, I think, I guess it tells the listeners that perhaps are experiencing that, that it we can sort of justify it and it's not something that's completely abnormal. It's something that does happen. And so hopefully you know the aim of this podcast is to sort of raise awareness of that vicarious trauma and tell people that it is OK that it's happening to you as well as how we can sort of prevent that and things that individuals can do and collectively as well. And I suppose I wondered if either of you had any sort of thoughts about recommendations about what organisations could do for their employees who do work in areas that are particularly tough.

00:47:09 Karen

What I would say to that is I think most organisations are not aware themselves about this, and the reason being is because they're all health and social care professionals, so we're managed by healthcare professionals. You go through your career as a healthcare professional and I think it's one of these feelings, as I would say that is, possibly up till now been so difficult to describe or actually say what's causing it, that it's difficult probably for somebody without that extra knowledge to help you. But then if we could train everybody to do that, do you know if that was a mandatory- you have to understand this can happen to people in your profession. Then I think they would take it more seriously. I also think though, the only time when it becomes a crisis point is if you've got numbers of staff off and they're all suffering from the same type of thing and could be also actually linked to the same event you know, but it's that kind of thing where I think, but it goes back to something that you just said earlier Lydia is, do you know you were in a busy chemotherapy unit. You're on hyper alert because you're waiting for reactions, but you've got no time to and space to process that because it's like a conveyor belt right now. So the guys are still in chemo units right now it's just go, go, go until you go home. And that's for 12 hours of a day and probably do you know, three of these dates. So it's not surprising

that they would be in a hypervigilant state, really, but it's that it's about that time and space to process and even going from an 8:00 at night shift to back on at 8:00 in the morning. That would give you no time to process. And I think that that's where we need to be very aware of healthcare professionals and social care Professionals health is they need time and space to process and they would be better and function better at their work.

00:49:31 Lisa

I mean, yeah, I agree with everything you say, Karen. And I think in some ways, you know, I think the scary bit often for kind of organisations management or have used all this is going to it's got huge time and cost implications. But actually I think in some ways it is not necessarily that because then I think the risk is that you know nothing, nothing changes so breaks between sessions, people that can listen to us if we need to offload something particularly difficult, you know? And really allowing people to take breaks have a space in between and to process, maybe movement as well, because movement can actually help to kind of process and shift things. In fact, the head teacher at the school the other day and he even in the three-quarter hour that we had went off and did his 15 minute walk that he does every day. And I was like, ohh OK, so that's impressive. You know, really stuck to doing the thing that he has found is really new, really helps him. But I think I also kind of you know on another note, I think managers need to be doing the training they need to be finding out, they need to be informing themselves. Cause often people are sent on these things and then the people who hold the purse strings, you know, within organizations actually have not got the awareness to actually support the sort of breaks and the spaces and the chances to offload induction for all new staff in being aware of this from the beginning of a new role or a new job. So there's a huge awareness raising need and I think it has to start from the top. So it is a whole culture.

00:51:13 Lydia

Practice what you preach a little bit like that Headteacher.

00:51:16 Lisa

Yeah, definitely.

00:51:18 Carly

Thanks so much. It's been really lovely to chat with you and I'm really looking forward to hearing more about what we can do to support ourselves and others in Part 2.

(Outro music)

00:51:28 Lydia

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00:51:49 Carly

If you enjoyed this episode, follow us so you don't miss Part 2, where we continue our conversation with Lisa and Karen.

00:51:56 Lydia

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00:52:03 Carly

I'm Carly

00:52:04 Lydia

And I'm Lydia, and you have been listening to the Cancer Professionals Podcast by Macmillan Cancer Support.