

Chapter 10

Self-Care for Professionals



At the root of this dilemma is the way we view mental health in this country. Whether an illness affects your heart, your leg, or your brain, it's still an illness, and there should be no distinction.—Michelle Obama

The idea of burnout exists in many different professions, especially those related to both mental health and criminal justice. No matter the political stance or outlook, most would agree that the job of police officers is a difficult one. For the most part, when police are involved in an incident, it is a negative one. Police patrol for traffic stops or speeding on highways, respond to emergency calls, and escort inmates when transferred or appearing in court. Often traffic stops and speeding result in tickets, and emergency calls can result in arrests and/or involvement of medical personnel. All of these are negative, again, much of the job of police. Now, consider repeating this scenario daily for years—tough thoughts, right? This is the reality for most that serve on the “front line,” yet, this sentiment can be widespread throughout the entire system coming into contact with individuals with mental illness.

10.1 What No One Talks About: Our Own Mental Health

In previous chapters, many topics were discussed as they relate to treatment for those with a mental health diagnosis as well as how those individuals interact with law enforcement, emergency medical services, and probation and parole. It is critical to take into account how these interactions impact the overall well-being of those frontline professionals. With their jobs being stressful, straining, and high intensity, there can and often will be adverse reactions. The irony is that often first responders, mental health professionals, and other law enforcement personnel spend much of their time helping others to a point where they begin neglecting themselves. Self-care for these people is not only essential for their wellness but also for their loved ones and those they are helping in the community.

Job strain and stress can influence anyone, both in the short and long terms. Repeating the same tasks over and over and receiving a similar result each time is frustrating no matter the context. Combining this frustration with encountering people (typically) in very negative and seemingly repetitive situations, one quickly realizes how overwhelming this can become. Stigma is also a concept that comes into play for professionals and self-care. Often, many professionals do not want to admit that they are in need of help. The idea of seeming “weak” in a profession like law enforcement can be detrimental to a career.

Burnout and compassion fatigue are two common consequences of an occupation working directly with individuals in crisis and related both to mental health and the criminal justice system. Both can touch many occupations that reach beyond first responders. Additionally, doctors, nurses, mental health professionals, case workers, and even lawyers can feel the effects of burnout and compassion fatigue. Further, the impact of burnout can vary depending on many factors. At times, a simple break or vacation can be enough to refuel and reconnect with one’s work. Unfortunately, in the American work culture, taking time off or for vacation is not often celebrated. In fact, many people allow their leave time to go unused.

Many professionals benefit from attending conferences and training sessions throughout their careers. No matter the length of time in a career, there are always new and innovative techniques and programs being developed. Learning from pioneers in the industry and even peers can be valuable. Additionally, interacting with others who work in the same industry and experience a similar daily life and schedule can aid in understanding processes. Commiserating with those who lead a related professional life can often take away stress and burden. This is not unlike unwinding after a class or day of work with friends to vent. The benefits of having professional friends can be immense.

Realistically, it is impossible *not* to be impacted by the job within these occupations. The better focus and idea is to find a balance and maintain a level of positivity and happiness outside of work. Often, these occupations require long hours and days outside of the typical “9–5” and work week. Working “odd hours” can prohibit a person from finding activities and hobbies of interest to maintain a work/life balance. These challenges can be taxing on a person, no matter the nature of their occupation.

10.1.1 Burnout, Compassion Fatigue, and Vicarious Trauma: Working with People in Crisis

The literature on work burnout is continuing to become more relevant in the workplace in the twenty-first century—with mental health professionals and beyond. The concept of designing workplaces to aid in the promotion of both physical and mental wellness certainly has gained momentum, for example, the heavyweights of Silicon Valley seem to compete on designing work campuses that include such things as food courts with healthy options, gardens, creative spaces, and so on. At

times, popular culture seems to highlight how some employers have taken this concept to an extreme. For example, in what has become one of the more infamous of these campuses, the Googleplex features a hair salon, on-site medical care, various cafeterias with free food, bicycles to use (free), child care (again, free), a full-service laundry room, massage therapy, and pet-friendly spaces to take advantage of the allowance of dogs on campus (Ulanoff, 2009). Mental health professionals seem to be more mindful of burnout than their colleagues in criminal justice due to the nature of their training; yet, both are at risk of two special factors that can complicate burnout—compassion fatigue and vicarious trauma (also known as secondary trauma).

Each of these terms—burnout, compassion fatigue, and secondary traumatic stress—is often conflated by various sources both professional and lay. While the three are intertwined, they are quite distinct. Burnout generally refers to feelings of exhaustion directly because of one's work. This burnout can come in the form of physical and/or emotional exhaustion and feeling drained, which can lead to low job satisfaction, interpersonal problems, sickness, substance use/misuse/abuse, and so on. For example, odds of experiencing burnout will almost always increase as one increases their work hours—if an employee consistently puts in 80, 90, or 100 h per week, burnout is almost guaranteed. While a 100-h work week may seem impossible, it can be very likely for most American medical residents as they prepare to launch into careers in medicine. The latest standards published by the Accreditation Council for Graduate Medical Education requires accredited programs to abide by the following rules: (1) "Duty hours must be limited to 80 hours per week, *averaged over a four-week period*, inclusive of all in-house call activities and all moonlighting," (2) "...up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale," and (3) "residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks" (ACGME, 2017). Of the 1515 studies on duty-hour limits identified by Philibert, Nasca, Brigham, and Shapiro (2013), these researchers assessed 83 of the highest quality ones to review the impact of limiting the work hours of medical residents. Not surprisingly, limitations on hours had a benefit on burnout and overall mood, with some evidence to support that these limitations also improved patient safety. Note that these findings have direct consequences for the quality of mental health services, particularly in teaching hospitals (e.g., where significantly more poor and uninsured patients receive their care), as young psychiatrists push themselves to meet their work demands. Evidence bears that burnout can be problematic for the employee as well as any others impacted by their work.

To investigate burnout in depth, Maslach developed an instrument—called the Maslach Burnout Inventory (MBI)—to assess what he postulated were the three dimensions of burnout (Maslach, Jackson, & Leiter, 2006). The first dimension is emotional exhaustion caused by one's overwhelming work demands, which saps one's perceived energy. The second dimension is depersonalization and cynicism, which results in feelings of detachment from one's job. The third and last dimension is feelings of inefficacy, which one perceives themselves as ineffective, not

growing or learning, and stuck in a rut. The MBI was developed in a way to gauge varying levels of burnout as Maslach felt it was not an all-or-none concept. As such, burnout is a dynamic concept that has been shown to have impacts in any vocation. It can be mitigated in various ways, such as the notorious concept of “loving what you do.” However, even those who are passionate about their work can experience burnout.

Compassion fatigue is a concept developed by Charles Figley (2002), which adapts the concept of burnout to individuals who serve to care for others, such as nurses, doctors, counselors, case workers, and so on (also known as caretakers and helpers, whether professional or lay, such as in a case of an adult child taking care of their aging parent(s)). These concepts align very closely; however, the effects of compassion fatigue tend to predominately result in desensitization, depression and anxiety disorders, disconnection with family and close friends, and social isolation (Mathieu, 2012). A common popular culture example of compassion fatigue lies with adult children having to take on caretaking duties of their ailing parents. Day, Anderson, and Davis explored this issue in a 2014 article in *Issues in Mental Health Nursing* among 12 adult daughters turned caregivers of a parent with dementia. Using semi-structured interviews, these researchers discovered four overarching themes that seemed to predict risk of developing compassion fatigue in these caregivers: uncertainty (mostly over the seemingly unpredictable sickness and what the future brings), doubt (mostly that the caregivers doubted their ability to take care of their parent in a manner they deserve), attachment (noting a close attachment with the parent), and strain (due to juggling the demands of life with the added responsibilities of caregiving). The interviews in the study gave striking life to the potential results of compassion fatigue—helplessness, hopelessness, diminishing empathy, and isolation: “When [my parent walked away from the house], it’s just been a constant in the back of my mind. What could happen next time?” “Not feeling that I’m able to take care of her the way I should be able to take care of her.” “That kind of has my rest broken, and when I get to work the next day, I’m just no good, I’ll sleep all day.” “Juggling my time, taking care of the house, and my house there, and my job and friends and family. It’s just hard to juggle sometimes.” “I think I had reached a point where I felt resentful toward her. I used to love the weekends. I dread Fridays because that means that I don’t have any relief at all. All Friday night...Saturdays... Sunday.” “You can’t stop” (Day, Anderson, & Davis, 2014).

Vicarious trauma layers on the potential complications that can arise in professionals or laypersons caused by caring for an individual(s) experiencing significant trauma in their lives. In a very real sense, the trauma that touches people’s lives rubs off on the individuals that seek to help in the recovery process. The most salient recent examples of this lies in first responders of 9/11, the Boston Marathon bombing, Hurricane Katrina, and so on. However, horrendous images of physical trauma are certainly not necessary to trigger vicarious trauma. Professionals who aid rape victims, children in child welfare cases, and so on are certainly at risk for being exposed to vicarious trauma. If this exposure goes unabated, it may develop into clinical diagnoses, such as post-traumatic stress disorder. Specifically, the *Diagnostic*

and Statistical Manual V (American Psychological Association, 2013) included new criteria for post-traumatic stress disorder (*italics emphasize modifications*):

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
 2. Witnessing, in person, the event(s) as it occurred to others.
 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
 4. *Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeated exposure to details of child abuse).*

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

As Levin, Kleinman, and Adler (2014) point out that no clear data exists on how the addition of A4 results in differences in PTSD incidence and prevalence or other potential impacts. Much more research needs to be done in this area. In fact, the literature on first responder physical and mental health after vicarious trauma exposure is at its nascent stage, with primary focus on line-officer police and emergency medical services personnel at this point. Further, research has yet to delve into the civilian and sworn staff who work in traumatic crime scenes (Rivera Waugh, 2016). In 2012, an extensive international search for extant literature uncovered 28 high-quality, peer-reviewed studies on PTSD prevalence among “rescue workers” through 2008 (Berger et al., 2012). On average, the “going rate” regarding prevalence of PTSD among first responders was found to be 10%. Not only is this figure alarming; Berger and his colleagues’ overall search for literature did not pick up on a large array of interest in the topic before 2008, reinforcing the idea that this area is fertile ground for much needed research.

10.2 Traumatic Experiences and Fatigue: What We Know

Across occupations, especially in jobs which entail interfacing with people in difficult and traumatic situations, the symptoms of burnout are strikingly similar: emotional exhaustion, depersonalization, decreased empathy, isolation, depression, anxiety, cynicism, losing a sense of self-worth (particularly when related to job performance and ability), and so on (Walsh, Taylor, & Hastings, 2012). Research has shown that when police officers are under stress and have negative coping strategies, it can lead to problem drinking (Swatt, Gibson, & Piquero, 2007). Specifically, researchers who studied Baltimore police officers found a strong relationship between stress on the job and drinking, with problematic drinking being mediated through anxiety and depression. In other words, officers who

were stressed tended to drink; yet, if they were stressed and anxious/depressed, they tended to be at higher risk to problem drink. This research echoes findings from other occupations; yet, perhaps not many other occupations experience the acute stress as do first responders.

It should not be a surprise to learn, then, that a growing array of research and treatment effort has been invested into coping skills for professionals; whereas, before the turn of the century, there was not much information to inform us (Anshel, 2000). Despite years of progress in research, there is not one particular evidence-based coping skills training program that is in regular use. Beyond just finding positive ways to cope, the development of a robust self-care program has become the best practice in public service. While the programming may not be as generous as the offerings at the Googleplex, the increasingly more prominent role of self-care programming seems to be a sustained pattern into the twenty-first century.

10.3 Self-Care: Why Is It Important

The 2016 National Survey on EMS Mental Health Services throws the importance of self-care in sharp relief (National Association of Emergency Medical Technicians, 2017). In this most recent edition of the survey, 58% of respondents (including paramedics, EMTs, EMS training coordinators, and medical and EMS directors and managers) either disagreed or strongly disagreed when asked if they are satisfied with the mental health services provided by their agency to their employees; 52% of respondents reported that their agency did not even have such mental health services (37%) or were not aware of these services if they were available (15%); only 26% of respondents claimed that their agency had programs available to help employees with substance use and dependence issues; 42% of respondents reported that their agency does not offer health and wellness services; and 41% of respondents reported that they disagree or strongly disagree when asked if they know where to go for help within their agency. The qualitative feedback is even more damning:

- Initiating mental health services through the [employee assistance program] is an invitation for mandatory competency evaluation, grounds for dismissal.
- Most of the people in my organization do not feel comfortable using any service provided by the organization for fear that the information will come back and be used against them in the future.
- [Employee assistance program] provided for three sessions per incident. I do not believe that to be adequate for someone seeking help.
- Currently, acute emotional injuries and mental health are not considered to be work-related by worker's company.
- I was seeing a mental health professional for PTSD after an ambulance accident that resulted in the death of the driver in the other. Worker's company denied my claim, leaving me stuck with the bills.

- The agency I work for sees mental health as a weakness. If you ask for help, you become verbally abused by coworkers, supervisors, and station managers. I needed help and was told, “that’s why women don’t belong in EMS. They’re overly emotional...”
- Mental health is a joke to management. They still operate on the philosophy that if you can’t handle it, you’re in the wrong line of work.
- Attitude at our department is, if you can’t handle it, get out, sissy.
- I strongly believe that in the workplace mental health is viewed as taboo, not to be talked about and, if found out, viewed as a weakness.
- In seeking help you are shamed, made fun of by superiors, and told to suck it up; it’s part of the job.
- There is absolutely no concern for the mental or physical health of employees at my agency.
- Rural agencies that operate off monies strictly derived by billing simply cannot afford to offer these types of services to their employees.

Surveys like these are important yet are relatively uncommon among first responders. As we begin to address these issues outlined above with EMS personnel, it is important to remember that they are likely occurring with regularity among all types of first responders. Much more research is direly needed to monitor these issues, particularly as we devise ways to offer improvement in self-care among our first responders.

10.4 Examples of Self-Care Programming

At this time, there appears to be a limited array of programming tailored to meet the needs of first responders. Such programs include Addiction and Trauma Recovery Integration Model (ATRIUM), Essence of Being Real, Risking Connection®, Sanctuary Model®, Seeking Safety, Trauma, Addiction, Mental Health, and Recovery (TAMAR), Trauma Affect Regulation: Guide for Education and Therapy (TARGET), and Trauma Recovery and Empowerment Model (TREM and M-TREM). Many of these programs generally target trauma exposure and are customized to first responders by those who adopt them and/or whose creators offer some guidance on such customizations for professionals themselves. A minority of these, such as ATRIUM, Essence of Being Real, and Risking Connection®, have been formulated for specifically professionals. Regardless, the industry standard for any of these trauma-informed approaches must garner the following key principles for the best result: (1) safety (e.g., the physical setting feels safe, and human interactions promote a sense of safety), (2) trustworthiness and transparency (e.g., any decisions by the organization or leadership is transparent), (3) peer support (e.g., support involves similarly situated individuals who have been exposed to trauma), (4) collaboration and mutuality (e.g., eliminating the perception of power differences between administrators and professional staff in regard to trauma-informed

Table 10.1 Risking Connection® summary of model, program goals, and expected outcomes, adapted from the California Evidence-Based Clearinghouse for Child Welfare (2017) resources

Emphasis	Programmatic goals	Expected measurable outcomes
A framework for understanding common trauma symptoms	Utilize the proprietary risking connection framework to respond to the impact of traumatic life events	Knowledge of content and models essential to risking connection
A common inclusive language	Frame common symptoms and behaviors as adaptations to traumatic life events	Shift in beliefs favorable to trauma-informed care
Relationships as the primary agent of change	Respond to survivors of traumatic experiences from a strength-based approach	Demonstration of behaviors aligned with trauma-informed care
Respect for, and care of, both the client and the service provider (vicarious traumatization) as critical to healing	Demonstrate collaborative crisis management that reduces the risk of re-traumatization	Changes in professional quality of life including an increase in compassion satisfaction, decrease in burnout, and a decrease in secondary (or vicarious) traumatic stress
Strategies and tools to support adoption of the model in clinical, social, and organizational processes	Demonstrate increased self-awareness of their reactions to individual clients	Responses that reduce the use of restraints and seclusion at organizations
	Integrate knowledge of the impact of vicarious traumatization in the formulation of organizational and individual self-care plans	Decreases in staff turnover, staff injuries from client management, increases in staff satisfaction with job
	Create trauma-responsive cultures including policies, processes, and people systems	Increases in foster parent retention and decreases in foster placement disruptions

care/services/support), (5) empowerment, voice, and choice (e.g., ensuring the organization supports trauma-informed care throughout its organizational structure), and (6) cultural, historical, and gender issues (e.g., the organization offers services that are responsive to gender, cultural, and historical issues; SAMHSA, 2014, 2017).

For example, Risking Connection® offers organizational consulting to aid in establishing a proprietary system that equates to a turnkey solution for self-care. As with many solutions discussed throughout this book, Risking Connection® was born as a response to litigation and developed with the mitigation of litigation risk in mind. The program offers an advantage in that it is grounded in theory (constructivist self-development theory, relational psychoanalytic theory, developmental psychopathology, and cognitive schemas) and the ability for professionals to enroll in “train-the-trainer” courses to ensure sustainability within an organization after launch. See Table 10.1 for a summary of Risking Connection® to get an idea of the

overall programmatic approach. Other programs named above use similar approaches to ensure that an organization develops and maintains a culture that is trauma-informed and trauma-responsive.

10.5 Conclusion

With the growth in incarcerated and justice-involved individuals, the demand on professionals has also increased. For first responders responding to a crisis, as well as those providing treatment during and after incarceration, strong anecdotal evidence documents the impact on these professionals from increasingly difficult encounters. Our system is overflowing, and those with the care and desire to help resolve it are being pushed to the limit. The importance of self-care should be evident, yet administrators of first responders have been slow to ratchet up support. Treatment is *essential* not only for the target population discussed throughout this book who seem to be in frequent contact with the criminal justice system but also for the people who spend their days helping this population. Our society needs to support and shelter those in need and ensure that all have the same access and ability to seek out and receive the treatment and care they deserve—including first responders.

For the little information that we have on the topic regarding the perceptions of mental health among first responders, coping skills, and the perception of first responder culture of being unfriendly to those who need help, there certainly is more than enough evidence to support a dire need for broader adoption of self-care programming. Remember, investing in our professionals is also investing in individuals with mental health concerns.

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