

PFSP Perspectives: *Alberta Doctors' Digest*

Dealing with distress from patients' trauma

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Last year I was approached about contributing a presentation about vicarious trauma to the Healthy Minds/Healthy Children (www.hmhc.ca/about.htm) online continuing professional development program.

I've had a lot of experience caring for traumatized individuals through my emergency medicine work, but I'd not given much thought to the effects on emergency workers of repeated exposure to patients' traumas.

Why is the concept of vicarious trauma important? How is vicarious trauma different from burnout and compassion fatigue?

Is our capacity for empathic care diminished or compromised in the course of repeated exposure to the trauma and suffering of those for whom we provide care? If it is, how do the individuals affected and our profession address this occupational hazard?

The literature describes various kinds of secondary stress in practitioners' lives.

Robert Wicks summarizes secondary stress as "the stress that results from reaching out to others in need."

Trippany, Kress and Wilcoxon define vicarious trauma as "a traumatic reaction to specific client-presented information . . . (that) occurs among those who work specifically with trauma survivors."

Wallace, Lemaire and Ghali tell us, "Burnout results when individuals feel emotionally overwhelmed by the demands of their jobs. Burnout is often associated with excessive workloads, chronic work-related stress and restricted autonomy."

Charles Figley's definition of compassion fatigue combines a number of related concepts. "Compassion fatigue is a more user-friendly term for secondary traumatic stress disorder, which is nearly identical to post-traumatic stress disorder, except it affects those emotionally affected by the trauma of another (usually a client or a family member)."

Dominguez-Gomez and Rutledge describe three characteristic symptoms of secondary traumatic stress that can lead to decreased job satisfaction. Arousal, avoidance and intrusive symptoms are manifest respectively in increased irritability, the avoidance of patients and recurring, troubling thoughts about certain patients.

These different kinds of symptoms roughly correspond to emotional, behavioral and cognitive aspects of the way some of us respond to psychological stress.

Other symptoms may include sleep disturbance, difficulties with concentration, loss of confidence, hyper-vigilance and a feeling of numbness.

Some researchers (Sabin-Farrell and Turpin) question the existence of vicarious trauma as a distinct entity among the various kinds of distress that may affect care workers.

Other researchers also note that the vulnerability to the negative effects of working with trauma victims varies among individual workers.

Ghahramanlou and Brodbeck report that among sexual assault trauma counsellors, "Personal trauma history, younger counsellor age and lower counselling satisfaction levels significantly predicted higher levels of secondary trauma intensity.

"Contrary to prediction, exposure to trauma survivors, emergency room work as primary client contact type, and education did not significantly predict psychological distress."

How three colleagues deal with vicarious trauma

Firefighters and paramedics, sexual assault response team members and emergency physicians are considered at risk for vicarious trauma.

I asked three colleagues who work in these areas what they found most difficult about caring for traumatized individuals. Secondly, how did they deal with any negative consequences of these emotionally charged encounters?

A paramedic replied, "I always had trouble with caring for, or being in the presence of, the 'bad guy.' The drunk driver who needs emergency medical services, the person who threw the gasoline on the camp fire and burned everyone around, the stepfather who shook the baby to death. . . .

"It seems the 'bad guys' get adequate care, but the caregiver enters a numb state."

A family doctor, who for many years worked as a member of a sexual assault response team, said, "The kind of encounter I found the most difficult to deal with was the severely physically traumatized sexual assault victim. In a few cases, victims would comment that the exam was just as bad as the assault.

“I always found this very upsetting as, of course, I was trying to help the victims. It was difficult to hear that they felt traumatized again and made me feel like a perpetrator of some sort of repeat trauma.”

An emergency medicine colleague said, “I’m most affected by those trauma events that occur to those I deem most innocent or most vulnerable – pediatric trauma, child abuse, geriatric abuse, motor vehicle crashes caused by drunk drivers. Also, traumas bring an association to my own life – a young crash victim who reminds me of my own children.”

Recurring motifs in their memories of these encounters include the young or older patient, the innocence of the victim, violence causing death and the moral offence of certain actions.

How did these three individuals deal with negative effects of vicarious trauma?

Their responses are similar to some of the recommendations in the literature for coping with adverse events, complaints and litigation. (See the Dealing with Adverse Medical Events brochure on the Physician and Family Support Program [PFSP] web page at www.albertadoctors.org/PFSP/AdverseEvents.)

The firefighter mentions critical stress debriefing as well as the importance of the less formal coffee talk. “Coffee is a ritual at the firehalls. There is always a hot pot on the warmer, waiting for the next story to be told.”

The family doctor also speaks of the benefit of debriefing with sexual assault response team members. In retrospect she says, “I have not utilized any special sort of counselling or psychology services, but I think this might have been helpful for a few cases.”

The emergency physician would encourage “the practice of mindful activities – meditation, running, gardening, woodworking.”

At the same time, he admits, “I probably rely more on discussing an emotionally difficult case with my spouse or other close friends.”

Other forms of assistance

Structured debriefing, self-care, informal conversations and personal therapy are part of the after-work we may engage in to reduce our work-related distress and suffering.

Organizational strategies are also required as part of a shared responsibility to address the issue of work stress. Jan Richardson, in *Guidebook on Vicarious Trauma*, describes critical-incident stress debriefing that has become a resource in many emergency workplaces.

She also speaks to the need for training programs, quality clinical supervision and shared power environments.

Ms Richardson defines this latter term as “workplaces where there is respect for diversity, mutuality and consensual decision-making rather than traditional hierarchical organization models.”

As a profession, physicians are increasingly aware of the dangers and difficulties of doing work that is complex and emotionally laden.

Physicians, residents and medical students call the PFSP toll-free line (1.877.767.4637) for assistance with workplace stress.

More than 10% of calls to the Alberta Medical Association (AMA) program relate to various stressful workplace issues.

The support and counselling available through PFSP is an example of the AMA’s recognition of the relevancy of this issue to many members of our profession.

Awareness of this practice issue and our profession’s response to it is one thing. More importantly, at the end of another busy day, do we recognize our own difficulties and seek help in a timely fashion?

Are we able to support a colleague who appears to be struggling unduly with the corrosive effects of work-related stress?

I would like to thank my colleagues who kindly responded to my queries about this difficult part of their work. “Ask a CMA Librarian” service (<http://www.cma.ca>) provided me with a list of references for the topic. Finally, my son, Sebastian, was a great help in meeting the technical challenges of the original presentation on vicarious trauma. The presentation will be posted on the Healthy Minds/Health Children website (www.hmhc.ca/online.htm).

References available upon request. □