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Caring for Caregivers Experiencing Secondary Trauma: A Call to Action

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Abstract

Secondary traumatic stress (STS) is the emotional duress caused by indirect exposure to distressing events experienced by others. Health care providers are particularly susceptible to secondary stress due to regular exposure to difficult and painful clinical situations that evoke intrinsic empathy necessary to provide effective care. Understanding STS as a normal stress response not only helps to make sense of the symptoms but also suggests a way forward. Opportunities for those in health care to address STS can be found among our colleagues and in our own settings and may provide a meaningful source of support if accessed effectively.

Keywords

secondary traumatic stress, burnout, trauma informed care

"Can you help in Room 45?" the nurse summoned as she rushed by. Room 45 is where "sibling sets" are often placed when they come to our medical evaluation program for children in foster care. There, Brian, Kevan, and Jay awaited medical clearance. The alcohol-induced pancreatitis that had sent their mother to the intensive care unit was the most recent traumatic event in the boys' lives—but it was only one of many adversities they had experienced. Only 15 months ago, Brian had found their stepfather dead from a drug overdose. Homeless for the past year, the boys had accompanied their mother in-and-out of temporary shelters where violence was common and virtual school attendance during the COVID pandemic was impossible. I opened the door to room 45 and saw Brian, sullen and hidden by a hoodie; Jay and Kevan were taking turns jumping off the exam table. The nurse was catching the brothers leaping off the exam table. I could see the tension and concern in her face, despite her mask.

Certainly, the traumas that families experience are painful: lost jobs, partners, hope, sobriety, touch with reality, and resources to care for themselves and their children. But after the patients' needs are addressed and they leave room 45, the experience of witnessing the effects of such traumas can linger and affect those of us who care for them. Later that week, in the few unscheduled moments between our morning team huddle and the arrival of our first patient, the nurse shared with our team the anger, frustration, grief, and sleeplessness that she was experiencing. She could not stop thinking about the young patients we see in room 45. As a team, we listened empathetically and provided understanding and support, turning our huddle into a "cuddle." However, I wondered how we could more effectively address her anguish. This article aims to introduce the concept and science behind secondary traumatic stress (STS) and to consider some strategies that can be employed in the pediatric setting to address this common issue.

Secondary traumatic stress is the emotional duress caused by indirect exposure to distressing events experienced by others (hearing a patient's traumatic history, observing the grief or intense emotions of patients), as opposed to personally experiencing the trauma.[1] Secondary traumatic stress in the medical provider can be a natural consequence of hearing disturbing narratives of adversities in an occupation that preferentially selects for and inculcates a deep capacity for empathy. Although a valued facet of medical practice, the genuine expression of empathy, compassion, and caring can exact a damaging cost to the individual. Hearing the

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horrendous stories of violence and abuse, homelessness, hunger, and neglect rouses deep emotional upset—more profound personal distress than that evoked by the discovery of surprisingly low hemoglobin values or abnormal x-rays. Health care providers with high capacity to feel and express empathy tend to be more vulnerable to STS.[2] Symptoms of STS can include anger, sleep difficulty, guilt, and problems with concentration, such as our nurse described. Over time, exhaustion, and illness, hypervigilance, avoidance, and mood change can also occur.[1] Job burnout, an epidemic in health care,[3] also can be associated with development of STS.[4-6] While there is a wealth of literature on STS and burnout, effective, and robust systems and programs to support the well-being of providers are urgently needed.

Humans perceive threat through a process called neuroception.[7] Well below one's conscious awareness, the limbic system constantly scans sensory information for the presence of threat or signals of safety. In humans, safety is often effectively achieved through protective relationships. Affiliation (also called "tend and befriend") is a biobehavioral response to threat which involves seeking protective and rewarding social bonds as a strategy to address danger. This response is prompted by the release of oxytocin in response to stress, which, along with the positive social responses of others, results in tempering of the sympathetic nervous system (SNS) and hypothalamic pituitary adrenal (HPA) axis. Ironically, the networks which allow humans to express empathy and understanding of the perspective of another, which is critical to the social sensitivity needed to identify protective relationships, can be overwhelmed when continually assailed with the suffering of others.[1,8]

When the affiliate response is overwhelmed and thus unavailable, the fight or flight response to threat is the most protective response left, in which humans aggressively confront or flee (literally or by avoidant behaviors) from the danger in response to SNS and HPA axis stimulation of stress hormones. Just as for our pediatric patients described above, who were chronically under threat, we too can lose the ability to affiliate or feel and express empathy when we perceive chronic threat. Overstimulation and dysregulation of our SNS and HPA axis can result, resulting in the fight or flight symptoms such as those our nurse experienced.[9]

Trauma informed care (TIC) is defined by the National Child Traumatic Stress Network as "medical care in which all parties involved assess, recognize, and respond to the effects of traumatic experiences on children, caregivers, and healthcare providers."[10] Millions of children in the United States like Brian, Kevan, and Jay annually endure traumas of abuse, caregiver impairment, violence, natural disaster, and other adversities. Dysregulation of stress hormones results when these traumas are experienced without adequate support from adults and can lead to what is called a toxic stress response. This impacts the developing brain and body,[11] perhaps explaining Brian's asthma,[12] Kevan's academic challenges,[13] and Jay's sleep difficulties.[14] The presentation of toxic stress in children includes a range of symptoms, such as developmental and educational delays, functional difficulties with eating, toileting and sleeping, behavioral health challenges including internalizing symptoms (anxiety, avoidance, depression, and dissociation), and externalizing symptoms (inattention, impulsivity, and interpersonal difficulties), and somatic concerns including asthma and increased risk of infection.[11-15] Furthermore, the association of toxic stress in childhood to illness across the lifespan has been well-described.[16] Advances in our understanding of trauma and evidence-based treatments have led to effective ways to ameliorate these symptoms of trauma in our patients.[15,17] Psychoeducation and positive parenting techniques can be provided to families in our offices or referral can be made to specially trained mental health professionals in mental health settings to provide evidence-based trauma therapies (for example, Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy).[15,17]

Yet, we have not intentionally applied the principles of TIC to address the needs of our providers experiencing STS. The call to action in room 45 is an example of the urgent need to embrace and extend the development of evidence-based trauma interventions not just to patients but also to medical providers. Integrated care (mental health care providers embedded in health care settings) and team-based care (e.g. co-located medical, nursing, and social work) is increasingly used to meet the multiple needs of youth who have experienced trauma. The providers may benefit as well. Studies have begun to validate the effectiveness of practices which promote affiliation and supportive relationships in the health care setting (Table 1). These include team huddles which purposely include team support,[18] and intentional discussion and de-briefing among the interdisciplinary care team.[22] Both of these interventions, like the "cuddles" we provided for our nurse, afford medical providers the opportunity to express frustration and sorrow about their experiences and allow emotions to be calmed and dissipated by the team response (tending and befriending) of concerned colleagues. Other strategies have been piloted and have shown some early success. For example, the "battle buddy system"[23] pairs providers for peer support. Applying the mental health model of reflective supervision[19] in medicine may have positive effects in health

Table 1. Practical Ways to Address Secondary Trauma.

	Recognize and reduce overall stimulation of stress responses	Promote affiliate response (tend and befriend)
Individual responses	• Recognize physiologic markers of stress response (increased heart rate, respiratory rate, and headache). • Identify techniques to use before, during, and after stressful events (guided relaxation, deep breathing, mindfulness practice, meditation, prayer, yoga, exercise, and book group). • Access psychoeducational material about the impact of stress. • Maintain routines as much as possible. • Attend to basic needs (nutrition, exercise, and sleep). • Limit media, phone, and computer access when not at work. • Use vacation time. • Other life demands—may require reducing work time when family needs are highest and considering career timelines that are nontraditional.	• Continue to participate in group teaching, virtual meet ups, and huddles. • Prioritize family and friend connections. • Invite colleague to share article, personal story, or meal. • Lighten mood with appropriate jokes and humor. • Take advantage of coaching or mentorship options. • Seek out meaningful friendships. • Connect regularly with family members.
Organizational responses	• Communicate honestly and frequently. • Address workforce needs related to childcare and eldercare. • Employ flexibility in career timeline and part-time options. • Routine debriefing for traumatic events (deaths and bad outcomes). • Train and deploy immediate physician supervisors to identify and respond to stress of unit members. • Supervisors should model limits to connectivity and demands on free time should not expect 24×7 responses.	• Highlight and value the health and well-being of all providers, not just in crisis (internal and external communication). • Financially support team or department opportunities for social connection. • Group/departmental newsletters, emails highlighting team efforts, and successes of members. • Train supervisors to provide feedback, reflective supervision, and communication to direct reports. • Pair team members in battle buddy system. • Provide access to a spectrum of supports from to coaching and mentorship, mental health supports, well-being spaces, and evidence-based trauma therapy.

References for table: Ludick et al,[2] Pimentel et al,[18] Tomlin et al,[19] The National Child Traumatic Stress Network,[1,20] and Shanafelt.[21]

care settings. In particular, reflective supervision components including the predictable attention of a supervisor, mutual respect and the structure and process of private quiet time to consider clinical situations and clinical relationships with opportunity to consider, learn, and improve in a nonjudgmental setting has been highlighted as valuable in the neonatal intensive care unit (NICU) setting.[19,24] Medical providers report feeling nurtured and better able to do relational work.[24]

Our understanding of the physiology of stress has informed the practice of TIC to improve outcomes for patients in situations like those in room 45. But we must also endeavor to further apply this knowledge to take care of ourselves. We must proceed with deliberate haste to employ academic rigor to the study and substantiation of the best practices to support our health care teams and caregivers. And we must ensure that our caregivers receive the evidence-based treatments and support needed in a stigma-free environment. In addition to daily team huddles, our division has adapted a version of reflective supervision for all of our clinicians. We schedule a monthly meeting for our team to discuss cases and their impact on each of us, facilitated by our lead psychiatrist. In our multispecialty setting, we have also set aside biweekly opportunities for the members of each discipline (social work, medical, and peer counselors) to review challenging scenarios with each other. For team-based integrated care to be fully successful, affiliation with others is likely what everyone in room 45 needs: patients and practitioners. In the long run, TIC will be

most effective when TIC principles and practices are applied to all who are affected.

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All authors are responsible for the content of the manuscript. All authors have participated in the concept and design, interpretation of literature, and drafting and revising of the manuscript. All authors have approved the manuscript as submitted.

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