

Trauma, Stress & Burnout Stewardship in the Mental Health Workforce

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Overview

- ▶ Emotional Labor
- ▶ Burnout/Exhaustion
- ▶ Vicarious Trauma Exposure
- ▶ Direct Trauma Exposure
- ▶ Moral Injury
- ▶ Betrayal Trauma

Emotional Labor

- ▶ Providing social and mental health services requires emotional labor
- ▶ Requires providers take a particular social & emotional stance with clients
- ▶ Literally adopt a certain physical posture, facial expressions and verbal tone
- ▶ In most social services this includes the provider intellectually and emotionally experience the world through the clients subjectivity - empathy
- ▶ Supervisees need a space to process, make sense and develop coping strategies for the work



Burnout

Pavlov - Transmarginal Inhibition

1. **equivalent phase:** when the response matches the stimuli, which is considered the normal baseline behavior.
 2. **paradoxical phase:** associated with quantity reversal, occurs when small stimuli receive major responses and major stimuli elicit small responses.
 3. **ultra-paradoxical:** the final stage, associated with quality reversal in which negative stimulation results in positive responses and vice versa
- ▶ Role of biologically-based temperament
 - ▶ Dramatic behavioral changes can occur in the face of chronic unanticipated, uncontrollable and ambiguous stimuli

Burnout

A response to recurring, chronic stress in the workplace

**Emotional
Exhaustion**

Depersonalization

**Reduced Personal
Accomplishment**



Burnout: Four Stages (James, 2013)

Stage	Description
Enthusiasm	High enthusiasm & high expectations for job and self “Rose-tinted” view
Stagnation	Needs aren’t being met Insufficient support or reinforcement at work Unanticipated stress or building pressure
Frustration	Questioning the impact of your work & values of your institution Feeling helpless/hopeless
Apathy	Chronic indifference to situation Lack of motivation to seek help “Why bother?”

Fatigue & Exhaustion

- ▶ Kirstensen et al. (2005)
 - ▶ Fatigue and exhaustion were the core features of burnout
 - ▶ Depersonalization and cynicism are coping attempts for the exhaustion
 - ▶ Decreased personal accomplishment is the consequence of this process
- ▶ Demerouti & Bakker (2007)
 - ▶ Two core dimensions
 - ▶ Affective, physical and cognitive exhaustion
 - ▶ Disengagement from work

What Causes Burnout?

Having little control
in your organization

Impatience

Lack of support from
supervisors/coworkers

Being
Overworked

Perfectionism
(internal/external)

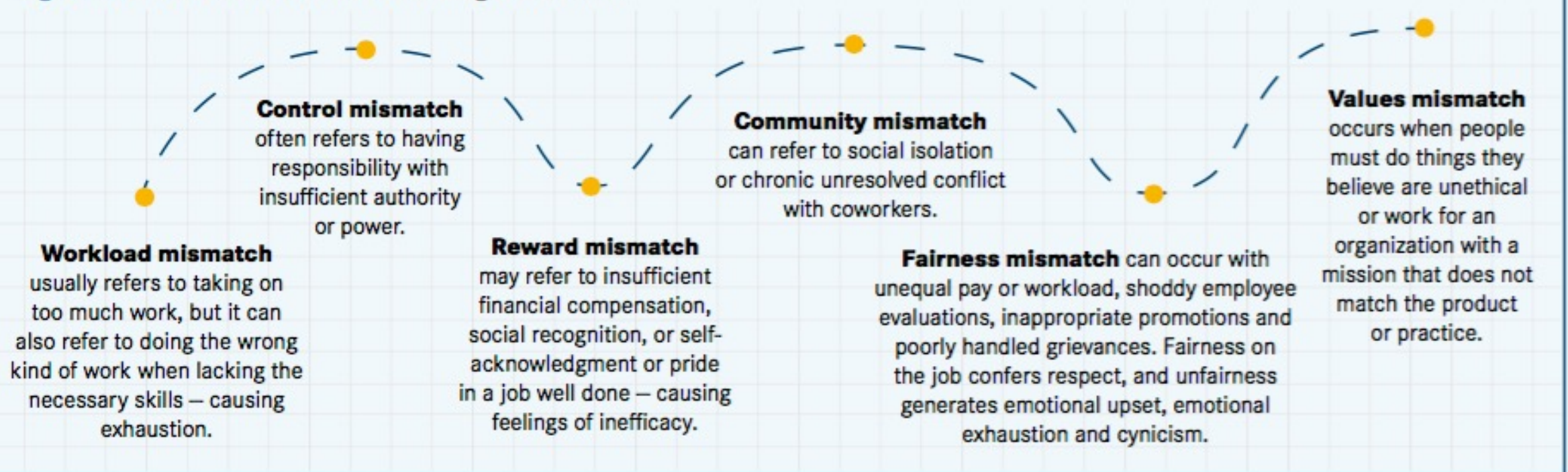
Feeling
underappreciated

Lack of
awareness of
your own
reactions to
trauma



What Causes Burnout?

Figure 1. Burnout Mismatches According to Maslach⁷



Impact of Burnout

- ▶ **Physical symptoms**
 - ▶ Fatigue, sleep difficulties, gastrointestinal disturbances, colds
- ▶ **Emotional symptoms**
 - ▶ Irritability, anxiety, depression, guilt, pessimism
- ▶ **Behavioral symptoms**
 - ▶ Aggression, substance abuse
- ▶ **Work-related symptoms**
 - ▶ Resigning from work, poor work, absenteeism, tardiness, misuse of work breaks
- ▶ **Interpersonal symptoms**
 - ▶ Difficulty concentrating, withdrawal, callousness





Impact of Burnout

- ▶ Impact of occupational burnout in the health care workforce
 - ▶ Bourne et al. (2019) - “defensive practice”
 - ▶ Avoidant coping strategy, substandard practice in response to criticism and which poses risks to the client
- ▶ Undermine professional standards and productivity declines

Burnout's antithesis?

- ▶ Work engagement
 - ▶ Consistent positive affective-motivational state of contentment which includes three components
 - ▶ Vigor
 - ▶ Dedication
 - ▶ Absorption
- ▶ Maslach & Leiter - work engagement is the opposite of burnout
- ▶ Alternatively, work engagement is simply a distinct separate state of affairs

Burnout's antithesis?

- ▶ Meta-analyses show that engagement is distinct from job satisfaction, organizational commitment and job involvement
- ▶ What drives work engagement?
 - ▶ Job resources - social support from co-workers and supervisors, transparent performance feedback, coaching, control and autonomy over job tasks
 - ▶ Personal resources - optimism, self-efficacy, resilience, extraversion, low neuroticism
- ▶ Work engagement is related to better performance reviews
- ▶ At extremes does work engagement equate to workaholism?

Burnout in Mental Health Professionals

- ▶ O'Connor, Neff & Pitman (2018) - meta-analysis
 - ▶ Average MHP has a “high” level of emotional exhaustion, a “moderate” level of depersonalization, and a “high” level of personal accomplishment
 - ▶ Overall, 40% of MHPs suffer from clinical levels of burnout
 - ▶ Age increases risk for depersonalization but also for high personal accomplishment
 - ▶ Higher workload predicts higher burnout
 - ▶ Sense of autonomy and perceived capacity to influence decisions at work predicted lower burnout
 - ▶ Lowest autonomy in general adult in-patient, but higher among those working in community-based teams and specialty teams.

Burnout in Mental Health Professionals

- ▶ O'Connor, Neff & Pitman (2018) - meta-analysis
 - ▶ Workplace relationships characterized by role conflict, role ambiguity and conflict increases risk for burnout
 - ▶ Those receiving clinical supervision, who believe they are treated fairly have lower levels of burnout.
- ▶ Yang & Hayes (2020)
 - ▶ Client factors
 - ▶ Personality variables
 - ▶ Specific psychological disorders
 - ▶ Work settings
 - ▶ independent practice have lower burnout

Burnout in Mental Health Professionals

- ▶ Yang & Hayes (2020)
 - ▶ Client factors
 - ▶ Personality variables
 - ▶ Specific psychological disorders
 - ▶ Work settings
 - ▶ independent practice have lower burnout
 - ▶ Steel argues that “healing involvement” (feeling a state of “flow” and strong client engagement during psychotherapy linked to feeling accomplished and lower burnout). Supervision that increases client engagement can reduce burnout.
 - ▶ Workload
 - ▶ Less than 35 hours per week of work = less cynicism and exhaustion

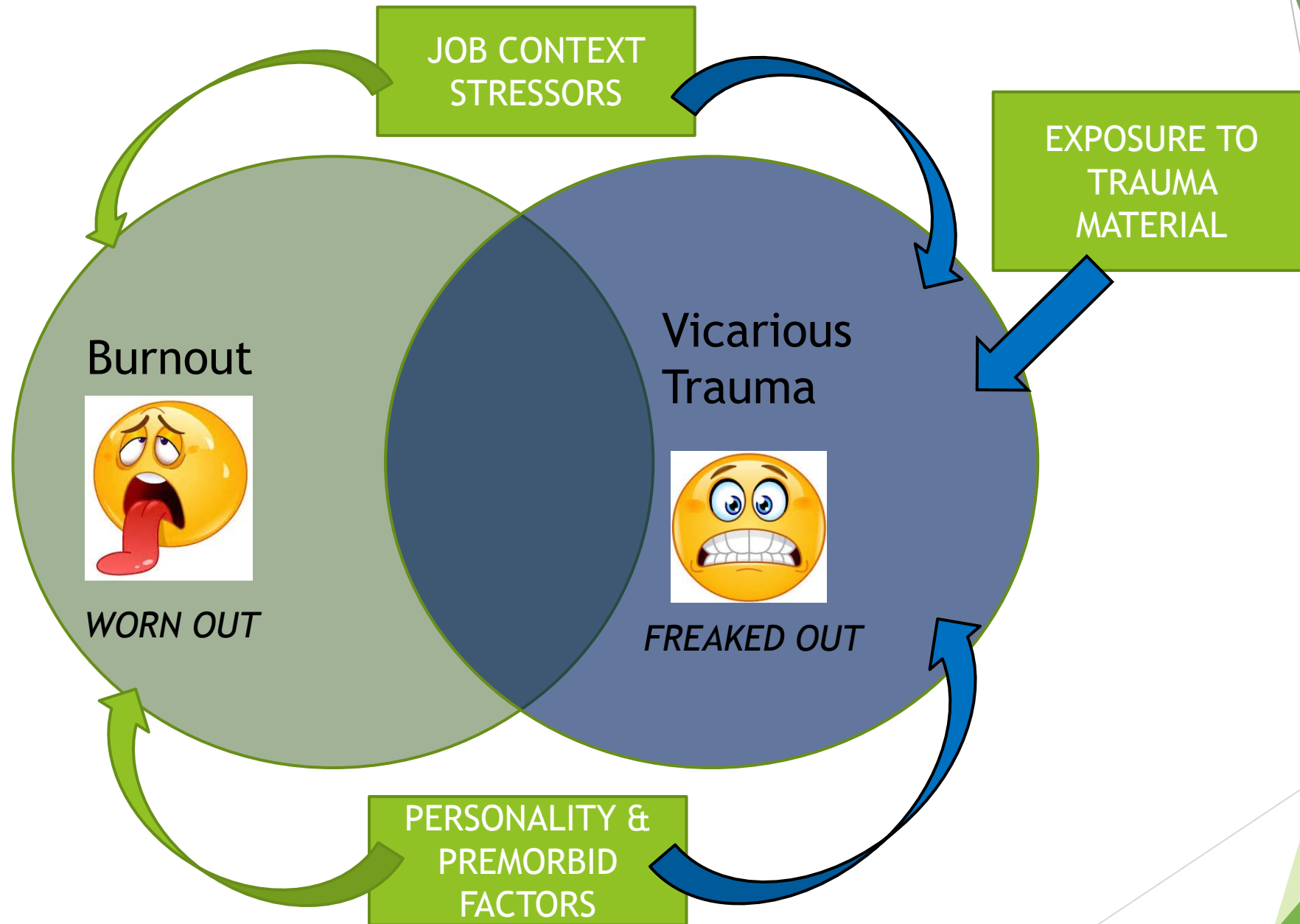
Burnout in Mental Health Professionals

- ▶ Yang & Hayes (2020)
 - ▶ Psychotherapist factors
 - ▶ Trauma history
 - ▶ White therapists have higher burnout, likely due to lower use of social support
 - ▶ Countertransference - particularly with clients with serious psychological disorders seen over longer period of time
 - ▶ Self-efficacy
 - ▶ Mindfulness
 - ▶ Coping strategies
 - ▶ Age - found a more complicated relationship

Burnout in Mental Health Professionals

- ▶ Yang & Hayes (2020)
 - ▶ Education level - Some evidence that people with higher degrees have more burnout - may be due to more complicated case loads
 - ▶ Parental status - therapists with children have lower burnout

Vicarious Trauma

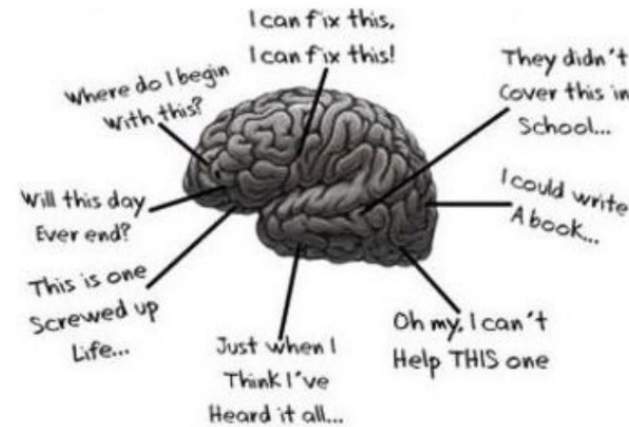


Vicarious Traumatization

- ▶ Somewhat unique to mental health professions due to exposure to client trauma materials
- ▶ VT is more severe than general effects of emotional labor alone and occurs in cases where the client shares trauma experiences with the provider
- ▶ The provider's empathic resonance with the client's stress is a key ingredient
- ▶ VT can result in fundamental changes to provider's professional and personal schemas - **schema alteration**

Vicarious Traumatization

- ▶ “transformation in the inner experience of the provider that comes about as a result of empathic engagement with the clients’ trauma material” (Saakvitne, 2002, pg. 31)
- ▶ May be similar to symptoms of PTSD, with extreme fear, withdrawal, and disturbed feelings of security (Pross, 2006)
 - ▶ Schema alteration (Dill



Moral Injury

Moral Injury

- ▶ A type of “identity wound”
- ▶ Objection to referring to provider exhaustion and cynicism of professionals as “burnout”, increasingly vicarious trauma and even moral injury are cited as better descriptors.
 - ▶ Type of victim-blaming
- ▶ Wendy Dean & Simon Talbot addressing phenomenon of physician burnout reframe this as moral injury
 - ▶ Providers have a set of moral values
 - ▶ Forced to either commit/support or bear witness to acts that violate their values
 - ▶ The cost of serving in a service profession such as law enforcement, healthcare, social services etc., is the cost of our integrity
 - ▶ The cost manifests as what they term moral injury.

Moral Injury

- ▶ When you are required to sacrifice your values for the sake of some other organizational priority or some external social pressure, we experience cognitive dissonance.
 - ▶ When that dissonance is chronic it morphs into chronic stress and negative emotion
- ▶ Provider is now in a chronic state of dissonance about their work and has two choices then?
 1. They reject the stifling realities of the industry and adhere to their own values
 2. They modify and abandon their values
 - ▶ Both choices leave the individual in a chronic dissonance/stress state

Moral Injury

- ▶ This long-term process of progressively adapting to the stifling demands of the system leads eventually to exhaustion, disillusionment and reduced effort.
- ▶ The provider, to protect their emotional well being, may distance from those they serve.
- ▶ A different take than burnout, which is a term that suggests the burden is on the professional primarily, moral injury highlights the ways that organizational systems and practices put professions in a chronic sequence of lose-lose situations.

Individual Strategies

Active Coping



Decompress & Recharge

- ☐ Recreation
- ☐ Physical Activity
- ☐ Sleep
- ☐ Eat well



Get help

- ☐ Family/friends
- ☐ Peer support
- ☐ Therapy
- ☐ Spiritual counseling



Shift Your Perspective

- ☐ Reframe success
- ☐ Remember & talk about the good



Connect to What's Important

- ☐ Family
- ☐ Spirituality
- ☐ Greater Purpose
- ☐ Meaningful activities

Active Coping

- ❑ Physical health benefits
 - ❑ Fewer illnesses, better sleep, fewer infections
- ❑ Sense of satisfaction and competence with work
 - ❑ Less missed work
- ❑ Feeling fulfilled in life
- ❑ Healthy relationships at work and at home



Thinking Forward

- ❑ We can't control everything that is happening
- ❑ We can't change what *has* happened
- ❑ How can we hold on to hope despite this?
 - ❑ Maintaining integrity - accepting the situation and committing to act in accordance with our values
 - ❑ Remembering and sharing the good stories
 - ❑ Redefining success



Peer Support

Peer Support as an Active Strategy

“Offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations”

“A system of giving and receiving”

Source: SAMHSA Core Competencies

Principles of Peer Support

- ❑ **Person-Centered**

- ❑ Personalized
- ❑ Specific hopes, goals, and needs

- ❑ **Voluntary**

- ❑ Never forced

- ❑ **Relationship-Focused**

- ❑ Trusting, empathetic, collaborative

- ❑ **Trauma-Informed**

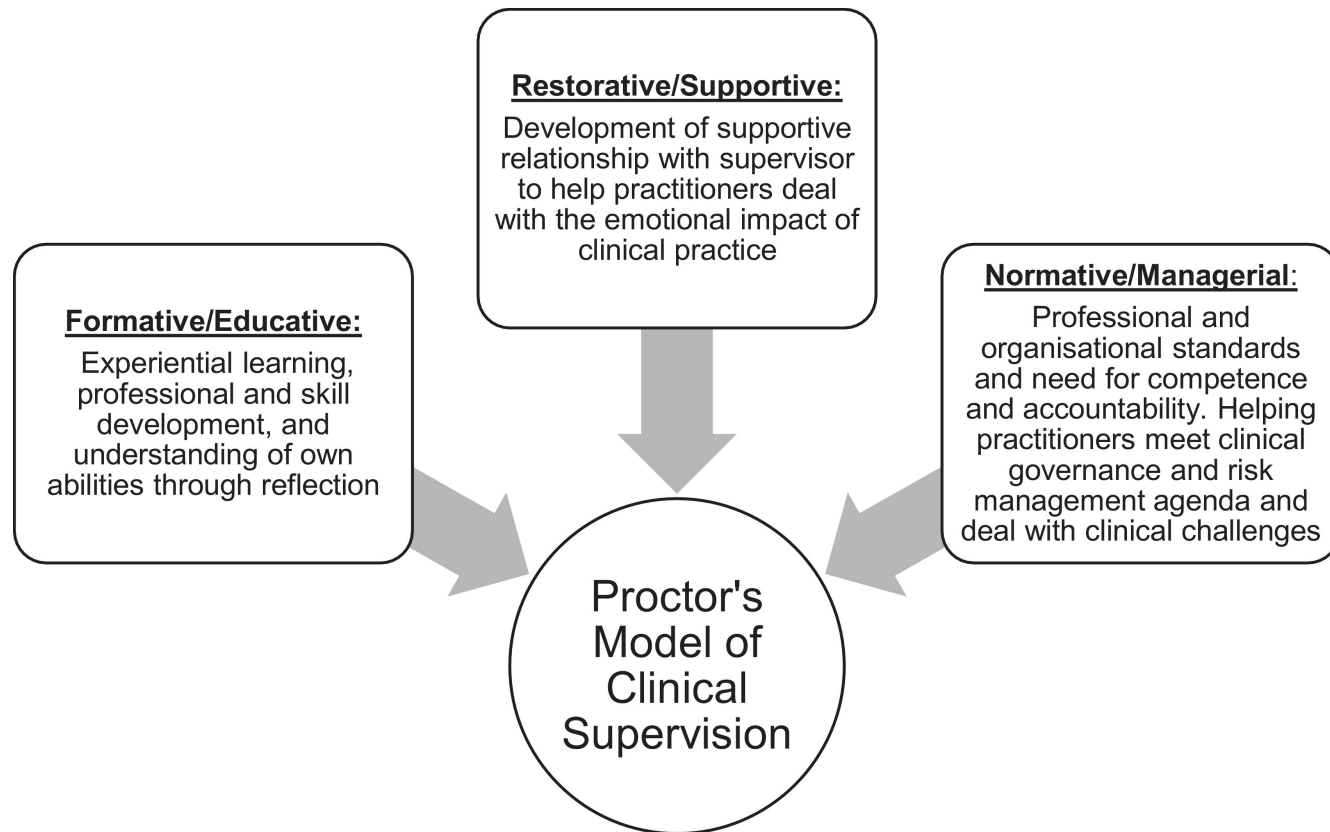
- ❑ Strengths-based framework
- ❑ Physical, psychological, and emotional safety

- ❑ **Recovery-Oriented**

- ❑ Meaningful and purposeful life
- ❑ Hope through partnership

Supportive/Restorative Supervision & Leadership

Three functions of supervision



Supportive & Restorative Supervision

- ▶ Human services & mental health work is emotional labor
- ▶ Risk of burnout and vicarious stress
- ▶ Double burden to provider and to impact on client services
- ▶ High rates of burnout and chronic stress in health services (at least 1/3 across most research)



Supportive & Restorative Supervision

- ▶ Supervision practice has a significant role to play in reducing burnout and vicarious trauma
- ▶ Supervision needs to be viewed through a systemic and organizational lens to successfully reduce these problems

Target Levels of Supportive Supervision

► The supervisee

- The coping repertoire of the supervisee
- In turn, this theoretically increases morale, motivation and professional development

► The organization

- Change agent role of the supervisor in seeking to improve the workplace system that sits outside of their formal supervisory relationship
- Want to avoid inadvertently encouraging the supervisee to accept and adapt to unjust, unhealthy and toxic workplace conditions
- We are not just sheltering the supervisee from the vagaries of the organization, ultimately goal is change agent advocacy

Trauma Informed Organizations

Trauma Informed Care

- ▶ An organizational culture shift
- ▶ Avoid retraumatizing those we serve and those who serve
- ▶ Parallel Process - avoid retraumatizing that who serve
- ▶ Examining a health or social service organization's service delivery, management strategies, unique worker stressors and making changes to create a culture of health, safety and wellness for leadership, workers and recipients

Organizational/Structural Role

- ▶ Provider's relationships with their supervisors have implications for the extent to which they perceive that the organization is fair and just (Knudsen, Ducharme, and Roman, 2008)
- ▶ Agencies
 - ▶ Reduce or balance caseloads
 - ▶ Offer additional supervision/personal therapy for mental health professionals and supervisors
 - ▶ Encourage self-care, like vacation and sick leave

Trauma-Informed Staff Development

- ▶ The employee's need for professionalization
- ▶ The employee's need for formative and summative evaluation with collaborative professional development goals
- ▶ The need for staff to have social support and recognition
- ▶ The importance of having a culture of self-care and training

Parallel Process in Systems



Parallel Process in Systems



The Trauma Organized System

- ❖ Lack of clear, consistent, comprehensive, & coherent theoretical model for delivering services that can be shared by staff, clients, and families
- ❖ Lack of safety (psychological, emotional, physical, social)
- ❖ Communication failures and broken feedback loops between and among component parts of the system
- ❖ Conflicts between various levels of staff as to what defines services

The Trauma Organized System

- ◆ Hierarchical management structures that encourage obedience to authority but do not encourage initiative, innovative problem solving, or direct conflict resolution
- ◆ Relative inability to sufficiently address the enormity, frequency, & complexity of trauma-based problems in people's lives
- ◆ Only partially effective methods for dealing with critical incidents, usually methods that leave staff with potential moral injury experiences
- ◆ Unclear about what constitutes success in these programs.

Resilience in Organizations

- ◆ Culture that values self-care, including a written policy that is widely disseminated
- ◆ Participation in peer and supervisory support
- ◆ Retreats, staff appreciation events/activities
- ◆ Provision for staff education based on staff choice
- ◆ Empower staff to create committees for quality of life at work
- ◆ Guarantee a sustainable workload
- ◆ Guarantee supervision and monitoring
- ◆ Periodic evaluation of system, organization

Post Crisis

- ▶ Risk of symptoms worsening after a major professional crisis has ended, pandemic offers example of this.
- ▶ Mental health care workers professional identity
 - ▶ Selfless
 - ▶ Procedural
 - ▶ Emotional Labor
 - ▶ Social values
- ▶ Crisis provides a huge “supply” of remoralizing experiences
 - ▶ Post-crisis can be an abrupt removal of this
- ▶ How can orgs notice and reinforce “everyday professionalism” to combat this let down?

Post Crisis

- ▶ Emphasize everyday professionalism
 - ▶ Use of outcome data - regular points of contact for workers to hear and see the impact their work is having during and outside of crisis periods
 - ▶ Combat tendency for extravagant acts of martyrdom to become the standard of practice
- ▶ Give the crisis it's due - debriefing and processing opportunities
 - ▶ Intentional and deliberate scheduling
 - ▶ Leadership needs to actively listen and lead by example
 - ▶ Ritualized and formal acknowledgement of sacrifices made during the crisis