Commentary Article

Caring for the Carers: the emotional effects of disasters on health care professionals

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Key Words: compassion fatigue, vicarious traumatisation, burnout, self-care

Ellen Zimmer and Mary Beth Williams, in their book "When a Community Weeps" (1999) talk about the way in which a tragedy can shatter ones world-view and long-held meaning – our daily existence is no longer predictable nor invulnerable to harm, and questions such as 'why has this happened to us?' get asked. Of course our lives have risk, but when catastrophic events, such as natural disasters occur that resulting in death and destruction and mass suffering, our belief frameworks can be challenged in ways we have not previously experienced. Not only is this an individual experience, but one experienced by communities, who face the resulting impact of these tragedies in the life of the community and their far-reaching social networks. Depending on the nature of the disaster, people may need to be able to cope with the consequences for some time without being able to access their usual resources and services.

Health professionals, by the very nature of their work, can be exposed to the suffering of others on a daily basis. This is part of the role. However, the sadness felt, and response to this suffering can in part, be offset and mitigated by the rewards of caring. When the health professional is also involved in the disaster at a personal level, the distress felt may be overwhelming. This can be related to the degree of destruction and death, as well as the often difficult circumstances of continuing to provide a medical response, and therefore special attention needs to be placed on providing support and care for those health care professionals.

Ehrenreich (2002), in *Caring for Others, Caring for Yourself*, gives the following characteristics of extraordinary traumatic events such as natural disasters:

- The characteristics and magnitude of the events mean that it is impossible for one individual to control them
- The events create feelings of intense fear, helplessness and horror
- The events can threaten individuals or their loved ones with the possibility of death or severe injury

Immediately following the disaster, emotional responses in those directly affected by the disaster can include numbing, heightened arousal, a diffuse anxiety – particularly a loss of a sense of safety, and sometimes "survivor guilt". There may be differences in nurturance – some people may need close contact while others emotionally distance themselves, and emotional and cognitive instability. In addition to having to provide care for others, health professionals may themselves be experiencing these emotional responses.

The USA-based Centre for the Study of Traumatic Stress (CSTS), as an organisation, brings together military and disaster psychiatry with an integration of disaster mental health and public health. Their *Health Care Providers* document (CSTS, 2011) describes some of the challenges for health care professionals in the post-disaster environment (see Table 1).

Table 1: Challenges for the Health Care Provider in the Post-Disaster Environment

Disaster areas are often physically ruined and socially unstable
The magnitude of suffering
Providing support as well as medical care
Unfamiliar and unexpected conditions
Poor conditions that are often substandard

When tragic events occur, one's usual ability to cope can be disrupted. Even if not physically harmed by the disaster, almost immediately afterwards health professionals may be involved with those who are. One's own additional vulnerability at this time may result in experiencing the effects of being vicariously

traumatised by witnessing this suffering of others. This vicarious trauma, also known as compassion fatigue, has been acknowledged as a normal consequence of caring for others (Figley, 1995; Stamm, 1995). Current thinking (Stamm, 2009) is that compassion fatigue is a combination of the effects of burnout and those of secondary traumatic stress (STS). STS, the result of being secondarily traumatised by witnessing the trauma of others, is less common than burnout, although often has a higher consequence impact, and is frequently driven by fear – fear of a threat to one's personal safety or the safety of significant others, and usually associated with one's workplace. This work-related trauma can result in a direct effect (primarily traumatised), indirect (secondarily traumatised) or a combination of the two (Huggard, Stamm, & Pearlman, 2011). Not only are these effects experienced by the individual health professional, but can "spill over" to those closest to them and impact on the health professional's immediate family. Sometimes compassion fatigue can occur in specific circumstances, such as being exposed to the death or severe injury of children, or of patients similar to ourselves or those closest to us. It can result in feeling completely overwhelmed and not able to see another patient.

The signs and symptoms of compassion fatigue are many and varied and can be a combination of physical (exhaustion, headaches, insomnia), behavioural (increase in alcohol use, anger, avoidance of certain clients, impaired ability to make certain decisions) and psychological (emotional exhaustion, distancing, negative self image, depression, reduced ability to feel empathy, feeling professional helplessness, fear, disruption of world view, heightened anxiety or irrational fears, increased sense of personal vulnerability). These responses are often those seen early on following the traumatic event. What must not be forgotten, are the possible long term consequences. A small number of people, both health professionals and others affected by a disaster, may go on to develop post traumatic stress disorder. The cluster of symptoms experienced can include intrusive imagery (nightmares, flashbacks), avoidance behaviour (inability to carry out our professional roles) and hypervigilance and hyperarousal (constantly scanning for threats and danger and being "on guard"). The spectrum of symptoms is broad, and in addition to those mentioned above can include depression and grief responses, dissociative experiences, somatic disorders, spiritual discontent, anxiety, and interpersonal difficulties. Single seemingly unrelated events can cause flashbacks, sometimes many years after the initial event. The triggers can be words, smells, a particular scene, re-experiencing certain emotions that were felt at the time, and re-experiencing similar conditions and events as before. Long term post-disaster mental health consequences are well `summarised by Watts and Wilson (1999).

These experiences can be seen as opportunities that remind one of personal vulnerability and give a message that these feelings must be given attention and processed in appropriate and helpful ways. Ways of processing these feelings include talking to those closest to you or to a trusted colleague, talking in peer, professional, or supervision groups, or to another health professional skilled in this area. These processes contribute to building and strengthening our communities – communities where we live, and where we work. This strengthening process has been observed in the growth that can occur when health professionals experience prolonged exposure to traumatised patients (Arnold, Calhoun, Tedeschi & Cann, 2005; Hernandez, Gangsei & Engstrom, 2007). In the same way that vicarious traumatisation can disrupt our world view and sense of self, vicarious transformation can lead to enhanced and deeper understandings of self and our world. This vicarious posttraumatic growth, or vicarious resilience, has been shown to lead to a reframing of negative events and enhanced coping skills (Hernandez, Gangsei, & Engstrom, 2007).

The Centre for the Study of Traumatic Stress (CSTS, 2011) recommends the following strategies for mitigating psychological distress in health care providers (Table 2).

Table 2: Strategies for Mitigating Psychological Distress in Health Care Providers

Communicate with colleagues clearly and in an optimistic manner.	Reach out and contact your loved ones, if possible.
Be sure to eat, drink and sleep regularly.	Acknowledge the different ways in which people respond - some people need to talk while others need to be alone. Recognize and respect these differences in yourself, your patients and your colleagues.
Give yourself a rest from tending to patients. Allow yourself to do something unrelated to the traumatic event and which you find comforting, fun or relaxing.	Stay updated by keeping informed of the situation, plans and events.

Connect with others by talking to your colleagues and receiving support from one another.	Check in with yourself by monitoring yourself over time for any symptoms of depression or stress disorder, prolonged sadness, difficulty sleeping, intrusive memories, hopelessness. Seek professional help if needed.

One of the most effective means of coping with a disaster, and in a healthy way, relates to the preparation carried out prior to the disaster. This includes knowing about such issues as vicarious trauma, compassion fatigue and burnout, and the way in which they may affect us, and in particular, acknowledging the possibility of delayed responses. Of importance is the setting of appropriate boundaries – particularly those between one's professional and private lives – and practicing good self-care. Additionally, an understanding and insight into the way in which one responds to stressors assists in developing one's self-care toolkit (Huggard, 2011). Health professionals involved in a disaster, are not immune to the experiences of their patients. Post-disaster, continual self-monitoring of personal responses and monitoring of those of colleagues, is important. An understanding of responses to stressors assists those involved in disasters to manage the effects of those stressors, and to actively work to rebuild and strengthen both professional and personal communities.

References

Arnold, D., Calhoun, L.G., Tedeschi, R. & Cann, A. (2005). Vicarious Posttraumatic Growth in Psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239-263.

CSTS. (2011). Health care providers sustaining care giving and psychological well-being while caring for disaster victims. Accessed March 27, 2011 at http://www.centerforthestudyoftraumaticstress.org

Ehrenreich, J.H. (2002). A Guide for Humanitarian, Health Care, and Human Rights Workers. Accessed March 27, 2011 at http://www.heartintl.net/HEART/102504/GuideHumanitarianHeal.pdf

Figley, C.R. (Ed.). (1995). *Compassion fatigue*. New York: Brunner/Mazel

Hernandez, P., Gangsei, D. & Engstrom, D. (2007). Vicarious Resilience: A New Concept in Work With Those Who Survive Trauma. *Family Process, 46*(2), 229-241.

Huggard, P.K. (2011). Caring for the carers: Compassion fatigue and disenfranchised grief. Australia and Royal Society of New Zealand ANZCCART Conference Proceedings. Accessed November 28, 2011 from http://www.royalsociety.org.nz/organisation/panels/anzccart/2011/.

Huggard. P.K., Stamm, B.H. & Pearlman, L.A. (2011). *Physician Stress: Compassion Satisfaction, Compassion Fatigue and Vicarious Traumatization.* In C.R. Figley, P.K. Huggard & C. Rees (Eds.), First Do No Self-Harm. New York: Oxford University Press. *In press.*

Stamm, B.H. (Ed.). (1995). *Secondary traumatic stress*. Baltimore: Sidran Press.

Stamm, B.H. (2009). The Concise ProQOL Manual. Pocatello, ID: ProQOL.org

Watts, R. & Wilson, M. (1999). The Kempsey Bus Disaster: The Effects on Australian Community Rescuers. In E.S. Zinner and M.B. Williams (Eds.). *When a Community Weeps* (pp. 73-85). London: Brunner/Mazel.

Zinner, E.S. and Williams, M.B. (Eds.). *When a Community Weeps* (pp. 73-85). London: Brunner/Mazel.

Caring for the Carers: the emotional effects of disasters on health care professionals. Jan 2011. 60-62. P Huggard. Huggard P. Caring for the Carers: the emotional effects of disasters on health care professionals. Australasian Jour-nal of Disaster and Trauma Studies 2011; 2: 60â€“62. Impact of the Christchurch Earthquakes on Hospital Staff.Â This article describes how Southern University School of Nursing (SUSON) participated in meeting the immediate health care needs of evacuees from New Orleans and environs that were victims of Hurricane Katrina. It describes how SUSON's advanced practice nurses use a mobile health unit (the Jag Mobile) to continue to serve evacuees that now live in Renaissance Village, a transitional housing trailer park.