ORIGINAL RESEARCH

# "Building through the Grief": Vicarious Trauma in a Group of Inner-City Family Physicians

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***Background:*** **Vicarious trauma is an understudied phenomenon among Canadian family physicians.**

***Objective:*** **This phenomenological study set out to explore the experiences of a group of inner-city family physicians caring for women using illicit drugs.**

***Methods:*** **Ten family physicians working in Toronto and Ottawa, Canada, participated in in-depth interviews. The data were analyzed using an iterative and interpretive process.**

***Results:*** **The first major theme emerging from the data analysis was the emotional impact of the work. Participants shared the challenges, sorrows, and joys they experienced as they struggled to care for their patients. The sub-themes identified were as follows: tragedy and death, difficult behaviors, and isolation from mainstream medical community. The second major theme identified was coping strategies. Participants were open, thoughtful, and eloquent as they reflected on the three primary coping strategies reported: adaptation and evolution of practice style, teamwork, and modification of expectations.**

***Conclusions:*** **Participants, narratives of loss, grief, and compassion were consistent with vicarious trauma and therefore participants risked developing compassion fatigue—a specific form of burnout. These are new and important findings. Further research exploring vicarious trauma as a possible contributor to burnout among family physicians is warranted. (J Am Board Fam Med 2012;25:840–846.)**

***Keywords:*** **Coping Skills, Family Medicine, Medically Underserved Area, Psychology, Substance Abuse**

There is an emotional cost to caring.[1] Listening to patients' narratives of traumatic events can provoke intense emotions such as profound sadness, helplessness, frustration, and anger. This emotional response is often termed *vicarious trauma* (VT).[2] By engaging in empathic relationships with patients, helping professionals such as family physicians undergo a transformation in their inner experiences that impacts emotions and cognitive patterns.[3,4] Far from being pathologic, VT is a normal part of any caring professional's emotional response. Just as trauma symptoms are a normal response to a traumatic event, VT is a normal response to working with traumatized patients.[2] Identification of VT is important because if left unchecked, it can lead to a specific form of burnout often referred to as compassion fatigue (CF).[3–7] Although VT is a normal part of the work, CF is not inevitable and can be prevented.[8,9]

This qualitative study set out to explore the phenomenon of VT in a group of inner-city family physicians caring for a patient population known to experience high levels of trauma: women using illicit drugs. Although there has been much research exploring VT and CF in non-physicians caring for similar populations,[3–7,10–13] little literature was found to explore these phenomena in family physicians.[14] This is a surprising gap in the literature because VT is known to contribute to burnout in non-physicians, and burnout is common among Canadian family physicians.[15–19] It is, therefore, worth understanding the possible contribution of

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VT to the high rates of burnout among family physicians, making this an area deserving of study.

## Methods

This phenomenological study used the qualitative method of in-depth interviews. Phenomenology allows for the exploration of individuals' experiences and understanding, whereas in-depth interviews are useful when exploring potentially sensitive subject matter.[20]

### *Participant Recruitment*

Inclusion criteria for this study were as follows: family physicians working in Toronto or Ottawa, Ontario, who provided care (at least a half-day a week) to vulnerable women using illicit drugs. Marijuana was not included in the definition of illicit drugs because we wanted to recruit physicians who cared for more vulnerable, street-involved women (eg, those using crack cocaine or opiates). Names of suitable family physicians were obtained through personal contacts with family medicine departments, managers at community health centers, managers of harm reduction programs, and family physician colleagues. Thirty-one potential participants were identified and initially contacted by phone or E-mail by the principal researcher (SW). If they expressed an interest, they were screened to ensure that they met the inclusion criteria. Twelve family physicians did not meet the inclusion criteria (ie, they did not provide care to this population) and 9 did not respond. Therefore, the final sample comprised 10 family physicians. By the sixth interview, no new data were revealed and previous data were not disconfirmed. This indicated that saturation had been achieved.[21,22] Because this was early in the data collection and analysis process, 4 more interviews were conducted to ensure that no new themes were emerging and that previous themes resonated with participants during the later interviews. This strategy is called member checking and involved asking participants whether identified themes, concepts, and interpretations were congruent with their own experiences.[21–23]

### *Data Collection*

One author (SW) conducted all the semistructured interviews using an interview guide. The interviews, which lasted between 45 to 75 minutes, took place in family physicians' offices or homes and were recorded using 2 tape recorders. Informed consent was obtained from all participants before each interview. All participants were asked the same open-ended question to begin the interview: "What is your experience of caring for women who use illicit drugs?" Probes were used as necessary and field notes were taken during each interview. See Appendix 1 for the full interview guide.

### *Data Analysis*

Each audio-taped interview was transcribed verbatim. The data were analyzed using an iterative and interpretive process. After each interview, the transcripts were read independently by each researcher to identify emerging themes. The researchers then met to compare and combine their respective analyses, looking for key words, phrases, or concepts. Common themes were introduced manually into a coding template, which was continually expanded, reviewed, and revised as new themes emerged. Upon reaching saturation, earlier transcripts were re-coded to ensure congruence with the final coding template.

Once all the data were analyzed, dominant themes were identified and the coding template was condensed. This iterative method of theme identification and coding is consistent with phenomenological methods.[22] Methodological rigor was increased in this study by having the authors immerse themselves into the data and constantly reflect on new interpretations.[24] This is called immersion and crystallization, a process that enhances the trustworthiness and credibility of results.[23] Having 2 investigators who did not work in the field of interest and who reviewed transcripts and analysis for indicators of bias (eg, leading questions, introduction of personal experiences, and other patient narratives into interviews and analysis) also enhanced methodological rigor.

### *Final Sample and Demographics*

A total of 10 family physicians were interviewed. Demographic characteristics are shown in Table 1. In addition, 70% devoted more than half of their practice time to inner-city health, and all respondents participated in advocacy activities related to poverty and social justice issues. Ethics approval was obtained from The University of Western Ontario's Research Ethics Board for Health Sciences Research Involving Human Subjects.

**Table 1. Demographics of Family Physician Participants**

| | Participants (n = 10) |
|---|---|
| Age, mean years (range) | 42 (32–58) |
| Average time in practice, mean years (range) | 13.5 (3.5–35) |
| Women | 4 |
| Race | |
| White | 8 |
| Asian | 1 |
| Black | 1 |
| Remuneration | |
| Salary | 5 |
| Alternate payment plan (blended model) | 1 |
| Fee for service | 4 |
| Location of practice | |
| Shelter | 2 |
| Community health center | 5 |
| Academic setting/university teaching centre | 2 |
| Family health team | 1 |

### *Findings*

The 2 major themes that emerged from the data analysis were emotional impact and coping strategies. Table 2 outlines these major themes, along with the identified subthemes and exemplar quotations.

### *Emotional Impact*

Participants shared the challenges, sorrows, and joys they experienced as they struggled to care for a population of patients with overwhelming physical, mental, and psychosocial needs. The 3 subthemes identified were tragedy and death, difficult behaviors, and isolation from the mainstream medical community.

#### *Tragedy and Death*

The participants' day-to-day work was expressed as frustrating and challenging, and many participants discussed how it was hard not to get "caught up in the chaos." Nearly all participants described the emotional impact of witnessing the overwhelming tragedy and untimely death experienced by the drug-using women for whom they cared. Patients' losses became family physicians' losses.

The deaths of vulnerable women using illicit drugs often were premature and violent, and participants reflected on how devastating and emotionally draining it was to have one of the women they cared for become another "statistic" on the news, brutally murdered. In fact, one participant had lost so many of her patients that she was constantly waiting to get news of another patient's death. Dealing with this constant loss and the subsequent grief was so emotionally and physically exhausting that some participants simply felt they could no longer invest the same intense commitment with current patients.

#### *Difficult Behaviors*

Dealing with difficult patient behaviors was another identified subtheme. The chaos in women's lives would occasionally manifest itself as difficult behaviors that participants both witnessed and managed. Participants recalled intense and emotionally charged interactions with angry, psychotic, and demanding patients. Interactions involved racial slurs, verbal aggression, and even death threats. At times, participants reported feeling scared and unsafe. Being exposed to these potentially risky situations even became a concern for one participant's partner. Almost all participants talked about the challenges of dealing with patients who were taking opiate medications or were seeking drugs. Coping with drug-seeking behaviors in a clinical setting where many patients have legitimate chronic pain problems was described as extremely challenging.

#### *Isolation from the Mainstream Medical Community*

Another recurring subtheme was feeling isolated from the mainstream medical community. Participants used language such as "fringe medicine" and "outsider" to describe this experience. One participant described feeling judged because the neighborhood in which he practiced had a "bad reputation." Participants also expressed how they felt isolated from the greater medical community. Given the lack of support from their traditional colleagues, participants described deriving support from working in an environment where other staff had similar interests.

### *Coping Strategies*

The second major theme emerging from the data analysis was coping strategies. Participants were open, thoughtful, and eloquent as they reflected on the strategies used to cope with their challenging jobs. The 3 primary coping strategies reported were adaptation and evolution of practice style, teamwork, and modification of expectations.

**Table 2. Themes Identified from Data Analysis of Transcripts**

| Major Theme | Subtheme | Exemplar Quotation |
|---|---|---|
| Emotional impact | Tragedy and death | "Some of them are so troubled … how fleeting their relief from suffering is … I try not to go through those roller-coaster rides with people." |
| | | "… You're traumatized by them." |
| | | "… when they talk about a sex trade worker being killed and it's splashed across the front page of the papers, we check … to see if it was someone who was known to us …" |
| | | "… the people who seem to be my dearest clients—like they've just been dropping.… And now that many of those people are gone it's been hard to … build through the grief … to recreate those connections with people.… I can think of a couple of people who I have … held onto who have stayed alive, I still just wait for the call that they're dead." |
| | Difficult behaviors | "… sometimes the interactions can be incredibly brutal.… There can be racial slurs … clients have had to be barred.…" |
| | | "… when you get death threats from patients … or when somebody steals your prescription pad … sometimes I have to fire people." |
| | | "… there have been a couple of times when you can feel really unsafe; and that's scary, right? And then you can come home and your partner … they get really mad. And then you end up calming them down." |
| | | "… it's very frustrating when people try to take advantage of me to get drugs." |
| | Isolation from mainstream medical community | "I even had someone say: 'Couldn't you do any better'? So, I mean, just by the fact of having chosen to work here, in many people's eyes, makes me seem quite fringe.…" |
| | | "When you talk about the challenges that you're dealing with.… People's eyes glaze over. They have no idea.… They're very focused on things that are superficial … that can be somewhat isolating." |
| | | "… while I might perceive myself as an outsider to [the] … medical community at large, I work in a really supportive environment." |
| Coping mechanisms | Adaptation and evolution | "It's a subtle shift … where you go from 'What's wrong with this person? … Why won't they just do what I tell them to do?' To understanding that is not where they're at." |
| | | "When somebody is in crisis, meeting the immediate needs but not putting everything I have into that, so that when they leave at the end of the day I'm not in a heap … a mess.'" |
| | Teamwork | "We … have regular team meetings where we'll discuss cases.… It's very practical case management. But other times it's just for psychological support for the caregivers.…" |
| | | "[feeling] not so isolated … I'm kind of part of some group that would support each other.…" |
| | Modification of expectations | "So you set your sights on an achievable level and you don't expect somebody to suddenly stop using them [drugs], go get a PhD and work and live happily ever after." |
| | | "Her sugars are coming down from 30 to 15. In my practice here in [middle class area] 15 would be intolerable as a glucose. I'd want to get from 15 to 7. With her [woman patient using drugs] I'm thrilled because it's down from 30 to 15." |

*Adaptation and Evolution of Practice Style*

Participants described the experience of evolving from a "rescuer"—someone with an overwhelming responsibility to fix all their patients' problems—to someone who learned to simply bear witness to their patients' suffering. Yet many participants described how it was difficult not to intervene in their patients' lives and rescue them. Most participants, however, felt they needed to set limits, establish boundaries, and recognize that they could not fix everything. This was an important survival skill learned through experience and necessity. Thus, setting appropriate boundaries and recognizing one's own limits was an effective way of coping with the stress of their work.

*Teamwork*

Receiving emotional support from fellow team members was another subtheme discussed by participants. When the daily demands of the work took its toll, participants turned first and foremost to their colleagues for support. Team structures

varied considerably, depending on where participants worked. Some participants worked in settings where there were formal team meetings and debriefings, allowing for opportunities to discuss complicated cases. Working in teams also allowed participants to take brief moments during a busy day to simply vent and process a troubling case. Support from team members also decreased feelings of isolation.

*Modification of Expectations*

Participants recognized that there were unique aspects to working with this challenging population and described clinical tools they used to maintain engagement with drug-using vulnerable women. One such clinical tool was modifying the expectations of what their patients were able to accomplish. For example, following suggested diabetes guidelines proved to be difficult for participants. A participant stated how his expectations with respect to diabetic management were quite different for a street-involved woman using drugs compared with someone in his middle-class practice. Another participant noted that if his only measure of success was full recovery, than he would constantly be disappointed.

## Discussion

This study has revealed the phenomenon of VT and the potential for CF, as well as coping strategies used by a group of inner-city family physicians. Participants described the emotional toll of witnessing the violent and premature deaths of their patients, dealing with difficult behaviors, and feeling marginalized by their peers. Given the interdisciplinary nature of inner-city work, further research using formal tools to quantify the extent of psychological trauma in both physicians and nonphysicians doing similar work is important.

The 3 primary coping strategies identified by participants in this study were adapting their practice style, teamwork, and modifying expectations. Participants identified how their practice styles had evolved over time as they acquired clinical experience. Another significant finding of our study was that participants learned to modify their expectations regarding patient outcomes. This strategy was a practical clinical tool allowing participants to find common ground with their patients and to be realistic about their own abilities.[25,26] The coping strategies identified by this small group of physicians may have broader applicability and merit further quantitative study.

These findings have implications on an organizational level and emphasize the importance of having adequate protocols and policies in place to deal with difficult patient behaviors, ensuring a respectful and safe workplace. In particular, the impact of some of the patient behaviors articulated by participants indicate suboptimal workplace environments. Feeling unsafe in the workplace is highly correlated with the development of CF. Having workplaces where staff feel safe and are trained to deal with challenging behaviors decreases staff disability and increases performance[13]. Previous studies have identified effective strategies to minimize VT and prevent CF, such as varying caseloads, education about burnout prevention, managerial support, professional development, Balint groups, and recognition of limitations.[9,13,14,27] However, none of this research has taken place in primary care settings. Our research findings suggest that such research is warranted.

Participants' stories indicate the hardship that caring for women drug users has on a small group of family physicians. We speculate that these hardships are not unique to this group of family physicians. We all bear witness to loss, crises, and despair from patients who come from all walks of life. As such, we suggest further research to explore the phenomenon of VT experienced by family physicians from diverse practice settings. An exploration of how VT may differ among family physicians working in marginalized settings compared with nonmarginalized settings would be useful.

Although the experience of VT may not be unique to this population of physicians, the feelings of being an outsider likely are. There may be a parallel process of marginalization experienced by family physicians working with severely marginalized women. Perhaps as women patients become more disenfranchised and isolated, the family physicians caring for them experience a similar process of marginalization from mainstream medicine. If this is true, then there are implications for how family physicians working with such populations should be trained and supported. This concept merits further exploration. Our study is limited by the limited geographical location of participants to Toronto and Ottawa, Ontario, and the narrow focus of the patient demographic.

## Conclusions

Study findings illuminated how caring for drug-using women took a significant emotional toll on this group of inner-city family physicians. Their narratives of loss, grief, and compassion were consistent with vicarious trauma, and therefore participants risked developing compassion fatigue. These are new and important findings. There is little research exploring these phenomena in primary health care settings, and further research exploring CF as a cause of burnout among family physicians is warranted. Evaluation of the coping strategies identified by participants would also be useful.

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## Appendix 1: Interview Guide

1. What is your experience of caring for women who use illicit drugs?

- How did you choose to serve this population?

2. Can you share with me some of the sorrows of caring for these women?

- What are some of the tragedies?
- What makes a difficult or bad day for you?
- Does the stress of the work ever affect your ability to function either at work or in your personal life? In what way?
- Can you describe some of the ways that you cope with dealing with such constant tragedies?
- What role does compassion play in your work?
- Are there times that it is difficult to be compassionate?

3. In doing the work that you do, do you find it hard to identify with your physician colleagues who are not doing inner city health work?

- Do you see yourself as an outsider? Can you tell me more about that?
- Can you relate with your colleagues who are working in a more traditional practice setting? (Can they relate with you?)

4. Can you describe some of the ways you modify your practice when caring for this population, for example, when developing a diabetic treatment plan?

- How are expectations of clinical outcomes modified (eg, with a diabetic patient)?
- Seeing as follow-up and follow-through are such a problem, how do you deal with complexity of illness?

5. Can you describe how you cope with difficult behaviors such as verbal or physical abuse?

- Where does drug seeking behavior fit into this?