PROFESSIONAL SELF-CARE SURVIVING AND THRIVING

Kia ora Tatou and Welcome

Nurses: Working, Living, Giving

James Cook Hotel Wellington 23 – 25 May 2019

OVERVIEW OF PRESENTATION

1. Introduce self and background

2. Why is self care in the workplace an important issue for health care professionals?

3. What are your existing self-care strategies?

4. Key concepts that are relevant to understanding and explaining the impact of the work

5. Research findings- literature review and qualitative, longitudinal inquiry

6. Why does work involving traumatic disclosure from clients impact differently from individual to individual worker?

7. What helps to maintain professional effectiveness?

8. What factors and characteristics are associated with the ability to rebound?

9. A comprehensive model of self care for working across fields of practice and contexts

ABOUT ME....

Dr Margaret Pack

1. Wellingtonian born and raised

2. My career began as a social worker

3. Case manager in National Trauma Unit

4. Social Work Academic in NZ and Australia- lecturer to associate professor/ discipline leader for social worker

5. Now working at Te Mahoe as counselling co-ordinator and in private practice offering clinical supervision and educational consultancy as a registered social worker

6. My Website: margaretpack.nz email: marg@margaretpack.nz

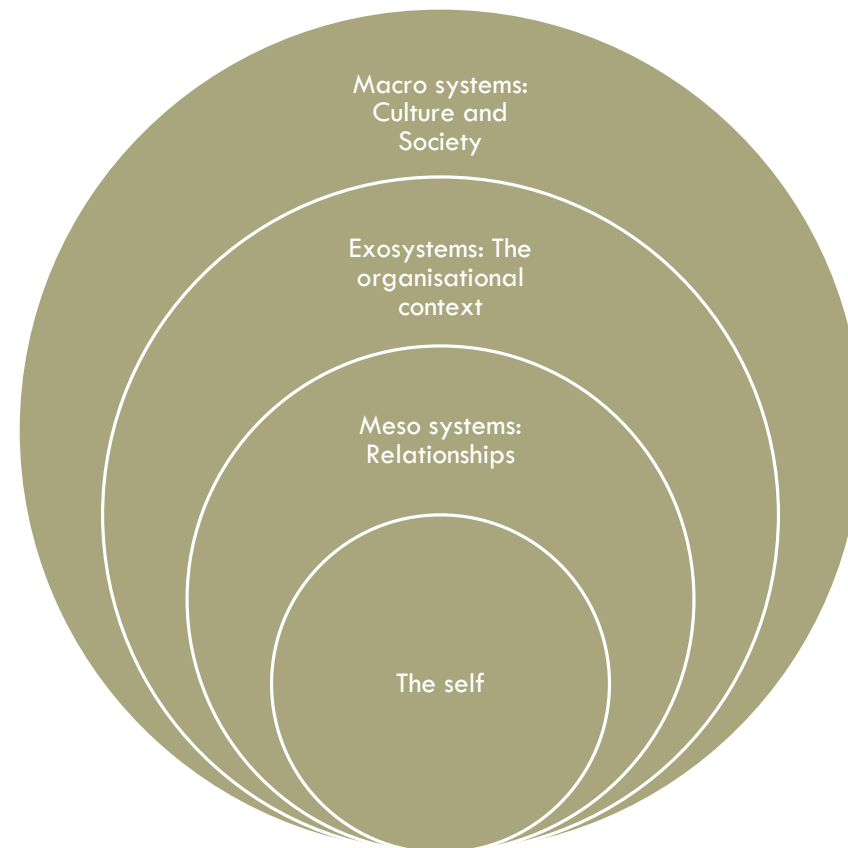# SELF-CARE FOR TRAUMA THERAPISTS: A PRACTITIONER'S GUIDE (PACK, 2017)
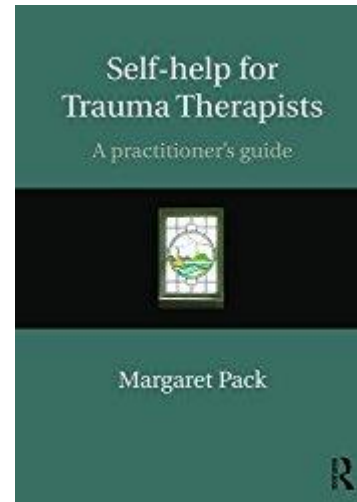
WHY IS SELF-CARE IMPORTANT?

Professional training and education stresses the well-being and therapeutic outcomes with clients and families but may under emphasise the health and well-being of the worker as being central to good outcomes for clients and their whanau.

a) Working with trauma and stress has identifiable and now acknowledged impacts on workers

b) Health care professionals are dealing with trauma disclosures routinely everyday

c) Workers need to be mindful of when/how they may be impacted both today and over time

d) Know what to do and where to go if for help if and when negatively affected

e) Employers have responsibilities to assist to protect and assist workers from psychological injury and to support well-being in the workplace

A MULTI-DIMENSIONAL MODEL OF SELF-CARE

Macro systems: Culture and Society

Exosystems: The organisational context

Meso systems: Relationships

The self

EXISTING SELF-CARE STRATEGIES IN THE WORKPLACE

I would like you to take a moment to think about how you look after your needs in the workplace currently and what has worked for you over the years in relation to professional and personal self care.

How do you care for yourself currently to remain effective in your practice?

Let's brainstorm for a moment...

EXISTING STRATEGIES

1. 'Go home at 5'; 'take regular breaks' throughout the day; 'holidays'
2. 'Clinical supervision'
3. Diet and exercise
4. Friends and family/socialising; Colleagues
5. Mindfulness/awareness of stress- journaling/critical reflection
6. 'Debriefing from tricky situations'
7. Keeping a 'to do' list
8. Sustaining Interests /Hobbies e.g. the crossword, reading, tramping, creative arts,yoga
9. Assertiveness and saying : 'no'

Let's now turn to becoming aware of some key concepts and some definitions that are central to self care…..

KEY CONCEPTS EXPLAINING THE IMPACT OF THE WORK- POSITIVE AND NEGATIVE RESPONSES

❖ Stress

❖ Post traumatic stress/traumatic stress

❖ Compassion fatigue

❖ Vicarious traumatisation

❖ Secondary traumatisation

❖ Burnout

❖ Compassion satisfaction

❖ Post traumatic growth

❖ Resilience or hardiness

WHAT DO WE MEAN BY 'STRESS'?

The impact of particular sources of stress known as 'stressors', singularly or together impact on individuals to produce certain effects. Stressors can relate to relationships at home at work, life events, or change in our lives/lifestyle

These effects include physical manifestations such as the 'fight and flight response', where we attempt to fend off or avoid any perceived threat to our survival or well-being.

The 'fight and flight' response can manifest in such symptoms as heart palpitations, increased perspiration, and nausea amongst others.

PSYCHOLOGICAL/PHYSICAL EFFECTS OF STRESS

Psychological effects often include negative thinking anxiety or worry and behavioural manifestations such as insomnia, irritability and anger.

Over time the triggering of such responses can result in coping strategies such as avoidance and absenteeism in the workplace; persistent ill health such as catching colds and flus repeatedly, as such tensions can trigger the release of hormones such as cortisol which over time can affect the immune system (Van Heugten, 2011).

Muscular tension can lead to back and other health problems when apparently there is no physical cause for ongoing aches and pains (Van Heugten, 2011).

POSITIVE SOURCES OF STRESS

How we perceive events as being 'stressful' or pleasurable will depend on factors such as previous experiences/responses, and may be tied to personality styles and existing coping strategies and resources.

Balance in one's work-life balance, altruism and variety in case load is also considered important in balancing stress with work rewards and a sense of fulfilment in one's personal and professional life (Collins, 2007; Gibbons et al, 2011)

On a personal level, good nutrition, sleep and exercise, absorbing hobbies and interests and a sense of belonging in the world of relationship/ community can all contribute to our well-being. Being in nature/wilderness is also considered restorative (Jirek, 2015; Martinek, 2010; Pack, 2016)

SOPHIA'S COMMENTS ON THE IMPACT OF STRESSORS IN HER LIFE

'*My life is much more satisfying now. I'm in charge of it (laugh) which is one thing I really like. Not being married is really good. I really love having my own place. I love it when the kids are this age now because they can look after themselves a lot now. I've got lots of good friends. Life's a struggle financially somewhat being solo. But my life is good, very full.*' (Pack, 2014).

Example of living well in the face of stress and trauma

IMPACT OF LONG TERM STRESS AND EXPOSURE TO TRAUMA

Feeling that we hold the locus of control over our life, is part of what can help us deal positively with the multiple challenges of juggling work and personal demands.

Where the locus of control feels constant with the other, or out of our control consistently can be a source of 'burnout' (van Heugten, 2011).

Other long term manifestations can include 'secondary traumatisation', 'compassion fatigue', 'vicarious traumatisation' and the more positive manifestations of continued engagement that include: 'post traumatic growth', 'compassion satisfaction' and 'vicarious resilience'

BURNOUT

'Burnout' is seen as encompassing a range of components including emotional exhaustion, feelings of depersonalisation and a sense of reduced accomplishments in one's work (Stamm, 2005).

The organisational culture is often cited as a source of burnout, when socio-economic factors lead to retrenchment and reduced services which make it extraordinarily difficult for ethical therapists to meet their personal and professional ethical standards of practice (Fulcher, 1988).

For example, Van Heugten discusses in her research amongst social workers the many difficult adaptations that workers make to their changing work contexts during organisational restructuring, often culminating in decisions to leave and set up in private or group practices (van Heugten, 2011)

BURNOUT- CONTRIBUTING FACTORS

Lack of clarity about one's work role coupled with conflicting responsibilities on the job and a lack of support are factors which contribute to 'burnout' (Leiter and Maslach, 1998)

Conflicts caused by clashes of personal ethics with organisational aims and ways of working

Individual symptomology of burnout, can often be an indicator of what is happening in the wider organisational culture and economy, yet this is often a neglected area in the literature where the focus is on individual responses with little attention is given to the surrounding organisational and societal context in which practice occurs.

TRAUMA AND SECONDARY TRAUMATIC STRESS

Trauma has been linked to a 'history of repeated interpersonal victimisation that has impacted adversely on a person's mental and potentially physical and social health across their life span' (Wall and Quadara, 2014 p. 4).

Secondary traumatic stress can be triggered by witnessing the distress of others in the aftermath of trauma (Herman, 2010).

Herman (1992) in her seminal work: *Trauma and Recovery* likens the therapist's responses to this engagement with trauma as a 'contagion' which gives some idea of how we affect one another by the telling and retelling our stories which involve traumatic material and particularly the material relating to the intentional harm of one human being to another.

PTSD AND SECONDARY EFFECTS

In DSMV the definition of 'trauma' within the diagnosis of Post-traumatic Stress Disorder now includes the secondary effects of those who witness trauma.

Herman (1992) in her seminal work: *Trauma and Recovery* likens the therapist's responses to this engagement with trauma as a 'contagion' which gives some idea of how we affect one another by the telling and retelling our stories which involve traumatic material and particularly the material relating to the intentional harm of one human being to another.

COMPASSION FATIGUE

The professional helper's empathetic responses to disclosures of trauma through the desire to help the other have been termed by Professor Charles Figley and colleagues as: 'compassion fatigue'. A secondary traumatic stress disorder experienced by trauma professionals.

The primary pathway to the onset of compassion fatigue is through the therapist's empathy for the client. The hallmarks of compassion fatigue as a specialised kind of helper secondary traumatic stress, are based in symptoms suggestive of secondary traumatic stress such as emotional lability and outbursts, anxiety, withdrawal and insomnia. To assess how engagement with trauma related work is impacting, the Compassion Fatigue Inventory is useful to periodically complete. This self-administered questionnaire can be found at:

http://ncwwi.org/files/Incentives__Work_Conditions/Compassion-Satisfaction-Fatigue-Self-Test.pdf

TRAUMATIC TRANSFERENCE AND COUNTERTRANSFERENCE

Wilson and Lindy (2001) from their research discovered that therapist responses to engagement to trauma range on a continuum of those who avoid emotional engagement at one end of the spectrum to those who are overinvolved in the material at the other.

As one can imagine, countertransference responses will be quite different depending on where one is at any one moment on this continuum of therapist countertransference responses. The implications for the development of vicarious traumatisation and burnout for those whose engagement forms an over-identification with the client, is likely to more easily be impacted by the traumatic disclosures. Whereabouts a therapist is on this continuum of avoidance- over-identification continuum may be influenced by one's experience of traumatisation including sexual abuse and neglect. A second factor in determining the impact of trauma on the self of the therapist is the openness to explore one's experiences of past trauma in contexts such as personal therapy (Gelso & Hayes, 2007).

VICARIOUS TRAUMATISATION (VT)

Vicarious traumatisation is a process that occurs when worker's sense of self and world view is negatively transformed through empathetic engagement with traumatic disclosures from clients (Pearlman & Saakvitne, 1995). The effects are considered to be cumulative, permanent and irreversible if unattended (Pearlman & Saakvitne, 1995). The basic premise of 'cognitive self-development theory', underpinning the concept of vicarious traumatisation, is that individuals 'construct their own personal realities through the development of complex cognitive structures which are used to interpret events' (McCann & Pearlman, 1990, p. 137).

POST TRAUMATIC GROWTH, RESILIENCE

These terms expand the scope of the more negative potential impacts of the work in the field of trauma to encompass the idea that over time, trauma therapists' engagement with trauma inspires a greater appreciation of life in general and reported satisfaction in the work.

One measure of enhanced quality of life is the use of the ProQOL III (Stamm, 2005) Quality of life scales focus also on growth of meaning and value given to the intangible aspects of everyday life that we may refer to as 'spirituality'

http://www.proqol.org/uploads/ProQOL_5_English_Self-Score_3-2012.pdf

COMPASSION SATISFACTION, VICARIOUS RESILIENCE

Compassion fatigue research has more recently focused attention on the allied term of 'compassion satisfaction' and 'post traumatic growth'. These terms expand the scope of compassion fatigue to encompass the idea that over time, trauma therapists' engagement with trauma inspires a greater appreciation of life in general and reported satisfaction in the work. Specialised trauma training and clinical supervision have been found to obviate the more negative impact of trauma therapy on therapists, as they enable therapists to evolve more positive meanings of providing trauma related psychological intervention (Rich, 1997).

Hernandez-Woolf et al (2007) have developed the term 'vicarious resilience' which is suggesting more positive effects from ongoing engagement with trauma than suggested in the VT literature.

Vicarious Resilience: A New Concept in Work With Those Who Survive Traumahttp://www.nursingacademy.com/uploads/6/4/8/8/6488931/vicariousresilience.pdf

COPING STRATEGIES IN THE WORKPLACE

In one study health professionals made a conscious effort to detach themselves from the client's experience to self-protect to gain a greater awareness of their own experience to avoid becoming lost within the various pressures (Badger et al., 2008 p. 70).

A regular forum for processing/debriefing and attending to self-care together with finding a work–leisure balance were found to be important to ameliorating the effects of trauma-related work in the hospital context (Badger et al., 2008, p. 70).

Humour has been found to be a protective factor in moderating vicarious traumatization as it enables helping professionals to cognitively reframe and reinterpret situations and so reduce stress and tension through communication and emotional expression (Moran, 2002, pp. 140–151).

RELATIONAL MODELS OF CLINICAL SUPERVISION

Providing opportunities for communicating the experience of the work in clinical supervision is recommended in the range of strategies for enabling therapists to maintain a fresh perspective in the work with trauma survivors (Knight, 2006). The vicarious traumatization and countertransference cycle in the area of worker self-disclosure and boundaries for survivor therapists has illuminated the need to develop specific models of clinical supervision for workers who deal with trauma (Etherington, 2000). These models simultaneously focus on the therapist, the client, and supervisees' experience of their work in clinical supervision and the therapists' own personal therapy (Etherington, 2000; Knight, 2006).

Having access to a comprehensive critical incident stress management programme in the workplace is considered essential to deal with critical incidents on the job

REFERENCE TO A WIDE RANGE OF THEORETICAL APPROACHES IN PRACTICE

Self-reports by health professionals of using evidence-based practices have been associated with post traumatic growth and resilience in recent studies (Craig & Sprang, 2010). A random sample of 2000 practitioners asked if the self- reported use of evidence-based practices predicted greater compassion satisfaction, and reduced burnout, and compassion fatigue.

 Using a professional quality of life scale known as the ProQOL III (Stamm, 2005) nearly half the clinicians surveyed reported high levels of compassion satisfaction. (Craig & Sprang, 2010).

RISK FACTORS PREDICTING IMPACT OF WORK

Risk factors to predicting burnout, VT and CF included being younger, having fewer years spent in practice

 Having a higher percentage of traumatised individuals on one's caseload, and not using evidence-based practices.

Having oppressive management systems that did not normalise the impact of the work or access to clinical supervision and critical incident debriefing services

PREDICTORS OF COMPASSION SATISFACTION

Predictors of compassion satisfaction included the number of years of clinical practice, and use of evidence-based practices with clients (Craig & Sprang, 2010).

These findings concur with previous research by Cunningham (2003) whose research suggested that maturity and professional experience buffers therapists from the more negative impact of engagement in clients who are making traumatic disclosures.

 The level of empathetic engagement is another variable that is of interest in the development of vicarious traumatisation and compassion fatigue (Figley, 1995; McCann & Pearlman, 1990).

FACTORS IN THE WORK ENVIRONMENT

The work environment and the way one is seen by colleagues in the workplace is a further variable identified in resilience. The workload, perceived value of one's work by self and others, and self –concept have been related to health professionals' resilience and growth (Gibbons, Murphy, & Joseph, 2011). These factors have been found to impact upon positive growth and resilience. Other factors such as role clarity and professional role identity and professional self-esteem are also thought to influence the potential for experiencing post traumatic growth and compassion satisfaction (Gelso & Hayes, 2002). It is thought that high job satisfaction can lead to positive self-concept and growth for those who engage with traumatised service users though further research is needed to establish this connection (Gibbons et al., 2011).

WHAT HELPS/ BUFFERS OR AMELIORATES NEGATIVE IMPACTS

These factors include the health professional's ability to actively access and use social supports, deal with organizational stressors present in their workplaces, and moderate their own empathy to regulate emotional responsiveness (Badger et al, 2008).

Strategies including the use of collegial and personal support, clinical supervision and personal therapy have all been discussed in relation to what promotes worker resilience in the field of trauma recovery from a social work perspective (Pack, 2004; Badger et al, 2008).

WHAT HELPS/ BUFFERS OR AMELIORATES NEGATIVE IMPACTS

Personal insight, conceptualizing skills, empathy, self integration and anxiety management have been found to be relevant to the well-being of the practitioner who engages with trauma disclosures (Gelso & Hayes, 2007, p. 102).

Knowledge of theoretical approaches facilitate awareness, understanding and integration of the distressing countertransference responses that are evoked in the work with trauma survivors , and provides a further means of making meaning from experience for clinicians (Gelso & Hayes, 2007).

Such factors promote resilience (Gelso & Hayes, 2007) which enables the practitioner to 'bounce back' from the usual challenges of trauma related helping

FINDINGS FROM MY RESEARCH

❖In-depth interviews with 22 Trauma therapists and their significant others.

❖The counselor- participants were interviewed individually using a qualitative research design and methods.

❖Ethical approval from Victoria University was obtained before the project commenced. The data from in-depth interviews was transcribed and analysed thematically, guided by a focus group who acted as consultants throughout the project to verify and analyse emerging themes.

❖A literature review identified factors that helped and hindered the work of therapists with abuse survivors. This review framed the data analysis and the major themes from interviews

IMPORTANCE OF SOCIAL JUSTICE/ANTI-OPPRESSIVE PRACTICES

This refocusing of attention onto context was itself a product of the historical times in which Herman and the new trauma therapists were witnesses as a culture of disbelief about abuse. Therapy as a political act to challenging the disbelief about the prevalence of abuse that exists in society has provided important framing to the disclosures from survivors (Herman, 1992).

In a similar way, the counsellor-participants described responding to the disbelief they encountered within the wider community about the prevalence of sexual abuse in the New Zealand context. They conceptualised their roles as therapists as enabling survivors to regain their voice and their narratives. Within such reclaiming, there is a potential for returning to principles of social justice in approaching sexual abuse and recovery.

JILL'S STORY

'When I went to do social work training, that was a real homecoming for me and just really reading Freire was the thing, and after that I always felt that I had this touchstone in a way. Because there wasn't really even any feminist counselling material out at that time, that wasn't quite psychodynamic. But I like that idea of Freire's , about being in solidarity with people, as they changed their perception of themselves, as they began to appreciate themselves in this way, and so I always just used that and I still revert to that. And I noticed in a book that's just been published by Freire's wife, after his death, about his thinking on getting on with the oppressed, which was the first book I read, and the first one he wrote, where he was saying that, in fact, that that was 'therapy'. What he was talking about was not just liberation theory, it was therapy. And I began to think about therapy as liberation and that was what we were doing really, and that a person needed to be liberated socially in terms of their personal safety but also that your mind has to be liberated as well. And so that's how I've always thought about what I do and still think about it in this way.'

SELF-CARE STRATEGIES

❖Societal discourses – adopting a political analysis and social justice paradigm

❖Therapeutic relationship with clients paramount

❖Organizational framework Clinical supervision Critical incident stress management Debriefing Policies and practices

❖Organizational cultures- 'normalising' responses to the work

❖Relationships with colleagues, family and friends

❖Values, beliefs and ways of being, lifestyle

❖Re-authoring one's narrative when imbued by apparent failure

❖Awareness of self, culture, identity, spirituality

SIGNIFICANT OTHERS

Carolyn: So then I moved into my aggressively 'anti-male mode'. All men were bastards, and while I have modified that quite a lot, I now don't automatically feel my hackles going up when any man opens his mouth. I still retain that clear analysis that men carry so much privilege that they are not aware of. The vast majority of them have absolutely no idea that they even have it [power], let alone how to manage it. But I am able to have more compassion for the fact that they don't notice it and so I just explore what I can do that might increase their awareness of it, especially their lack of awareness that it is stuffing up their lives all the time.

SIGNIFICANT OTHERS

What changes do I see in my relationships within your social networks, including:

1 Partners, husbands, wives and lovers?

2 Friends, family members, children?

 3 Neighbours, acquaintances and work colleagues?

4 Strangers?

5 Are my professional networks becoming my personal networks?

6 What mix of personal and professional relationships do I wish to have in my life?

7 Have I the right balance of the personal and the professional?

8 Where do I need to make changes?

THE IMPACT ON THOSE AROUND US

Have you ever felt upset or threatened in any way by the work that I do with trauma survivors?

● Do you like me doing this work? Why?

● What have you noticed about me and my responses to you over the time I have been engaged as a trauma therapist?

● Has my response/attitude to you changed in any way over time? How?

● Can you give me an example of this

SEEK SUPPORT

Physical intimacy was an area that the husbands of the counsellor-participants discussed as being negatively impacted by their wives involvement in sexual abuse therapy .Not surprisingly psychotherapists' effectiveness in working with survivors of trauma is dependent on the quality of personal and professional support they access and use (Pearlman and Saakvitne, 1995).

CLOSING SUMMARY: REMEMBER YOUR ABC

A Awareness

B Balance

C Connection

(Pearlman and Saakvitne, 1995)

YOUR QUESTIONS….. AND NEXT STEPS TO DEVELOPING A SELF-CARE PLAN

What are your next steps?

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