VIII. Caring for the Clinicians Who Care for Traumatically Injured Patients

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The experiences of physically injured patients impact their surgeons, other physicians, therapists, nursing staff, and administrators. The intensity of caring for these patients may contribute to the treatment team's own stress and burnout. Enhancing the clinicians' understanding of how their feelings and perceptions contribute to their responses to trauma patients can decrease the amount of stress and burnout experienced by both clinician and patients. Clinicians' responses to their patients are often dependent upon the formers' experiences and coping styles.

Vicarious Traumatization

McCann and Pearlman (1990) acknowledged that clinicians who work with trauma victims may experience vicarious traumatization. Vicarious or secondary trauma is a countertransference reaction experienced by the clinician as a result of the victim's retelling of the trauma (Benedek, 1984). Clinicians working with trauma victims often experience a myriad of countertransferential feelings. Clinicians' responses to the trauma endured by their patients may affect therapeutic alliances and ultimately the effectiveness of the clinicians (Fischman, 1991; Lyon, 1993).

Clinicians may be affected by painful or disruptive psychological sequelae in the months or even years following their work with trauma victims. The affective reactions of therapists who worked with Holocaust survivors and their children included bystander's guilt, rage, grief and mourning, dread, horror, and inability to contain intense emotions (Danieli, 1984). Clinicians working with patients who have suffered the extreme trauma of torture may be more vulnerable to intense affective reactions themselves (Fischman, 1984; Fischman & Ross, 1990).

Riba and Reches (2002) conducted a study to understand experiences of nurses caring for victims of trauma. Nurse described being anxious and afraid of what they were going to see. Fears about not being able to perform their job or function properly were reported more often by younger nurses. Nurses described feelings of frustration and guilt, especially if their patient died. Nurses experienced restlessness, sleeplessness, and nightmares following the care of trauma patients.

In another study, nurses working with victims of a bombing reported sadness, grief, depression, anxiety, dread and horror, fear, rage, and shame (Collins, 2001). Nurses also reported difficulties initiating or maintaining sleep, problems with irritability/outbursts of anger, and difficulty concentrating. Interestingly, not only psychological symptoms evolve; nurses involved with trauma patients may present with somatic complaints such as persistent headaches, backache, and gastrointestinal distress (Collins, 2001; Lyon, 1993). In summary, trauma nurses may experience vicarious traumatization leading to such symptoms as depression and suicidal tendencies, panic attacks, and alcohol abuse. Others experienced post-traumatic stress disorder (Collins, 2001).

Alexander (1990) similarly suggested that other hospital staff working with trauma or disaster victims might become hidden victims (e.g., dietary, OT, PT, etc.). All of these reports emphasize that hospital administration must recognize the stress placed on the hospital staff who closely work with these victims and must also provide needed interventions and support to them.

Burnout

Taking care of trauma patients for long periods can take a toll on the staff, resulting in "burnout." Solite and Solite (2003) define burnout as "a state of physical, emotional, and mental exhaustion that results from intense involvement with people over long periods of time." Symptoms of burnout include feeling strained by having to work with people, increasing difficulty sustaining concentration and attention levels throughout prolonged periods of work, decreasing memory for work-related details, and reacting to challenges with increasing cognitive rigidity rather than with cognitive flexibility.

Among physicians, surgeons may be at the greatest risk of burnout. In a recent study (Michigan Medicine, 2002) graduates of the University of Michigan surgical residency programs were asked to rate their level of burnout. One third of the respondents reported "emotional exhaustion" indicating that they "had nothing left to give" and one sixth reported "depersonalization," meaning they distanced themselves from the experience of taking care of patients. Nursing staff is a group that interacts with trauma patients around the clock and may be more vulnerable than other clinician groups.

Strategies for Addressing Vicarious Traumatization at Burnout

The Walter Reed Army Medical Center (WRAMC) Psychiatry Consultation Liaison Service (PCLS) focuses on the following methods for preventing burnout:

- managing relationships
- maintaining collaboration and collegiality at work and intimate connections at home
- making regular adjustments in one's lifestyle
- living in harmony with ones innermost values
- managing one's attitude
- developing philosophies that foster hope and reasonable optimism about one's future.

A mental health consultant can facilitate the use of these methods. Tips for managing stress that can be shared with clinical staff include ensuring one's own safety, accepting support when offered, and making phone calls to speak with helpful family members or friends. These methods allow clinicians to distance themselves from the day-to-day emotionally taxing tasks of caring for trauma patients. Clinical staff should also be instructed to take time to seek enjoyment from outside activities; use deep breathing techniques, muscle contraction or other effective relaxation techniques; make good use of humor; avoid becoming absorbed in negative news; and use support services as available. Clinicians may also benefit by taking the opportunity to become more knowledgeable about other non-trauma care-related subjects, remembering to employ other previously successful coping styles, watching for signs of depression or anxiety in themselves and co-workers, and contacting local mental health resources for additional options, when necessary.

WRAMC PCLS has developed ongoing programs to provide support to the hospital staff. Attendance at nursing morning reports and shift changes has allowed PCLS staff members to provide encouragement and education to the nursing staff. Support groups or venting sessions worked initially in the beginning of Operation Iraqi Freedom. As nurses became more clinically proficient and gained mastery, plans and protocols to take care of injured soldiers were developed

and with that came greater mastery to meet this clinical challenge. As time passed fewer nurses attended these support sessions, suggesting greater self-sufficiency and confidence.

Another perceived helpful recommendation to the nursing staff was to suggest that they leave their assigned clinical environments to see the progress patients were making further into recovery. Nurses were encouraged to visit during patient physical therapy (learning to walk with a prosthetic limb) or occupational therapy (shaving for the first time with a prosthetic arm) sessions. These visits permitted the nursing staff (especially operating room and intensive care units nurses) to see that patients were getting better and more capable despite the staff's initial less hopeful perceptions. Other staff members would likely benefit from a similar approach.

The recent influx of critically injured young men and women with amputations from Iraq has posed a new and unusual challenge to the medical treatment teams. The staff has had to rapidly assimilate new knowledge in providing clinical treatment to this population, as well as appreciate and deal with the emotional impact of the loss of a limb on a service member. The patient or his/her family member often go through stages of grieving that can understandably result in anger or resentment regarding the injury. Not infrequently, staff members bear the brunt of this ill feeling. Often, discussion of the dynamics of patient and family member's responses can be extremely helpful to members of the treatment team in order to put unpleasant interactions into perspective and maintain an empathic stance toward the patient.

Frequently, patients, family members, or staff members benefit from a discussion of their emotional responses to the traumatic event or the resulting treatments. This might occur in either individual or small group settings. As embedded members of the trauma team, PCLS clinicians facilitate patient and staff acceptance of interventions without the fear their responses or "symptoms" are going to be labeled as pathological. Offerings of support, encouragement and normalization of response are necessary and experienced as helpful. Encouragement of appropriate laughter, use of relaxation techniques for staff and patients alike, building of esprit de corps, and the opportunity to share food all help. Most important is communicating respect and genuine concern for each other.

Physicians, particularly surgeons, work extended hours**.** Their unique burden is best exemplified in the words of one WRAMC physician: "How difficult it was for me when I needed to cut off the legs of that young boy." Psychiatrists and other mental health clinicians work side-by-side with the surgeons as part of the trauma team. Similar to nursing, physician staff support groups were established at the onset of the Operation Iraqi Freedom. These groups were usually scheduled prior to their respective clinical rounds. Psychoeducational approaches have also been useful. PCLS members have presented at surgical department Grand Rounds or staff forums on topics related to stress, burnout and the management of difficult patients. By encouraging availability through informal curb siding, frequent phone calls and spontaneous as-needed appointments has improved perceived availability and interest on the part of PCLS staff members. Of course, e-mail similarly supports such communication and also has the benefit of making additional resources quickly available to hospital staff through attached document files or hyperlinks to useful websites.

Conclusions

Hospital clinicians treating trauma patients are at risk for emotional reactions that, if left unattended, can lead to psychological stress, burnout, and reduction in clinical efficiency and effectiveness. The Walter Reed PCLS service recommends a combination of approaches that serve

to develop and sustain liaison relationships with all members of the treatment team. Techniques include attending to the emotional responses of patients and staff members through attentive but nonjudgmental listening. This may be accomplished in an individual or group format. Psychoeducational approaches can provide information about self-care, stress reduction, and burnout recognition in oneself and others. Finally, helping staff members gain perspective regarding their participation in the therapeutic process can be extremely helpful. To observe a seriously injured patient advance to use a prosthetic device and reestablish preexisting function can provide a clinician with a rejuvenated sense of purpose and meaning.

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