

# Vicarious Trauma & Burnout in Healthcare Providers and How a Trauma Informed System Can Help

IHS Trauma Informed Care & Historical Trauma Informed  
Care Webinar Series: Part III in 3 Part Series for healthcare  
Providers

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# Introduction

- IHS has partnered with the University of New Mexico School of Medicine Division of Community Behavioral Health to
- Present an integrated approach to Historical Trauma, Trauma, and Trauma Informed Care in health and behavioral health settings
- Rollout of:
  - A series of webinars
  - Monthly case consultations
- Today's webinar is Part 3 in a 3 part series for healthcare providers

# Objectives

- As a result of having participated in this webinar, participants will be able to:
  - Examine five effects of vicarious trauma and burnout on healthcare providers.
  - Apply effective strategies to prevent personal burnout from the effects of vicarious trauma.
  - Explain how core values of Trauma Informed Care affect systems of care.

## Trauma Informed Paradigm

“What happened to this person?”

“What’s strong with you?”

### **Historical trauma informed:**

“What tribal traumatic events happened over time?”

“What kind of school did you and family members attend?”

## Standard Paradigm

“What’s wrong with this person?”

“What’s wrong with you?”

NOT asking about collective tribal history

NOT asking about boarding school history or other tribal-specific experiences and culture

# Historical Trauma



# Historical Trauma and Unresolved Grief

- ***Historical trauma*** - Cumulative emotional and psychological wounding from massive group trauma across generations, including lifespan
- ***Historical trauma response*** (HTR) is a constellation of features in reaction to massive group trauma, includes ***historical unresolved grief*** (similar to Child of Survivors Complex re: Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants), depression, PTSD

(Brave Heart, 1998, 1999, 2000)

trauma

# What Is Trauma?

“trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being”



# Types of Trauma

- Single event
  - E.g. being in a car crash, natural disaster, sexual assault
- Multiple events, over time
  - E.g. incest, war, racism, micro-aggressions
  - Can lead to Complex Trauma
- Vicarious or secondary trauma
- Multigenerational including historical trauma
- Complex trauma

# Caveats

- What is traumatic to 1 person may not be to another
- Trauma affects a person's neurobiology in ways that are long lasting or permanent
- Trauma can lead to
  - adverse health outcomes
  - PTSD
- Not everyone who has experienced trauma develops PTSD or adverse health outcomes
- Cumulative trauma has cumulative effects
- There are effective treatments for trauma

# Impact of Trauma on American Indian and Alaska Native Communities

- AI/AN between 2-3 times more likely to meet PTSD criteria compared to US adult population
- 2.5 times greater risk than the national average of experiencing physical, emotional, and/or sexual abuse
- AI/AN youth have the highest rates of emotional or physical neglect across all populations
- Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood
- 12-16% of AI/AN homes experience alcohol and/or drug abuse (national average is 4-6%)
- Unresolved grief and historical trauma can become ingrained in the identity of individuals and communities

Slide courtesy of Christopher Morris

Gone & Trimble, 2012; DS Bigfoot, 2008; Brave Heart & DeBruyn, 1998; Copeland et al., 2007; National Center for Children in Poverty, 2007; Beals et.al., 2013

# Culture and Trauma

Culture determines acceptable responses to trauma and shapes the expression of distress

- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help

Culture can provide a source of strength, unique coping strategies, and specific resources.

Cultural assessment is essential for appropriate diagnosis and care

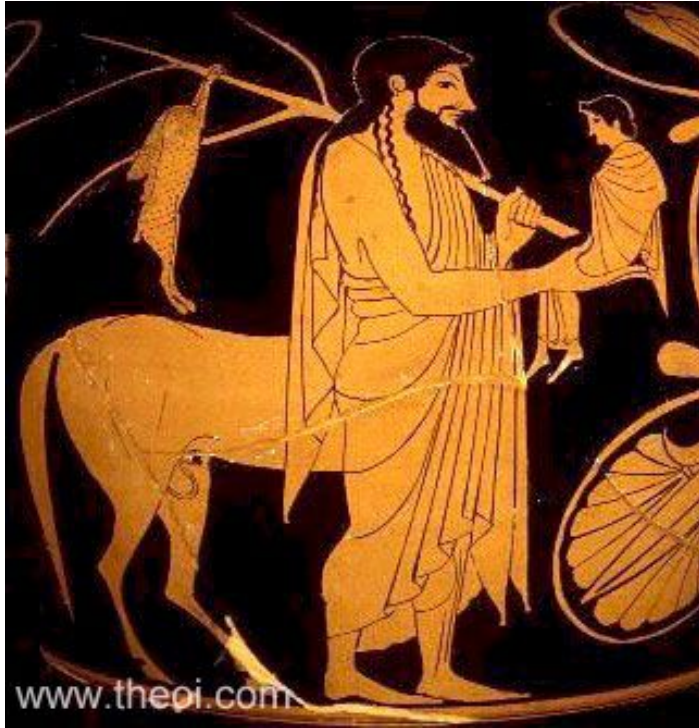
# Vicarious or Secondary Trauma

- Experienced by behavioral health providers
  - Experiencing historical trauma themselves
  - Experiencing trauma themselves
  - Hearing stories of trauma from their clients
  - Non-trauma informed workplace?

# Vicarious or Secondary Trauma

- Experienced by medical/nursing providers
  - Experiencing historical trauma themselves
  - Experiencing trauma themselves
  - Patients ill and dying
  - Hearing stories of medical trauma
  - Medical errors
  - Non-trauma informed workplace?

# The Wounded Healer-Chiron



- A centaur in Greek mythology
- Accidentally wounded, in chronic severe pain, incurable
- Renowned teacher and healer

# The Wounded Healer-Carl Jung

- “the doctor is effective only when he himself is affected. Only the wounded physician heals.
- Developed the “wounded healer archetype”



*"Your vision will become clear only when you can look into your own heart. Who looks outside, dreams; who looks inside, awakes."*

*Carl Jung*



# The Wounded Healer in AI/AN Tradition

- AI/AN people are all trauma survivors
  - Historical trauma
  - Personal trauma
- Many AI/N healers have had dreams and visions after surviving a physical illness
- Illness was seen as part of the process for visions and receiving spiritual powers
- Black Elk described in Black Elk Speaks receiving healing powers after an illness

# Compassion Fatigue

The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. It differs from burn-out, but can co-exist. Compassion Fatigue can occur due to exposure on one case or can be due to a “cumulative” level of trauma.

# Signs and Symptoms of Compassion Fatigue

- Exhaustion
- Reduced ability to feel sympathy and empathy
- Anger and irritability
- Increased use of alcohol and drugs
- Dread of working with certain clients/patients
- Diminished sense of enjoyment of career
- Disruption to world view
- Heightened anxiety or irrational fears

# More Signs and Symptoms of Compassion Fatigue

- Intrusive imagery or dissociation
- Hypersensitivity or Insensitivity to emotional material
- Difficulty separating work life from personal life
- Absenteeism – missing work, taking many sick days
- Impaired ability to make decisions and care for clients/patients
- Problems with intimacy and in personal relationships

# Burn Out

- “A syndrome of emotional exhaustion, depersonalization and lack of feelings of personal accomplishment” (Lee & Ashforth)
- Cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress, NOT trauma-related. (American Institute of Stress)

# Maslach-6 Areas of Burnout

- Workload
  - Too much, not enough resources
- Control
  - Micromanagement, accountability without power
- Reward
  - Money, acknowledgement, satisfaction
- Community
  - Isolation, conflict, disrespect
- Fairness
  - Discrimination, favoritism
- Values
  - Ethical conflicts, meaningless tasks

# The System(s) we work in Can be Traumatizing/Retraumatizing for us

- We are all affected by systemic stressors
- We are trained (hidden curriculum) to ignore our own emotions, thoughts, and needs
- We are trained to focus on the patient and their needs, and that if we focus on our needs we will provide worse care, and might even harm the patient
- This can lead to compassion fatigue and burn out

# Maslach Burnout Inventory

- Has a version for medical personnel
- Looks at 3 scales
  - Emotional exhaustion
  - Depersonalization
  - Personal accomplishment
- Burnout can be addressed 2 main ways
  - Individual
  - organizational
- **Both ways need to be addressed!**

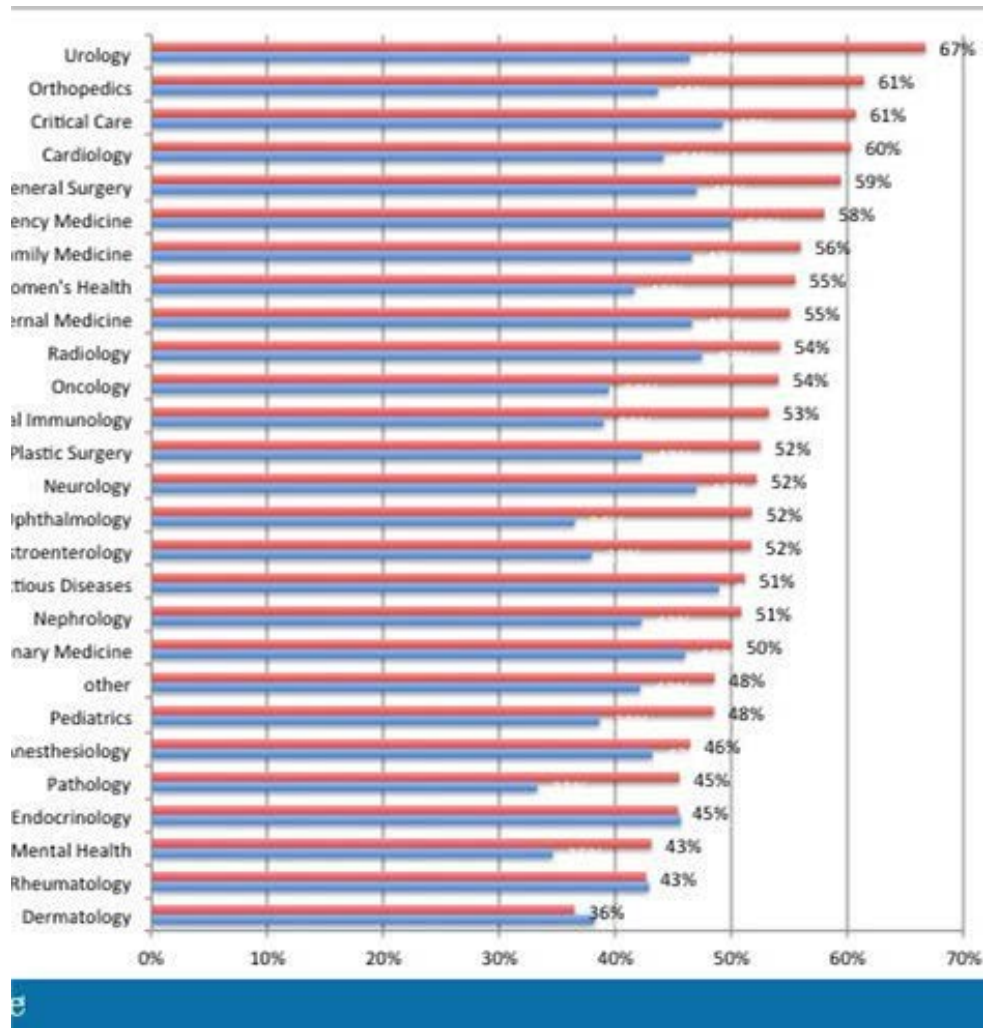


# Burnout in Healthcare Professionals

- High burnout rates in healthcare professionals
- Linked to multiple factors
  - Aging population
  - Low pay
  - Job demands
  - Changes in healthcare field

# Physician Burnout

- Approximately 50% of physicians meet criteria for burnout
- Female physicians are 1.6 times as likely as male physicians to report burnout
- Primary care and ED physicians more likely to burnout
- Burnout may be linked to 4 values of physicians reinforced in medical training:
  - Service, excellence, curative competence, compassion
  - Can lead to deprivation, invincibility, omnipotence, and isolation



# Gender and Burnout

# The Effects of Burnout on Patient Care

- Physician burnout adversely affects
  - Quality of care
  - Patient safety
  - Patient satisfaction
  - Risk of malpractice suits
  - Prescribing habits
  - Test ordering
  - Patient adherence to medical recommendations

# The Economic Cost of Burnout

- Increased physician turnover
  - Cost of replacing a physician is 2-3x the cost of a physician's annual salary
- Decreased work effort/productivity
- Early retirement
- Decrease to part time work

# Focus on Service Can Lead To:

- Sense of deprivation due to need for personal sacrifice
  - Sleep, food, toilet, exercise
  - Family time
  - hobbies
- Entitlement “I deserve it because I work so hard”
  - bad financial decisions
  - Bad relationship decisions
- Excellence
  - zero tolerance of mistakes,
  - perfectionism,
  - can feel invincible, incapable of making a mistake,
  - can't talk about mistakes, errors

# Focus on Service Can Also Lead To:

- Curative competence—
  - taking responsibility for patient outcomes, but we can't control everything,
  - can lead to premature action (surgery)
  - intolerance for ambiguity, seeing patients who question us as difficult
- “imposter syndrome” emotional distress, leads to “embracing omnipotence”
- Compassion—balancing act between empathy and appropriate emotional boundaries—can suppress emotions and lead to sense of isolation

# Physician Suicide

- Physicians have an increased risk of dying by suicide
- Estimated 1 physician suicide per day in US
- Suicide among physicians more common in depression, BPAD, substance use, and burnout
- Depression affects 12% of male and 19.5% of female physicians
- Depression affects 15-30% of medical students and residents
- Depression is linked to risk for MI in male physicians



# Physician Suicide-continued

- Stigma in medical profession against seeking help for depression
  - >60% of doctors with SI didn't seek help due to concern it would affect their medical license
  - 1/3 of doctors don't have a PCP
- Physicians have greater access to lethal means
  - most common methods are overdose and firearms

# Characteristics of Physicians that Interfere with Seeking Help

- Denial
- Feel obliged to present self as healthy
- Trained to ignore own needs and think of the patient
- Tendency to diagnose and treat self
- Difficulty asking for help
- “high control”
- VIP syndrome

# The Good News

- Although depression and substance abuse are more common among physicians, they are also more treatable
- Physicians have a strong motivation to continue their profession

# Physician Resiliency

- Service, excellence, curative competence, and compassion are also the key to finding joy and meaning in our work
- We can retrain ourselves and our minds
- Use self compassion when we recognize negative self talk
- Reframing
- Appreciation and gratitude
- Self-awareness and self-care
- **Systems change**

# Questions to Raise Self-Awareness and Build Resiliency

- What did I learn today? Would I do anything differently?
- What 3 things am I grateful for today? What inspired me?
- How did I talk to myself today? Did I take myself too seriously? Did anything surprise me?

# Actions to Improve Quality of Life

- Find ways to add humor and laughter into your day and week
- Choose to live less financially affluent
- Plan a daily self-care activity

# Protective Factors to Prevent Burnout & Compassion Fatigue

- Team spirit/cohesion
- Sense of accomplishment
- Training
- Supervision
- Balance in life outside of work
- Connection to others
- Self-care

# The Ethics of Self-Care:

## Standards of self-care guidelines:

- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care



# Systems Change to Decrease Burnout

- Physicians who spend 20%+ of their time in work they find most meaningful are at greatly decreased risk of burnout
- Improve inefficiency in work environment/clerical burden
- Cultivate community at work
- Wise use of rewards and incentives
- Align values and strengthen integration
- Promote flexibility and work-life integration
- Provide resources to promote resilience and self-care

Trauma informed care

# What is Trauma Informed Care?

- Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.
- Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

# Trauma Informed Care

“Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

# Standard Human Services Paradigm

- Primary goal of services are stability and the absence of symptoms or social problems, not patient wellness
- Services crisis driven
- Focused on acute problem(s)
- Time limits of visits, services driven by financial and administrative needs (not patient needs)
- Medical model
- Problems attributed to the individual, limited focus on social context
- Problems treated in separate service systems, not integrated

## Standard

- Hierarchical
- Trust is assumed
- Safety is assumed
  
- Patient is passive recipient of services (or chooses from a menu)

## Trauma-Informed

- Collaborative
- Trust is developed over time
- Steps are taken to ensure safety
- Patient is encouraged/skills developed to express choice

# What is Historical Trauma Informed Care?

- Understanding the importance of cross generational and ancestral ties in tribal communities and families
- Addressing cultural norms for addressing trauma and healing, traditional bereavement
- Examining the collective traumatic tribal history as well as traditional cultural wisdom and resilience

# Why Institute Trauma Informed Care?

- Benefits

- Better clinical care for all patients
- Improves patients' adherence with visits/treatment
- Better health outcomes for our patients
- Improves health and wellness of clinicians
- Improves the working environment for clinicians, staff, and management
- Improves clinicians' ability to understand and/or work with the community



# It Matters

- It matters how organizations treat their employees, their patients/clients, themselves
- Patients are more likely to adhere to recommended treatment and to follow up with care in TIC systems
- Our systems and how we act with patients can re-traumatize them or
- Our systems can help patients to heal and improve their clinical outcomes

# Language Has Meaning

- English, tribal language
- Consumer, client, patient, relatives
- First name, last name
- Trauma survivor, cancer survivor, incest survivor
- Doctor, physician, clinician, therapist, counselor, provider, prescriber
- Empowerment, encouragement
- Control
- The way we talk to patients
  - Open ended versus close ended questions
  - “You shouldn’t, you can’t”
- Do we explain symptoms in a culturally appropriate/understandable way?

# Trauma Informed Care Is...

- Recovery oriented
- Patient/client/consumer driven
- Involves cultural humility/co-learning
- Provides trauma specific services

# TIC Does Not Mean...

- Just being nicer
- Permitting unacceptable or unsafe behavior
- Just a change in clinical care

# 5 Principles of Trauma-Informed Care

(modified from CCTIC)

- Safety
- Trustworthiness
  - Making tasks clear
  - Maintaining appropriate boundaries
- Choice
  - Prioritizing consumer choice and control
- Collaboration
  - Between clinicians and consumers
  - Emphasizing working together on goals, not top down
- Encouragement
  - Recognizing strengths
  - Skill building

# Provider Support and Well-Being

- Support and care for entire staff
- Follows the same 5 principles as used with patients:
  - Safety, trustworthiness, choice, collaboration, encouragement
- In order to care for others we need to function well ourselves
  - Able to teach, role model, not be reactive, self-controlled, never abuse power
  - Minimize vicarious/secondary trauma

In the introductory webinar we reviewed 5 principles of Trauma Informed Systems as they apply to **patients and families**

The following looks at these principles of Trauma Informed Systems as they apply to **providers**

# Creating a Safe Context-Physical Safety

- How is physical safety of providers ensured?
  - Do providers work in areas outside the office? (patients' homes, etc.)  
How safe are they in these settings?
  - Is the clinic/office/service unit physically safe?
    - Assistance if needed
    - Adequate space to see patients



# Creating a Safe Context-Emotional Safety

- Do providers feel comfortable bringing their concerns to team meetings, supervision, their supervisor?
- Does the program look at emotional safety needs of providers, and support staff?
- Is spiritual safety considered?

# Trustworthiness

- Do managers/supervisors understand the work of direct care providers?
- Is self care encouraged/supported?
- How are dual relationships handled?
  - How are boundaries protected?
- Is there conflict with your agency and tribal leadership on decision making and care plans?
- Are expectations clear and consistent?

# Choice

- Is there a balance of autonomy and clear guidelines?
- Are providers allowed to give input into factors affecting their work?
  - Caseload
  - Working hours
  - Vacation/leave
  - Trainings offered
  - Approaches to clinical care
  - Location and décor of office/clinic

# Collaboration

- Is provider life experience and history respected?
  - Awareness of strengths and skills?
- Are providers' opinions valued by management?
- Is feedback welcomed?
- Are changes in system/workload etc. done collaboratively?

# Encouragement

- Are individuals' strengths and skills utilized maximally?
- Do providers do work that is consistent with their values?
- Are there adequate and relevant training opportunities?
- Do providers receive training on trauma, historical trauma, trauma informed care?
- Do directors/supervisors have a positive, affirming attitude?
- Is feedback constructive rather than critical?

# Staff Training

- Does the program train non native staff about culture?
- Do staff feel comfortable talking about culture? Blind spots?
- Does the program train on the concept of internalized depression?
- Does the program train on trauma, including the impact of workplace stressors?
- Do staff feel spiritually safe? Is there opportunity for spiritual cleansing?

# Steps to Creating a Trauma Informed System

- Culture shift
  - Not just new information or services
  - New way of thinking and acting
- Involves everyone: administrators, supervisors, line staff, clinicians, patients, families
- Begin with small steps
- Use the same principles we use with patients
  - Safety, trustworthiness, choice, collaboration, encouragement

# Culture Shift

- Incorporate knowledge about trauma and HT into all aspects of services
  - Not just for patients or providers we know have experienced trauma
- Minimize re-victimization of patients and providers
  - Do no harm/ non maleficence
  - Awareness that the service system (IHS, medical, dental) has been re-traumatizing to patients and to providers



# Upcoming Webinars and Case Consultations for Healthcare Providers

- Part I: ACES and Why They Matter in Healthcare 9/26
- Part II: Trauma, Attachment & DSM 5 Diagnoses 10/17
- Part III: Vicarious Trauma & Burnout in Healthcare Providers & How a Trauma Informed System Can Help 11/15
- Monthly case consultations 10:00-11:00 MST
  - Sept 20, Oct 18,. Nov 15, Dec 13, 2017
  - Jan 17, Feb 14 2018

# Selected References

- Roger D. Fallot and Maxine Harris, Community Connections: Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol, 2009
- Christina Maslach & Michael P Leiter, “Reversing Burnout”, Stanford Social Innovation Review [www.ssireview.com](http://www.ssireview.com) 2006
- Nedrow A, Steckler NA, Hardman J. Physician resilience and burnout: can you make the switch? Fam Pract Manag. 2013;20:25-30

## Selected References-2

- Carol Peckham, “Physician Burnout: It Just Keeps Getting Worse” Medscape Psychiatry January 26, 2015 <http://www.medscape.com/viewarticle/838437> 4
- Tait D Shanafelt and John H Noseworthy, “Executive Leadership and Physician Well-being” Nine Organizational Strategies to Promote Engagement and Reduce Burnout, "Mayo Clin Proc. n January 2017;92(1):129-146 n <http://dx.doi.org/10.1016/j.mayocp.2016.10.004> www.mayoclinicproceedings.org n  
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# Websites

ACES Connection <http://www.acesconnection.com/>

ACES Too High [www.acestoohigh.com](http://www.acestoohigh.com)

Child Trauma Academy <http://childtrauma.org/nmt-model/>

International Society for Traumatic Stress Studies (ISTSS)

[www.istss.org](http://www.istss.org)

The National Council for Behavioral Health

<https://www.thenationalcouncil.org/topics/trauma-informed-care/>

National Child Traumatic Stress Network (NCTSN)

<http://www.nctsn.org/>

# Websites-continued

PTSD: National Center for PTSD (US Department of Veterans Affairs)

<https://www.ptsd.va.gov/>

SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC)

<https://www.samhsa.gov/nctic>

SAMHSA National Child Traumatic Stress Initiative (NCTSI)

<https://www.samhsa.gov/child-trauma>

TF-CBTWeb <https://tfcbt.musc.edu/>