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REVIEW ARTICLE

Mental health support in northern communities: reviewing issues on isolated practice and secondary trauma

LK O'Neill
University of Northern BC, Prince George, British Columbia, Canada

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O'Neill LK

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ABSTRACT

Context: Communities in northern Canada face many mental health concerns related to isolation, historical and intergenerational trauma effects, and economic issues. Access to mental health services is problematic due to geographic, cultural and economic issues. Reduced mental health services have resulted in more responsibility and stress for the remaining formal mental health practitioners (including counsellors, psychologists, social workers and nurses) and on informal mental health support, such as lay counsellors, Elders, family members, and community-identified helpers.

Issue: This review explores the unique conditions found in northern-based mental health support in on-going efforts to develop a practice model for mental health support in the North and to better understand the connection between isolated practice and secondary trauma. Practitioners who work in isolated settings are often removed from other professionals, training opportunities, clinical supervision, and family support, with this seclusion contributing to feelings of professional and personal isolation. Aspects of isolation as well as the requirements of empathic engagement with clients leave practitioners vulnerable to various constructs of secondary trauma. The unique challenges of northern practice may contribute to added risk of secondary trauma for formal and informal mental health practitioners. Secondary trauma is defined under the constructs of burn-out, compassion fatigue, secondary

traumatic stress, and vicarious trauma. Although research on the contribution of secondary trauma to the high-turnover rate of professionals in the North is scarce, informal reports suggest that northern practice may be detrimental to longevity in the field for mental health practitioners, especially those who come from outside northern communities.

Lessons learned: The reviewed literature presents the unique challenges of formal (professional) and informal (para-professional and other) mental health practice in northern communities including: isolation related to the principle of confidentiality, geography, and lack of supervision; high visibility and lack of anonymity; and the struggle of negotiating membership in a community with professional and para-professional practice. The literature indicates that practitioners are challenged and effected by the work they do, including both negative and positive aspects.

Professional and physical isolation are key areas to consider in the development of a practice model for northern mental health providers and in gaining a better understanding of the impact of isolation on the phenomenon of secondary trauma. Differing views and definitions on the phenomenon of secondary trauma continue to be espoused. The specific context of northern mental health support needs to be considered when practitioners use various construct labels to describe what is happening to them. As suggested by the literature, an understanding of northern cultures is essential for competent practice in such settings. This understanding includes the diversity of culture and also work and economic factors influence on the social psychology of communities and the resulting impact on mental health supporters. It is proposed that a conceptual and practice model be developed specifically for isolated mental health support in the North, and broadened to include informal mental health providers as well as formal practitioners.

Key words: First Nations, informal helpers, isolated practice, mental health support, northern Canada, secondary trauma.

Introduction

Northern communities reflect the health of community members, with the social and economic wellbeing of communities and the mental wellbeing of members interconnected in a symbiotic relationship. The effects of isolation, community disruption related to exploration activity, economic downturns, and the legacy of the residential school system has resulted in serious mental health concerns in the North. The situation of mental health practitioners who attempt to address these concerns in northern communities is the focus of this review of the literature in order to conceptualize the challenging context of such work. The purpose of this article was to understand the implications for northern-based formal and informal mental health practitioners in the potential development of secondary trauma and to initially explore components required for a relevant practice model for mental health support in northern communities.

Circumpolar Canada has been described as an enormous wilderness area that stretches the definition of low population density beyond relevance[1]. Remote and rural areas in Canada occupy 90% of the land mass, yet the entire northern region is sparsely populated with approximately 101 310 individuals living in various communities[2]. Low population density accentuated by geographical isolation results in a northern human and health service system with a scarcity of physical and human resources, which in turn leads to problematic mental health support[3-7]. The uncontrollable nature of weather conditions in the North add to the challenging geographical conditions and the sense of isolation, with winter travel adding unique difficulties for inhabitants[6,8]. This combination of challenging physical and sociocultural environments results in limited health options, including mental health services, for northern inhabitants[4].

The remoteness of northern communities makes all types of service delivery challenging, including mental health services[4,7,9]. With access to mental health specialists severely limited, mental health support is often left to formal

(professional) and informal (para-professional and other) helping practitioners in various fields who have different levels of training and supervision[3,10]. Professional mental health practitioners include counsellors, psychologists, clinical social workers, and nurses. Para-professionals who provide informal mental health support in the North may include drug and alcohol workers, family support workers, and other community helpers; while other forms of informal support include Elders and family members. All communities in Canada have been affected by diminished health and social services and cutbacks, but rural and remote areas that already struggle with human service delivery have been greatly impacted[11]. Reduced mental health services have resulted in more responsibility and stress on the few remaining mental health practitioners and on informal mental health supporters.

Professionals who come into northern communities or who come back to home communities after receiving training are challenged to become or remain community members and keep their professional identity at the same time[12]. Formal mental health support contributes to personal and professional isolation through the covenant of confidentiality, a covenant that may also prove difficult for informal mental health supporters to negotiate. This inherent professional isolation is compounded by geographical and climatic conditions that lead to physical isolation. This level of professional and physical isolation may contribute to secondary trauma in northern mental health practice

Context

Defining northern practice

Remote settings are essentially secluded from mainstream society, which contributes to feelings of professional and personal isolation[13]. Research-based information on the unique conditions found in northern informal and formal mental health practice is scarce, with the majority of research procured from the fields of nursing and social work[7,14-16]. Research into the situation of professional mental health workers such as counsellors and psychologists, and informal mental health workers such as community para-professionals and family members appears to be even more limited.

In their study of nurses working alone in remote and rural areas of Canada, Andrews and colleagues[17] found that two of the common variables identified in the existing outpost nursing research were professional isolation and lack of adequate preparation. In a study of psychologists working in northern and rural Manitoba, Barbopoulos and Clark[8] found the geographical environment, unique qualities of the residents, and the need for greater availability of services as the main challenges, with psychologists required to be generalists who can address the broad spectrum of psychological needs within such settings. The scarcity of mental health specialists in isolated and rural communities forces some specialists to practice hundreds of miles away from home and from professional support[13].

Practitioners from within communities and from 'away'

Transitioning into isolated and rural communities: Practitioners in small northern communities face difficulties transitioning into northern environments including: increased need for flexibility, personal independence and creativity, risk of professional and personal isolation, and limited community resources and lack of referral sources[13]. These difficulties result in an increased need to incorporate para-professionals into the counselling and helping process. Social and health related interdisciplinary teams in northern communities, particularly in Canada's Aboriginal communities, are unique[3]. The range of workers available to work in the North, including their varied levels of job preparation and limited number of individuals representative of an area of support, are issues particular to remote communities.

Mental health practitioners who are 'outsiders' often have different orientations of culture, lifestyle, and educational background from the populations and communities with whom they come to work[18,19]. Practitioners from the outside

are under pressure to quickly build trusting relationships in order to work effectively[18]. The literature suggests that an understanding of isolated northern cultures is essential for competent practice in such settings[20], but such understanding takes time. Entry into the community can be highly stressful, even when the practitioner has been invited by some members to work in the community.

Isolated communities are often closed systems that exhibit wariness of 'outsiders'. Helping practitioners must find a 'fit' with the community in terms of their personal characteristics and the community's value system[13]. Kirmayer and colleagues[21] note that non-Aboriginal mental health professionals may face difficulties from their position in the community if problems are approached from an outsider's perspective, unaware of the inherent socioeconomic and power disparities. Practitioners from the south often lack an understanding of community differences and assume more homogeneity than actually exists in Aboriginal communities[3]. Such practitioners also tend to focus on the disintegrative aspects of social conditions, seeing only problems without recognizing strengths and the work being done within the community by para-professionals and other community helpers. Zapf[1] suggests that practitioners from outside may view northern communities with a southern lens, interpreting what they see as a pathological version of the southern experience.

Culture shock: The culture-shock often experienced by practitioners who move into isolated communities is often the result of the discontinuities between personal, professional, and community domains[22]. Zapf[1] suggests that there are generally four stages of adjustment for outside practitioners. Initially, the practitioner experiences optimism and a sense of challenge, feelings that then turn to frustration and confusion as the practitioner struggles with his or her ability to interact and prove effective in the new community. This experience is described as culture shock. The resolution of this struggle leads to integration with the new culture and community, while failure to do so usually results in the practitioner leaving the community. This phenomenon may explain the high turn-over of mental health and social service workers in the North[6,7].

Originating in rural communities: For those practitioners who are from the communities where they work, other issues come into play. Barbopoulos and Clark[8] suggest that outside professionals learn to appreciate the various training and educational backgrounds of para-professionals and other mental health workers. Local workers may view therapy and intervention from an interpersonal, familial, or non-directive orientation, in addition to coming from diverse backgrounds. For some local workers, education is based on personal experience of a particular problem or disorder, or self-learning and other informal training.

Northern communities are often locations where everyone knows everyone, whether they want to or not[23], resulting in the greatest challenge to the covenant of confidentiality through the difficulty of ensuring client privacy[24]. In many small northern communities, informal mental health practitioners working in their home communities may be related to other community members. Their role in the community may change their relationships with fellow community members, partly due to issues of confidentiality, where they may be asked to share information informally[3]. The potential of increased isolation of community practitioners is due to their concerns about sharing confidential information.

The concept of 'weak-tie' and 'strong-tie' orientations in communities has been used to differentiate communities[23]. Strong-tie communities, such as those found in the North, provide a sense of belonging to members, but may also result in members conforming to the dominant values of the community. Rawsthorne[23] explains that these values are considered to be structurally determined by the social bonds of community members. Practitioners coming into communities may have weak-tie orientations and bring new perspectives, challenges, and ideas that go against some traditions and values. Such perspectives can help to undermine oppressive traditions, but may also alienate potential clients.

Those who live and work in isolated communities are considered by some researchers and community members to best know what is needed and what works, while others acknowledge that outsiders who live and work in the community have the potential to create safe spaces for clients, especially those who suffer abuse or go against collective norms[11]. Respecting one another's expertise and understanding one another's roles are listed as important challenges in working relationships between community para-professionals and outside professionals.

High visibility

High visibility with a loss of privacy and anonymity; mistrust and trust of professionals, and the blurring of personal and professional boundaries due to multiple roles that occur in small communities are fundamental issues for isolated/rural practitioners[25,26]. In northern communities, lack of anonymity and personal privacy is a major challenge. Separating the practitioner's personal and professional life and one's membership in a mental health system from one's presence as a new community member in a northern community is extremely difficult[3]. Professionals who come to northern communities often feel as though they are scrutinized, often with a critical lens, by community members[7]. Shank and Skovholts's[27] term 'small-world hazards' sums up the minefield of potential problems practitioners new to a northern community might face.

Dual relationships

Negotiating dual relationships while maintaining confidentiality is a challenging prospect as previously discussed, due to the web of over-lapping personal and professional relationships found in small, isolated communities[13,24]. If pre-existing relationships ethically preclude a practitioner from beginning a professional helping relationship, many clients in northern communities would never receive help. Northern practitioners must become active community participants in the process of building trust, which results in a complexity of simultaneous relationships. It is helpful to visualize rural and northern practitioners working with whole communities rather than individuals[9]. Both professionals and para-professionals will eventually treat friends and even family members[27]. They will also inevitably spend time with clients or simply encounter them in public outside their sessions due to small population size, situations requiring clarification of boundary issues. In small northern communities, most members are interconnected and dependent on each other for all types of services.

Limits of practice

Northern psychologists and counsellors following ethical codes of practice are encouraged to practice within their limits; however northern practice puts pressure on practitioners to go beyond their limits of training because of the difficulty in accessing the services of specialists[20]. Potential problems may also develop when new outside practitioners work closely with community practitioners who have different practice beliefs and epistemologies. Practitioners may adopt practices without understanding appropriate applications, going far beyond their area of expertise[8].

Supervision

Northern para-professionals and professional mental health practitioners often feel cut off from professional understanding, training, and supervision when working in isolated communities[28,29]. Serious professional and ethical concerns exist including potential risks to clients when counselling services are provided without adequate supervision[13]. This risk includes the situation of novice practitioners who may feel obligated or pressured to practice far beyond their capabilities. Self-education is essential when practitioners adapt interventions for community conditions with which they have limited experience[8]. For many informal mental health practitioners, there is often a complete lack of supervision at any level.

Intergenerational issues

Approximately 69% of the population of the Yukon, Northwest Territories, and Nunavut are Aboriginal, and

these three territories each have a greater proportion of Aboriginal inhabitants than any of Canada's provinces[30]. In Canada, Aboriginal peoples include First Nations, Inuit and Metis, with First Nations and Inuit forming the majority population in most areas in the North. Many northern communities have experienced historical trauma: the collective cumulative psychological and emotional wounding resulting from massive group trauma experiences across generations affecting First Nations people, as well as current psychosocial conditions linked to the legacy of colonization[31-34]. The ongoing intergenerational trauma, the direct and indirect psychological influence of an earlier generation on attitudes, behaviours, and parenting of the next generation, all require awareness of the impact of multigenerational disruption on positive individual, familial, and cultural development[35].

In their group work with First Nations' trauma survivors and clinicians working with First Nations, Brave Heart and DeBruyn[36] describe the impact on both survivors and clinicians in discussing historical trauma and unresolved communal grief. Experienced facilitators who had years of clinical experience were described as being challenged and sometimes overwhelmed by the power of unresolved historical grief.

Intergenerational trauma affects non-Aboriginal family members as well as Aboriginal families. The specific context of trauma that affects many Aboriginal and non-Aboriginal people in the North may also affect practitioners who offer informal mental health services and who often have limited training and supervision.

Issue

Risks in northern practice: secondary trauma

All of the previously described aspects of northern practice may contribute to the development of secondary trauma in northern practitioners. Culture shock for practitioners coming into northern communities, high visibility of life found in small communities, negotiation of complex overlapping relationships, lack of clinical supervision, and continued engagement with traumatic material may add extra stress to practitioners, increasing their vulnerability to aspects of secondary trauma. Secondary trauma is defined under the constructs of burn-out, compassion fatigue, secondary traumatic stress, and vicarious trauma. Confusion over the terms has resulted in researchers attempting to clarify the differences and overlap among the concepts of vicarious trauma, burnout, compassion fatigue, and secondary traumatic stress[37,38]. Yet agreement is found in the end results; there are profound effects on practitioners that result from empathic engagement with client trauma[39].

In theory, secondary traumatic stress and compassion fatigue focus on emotional responses and symptoms that result from work with traumatized clients, without emphasis on specific cognitive changes found in the definition of vicarious trauma[37,38]. Yet the concept of vicarious trauma has become less defined as some researchers use the term secondary traumatic stress in discussing cognitive changes as the result of working with traumatized clients, and others discuss vicarious trauma while focusing on symptomology[38,40].

Secondary traumatic stress

Secondary traumatic stress is defined as the presence of post-traumatic stress disorder (PTSD) symptoms in caregivers connected to the client's trauma experience rather than the caregiver's own trauma[41]. Secondary traumatic stress and vicarious trauma refer to the same observed phenomenon. However secondary traumatic stress focuses on clinically observed PTSD symptomatology of sudden onset, whereas vicarious trauma is a theory-driven concept, cumulative in nature and emphasizing gradual, permanent changes in cognitive schema[42,43,39]. Researchers suggest that there is a connection between length of career, large caseloads, long working hours, and more contact with clients and secondary traumatic stress[41], situations that are commonly found in isolated practice.

Burnout

The concept of burnout is described as a gradual process increasing in intensity and involving emotional and mental exhaustion, preceded by high job stress in emotionally demanding situations[41,44,45,39]. The main risk factor of burnout is employment in a setting where employees work with high levels of interpersonal demands without adequate structural support for meeting those demands[42]; the demand exceeds the capacity. The lack of access to clinical supervision in isolated communities might be considered an example of inadequate structural support. The main difference between burnout and secondary traumatic stress is described as the gradual onset of burnout compared to the often sudden onset of secondary traumatic stress, which is related to client trauma rather than the occupational stress source of burnout[38]. The coping strategy of distancing has been found consistently in burnout research and is viewed as a common reaction to exhaustion and depersonalization[41]. In their study on the contribution of therapists' beliefs to psychological distress, McLean and Wade[46] found the two constructs to be not completely independent or identical, but rather slightly overlapping.

Compassion fatigue

Compassion fatigue is defined as the natural consequence of working with traumatized clients or those who have experienced extremely stressful events in tandem with the level of empathy practitioners have for such clients[41,45]. Compassion fatigue includes a reduced interest and capacity by the practitioner to engage at an empathic level with clients and involves both secondary trauma and job burnout[47]. In the case of compassion fatigue empathy, which is considered to be helping practitioners' greatest strength, can become their greatest liability[48]. Some researchers believe that compassion fatigue can be used interchangeably with secondary traumatic stress, mainly because they are less comfortable with the latter[44,45].

Vicarious trauma

The concept of vicarious trauma as developed by McCann and Pearlman[49] includes aspects of the previously mentioned concepts, but differs with a theoretical focus on the therapist's inner experience, more specifically cognitive changes that occur as well as those in adaptation and meaning. The changes that are proposed to occur with vicarious traumatization include changes in worldview, self-capacities and abilities, spirituality, and psychological beliefs and needs[50]. These changes may occur through the accumulation and incorporation of clients' traumatic material into the helper's worldview[51]. There are five areas of psychological need subject to cognitive distortion in vicarious trauma: control; safety; trust; esteem; and intimacy[50]. Sensory reactions may also occur including imagery intrusions and bodily sensations plus the addition of actual PTSD symptoms[51,38].

McCann and Pearlman[49] describe vicarious trauma in theoretical terms of cognitive development and constructivism, focusing on changes to cognitive schemas in the process of meaning-making that consist of beliefs, expectations, and assumptions of self and the world. In conceptualizing vicarious trauma, the authors suggest that the disruption or changes in therapists' schemas may result from client's trauma due to exposure to the client's lack of safety, feelings of powerlessness, and abuse of trust issues.

Regardless of what labels are used, the consequences of working with traumatized clients for an extended time appear to be the same: profound changes in beliefs, expectations, and assumptions of self and the world[41,43]. These changes are not always negative, and researchers are also studying vicarious post-traumatic growth. Arnold, Calhoun, Tedeschi, and Cann[52] suggest that the adoption of an inclusive conceptualization of trauma work as an endeavor holding both pain and life-affirming benefits may help practitioners view the process in a new, empowering way.

Secondary trauma and mental health practitioners in northern communities

There is a lack of information regarding secondary trauma and coping strategies of formal and informal mental health practitioners in the North. A study by Morrissette and Naden[53] describes some of the unique factors and context in working with First Nations populations. The extraordinary bond among, and respect for, extended family within many First Nations communities results in a unique complexity in the disclosure process among First Nations families. First Nations' counsellors describe the emotional turmoil following disclosures, including some from immediate or extended family members. Feelings of shame, anger, resentment, bitterness, and being overwhelmed and emotionally paralyzed followed such interactions. In many First Nations communities, a protective membrane of support is provided by the significant people in the survivor's life[53]. Secondary trauma can result from community and family members' participation as part of this protective membrane.

The most recent study was conducted by the author in small, isolated communities in circumpolar areas of northern BC and Yukon, Canada[54]. In this qualitative study eight helping practitioners who provide formal and informal mental health support to clients experiencing trauma, ranging from 7 to 40 years of experience, were interviewed to make explicit their experiences of working in isolated communities[54]. The practitioners were all affected by their work with clients who have experienced trauma, describing personal, multidirectional changes occurring over time. Difficulty in accessing training and supervision and the lack of adequate preparation were some of the challenges described by the practitioners, mirroring components from the literature[29,13,47]. Practitioners aligned themselves with other literature regarding the challenges of having highly visible profiles and the associated community scrutiny[7,25]. Sensory reactions were described by the majority of participants involving noticeable increase in anticipation of danger, suggesting secondary traumatic stress symptoms. Engagement with clients' trauma response did change participants' internal schemas as suggested in the conceptualization of vicarious trauma[50], but was not always portrayed as disruptive in nature, particularly in the case of embedded practitioners working in their home communities. A new discourse to emerge from this study was from embedded practitioners who felt invested in the communities they served and saw their dedication and commitment as protective factors

Lessons learned

Discussion

The challenges of physical and professional isolation are key areas to consider in the development of a practice model for northern mental health providers and in gaining a better understanding of the phenomenon of secondary trauma. As suggested by the literature, an understanding of northern cultures is essential for competent practice in such settings[20]. This understanding includes diversity of culture but also work and economic factors influence on the social psychology of communities. Barbopoulis and Clark[8] stress the need for a body of empirical evidence and well-founded theory on rural psychology, leading to a conceptual model of rural psychology. The author proposes that such a model be developed specifically for isolated mental health support in the North and broadened to include informal mental health providers as well as formal practitioners.

Traumatic situations are conceptualized not only to disrupt peoples' schemas about themselves, but also their perceptions of others and the world[55]. Negative and positive aspects of change are found in the literature, indicating recognition of the potential for positive outcomes in trauma support[50]. This is consistent with McCann and Pearlman's[49] constructivist self-development theory and the conceptualization of the contribution of personal levels of need in the areas of safety, independence, dependency and trust, power, intimacy, and self-esteem.

Ethical dilemmas abound in northern practice, as ethical codes, standards, and regulations are not always applicable in small community settings[24,27]. The application of ethics codes and standards of practice are problematic due to the reality of extremely complex relationships and the blurring of professional and personal boundaries in small community practice[13,27], adding more stress to the work environment. A recent study by Harrison[43] found that protective practices for countering personal, professional, and spiritual isolation identified by mental health counsellors included access to supervision, training, organizational support, and personal and spiritual community. These practices may all be problematic in the context of northern communities. The ethical covenant of confidentiality makes social relationships difficult for practitioners in isolated or rural communities, yet the building of trusting relationships is key to sustained mental health support. Difficulty in developing supportive social networks combined with a lack of clinical supervision leaves formal mental health practitioners isolated on both personal and professional levels, with support from supervisors, colleagues, and family defined as an essential strategy in much of the literature.

Empathy is the connective tissue of mental health support and the major resource of counsellors, psychologists and informal practitioners, involving emotional, cognitive, and physiological responses[44,45,48]. The components of empathic ability, empathic concern, and empathic response[56] are also applicable to informal mental health practitioners even if they are not aware of such labels. Operating at the required level of arousal contributes to burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma. Literature on secondary trauma suggests that dosage of exposure and the degree of empathic engagement has the potential to result in detrimental effects[41,46], yet a general wearing down of practitioners was also identified[54]. Trauma disrupts the everyday realities[57], and the everyday traumas were suggested as causing disruption and wear on practitioners[54].

Differing views and definitions on the phenomenon of secondary trauma continue to be espoused. The specific context of northern mental health support needs to be considered when practitioners use various construct labels to describe what is happening to them. Based on the patterns and rates of unintentional and intentional trauma mortality for Aboriginal people in Canada[58,59,21], increased levels of wariness and anticipation of danger reported by practitioners[54] may often be logical rather than framing such anticipation and concern as hyper-vigilance or cognitive distortions as suggested in the theory of vicarious trauma[49]. The PTSD effects of secondary traumatic stress could be interpreted as visions by some practitioners. In conversations with numerous northern practitioners, the term burn-out is most often used.

Drawing on the fields of physiology, sociology, psychology, and trauma counselling, Valent[60] postulates that there are eight survival strategies that people use in response to trauma: fight, flight, rescue, competition, cooperation, attachment, assertiveness, and acceptance. The literature reviewed appears to indicate that northern mental health providers use the strategies of flight, cooperation, attachment, and acceptance in order to cope with challenging work and living conditions. Individual meaning of exposure to trauma depends on peoples' psychological development which determines areas and degree of need and subsequent survival strategies[49].

Several articles described the flight of practitioners from isolated communities due to difficult working conditions[6,7,54]. These challenging working conditions include lack of anonymity and privacy and the need to negotiate multiple relationships, pervasive themes in the literature[13,24,61]. Practitioners who came from within their communities appeared to have developed wider, more flexible boundaries out of either necessity or cultural values and appropriateness[54], but could still be affected by secondary trauma through deep interconnections[53]. For practitioners from within communities or embedded helpers, the strategy of attachment appears to help them continue their work. Transparent living was another strategy used as a way to make peace with living in a 'goldfish bowl'[54], illustrating aspects of cooperation.

In the context of isolated northern practice and secondary trauma, acceptance as a survival strategy[60] involves acceptance of personal changes in worldview, levels of compassion, and emotions and appears to be a way of coping with the effects of empathic work. Vicarious trauma and the inevitable transformation of beliefs and meaning through empathic engagement[49] may require acceptance as a naturally occurring phenomenon, and a new name to better define its effects and overarching capacity[54].

Conclusion

The material in this review can only begin to present the multiplicity of issues and complexity of relationships found in the interactions of isolated mental health support, secondary trauma and theories of both historical and intergenerational trauma to life and work in northern isolation. The vulnerability and resilience of informal and formal mental health providers in the North is envisioned to be at the centre of these interactions.

Place entities exist as creations of social processes and social constructs, not defined simply according to geography[62]. The tyranny of space created by northern geography[63], the space between cultures, and mental health practice intersect at the location of northern practitioners' experience.

The information presented in the literature helps to consolidate important pieces for both a conceptual and practice model of isolated mental health support in the North. More questions need to be explored to fully develop such models. One area yet to be fully understood is the situation of informal mental health supporters such as Elders, locally identified healers, and family members and their needs in providing such support.

Research has indicated that members of ethnic minorities tend to use informal sources of care, including family, friends, and traditional healers[64], suggesting that such research may be relevant to Aboriginal communities. Those individuals dealing with mental health issues come to depend on the resources of family, group, and communal networks. Informed supervision and educational support for these resources may benefit many northern communities. Such research would inform new workers and practitioners already working in isolated conditions. Further research specific to mental health practice in circumpolar regions is needed to complete conceptual and practice models and ensure the mental wellbeing of both northern community members and formal and informal practitioners who provide essential mental health support.

References

1. Zapf MK. Remote practice and culture shock: social workers moving to isolated northern regions. *Social Work* 1993; **38(6):** 694-704.

2. Statistics Canada. *2006 census data*. (Online) 2006. Available: http://www.statcan.ca/menu-en.htm (Accessed 20 June 2009).

3. Boone M, Minore B, Katt M, Katt P. Strength through sharing: interdisciplinary teamwork in providing health and social services to northern Native communities. *Canadian Journal of Community Mental Health* 1997; 16: 15-28.

4. Leipert B, Reutter L. Developing resilience: How women maintain their health in northern geographically isolated settings. *Qualitative Health Research* 2005; **15(1):** 49-65.

5. Lonne B, Cheers B. Retaining rural social workers: an Australian study. *Rural Society* 2004; **14(2):** 163-177.

6. Sangha D. Anti-racist/anti-oppressive social work practice in rural communities: challenges and considerations. *Rural Social Work* 2004; **9:** 209-215.

7. Schmidt GG. Remote, northern communities. *International Social Work* 2000; **43(3):** 337-349.

8. Barbopoulos A, Clark J M. Practicing psychology in rural settings: issues and guidelines. *Canadian Psychology* 2003; **44(4):** 410-424.

9. Delaney R, Brownlee K. Ethical considerations for northern social work practice. In R. Delaney, K. Brownlee, J.R. Graham (Eds). *Strategies for northern social work practice*. Toronto, ON: Lakehead University, Centre for Northern Studies, 1997; 35-53.

10. Trippany R, Kress V, Wilcoxon S. Preventing vicarious trauma: What counsellors should know when working with trauma survivors. *Journal of Counselling & Development* 2004; **82(1):** 31-37.

11. Hornosty J, Doherty D. Resistance and change: building a framework for helping abused rural women. *Rural Social Work* 2004; **9:** 106-117.

12. Transken S. Dancing with diverse diversities: creativity and social work professing in small/rural northern communities. *Rural Social Work* 2004; **9:** 118-128.

13. Weigel DJ, Baker BG. Unique issues in rural couple and family counselling. *The Family Journal* 2002; **10(1):** 61-69.

14. Tarlier D, Johnson J, Whyte N. Voices from the wilderness: an interpretive study describing the role and practice of outpost nurses. *Canadian Journal of Public Health* 2003; **94(3):** 180-184.

15. Vukic A. Northern outpost nursing: literature review. *Aboriginal Nurse* 1996; **11(1):** 4-8.

16. Vukic A, Keddy B. Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing* 2002; **40(5):** 542-548.

17. Andrews M, Stewart N, Pitblado J, Morgan D, Forbes D, D'Arcy C. Registered nurses working alone in rural and remote Canada. *Canadian Journal of Nursing Research* 2005; **37(1):** 5-33.

18. Cruikshank J. The outsider: an uneasy role in community development. *Canadian Social Work Review/Revue Canadienne De Service Social* 1990; **7(2):** 245-259.

19. Linzmayer C. Integrated human services in rural areas: a social work approach.. *Rural Social Work* 2003; **8(1):** 25-37.

20. McIlwraith RD, Dyck KG, Holms VL, Carlson TE, Prober NG. Manitoba's rural and northern community-based training program for psychology. interns and residents. *Professional Psychology: Research & Practice* 2005; **36(2):** 164-172.

21. Kirmayer L, Simpson C, Cargo M. Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry* 2003; **11:** 15-23.

22. Cheers B. The place of care-rural human services on the fringe. *Rural Social Work* 2004; **9:** 9-22.

23. Rawsthorne M. Social work and prevention of sexual violence in rural communities: the ties that bind. *Rural Social Work* 2003; **8(1):** 4-11.

24. Galambos C, Watt J, Anderson K, Danis F. Ethics forum: Rural social work practice: maintaining confidentiality in the face of dual relationships. *Journal of Social Work Values and Ethics*. (Online) 2006. Available: http://www.socialworker.com (Accessed 17 May 2006).

25. Green R, Gregory R, Mason R. It's no picnic: personal and family safety for rural social workers. *Australian Social Work* 2003; **56(2):** 94-106.

26. Munn P, Munn T. Rural social work: moving forward. *Rural Society* 2003; **13(1):** 22-34.

27. Schank J, Skovholt T. Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice* 1997; **28(1):** 44-49.

28. Birk J M. Country roads: counselling psychology's rural initiative. *The Counselling Psychologist* 1994; **22(1):** 183-196.

29. Crago H, Sturney R, Monson J. Myth and reality in rural counselling: towards a new model for training rural/remote area helping professionals. *The Australian and New Zealand Journal of Family Therapy* 1996; **17(2):** 61-74.

30. Statistics Canada. *2001 census data.* (Online) 2001. Available: http://www.statcan.ca/menu-en.htm (Accessed 14 December 2006).

31. Brave Heart MYH. The historical trauma response among Natives and its relationship with substance abuse: a Lakota illustration. *Journal of Psychoactive Drugs* 2003; **35(1):** 7-13.

32. Duran E, Duran B. *Native American postcolonial psychology*. Albany, NY: State University of New York Press, 1995.

33. Duran E, Duran B, Brave Heart MYH, Davis-Yellowhorse S. Healing the American Indian soul wound. In Y Danieli (Ed.). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press, 1998; 341-354.

34. Evans-Campbell T. Historical trauma in American Indian/Native Alaska communities. *Journal of Interpersonal Violence* 2008; **23(3):** 316-338.

35. Tafoya N, Del Vecchio A. Back to the future: an examination of the Native American holocaust experience. In: M McGoldrick, J Giordano (Eds). *Ethnicity.and family therapy*, 2nd edn. New York, NY: Guilford Press, 1996; 45-54.

36. Brave Heart MYH, DeBruyn L. The American Indian Holocaust: healing historical unresolved grief. *American Indian & Alaska Native Mental Health Research* 1998; **8(2):** 60-82.

37. Canfield J. Secondary traumatisation, burnout, and vicarious traumatisation: a review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work* 2005; **75(2):** 81-101.

38. Sabine-Farrell R, Turpin G. Vicarious traumatisation: implications for the mental health of health workers? *Clinical Psychology Review* 2003; **23:** 449-480.

39. Rasmussen B. An intersubjective perspective on vicarious trauma and its impact on the clinical process. *Journal of Social Work Practice* 2005; **19(1):** 19-30.

40. Thomas R, Wilson J. Issues and controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatisation, and secondary traumatic. stress disorder. *International Journal of Emergency Mental Health* 2004; **6(2):** 81-92.

41. Collins S, Long A. Working with the psychological effects of trauma: consequences for mental health-care workers: a literature review. *Journal of Psychiatric & Mental Health Nursing* 2003; **10(4):** 417-424.

42. Baird S, Jenkins S. Vicarious traumatisation, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence & Victims* 2003; **18(1):** 71-86.

43. Harrison RL, Westwood MJ. Preventing vicarious traumatization of mental health. Therapists: identifying protective practices. *Psychotherapy, Theory, Research, Training* 2009; **46(2):** 203-219.

44. Figley CR. Compassion fatigue as secondary traumatic stress disorder: an overview. In: C Figley (Ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner-Routledge, 1995; 1-20.

45. Figley C R. *Treating compassion fatigue*. New York: Brunner-Routledge, 2002.

46. McLean S, Wade T. The contribution of therapists' beliefs to psychological distress in therapists: an investigation of vicarious traumatisation, burnout and symptoms of avoidance and intrusion. *Behavioural & Cognitive Psychotherapy* 2003; **31(4):** 417-428.

47. Adams RE, Boscarino J A, Figley CR. Compassion fatigue and psychological distress among social workers: a validation study. *American Journal of Orthopsychiatry* 2006; **76(1):** 103-108.

48. Rothschild B. *Help for the helper: the psychophysiology of compassion fatigue and vicarious trauma*. New York: WW Norton, 2006.

49. McCann I, Pearlman L. Vicarious traumatisation: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress* 1990; **3:** 131-149.

50. Pearlman L, Saakvitne K. *Trauma and the therapist.* London: WW Norton,1995.

51. Bober T, Regehr C, Zhou YR. Development of the coping strategies. Inventory for trauma counsellors. *Journal of Loss and Trauma* 2006; **11:** 71-83.

52. Arnold D, Calhoun L, Tedeschi R, Cann A. Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology* 2005; **45(2):** 239-263.

53. Morrissette P, Naden M. An interactional view of traumatic stress among. First Nations counsellors. *Journal of Family Psychotherapy* 1998; **9(3):** 43-60.

54. O'Neill LK. Northern helping practitioners and the phenomenon of secondary. trauma. *Canadian Journal of Counselling* 2010; **44(2):** 130-149.

55. Janoff-Bulman R. *Shattered assumptions: towards a new psychology of trauma*. New York: The Free Press, 1992.

56. Figley CR. Compassion fatigue: psychotherapists' chronic lack of self-care. *JCLP/ In Session: Psychotherapy in Practice* 2002; **58(11):** 1433-1441.

57. Crossley ML. Narrative psychology, trauma, and the study of self/identity. *Theory & Psychology* 2000; **10(4):** 527-546.

58. Karmali S, Laupland K, Harrop A, Findlay Kirkpatrick A, Winston BK et al. Epidemiology of severe trauma among status Aboriginal Canadians: a population-. based study. *Canadian Medical Association Journal* 2005; **17:** 1007-1011.

59. Kinnon D. *Improving population health, health promotion, disease prevention and health protection services and programs for Aboriginal People*. Ottawa, ON: National Aboriginal Health Organization, 2002.

60. Valent P. Survival strategies: a framework for understanding secondary traumatic stress and coping in helpers. In: C Figley (Ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner-Routledge, 1995; 21-50.

61. Erickson SH. Multiple relationships in rural counselling. *The Family Journal* 2001; **9(3):** 302-304.

62. Nilsen E. Rethinking place in planning: opportunities in Northern and Aboriginal planning in Nunavut, Canada. *Canadian Journal of Urban Research* 2005; **14(1):** 22-36.

63. Berman GS. Social services and Indigenous populations in remote areas: Alaska Natives and Negev Bedouin. *International Social Work* 2006; **49(1):** 97-106.

64. Yeh C, Hunter C, Madan-Bahel A, Chiang L, Arora A. Indigenous and interdependent perspectives of healing: implications for counselling and research. *Journal of Counselling & Development* 2004; **82:** 410-419.

