Caring for the Caregiver: Managing Occupational Stress

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SINCE 1987, I have spoken to over 300 health care workers who have incurred occupational exposures. Approximately two thirds of the interventions were through my position as Clinical Director of Counseling at our University/public health teaching hospital. These health care workers come for human immunodeficiency virus (HIV) test results, post-test counseling sessions, and crisis intervention after their occupational exposure. Their needle stick, laceration, or blood or urine splash has brought us together.

The remaining one third—approximately 100 health care workers—came through my private practice in a neighboring suburban town that has three major hospitals in a 4-mile radius. They were referred by their physicians, friends, or colleagues for brief counseling or long-term psychotherapy for interpersonal and/or familial relationship problems. Although the initial presenting problems were different between these two groups, the concerns of occupational exposure were pervasive.

The fears and feelings of health care workers in both public and private health care settings have commonality. After all, in whatever setting, these health providers are dedicated to their work and their patients. They show a vulnerability, a humanness. Obviously, seroconversion to HIV+ status tops their list of fears. The ways in which this fear manifests itself are dependent on a multitude of variables. The primary ones are (1) availability or unavailability of daily support systems through work and home (coworkers, supervisors, family, friends), (2) pending psychological issues in their personal and professional lives, which are or are not being addressed at the time of the occupational accident, (3) presence or absence of consistent self-nurturance, and (4) absence of appropriate knowledge or education about HIV.

This psychological response (intensity of emotion) to the occupational accident is most often disproportionate to the exposure risk level. The smallest urine splash to the eye can illicit the greatest attack of anxiety. A deep needle stick from a late-stage HIV-positive patient can bring calm, spiritual reflection. Familiar responses have been: "Whatever God has in store for me I'll handle;" "Medical school taught me to distance myself from death so I can save lives. It comes in handy when denying my own feelings of mortality." Other common responses have been: "I'm the one in my family who's the perfectionist, the over-achiever. So how can I admit something in my world *wasn't* perfect?" or, "My husband and I are making temporary sacrifices in our relationship so I can get through med school. I hadn't planned on a possible permanent sacrifice...."

In this article, you will read experiences of your contemporaries. I have purposely used descriptions pertaining to several different incidents, and combined them from time to time. This is to protect your confidentiality with extended sword. I have specifically taken from the most repetitive situations encountered with health care workers, and also with anesthesia care providers specifically. Perhaps you will find some comfort in knowing you are not alone. You will learn that job accidents happen in health care for the same basic reasons they happen in the computer industry or in the hotel/restaurant trade: We are human. We are imperfect, and so is the world around us.

Over these years, I have been the privileged observer of your stories and of the emotional pain that unfolds. I have heard your countless depictions of burdensome, everyday realities (overworked, understaffed; overflowing needle disposal containers out of reach). I have watched your faces of anguish as traumatic childhood

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memories or unresolved grief surfaces without restraint. In my heart lies empathy, compassion, and concern. I understand. For I, too, am a health provider; a human being. I know my intuition, combined with my skills and experience, have allowed me to guide you through your crises. We unite in this confidential, psychosocial journey. I see your terror, your pain, and, in numerous cases, your shame and self-blame.

Sometimes, you ask for a hug. I give it, and I want to give more; namely, a fast solution to your anxiety. But I know I can't. You see, codependency can be a big issue for psychotherapists, as well as for health providers across the specialties. After all, we can get paid for being codependent. To ensure professional longevity, it is one title to disown. I've learned to respect, allow, and foster the unique processes of my clients. I'm comfortable leaving the "fix-it" concept to Home Depot.

Sharon is a client who asked for a hug one day. She is in her early thirties; the first child in her family and the caregiver/enabler of the family. For years, she provided nurturance and was the "fix-it" person for those she loved. She is a mentor for younger family members. She overcompensates and overachieves for those siblings who can't. She also behaves this way to win the love of an emotionally distant parent. Friends seek her as the understanding one who listens and accepts them unconditionally. By the time she reached medical school, her caregiver status was solidified. Her affinity for the science of medicine, combined with her keen ability to communicate with others, makes her the wunderkind among her colleagues. We could say Sharon has some codependent tendencies. All of us do to some extent. But our health professions behaviorally reinforce it, then again legitimizes it through our professional fees.

Everything was going right for Sharon. Her star was on the rise. Then came the needle stick. The work environment was too small, too crowded, and too hurried. And a colleague was too careless; a colleague, who bumped her arm, causing the needle, which had been in her patient's arm, to end up in hers.

"Inside, I was screaming and hysterically punching my team member with both my fists. Outside, my whole facial expression went blank. A numbness came over me. I tried to speak, but I couldn't. It seemed minutes passed, but I guess it was only really seconds. Randy, my team member, said, 'God, Sharon, I'm sorry! I'm really sorry!' I looked at him and his eyes were full of grief. A few words slipped outta my mouth. They sounded so distant and hollow, like when I was a kid and I'd press my palms over my ears, and talk: 'That's okay. That's okay, don't worry about it.' "

Sharon was wearing gloves when the occupational exposure occurred. Her patient was HIV+ and symptomatic. She had vivid dreams nightly that placed her in life-threatening situations. Once, she bolted from her bed because she was lying directly on a mattress made of thousands of used needles. Another time, her significant other kissed her while she was sleeping and she felt a dirty needle graze her cheek. These experiences caused her to begin her days feeling tired. Amazingly, she was able to cope with her usual daily responsibilities. Sharon's anxiety decreased most noticeably after 3 weeks. We had in-person sessions and phone consultations. She learned stress-reduction skills and behavior modification. We reorganized her life to include some new support systems and consistent self-nurturance.

The largest number of health care workers have heightened anxiety during the first week postexposure. This often includes significant changes in eating and/or sleeping habits. Sharon's 3-week scenario illustrates the commonplace. Often, the anxiety markedly drops, then rises again 1 or 2 days before coming in for follow-up sessions, whether for the HIV blood draws with the nurse practitioners or the HIV test results disclosure and counseling with me. I encourage health care workers to share their feelings with others they trust, and especially with colleagues they trust. This normalizes the occupational exposure as a job-related accident. It is human to err.

Their common reply is: "Won't I be deluged with people wanting to hear my tale over and over?" With this comes the fear of reliving the accident repeatedly.

Although you may feel loss of control over the needle stick or splash, you can assert control in how you respond to others—and still receive their support, whereas, silence or avoidance keeps much-needed support at bay

because no one knows how much you need it. Simple, brief comments are sufficient. When a coworker who knows of the occupational exposure asks how you are, answer without re-creating the entire incident: "I'm still anxious today, so I could use some support," "I'm getting through this one day at a time." Or, "If I say 'fine,' I'm not."

There is the fear of questions from the caring and, annoyingly, from the curious. Speak up from the beginning: "I appreciate your concern and I can really use your support. I can't talk about what happened right now. It's too uncomfortable."

Dr Hacib Aoun was a physician who acquired HIV through an occupational exposure and subsequently died. In his article "From the Eye of the Storm, with the Eyes of a Physician,"[1] he described his experience crossing over that invisible line from physician to patient the moment of the occupational exposure. Other health care workers have also expressed their experiences after crossing over.

This line is an ever-present metaphor for the anesthesia care provider, as the tubing is connected to listen to the patient's breathing and heartbeat via the precordial or esophageal stethoscope. It's an extremely intimate role you play in the well-being of one you barely know; never farther away than this tubing. You are fully present and prepared to monitor this rhythm of life. In fact, you are the orchestrator who initiates a serious health care passage resulting in a family's joy or grief. It is a significant moment, but no one is applauding in the audience.

You enter the treatment provider team late in the plan, most often when the other provider/patient relationships are established. Like providers in other specialties, you are conditioned to remain "on your side of that fine line" between you and your patient. You have learned to do your part with skill, efficiency, and humanity. And like providers in other specialties, you, too, ask yourself: "What balance of thinking and feeling will allow me to do my work responsibly to the team, to the patient, and to myself." "How do I protect my vulnerability?"

Earlier, when you met with that 10-year-old patient's parents, you remembered the last storybook you shared with your own child. You watched a unilateral mastectomy; and wondered how much longer your mother would survive breast cancer.

Then, you incur a needle stick. You are wearing gloves. It's a 14-gauge needle. Whether it's your first stick in four years or your first stick this year, it doesn't really matter. Your critical-parent voice emerges: "Fool! Stupid move! It shouldn't have happened." You've heard the "stick stories" from colleagues. No seroconversions yet. Then why are you perspiring? Why are you mildly hyperventilating?

It's the chronic condition of being human.

Occupational exposures can elevate this condition to uncomfortable heights. As in Sharon's case, the anxiety may be the primary focus. However, in all cases, I observed that the exposure did not initiate a cascade of personal stressful events. Rather, there had been one or more markedly stressful events that were not resolved in the person's life preceding the exposure. The needle stick, laceration, or splash seemed to break down the door to previously unattended problems. Stressors most often reported are: (1) divorce, separation, or other major interpersonal conflicts with significant others; (2) death of a loved one; (3) diagnosis of life-threatening illness of a loved one; (4) job termination for a significant other; (5) conduct difficulties with children; (6) role responsibilities preestablished by one's culture. The first, divorce, separation, or other major interpersonal conflicts with significant others, is commonly a factor for physicians and nurses across the spectrum of medical, nursing, and advanced schooling, whether they are attending or in private practice. Their primary relationship with their significant other is impeded by long hours of physical and emotional separation. For those on grueling rotations, intimacy with one's pillow is the foremost quest after leaving the hospital. Nonstudents most often cite the second, diagnosis of life-threatening illness in the family and death of that loved one, as the previously unresolved stressor.

Emotional stress is added based on where health workers rank in the reporting line. Medical students need the support of their supervisors postexposure, but also know their work is being judged by them. There is pressure to perform. Therefore, they withhold information about their feelings (and in many cases, avoid report-

ing the exposure). In addition, they will not share their feelings with others because the word may get back to their supervisors. Yet support from their supervisors and coworkers might help diminish their anxiety. Theirs is an increased tendency to blame themselves, even when the exposure is blatantly caused by a coworker or another uncontrollable event.

Obviously, accidents *do* happen. However, the age of HIV makes our job accidents unlike all others. Our immediate work environment regularly confronts us with the debilitating horror of this disease up close. So that simple, superficial needle poke takes on exaggerated meaning. Our rational thought, "I have a low-risk needle stick" may be overridden by our irrational thought, "I don't know how much longer I can practice medicine."

In my sessions, I strive to educate people about specific exposure risk because it may help alleviate such irrational thinking. But, depending on one's previously existing life stressors, it may not. There appears to be little correlation between specific exposure risk and health care worker anxiety level.

So, to reduce anxiety? Take a slow, deep breath, with nurturance and self-caregiving. Cross over that line from provider to patient, just long enough for you to receive all you give them.

It's my hope the observations herein will increase our understanding of each other across the specialties, across the public and private sectors, and across the miles. That we may commit to the importance of caregiving to ourselves and to our colleagues, which can only enhance our caregiving to our patients.

I leave you with a hug.

Reference

1. Aoun H: From the eye of the storm, with the eyes of a physician. Ann Intern Med 116:335-338, 1992