Trauma 101: The Trauma Continuum

Michael F. Barnes, Ph.D., MAC, LPC
Chief Clinical Officer

Foundry Treatment Center
Steamboat Springs
Colorado

Rocky Mountain Health Plan Trauma-Informed Care Webinar Series 2020
EACH DAY IN THE UNITED STATES, ALL OF THE TRAUMATIC EVENTS TAKE PLACE.

- 43 people will be murdered (15,695 annual)
- 2,200 rapes (moderate estimate) (803,000 annual)
- 123 suicides (20 veterans per day) (44,895 annual)
- 128 opiate overdose deaths (46,720 annual)
- 241 alcohol related deaths (87,965 annual)
- 4,754 people with be diagnosed with cancer and 1,670 will die from cancer. (609,550 annual)
- 2,191 people die from heart disease (800,000 annual), 573 die from sudden cardiac arrest (209,145 annual)
- 1,808 people will die in tobacco related illnesses (659,920 annual)
- 102 people die from automobile accidents (37,230 annual)
- Mass shootings in schools, churches, etc.
CONTINUUM OF TRAUMATIC STRESS

Primary Trauma (Primary Trauma Victim)

Secondary Trauma (Trauma Experienced by Family Members, Friends, First-Responders, Helping Professionals, etc.)

Compassion Fatigue (Trauma Experienced by Care-Givers and Helping Professionals)

Organizational Trauma

Posttraumatic Stress Disorder

Secondary Trauma

Developmental/Complex Trauma

Burnout
PRIMARY TRAUMA – PTSD

WHEN YOU ARE TRAUMATIZED BY AN EVENT
(PERSONAL, FAMILY, WORK, ETC.)
INTRODUCTION - WHAT IS PTSD?

It is a:

**Bio**-Psycho-Social-Spiritual Disorder

At its core, PTSD is a biological process that results in significant emotional, systemic, and behavioral consequences.

Trauma Integrated addiction treatment MUST recognize the biological and systemic factors that maintain the disorder and identify appropriate interventions for treating each.

Like Addiction, Trauma is a family issue!
WHAT KIND OF EVENTS CAUSE TRAUMA?

• Combat, First Responder

• Natural Disaster Events - Hurricanes, Earthquakes, Tornadoes, Floods, Fires, etc.

• High Speed Events - Car & Bike Accidents, Falls, etc.

• Assault Events - Assault, Rape, Incest, Animal Attacks

• Global Threat Events - Drowning, Electrocution, Caesarian, etc.

• Major Illness/Hospital Events - Cancer, Heart Attacks, Asthma, Full Anesthesia Surgeries

• Cyclical Trauma – Anniversary of major traumatic event

• Major Family Events - Divorce, Affairs, Death of a loved one, etc.

• Cultural/Historic Trauma (Racism, Holocaust Survivors, Native Americans)

• Developmental Trauma –
  
  • Dysfunctional Family Systems (ACE Study)

  • Abandonment or Attachment Trauma

  • Living in an alcoholic, mental illness, Neglect, or otherwise dysfunctional family

  • It’s not always what was done to you. Sometimes it’s what WASN’T done for you!
SIGNIFICANCE OF TRAUMA

• According to the National Center for PTSD:
  • 61% of men and 51% of women report having experienced at least one traumatic event (lifetime)
  • 10% of men and 6% of women report having experienced four or more traumatic events (lifetime)

• Of these trauma victims, 8.7% of US population receive diagnosis of PTSD
  • Numbers for EMS Professionals vary from 4.8% to 40% with PTSD Diagnosis

• Women are twice as likely to be diagnosed with PTSD as Men! 10% of Women and 5% of men who experience traumatic event will be diagnosed! (Tolin & Foa, 2006)
Prevalence of PTSD and Substance Use Disorders

Bride (2007) - of treatment seeking substance abusers:

- 60% to 90% have history of physical or sexual abuse.
- 30% to 50% meet criteria for PTSD.

Among persons who develop PTSD, 52% of men and 28% of women are estimated to develop an alcohol use disorder. 35% of men and 27% of women develop a drug use disorder (Najavits, 2007)

The numbers are even higher for veterans, prisoners, victims of domestic violence, first responders, etc. (Najavits, 2004a, 2004b, 2007)

Individuals with PTSD are 3 to 4 times more likely to develop SUD’s than individuals without PTSD have earlier histories with A & D, more severe use, and poor treatment adherence. (Khantzian & Albanese, 2008)
DSM-5 DIAGNOSTIC CRITERIA FOR PTSD

• Criterion A: Traumatic Event
  
  How does someone get traumatized?

  • Direct personal experience of an event that involves threatened death, actual or threatened serious injury, or threat to one’s physical integrity;

  • Or witnessing an event that involves death, injury, or a threat to the physical integrity of another person;

  • Or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates;

  • Or experiencing repeated or extreme exposure to aversive details of the traumatic event (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

DSM V
DSM-5 DIAGNOSTIC CRITERIA FOR PTSD

- **Criterion B: Intrusion or Re-Experiencing**
  - Intrusive thoughts or memories
  - **Nightmares** related to the traumatic event
  - Flashbacks, feeling like the event is happening again
  - Psychological and physical reactivity to reminders of the traumatic event, such as an anniversary

- **Criterion C: Avoidant Symptoms**
  - Avoidant symptoms describe ways that someone may try to avoid any **memory** of the event, and must include one of the following:
    - **Defensive Avoidance**
      - Avoiding thoughts or feelings connected to the traumatic event
      - Avoiding people or situations connected to the traumatic event
• Criterion D: Negative alterations in mood or cognitions
  • Decline in someone’s mood or thought patterns following the traumatic event, which can include:
    • Memory problems that are exclusive to the event (inability to recall key features)
    • Negative thoughts or beliefs about one’s self or the world
    • Distorted sense of blame for one’s self or others, related to the event
    • Being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness)
    • Severely reduced interest in pre-trauma activities
    • Feeling detached, isolated or disconnected from other people

• Criterion E: Increased Arousal Symptoms
  • symptoms are used to describe the ways that the brain remains “on edge,” wary and watchful of further threats. Symptoms include the following:
    • Difficulty concentrating
    • Irritability, increased temper or anger
    • Difficulty falling or staying asleep
    • Hypervigilance and efforts to control
    • Being easily startled
STATE 0: (zero): calm, responsive, awake

STATE 1: slightly anxious, annoyed, nervous, physical tension

STATE 2: highly anxious, angry, panic symptoms, intense physical tension (stomach, chest, breathing), powerful fight or flight responses

STATE 3: Dual activated (a mixture of activation with dissociative symptoms): tension with somatic collapse, anxiety, sleepy, panic, hopelessness, heaviness, blurred vision

STATE 4: pure dissociation marked by a distinct lack of physical sensation and flat affect, numbed out, blank, feeling ‘floaty’, depersonalized, and disconnected
PRIMARY TRAUMA – DEVELOPMENTAL/COMPLEX TRAUMA

WHEN YOU ARE TRAUMATIZED BY YOUR FAMILY OF ORIGIN, HOME ENVIRONMENT, NEIGHBORHOOD
TRAUMA-INTEGRATED TREATMENT: SHOCK TRAUMA VS. DEVELOPMENTAL TRAUMA

• To be truly Trauma-Integrated, must be able to address both Shock Trauma (Big T) and Developmental Trauma (chronic little t).

**Shock Trauma is classic PTSD.**
- Defensive Orienting Response is overwhelmed, incomplete Fight/Flight Response, and Remain stuck in incomplete orienting response, resulting in hypervigilant and controlling.
- Anxiety, intrusive thoughts, defensive avoidance, dissociation, etc.

**Developmental Trauma:** may have similar symptoms as PTSD, but often does not have a Criteria A trauma event.
- Based on consistent mis-attunement from care givers, chronic early abuse and neglect, poor attachment, and a variety of childhood shock traumas
- Live in high state of Sympathetic Nervous System Response, due to constant threat
- Only other alternative is Parasympathetic Freeze Response
- Live in Dually-Activated Autonomic Nervous System States
- Become disconnected from emotions and body response to stress

• **Fail to develop and meet biologically based core needs:**
  - Connection, Attunement, Trust, Autonomy, Love-Sexuality
ADVERSE CHILDHOOD EVENTS – ACE STUDY

• Original ACE Study – Longitudinal study carried out by the Centers for Disease Control and Prevention (2009) and Kaiser Permanente Department of Preventive Medicine (17,421 sample size)

• Significant number of studies published since original ACE Studies.

• Typically include 10 specific types of ACES:
  • **Childhood Abuse** (Emotional, Physical and Sexual)
  • **Neglect** (Emotional and Physical) – This is where the Mis-Attunement of Needs is most pronounced
  • Witness **domestic violence**,
  • Parental **marital discord**
  • Living with **substance abusing, mentally ill, or criminal household members**
    • Original study included having a family member who was **incarcerated**.
    • 2/3 (67% of Population) research participants reported 1 ACE in their childhood.
    • Of those reporting 1 Ace 86% were also exposed to at least 1 additional ACE.
    • 38.5% (1 in every 14 people) reported 4 or more additional exposures.

(Dong, Anda, Felitti, Dube, Williamson, Thompson, Loo & Giles, 2004)
ADVERSE CHILDHOOD EXPERIENCES (ACES) – INFLUENCE ON NEGATIVE HEALTH OUTCOMES

Individuals with ACES have higher likelihood of experiencing physical and/or psychological health consequences (Afifi et al., 2008)

- Alcoholism (7.4 x higher), IV drug use (11.3 x higher), Depression (4.5 x higher), Suicide attempts (12 to 15 x higher)
- Emotional dysregulation, dissociation, poor attachment, Obsessive-Compulsive Disorder, Depression,

Often engage in high risk behaviors that are often the cause of premature death:

- Heart Disease, Stroke, liver disease, lung cancer, COPD, rheumatoid arthritis
- Sex with over 50 individuals, unwanted pregnancies, sexually transmitted diseases (Dube & Felitti, 2003)
- Hepatitis, Diabetes, Cirrhosis
# Developmental/Complex Trauma and Attachment – Core Needs

*(Heller & Lapierre, 2012)*

<table>
<thead>
<tr>
<th>Core Needs</th>
<th>Core Capacities for Well-Being</th>
<th>Core Difficulties – Survival Strategies</th>
</tr>
</thead>
</table>
| **Connection**  
  *(With Self & Others)* | Be in touch with body and emotions  
  Be in connection with others | Disconnected from physical and emotional self  
  Difficulty relating to others |
| **Attunement**  
  *(Needs)*            | Attune to our needs and emotions  
  Recognize, reach out for, and take in physical and emotional nourishment | Difficulty knowing what we need  
  Feeling our needs do not deserve to be met |
| **Trust**  
  *(Trust Self & Others)* | Healthy dependence and interdependence | Feeling we cannot depend on anyone but ourselves  
  Feeling we have to always be in control |
| **Autonomy**          | Set appropriate boundaries  
  Say no and set limits  
  Speak our mind without guilt or fear | Feeling burdened and pressured  
  Difficulty setting limits and saying no directly |
| **Love-Sex**          | Live with an open heart  
  Integrate in loving relationship with a vital sexuality | Difficulty integrating heart and sexuality  
  Self-esteem based on looks and performance |
<table>
<thead>
<tr>
<th>Survival Style</th>
<th>Shame-Based Identifications</th>
<th>(Both – And)</th>
<th>Pride-Based Identifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection</td>
<td>Shame at existing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling like a burden</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling of not belonging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attunement (Needs)</td>
<td>Needy</td>
<td></td>
<td>Caretaker</td>
</tr>
<tr>
<td></td>
<td>Unfulfilled</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Empty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undeserving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>Small</td>
<td></td>
<td>Strong and in control</td>
</tr>
<tr>
<td></td>
<td>Powerless</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Used</td>
<td></td>
<td>Successful</td>
</tr>
<tr>
<td></td>
<td>Betrayed</td>
<td></td>
<td>Larger than life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>User, betrayer</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Angry</td>
<td></td>
<td>Nice, Sweet</td>
</tr>
<tr>
<td></td>
<td>Resentful of authority</td>
<td></td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td>Rebellious</td>
<td></td>
<td>Good boy/girl</td>
</tr>
<tr>
<td></td>
<td>Enjoys disappointing others</td>
<td></td>
<td>Fear of disappointing others</td>
</tr>
<tr>
<td>Love-Sex</td>
<td>Hurt</td>
<td></td>
<td>Rejects first</td>
</tr>
<tr>
<td></td>
<td>Rejected</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physically flawed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unloved &amp; unlovable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ADULT SYMPTOMS OF CHILDHOOD/DEVELOPMENTAL TRAUMA
(SCHWARTZ, 2016)

- **Cognitive Distortions** (inaccurate beliefs about self, others, the World)
- **Emotional Distress** (Overwhelmed, Anxious, Helpless, Hopeless, Loneliness, Shame, Unfairness, Injustice, Depression, Suicidal Thoughts)
- **Disturbing Somatic Sensations** (Disconnect from body)
- **Disorientation** (Loss of orientation between the past, present, and future)
- **Hypervigilance** and efforts to **Control** Environment, Other people, Clients, etc.
- **Avoidance** of stressors, people, places associated with stress/trauma
- **Interpersonal Problems** (withdrawing from, blaming, pushing away, or criticizing friends and family. Patterns probably learned from family of origin)
- **Reduced Brain Development** (Deficits in social skills and academic success)
- **Health Problems** (High blood pressure, blood sugar imbalances, food cravings, addictions, suppress immunity, digestive disturbances, sleep disturbances)
Co-Dependency

- Can develop in childhood or adult relationships
- Rejection, abandonment,
- Shame and Low Self-esteem
- Engage in Caretaking, Enabling, Perfectionistic behaviors.
- People Pleasing
- Poor Boundaries
- Symptoms deeply ingrained.
- Anger, resentment, depression, hopelessness, despair.
- Emotional Reactivity
- Closed off and withdrawn, difficult for others to get close to.

Complex Trauma Response

- Can be childhood or adult trauma response
- Involve chronic relational/family and interpersonal trauma.
- Abandonment, neglect, lack of protection, & emotional, verbal, sexual, physical abuse, shaming, etc.
- Shame and Low Self-Esteem
- Engage in Caretaking, Enabling, Perfectionistic behaviors
- Survival reactions become ingrained.
- Often struggle with anger, resentment, loneliness, helplessness/passivity and self-loathing.
- Fluctuate between intense emotional reactivity, physiological distress and being detached and unable to express or feel any emotion at all.
- Often feel like outsiders, try but never fit in.
SECONDARY TRAUMA EXPERIENCED BY FIRST RESPONDERS, FAMILIES, THERAPISTS, LAWYERS, REPORTERS, ETC.

WHEN YOU ARE TRAUMATIZED BY CONSISTENT INTERACTIONS WITH TRAUMATIZED PATIENTS, THEIR TRAUMA SYMPTOMS, AND THEIR TRAUMA STORIES
DSM-5 DIAGNOSTIC CRITERIA FOR PTSD

• Criterion A: Traumatic Event
  • *How does someone get traumatized?*

  • Direct **personal experience** of an event that involves threatened death, actual or threatened serious injury, or threat to one’s physical integrity;

  • Or **witnessing an event** that involves death, injury, or a threat to the physical integrity of another person;

  • Or **learning about** unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates;

  • Or **experiencing repeated or extreme exposure to aversive details of the traumatic event** (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
BEFORE YOU CAN CREATE A "NEW NORMAL" MUST UNDERSTAND PAST/CURRENT NORMAL - HOMEOSTASIS

Like a mobile adjusts to wind to maintain stability, all families adjust to life's demands to maintain stability, and system integrity.

- Intoxication
- Anxiety, Hyperarousal/Agitation
- Intrusive Thoughts, Nightmares
- Dissociation, Depression
- Anger, Conflict, Arguments
- Medical, Legal, Employment Crises

“Trauma Survivor/Patient”
FAMILY INFORMED TRAUMA TREATMENT (FITT) MODEL

Adapted from Kiser & Black, 2005

Familial and Intergenerational Trauma Context/Event

- Child Response
- Adult/Parental Response
- Sibling Relations
- Parent-Child Relations
- Parenting Practices & Quality
- Adult Intimate Relations
- Intergenerational Response

Family Unit

- Individual and Family Outcomes

Time

Acute and longer-term effects, Individual Development, Family life cycle
There are multiple ways that families can transmit and maintain trauma and/or addiction from one generation to the next:

1.) Epigenetics
2.) Attachment
3.) ACES
4.) Family System Organization/interactions

The majority of this presentation will focus on:
- family system organization,
- how families adapt to crisis/trauma
- how to treat it.
Identified Client/Patient

1. Trauma/Addiction
2. Intoxication
3. Anxiety, Hyperarousal/Agitation
4. Anger, Conflict Arguments
5. Medical Legal, Employment Crises
6. Intrusive Thoughts/Nightmares
7. Dissociation, Depression

Foundry
**Posttraumatic Stress Response**

- Family members report having experienced emotional, cognitive and behavioral symptoms that are similar to those reported by the primary victim.

- Anxiety, Fear, Anger
- Intrusive thoughts about the traumatic event
- Nightmares
- Flashbacks
- Hypervigilance
- Feeling a need to control others behavior, the environment, their own feelings.

- Sleep disturbances, Fatigue, Dissociation
- Feeling detached or estranged from others.
- Avoidance of activities that remind them of the trauma
- Avoidance of places that remind them of the trauma
FAMILY RESPONSE TO LIVING WITH ACTIVE ADDITION/TRAUMA – INDIVIDUAL RESPONSE

**Common Feeling**
- Anger
- Fear
- Grief
- Guilt
- Horror
- Terror
- Shock
- Hurt
- Depression
- Frustration
- Shame

**Common Defense Mechanisms**
- Denial
- Rationalization
- Intellectualization
- Projection

**Common Cognitive Responses**
- Obsession
- Intrusive Thoughts
- Uncertainty
- Self Blame
- Fault Finding
- Resentments
- Hopelessness
- Helplessness
- Fear of the Future

**Common Physical Responses**
- Sleeplessness
- Exhaustion
- Nightmares
- Startle Response

**Common Behavioral Responses**
- Hypervigilance
- Control—self/others
- Care Taking
- Impose Structure
- Avoid triggers & Reminders

Anxiety/worry - hypervigilance/control
Traumatic Stress Response
Frustration with Medical Community
SECONDARY TRAUMA – IMPACT ON SAFETY & AUTONOMIC NERVOUS SYSTEM DYSREGULATION

- **Physiological Response** - Because of the consistent experience of fight/flight and anxiety, family members frequently experience a change in world view (perception) associated with personal vulnerability, safety, and control.

- **Cognitive Response** – Shattered Assumptions (Janoff-Bulman, 1985)
  - The world is safe & relatively benevolent. We are relatively invulnerable.
  - The world is meaningful. If I am responsible I will have some control over what happens to me/family
  - Good things generally happen to good people.

- Following a traumatic event, families commonly experience a shift in attitudes and beliefs that represent a need to focus on safety issues, related to self and others.

- **Due to concerns about safety and vulnerability, families engage in protective behaviors:**
  - Hypervigilant, Control, Enabling, overprotection, defensiveness, etc.
  - Focus on traumatized family member, avoid focus on their own response
• Family member perceptions/experience of stress/anxiety associated with the traumatizing event will influence interactional patterns, coping mechanisms, and degree of emotional sequelae experienced by family system.

• “The crisis is not the problem, but it is the family’s constraining beliefs that restrict alternative views about the crisis that becomes the problem” (Shaw & Halliday, 1992)
FAMILY DISTRESS MODEL (CORNILLE & BOROTO)

New Normal
Organize Around the Problem
Rules, Roles, Routines, Rituals & Relationships (5 R’s)

UNDERSTANDING & ASSESSING POST-CRISIS ADAPTATION (OLD NORMAL)

Over Time, begin to see a shift in Values & Goals!

Changes in 5 R’s: Rules, Roles, Routines, Rituals & Relationships (Boundaries)

Pre-Crisis/Trauma

Crisis/Trauma Both

Post-Crisis/Trauma

More Rigid/less flexible

Existing & New Resources

Existing Resources

Perception of “a”

Perception of X + aA + bB

Values & Goals
SECONDARY TRAUMA – IMPACT ON FAMILY SYSTEMIC FUNCTIONING
SYSTEMIC TRAUMA

- See significant change/disruption to coping strategies
  - Shifts in family organization: Rules, Roles, Routines, Rituals & Relationships/Boundaries

- Increased Conflict, Anger, Resentment, Emotional Distance, Emotional Intensity, shifts in intimacy, shifts in parenting, shifts in decision making, etc.

- Rigid External Boundaries
- Diffuse Internal Boundaries
- Enmeshment
- Lack of external support
- Promote Covert rules
- Organizing around problem

Adult Child

Triangulation

Mother  Father

Brothers  Sisters

Sibling Role Changes
COMPASSION FATIGUE
BURNOUT & SECONDARY TRAUMA

WHEN YOUR WORK ENVIRONMENT BECOMES OVERWHELMING, EXHAUSTING, CREATING BURNOUT AND INCREASED SECONDARY TRAUMA
IS IT EMPATHY FATIGUE OR COMPASSION FATIGUE?

• Based on Merriam-Webster Dictionary:

  • **Empathy:** the action of *understanding, being aware of, being sensitive to, and vicariously experiencing* the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively *explicit* manner.

  • **Compassion:** sympathetic *consciousness* of others' distress together with a *desire to alleviate it.*

• As we will see, burnout results from a helper’s feeling of disillusionment as they realize that they did not have the ability to help others heal.

• Powerlessness to positively impact another’s pain!
According to Carla Joinson (Nursing92), there are four reasons why you need to be aware of compassion fatigue and respond appropriately to it:

1. Compassion Fatigue is **emotionally devastating**.
   - May experience great sadness, grief, depression, exhaustion

2. Caregivers’ **personalities lead them toward it**.
   - You can’t get compassion fatigue if you are not compassionate, caring, etc.

3. The outside **sources that cause it are unavoidable**.
   - Working with death, trauma, grief, anger, conflict have a cost!

4. Compassion Fatigue almost **impossible to recognize without a heightened awareness of it**.
   - Employees must understand what to look in themselves and their co-workers.
   - The person with it is usually the last one to know.
COMPASSION FATIGUE: WHICH CAME FIRST?

BURNOUT

Greater employee stress, burnout or exhaustion, results in reduced ego defenses.

Weaker ego defenses, creates likelihood that the employee will be impacted by normal daily trauma narratives.

Trauma that would typically be acknowledged and empathically let go of!

SECONDARY TRAUMA

The more traumatic the trauma narrative/story, the greater the likely the employee will experience secondary (Vicarious) trauma response.

Experience Intrusive Thoughts, Defensive Avoidance, Dissociation, etc.

Increased Secondary Trauma requires more energy to carry out work activities and leads to increased burnout!
What is Burnout?
- Burnout is a state of physical, emotional, and mental exhaustion.
- The deleterious effects the environmental demands of the workplace have on the worker. (Gentry, 2002)

“Rustout” is a much better term, because it better represents the slow, gradual process that eats away at a caregiver’s spirit. (Kottler, 2010)

Burnout in the work Environment
- On a personal level burnout is a leading cause of reduced compassion satisfaction (job satisfaction).
- On organizational level, the more employees experiencing burnout the greater the employee perceptions of a toxic workplace (more gossip, more conflict, more turnover, more entitlement, etc.). (Mathieu, 2012)
Maslach (2003), Three dimensions of burnout:

- **Disillusionment** related to a sense of ineffectiveness and lack of accomplishment.
  - Begin to feel that we aren’t doing a good enough job. Need to either do more or get out of this job!
  - For new professionals or recent grads there is often a “loss of innocence.”
    - The greater the imagined success and power, the greater the potential for disillusionment.
    - “I thought I would have more say in my day to day work activities.”
    - “We worry more about compliance than we do about clients getting the help that they need.”
    - “I’m not able to use the tools that I learned in school!”

- **Exhaustion** related to great need for services, but limited resources with which to help a client.

- **Cynicism** resulting from unrealistic expectations and a lack of resources.
  - “Thinly disguised contempt.” Passive aggressive. Gallows humor!

Employees (and managers/supervisors) must understand their motives for getting into this field and how they influence the three dimensions above!
COMMONLY REPORTED SOURCES OF EMPLOYEE BURNOUT

- **Lack of control in work environment**
  - (High job demand + lack of control = poor employee health & Morale)

- **Lack of Empowerment to make decisions**
  - (No inclusion in decisions that impact employees job responsibility, micromanagement, limited autonomy)

- **Lack of collaboration with manager and with team**
  - (Poor team communication, little to no supervision)

- **Poor Communication**

- **Insufficient Orientation to the organization and the job**

- **Work Overload**
  - (Unrealistic case loads, 24 hour digital obligations, pressure not to take PTO, working shorthanded)

- **Management Culture is Unfair**
  - (favoritism, no accountability for some, arbitrary promotions, lack of honesty/insiders get information)

- **Too Much Change/Unclear Requirements**
  - (Requirements constantly changing, poor roll out of changes, etc.)

- **Impossible Requirements**
  - (Unrealistic time frames, insufficient staff to complete task)

- **Values conflict between employee core values and core values of the organization.**

- **Insufficient reward**
  - (feel taken for granted, lack recognition of efforts/successes, Insufficient compensation)
TYPES OF SECONDARY TRAUMA

Vicarious Trauma
- Single member of a system is affected due to regular contact with traumatized individual. (McCann & Pearlman, 1995)
  - Accumulation of memories of clients’ traumatic material that affects and is affected by the helper’s perspective of the world.
  - Appropriate boundaries prevent employee from processing trauma with the patient.

Chiasmal or Secondary Trauma
- Entire system infected by trauma experienced by one system member. (Kisher, 1984)
  - An individual observing another person experiences emotional responses parallel to the person’s actual or anticipated emotion.
EMployee Response to Compassion Fatigue

• **Re-experiencing traumatic events**
  • Recollections of the events, sudden intrusive thoughts
  • Dreams and or nightmares

• **Avoidance or numbing of reminders**
  • Depression
  • Dissociation/Depersonalization
  • Efforts to avoid/disconnected from thoughts and feelings
  • Efforts to avoid people who are associated with the stress.
  • Diminished interest in activities
  • Detached estrangement from others (difficulty with intimacy)

• **Persistent arousal**
  • Anxiety
  • Hypervigilance
  • Irritability or outbursts of anger
  • Difficulty concentrating
  • Startle response

All three are part of PTSD
Criteria from DSM V
### Physical symptoms
- Headaches
- Digestive problems: diarrhea, constipation, upset stomach
- Muscle tension
- Sleep disturbances: inability to sleep, insomnia, too much sleep
- Fatigue
- Cardiac symptoms: chest pain/pressure, palpitations, tachycardia

### Emotional symptoms
- Mood swings
- Restlessness
- Irritability
- Oversensitivity
- Anxiety
- Excessive use of substances: nicotine, alcohol, illicit drugs
- Depression
- Anger and Resentment
- Loss of Objectivity
- Memory issues
- Poor concentration, focus, and judgment.
- Hopelessness, Helplessness
- Loss of purpose

### Work-related symptoms
- Avoidance or dread of working with certain patients or in certain situations
- Reduced ability to feel empathy towards patients or their families
- Frequent use of sick days
- Lack of joyfulness
- Exaggerated sense of responsibility [becoming addicted to the need to be needed, getting hooked on involvement in others lives, (Mathieu, 2012)]
- Impaired ability to make decision/Questionable ethics (eg., med errors, etc.)
### Physical Self-Care:
- Eat healthily
- Exercise
- Get a massage
- Get medical care when sick
- Take time to be sexual
- Get enough sleep
- Take a vacation

### Psychological Self-Care:
- Take time to reflect
- Write in a journal
- Get personal therapy
- Decrease life stress
- Be curious, try new things

### Spiritual Self-Care:
- Find a spiritual connection or community
- Be open to inspiration
- Be open to not knowing
- Meditate
- Pray

### Relationship Care:
- Spend time with family members
- Stay in contact with other important people in your life (friends, co-workers).
- Seek out comforting activities with the important people in your life
- Allow the important people in your life to really get to know you.

### Miscellaneous:
- Receive Supervision/Consultation
- Mindfulness Meditation
- Resourcing
- Gardening
- Music
- Hobbies/Crafts
- Asking for help
- Focus on Solutions
- Watch feel-good movies
- Attend Professional Development Activities
- Laughing with co-workers
ORGANIZATIONAL TRAUMA

ENTIRE ORGANIZATION BECOMES TRAUMATIZED BY WORKING WITH CHRONIC TRAUMA, TRAUMATIZED LEADERSHIP, TRAUMATIZED PEERS, AND TRAUMATIZED WORK CULTURE
Organizational Trauma

- Stein 2004 - “At any level, trauma is an experience for which a person - family – group is emotionally (not only cognitively) unprepared, an experience that overwhims one’s defensive (self-protective) structure and leaves one feeling totally vulnerable and at least temporarily helpless.”

- Workplace organizations can experience trauma just as individuals and families can.
- Single traumatic event such as a client death, single assault resulting in injury to an employee, death of a trusted leader. Consider impact of Columbine shooting, Oklahoma City Bombing, etc.
- Accumulated events such as ongoing injury to employees, ongoing assaults/threats to employees, leadership changes resulting in significant changes in job satisfaction (employees feeling less safe).
- Significant number of employees with Compassion Fatigue (i.e., burnout & secondary trauma)
SYMPTOMS OF ORGANIZATIONAL TRAUMA

- See significant change/disruption to department organization, values, coping strategies
  - Shifts in Values, Rules, Roles, Routines, Rituals & Relationships/Boundaries

- Increased Conflict, Anger, Resentment, Emotional Distance, Emotional Intensity, shifts in intimacy, shifts in parenting, shifts in decision making, conflict between labor and management, etc.

- Excessive amount of Worker’s Comp claims
- High absenteeism
- Changes in co-workers relationships (conflicts)
- Inability for teams to work well together
- Staff challenges organization rules & regulations
- Inability of staff to complete assigned tasks
- Staff displays lack of flexibility
- Constant changes in organizational policies
- Unhealthy competition between staff members.

- Shift from Solution Oriented thinking to blame and Fault Finding
- Aggressive behavior, lack of empathy tolerated between staff/clients
- Managers looking the other way, not addressing clear and present issues.
- Exceptions made, rather than assistance provided
- Rampent rumors & gossip

As stress & burnout increase, perception of what is happening in the department becomes more important than what is actually happening!

Rumors, Gossip, Private Conversations, Secrets, Closed Boundaries guide the narrative about what is really happening!

Smith - Compassion Fatigue Awareness Project, 2008/2009
ASSESS THE ORGANIZATIONAL HEALTH OF YOUR TEAM

**Values**
- What are your agency values?
- What are your team values?
- What kind of culture do they create?
- Have they changed in recent weeks/months?
- Is there an event that this change is correlated with?

**Rules**
- What are the rules associated with communication?
- How do you address secrets?
- How do you address employee complaints?
- How do you address rumors?
- Do you share more or less with employees/certain employees?
- How do you deal with deviation from rules, guidelines, policies/procedures?
- Have these changed in recent weeks/months?

**Roles**
- Is there a clear delineation in terms of who does what, work responsibilities, information sharing, decision making, etc.?
- Are employees aware of and adhere to their role and responsibility?
- Do you ask team members to work outside of their responsibility?

**Routines**
- Is there a structure to what is expected on your team, formal and informal rules?
- Is everyone clear on the Policies & Procedures for their daily work?
- Are you aware of work-arounds and informal agreements to work outside of policies?
- Do people adhere to policies regarding sick time, calling off?
- Do you routinely maintain informal contact with your team?

**Rituals**
- Do you have unique ways to recognize your employees for a job well done?
- Do you have unique ways to support an employee who is having a difficult time? CF?
- Do you celebrate birthdays, births, etc.

**Relationships**
- Have relationships changed between you and your team members?
- Are there team members who feel like insiders and others who don’t feel included (outsiders)?
- Has there been more conflict between team members or between management & the team?
- Have there been shifts in team collaboration, teamwork, etc.
MICHAEL F. BARNES, PH.D., MAC, LPC
CHIEF CLINICAL OFFICER

Foundry Steamboat Springs
1915 Alpine Plaza C4
Steamboat Springs, CO 80487

Email: mike.barnes@foundrysteamboat.com
Phone #: 303-885-1846
Foundry Website: www.forgingnewlives.com
Dr. Barnes Website: www.drmikebarnes.com