Shared Trauma, Resiliency, and Peer Support Programs

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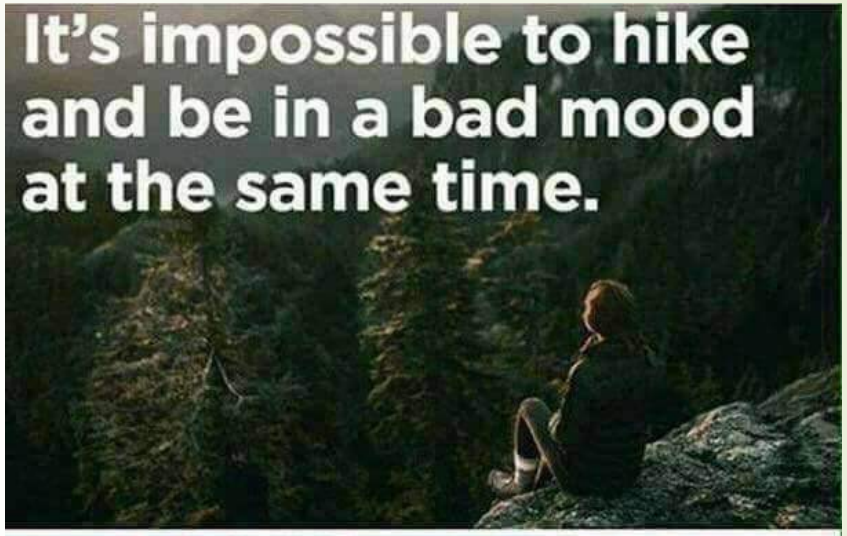
Disclaimer: The views expressed in this presentation are those of the author and do not reflect the official policy of the Department of Army, Department of Defense, or U.S. Government

LET THE JOURNEY BEGIN:

- Today I am going to invite you to come along with me on a journey.
  - Topics we are about to cover are vast (numerous books and research articles). We are going to briefly touch on these subjects.
  - Stories often resonate on a deeper emotional level.
  - Invitation to be an active rather than passive participant.
  - This presentation is going to attempt to bring to light these subjects in a meaningful way as a call to action in order to shift the very culture of our profession.
  - <u>Agenda (So What to Now What:</u>
  - Professional experiences related to Shared Trauma/Burnout.
  - Quick overview of Shared Trauma/Resiliency Dissertation.
  - Compassion/Compassion Fatigue.
  - Peer Support Programs.



PACKING LIST/GEAR:

- **Definitions**:
  - **Shared Trauma**: Concept related to the effects on clinicians when caring for clients dealing with trauma while simultaneously experiencing the same situation personally (Tosone et al., 2011).
  - **Secondary Traumatic Stress**: Witnessing/interacting with traumatized or suffering individuals, symptoms nearly identical to PTSD (anxiety + avoidance), and it is often gradual and cumulative (Gentry & Dietz, 2020).
  - **Burnout**: All the things in the environment. Cause = demanding and toxic work environment/or perception. Symptoms being anxiety transitioning to hopelessness. Cognitive and perceptual in nature (Gentry & Dietz, 2020)
  - **Compassion Fatigue (CF)**: 2 primary components = secondary traumatic stress (shared trauma) and burnout (Figley, 1995).
  - **Resiliency**: Meanings individuals place on stressful events as they attempt to understand the trauma within their overall life experience (Bartone, 2006).

- That which is to give light must endure burning-Viktor Frankl

LET'S STEP OFF…

- When was the first time I remember hearing about or experiencing shared trauma/ burnout/compassion fatigue (CF)?
  - Child welfare experience. Knew burnout/CF was there all around us, but no one dare utter the word. Some people got out quick others were in a constant smoldering state.
  - 68x experience: One of those instances where, people don't always remember what you say but they will always remember how you made them feel.
    - All stuffed into a room = jobs make us high risk for burnout but if we are resilient enough and execute good self-care, we won't catch on fire.
    - I was still young and naive = leaving the training thinking…I am a hard worker, and I won't ever let it catch me.

A HUGE LEAP FORWARD…

- Going to take a huge leap forward in my professional timeline (hold on)
  - In the blink of an eye, I am a 1LT in Afghanistan standing-up a Combat Operational Stress Control Prevention team in a new Aera of Operation. (circa 2012-2013)
  - PROFIS (professional filler system): to the 219th COSC = only one from my unit deploying/meet my new unit in Bagram Air Base, Afghanistan.
  - FOB: Only Behavioral Health Provider, no Chaplains on my FOB, living along side a Forward Surgical Team.
  - Base comprised of half U.S. and half Polish. US side had Navy, Airforce, Army, and Reserve personnel.
  - Very busy, in go mode, no time to dwell or process.
  - Feelings of, "they didn't tell me how to handle this in school." Also, a lot of trusting my clinical gut.
  - Had COSC/ Traumatic Event Management course/also conducted several TEM's

TRANSITION HOME:

- Jumped straight into out-processing
- Jumped out of airplanes
- Reintegrated with my family in a Permanent Change of Station (PCS) road trip from Kansas to Alaska.
- Not to mention now it is time to complete my doctoral dissertation

WATER BREAK/AZMITH CHECK:

- Most of us have chosen to be caregivers during the darkest times in people's lives.

- I have watched many excellent caregivers in this filed suffer greatly from symptoms of compassion fatigue. I myself am not immune to CF.

- HOWEVER,…it often **SEEMS EASIER** and sometimes rewarded to **REMAIN IN DENIAL**(or silent) about the effects of secondary traumatic stress and burnout (Gentry & Dietz, 2020)

- Perception (whether implicit or explicit) is to believe those falling around us are "weak" as we grind forward clinging to our, "I will never let it happen to me mantra" (Gentry& Dietz, 2020).

- **Gentry & Dietz (2020) proposes that there are a few "truths"** about the effects of our work.

1. No one is immune to CF.

2. If we refuse to address issues of resiliency, maturation, and self-care we may get lucky and catch on fire quickly and make necessary adjustments in our lives BUT for those less fortunate, they get the slow burn.

SHARED TRAUMA AND RESILIENCY:

- Qualitative/Phenomenological Study: The purpose of this study was to gain an in-depth understanding of the meaning military mental health providers assign to their deployment experience.
- Participant group: individuals who previously served on Active Duty, National Guard, or Reserve components and deployed for four months or more to Forward Operating Bases (FOB) in active combat zones as mental health professionals during OIF/OEF. A sample size of (N=7) individuals was selected purposefully for this study.
- Overarching Themes:

	Environmental hazards	Mission purpose	Posttraumatic growth	Shared trauma
P1	X	X	X	X
P2	X	X	X	X
P3	X	X	X	X
P4	X	X	X	X
P5	X	X	X	X
P6	X		X	X
P7	X		X	X

Miller, Tashina. Shared Trauma and Resiliency among Military Mental Health Veterans: A Heuristic Inquiry. Submitted as Doctoral Dissertation. 2015 March.

Shared Trauma and Resiliency Findings:

- RQ3: What meanings do MMHP choose to assign to their shared trauma experiences?
  - Posttraumatic Growth
  - Lessons Learned
  - Change in Belief Systems
- PTG: P7 stated, "It was the most impactful single experience I have ever had. Not just in the military but my entire life and I have traveled extensively in my life, and this is still far and away the most productive I have ever felt, the most useful I ever felt, and the most I guess more of a healer than I have ever felt before or since."
- Lessons Learned: P2 stated, "I think number one is you got to be prepared and to be honest with you I don't know if there is any way you can truly be prepared because until you are actually in the middle of dealing with all that death. I had spent 22 years preparing for that but, until you're actually in the middle of it, its indescribable."
- Changes in Belief Systems: P4 reports, "I also get angry easier when I hear people who are clueless to the military and what military men and women have sacrificed. Most civilians who are not part of the military have no idea what goes on or what kind of sacrifices are made."

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DETOUR or IS IT REALLY:

- Presentation up to this point would probably not make the cut for the Army Social Work Recruiting Video.

- Be All you can be…by becoming an Army Behavioral Health Officer. Your experience will include:
  - Meeting with people during the most vulnerable points in their lives.
  - Being the sole BH provider in a combat zone with limited peer support.
  - Not only putting yourself in harms way physically but mentally=high risk for compassion fatigue/burnout.

  - Is this still the case?? scrolling through social media I find an anonymous post stating: it is hard as a behavioral health professional to need support, I don't feel like we can ask for support in the military; instead, we must be the support for everyone else.

Compassion ??

I became a social worker/mental health provider because I wanted to _____.

The Art and Science of Medicine

Vs.

Compassion is great and a necessary component to medicine but…healthcare is a business and compassion doesn't pay the bills

**Spoiler alert: what if I could demonstrate (through research) that compassion can produce higher quality, lower cost, and a more financially sustainable healthcare delivery platform.

You are not alone:

- Burnout rates and compassion fatigue among healthcare professionals is a known issue. So well known in fact there are:
  - Journal articles/media
  - Pop culture satire (videos and memes)

***Research has identified three hallmarks of burnout: emotional exhaustion, a lack of personal accomplishment, and depersonalization.**

Compassionomics

- ***Compassionomics: the scientific evidence that caring makes a difference***. The data and assertions which follow were complied using a systematic review: More than 1,000 scientific abstracts were examined and reviewed as well as more than 250 research papers.
- People in healthcare have always understood that treating patient with compassion is the right thing to do as a moral imperative; however, few health care providers realize the extent to which compassion matters.
- Once you understand the data. You will realize that your compassion can be more powerful than you have ever known. When you come to realize the power of your compassion, you will want to use it every opportunity you have.

Trzeciak, Stephen, & Mazzarelli, Anthony (2019). Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference. Pensacola, Florida: Studer Group.

Hypotheses:

- There are three interrelated hypotheses that compassion matters:

1. For patients (through better patient outcomes).
2. For patients through higher quality, lower costs, and better financial sustainability for healthcare settings.
3. For those who care for patients by promoting the resilience of healthcare providers and staff as well as lowering burnout.

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How Compassion Works

- Literature review found there are four main areas of patient outcomes which are affected by compassion to include: physiological effects, psychological effects, enhanced patient self-care, and increased quality of care.
- When providers have compassion for a patient, they are more likely to be meticulous about their care and therefore less likely to make a major medical error.
- Physiological effects: compassion can buffer stress-related disease and modulate a patient's perception of pain.
- Psychologically: compassion for patients can motive patients to better self-care.

****Compassion is not a substitute for quality clinical care: clinical excellence and compassion-when used in combination-deliver the best outcomes.**

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The Power of 40 seconds:

- A 2018 study from the Mayo Clinic now clocks the time to first interruption, by the provider, at 11 seconds. These researchers have found patients only need, on average, 29 seconds to state their main concern.

- Researchers found that **56% of physicians believe they do not have time to treat patients with compassion**.

- **40 seconds of compassion is all you need to make meaningful difference for a patient.** Study found that enhanced compassion interventions included the following from the physician:
  - **We will be with you all the way.**
  - **We will do, and continue to do, our very best for you.**
  - **Whatever happens, we will never abandon you. You are not facing this alone.**

- "People don't care how much you know until they know how much you care." –Theodore Roosevelt

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Compassion is Vital for Health Care Quality:

- Making a personal connection is critical as lack of compassion is a threat to patient safety.
  - **Depersonalization and lack of compassion can predispose health care providers to giving suboptimal care**.
  - In 2009, researchers from the **Mayo Clinic published a longitudinal study** in which they examined 380 internal medicine resident physicians and tested the association between their scores for depersonalization and emotional exhaustion and the incidence or major medical errors committed by the physicians. This exploration found: physicians who scored high for depersonalization were significantly more likely to commit a major medical error in the next three months. **The data indicated 45% higher odds of a major medical error in the next three months for physicians scoring in the highest tier of depersonalization**.

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Compassion Drives Revenue and Cuts Cost:

- **Expense growth is outpacing revenue growth for most American health systems.**
  - When it comes to cost, the health care industry is teetering dangerously at the edge of a precipice. You might even call it a tipping point. **Medicare is expected to grow in spending 7.4% each year until 2026.**
  - **Patient experience drives business. Hospitals that are rated highly on their patient experience scores are also higher performing hospitals financially**. A Deloitte study showed that **hospitals rated by patients as "excellent"** on the survey **earned** (average net patient revenue, per adjusted patient day) **127% of what hospitals that were rated as "low" earned.**
  - **Additionally, hospitals with higher reported patient experiences are more profitable (revenue exceeds their costs by a higher amount). Hospitals rated as "excellent" outperformed low performers with a margin of 4.7%, on average, compared to just 1.8%.**

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Medical Errors:

- According to a 2010 study sponsored by the Society for Actuaries, **medical errors cost the U.S. $19.5 billion dollars annually, with $17 billion due to avoidable medical costs attributable to the errors.**
- As mentioned before, **compassionate care means more meticulous** care for better clinical outcomes. **If an increase in compassionate care could reduce medical errors in such a way that recaptures even a small fraction of that lost revenue, it would be an enormous benefit.**
- **Patients who do not feel a strong personal connection with their physician receive more referrals to specialists and undergo more diagnostic test.**

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Compassion as an Antidote to Burnout:

- 70% of people experience a feel-good sensation when giving meaningful help to others in need.
- Compassion for others can overcome the distress associated with seeing other people in distress.
- It appears that when health care providers are under the most stress, that compassion is needed the most for their own well-being.
- **Finally, if we don't feel the need to address burnout/compassion fatigue for our own benefit AT LEAST look at it as a necessary component in offering clinically sound treatment to our clients.**

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Final Leap: Hang in There

Peer-to-Peer Support Interventions for Healthcare Providers: A Series of Literature Reviews

- In 2012: WH Executive Order to address Military MH Challenges with 3 goals: 1. Reducing barriers to MH care, 2. Enhancing access for SM, and 3. Support Research for effective treatment.
- Achievement of these goals requires high-functioning healthcare providers who can respond to the MH needs of their patients (Crandell et al., 2022).
- RAND project focused on the evidence for peer-to-peer interventions for healthcare providers.
- Providing appropriate MH support to providers has been challenging = limited MH specialist, issues of privacy and sigma, and the need to address systemic issues that influence provider distress and burnout/CF (Crandell et al., 2022).
- Limited research has been conducted regarding peer-to-peer support for healthcare providers (Crandell et al., 2022).

Peer Support:

- Literature review mentioned several different programs to include Balint groups and Support Net program.
- Balint groups been around since 1950's: focus of the group is on ameliorating provider stress related to current cases.
- Support Net Program: designed to provide peer support to military providers. Peer assisted coach = someone provider can talk through challenges with.
- Summary notes: Many studies investigated interventions that provided psychological fist aid AFTER adverse incidences.
- Practitioners and policy makers should determine the importance of preventative care related to healthcare provider burnout/CF

Crandall, C.J., Danz, M., Dung, H.T., Baxi, S.M., Rubenstien, L.V., Thomposn, G., Al-Ibrahim, H., Larkin, J., Motala, A., Akinniranye, G., Susanne, H. (2022). Peer-to-Peer Support Interventions for Health Care Providers: A series of Literature Reviews. RAND Corporation: California.

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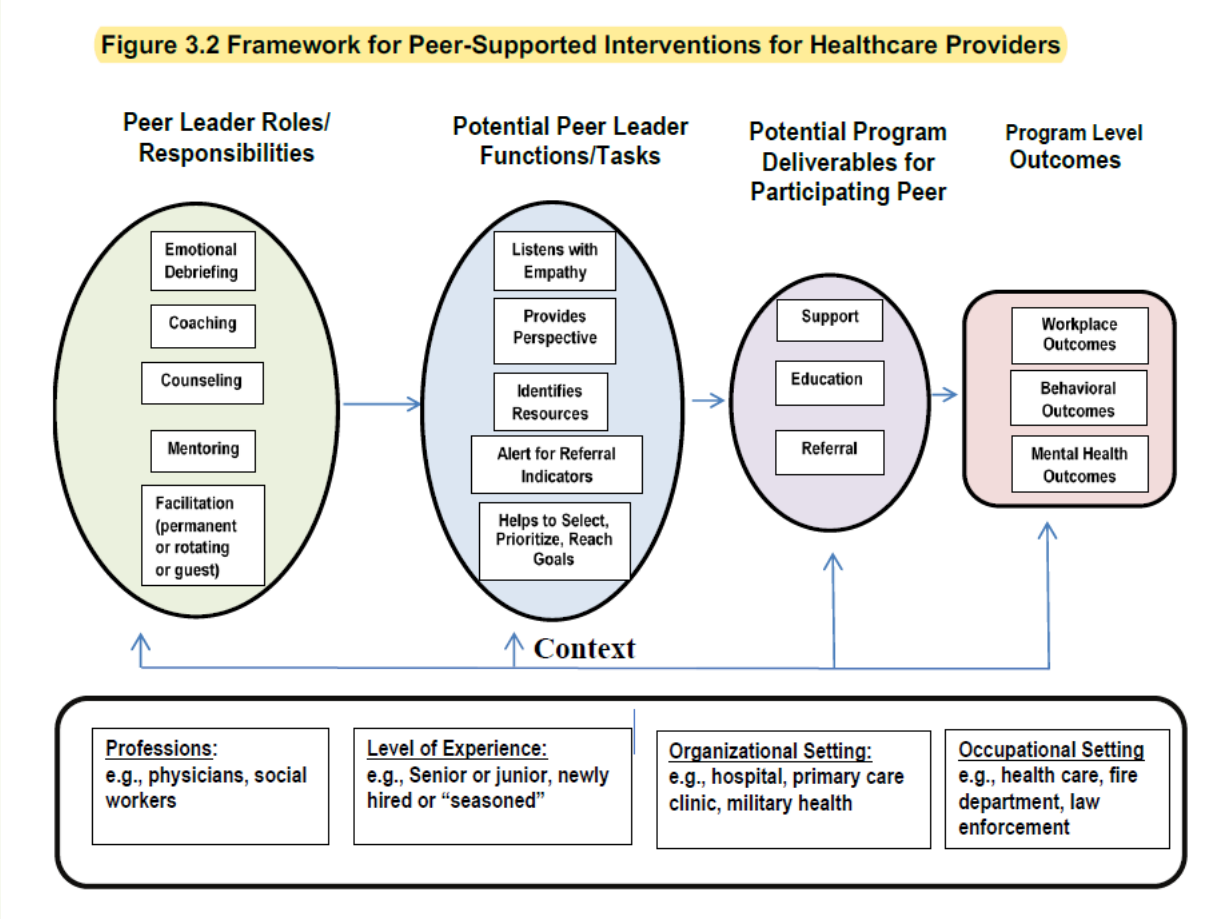

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Summary:

- This presentation is not meant to be an indictement rather a call to action, for all of us. It is not IF but WHEN we will experience compassion fatigue.

- With the current world climate dictating the need for MMHP to continue to be placed in austere environments; the military as an organization must take the lead in ensuring MMHP are adequately equipped for the personal and professional strains of shared trauma/CF and cared for to prevent burnout.

- As agents of social change, leaders within the mental health disciplines must find ways to develop cultural norms which foster the inherent right and need for those in the role of caretaker to employ peer support and self-care techniques.

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