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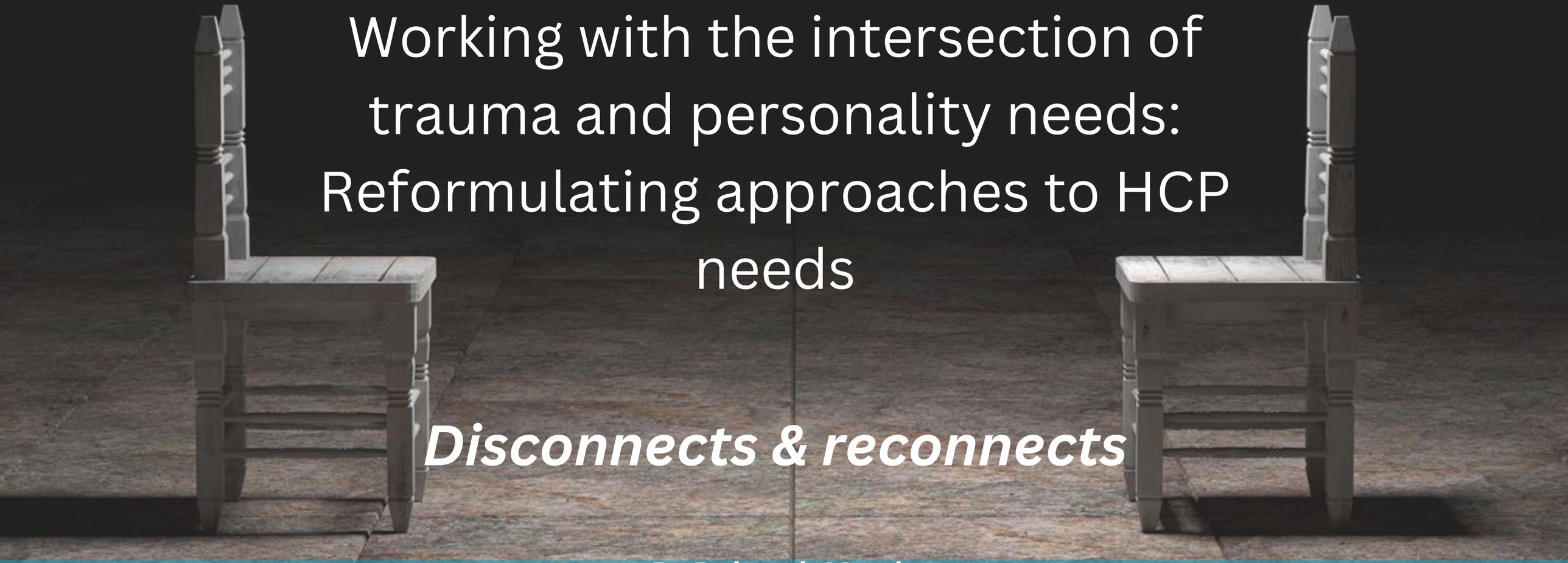
Centre for Developmental and Complex Trauma
Part of St Andrew's Healthcare

Working with the intersection of trauma and personality needs: Reformulating approaches to HCP needs



Disconnects & reconnects

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Aims of the presentation

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- Overall aim, to reconnect the disconnects in research and practice relating to occupational distress / wellbeing
- **Paper in 3 parts**
- Briefly set the scene
- **Part 1 Disconnects:** The current approach of occupational distress research and wellbeing practice
- **Part 2 Reconnects:** Outline relevant models and evidence base to those working with high trauma-exposed populations
- **Part 3: Reconnecting** with core psychotherapy knowledge and skills

Clinician wellbeing - negative biopsychosocial outcomes

- The wellbeing of HCPs is one of the most debated and researched areas in the health sector, currently. The 2022 NHS staff survey showed that, whilst challenges remain, small areas of progress in improvements of wellbeing were apparent:
  - 56.5% - organisation takes positive action for health and wellbeing
  - 69% - manager takes a positive interest in wellbeing
  - 34% reported feeling ‘burnt out’
  - 44.8% reported feeling unwell due to work-related stress

Psychological
Anxiety
Depression
Vicarious trauma
PTSD
CPTSD

Somatic concerns
Headaches
Sleep disturbance
Appetite disturbance

Physical health
Hypertension
Cardiovascular disease
Physical injuries

Interpersonal
Social withdrawal
Disruptions in personal and work relationships

Impact on care
Lack of continuity and reduced quality of care for service users
Less compassionate care

Data from staff groups with exposure to high trauma-exposed populations and working with people with personality disorders

- In addition to negative sequalae, staff working with high trauma-exposed populations also report….

Exposure to violence

- Higher levels of exposure to physical violence

Exposure to verbal aggression

- Higher levels of exposure to verbal aggression

“Burnout”

- Higher levels of burnout
- Higher proportion of ‘high levels of burnout’

Primary and secondary trauma

- Higher levels of PTSD, CPTSD & Secondary trauma

The ‘pull to punish’

The ‘pull to withdraw’

Ethical & professional challenges of working with trauma-exposed populations as sources of distress

Chronically exposed to distressing histories, that are often invalidated

Exposure to acute and high levels of distress, over prolonged periods of time

More likely to work with self harm and suicide ideation

To engage with service users subject to restrictive legislation and practices

To engage with coercive practices (working conditions that lend themselves to ethical and professional tensions

‘Problem child’ services - Exposed to higher levels of organisational distress / CQC concerns

Limited resources, high levels of sickness / turnover, not always able to provide care needed

moral distress and ethical dilemna’s

The organisational and financial impact of occupational distress

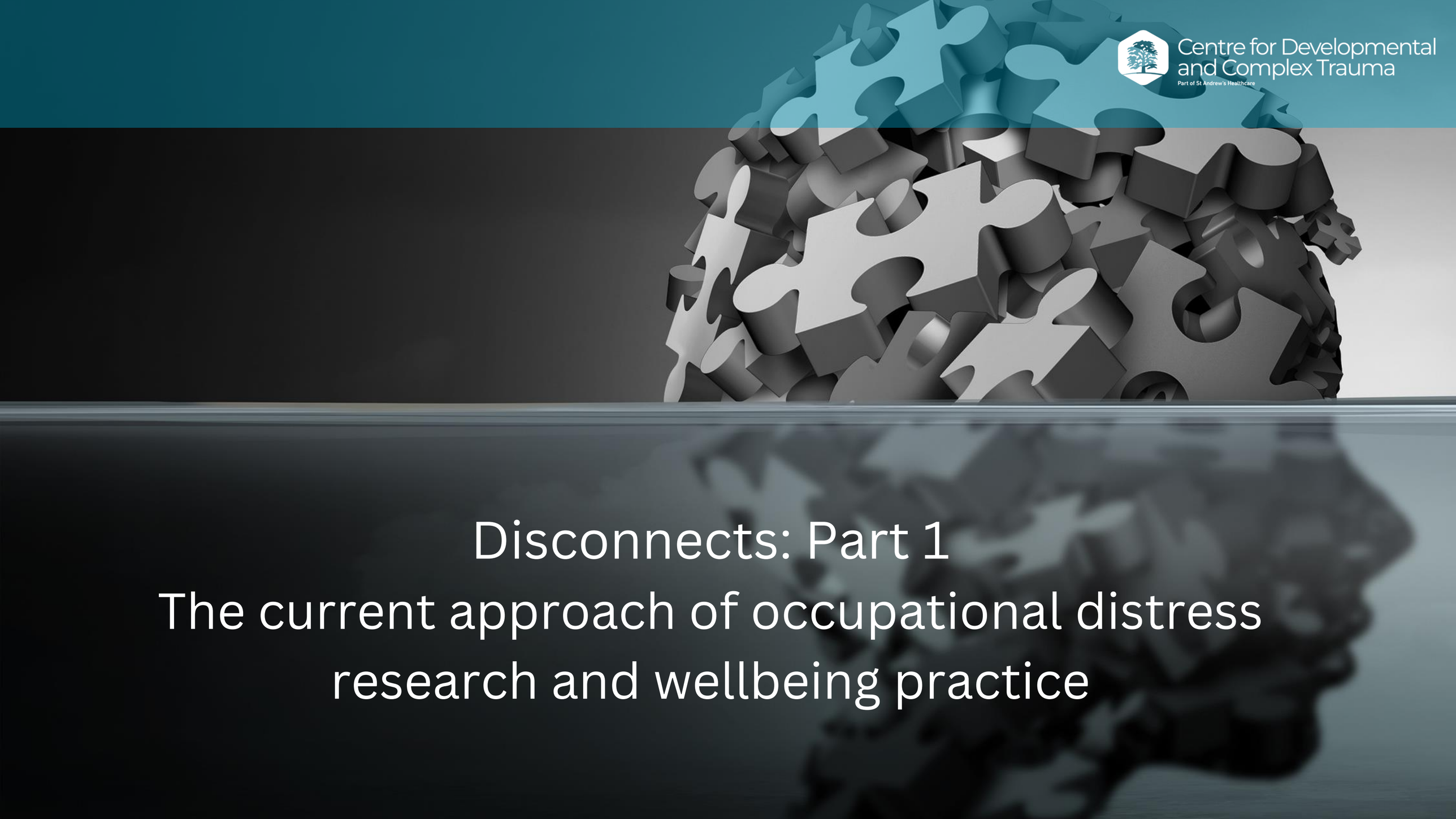
- The 2022 report by the IPPO (international Public Policy Observatory), UEA and RAND Europe concluded that poor mental health and wellbeing in the NHS amounted to £12.1 billion (9.39% of total NHS budget of £133billion for 2020)

- Direct organisational consequences included
  - Compromised quality of patient care reduced quality of care
  - Poor financial performance
  - Reduced patient satisfaction

- NHS trusts and independent provides are under significant pressure to produce policies and action plans that address staff wellbeing and reverse long standing trends.

- Pressure to roll out interventions is likely impacting on the consideration and quality of initiatives

- Pressure to roll out interventions is creating ‘disconnects’ between theory and practice in research that aims to understand occupational distress and the programmes that seek to prevent or reduce it.



Disconnects: Part 1
The current approach of occupational distress research and wellbeing practice

Current approaches to workplace trauma: disconnects and discordance

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- There is a significant and growing body of research relating to the causes of occupational distress and wellbeing programmes, yet

- The is a discordance in how we approach service user wellbeing and staff wellbeing, both clinically and in research

- **Service user interventions are derived from**
  - Assessments
  - (agreed) formulation of need
  - (agreed) intervention plan, derived from the evidence base

- **Staff interventions**
  - Action plans are often implemented in the absence of a detailed assessment of need
  - Not grounded in an evidence base
  - Not subject to academic rigor in terms of development and evaluation

Current approaches to workplace distress

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- Systematic reviews have consistently reported that the poor design of evaluations of staff wellbeing initiatives impedes growing an evidence base

- Current approaches are predominantly focused on individual factors – common approaches include coping interventions and resilience-based training, mindfulness-based stress reduction programs, meditation and relaxation exercises, autonomy and workload management training, and psychoeducation.

- Interventions for staff distress often focus on transactional balance - the idea that resources don't match demand - without exploration of meaning attached to distressing events.

- Focus is also largely on management strategies above prevention - distress is primarily treated once it has arisen as opposed to being targeted at its root, likely bearing greater individual, organisational and economic costs in the long-term

- Longer lasting positive outcomes have been reported when individually-focused interventions are applied in combination with organisation-directed interventions (Awa et al., 2009)

- A review of 35 years of burnout intervention research in mental healthcare providers indicated minimal impacts on staff distress, suggesting a need for a wider breadth of interventions that address organisational and individual needs (Dreison et al., 2018)

Disconnects in research exploring occupational distress that inform wellbeing programmes

Research exploring occupational distress (OD) serves a number of functions

- Surrogate assessment of need: scope and nature of the problem
- Inform interventions to prevent and manage OD

Limitations in current occupational distress research

- Studies typically look at a small number of diagnostic categories
- Fail to explore their relationship with each other or functioning
- Largely focuses on organisation factors as active mechanisms of harm, rather than non occupational factors (we live in a vacuum)

Assumptions

- All staff experience occupational distress in the same way
  - settings, role and individual factors (homogenous sample)

- Measures of occupational distress reflect ***occupational*** **sources of** distress
  - With the exception of social support, research largely ignores non occupational sources of distress that contribute to current picture

- Vital to ensure that we have the correct understanding of the causes of OD, to ensure that we have interventions to improve wellbeing

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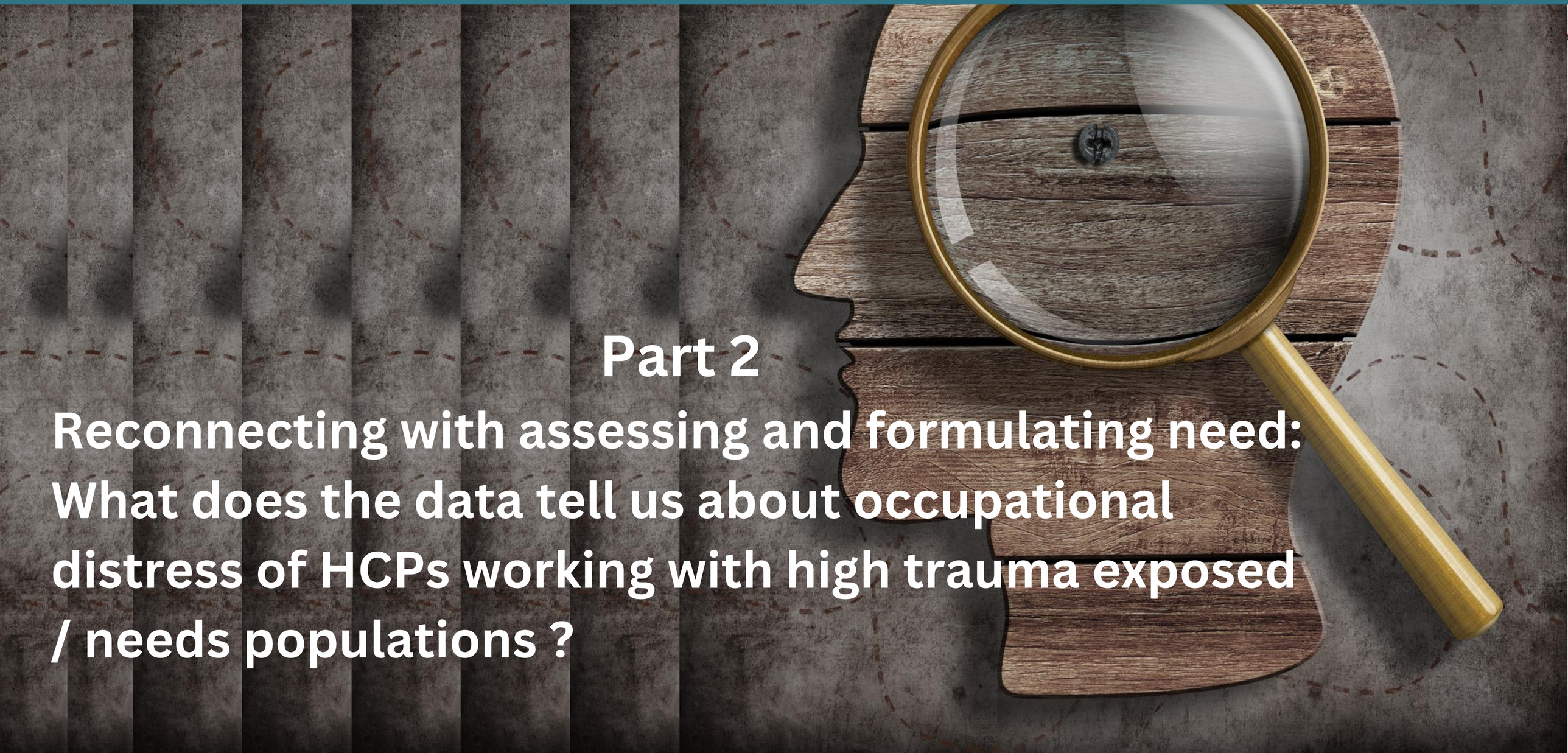


Part 2

Reconnecting with assessing and formulating need: What does the data tell us about occupational distress of HCPs working with high trauma exposed / needs populations ?

Occupational Distress in staff working in high trauma exposed settings

A series of studies undertaken with a staff group who work with service users with high levels of trauma exposure and comorbidities.

Service user population

- High levels of ACEs in patient population
  - 4+ ACEs - 58%- 73.1%
  - 6+ ACEs - 36%; 57.7%

- High levels of CPTSD (32%-67%) as comorbid diagnoses

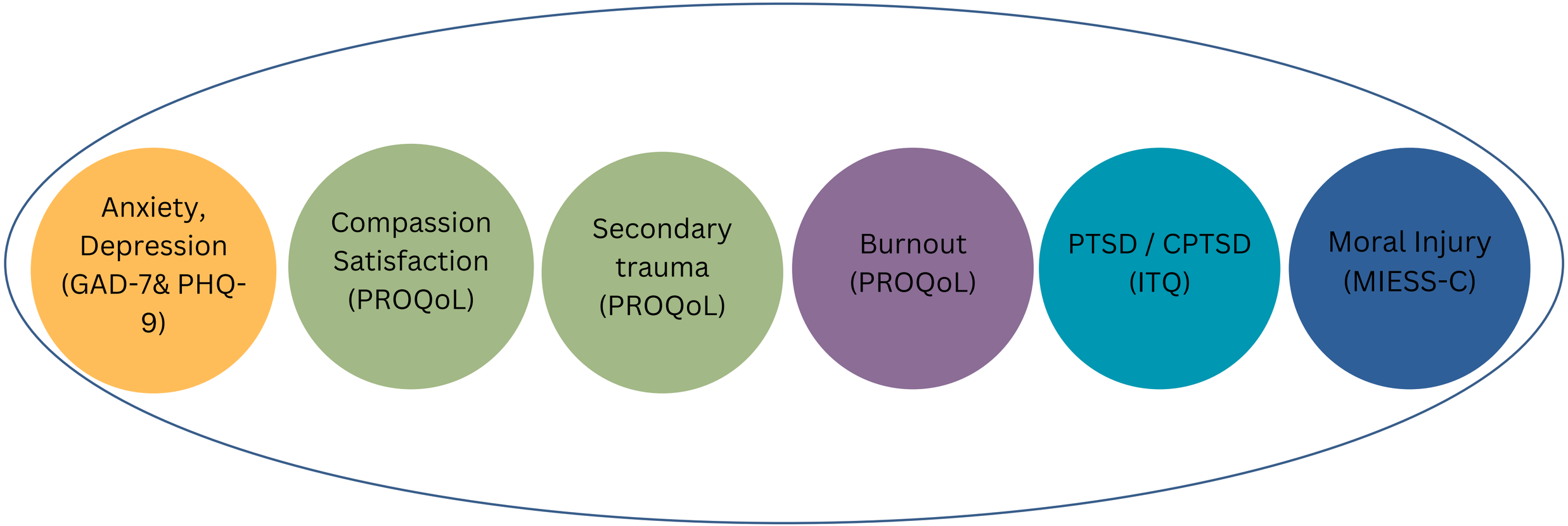
- High levels of Developmental Trauma Disorder (65%) as comorbid diagnoses

- Common comorbidities are
  - Personality Disorder
  - Psychosis
  - Developmental needs
  - Bipolar Disorder

Key Questions

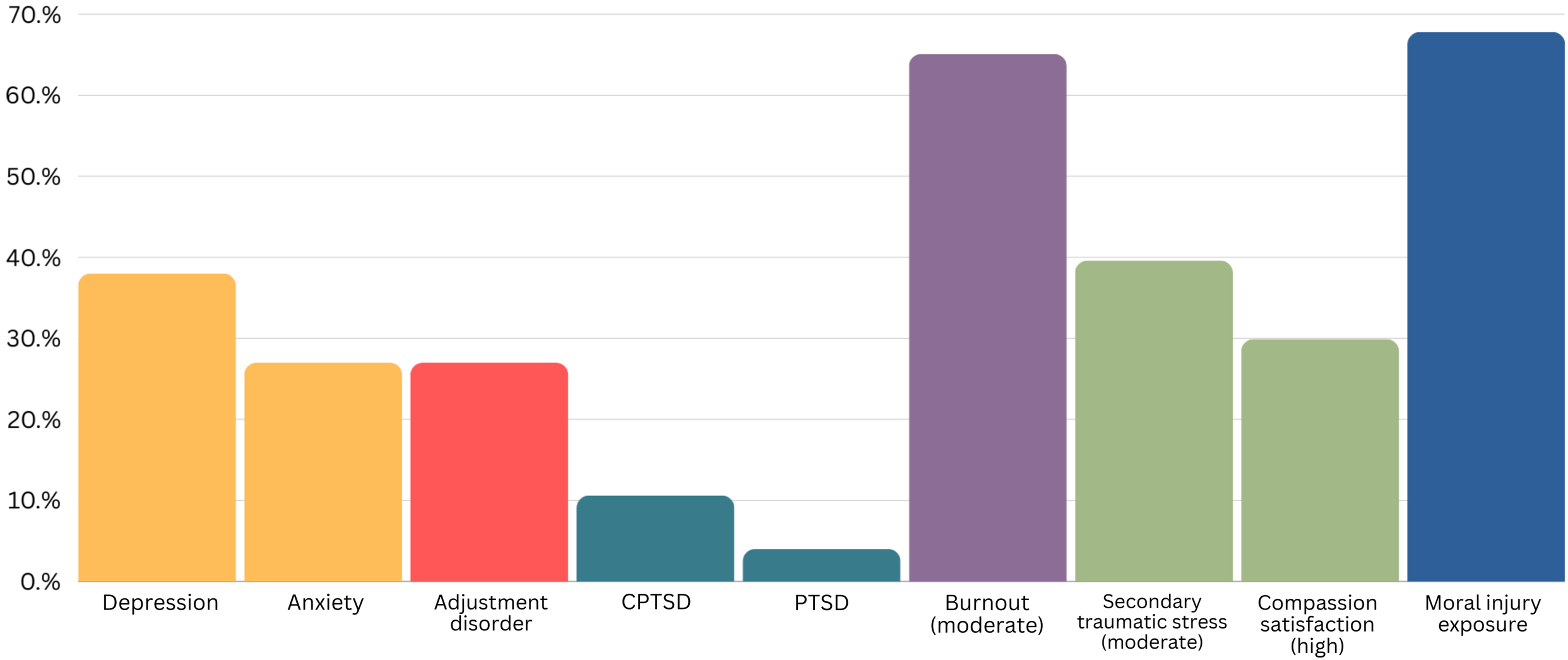
- What does clinician distress look like?
- What frameworks account for clinician distress / functioning
- What is the role of non occupational factors

The potential negative trauma related psychological consequences of working with traumatised populations



- Sources of non occupational distress (inc IADQ)
- Levels of functioning (WSAS)

The negative trauma related psychological consequences of endorsed by HCP's



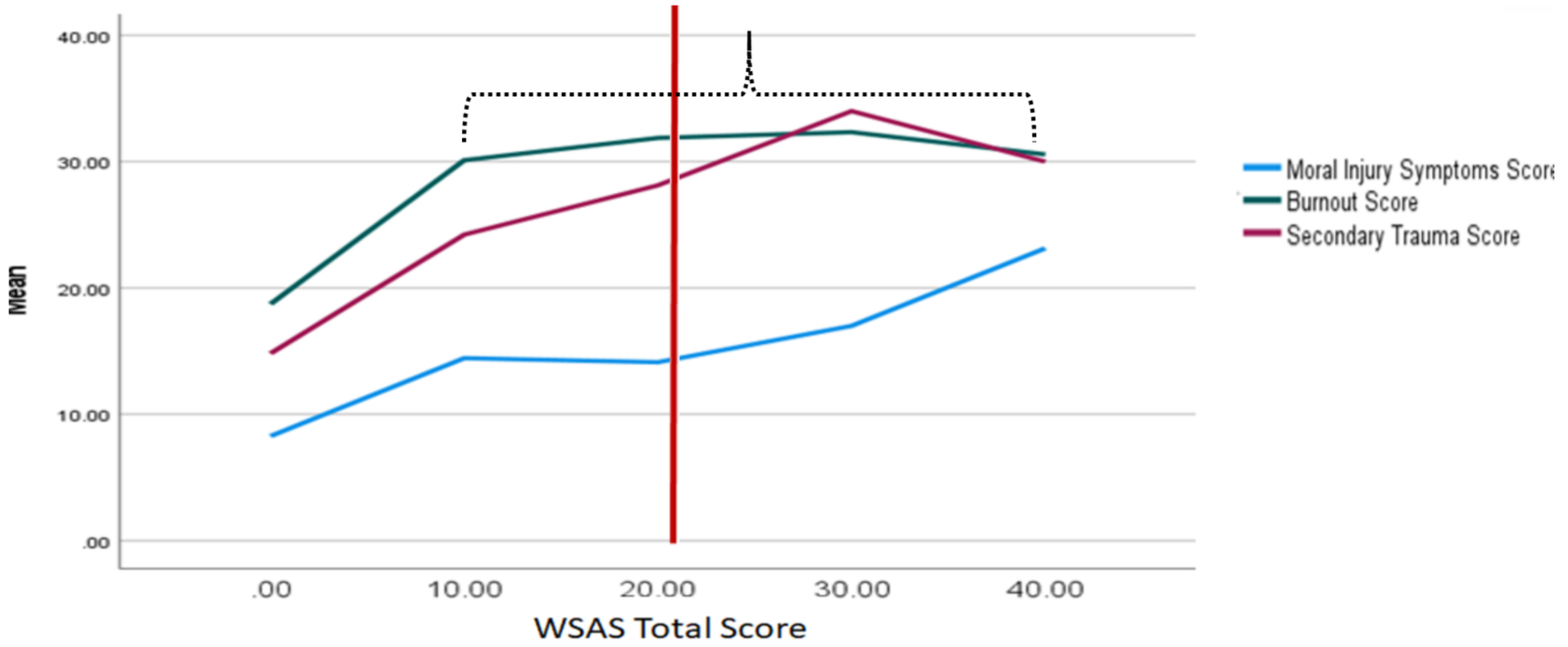
Relevant paradigms and Frameworks in relation to functioning

Diagnostic frameworks and relationship with functioning

- Moderate associations between diagnostic frameworks and functioning
- Specifically, as pathology increased so did functional impairment

Non diagnostic frameworks and functioning

- Similar pattern emerged
- Unexpected pattern with burnout scores



Functional impairment was significantly predicted by moral injury (B=.79, p=.001), burnout (B=.99, *p*=.001), and secondary trauma (B=.69, *p*=.001).

Lack of change in BO score noted from mild to very severe levels of functional impairment

Which frameworks predict functional impairment in HCPs?

Model 1: Diagnostic categories:

The model, as a whole was predictive, however, no single diagnostic category were independent predictors of impairment

Model 2: Non diagnostic categories:

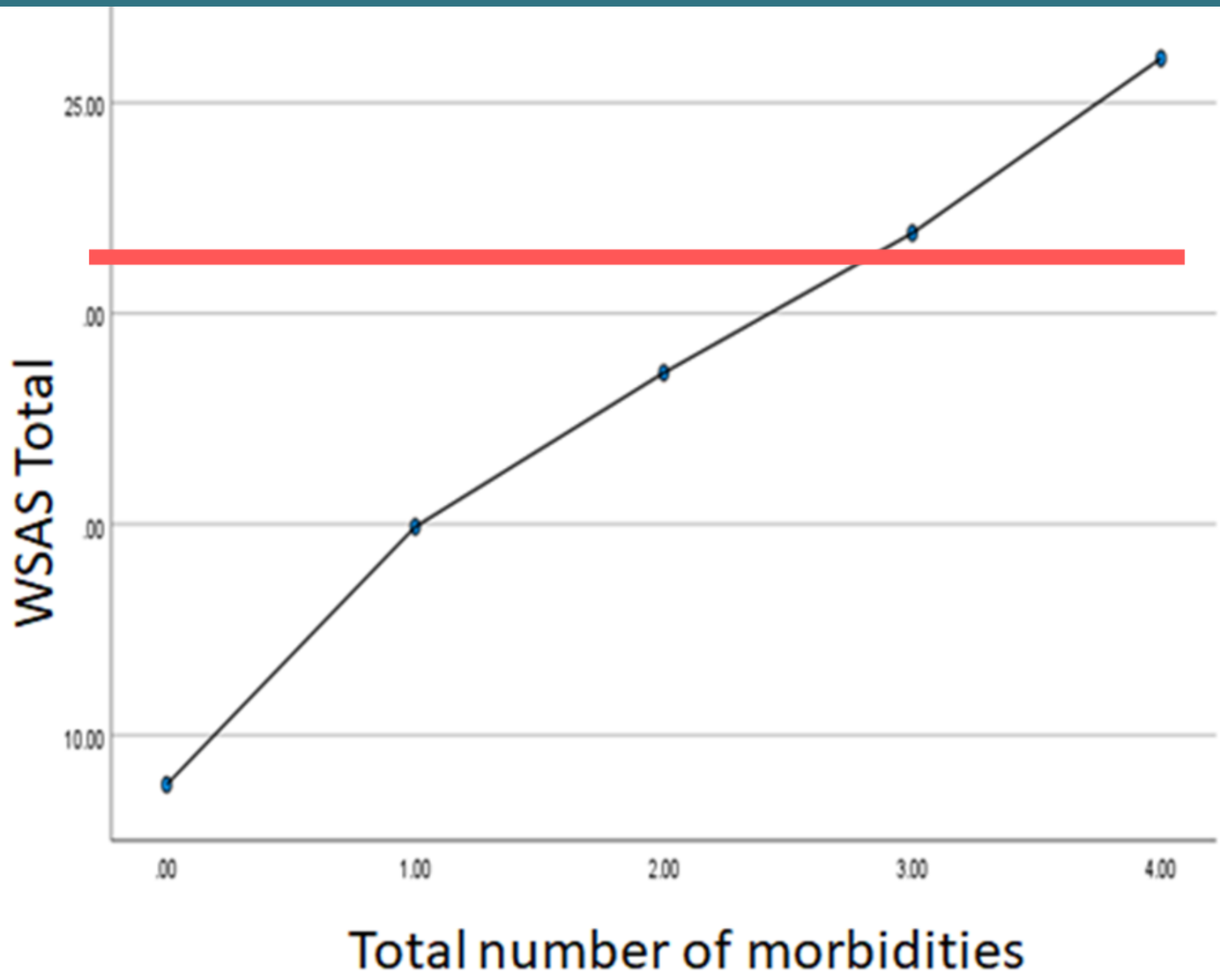
- The model as a whole was predictive of functional scores.
  - Secondary trauma and burnout predicted Functional scores.
  - However, when moral injury was introduced secondary trauma was no longer a significant independent predictor of functional impact.
  - Only moral Injury and Burnout were independent predictors
  - The additional of MI significantly added to the model and was the strongest contributor to accounting for WSAS scores

Model 3: Combined diagnostic and non diagnostic categories?

- Model was significant predictor of functioning. Burnout and moral injury were the only significant independent predictors
  - Final model: 44.7% of variance explained
  - MI biggest contributor 9.5%

The impact of multiple pathologies and functioning

- Number of morbidities significantly positively predicted level of functional impairment (B=4.33, p=.001)
- Relative risk for moderately severe functional impairment increased with the number of morbidities
- Series of regression analyses found that the number of morbidities didn't significantly add to the predictive power of the model over the contribution of individual pathologies
- Again, burnout and moral injury were independent significant predictors of functioning
- Moral injury was the largest predictor of functioning



What are the sources of moral injury endorsed by HCP’s

- Troubled by being betrayed by specific people
- Troubled by own omissions (things I didn’t do e.g. fail to intervene)
- Troubling seeing actions of others
- Troubled by being betrayed by institutions

Relationship between MI and Burnout?

Burnout scores were moderately associated with being:

- Troubled by being betrayed by institution's
- Troubled by being betrayed by specific people
- Troubled seeing the actions of others

Job role-related sources of occupational distress

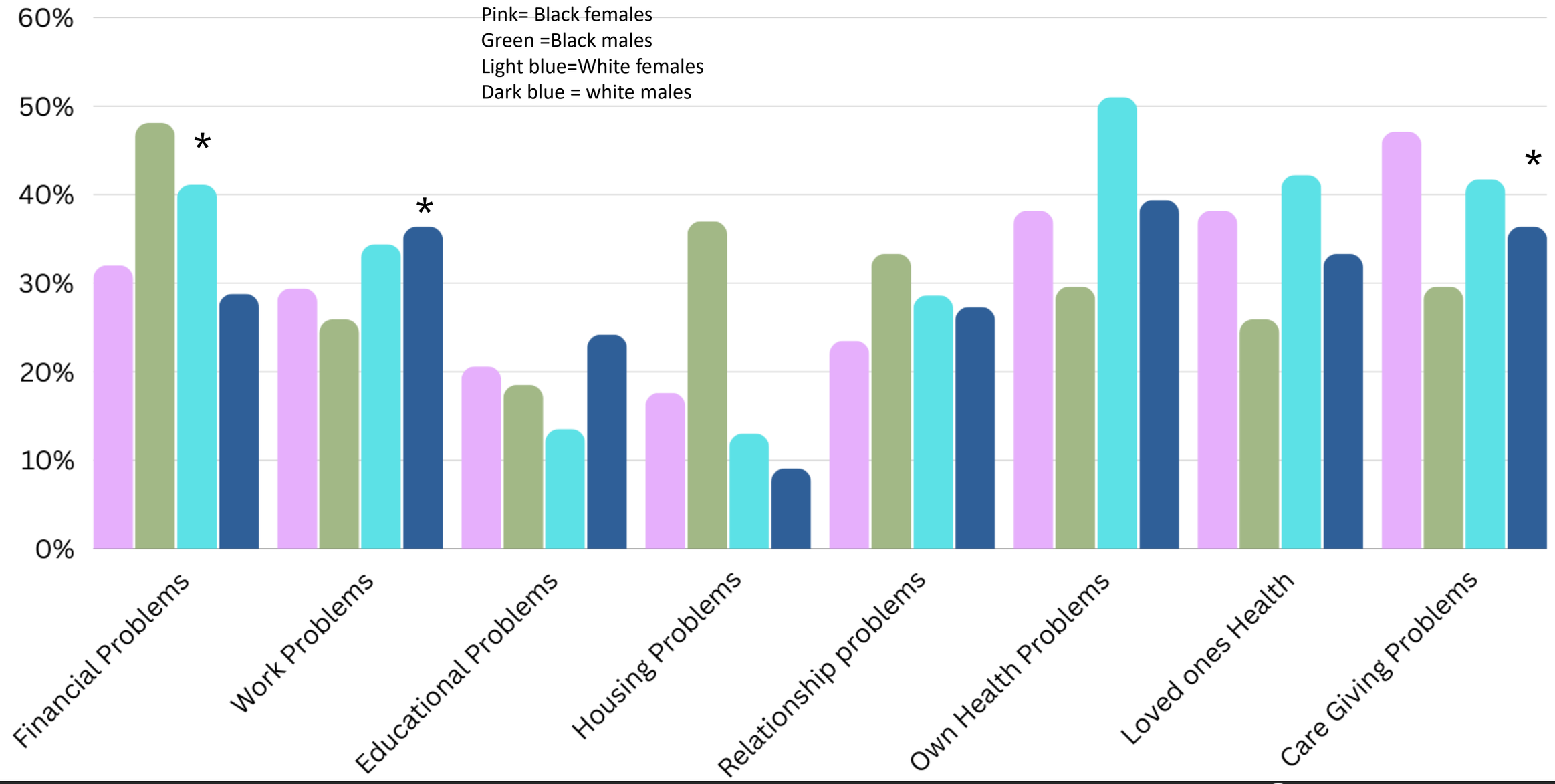
- Frequency of exposure to violence in the workplace (aggression, self-harm, inappropriate sexual behaviour) = significant positive predictor of moral injury exposure and symptoms in white female healthcare workers

- Frequency of involvement in restrictive practices (restraints and seclusions) = significant positive predictor of moral injury exposure and symptoms in white female healthcare workers

- Working across wards of mixed genders (lack of secure base) for those working in areas with higher levels of acuity associated with greater distress

- Significant differences between profession groups limited to secondary traumatic stress (↑ nursing vs. non-clinicians) and moral injury exposure (↑ MDT vs. non-clinicians)

HCPs do not live in a vacuum: Sources of non occupational stressors in HCP



Sources and markers of non occupational stress that impact on overall distress and functioning

Greater number of life stressors (exclusive of work related worries) was associated with:

- Greater moral injury exposure and symptoms
- Greater burnout
- Greater secondary traumatic stress
- Greater depression
- Greater anxiety
- Greater PTSD
- Greater CPTSD
- Reduced compassion satisfaction

- Males without social support reported:
  - Higher burnout, depressive symptoms, CPTSD symptoms and somatic concerns
  - Lower compassion satisfaction
  - Higher overall no. of psychiatric diagnoses met

- For females, differences based on social support were in functional impairment and CPTSD only (.05 level)

Key information

2/3 of traumas reported on the ITQ were not work related

Previous MH treatment = ↑ secondary traumatic stress, burnout, depression, anxiety, somatic symptoms, functional impairment, PTSD and CPTSD, and moral injury exposure and symptoms

↑ **Self-reported physical health problem**s = ↑ secondary traumatic stress, burnout, depression, anxiety, somatic symptoms, functional impairment, CPTSD, moral injury exposure and symptoms; ↓ compassion satisfaction

↑ **Self-reported *personal* impact of Covid-19** = ↑ secondary traumatic stress, burnout, depression, anxiety, somatic symptoms, functional impairment, moral injury exposure and symptoms; ↓ compassion satisfaction

Reconnecting knowledge and practice: Implications for interventions to improve wellbeing (or prevent distress)

- HCP's working with trauma exposed populations and comorbid needs are resilient, but that needs to be balanced against the need to support and nurture

- Distress is multifaceted and from multiple sources

- HCP's struggle when working in contexts where 'what is right' is violated or transgressed.

- HCP's do not exist within a vacuum, with non work sources of distress also being impactful, need also to be realistic about what work focused interventions (alone) can achieve.

- HCPs experience the healthcare environment (and life events) differently, intersectional differences were noted in sources and impacts of stressors.

- When designing interventions to improve occupational wellbeing we need to first assess and formulate need
  - Take into account a wide range of diagnostic and non diagnostic frameworks that are likely to be present in HCPs with high levels of trauma exposure
  - Measures of functioning will help prioritise critical areas of need
  - Assessing moral injury is key to include in assessments for staff working in high trauma exposed populations
  - Including role and non occupational factors is critical
  - Different roles and demographic groups will have differential causes and experiences of occupational distress

Reconnecting knowledge and practice: Implications for interventions to improve wellbeing (or prevent distress)

- Interventions to improve wellbeing in the workplace that have a transactional focus and do not attend to MI (meanings) are likely to be of limited efficacy - the meaning that HCPs attach to events is an important area to target for change

- Interventions focusing on moral injury need to reflect the ***interpersonal*** nature of 'betrayals' and 'transgressions'
  - Restorative justice approaches may have utility here
  - Schwartz rounds?

- Interventions that negate the impact of life outside of work, may also be of limited impact
  - Do we need social workers in wellbeing programmes rather than an exclusively psychological focus

- Do we need to have pragmatic discussions about how colleagues who have mental health needs, not necessarily relate to work, access support?
  - Costs benefits ratio needs to be explored

Reconnection: Implications for interventions to improve wellbeing: Attending to the moral context of our roles work

- Ethical dilemmas are inherent in healthcare settings, especially in working with populations who are subject to restrictions, access to services and who are socially marginalised

- The challenge in healthcare is to distinguish between what is preventable and what is not preventable

- How we approach the two will likely require differential approaches

International guidance on developing morally healthily healthcare organisations

- Recent international Delphi study of 40+ moral injury experts from Europe, USA, China and Australasia generated 15 areas of practice guidance for developing morally centered healthcare organisations, with 111 recommendations for the prevention and management of moral injury in healthcare (Morris, Dean, Webb et al., 2023)

- How we navigate and work with the regulatory environment
  - Healthcare environment: Priorities, culture and engagement with staff groups
  - Leaders: What they need and what we need from leaders
  - Operational leaders: Workforce, resources, values, practice, behaviour of managers and supervisors
  - Valuing people: Operational approaches
  - People management, wellbeing, supervision and how we manage transgressions in the workplace
  - Investing in moral considerations: Policies, training, research and communications
  - Evidencing how we mitigate moral distress / injury

Part 3

Reconnecting with core psychotherapy knowledge and skills: The role of clinical supervision in remediating the impact of occupational distress in staff groups who work with people with trauma needs

The critical role of clinical supervision in enhancing wellbeing of HCPs

Martin et al., 2021

- Several recent systematic reviews have highlighted the critical importance of good clinical supervision in
  - Improving overall wellbeing
  - Mitigating the impact of burnout (depersonalization and exhaustion)
  - Greater job satisfaction
  - Constructive feedback was specifically highlighted in enthusing staff to want to ‘give something back’

  - Organizational benefits also noted
    - Retention
    - Improved work environment
    - Better uptake of policies & processes

  - By contrast inadequate supervision is associated with
    - Increased stress
    - Increased burnout.

Rothwell et al., 2021

Enablers

- Regular supervision,
- Protected time, in a private space and flexibly delivered
- Choice of supervisor
- Supervision based on mutual trust and a positive relationship;
- Cultural understanding between supervisor and supervisee;
- Shared understanding of the purpose of supervision,
- Based on individual needs,
- Focused on enhancing knowledge and skills;
- training and feedback being provided for supervisors;
- Use of a mixed supervisor model, delivered by several supervisors, or by those trained to manage the overlapping (and potentially conflicting) needs of the individual and the service.

Barriers

- Lack of time, space and trust.
- Lack of shared understanding to the purpose of the supervision
- Lack of ongoing support
- Lack of engagement from leadership and organisations

One example of how we could use clinical supervision: Transference and counter transference

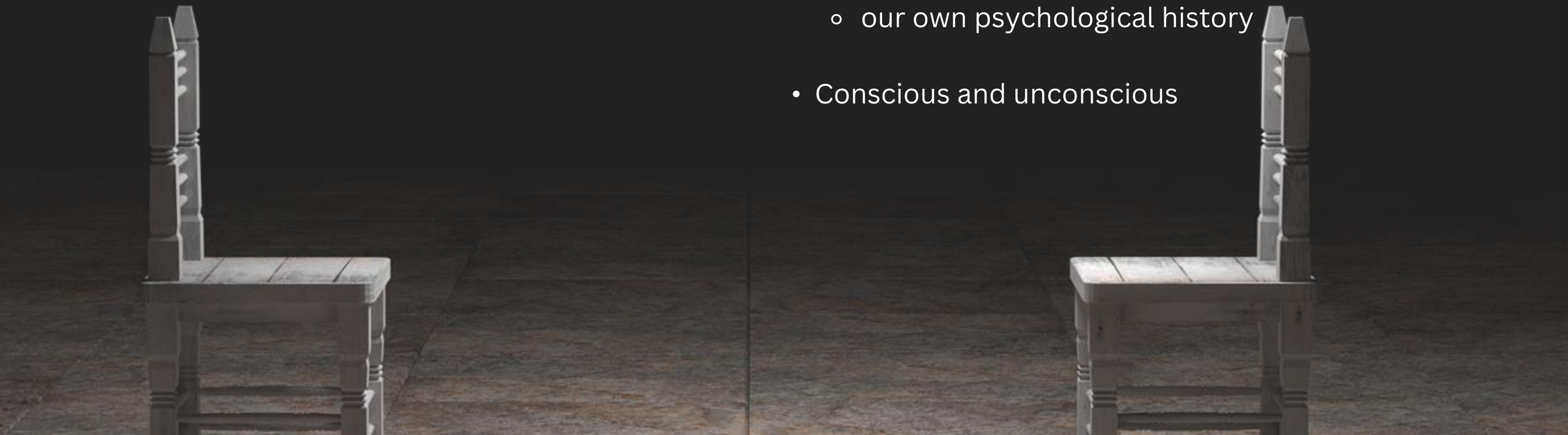
Transference

- Deep, intense transfer of feelings
- Positive, negative and sexualised
- Transference from specific patient groups can be especially challenging
  - people who are suicidal

Counter - Transference

- initially formulated as our reactions to the ‘projections’ of our clients
- Contemporary approaches acknowledge that it is the complex interplay between
  - Behaviours of service users
  - Clinical systems
  - our own psychological history

- Conscious and unconscious



What is the relationship between counter transference, well-being and care?

- Adverse Counter Transference can have a detrimental effect clinician wellbeing and the quality of care they provide.
  - Clinician distress
  - Therapy outcomes
  - Management of counter transference (in the clinician) can alter outcomes

- Individuals with trauma and personality disorder needs can elicit strong attitudes and behaviours from HCPs
- This is especially true when working with people who present with suicidal ideation, intent or behaviours
  - Associated with increased clinician distress, especially anxiety
  - Associated with negative impacts in care in terms of
  - Clinician attitudes to SU's, Clinical decision making,
  - Predict short and long term suicidal behaviour and outcomes

- Adverse counter transference reactions (from therapists) include
  - disinterest, angriness, anxiety, confusion, overwhelming, entrapment,
  - sense of rejection, inadequacy, helplessness or distress

- TRQ-SF (Measure of counter transference)
  - Hope
  - Distress
  - Affiliation
- Counter transference management scale

Summary

- Data, collected from the NHS suggests that small improvements in wellbeing are being reported, yet ill-being in HCPs continues represent £12.1 billion of the NHS budget.
- HCP's working with high trauma exposed populations / additional needs are resilient, want to do what is right and are exposed to stressors in and outside of the workplace. Both sources of stressors were impactful
- HCP distress comprises of both diagnostic and non diagnostic frameworks, with key roles likely played by burnout and moral injury
- HCP's are not a homogeneous group, experiencing the workplace and sources of stress differently.
- Current approaches to occupational wellbeing / distress are often disconnected from assessments of need, from research and from acknowledging the work and private worlds of staff
- The 'meaning' that we attached to workplace transgressions may be critical, but needs further exploration, at the very least 30 years of 'transactional' based interventions have produced limited long term positive changes
- Whilst we continue to search for innovations in workplace wellbeing, reconnecting with the benefits of clinical supervision is critical for HCPs working with populations who themselves have to work incredibly hard in their own recoveries.

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