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# The Dyadic Relationship: Psychospiritual Elements in Trauma-Informed, Whole-Person Centered Care

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**ABSTRACT**

This mixed-methods survey combined a quantitative survey with a qualitative narrative analysis to explore the impact of trauma-informed, whole-person-centered care (TIWPCC) on healthcare providers.

The investigator used a thirty seven question survey to explore four key aspects: (1) how TIWPCC fosters authentic, compassionate, and dynamic patient-provider relationships, leading to increased job satisfaction; (2) the role of TIWPCC in promoting self-awareness and resilience among healthcare providers amidst escalating healthcare demands; (3) the correlation between providers' holistic care practices and their engagement in self-care across physical, spiritual, and emotional domains; and (4) providers' ability to articulate the personal benefits of TIWPCC.

The quantitative portion prioritized objective information with numerical measurement. With the statistical analysis portion, a professor at a major northeastern university with expertise in analytic research methods helped with multivariate statistical analysis on selected subsets of the data, a statistical correlation analysis on those subsets, and created several general linear models to better understand TIWPCC concerning healthcare providers' well-being.

The qualitative analysis involved a reflective examination of participants' responses, highlighting the importance of TIWPCC practices in building provider resilience and improving patient care. This process was guided by the expertise of a trauma-focused psychoanalyst and professor, who provided valuable support to the investigator.

The survey identified positive correlations between trauma-informed, whole-person-centered care (TIWPCC) and increased job satisfaction, resilience, and patient engagement among healthcare providers. Additionally, participants could clearly articulate how adopting a TIWPCC

approach benefits their professional and personal well-being. While the findings supported the advantages of TIWPCC practices, they also reveal opportunities for further research to explore additional dimensions and implications of these correlations.

*Keywords*: holistic care practices, reflective examination, provider resilience, trauma-informed, whole-person centered care, personal and professional well-being.

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# The Dyadic Relationship: Psychospiritual Elements in Trauma-Informed, Whole-Person Centered Care

## Statement of Need

As a chaplain and spiritual care provider, I have the unique privilege of ministering not only to patients and families but also to healthcare providers who are often overwhelmed by the demands of their profession. Through my interactions with these dedicated individuals, I have witnessed the immense stress and responsibility they face daily. From my vantage point, I can assess interactions between healthcare providers, families, and patients from a wider perspective. I often observe defensiveness and reactivity from healthcare providers in response to feeling uncomfortable during difficult interactions. These responses can inadvertently exacerbate tension and shut down communication between the provider and the patient.

Witnessing these interactions deeply moved me. They highlighted the urgent need for a supportive and compassionate approach to care. This realization led me to think about trauma-informed, whole-person-centered care and its benefits for healthcare providers, recognizing its potential to foster authentic, compassionate, and dynamic patient-provider relationships. I explored four areas of focus.

As the healthcare industry is facing unprecedented challenges, including escalating demands and increasing burnout among providers, I wondered whether TIWPCC enhances job satisfaction among healthcare providers by promoting deeper connections with patients. By prioritizing empathy and understanding, providers can create a supportive environment that improves patient outcomes and enriches their professional experience. This approach is essential for cultivating a healthcare system that values patients' well-being and providers' satisfaction.

Providers must develop self-awareness and resilience to maintain their effectiveness and well-being. TIWPCC plays a crucial role in this process by encouraging providers to reflect on

their experiences and emotions. This self-awareness enables them to manage stress better and build resilience, leading to more sustainable and fulfilling careers. As healthcare providers navigate the complexities of their profession, can the integration of TIWPCC principles serve as a vital tool for enhancing their ability to cope with challenges and maintain a high level of care for their patients?

Furthermore, I believe there is a strong correlation between providers' holistic care practices and their engagement in self-care across physical, spiritual, and emotional domains. TIWPCC encourages providers to adopt a comprehensive approach to their own well-being, recognizing the importance of self-care in delivering effective patient care. By articulating the personal benefits of TIWPCC, providers can advocate for its widespread adoption, highlighting how it supports their professional growth and personal fulfillment. Embracing TIWPCC is not only beneficial for patients but also essential for the long-term health and satisfaction of healthcare providers, making it a critical component of a thriving healthcare system.

## History of the Relationship Between Provider and Patient

Over the past two decades, the dynamic between medical care providers and patients has shifted from the traditional 'provider knows best' mentality, where patients were expected to follow orders without question, to a modern partnership built on mutual understanding and collaboration (Kaba & Sooriakumaran, 2006, p.58; Fuertes et al, 2017, p.614). It is essential to be aware of history to comprehend the evolution of trauma-informed, whole-person-centered care (TIWPCC). The provider-patient dyad cannot be separated from its social, political, and cultural context (Frank, 1995, p. 113; Herman, 1992/2022, p. 13; Kleinman, 1988, p. 9). Dominant societal beliefs and values shape the provision of medical care, influencing the cultural perspectives on illness, disease, and healing. This study area is a subdivision of anthropology known as “ethnomedicine” (Morrill, 2009, p.74).  Writer and scholar David Morris (1998) says,

"We must explore these complex relations between biology and culture if we hope to understand the contemporary experience of illness and, ultimately, ourselves" (p.3). The history, research, and literature on approaches to medical care, disease, and illness typically focus on benefits to the patients who receive care. This survey explores the benefits, if any, that trauma-informed, whole-person-centered care might have for those healthcare practitioners using this approach.

**Early Medicine**

The earliest healers were typically religious leaders based in their community (Ellenberger, 1970, p. 11; Koenig, 2012, p.1). Curing illness was a combination of spiritual rituals and natural remedies, as the body, the spiritual world, and the natural world were inextricably linked. (Ellenberger, 1970, p.3; Kleinmann, 1988, p.13). The Medicine Man of Indigenous communities who lived (and still lives) in reciprocity with the natural world that fed and healed both .individual spirit/soul and the communal body (Deloria et al., 2022, p.2; Ellenberger, 1970, p. 38; Kimmerer, 2013, p.30; Morris, 1998, p.4).

La Bruja and Curandera, figures in Mexican culture (Garcia, 2010, p. 2), provided healing and cq cures. The Bruja, or witch, offered services through magic, such as spells and hexes, while the Curandera (healer) employed herbal remedies and other naturopathic approaches (Toohey & Dezelsky, 1980, p.2).

Medieval and Renaissance midwives played a crucial role in early female healthcare. There were clear religious connections to the obstetrical and gynecological care of women (Minkowski, 1992, p. 294; Wright, 2016, p. 49). Although the midwife and other female healers were not recognized as religious leaders, they were often accused and persecuted for being witches or consorting with the devil. Clinical professor and Jungian analyst Jean Shinoda Bolen (2001)

shares a reminder that "the first women to go to the stake were the midwives and healers; older women who eased the pain of childbirth and delivered babies, who knew herbal medicine, whose power came from observation and experience" (p.57).

The exorcising priest offered healing from the diseases and afflictions brought upon the unfaithful as punishments from God (Dumitrescu, 2015, p. 29; Ellenberger, 1970, p. 13; Henning, 2023, p. 355). Despite significant geographic and religious differences, physician and acclaimed medical historian Fielding Garrison (1922) identified many commonalities between folk medicine and superstition. He concludes that, regardless of country, state, or culture, "there was and always will be a collective thrust towards self-preservation and reproduction" (p.17).

Medicine and healthcare emerge from the crucible of relationships focused on healing, cure, and ultimate survival. This survey assumes that the physical impulse towards life cannot be separated from the psychological and spiritual domains of being human. With this basic premise, healthcare must include awareness of the healthcare provider's personhood as well as the patient's (Kleinman, 1988, p. 210; Miller, 2022, p. 39).

**Greek Enlightenment**

During the Greek Enlightenment, in the 5th century, 'magic' was denounced, and a more observational and concretized approach toward illness developed (Kaba and Sooriakuman, 2007, p. 58; Kleinman, 1988, p. 12; Morrill, 2009, p. 72). The Hippocratic Treatises provided physicians of the time with terminology and treatment guidance in the face of illness (Ellenberger, 1970, p. 41; Morrill, 2009, p. 87). While the passive role of the patient as an object remained unchanged (Edelstein, 1937, p. 58), the Hippocratic Oath provided documented ethical guidelines for physicians and recognized the patient's rights (Kaba and Sooriakuman, 2007, p.

58; Puchalski and Ferrell, 2010, p. 111). According to London physicians Kaba and Sooriakuman (2007):

> The oath provides a higher degree of humanism in dealing with people's needs, well-being, and interests when compared to previous codes of conduct. In this, the Hippocratic Oath raised medical ethics above the self-interest of class and status (p. 58).

**Biomedical Model**

As industrialization and technology advanced, the spiritual and religious aspects of healing increasingly diverged from the practice of medicine. René Descartes, in the 17th century, asserted that the world functioned in a mathematical and mechanistic manner, thus further separating 'science' from religion (Cassell, 1982, p. 132; Frank, 1995, p.2). He believed the mind and body were separate entities; one corporeal and non-thinking, and the other non-physical but thinking: "I think, therefore I am" (Correll, 2022, p.52; Ellenberger, 1970, p. 402; Thibault, 2018). The results of the rise of scientific inquiry "raised doubts about the authority of the church, the power of the monarchy, and the salience of communal folkways" (Cushman, 1995, p. 34). Like an unraveling braid, the areas of body (medicine), mind (philosophy), and religious impulse (spirit) became ever more separate. Thus, the patient became a biological entity with external symptoms or illnesses that needed curing, with little consideration of the mind or spirit. (Correll, 2022, p. 49). This is the beginning of the biomedical approach, and it continues to influence the current Western healthcare system (Ellenberger, 1970, p. 47; Kaba and Sooriakuman, 2007, p. 59; Puchalski & Ferrell, 2010, p.12).

**Psychoanalysis and Medicine**

With S. Freud and the rise of formalized psychotherapy, the patient became a more integral part of their own illness and medical care. The patient was a cooperative participant who was understood as having an internal set of subconscious realities and beliefs that influenced behaviors and health (Kaba and Sooriakumaran, 2007, p. 59; Puchalski and Ferrell, 2010, p. 14). It was up to the analyst to provide answers and insights gleaned from the patient's thoughts and stories, thus attending to the unconscious (Cushman, 1995, p. 152; Ellenberger, 1970, p. 115; Kahn, 2002, p. 6).

There was a tension between physical-somatic medicine and psychology. Can one be healed by approaching the brain as any other body organ that exerts influence on healing and survival responses (bottom-up), or must there be a component of thinking consciousness in which the non-physical "self" (top-down) works upon the physical body usually related to social connection, emotion, and safety (Holmes & Slade, 2017, p. 189; van der Kolk, 2014, p. 86). According to Franz Alexander (1931), a Hungarian-born psychoanalyst who worked at the Chicago Institute for Psychoanalysis:

> Psychoanalysis deals with psychic phenomena and this brings quite a new element into medicine. It introduces a subject matter which cannot be expressed in terms of time and space and threatens to disturb the homogeneity of medicine, which would prefer to deal exclusively with physiochemical facts and to employ chiefly experimental methods (p.1353).

In other words, the science of medicine resisted the exploration of the areas of the subconscious, personality, and mystery, preferring concrete, measurable facts. (Puchalski & Ferrell, 2010, p. 12; Alexander, 1931, p. 1352).

As they interacted, the two disciplines could not help but influence one another. A report from the Planning Committee of the Royal College of Physicians on Medical Education wrote, in 1944 (as quoted in the Kaba & Sooriakumaran article), "from the beginning of his clinical career, the student should be encouraged to study his patient's personality...just as he studies his patient's physical signs and the data on the temperature chart." [1](p.60). This statement emphasizes the importance of viewing the patient as a whole person, rather than just a collection of physical symptoms; however, the information-gathering process was still primarily focused on medical and biological diagnosis (Wicks et al., 2017, p. 127). Psychoanalysts and Psychiatrists remained in the powerful, adult-like role of experts, while patients were expected to comply as if they were children (Frank, 1995, p. 5; Kleinmann, 1988, p. 222; Puchalski & Ferrell, 2010, p. 12).

**Physician As Medicine**

In the late 1950s, physician and psychoanalyst Michael Balint introduced the "doctor as medicine," which promoted an authentic engagement with patients' psychosocial context that he believed helpful for healing (Elder et al., 2023, p. 87). Balint understood that the physician's investment in the dyadic relationship with the patient was as powerful and important as any other prescriptive treatment, and the best therapeutic tool was the physician himself (Balint, 1955, p.683; Kaba & Sooriakumaran, 2007). He used "mutual education" to describe the equally beneficial potential for feedback and learning when provider and patient establish an ongoing therapeutic relationship (Balint & Shelton, 1996, p. 890). Balint realized that a doctor's [or any healthcare provider's] insensitivity or carelessness could have far-reaching consequences,

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[1] The male language is typical of the era. It will be decades before a more inclusive language is used. There are wonderful resources addressing the misogyny, racism, and ableism that shaped medicine historically, often leaving generational trauma in its wake.

affecting not only the immediate health and well-being of the patient but also their trust in the medical profession, potentially leading to a lack of compliance, worsening conditions, and even long-term psychological trauma (Balint, 1955, p. 685). To this end, “Balint” societies and groups still gather to discuss and process case studies focusing on the patient’s psychological and relational aspects of care (Kleinman, 1988, p. 244; Meier et al, 2001, p.3012; Rabin et al, 2009, p.140).

**Bio-psycho-social Model**

In 1977, a pivotal paper visually showed what had been suspected, that *physical* illness is biological and has psychological and sociological components. Psychiatrist and internal medicine doctor George Engel’s research results documented connections between the psychological and social to the physical, illustrating that just a biomedical approach was no longer sufficient (Engel, 1977, p. 131; Puchalski and Ferrell, 2010, p.103). His most famous case involved an infant with a gastronomy tube (Dowling, 2005, p.2039; Taylor, 2002, p.451).

*The Monica Case* revealed the connection between relationships, attachment, and safety to bodily functioning. “Monica” was a 15-month-old who was being fed via a stomach tube. Her gastric juices increased when she was with people she trusted or when she was angry. When in the company of strangers, her gastric juices decreased in a “depression-withdrawal implying an energy-saving defensive operation” (Engel et al., 1979, p. 107). This was a 25-year study of “Monica” that documented ongoing attachment difficulties resulting from early hospitalizations (separation from an emotionally unavailable mother) and chronic illness (Engel et al., 1979, p.452; Taylor, 2002, p. 451). From Engel’s (1977) observations of the psycho-somatic correlation came his Biopsychosocial Framework of care, stating, “The dominant model of disease today is biomedical, and it leaves no room within this framework for the social,

psychological, and behavioral dimensions of illness" (p.135). As Puchalski and Ferrell (2010) pointed out, the spiritual aspect of patients and illnesses were still not considered (p.103).

Engel's work was significant as it bridged the ongoing gap between physical medicine, a hard science, and the notion that psychological and personality development theories were less scientific because they could not be directly measured (Engel, 1977, p. 129). Engel's work saw what the theorists long believed. Throughout this longitudinal study, Engel also documented his own physical health and correlated his psychogenic pain and illnesses with anniversary dates of trauma, grief, and loss (Taylor, 2002, p.454). The findings of this exemplary study facilitated the reconnection between the biological and psychological aspects of medical care, health, and healing.

While there were significant other medical advances of the 20th century, including the discovery of penicillin (1928), the first description of DNA (1953), and the birth of the first in-vitro fertilization infant (1978), it would be another eighteen years before the use of functional magnetic resonance imaging (fMRI) allowed real-time visualization of brain activation research confirming not only Engel's work but that of other physicians and psychological experts studying mind, body and social intersections and connections (Bandettini, 2012, p.157; Schore, 2015, p. xxxiv).

**Trauma-informed, Whole-person Centered Care**

The shift toward whole-person-centered care stems from a trauma-informed approach, which addresses how trauma influences all aspects of health (Miller & Sprang, 2017, p. 153; Tumminio-Hansen, 2024, p. 21; van der Kolk, 2014, p. 86). Technological advancements, such as biofeedback measurements, functional MRIs, and the ability to measure neurotransmitter levels, enable a

deeper and real-time understanding of how various approaches to health can enhance or hinder healing. (Clough & Casey, 2011; p.698; van der Kolk et al, 1996, p.39). Whole-person-centered care recognizes the patient as a bio-psycho-social and spiritual being, understanding how these dimensions merge, separate, and influence one another to promote whole-person healing (Puchalski & Ferrell, 2010, p.55).

While there is not one definition of WPCC, a 2018 review of literature identified six common components that include a multidimensional, integrated approach; the importance of the therapeutic relationship; acknowledging the doctors' (providers') humanity; recognizing patients' individual personhood; viewing health as more than absence of disease; and employing a range of treatment modalities (Thomas et al, 2018, p.3). The third component, identifying the professionals' humanity, should not be underestimated. The healthcare provider is also a biopsychosocial and spiritual being. They not only influence the patient and their care, but each encounter with their patients also influences them.

***Definition of Trauma***

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) defines individual trauma as "an event or circumstance resulting in: physical harm, emotional harm, and/or life-threatening harm". The definition includes "lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (p. 2). Herman (1992) says, "At the moment of trauma, the victim is rendered helpless by overwhelming force" (p. 48). As a result, normal thinking, connecting, coping, and communicating are disrupted (Kalsched, 1996, p. 1; Howell, 2020, p. 30; Howell & Itzkowitz, 2016, p. 34).

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, DSM-5-TR, (2022), there are specific diagnostic criteria for post-traumatic stress disorder (PTSD). They are being exposed to or witnessing a traumatic event, intrusive symptoms resulting from the event (like nightmares or flashbacks), avoidance of reminders of the event, changes in mood and thinking, and alterations in reactivity and arousal (like hypervigilance, poor sleep, or acting out). These symptoms must last for more than a month and negatively affect a person's ability to function. However, even if an individual does not meet the criteria of PTSD, they may still experience significant trauma-related effects in their life (Howell & Itzkowitz, 2016, p. 39; SAMSHA, 2012, p.7).

Responses to potentially traumatic experiences and their lasting effects differ for everyone (Howell & Itzkowitz, 2016, p. 43; van der Kolk & van der Hart, 1991, p. 428). Trauma affects families, communities, cultures, and generations (Tumminio-Hansen, 2024, p.2; van der Kolk, 2014, p. 152). No one is immune to overwhelming, threatening, and life-altering experiences. As healers and healthcare providers, it is important to remember that illness, disease, and end-of-life issues can trigger primitive defensive behaviors that, while they may feel unhelpful or destructive, function to assist in the traumatized person's survival (Howell, 2020, p. 35; Kalsched, 1996, p. 218; McWilliams, 2011, p. 115).

## History of Trauma

### *Charcot & Janet*

The study of traumatic or existentially threatening experiences is not new. In the 19th century, French neurologist Jean-Martin Charcot connected the origins of hysteria to trauma, suggesting that traumatic experiences become unconscious "fixed ideas" (Ellenberger, 1970, p.102; Herman,

1992/2022, p. 13). As Ellenberger (1970) states, “Charcot was the man who had explored the abysses of the human mind, hence his nickname, ‘Napoleon of Neuroses” (p.95). His work would be further explored and developed by his students, Sigmund Freud and Pierre Janet. Historically, much is known about Freud and his theories. Janet is less well-known but equally important. His work included writing *L’automatisme psychologique,* which explores the transformation of traumatic experiences into psychopathology. Janet contributed to the study of dissociation while working with individuals who had experienced overwhelming and terrorizing experiences (Herman, 1992, p. 50; Howell & Itzkowitz, 2016, p. 44; McWilliams, 2011, p. 333). Through detailed observation and careful documentation, he used Charcot’s theory of fixed ideas to develop an understanding of traumatic memory, which remains activated and alive, breaking through into ordinary consciousness via re-enactments (Ellenberger, 1970, p. 392-393; Howell & Itzkowitz,2016, p. 47; Kalsched, 1996, p. 69; Putnam,1997, p. 3).

***Sándor Ferenczi***

Ferenczi was a pioneer in psychoanalysis whose work significantly impacted the study of trauma. As a colleague of Sigmund Freud, Ferenczi initially expanded upon Freud's theories (Cushman, 1995, p. 142; Ellenberger, 1970, p. 799).

He introduced controversial ideas that emphasized the role of interpersonal relationships in psychological development and healing (Dimitrijević et al., 2018, p. 166; Howell & Itzkowitz, 2016, p. 67). Ferenczi explored mutuality in the therapist-client relationship. This approach was more empathic and engaged by making the psychoanalyst an active participant, willing to receive feedback from the analysand’s experience of the analyst. Mutuality in psychoanalysis meant “the analyst is an unwitting co-participant in the repetition of patients’ core relational patterns, with the aim that this mutual enactment will evolve into something new and better” (Dimitrijević et al.,

2018, p.165) This marked a split of philosophies and approaches leading to the dissolution of any connection between him and Freud (Ellenberger, 1970, p. 520; Rudnytsky, 2021, p.265).

Ferenczi's seminal paper called "The Confusion of Tongues" (1933) explained the devastating effects of abusive dynamics between adults and children, focusing on how trauma is communicated and internalized via the victim-perpetrator relationship (Herman, 1992, p.157; Kalsched, 2013, p. 291). Ferenczi's insights laid the foundation for modern understandings of trauma and relational therapy, cementing his legacy as one of the most influential figures in psychoanalytic thought (Dimitrijević et al., 2018; Kalsched, 2013, p. 86; Schore, 2015, p.346).

The twentieth century saw the continuation of the exploration of trauma and its effects on the human mind, body, and spirit.

***Later Pioneers in Trauma Work***

***Henry Krystal***. Krystal's research in the 1970s through the 1990s centered on the psychological effects of trauma, while working closely with Holocaust survivors (Herman, 1992/2022, p. 123; Krystal, 1991, p.95). He studied the long-term impact of trauma on emotional regulation and the development of psychosomatic disorders, believing that trauma isn't just an overload of the human system from traumatic experiences but that *meaning* is created from it. "I must have done something to deserve it" (Kalsched, 1996, p. 58). In his work with Holocaust survivors and Vietnam vets who were prisoners of war, Krystal developed therapies to address the guilt of surviving traumatic experiences when others perished (Krystal, 1991, p.95). He (1991) states, "we come to the point where our past lies unfolded before us and the question is what should be done with it? The answer is-it must be accepted, or one must keep waging an internal war against the ghosts of one's past" (p. 96).

***Frank Putnam***. Renowned for his groundbreaking work on dissociative disorders, Psychiatrist Frank Putnam significantly advanced the understanding of how trauma impacts the mind, leading to the emergence of distinct parts or personalities as a mechanism to sustain and protect one's life (Herman, 1992/2022, p. 183; Howell, 2022, p. 178). His work emphasized the role of dissociation as a coping mechanism for trauma survivors, particularly because of childhood abuse and neglect (McWilliams, 2011, p.339; Putnam, 1989, p. 8). Putnam (1989) mapped out sensitive and compassionate treatment guidelines for those diagnosed with multiple personality disorder (MPD)- now dissociative identity disorder (DID) in Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, DSM-5-TR, 2022), reminding providers, " most staff members will have a strong reaction to multiples" pointing out that those who accept the existence of multiple identities are advised to be aware of their boundaries as fascination with the patient may promote special or exploitive relationships while those who deny the existence of other personalities both undermine treatment and cause harm with the denial of the original abuse (p.273) (Herman, 1992/2022, pp. 363-364).

***James Grotstein***. Grotstein, a psychoanalyst deeply influenced by the works of Melanie Klein and Wilfred Bion, focused on psychoanalysis and the unconscious mind (Kalsched, 1996, p. 130). While his primary focus was on psychoanalytic theory, his contributions to understanding trauma are notable. Grotstein explored how early relational experiences, and unconscious processes shape the psyche, particularly in the context of trauma (Howell, 2020, p. 20; Kalsched, 2013, p.4). He emphasized the role of the "unthought known"—deep, unprocessed emotional experiences—and how these can manifest in individuals' lives. His work often delved into the interplay between trauma, dissociation, and the unconscious mind, offering insights into how individuals process and

create self-narratives from overwhelming experiences, often in dreams (Grotstein, 2013, p. 37; Kalsched, 2013, p.285).

> Dreams are mercifully disguised to diffuse and suspend the immediacy of toxic meaning and are dramatically vivid, like symptoms, to attract and fix our attention on their themes. Dreams are like archipelagos. Each dream may be unique and specific in its own right, but under the surface we may glimpse the presence of a continuum, the dream of dreams, which is the mythic fingerprint, the unconscious life theme, the theme of themes, for the dreaming subject (Grotstein, 2013, p.7).

Grotstein (2013) critiqued two-person psychoanalysis by cautioning that an emphasis on the traumatic event itself could lead the analyst-analysand dyad to overlook the narrative significance of the trauma, potentially bypassing the analysand's "psychic determinism"—their innate ability to find meaning and construct their own life narrative. (p.37). Professor of Spiritual Care D. Tumminio-Hansen (2024) notes that meaning-making, the ability to reconcile trauma in the face of embedded beliefs and expectations around how the world functions, is a component of post-traumatic growth (p. 49).

***Judith Herman.*** Psychiatrist Judith Herman delved into the experiences of social and historical trauma and its effect on the victims. Herman began her work with survivors of domestic violence, eventually also researching the effects of war and moral injury on veterans (Herman, 1992/2022, p. 3). Herman (1992/2022) describes her work as "restoring connections: between public and private worlds, between the individual and community, between men and women" (p.3). From her socio-political stance, she wrote,

> It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander does nothing- - -the victim, on the contrary, asks the bystander to share the burden of pain (p.10).

Herman's context is in "socially validated reality." Her work addressed the relationship between provider and patient, as she believed that:

> Advances in the field occur only when they are supported by a political movement powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silence and denial (p.12).

In other words, to effect change and promote healing, strong collaboration between patients, healthcare providers, and researchers must be backed by social momentum sufficient to shift support to the victims' side. When considering the work of Herman and her colleagues, the importance of the socio-cultural connections between the provider and the patient is undeniable.

***Vincent Felitti.*** While psychiatrists, psychoanalysts, and psychologists were furthering trauma research, a discovery emerged from an unexpected place that further highlighted the far-reaching and complex nature of trauma. Researcher and physician Dr Vincent Felitti ran an obesity clinic in the 1980s and 1990s. He made a startling discovery as he explored why some of his (mostly) women clients could lose weight and keep it off, and others could not. He found a connection between obesity and a history of sexual abuse (Felitti et al., 2010, p. 25; van der Kolk, 2014, p.147). His peers initially rejected his findings, but a physician from the Centers for Disease Control and Prevention became interested in Felitti's results. Their research partnership led to the groundbreaking Adverse Childhood Events (ACES) study (Herman, 1992/2022, p.359; Felitti, 2019, p. 787). This study documented the links between childhood trauma and its lifelong health

implications. Results of over 17,000 respondents proved connections to the following adult disease and health issues; obesity, unintended pregnancies, chronic obstructive pulmonary disease (due to higher rates of tobacco use), heart and liver disease, mental health disorders along with increased rates of domestic violence and cancer (Felitti et al., 1998, p.251; Monnat & Chandler,2015, p.12).

Initially, ACES respondents were predominantly middle-class, white, middle-aged, and educated, with health insurance; however, only one-third had an ACE score of zero or no significant trauma (van der Kolk, 2014, p.156). These startling results showed how pervasive childhood trauma was (is) and that almost everyone has varying levels of trauma and dysfunction affecting bodies, minds, and spirits every day. No one is immune to exposure or the effects of traumatic experiences. Physicians and healthcare providers are included. Each of us brings our whole selves into many interactions each day. This is why healthcare providers must understand themselves and how their history manifests in patient encounters. As Ellenberger (1970) warns, historically, once the scientific approach to medicine became the norm, "training is purely rational and does not take into consideration the personal, medical, or emotional problems of the physician" (p. 47).

**Today's Healthcare Relationships**

The modern, Westernized medicine has altered the patient-provider dyad. Managed care, which incentivizes medical practice through financial gain connected to productivity, challenges the ability to provide comprehensive, whole-person-centered care. (Emanuel & Dubler, 1995, p.323; Puchalski& Ferrell, 2010, p.167). There are healthcare concerns on a global level. According to one source in an article from The Lancet (2010),

> New infectious, environmental, and behavioral risks, at a time of rapid demographic and epidemiological transitions, threaten health security of all. Health systems worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers (Frenk, et. al, p.1).

With the rise of the internet, patients now have greater access to information and are less likely to accept physicians' authoritative expertise unquestioningly (Broom, 2007, p. 326; Nwouso & Cox, 2000, p. 158). Recent studies have shown that cooperative and trusted relationships between doctors and their patients are mutually beneficial (Meier et al., 2001, p. 3013; Stewart et al., 2000; Weilenmann et al., 2018, p. 2). Trust and feeling understood increase the likelihood of compliance and successful treatment (Bass, 2009, p. 463; Little et al., 2001, p. 797). Access to personalized, culturally sensitive care that takes the time to assess religion, spirituality, and the particularities of the patient's specific life circumstances leads to a greater sense of well-being for the patient (Fuertes et al., 2017, p.614; Puchalski & Ferrell, 2010, p.106).

How can trusting patient-provider alliances be created by any medical provider accountable to external performance pressures and fiscal constraints? What is the experience of the healthcare providers who, while fully embracing TIWPCC, are also experiencing shifting social, political, and cultural identities? As one medical student put it, during a reflection assignment in class:

> Is a good doctor one who dedicates 24 hours a day and 7 days a week to her patients? If that is what it means, I am sure to fail. While I aspire to do everything I can for my future patients, I also have personal dreams and aspirations that are sure to take some of my time and focus away from medicine (Baruch, 2014).

According to the CDC's Vital Signs, last updated in early 2023, the post-pandemic numbers of healthcare workers feeling burned out "very often" were as high as 46 percent, nearly half of those polled. 44 percent planned to look for a new job (Nigam, et al. 2023, p. 1198). While some of the latest statistics drawn from the CDC Violent Death Reporting (Gold, Schwenk & Sen, 2021, p. 1564) show physician suicide rates are no higher than those of the general population, within the profession, their suicide rates have increased (Elkbuli, et. al, 2022, p. e372). Miller (2022) proposes that healthcare providers who engage in authentic relationships with their clients receive an "inoculating" factor against burnout and compassion fatigue (p. 15). But what defines an authentic relationship in the context of provider-client? The definition of an authentic relationship encompasses trauma-informed, whole-patient-centered care (TIWPCC), which necessitates a dynamic and genuine connection between the healthcare provider and the patient (Fuertes et al., 2017, p. 611; Puchalski & Ferrell, 2010, p. 68; Yedidia,2007, p. 50).

# Literature Review: Psychological Considerations

## The Self

### *Defining Self*

The definition of Self can be approached in various ways: psychologically, philosophically, neurobiologically, and spiritually. All these perspectives acknowledge that 'the self' is a complex interaction of relationships, experiences, awareness, and a sense of continuity that is open to change from both internal and external influences (Ellenberger, 1970, p. 204; James, 1999/2012, p. 489; Kalsched, 2013, p. 7). It is out of these complex and intertwining experiences that the consciousness of an "I" separate from "You", or "It" is born.

***Jung and Kohut.*** The work of C.G. Jung and Heinz Kohut remains relevant to understanding today's multifaceted concept of self, which integrates introspection with social and emotional relationships.

**Jung.** C. G. Jung was a Swiss psychiatrist and psychoanalyst who founded analytical psychology. His approach included the spiritual and symbolic parts of the psyche (Kalsched, 2013, p. 3). He introduced concepts like archetypes, the collective unconscious, and individuation, which explore how universal patterns and personal growth shape human behavior (Kalsched, 2013, p. 128; Rizzuto, 1979, p. 37).

***Self-System.*** Jung defined Self as the totality of the psyche, encompassing both conscious and unconscious elements (Ellenberger, 1970, p. 710; Jung & Yates, 2020, p. 6; Kalsched, 2013, p. 77). According to Jung, wholeness is the central guiding force in an individual's journey toward individuation—a process of integrating all aspects of the personality into harmony. Jung believed human life to be an ongoing unfolding process described as "metamorphoses" (Ellenberger, 1970, p. 711; Jung & Yates, 2020, p. 26; Samuels et al., 1986, p. 135). Jung rejected the analytic-reductive method of faceless contact with the analysand on the couch, but instead preferred a face-to-face, interactive, and collaborative approach (Ellenberger, 1970, p. 715).

**Kohut.** Heinz Kohut was an Austrian-born, American psychoanalyst best known for developing self-psychology, an important approach within psychoanalytic theory (Cushman, 1995, p. 211; Kohut, 2012, p. 69; McWilliams, 2011, p. 37).

***Self-Psychology.*** Kohut's self-psychology emphasized the importance of empathy and "self-objects"—people or experiences that provide emotional support and validation—in shaping

a cohesive sense of self (Bowlby, 1988, p. 34; Cushman, 1995, p. 214; Schore, 2015, p. 362). He believed that psychological issues often stem from unmet developmental needs and a lack of empathic responses during childhood. His work transformed psychoanalytic practice, focusing on relational and emotional aspects of therapy (Howell & Itzkowitz, 2016, p. 127; Kohut, 2012, p. 251; McWilliams, 2013, p. 38).

### ***Implications for Providers***

Kohut's self-psychology, emphasizing empathy and the self-object's role, underscores the relational aspect of self-development, highlighting how connections with others shape our sense of self (McWilliams, 2011, p.189). Jung's concept of the self as the unification of conscious and unconscious elements emphasizes the importance of inner balance and personal growth through individuation (Ellenberger, 1970, p. 672). This resonates deeply in current discussions about self-awareness and psychological well-being (Guntrip, 1973, p. 47). These understandings of the self can be easily applied to both patients and providers using a trauma-informed, whole-person-centered care approach.

### ***Know Thyself***

All human relationships are dynamic, continuously being shaped by the interactions and experiences of those involved. This requires that providers acknowledge their own humanity, including their strengths, vulnerabilities, and limitations, which helps build a more authentic connection with their patients (Meier, Back & Morrison, 2001, p.3007; Weilenem et al., 2018, p. 2). The more a provider understands not only who they are but how their internal world operates, the more likely they are to function in healthy and life-affirming ways within the physician-patient relationship (Back et al., 2010; 125; Farber et al., 1997, p. 2291). Building on the ideas of

Balint, Engel, Herman, and others, providers must be aware of themselves to respond appropriately to the stresses, nuances, and discomforts that arise between patients and providers (Back et al., 2010, p. 140; Bass, 2009, p. 463). Puchalski & Ferrell (2010) wonder, "Perhaps our best work as health professionals is not about something we do but about something we are, something we become and bring into all our relationships" (p.xviii).

### *Developing Self*

Developmental theorists, such as Jean Piaget and Erik Erikson, believed that consciousness and awareness of the self develops through stages as cognition matures and social interactions widen beyond primary caretakers (Schore, 2006, p. 22; Shapiro, 1965, p. 146). According to Erikson's psychosocial framework, each growth stage requires certain milestones to be achieved in response to social expectations (Ellenberger, 1970, p. 732; Erikson, 1980, pp. 25, 163; Shapiro, 1965, p. 11). For example, a woman in her seventies facing a terminal diagnosis and who feels a sense of contentment as she looks back on her life (integrity) may find it easier to address end-of-life concerns than another person her age who feels they missed out on too many opportunities and feel dissatisfied with their aging (despair) (Erickson, 1980, p. 104).

While different schools of developmental theories are helpful in the clinical setting and to contextualize one's own current lens of experience, attachment theory explores the quality of the earliest relationships in greater depth and how they shape lifelong coping and defenses (Wallin, 2007, p. 100). "In this model, emotion, which serves the function of organizing object relations, is seen as developing within an interpersonal context rather than in terms of the organism's interaction with the physical environment" (Schore, 2015, p. 25).

## Attachment

Everyone has a unique way of being in the world, yet our earliest relationships profoundly influence us. The caretaker-infant bond, birth order, and societal influences play pivotal roles. These foundational experiences persist in affecting our relationships throughout our lives (Farber et al, 1997; 2291; Howell, 2020; p. 162; Bowlby, 1988, p.14). Herman (1992/2022) writes,

> The belief in a meaningful world is formed in relation to others and begins in earliest life. Basic trust, acquired in the primary intimate relationship, is the foundation of faith. Later elaborations of the sense of law, justice, and fairness are developed in childhood in relation to both caretakers and peers (p.82).

***Early Attachment***

Infants' earliest relationships shape who they are and how they react to the world, influencing important future relationships (Ainsworth, 1985, p. 792; Bowlby, 1988, p. 160; Schore, 2017, p. 247). Building an internal sense of self becomes a crucial link to how humans respond to stress and perceived threats for the remainder of their lives (Bowlby, 1988, p. 46; Wallin, 2017, p. 31). "Human infants, we can safely conclude, like infants of other species, are preprogrammed to develop in a socially cooperative way; whether they do so or not turns in a high degree on how they were treated" (Bowlby, 1988, p.9). Understanding attachment and the resulting defensive mechanism of behavior becomes crucial to effective healthcare.

> Attachment, we suggest, offers a perspective that is both humanistic and optimistic. It is humanistic because it focuses on the totality of a life, people's inner landscape and actual relationships, and the developmental and current contexts from which they emerge. It is humanistic, too, because only by establishing and protecting connections with our fellow humans is it safe to go out into the world (Holmes & Slade, 2017, p.192).

Much research has been conducted on the factors contributing to healthy or secure attachments. American pediatrician T. Berry Brazelton (1990) believed that attachment begins with the initial maternal desire to become pregnant, linking it to personal, social, and cultural factors. He described this as *the pre-history of attachment* (Chapter 1). According to Brazelton (1990), attachment is an ongoing process of mutually reinforcing interactions that unfold between the infant and the mother (p. 46). Clinical psychologist and psychoanalyst Peter Fonagy (1997) agrees, saying, “There is now evidence that the caregiver brings something to the parent-child relationship, evident even before the birth, which may be critical in the child’s establishment of both secure attachment and mentalization” (p.689). Increasing research in the neurobiology of attachment and epigenetic effects of generational trauma affirms visually what Bowlby, Fonagy, and others have long studied. Each generation connects to and affects the one that follows, just as the one before did to them (Herman, 1992/2022, p. 166; Howell & Itzkowitz, 2016, p. 223; van der Kolk, 2015, p. 152).

***The Strange Situation***

The Strange Situation is a long-term research study on attachment run by two research psychologists, Mary Ainsworth in the 1970s and further developed by Mary Main in the 1980s. Both observed the children’s reactions (ages one to six years old) as their caregivers (mostly mothers) and a stranger left the room and then returned, either alone or together (George et al., 1985; Schore, 2015, p. 97).

Four types of reactions were identified as attachment styles. Secure, insecure-ambivalent, insecure-avoidant, and later, disorganized/disoriented as identified by Mary Main. Ainsworth (1989) states:

> The behavioral system includes not only its outward manifestations, but also an inner organization, presumably rooted in neurophysiological processes. This inner organization is subject to developmental change, not only because it is under genetic guidance but also because it is sensitive to environmental influences. As the inner organization changes in the course of development, so do the outwardly observable behavioral manifestations and the situations in which they are evoked (pp. 709–710).

Mary Main explored the connection of attachment-style behaviors to inner emotional states, concluding that early attachment experiences build representational internal working models for relating to others that were long-lasting and applied to more general relationships (Main et al. 1985, p.67).

These studies have clinical significance, as up to 75% of participants exhibited the same attachment style in when re-evaluated in adulthood (George, Main, & Kaplan, 1985; McWilliams, 2011, p. 54; van der Kolk, 2014, p. 116). Psychological professionals still use Mary Main's Adult Attachment Inventory Tool today to help assess and support adults struggling with relationship challenges. As Fonagy (1997) identified:

> The strength of the Strange Situation (SSn) as a method of psychological assessment is to provide a powerful analogue of past situational contexts within which the "how" of behavior with a specific caregiver is accrued. In this sense attachment is a skill, one which is acquired in relation to a specific caregiver, encoded into a teleological model of behavior (p.685).

### *Containment: Bion*

English psychoanalyst Wilfred Bion used the term "containment" to describe how an infant, due to the immaturity of the brain (inability to think/mentalize), cannot make sense of the painful

experiences of development, including birth itself (LaFarge,2000, p.67-68; Holmes & Slade, 2016, p. 36). The intolerable feelings are projected onto and introjected into the caregiver (Holmes & Slade, 2015, p. 67; Schore, 2015, p. 465). "In a healthy situation, the parent or other caregiver can contain and tolerate the anxiety and destructiveness of the child's projection and elaborate it into a meaningful, less concrete and anxiety-filled experience, which the child can internalize and experience as a thought" (Howell & Itkowitz, 2016, p.110). When a mother soothes a hungry, crying infant, acknowledging the distress with words and touch and then relieving the hunger, she transforms the baby's raw and overwhelming emotions into a more understandable and manageable experience (Bion, 1962, p. 308). The baby begins to feel understood and calmed by the mother's response, learning that their distress can be communicated and alleviated.

### *True Self and False Self: Winnicott*

***True Self.*** Donald Winnicott, a renowned British pediatrician who became psychoanalyst, introduced the concepts of the true and false selves in the 1960s. His theory explores the development of these two aspects of the self and their impact on an individual's internal sense of well-being. Winnicott says (1960/1965) "The true self comes from the aliveness of the body tissues and the working of body-functions, including the heart's actions and breathing" (p. 148). Spontaneity, authenticity, creativity, and expressiveness define the true self. The development of a true self depends on the primary caregiver's ability to allow spontaneous and authentic expressions of the infant or child in a supportive environment that fosters progression toward independence (Winnicott, 1960/1965, p. 145). Winnicott describes "the good enough mother" as one who accepts the infant's negativity and destruction (such as tantrums, rejection, and frustrations) while encouraging and celebrating the spontaneous expression of their child.

Winnicott (1960/1965) uses the word “devotion” to describe the good enough mother’s emotional stance (p. 148). As a result, an attentive but not overly involved caregiver creates a holding environment that allows the infant to explore, grow, and experience themselves as an “I”. Winnicott (1958) used the word ego-relatedness (p.33). Ego-relatedness is the capacity of an individual to form meaningful and supportive relationships with others. It involves the ability to connect with others while maintaining a sense of individuality and autonomy. (Ulanov, 2001, p. 68; Winnicott, 1958, p. 30).

***False Self.*** When a caregiver is absent, inconsistent in their responses to a baby, or uses the baby to meet their own needs, the false self develops as a protective mechanism for the inner core of one’s being. The false self is the facade put on to hide and protect the true self. The presence of the false self is not necessarily dysfunctional. In social roles or in response to external factors, someone may intentionally and appropriately employ the false self (Winnicott, 1960/1965, p. 150).

For example, a medical provider professionally presents themselves and speaks more formally than they would at a family gathering. This approach is a healthy way to maintain boundaries of the provider-patient relationship. The false self is problematic when a person is unaware that they are disconnected from their true essence (Winnicott, 1960/1965, p.144). Winnicott shares the example of a person outwardly appearing successful. They are smart, capable, and appear to have achieved professional, personal, or social status while privately struggling with identity (Winnicott, 1965, p. 224). The false self relies on intellect and thought to defend the true self, looking for identification through others rather than trusting that there is space in the world for them. The essence of the true self remains locked away in the somatic experience, exiled from expression, resulting in mind-body disengagement (Winnicott,

1960/1965, pp. 142-143). This hinders the space of ego-relatedness, creating “a feared gap into which we may at any time plunge, we do not open up to the world with its true resources that encourage us to unfold our true being. Nor do we feel the world opening up to our endowment of creative imagination” (Ulanov, 2001, p. 119).

### *Mirroring: Fonagy*

Fonagy’s understanding of the self builds on Winnicott’s *mirroring* behaviors of open parents who can identify with and reflect their child’s feelings back to them. (Holmes & Slade, 2017, p. 44; Wallin, 2007, p. 103). Fonagy uses the example of anxiety, describing it as a mixture of physical experiences and confusing ideas. When a mother can hold, identify, and reflect “anxiety”, the infant comes to know, “This is anxiety” (Fonagy & Target, 1997, p. 683). This integration of knowing, or mentalizing, of emotions assists in the representational mapping of emotions linked with mental identification of the internal state with external experience. This theory of mind attributes mental states—such as beliefs, intentions, desires, emotions, and knowledge—to oneself and others. Understanding that others have perspectives, thoughts, and feelings that may differ from one's own is crucial. Empathy and healthy social interactions are born from the ability to recognize I as separate from You (Fonagy, 1997, p. 687).

## Implications for Providers

A healthcare provider who is grounded in their own self-individuation, attachment identity and true self is better able to navigate difficult patient encounters by understanding their own identity as a separate and self-actualized person (Back et al. 2010, p.140; Bass, 2001, p.700; Farber,et al, 1997, p. 2291). Emotional regulation and non-defensive responses on the part of the provider towards a patient, family, or staff member who is dysregulated, angry, blaming, or acutely grieving create a safe transitional space to hold the emotions. Emotions are data pointing

to what is valued and important to the other person (Back et al., 2010, p.26). However, if a provider is practicing unaware of their own insecurity, fears, and anxieties, it becomes difficult to respond in ways that will build relationships. Emptiness, cut-off, and rigidity all describe the defensive posture of a false self (Farber et al., 1997, p. 2292; McWilliams, 2011, p. 247; Puchalski & Ferrell, 2010, p. 43; Yedidia, 2017, p. 55).

**Primary Defenses**

With whole-person-centered care that is trauma-informed, interactions are understood as psychological, emotional, spiritual, and relational in nature, not just biological (Griffith & Griffith, 2002, p. 26; Tumminio-Hansen, 2024, p.21) . This approach requires medical caregivers to know how these forces function within the medical system. It is their responsibility to learn how to support the patient and encourage trust rather than undermine potential areas of healing (Bass, 2001, pp. 690-691; Fuertes et al., 2017, pp. 613-614). One way towards this is to recognize that primitive or primary defenses are present in all of us. They exist as adaptive ways of functioning in and experiencing the world (McWilliams, 2011, p. 100).

Jungian analyst and clinical psychologist Donald Kalsched (2013) offers a helpful understanding of the self-care system when he talks of binocular vision being the "space between our private subjectivity and our inter-subjectivity [as] crucial for understanding the human condition and also for healing the places where we have found it intolerable and escaped into one world or the other" (p.9). It is from this liminal threshold space that humans learn to adapt, defend, protect, and survive (Holmes & Slade, 2017, p. 271; Howell, 202, p. 163; McWilliams, 2011, p. 39; Ulanov, 2001, p. 7).

In relation to trauma-informed, whole-person, centered care, the binocular awareness of the inner processes held in tension with the relational interactions between the provider and patient

(or family) creates space for authentic engagement, with the goal of healing and wholeness. In this context, healing may not include a physical 'cure,' but rather hope in the face of suffering, peace in the face of death, and meaning in the face of pain and uncertainty (Frank, 1995, p. 9; Puchalski & Ferrell, 2010, p.55).

While medical professionals are not psychoanalysts, a basic awareness of this self-care system and the primary defensive structure enables the provider to maintain healthy boundaries, deepen their awareness of what is occurring between the patient and provider, and recognize the level of defensive functioning present (McWilliams, 2011, p. 101). The caregiver becomes attuned to when they may be transferring their issues to patients and families and recognizes when patients and families project fears onto and into them (Back et al., 2009, p. 141; Tumminio-Hansen, 2024, p. 20).

Put another way:

> To become a separate self, capable of sustained and rewarding interest in an other- whether a partner, a vision in science, a problem in art, a vow in religion- contributes to social welfare. Self-experience feeds others and receives from others. It promotes growth into the deepest and highest human fulfillment (Ulanov, 2001, p.89).

Emotions and the resulting nonverbal communication are beyond conscious control, yet they convey a wealth of information (Löffler-Staska et al., 2017, p. 3; Tumminio-Hansen, 2024, p. 51; van Löben Sels, 2019, p. 217). Learning the language of human interaction and communication is not often taught in medical programs (Back et al., 2010, p. 3 ; Ludermer, 2019, p. 839; Puchalski & Ferrell, 2010, p. 155). One source states, "the critical task for clinicians is to find a way to integrate complicated biomedical facts and realities with emotional, psychological, and

social realities that are equally complex but not very well represented in the language of medicine" (Back et al., 2010, p. 5).

Dr. Brian C. Miller (2022), in his work on supporting those in the helper professions, claims that until providers are aware and able to manage their own emotions, "clinical interventions will fail" (p.5). Interacting with ill patients will bring up both pleasant and unpleasant feelings. Poorly understood feelings and emotions can alter the course of a patient's care and affect the health care provider's well-being (Holmes & Slade, 2017, p. 110; Weilenem, et al, 2018; Miller, 2022). Several studies by different researchers (Meier et al., 2001; Fernando & Constantin, 2014; Yedidia, 2007) demonstrate that providers who struggle with emotional regulation are at risk for boundary violations, avoiding patients, influencing medical decision-making, and providing poorer quality care. The same studies identify the results of unexamined emotions in medical providers, such as professional isolation, guilt, self-blame, over-functioning, and experiencing contempt or anger towards their patients.

***Avoidance***

Avoidance as a primary defense refers to a psychological or behavioral strategy employed to avoid situations, experiences, or stimuli that may evoke fear, discomfort, or perceived danger (McWilliams, 2011, p. 302; Miller, 2022, p. 33). This can manifest in various ways, such as avoiding confrontation, procrastination, social withdrawal, or evasion of environments triggering anxiety (Fernando & Consedine, 2014, p. 293; Holmes & Slade, 2017, p. 158). While avoidance can sometimes provide temporary relief or protection, it may hinder personal growth or problem resolution when overused (Miller, 2022, p. 20). Puchalski & Ferrell (2010) use the term "distancing" to describe healthcare providers' use of an avoidant withdrawal from patients (p. 42).

### *Projection, Introjection, Identification with Aggressor, and Projective Identification*

***Projection***. Projection is a defense mechanism where individuals attribute their own unwanted thoughts, feelings, and impulses to others (Wallin, 2007, p. 141). Or as analyst and educator Nancy McWilliams (2011) puts it, "Projection is the process whereby what is inside is misunderstood as coming from the outside" (p.111). McWilliams identifies healthy projection as the foundation for empathy, as it allows individuals to imagine or "project" what someone else might be experiencing, even though they can never fully share the exact same experience. Less healthy forms of projection create what Wallin (2007) calls "psychic equivalents," meaning that internal, uncomfortable, and unacceptable emotions are experienced, rejected, and projected onto others externally (pp. 140-141). The internal experience is conflated with an external reality.

For example, a nurse feeling guilty about working extra hours that take him away from his family may project his guilt onto a patient. The nurse may spend extra time with that patient and offer extra support even though the patient does not feel lonely, abandoned, or without support. From the other perspective, if a physician cannot recognize a patient projecting their fear and helplessness about a cancer diagnosis onto them, she may not realize that the patient believes the doctor feels the prognosis is hopeless and, as a result, stops coming in for follow-up appointments.

***Introjection***. Introjection involves internalizing the attributes, beliefs, or feelings of others into one's own psyche. This happens unconsciously and is a normal part of development, as in

a child adopting a parent's attitudes or values (Erickson, 1980, p. 96; Rizzuto, 1979, p. 29; Shapiro, 1965, p.158). McWilliams (2011) suggests that neurobiological studies hint at mirror neuron activity and other brain processes as part of absorbing aspects of others (p. 112). Mirror

neurons are in the frontal lobe and contain “our ability to feel into someone else” (van der Kolk, 2014, p. 58).

***Identification With the Aggressor.*** Fear and vulnerability can be overwhelming when individuals do not feel heard, seen, or mirrored. (Howell & Itzkowitz,2016, p. 67; Frankel, 2002, p.101) It is not only blatant physical, sexual, or verbal abuse but also persistent negative comments from caregivers, teachers, or other important individuals that influence the individual’s sense of self and becomes a fact within the psyche. An extreme example is the theory of “identification with the aggressor” following abuse by a caregiver, as explained by Sandor Ferenczi (1933), “that the weak and undeveloped personality reacts to sudden unpleasure not by defence, but by anxiety-ridden identification and by introjection of the menacing person or aggressor” (p.163). What Ferenczi is saying is that initially, there is a dissociative traumatic response that occurs in the face of being victimized (Howell, 2014, p.48). Over time, this split becomes internalized, maintaining both the sense of victim and mimicry of the former aggressor. Identifying with an abuser is not a conscious decision, but rather a fixed identification that turns external aggression, which should be “out there,” inward as a form of survival (Ferenczi, 1933, p. 163; Kalsched, 2013, p. 190). When a vulnerable person relies on someone for their survival, especially if that person is abusive, they may cope with the fear of their situation by believing they somehow deserve mistreatment. This belief can act as a psychological shield because admitting the caregiver is truly bad or harmful feels too terrifying—it directly threatens their sense of safety and survival (Holmes & Slade, 2017, p.110; McWilliams, 2011, p.144). The result is repeating the behaviors of the abuser upon others as a protective stance: “No one will hurt me. I am as powerful as them.” Or self-harming behaviors that leave the person open to

future victimhood. “I must be bad, so I deserve this” (Howell, 2014, p. 56; Kalsched, 1998, p.17).

As an example from a teaching hospital, a senior physician is unhappy with a particular medical student’s performance. The physician tells the resident to “start a wall of shame and put [the medical student’s] picture up there.” Publicly shamed, the medical student internalizes the criticism and sets up a self-attack. Eventually, his internal shame prompts publicly shaming others and pointing out his classmate's mistakes to shield himself from further vulnerability.

***Projective Identification***. Projective identification is complex. In this process, first described by psychoanalyst and object relations theorist Melanie Klein, parts of the self are projected onto another person, who begins to act out these projected attributes (Cushman, 1995, p. 195; Ellenberger, 1970, p. 854). This process often involves both unconscious projection and introjection and can influence the behavior and feelings of both individuals involved in the dynamic (Cushman, 1995, p. 199; Guntrip, 1973, p. 66; McWilliams, 2011, p.113). Taking a trauma-informed approach, Judith Herman (1992/2022) reports that clients create a dynamic where “the perpetrator plays a shadow role,” adding the presence of a third (the abuser and representations of the abuse) into the patient-provider dyad (p. 200).

Imagine a family is anxious, worried, and feeling guilty about their loved one’s accident. A chaplain in the intensive care unit visits twice to offer support. The family members begin to project their anxiety and guilt onto the chaplain. Internalizing unconsciously, the chaplain feels anxiety and guilt as their own and begins to doubt their ability to assist with the spiritual support of the family. This begins a feedback loop of anxiety and guilt that results in the chaplain avoiding visiting the family.

### *Defensive Splitting of the Ego*

This defensive mechanism may be a more familiar defense for healthcare professionals. Dividing the world, people, and ideas into good or bad is not unusual (McWilliams, 2011, p. 116; Wallin, 2007, p. 136). This is a way of "othering" people to feel a sense of safety, belonging, and power. Internally, splitting may result in projecting unacceptable feelings of anger or jealousy onto someone else instead of accepting them as part of the self (Jung, 1957/1990, p. 5 [592]; Kalsched, 2013, p. 121). External splitting, the most familiar for healthcare providers, happens when one patient becomes the topic of many conversations; half of the staff is compassionate, and the other is frustrated and angry (Herman, 1992/2022, p.219). The danger lies in healthcare providers projecting their biases and beliefs of "badness" onto those typically marginalized as other: the unhoused, those with abuse and dependency issues, the incarcerated, or those from other cultures and religious traditions (Herman,1992/ 2022, p. 171; Rogers, 1965, p. 446). Splitting encourages the dehumanization of others to bolster one's internal need for safety, a sense of goodness, and control (Ulanov, 2001, p.58).

### *Somatization*

Before there is language, there is felt sense. Before conscious awareness, there are interactions with the material world and others. There is total dependence before a capacity to act (McWilliams, 2011, p. 118; Winnicott, 1954, p.202). Mind, or conscious awareness, and body, a sense of physical self, are interrelated or, as van der Kolk (2014) puts it, "the body keeps the score". Somatization is not a factitious disorder (malingering) or illness anxiety (hypochondria). Rather, it is the "physioneurosis" (Herman, 1992/2022, p. 185; Taylor, 2002, p.452) of trauma, fear, and helplessness (van der Kolk, 2014, p. 218). The body becomes separated from the

psyche and acts to express what the psyche cannot voice (McWilliams, 2011, p. 117; Ulanov, 2001, p. 45; Winnicott, 1954, p.204).

As discussed earlier, George Engel promoted a biopsychosocial approach to patients and linked emotional affect states to changes in his patient Monica's gastrointestinal functioning. This is an example of somatization—unconscious and unintentional physical responses to an uncomfortable, anxiety-producing situation. For a period of ten years, he documented his own psychogenic pain and illnesses, correlating them with personal anniversary dates of trauma, grief, and loss (Taylor, 2002, p.454).

***Denial***

Denial is a primary defense mechanism that everyone uses. (McWilliams,2011, p.105; Wicks et al.,1985, p.540). Denial can help people escape stressful times by temporarily refusing to acknowledge or accept a situation. It becomes problematic when a refusal to acknowledge reality adversely affects oneself or others. This is why the first step in many substance dependence recovery programs is to admit that there is a problem(12 Steppers, The 12 Steps & 12 Step Programs - 12 Step Recovery Resources - 12 Steppers, accessed 6/4/2025; Wicks et al., 1985. P. 503).

In the medical setting, denial as a defense mechanism can manifest in various ways. For instance, a patient diagnosed with a serious illness might refuse to accept the diagnosis, insisting that the test results are incorrect or that the symptoms are temporary. This denial can lead to treatment delays, as the patient might refuse follow-up appointments or ignore medical advice. Healthcare professionals encounter denial in family members who refuse to acknowledge the severity of a loved one's condition, often clinging to the hope of a miraculous recovery despite

clear medical evidence to the contrary (Puchalski & Ferrell, 2010, p.51). This can create challenges in communication and decision-making, as the medical team must navigate these emotional barriers to provide adequate care and support. Denial is often the initial response to initiating end-of-life or do-not-resuscitate conversations. (Back, et al., 2009, p.121).

Healthcare providers may use denial as a defense mechanism to cope with the emotional and psychological stress of their work (Miller, 2022, p.135). For example, a doctor might downplay the severity of a patient’s condition to avoid feeling overwhelmed by the potential outcome (Back, et al., 2009, p.140). This can help them maintain control and continue functioning effectively in high-pressure situations. However, this denial can lead to burnout or influence their decision-making and patient care if not appropriately managed. Healthcare professionals need to recognize when they are using denial and seek support, whether through peer discussions, counseling, or stress management techniques, to ensure they can provide the best care for their patients while also taking care of their own well-being (Miller, 2022, p.156; Rabin, 2018, p.4).

***Omnipotent Control***

The defense of omnipotent control is developed in the infant as a sense of control of their environment. This is before a sense of reality or realization that there are limits to one’s power. This belief stems from a fantasy that one’s actions and desires control outcomes, disregarding the influence of external factors or other individuals (McWilliams, 2011, p. 107). This mechanism can provide a sense of control and security, especially when the person feels vulnerable or helpless. As individuals grow, a strong sense of self-esteem is important and not necessarily unhealthy. However, believing one is always in control of one’s environment can lead to unrealistic expectations and difficulties in accepting the limitations of one’s influence

This defense in medical settings may manifest when healthcare professionals show an exaggerated sense of control over patient outcomes and medical processes. This defense mechanism might lead to overestimating their ability to manage complex medical situations, potentially resulting in unrealistic expectations and increased stress. Boundary violations and practicing beyond one's scope may result from beliefs of omnipotence (Meier et al., 2001, p. 3011; Puchalski & Ferrell, 2010, p.45). Omnipotent control can also lead to micromanaging, where the professional feels the need to be involved in every detail, potentially stifling collaboration and innovation within the healthcare team. Recognizing and addressing this defense can foster a more balanced approach, promoting teamwork, realistic goal setting, and ultimately better patient care.

***Idealization and Devaluing***

***Idealization.*** Idealizing occurs when only positive attributes are assigned to someone, driven by a sense of necessity (Wallin, 2007, p. 219) to believe that a powerful, benevolent, and protective other is in charge and able to keep us safe (McWilliams, 2011, p. 108). Everyone idealizes to some degree, be it a new partner, a mentor, or, in the case of medicine, one's physician or therapist. When one has a new cancer diagnosis, there is value in believing one's oncologist is the best in the field with access to treatments that others don't have. In healthy idealization, there is room for recognizing that no one is perfect, and repair, after rupture, can occur.

***Devaluing.*** Devaluing is the opposite. It's when someone attributes exaggerated negative qualities to another person, object, or concept. By focusing on negative and ignoring positive aspects, individuals can distance themselves emotionally and protect themselves from perceived threats or disappointments (McWilliams, 2011, p.110) .Devaluing can be a way to cope with

hurt, anger, or betrayal by reducing the importance of the person or thing that caused those feelings.

Both defenses can be part of a larger coping strategy for managing difficult emotions and maintaining control. However, if used excessively, they can also distort perception and relationships. Puchalski and Ferrell (2010) use the term "distancing" to describe how a provider "does not allow himself or herself to empathize or connect to the patient's pain or suffering" (p.42). In this scenario, a patient or family may be labeled as non-compliant, or difficult, or hostile. Assigning these attributes to another human being, without consideration of the fullness of their humanity, justifies devaluing and avoiding the patient or family (Back et al, 2009, p. 94; Fernando & Consedine, 2014, p. 293; Miller, 2022, p.33).

### *Dissociation*

When someone faces a threatening situation that overwhelms their ability to cope and survival is necessary, the parasympathetic system can cause a protective separation of mind and body (Herman, 1992/2022, p. 148; van der Kolk, 2014, p.218; Wallin, 2007, p.71). This is the flight, freeze, fight response arising from the amygdala. If the threat is too much to bear, a split in the ego, or inner self, may shield the person from their thoughts, feelings, emotions, and memories (Kalsched, 2008, p.34; Rogers, 1951, p.508; van der Kolk et al., 1989, p.366). During experiences of trauma, dissociation may arise spontaneously (Howell, 2005, p. 147). Dissociation is a defense mechanism that alters consciousness and memory via trance-like states (Herman, 1992/2022, p.183; van der Kolk, 2014, p. 72). While many people assume that dissociation is a severe trauma response, as illustrated in Schreiber's 1973 book Sybil, and results in dissociative identity disorder, it is a commonly used defense (McWilliams, 2011, p.

124; Putnam, 1989, p. 10). Putnam (1997) states, “But if you look around you, you can observe people shifting states of consciousness” (p. 98). McWilliams (2011) says, “dissociation exists on a continuum from normal and minor to aberrant” (p.124). Anyone who has “checked out” while doing laundry or experienced “auto-pilot” while driving their car has experienced dissociation.

In the healthcare setting, words like “numb”, “detached,” and “outside my body” are cues that some level of dissociation may be occurring. While this applies to patients, listening to colleagues is helpful, too, especially following traumatic or difficult cases. Strong trigger-like reactions to touch, sounds, or smells indicate dissociation from a previous trauma that is now being re-memorized (McWilliams, 2011, p. 124; van der Kolk, 2014, p. 85). Awareness of boundaries and power differentials regarding gender, race, culture, and trauma experiences is important to build a therapeutic alliance that is safe for both the patient and provider (Farber et al., 1997, p. 2291; Herman, 1992/2022, p. 379; van der Kolk, 2014, p. 85) This safety fosters trust, which is essential for patients who may already struggle with fragmented experiences of self and reality (Fuertes et al., 2017, p.612; Wallin, 2007, p.117).

***Repression***

Repression is another way of ‘not’ remembering. When something is repressed, the mind suppresses what is deemed intolerable by unconsciously burying the associated memories, keeping them hidden from conscious awareness (Bowlby, 1988, p.71; Wicks et al., 1985, p. 453). It is considered a horizontal split from consciousness, while dissociation is a vertical split. The vertical split creates separate but functioning consciousness, as seen in dissociative identity disorder (Howell, 2020, p. 91; Howell & Itzkowitz, 2016, p. 75). Repression may present as somatic or psychological symptoms that the patient is unaware are connected to trauma.

Dissociation is a disconnect between self and reality, characterized by gaps in time, story, confusion, memory, or identity (van der Kolk, 2014, p. 176; Wallin, 2007, p. 117).

### *Acting Out*

Acting out is a defense mechanism in which an individual expresses emotions or impulses through behavior rather than words or introspection. This may involve impulsive or disruptive behavior, such as tantrums, aggression, substance abuse, or sexual acting out. The individual may act out to temporarily relieve emotional tension or express distress (Farber et al., 1997, p. 2293; Shapiro, 1965, p. 142; Valliant, 1994, p.45).

Unfortunately, "acting out" can often mean any behavior that providers disagree with, don't understand, or find unacceptable in the healthcare setting, which can result in a missed opportunity to explore what is happening (Eigen & Philips, 2018, p. xviii; McWilliams, 2011, p.121). Adverse reactions experienced by healthcare providers towards the person's behavior are called enactments and are part of the defensive process. When something cannot be spoken, the patient unconsciously makes the provider *feel* something, drawing them into the drama of reliving trauma (Wallin, 2007, p. 271; Howell & Itzkowitz, 2016, p. 122).

A young African American man under police custody was shouting, calling staff names, and refusing care. While the law enforcement officers responded aggressively, the medical staff retreated. A chaplain entered as a non-reactive, non-anxious presence, de-escalating the situation by offering curiosity. As it turned out, the young patient was frustrated and vulnerable because the staff used medical terms and gave directions he did not understand. Once revealed, tools and strategies could be shared to improve communication.

Healthcare providers also act out. According to one study, 10-15% of healthcare professionals will have substance misuse at some point during their career (Baldisseri, 2007, p.1).
While the rates of substance use disorder are about the same as the general population (Bennett & O'Donovan, 2001, p. 195; Amirouche et al, 2023, p. 259) the danger posed to the patients cared for by healthcare professionals under the influence cannot be overstated (Bennett & O'Donovan, 2001; Kenna et al., 2008, p.6). Other forms of professional acting-out include emotional outbursts aimed at other colleagues, coworkers, patients, or families and inappropriate sexual relationships with coworkers or patients (Back et al., 2010, pp. 102-103; Farber et al., 1997, p. 229; Miller,2022, p.136).

***Instinctualization/Sexualization***

Instinctualization or sexualization, as a primary defense, is a psychological mechanism where anxiety, fear, or emotional conflict is channeled unconsciously into instinctual or sexual behavior (Guntrip, 1973, p. 36; McWilliams, 2011, p. 122, van der Kolk, 2014, p. 120). This can manifest as an exaggerated focus on physical attraction, flirtation, or sexual behavior, sometimes used to avoid confronting deeper emotional issues or vulnerabilities (Bowlby, 1998, p. 5). This defense is not about sex or sexuality. Sexualization requires the objectification of another (Farber et al., 1997, p. 2293; Levin & Kilbourne, 2008, p. 7). It's another way to cope with distress and intolerable feelings by redirecting attention to instinctual, exciting, stimulating behaviors rather than addressing the root cause (Ulanov, 2001, p. 84).

Isolation and unhappiness in healthcare professionals can lead to inappropriate relationships with patients or colleagues (Farber et al. 1997, p. 2293; Pargament, 2007, p. 281). Patients may become flirtatious with their providers instead of addressing the fear of illness and diagnosis.

## Communication

### *Nonverbal and Bodily Ways of Communicating*

Communication is only partially verbal. Howell (2022) points out that "affects are conveyed procedurally and implicitly by somatic states, by body rhythms, and by facial expressions in ways that are not accessible to ordinary verbal consciousness" (p.67). Howell's insight about affects being conveyed through somatic states, body rhythms, and facial expressions underscores the need for caregivers to attune to nonverbal cues that reflect a patient's emotional and physiological state (Tumminio Hansen, 2024, p. 53; van der Kolk, 2014, p. 86)

Alan Schore (2022), building on Ferenczi's idea of an intersubjective dialogue occurring between one unconscious mind and another, highlighted a dynamic and reciprocal exchange at an unconscious level, stating, "I am suggesting that we are experiencing a paradigm shift from left brain conscious cognition to right brain unconscious emotional and relational functions" (p. 2). Right-brain processes are crucial for forming deep interpersonal connections and cultivating an empathetic, relational approach where the healthcare provider engages with the patient in an emotionally attuned and nonverbal manner (van der Kolk, 2014, p. 301; van Löben Sels, 2020, p. 201).

Trauma-informed whole-person-centered care requires providers to create environments of safety and trust, which involves recognizing and responding to subtle signals that may reveal underlying distress (Back et al., 2009, p. 28; Frank, 1995, p. 143; Tumminio-Hansen, 2024, p. 24). McWilliams (2011) states

> A therapeutic relationship is likely to get off to a good start if the client feels the clinician's curiosity, relative lack of anxiety, and conviction that the appropriate treatment can begin once the patient is better understood (p.16)

Although McWilliams is referencing the psychotherapeutic relationship, the same applies to other modalities. Addressing healthcare providers in Mastering Communication with Seriously Ill People, Back, Arnold, and Tulsky (2010) assert that with patient access to the internet and the increasing amount of intricate medical information, “communication between patients and physicians must integrate a mountain of biomedical information with their patients’ values, hopes and priorities. The internet has a place but does substitute for a skilled, caring physician” (p.3).

***Transference & Countertransference***

Although the phenomenon of transference and countertransference is most frequently associated with psychotherapeutic encounters, they occur regularly in any setting where help is being sought from a provider (Bass, 2009, p. 463; Muskin & Epstein, 2009, p. 2). In fact, these defenses are used by everyone in everyday settings. The subtle favoritism shown by a boss to the employee who reminds them of a younger sibling. The friend who is easily offended because of their own feelings of vulnerability. Transference and countertransference can open communication pathways and deepen relationships when they are named aloud (Wallin, 2007, p. 125).

***Transference.*** Transference occurs when someone associates a provider (their doctor, nurse, social worker, or chaplain) with someone else in their life, often from childhood relationships. For instance, patients who have been harmed by organized religion can transfer those

experiences and feelings to the chaplain who unwittingly shows up to offer support. If the patient is willing to engage, that can be an opportunity to explore the transference.

***Countertransference.*** Countertransference occurs when that is reversed, and a provider correlates their experiences of past relationships with those they serve (Holmes & Slade, 2017, p.20; Muskin & Epstein, 2009, p.26) When a patient reminds the provider of their overbearing sister, the provider may begin to avoid that patient, which could affect care. A social worker may become drawn to caring for patients who remind him of his deceased grandfather.

***Intersubjectivity and Right Brain Connections: Stern, Schore***

Emotional attunement between humans is a hard-wired trait (Howell,2020; Ramberg, 2006; Schechter, 2017). Winnicott's "good enough mother", Bowlby, Ainsworth and Mains' styles of attachment, and the ego-consciousness developmental theorists, agree that the infant's survival relies upon the earliest caregiver (mother) infant bond. Those initial bonds' health, consistency, and stability shape the infant's internal beliefs about themselves and influence their future relationships. Medical providers (because they are also human) are included in this.

Psychoanalyst/physician Daniel Stern writes about intersubjectivity as the ability of the analyst and analysand to co-create a shared reality in the present moment that awakens both to a new way of relating (Ramberg, 2006, p.26). In the context of a health provider-patient relationship, intersubjectivity—the ability to recognize and relate to each other's emotions without avoiding or diminishing them—creates unique opportunities for healing in more intimate, less physical ways (Back et al., 2010 p. 33; Miller, 2022, p.140; Ramberg, 2006, p. 27).

When both parties are open to expressing and feeling difficult emotions, described by Stern as rupture and repair, trust is built through mutual emotional regulation (Schechter, 2017, p. 253).

Imagine a patient arriving in the oncology office to receive test results. She is wondering if her cancer is back. The oncologist is an experienced physician well-known in town. He enters the room, gives her the good news that her scan was clear, and narrates the visit into her electronic patient file. He says, “If to reoccur, the patient most likely would be salvageable.” The patient’s face flushes, and she stiffens in her chair. The oncologist sees this and replies, “Oh, that’s just a medical term, and dictating now saves us all time.” She leaves the office feeling like an object rather than a human being. The oncologist goes on with his day, disconnected from his own emotions about his work.

Intersubjectivity could have created a space for connection between the patient and her physician, centered around the cancer diagnosis, treatments, and the vulnerability associated with human fragility and illness. The patient might have expressed her feelings about her body’s response to the term "salvageable" when it was applied to her. She could have said, “What am I? A car?!” In response, the physician could have set aside his microphone, acknowledged her emotions, and offered an apology. Engaging in a conversation about the challenges of the cancer experience for both parties could have strengthened the patient's trust in her oncologist. In turn, this openness could have reassured the oncologist that his life's work has made a meaningful difference.

### *Mentalization*

Mentalization refers to a symbolic framework that enables individuals to reflect on their own emotional states and intentions and understand and consider the similar mental states of others (Howell & Itzkowitz, 2016, p. 114). Wallin (2007) states,

> The mentalizing stance enhances our ability to identify and modulate our affects, so that they do indeed serve their primary function-namely, to help us evaluate our experience of

> the world and, on the basis of such evaluation, to guide our actions in an adaptive fashion (p.136).

Professionals in healthcare are faced with complex emotions being expressed by patients and families in the context of illness, end-of-life issues, pain, and uncertainty of physical and/or mental challenges. During patient visits, it can be challenging to accurately monitor both verbal and nonverbal communication, especially when influenced by defense mechanisms. Stressful situations can trigger the amygdala, and defensive survival reactions may arise in both the patient and the provider thus affecting communication (Back, et al., 2009, p.23-24; Meier et al.,2001, p. 3007; van der Kolk, 2014, p.61; Wallin, 2007, p.138-139). In other words, patients and families frequently do not present their best selves in healthcare settings. And healthcare providers are human, too.

Navigating communication in emotionally charged scenarios can leave care providers feeling frustrated, ineffective, hopeless, and angry (Miller, 2020; Puchalski & Ferrell, 2010; Wallin, 2007, p.313). However, skillful mentalization, or metacognition, can increase empathy by allowing individuals to be cognitively self-aware of their reactions, thereby increasing the likelihood of creating a healing space between provider and patient. Using mentalization can reduce the emotional labor required to remain present in challenging situations (Herman, 1992/2022, pp. 220-221; Wallin, 2007, p. 312). Peter Fonagy (2008), a psychoanalyst and clinical psychologist, and his co-authors, Anthony Bateman and Jon Allen, define mentalization as “imaginatively perceiving or interpreting behavior as conjoined with intentional mental states” (p. 4).

For example, in a family meeting, the social worker may notice a family member clenching a fist and wiping away a tear (nonverbal cues, stress response). Anxiety and tension rise in the

room. That is an opportunity to pause and ask what prompted the observed behaviors. The person may share that they feel upset that they did not understand their loved one's serious prognosis. A provider skilled in mentalizing, now empathizing with the family, validates how hard these conversations are and slows down the meeting to process those upset feelings (mirroring).

Perhaps some other healthcare professionals also observed the nonverbal body language and made assumptions (projections) that the family feels negatively towards the care team. Now, their anxiety turns into empathy. The attending resident, whose mother died six months ago yesterday (anniversary date), privately acknowledges the headache she felt all day could be related to the anxiety that she experienced when meeting with her mother's caregivers in a family meeting (somatizing). She decides to do something relaxing after work, offering herself compassion. The emotional state was named after observing and asking about the observed behavior, and a space for a healthy intersubjective exchange was created.

**Mind and Body Entering the Realm of the Spirit**

The art of healing is more than a physical endeavor. Puchalski and Ferrell (2010) frame illness and disease as interruptions in relationships that affect the underlying, deeper reality and order.

> Thus, one can say that illness disturbs relationships both inside and outside the body of the human person. Inside the body, the disturbances are two-fold: (a)the relationships between and among the various body parts and biochemical processes and (b) the relationship between mind and body. Outside the body, these disturbances are also twofold-(a) the relationship between the individual patient and his or her environment, including the ecological, physical, familial, social, and political nexus of relationships

> surrounding the patient, and (b) the relationship between the patient and the transcendent (p. 105).

Psychology also recognizes the ineffable sense of mystery that arrives within this relational, interacting space. The language used to describe it is not enough, as it attempts to articulate the inexpressible and shape the shapeless (Griffith & Griffith, 2002, p.25; Ulanov, 2001, p.120-130).

American psychologist and psychoanalyst Philip Bromberg (2016) offers the idea of a deeper knowing within the psychoanalytic relationship, described as a secret, unattainable by words but experienced by both within the emotional field. (p.120). In interactions with patients and families, there is an awareness of space, of emotions, all being fully present and alive in the moment. Winnicott (1962/1965) says:

> The non-communicating central self, forever immune from the reality principle, and forever silent. Here communication is non-verbal; we hear it, like the music of the spheres in absolutely personal ways. It belongs to being alive. And in health, it is out of this that communication naturally arises (p. 192).

English psychoanalyst Wilfred Bion (1977) describes this feeling of ultimate reality as "O".

> "O" does not fall in the domain of knowledge or learning save incidentally; it can "become," but it cannot be "known." It is darkness and formlessness but it enters the domain K (knowledge) when it has evolved to a point where it can be known, through knowledge gained by experience, and formulated in terms derived from sensuous experience; its existence is conjectured phenomenologically. (p. 66)

Like Winnicott's "true self", it is the sense of fully *being* rather than thinking, knowing, or doing (Eigen, 2014, p. 84; Ulanov, 2001, p. 126). Within this liminal space of human interaction, a mysterious and tender sacredness arises. Here, the life force and sense of ultimate reality are

discovered, felt, and experienced.

Vine Deloria, Jr. was a Dakota Sioux intellectual, theologian, and political leader fascinated by C.G. Jung's interactions with the peoples of New Mexico's Taos Pueblo in the 1920s. In his book, C.G. Jung and the Sioux Traditions (2022), he wrote,

> Jung's understanding of the psyche is similar to the descriptions of the physical world given to us by modern physics. Consider, for example, David Bohm's idea of an implicate order, in which mind and matter are two different projections or manifestations of an underlying order. They are two related expressions of a single deeper reality that can be measured or experienced (p.79).

The disciplines of psychology, medicine, and theology each seek to understand the deeper realities underlying human existence thus promoting human wholeness. Medicine increasingly recognizes the importance of interconnectedness in healing, acknowledging that physical health is intertwined with mental and spiritual well-being (Löffler-Staska, 2017, p.2, Miller & Sprang, 2017, p. 153; Yedidia, 2006, p. 47). In theology, the concept of an implicate order resonates with notions of divine interconnectedness or a spiritual dimension that unites the mind, body, and soul (Moore, 1992, p. 5). This shared foundation supports all creation.

## Literature Review: Theological Considerations

Illness encompasses the human dimensions of suffering, meaning-making, uncertainty, pain, and fear (Frank, 1995, p. 169; Morrill, 2009, p. 32; Puchalski & Ferrell, 2010, p. 5). These issues are theological in nature. Being human necessitates questioning what it means to be alive, knowing death eventually comes for all. Illness and disease draw death closer. When approached from the earliest relationships (e.g., attachment theorists), the defenses of ego ask, "Am I loved?

Am I enough?" From the collective unconscious of Jungian depth psychology, the question becomes, "Am I whole? Am I integrated?" (Jung, 1957, p. 122; Storr, 1991, p. 81). These existential and spiritual questions must be addressed existentially and spiritually through a theological lens.

**Spirituality**

From the perspective of trauma-informed, whole-person-centered care, spirituality addresses meaningful connections, meaning-making, and transcendence. While spirituality may encompass religiosity, it is not a prerequisite. According to Merriam-Webster and etymology sources, the word spirituality comes from the Latin term *spiritus.*

> --from a Medieval Latin ecclesiastical use of Latin spiritualis "pertaining to spirit; of or pertaining to breath, breathing, wind, or air," from spiritus "of breathing; of the spirit"

While spirit describes something immaterial, the basis of religion begins in relationships. The source of the word 'religious' arises from connection.

> -- popular etymology among the later ancients (Servius, Lactantius, Augustine) and the interpretation of many modern writers connects it with *religare* "to bind fast" via the notion of "place an obligation on," or "bond between humans and gods." (Merriam-Webster & Harper, 2024).

Trauma-informed, whole-person-centered care does not try to define, prove, disprove, or debate the ideals of formalized religion. Instead, it recognizes religious impulse as part of the multidimensionality of humanity (Carrette, 2004, np; Frankl, 2000, p.152; Rizzuto, 1981, p. 88; van Löben Sels, 2020, p. 206). This approach recognizes religion and religiosity as a continued richness interwoven with all aspects of life, including illness and suffering (Herman, 1992/2022,

p. 75; Kleinman, 1988, p. 28; Tumminio-Hansen, 2024, p. 10). Trauma-informed, whole-person-centered care encompasses the immaterial (spiritus) aspect and adopts a relational (religare) stance. This holistic approach shifts the perspective of illness, disease, and suffering (Kalsched, 2013, pp. 4-5; Ulanov, 2001, p. 142). "What is wrong with you?" becomes "What happened to you?" "What do you believe?" becomes "What do you love at the core of your being?". Pargament (2007) defines spirituality in terms of 'spiritual process', stating;

> The answer to this critical question does not lie exclusively within or outside of any particular religious tradition. Nor does it lie solely within the individual, for spirituality is more than a quality of a person; it is a quality of a person *in interaction with situations and their larger contexts* [emphasis added] (p. 134).

Spirituality as a process, understanding one's relationship to another, provides a space for creativity and making meaning. This sense of personhood is not static. It is animated and enlivened, much like the intersecting space of the infinity symbol, where energy moves between provider and patient.

> The notions of community and connectedness underscore the importance of "relationship" in the spiritual well-being of patients and the salience of spiritual care interventions that promote such connectedness (Puchalski & Ferrell, 2010, p. 22).

Interplay and paradox happen in relation to one another.

> At the same time that we are connected, or in union, with everything, we're also distinct. This balance of identification and distinction is what I call the distinction-union structure because both elements are always co-present and nourish and antagonize one another (Eigen, 2014, p. 110).

True connection arises from understanding and embracing the natural flow of life, which encompasses both unity and distinction (Eigen, 2004, p. 84; Hinnells, 1998, p. 464; Sharma, ed., 1993, p. 241).

**Numinosity**

The profound sense of awe, wonder, and even the terror and helplessness of *mysterium tremendum* that may emerge through the healing process, transcends the purely physical, rational, and scientific aspects of medicine, and is known as numinosity (Kalsched, 1996, p. 163; Harvey, 1992, p. 122; Pargament, 2007, p.86). Theologian Rudolf Otto first used the term to describe the 'wholly otherness' of experiences that can only be felt, experienced, not taught or created (Ellenberger, 1970, p. 723-724; Otto, 1923, p. 11). It encompasses those moments where science and the human spirit intersect—when patients and providers experience a deep connection to something greater and outside themselves, whether through acts of compassion, resilience in the face of adversity, or the mystery of life itself (Cassell, 1982, p. 138). The numinous may appear in the way a family tends to their dying loved one, in an unexpected physical or cognitive recovery, the way a provider is moved to tears when interacting with a patient, or in the miracle of new life entering the world (Griffith & Griffith, 2002, p. 25; Kalsched, 2013, p. 2, Wicks et al., 1985, p. 38). In its essence, the numinous reminds us that healthcare is not solely about curing illnesses but also about nurturing the soul, fostering hope, and honoring the sacred dimensions of human existence.

**Love**

Discussing love in a clinical setting may seem inappropriate or silly to some. Yet, if humans seek healing and wholeness, and healthcare aims to alleviate suffering and restore functioning, then the language of love is necessary (Guntrip, 1973, p. 7; Ulanov, 2001, p. 48; van der Kolk,

2014, p. 27). What else but love shows up at three in the morning to tend to a stranger's injuries? What else but love sits quietly as a father weeps and a mother wails at a child's death? A healthcare provider may say, "Love has no place here," yet will share that their path to medicine came out of a childhood experience with a dying grandparent or an injured sibling. Van der Kolk (2014) shares a lesson from a beloved medical school professor, stating, "Semrad taught us that most human suffering is related to love and loss and that the job of therapists is to help people acknowledge, experience and bear the reality of life-with all its pleasures and heartbreak" (p. 26). In the words of the late Queen Elizabeth II, "Grief is the price we pay for love" (as referenced by A. Whiston, 2023, p. 53). All religions and spiritual belief systems share love as their core.

***Love As Religious Mandate***

Central to Judaism is Leviticus 19:18, which commands, "You shall love your neighbor as yourself: I am the Lord." (Jewish Study Bible, 2004, p. 254) For Buddhists, the mandate to love one another is deeply rooted in the teachings of Metta (loving-kindness) and Karuna (compassion) (Ellwood & McGraw, 2005, p.169). These principles encourage individuals to cultivate unconditional love and empathy for all beings, transcending personal attachments and biases. (Ellwood & McGraw, 2004, p.176; Knitter, 2009, p.149). Humanists believe that love is not only an emotion but requires an ethical commitment to act in ways that affirm the common good and uphold the rights and dignity of every individual (Olds, 1996, p.22; Wentz, 2003, p.44). The Qur'an emphasizes compassion and mercy as central to human relationships, with verses like "And lower your wing to the believers who follow you" (Qur'an 26:216), symbolizing humility and care (Farīd, 2002, p. 763). Jesus in John 13:34-35 (NSRV), says, "A new command I give you: Love one another. As I have loved you, so must you love one another. By this

everyone will know that you are my disciples, if you love one another"(Meeks,1993, p.2041) This commandment calls for a selfless, sacrificial love modeled on Jesus' own example. This love prioritizes the well-being of others and transcends personal gain.

***Agape***

Agape, the type of love that is most easily applied to healthcare, is defined by its altruism. It is a radical and inclusive approach to engaging with other human beings, including those who may be perceived as undeserving. "Agape possesses no agenda; it seeks to promote life in its individual idiosyncratic forms so that each living thing fully fills out its nature and recognizes the same in others" (Ulanov, 2001, P. 77).

According to Merriam-Webster and Etymology Online,

> Agape is a noun originating from Late Latin agapē, borrowed from Greek agápē, meaning "brotherly love." It is a back-formation from agapân, which means "to regard with affection, be fond of, be contented (with)," or agapázein, meaning "to welcome warmly."

This form of love concerns itself with the well-being of others. R. Enright et al. (2022) insist that Agape should have a place in scientific psychology and encourage ongoing research. He claims,

> Why do we say this? From both a theological and philosophical perspective, *agape* seems to be one of the most important virtues because it can lead to deep connection between and among people who willingly decide to offer it to one another. Even if it is not mutually reciprocated, *agape* can uplift others so that they have a chance to thrive (p.234).

Healthcare providers, as healers, bring their whole selves into intimate and often complex situations with patients and families who are initially strangers. Moreover, their explicit purpose

is to help them heal. All healthcare providers take an oath or agree to, at the very least, a set of ethical guidelines in which no intentional harm is to be done. The Hippocratic Oath, written for physicians in ancient Greece, has had numerous revisions and rewrites throughout the centuries. According to the American Medical Association website:

> The AMA House of Delegates adopted the Declaration of Professional Responsibility on December 4, 2001, as an oath by which 21st-century physicians can publicly uphold and celebrate the ideals that have inspired individuals to enter medicine and earn society's trust in the healing profession[2].

The original Nightingale Pledge was revised in response to COVID-19 as the Nurses' Pledge for the 21st century[3]. All board-certified chaplains agree to a Code of Ethical Guidelines.[4] The National Association of Social Workers Code of Ethics is available in booklet format and offers in-depth and thoughtful guidelines on ethical decision-making and conduct. [5]

**Repair: Tillich and Nouwen**

Theologian Paul Tillich's understanding of love as the unifying force of existence provides a profound lens through which to view medicine. He discusses the *qualities* of various forms of love and their interrelationships (Tillich, 1954, p. 5). Tillich (1954) believed love was the "drive toward the unity of the separated," encompassing eros (desire) and agape (selfless love) (p.25). "One could call agape the depth of love or love in relation to the ground of life. One could say that in agape, ultimate reality manifests itself and transforms life and love" (Tillich, 1954, p. 33).

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[2] AMA Declaration of Professional Responsibility | American Medical Association
[3] 2020-05-12 | MNA Nurses and Healthcare Professionals Issue 'A Nurse's Pledge for the 21st Century' During National Nurses Week and the COVID-19 Pandemic | Press Release
[4] APC Code of Ethics 2000
[5] Code of Ethics: English

Another theologian, most well-known for talking about the wounded healer, Henri Nouwen (1969) identifies a conversion that occurs when the possibility of love opens:

> Love is based on the mutuality of the confession of our total self to each other. This makes us free to declare not only : 'My strength is your strength' but also: 'your pain is my pain, your weakness is my weakness, your sin is my sin'. It is in this intimate fellowship of the weak that love is born (p. 29).

Tillich (1952) directly addresses the necessity of cooperation of medical providers and psychiatrists with the philosophers and theologians:

> He cannot avoid the question of human nature since in his practicing of his profession he cannot avoid the difference between health and illness, existential and pathological anxiety. This is why more and more representatives of medicine generally and psychotherapy specifically ask for cooperation with philosophers and theologians—Both the doctrine about man and doctrine that help man are a matter of cooperation from many points of view (pp.71-72).

Tillich and Nouwen identify the existential responsibility of human beings to recognize one another as both flawed and beautiful. With this spiritual lens applied to healthcare providers, there is an invitation to approach relationships with oneself, with colleagues, and with patients in deeper, more forgiving, and more authentic ways.

**Relation: Buber**

Humans are relational and interact with one another in a myriad of conscious and unconscious ways. Again, quantum physics provides a language through an interactive and dynamic scientific

model, complementing the psychological, biological, and spiritual approaches to human relationships.

> Nowadays, we believe that the observer is always involved in the process of observing and, in spite of his or her best efforts to the contrary, will *always* influence the experiment and its eventual outcome. In a participatory universe, there is no such thing as a neutral observer (O'Murchu, 2003, p. 33).

That statement offers a spiritual way of relating by understanding that simply being present with another person creates connection and change. Mirror neurons and the neurobiology of attunement are activated when someone performs an action and also when one observes someone else performing it (Holmes & Slade, 2017, p.55; Schore, 2015, p. 81). Martin Buber's concept of the I-Thou relationship offers a spiritual dimension to this understanding.

Martin Buber was a prolific and influential Viennese Jewish author in Israel who was criticized for his "cultural form of Zionism and openness to the Arab population there" (Dorff & Newman, 1998, p.516). Buber wrote *Ich-Du [I-Thou]* (1938) as an invitation into ways of relating to one another authentically and fully, transcending objectification and fostering a deep, mutual presence (Frank, 1995, p. 35; Frankl, 2000, p.151; Tillich, 1959, p.192). Buber observed that humans tend to relate to others as objects (I-It, I-He, I-She) or as extensions of their own interests (I-I) (Buber, 1925, p.65).

For example, a patient may be discussed as "the brain bleed in room sixteen" or "another street person coming in high." A diagnosis can cover up a person's individuality, be a biased judgment, or result from providers not being emotionally or cognitively present. In the case of interdisciplinary approaches, a medical team might rely solely on a social worker to handle discharge planning without engaging them in addressing the patient's psychosocial needs. In this

way, the social worker becomes a means to an end for the others by handling logistics rather than being an integral part of the holistic approach to patient care.

An I-Thou approach acknowledges that the dynamic nature of interacting with another human being is not simply a means to an end but a process that provides a meaningful connection between the individuals. People are ends in and of themselves.

> ...every It borders on other Its; It is only by virtue of bordering on others. But where Thou is said there is no something. Thou has no borders. Whoever says Thou does not have something; he has nothing. But he stands in relation (Buber, 1924, p.55).

Healthcare providers no longer treat a body with cancer (biological model). They recognize another human being *with* cancer, assessing the emotional and social components (bio-psycho-social model) to provide more holistic care (Frank, 1995, p.2; Puchalski & Ferrell, 2010, p. 12). Adding a spiritual approach and acknowledging one another's humanity creates a space for hope, possibility, and compassion (Dykstra, 2005, p. 33; Puchalski & Ferrell, 2010, pp. 167). This mirrors how our brains respond to others, suggesting that our biology and spirituality are attuned to meaningful connection. These ideas underscore the profound interplay between the physical and the spiritual in human relationships, encompassing medical healing and wholeness.

**Life Force**

Winnicott's "music of the spheres", Bion's "O", Bromberg's "secret", Tillich's ground of our being, and Otto's religious experience arise out of the energy and impulse of being alive. Psychology and spirituality share an intimate relationship as they seek to find the inner space of the human mind and spirit. Together, they address mental and emotional health and the deeper questions of existence, enabling individuals to find meaning, purpose, and healing towards

wholeness. Each has its own language to address the life force. Religious and faith traditions know this animated vitality of aliveness.

The Taoists know it as Qi (Ellwood & McGraw, 2005, p.234, van Löben Sels, 2020, p. 179). In Hinduism, it is called Prajna (Ellwood & McGraw, 2005, p.149). Nephesh (נֶפֶשׁ) in Hebrew means soul and life as it pertains to a person's vital force (Bentorah, 2019, p.1; Jewish Study Bible, 2004, p. 1396; van Löben Sels,2020, p.178). The Christian song This Little Light of Mine, based on Matthew 5: 14-16, is about the essential flame in all of us which God says is to be shared (Meeks, 1989, p.1866).

> There is no single, agreed-upon God, only different experiences and concepts of God or of ultimate reality. . . . The psyche itself is universal. . . . The divine as Mind structures the world as we know it, and spirit is actually synonymous with transpersonal levels of the psyche—we use the word 'psychological' rather than 'spiritual' when we think we understand what is happening. (Corbett, 1996, p. 3)

This is where the true self resides. And what the false self protects. What is healthcare if not the support and protection of the mysterious animation called 'alive' in body, mind, and spirit? Sacred texts from diverse religions and belief systems address the liminal, sacred space between living beings.

**Sacred Texts**

From the Taoist tradition:

> "Without a concept of an other, there is no separate I. Without the sense of an I, nothing can be seen as other. There is some power that determines things, but I don't know what that is. It has no form or substance, acts without doing, keeps the universe in order, and

seems to get along perfectly well without me" -Second Book of the Tao Te Ching, ch.29. (Mitchell,2009, p.58).

Hindu text says:

"I Am the self-existent one. I can be found in every heart. I Am the beginning; I Am the middle; and I Am the end of all things- Bhagavad Gita, 10:20 (Hooper, 2007, p. 82; Yogananda, 2006, p.398).

Ancient Christianity claims:

"I Am You and you are me. Where you are, there also am I. I am planted in all things, and when the harvest comes, it is I which you reap" -The Gospel of Eve (Deese,2018, p.449; Hooper, 2007, p.85).

The modern Christian Scriptures read:

"For where two or three are gathered in my name, I am there among them." -Matthew 18:20 (NSRV translation).

Judaism reminds followers:

"Love your fellow as yourself: I am the Lord" Torah, Leviticus 19. 18 (Jewish Study Bible, p.254).

And from Islamic texts:

"Say, He is Allah, [Who is] One, Allah, the Eternal Refuge. He neither begets nor is born, nor is there to Him any equivalent." Quran; Surah Ikhlas (112:1-4).

Compassion for and connection with others is possible when providers are willing to feel their emotions rather than deny or avoid them. (Miller, 2022, p.41; Puchalski and Ferrell, 2010, p. 42). Trauma-informed, whole-person-centered care benefits providers by actively partnering with their patients to provide effective care. By engaging with patients' physical, emotional, spiritual,

and psychological needs, providers become more than just medical professionals; they become partners in the healing journey. This collaborative approach enhances the therapeutic relationship and empowers both the patient and the provider, leading to more meaningful and effective healthcare outcomes (Meier, et al. 2001, p. 3008; Puchalski and Ferrell, 2010, p.70).

One of the 11th-century Tibetan Buddhists, Machik Labdrön's teachers gave her the following advice: "Confess your hidden faults. Approach what you find repulsive. Help those you think you cannot help. Anything you are attached to, let it go. Go to the places that scare you" (Chödron, 2001, i). This is an invitation to know and accept oneself, acknowledging human imperfections, mistakes, and faults.

## Survey Narrative

### Topics of Interest

This is a quantitative survey, with qualitative narrative portions, exploring the following:

1. Healthcare providers who use trauma-informed, whole-person-centered care (TIWPCC) develop authentic, compassionate, and dynamic relationships with their patients, thus increasing job satisfaction.
2. Trauma-informed, whole-person-centered care encourages healthcare providers to be self-aware and honor their own personhood despite increasing healthcare demands, thus increasing resiliency.
3. If providers practice holistic care and provide it to their patients, are they more likely to care for themselves via physical, spiritual, and emotional resources?
4. Can healthcare providers articulate how trauma-informed, whole-person-centered care benefits them?

"Quantitative approaches to research center on achieving objectivity, control, and precise measurement" (Leavy, 2017, p. 87). This survey also has a qualitative element as questions ask providers to reflect upon experiences, emotions, and beliefs about what they do and how they do it. Nkwi, Nyamongo, & Ryan (2001), researchers with the United Nations, offer the following definition, "Qualitative research involves any research that uses data that do not indicate ordinal values" (p.1). In other words, various data using words, pictures, and sounds can illustrate and explore an issue, observe patterns, and offer direction for further exploration. This survey analyzes the numerical results while incorporating a reflective analysis, in the form of grounded research, informed by the language and terminology expressed in participants' qualitative responses.

***Survey Method***

This voluntary survey (see appendix C-survey copy) consisted of 37 quantitative questions with three qualitative narrative portions. It was distributed to a variety of healthcare providers. For the purposes of this survey, the healthcare provider is defined as any medical or healthcare professional who provides face-to-face patient or family care. Respondents included physicians, mid-level nurse practitioners and physician assistants, registered nurses, social workers/counselors, chaplains, and administrators. Respondents were in Florida, South Carolina, New York, Texas and New Mexico.

***Participants***

Survey King distributed the survey via email invitation (see Appendix A- invitation with disclosure), and it could be forwarded to other colleagues by anonymous link or QR code. Surveys were sent to specific New Mexican medical teams and chaplains who were invited to

participate. Other providers from the Southeast and Northeast parts of the country also responded. At the close of the survey, there were 59 responses.

### *Survey Process and Structure*

The survey was electronically sent to potential respondents through Survey King on December 9, 2024. It included consent and disclosure information as part of the invitation to participate (see Appendix B). The closing date was December 18th, and it closed at 5 p.m. on that day.

The survey consisted of four parts: demographics to assess the respondents, work-related questions to evaluate their institutional work conditions, self-awareness questions about stress, self-care, and attitudes towards their work, and finally, inquiries into spirituality, religious values, and feelings about how TIWPCC benefits them.

## Survey Results

### Section I

### *Demographics Portion*

The first question in the demographic section asked about the types of healthcare providers participating in the survey. Figure 1.0 (below) illustrates the breakdown of respondents' roles in the healthcare setting. Most respondents were social workers at 34% (21). Next were chaplains at 28% (17). Physicians made up 23% (14). A few nurse practitioners and/or physician assistants participated at 5% (3). One registered nurse (RN) or licensed practical nurse (LPN), which was

2%. Finally, the "other" category made up 9% with 5 respondents. One identified as a medical resident. Four did not identify themselves in the "other" category.

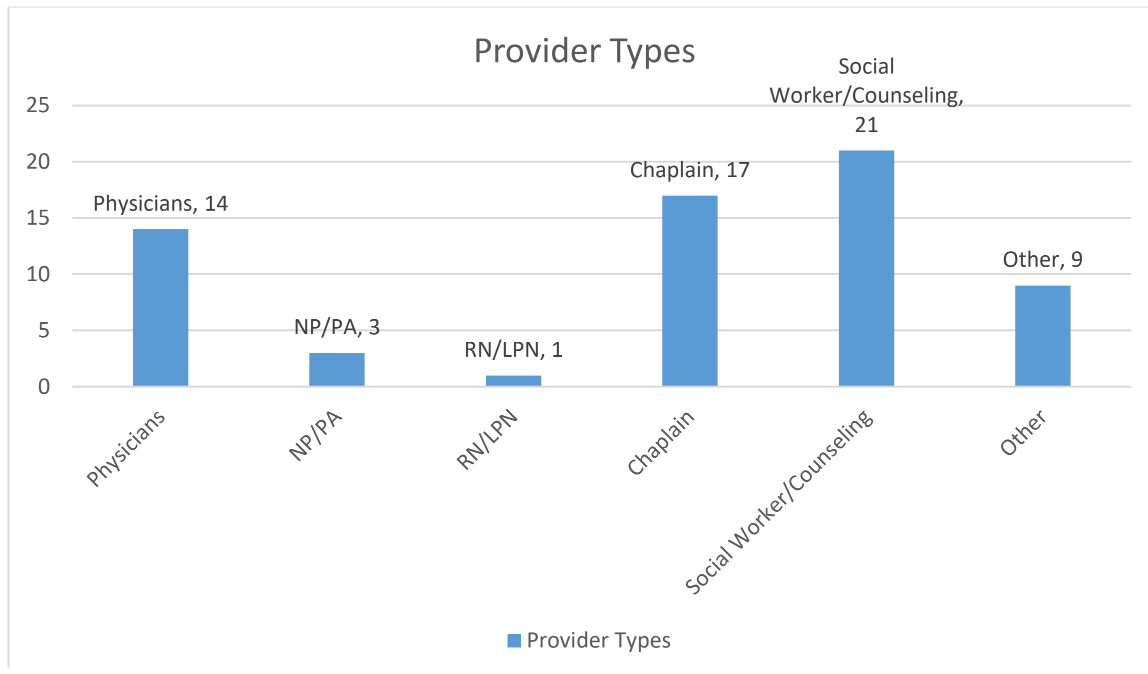



**Figure 1.0**

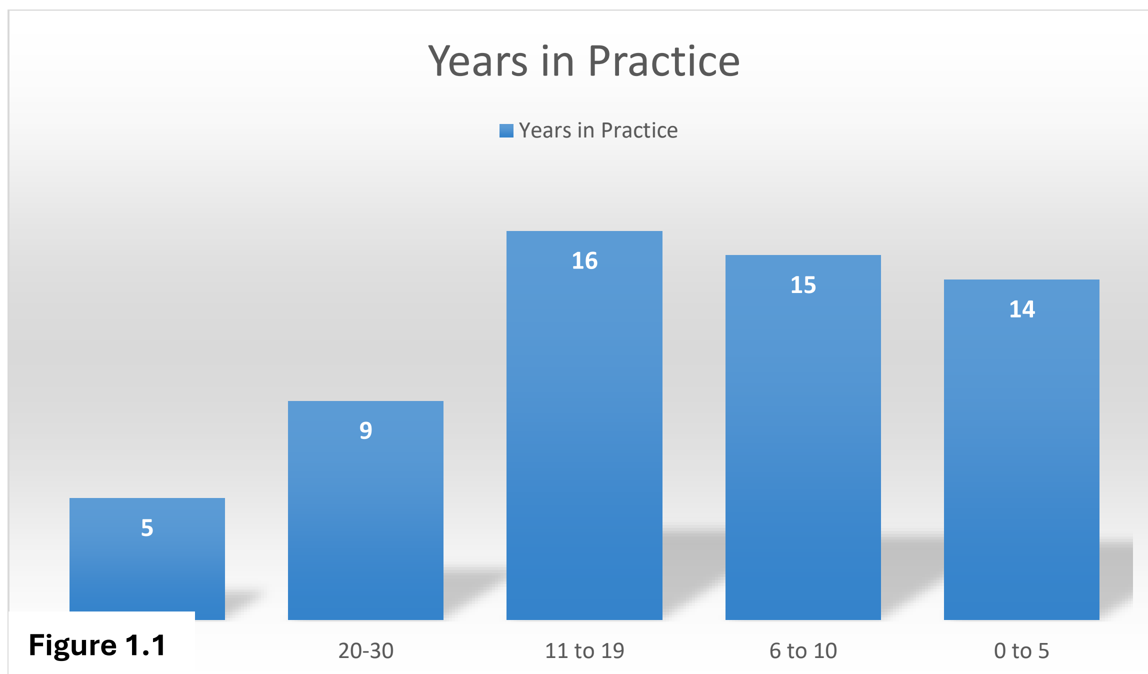



**Figure 1.1**

Question 2 (Figure 1.1 above) asked about respondents' years in healthcare. 51% (30) of respondents have been in the field for over ten years. This indicates that most respondents have reached an "expertise" level in their respective disciplines initial (Ericsson, et al, 2007, p. 5; Ross, 2006, p.69). 8% (5) have practiced for over thirty years. 15% (9) show twenty to thirty years of work. Eleven to nineteen years in healthcare makes up 27% (16) of responses. 25% (15) show six to ten years. Finally, 24% (14) of those answered have been in healthcare for five years or less.

Question 3 (see figure 1.2 on next page) gathered information about areas of specialty in practice. The two most common areas named by respondents were related to Palliative Care (21) and/or Hospice (11), which represent 36% and 19%, respectively. These specialties, while related, are distinct from one another, recognizing that Palliative Care is a service available for anyone living with a serious, chronic, and life-altering condition, whereas hospice is specifically for the end of life (National Institute on Aging, 2021, p. 1). Trauma and/or emergency were named in 7 answers, 12%. Other areas named were behavioral or mental health (5%), oncology (7%), bereavement (4%) and family medicine (4%). Two respondents work with the aging geriatric population (4%), while another two (4%) specifically mention pediatric populations. There was one self-identified as functioning in healthcare administration (2%). The work settings were not specifically asked of respondents; however, there is a representation of healthcare providers including those in the general community (police chaplain, hospice, parish), outpatient providers (family medicine, women's health, palliative care, oncology), and inpatient settings (emergency, trauma units, neurology, oncology, palliative care) healthcare providers represented.

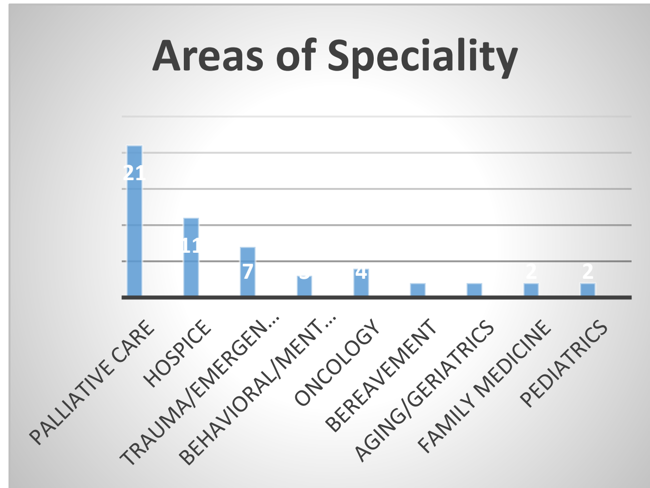
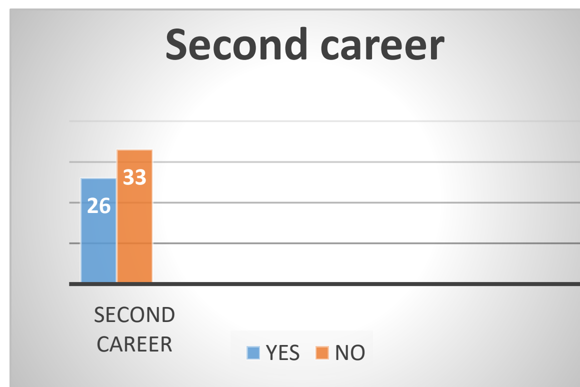



**Figure 1.2**

Question 4 (Figure 1.3 below) compares the number of respondents who entered healthcare as a second career. 44%, or 26, respondents came from other professional positions. 56% (33), or the majority, have only worked in healthcare.

**Figure 1.3**




Question 5 (Figure 1.4 below) asked about previous professional roles, careers, and experiences. A few categories were noted when reviewing the types of careers that respondents came from.

They were business/administration (6), science/technology (3), education (7), non-profit, community and public sectors (4), service industry (3), behavioral and mental health (4), military (2), and parish ministry (2).

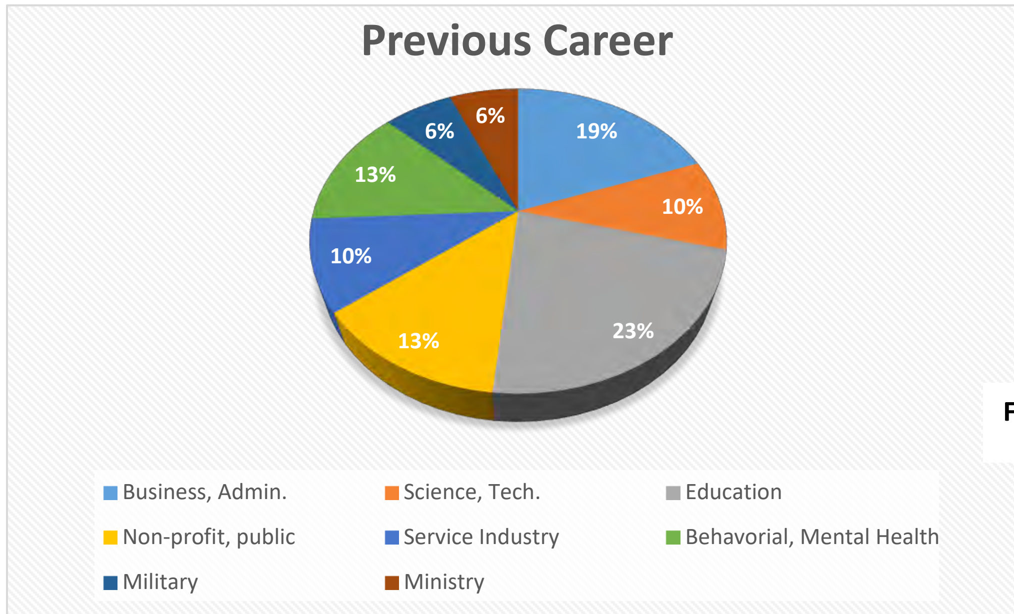



**Figure 1.4**

Question 6 (Figure 1.5 below) asked respondents to share the number of hours worked in a typical week. Forty hours is the most common answer at 42% (25). 7% (4) reported working between 42-45 hours per week. 19% (11) work 50-55 hours each week. 14% (8) reported working 60-65 hours per week. On the other end of the working spectrum, 7% (4) report 20-26 hours of work a week. 8% (5) work between 30 and 38 hours a week. The outliers were one (2%) who reported 70 hours a week. There was one respondent who documented 0 hours of work.

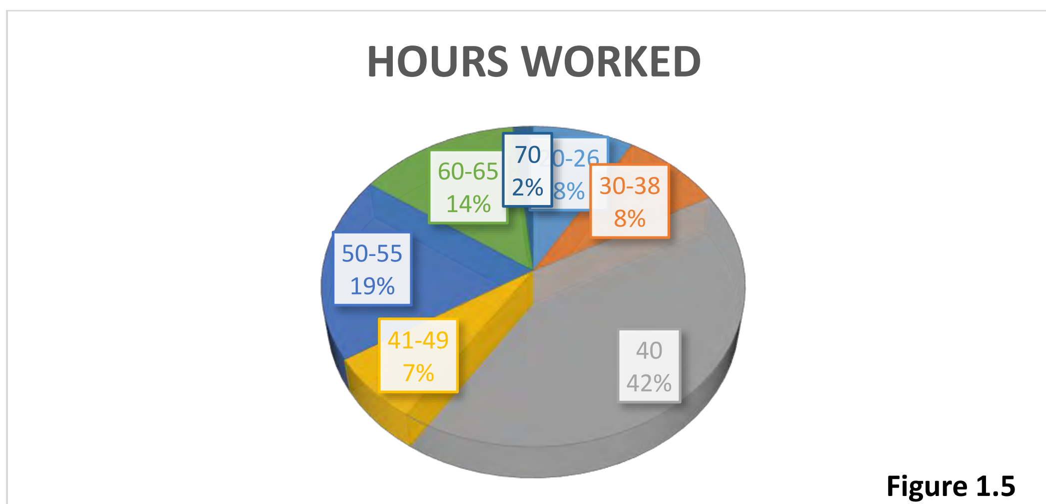



**Figure 1.5**

Question 7 (Figure 1.6 below) asked about respondents' ages. The average age of fifty-eight respondents was 49 years old. One of the 59 answered with age 1 year old and was not included in the data. 7% of respondents were between the ages of 24 and 29. The youngest respondent was twenty-four. 26% were between 30 and 39 years of age. 16% were in their forties. 26% were in their fifties. 21% were in their sixties. And 5% reported being in their seventies. The oldest respondent was 72 years old.

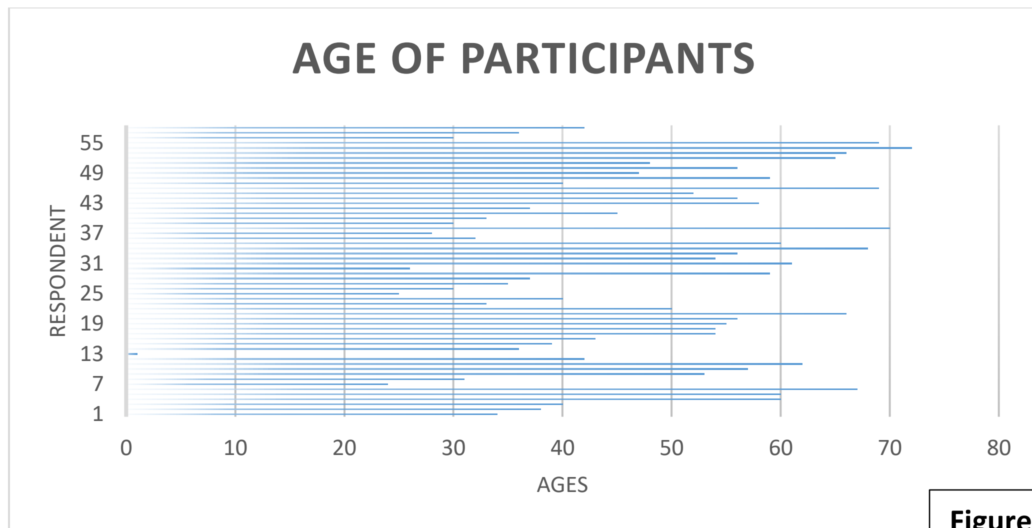



Figure 1.6

Question 8 (Figure 1.7 below) shows the gender breakdown when asked about gender identity. Out of the 58 who answered, 42 (72%) were female, while 16 (28%) identified as male. No one self-identified with any nonbinary categories.

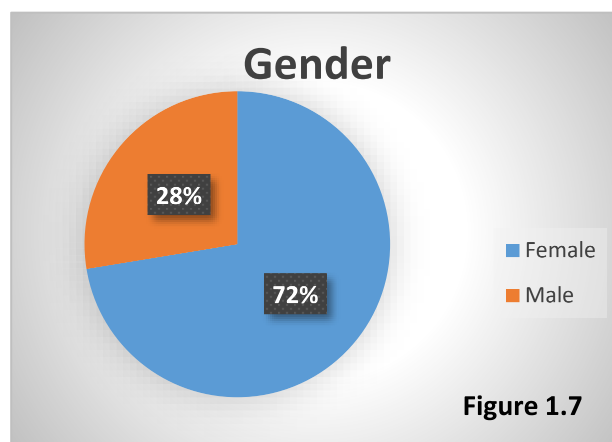



Figure 1.7

The final question (Figure 1.8 below) in the demographics section inquired about religious and spiritual beliefs or identity. 25 (42%) self-identified as part of a Christian denomination. 34 (58%) named other traditions and belief systems, including the self-named categories of "none, atheist, agnostic, and N/A." Those respondents who identified as Catholic, Roman Catholic, or RC are included in the Christian-identified answers in Figure 1.8 below.

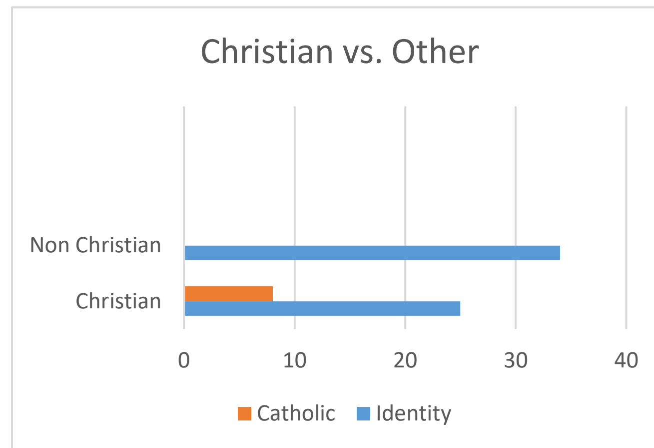



Figure 1.8

The denominations identified included Lutheran, Methodist, 7th Day Adventist, United Church of Christ, non-denominational, Baptist, and "follower of Jesus Christ."
Figure 1.9 further examines the specific religious and spiritual categories of respondents who reported other than Christian. Catholics were included as a specific group of a Christian identity. They made up 14% of the total responses.

The breakdown of other identified traditions and beliefs (34 total) were Jewish (4) 12%, Atheist, None, N/A (4) 12%, Pagan Wiccan, Nature based (2) 6%, Unitarian Universalist (2) 6%, Buddhist (2) 6%, Native Traditional (1) 3%, Hindu (1) 3%, Humanist (1) 3%. The total combined responses for religion and beliefs is seen in Figure 1.9 below.

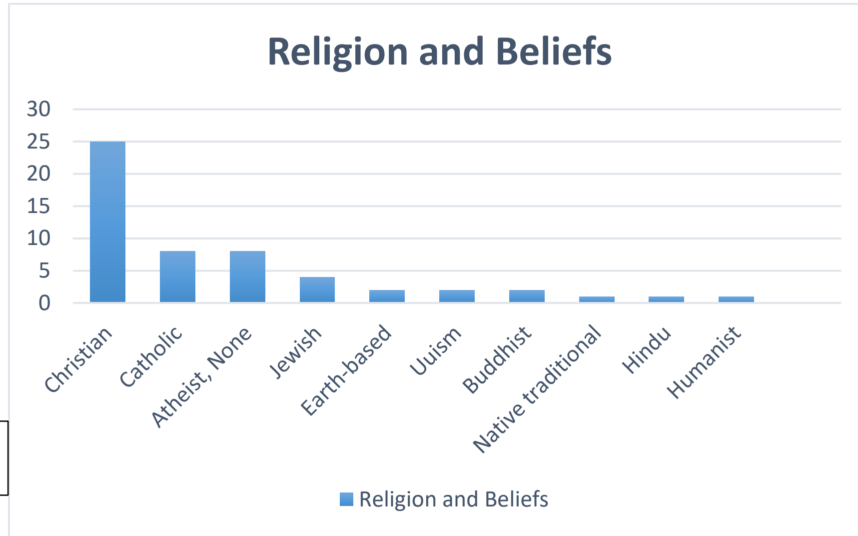



**Figure 1.9**

## Section 2

### *Work Related*

Question 10 (Figure 2.0 below), the first question in the work-related section, asks about attitudes towards working in healthcare. It specifically asks respondents to rate the statement "helping people is more than just collecting a paycheck." 22 (37%) agreed with the statement, and 37 (63%) strongly agreed.

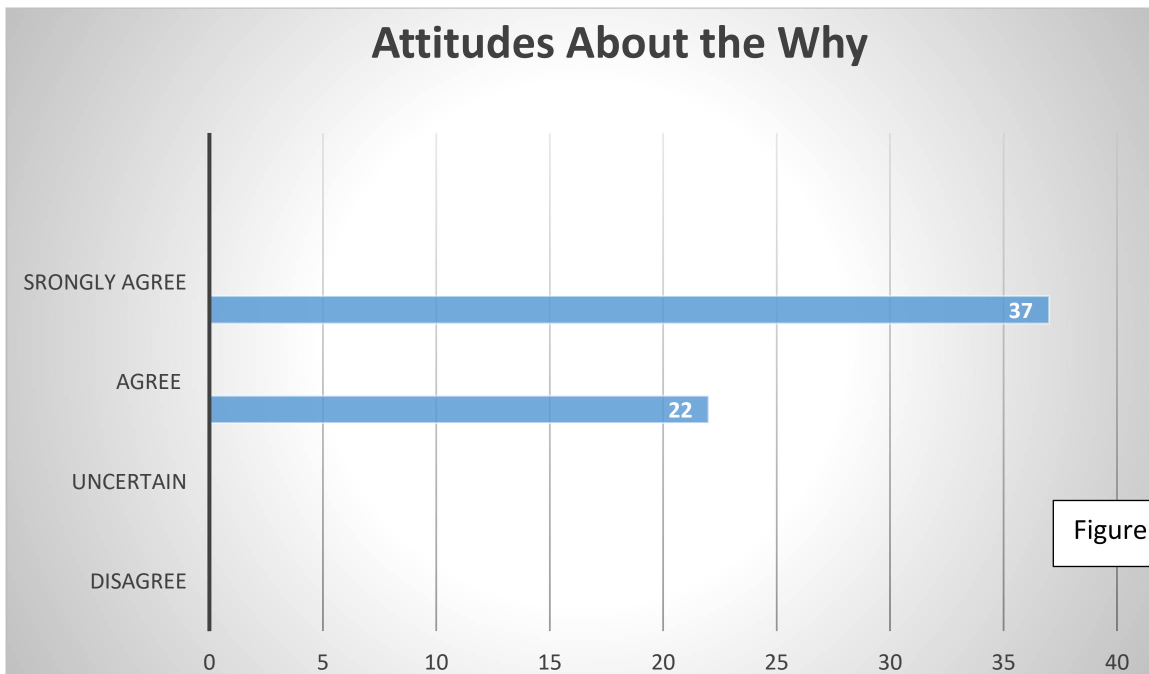



Figure 2.0

Question 11 (Figure 2.1 below) asks if respondents can remember, on their worst days, that their work is more than just a job. None strongly disagreed while one (2%) disagreed. Five (8%) were uncertain. 33 (56%) agreed while 19 (32%) strongly agreed that on their worst days they can recall why they chose healthcare.

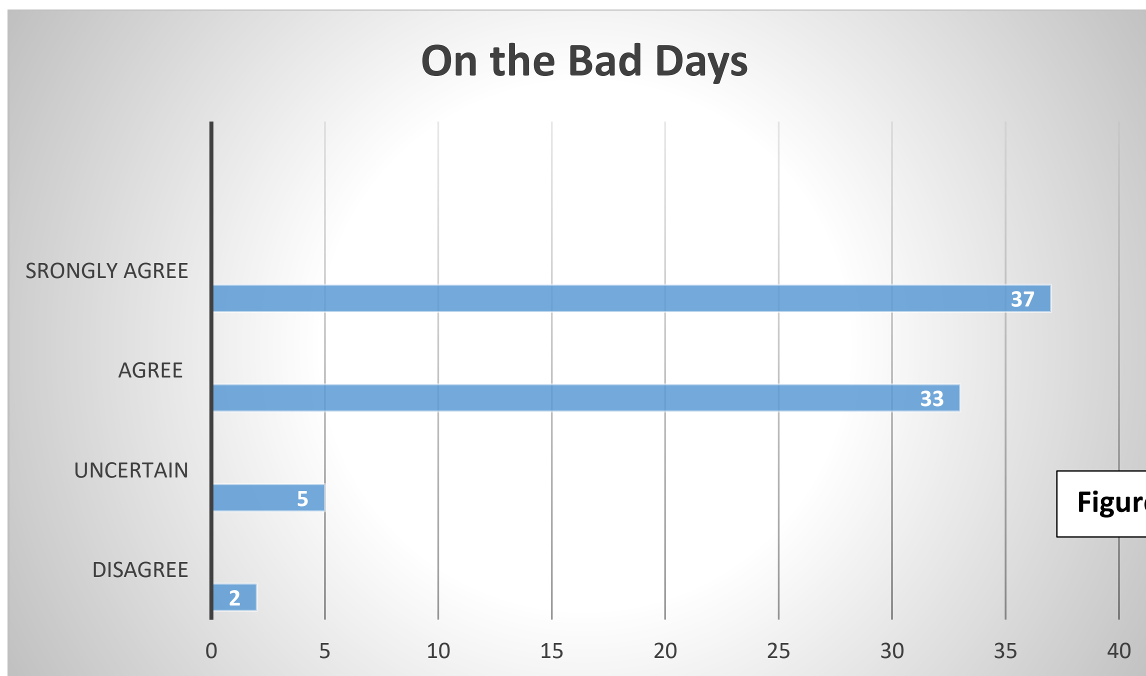



Figure 2.1

In question 11, providers were asked if they felt energized to come to work. Answers ranged from no days (3%), few days (17%), most days (69%) to all days (10%).

Figure 2.2 (below) illustrates the range of answers.

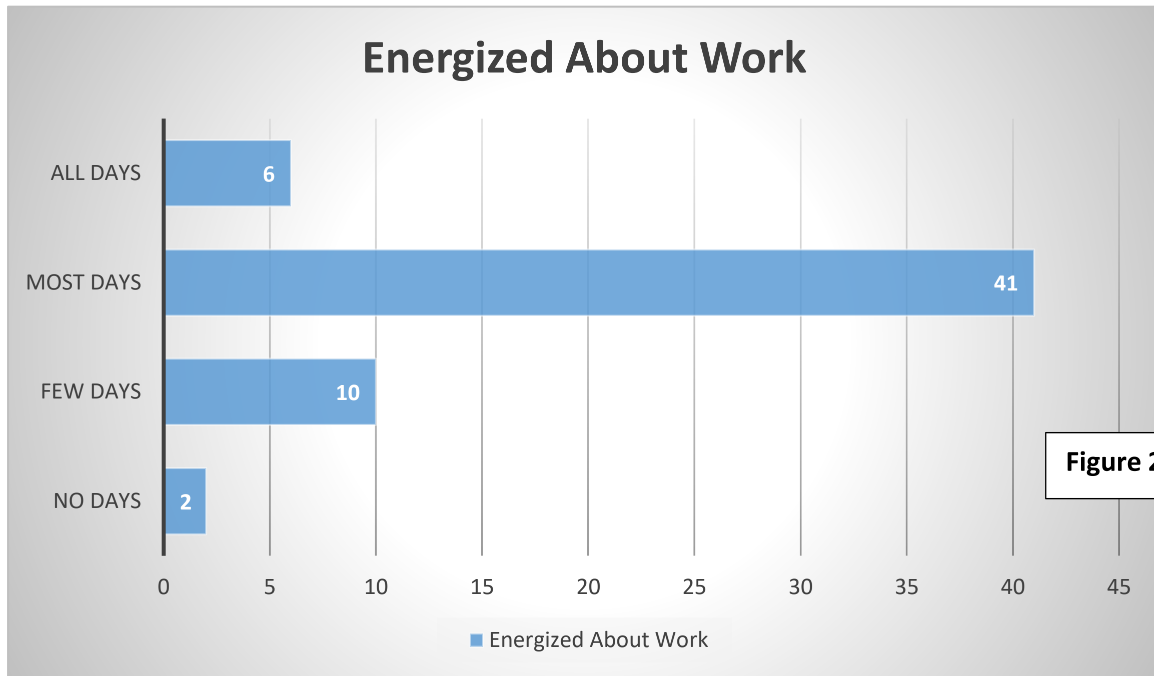



Figure 2.2

Question 12, illustrated below in Figure 2.3, asks if providers thrive under workplace stress. 5% (8) strongly disagreed, 22% (13) disagreed, and 20% (12) reported feeling neutral about workplace stress. 36% (21) agreed that workplace stress was positive, and 14% (8) strongly agreed that they thrive under workplace stress.

Thrive Under Workplace Stress

Figure 2.3

Question 14, as charted in figure 2.4 below, asked the providers how often they were able to leave work at work, rather than bringing it home. The question did not specify if "work" was related to specific tasks (documentation, research, phone calls) or if it was a mental, emotional aspect of work intruding into home life. For example, thinking about a particular case or emotionally preparing for an upcoming family meeting. The majority (35), 59%, can leave work at work most days. Only 5% (3) say work stays at work all days. 28% (17) report that they can leave work for a few days, while 7% (4) are never able to get a break from work.

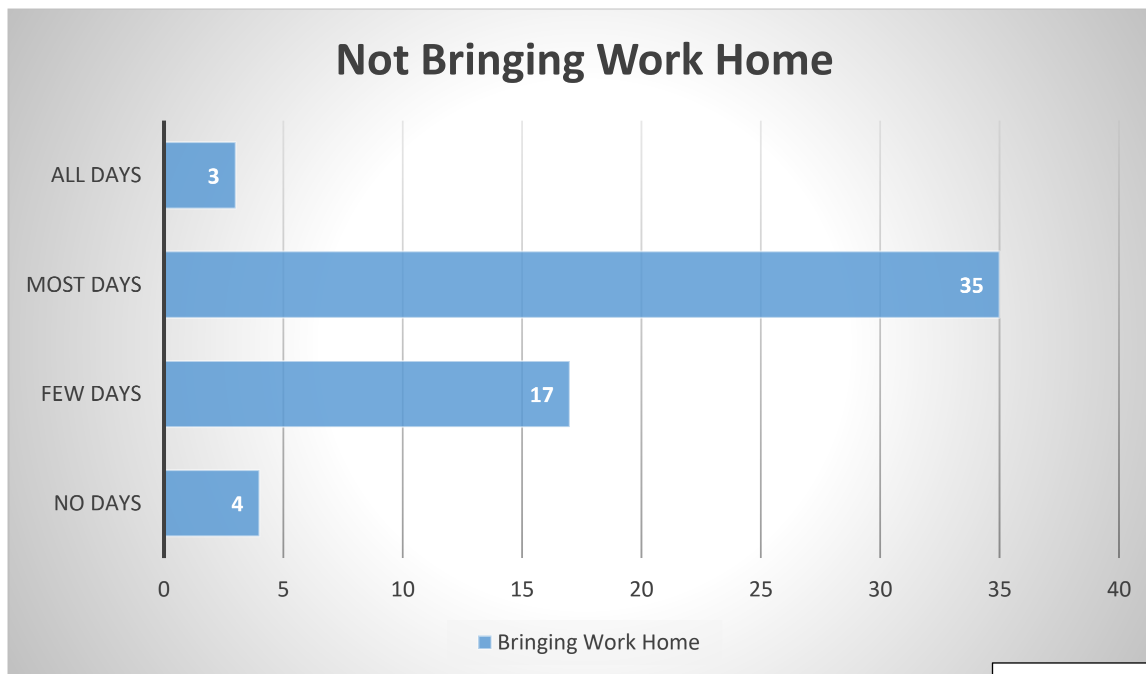
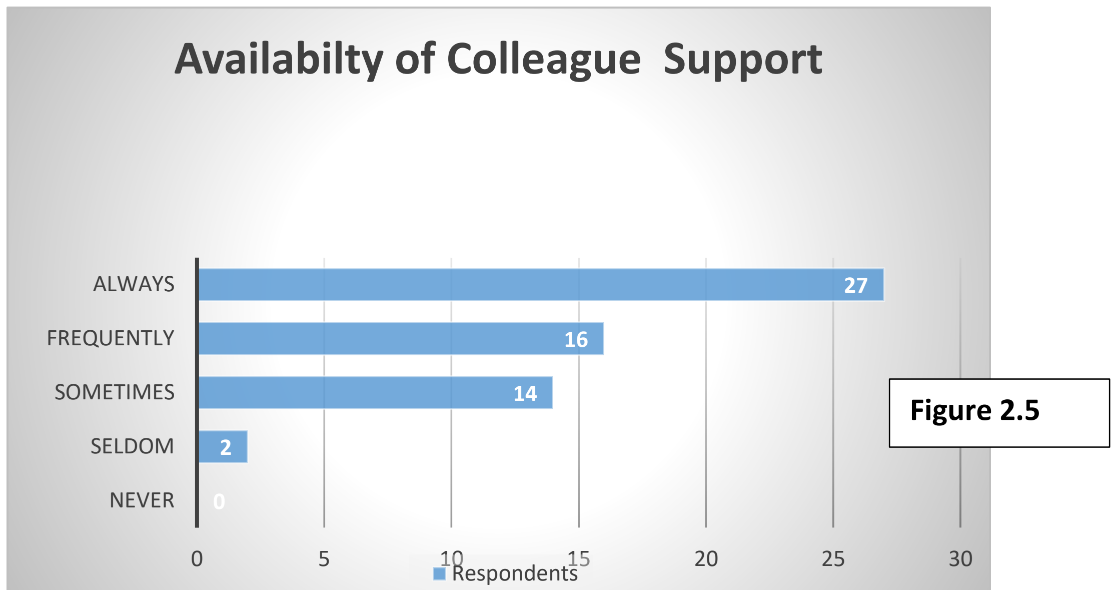
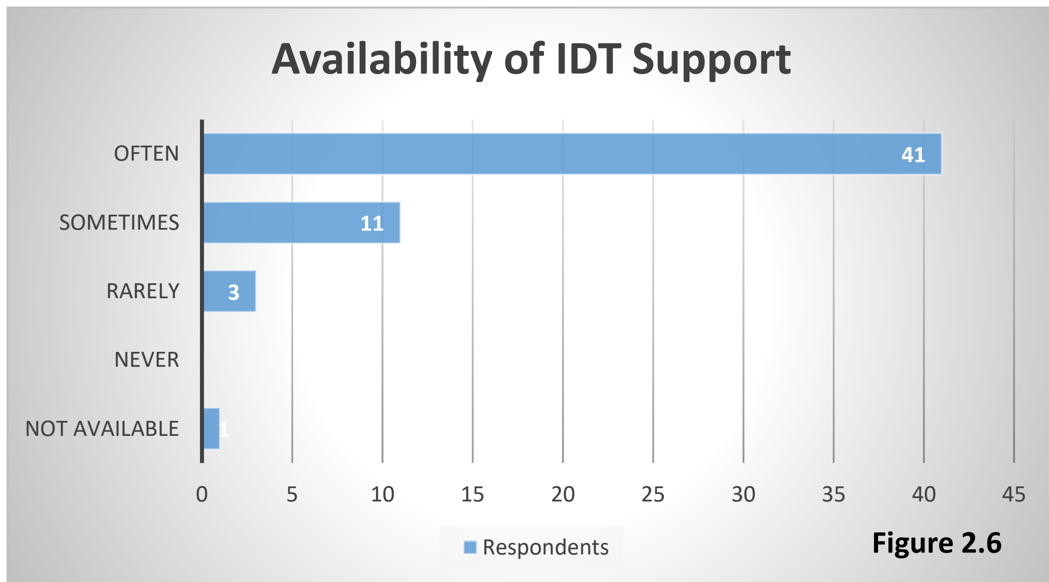



Figure 2.4

Question 15 (Figure 2.5) explores the availability of colleagues to help process personally challenging clinical situations. All the respondents have some access to collegial support. 27 (46%) always have collegial support. 16 (27%) frequently have access. 14 (24%) report that they sometimes have access. 2 (3%) seldom have opportunities for support. 0 reported that they never have available colleagues.




Question 16 (Figure 2.6 below) inquired about access to and utilization of opportunities for regular input from members of the interdisciplinary team (IDT). This multidisciplinary approach is a principle of trauma-informed care (SAMHSA, 2023, p. 20) as well as whole-person-centered care (Puchalski & Ferrell, 2010, p. 66). One respondent (2%) reported that IDT sources were not available to them. Three (5%) reported rarely using IDT input to manage cases. 11 (24%) sometimes used input from other disciplines. 41 (69%) of the responses reported that they often used interdisciplinary input.



Question 17 (see figure 2.7 on next page), the final question in the workplace section, asked how often the respondents felt overwhelmed with everyday tasks at work. None of them (0) reported never feeling overwhelmed. 43 (73%) reported seldom feeling overwhelmed. 15 (25%) reported frequently being overwhelmed. Finally, 1 respondent (2%) reported always feeling overwhelmed with basic tasks at work.

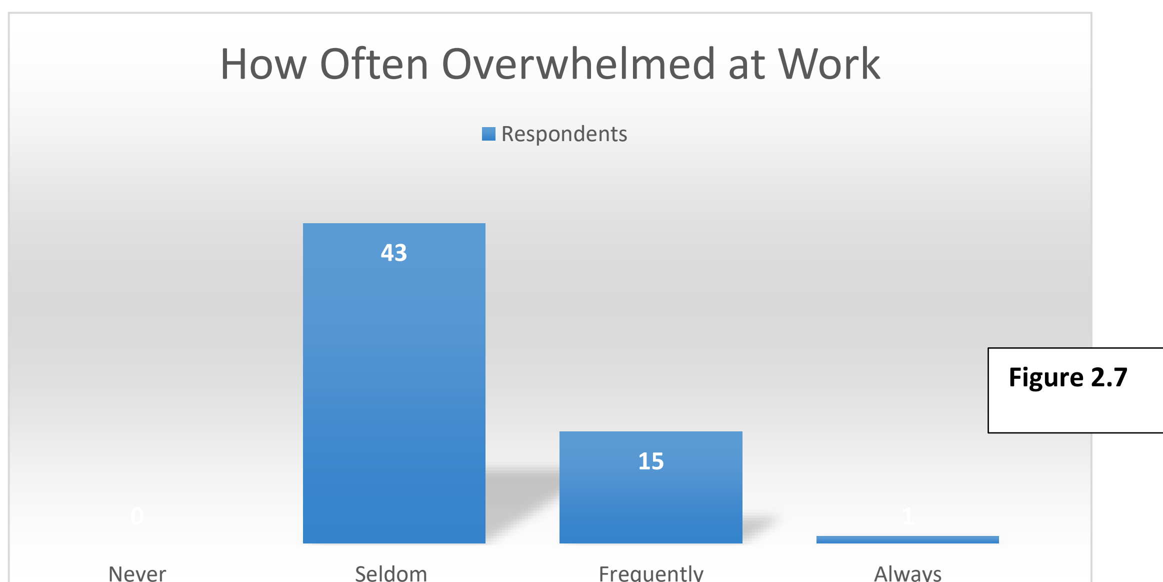



**Figure 2.7**

**Section 3**

***Self-Awareness***

Questions 18 and 19 (See Figure 3.0 below) were combined into a single comparative chart (Figure 3.0 below) to illustrate the comfort level of providers when discussing difficult news. Question 18 focused on giving and discussing hard news with patients, while question 19 addressed the same with families. The chart shows that 53% of respondents always feel comfortable discussing hard news with patients, compared to 56% with families. Additionally,

42% often feel comfortable with patients, whereas only 32% feel the same with families. Lastly, 5% of respondents seldom feel comfortable discussing difficult news with either patients or families. None answered that they never feel comfortable giving or discussing hard news with patients or families.

**Fig.3.0**

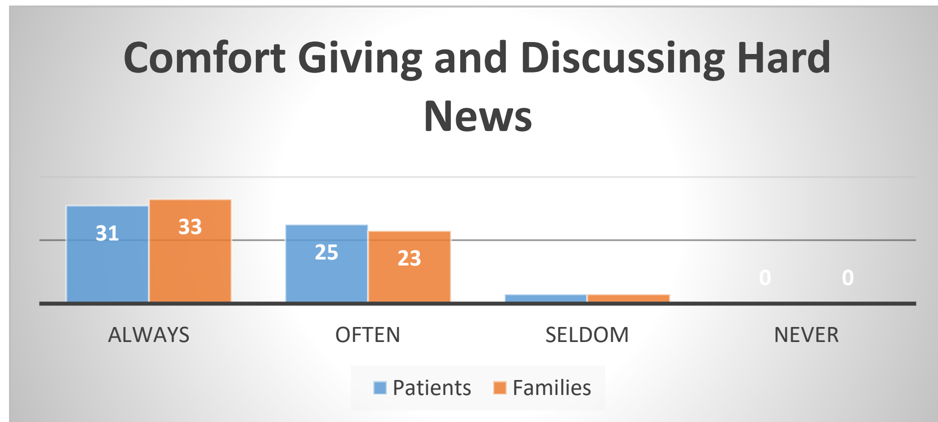
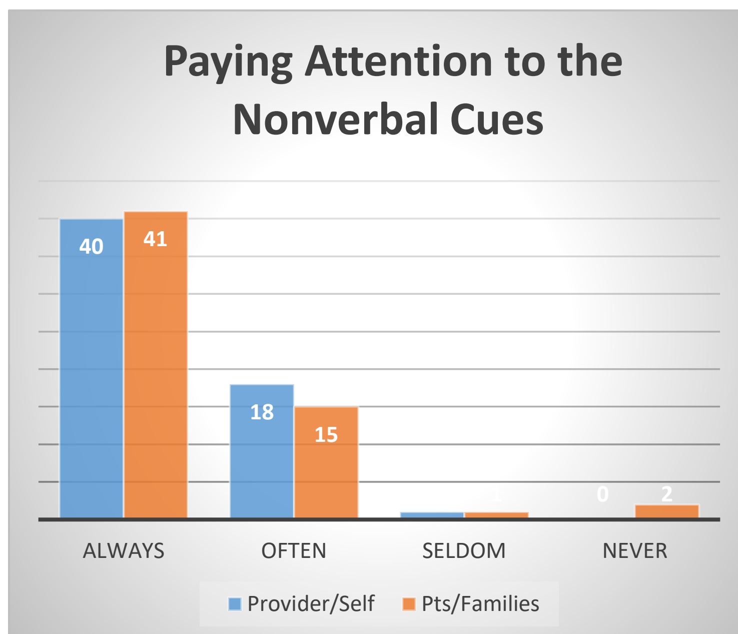



Figure 3.1 (below) compares the responses to questions 20 and 21. Question 20 asked participants to rate how often they are aware of their own nonverbal cues and body language during interactions with patients and their families. Question 21 asked participants to rate how often they pay attention to the nonverbal cues and body language of their patients and family members.

**Fig.3.1**



68% of providers report staying aware of their own body language and nonverbal cues, while 69% say they are always aware of the body language and nonverbal cues of their patients and their patients' families. 31% state they are often aware of their body language and nonverbal cues, but only 25% say they are often aware of their patients' and families' nonverbal cues and body language. Two percent, one respondent, is seldom aware of either their own or others' nonverbal cues and body language. Two participants, or 3%, share that they never pay attention to the nonverbal cues and body language of patients and their families.

Question 22 (Figure 3.2 below) asked respondents how often they inquire about other aspects of patients' lives. 59% (35) report always asking their patients about things other than medical issues. 37% (22) often ask about other aspects of the patient's life. 3% (2) report they seldom ask about other aspects of their patients' lives. None of the respondents reported never asking about other aspects.

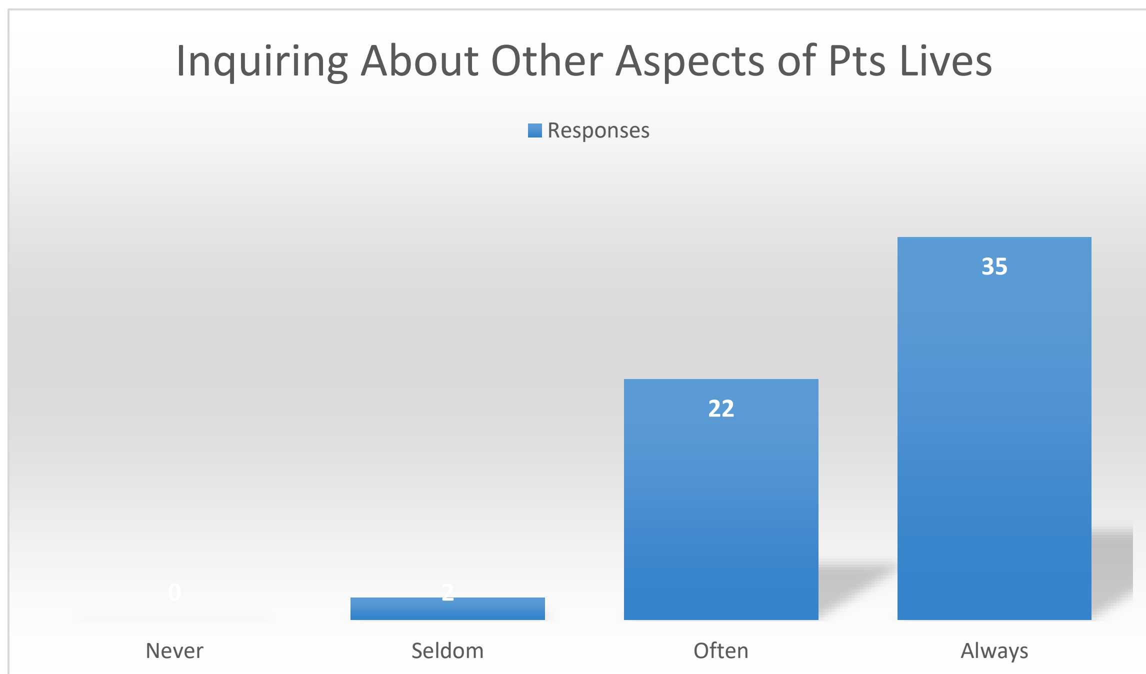



Fig.3.2

Question 23 (figure 3.3 below) then asked which aspects of their patients' lives providers specifically asked about. 18% (55) of respondents asked about personal interests like hobbies or volunteering. 19% (56) of providers asked about employment and work. 18% (54) explored family background. 15% (44) of providers assessed coping styles. 14% (43) of respondents asked about religion. 11% (34) of providers inquired about trauma history.

Question 23 also included an "other" category, allowing comments and narrative space. Specific topics identified included living situations, the presence of support systems, access to resources and community, meaningful connections, and what makes life joyful for the patient. Three out of ten respondents addressed the categories of "religion" and "trauma" by stating that they inquire into these aspects of patients' lives by asking about spirituality, assessing what provides peace, and inviting patients to share about faith and beliefs that are important to them.

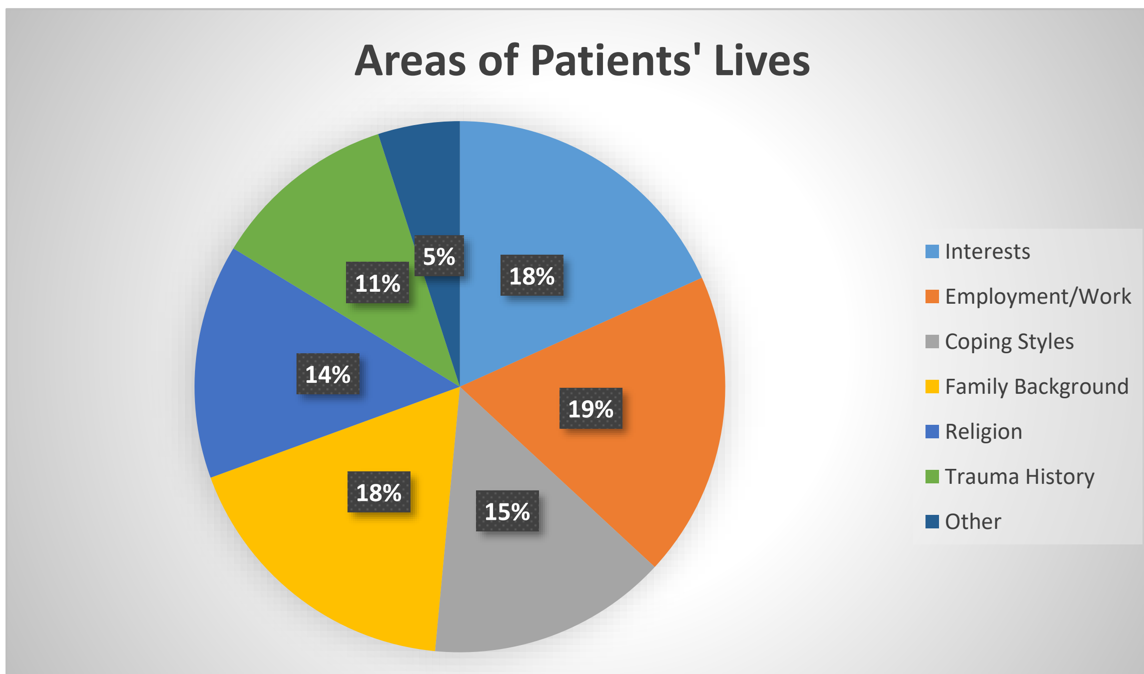



Figure 3.3

Question 24 (Figure 3.4 below) asked the participants if they could access professional therapeutic support. 86% (51) said “yes” to the question. One (2%) said no. Twelve percent (7) were unsure if they had access to professional therapeutic support.

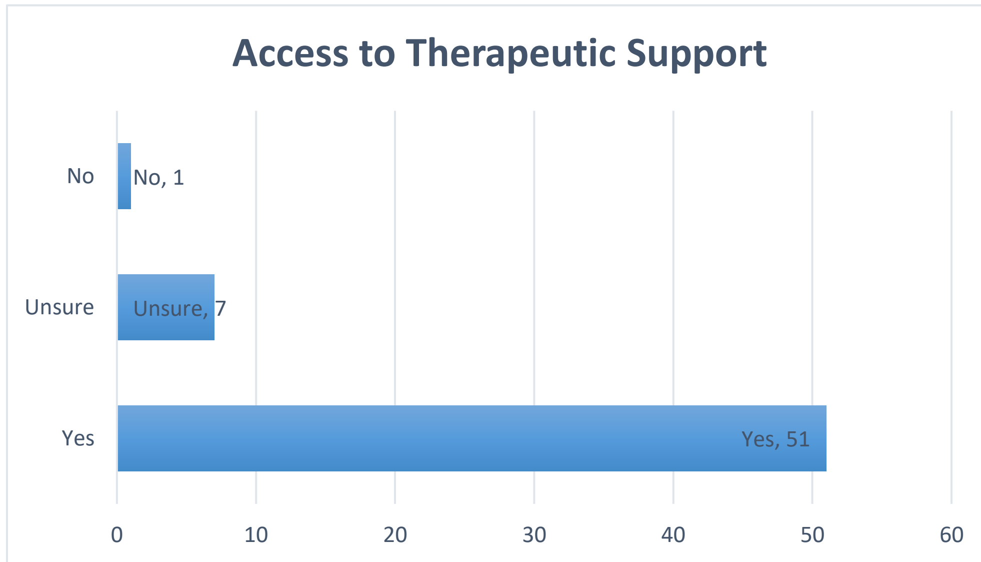



Figure 3.4

Question 25 (Figure 3.5 below), the final question in the self-awareness portion of the survey, inquired further by asking if the provider would feel comfortable seeking out professional therapeutic support if needed. 46 (78%) responded that they felt comfortable seeking professional support. 4 (7%) said no, 8 (14%) were unsure. One participant (2%) preferred not to answer.

**Figure 3.5**

**Section 4**

***Spirituality, Religiosity, Care of Self and Trauma-Informed Whole Person-Centered Care Benefits***

Question 25 (figure 4.0 below) asked participants how often they feel compassion toward their patients. Compassion was not defined. 63% (37) reported always feeling compassionate towards their patients, 37% (22) often feel compassion towards those they care for, and none answered that they seldom or never feel compassion towards their patients.

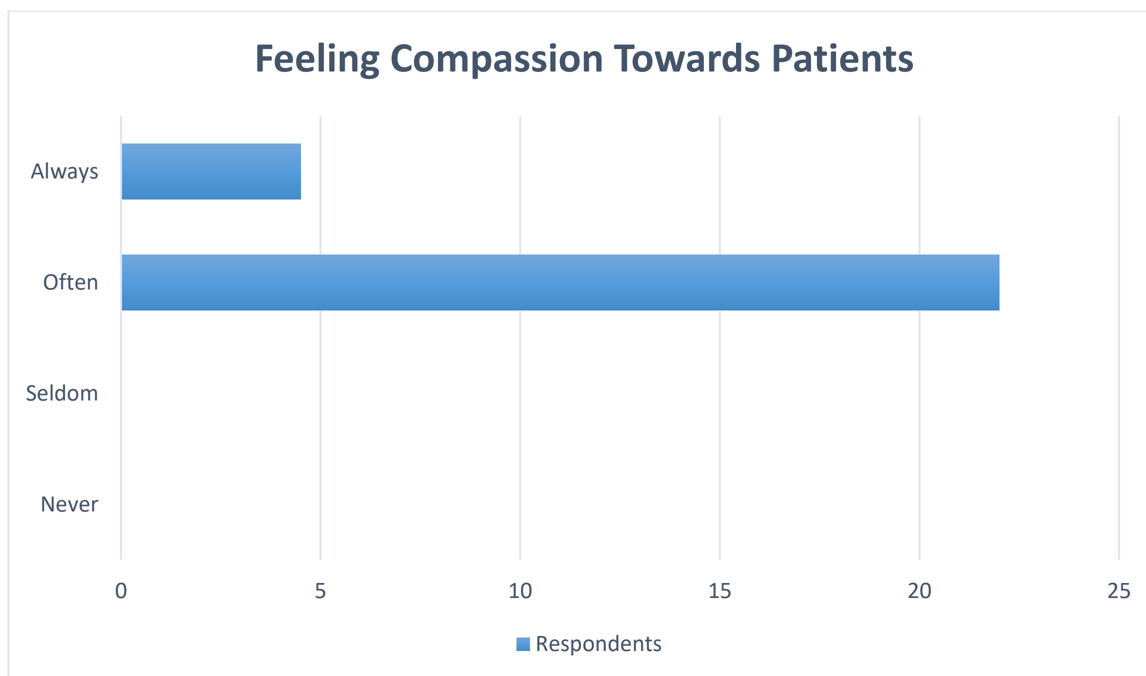



**Figure 4.0**

Question 26 (Figure 4.1 on next page) then asked providers how often they feel compassion for themselves. 12% (7) always feel compassion for themselves, 64% (38) often feel compassion for themselves, and 24% (16) seldom feel compassion for themselves. No one said they never feel compassion for themselves.

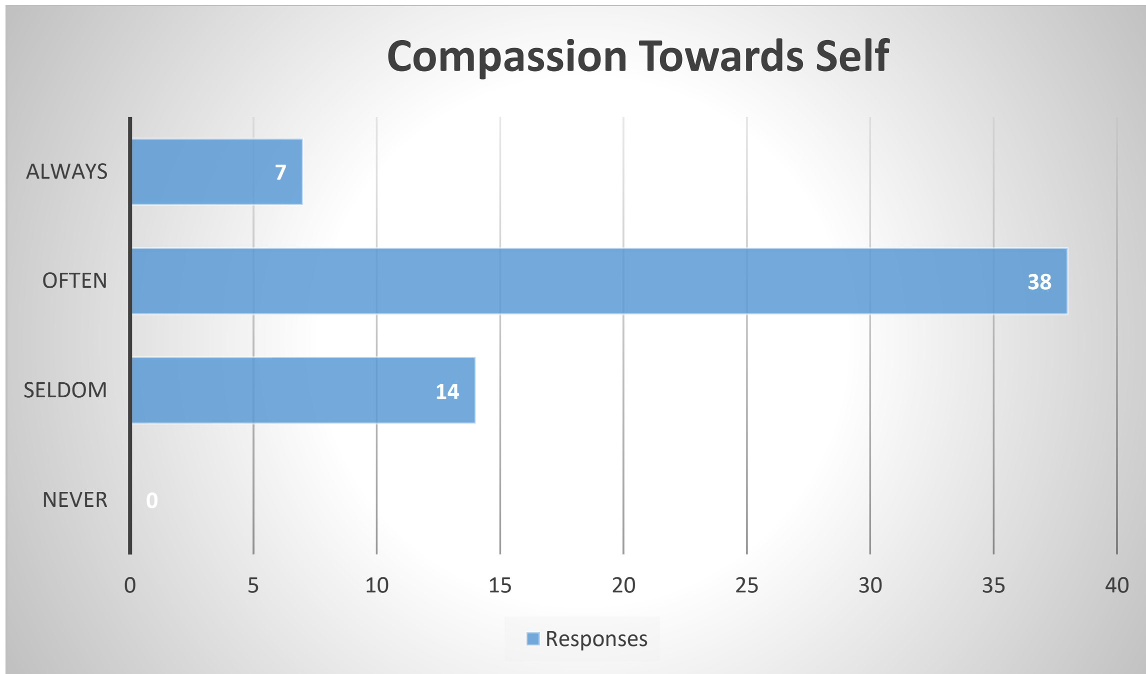



**Figure 4.1**

Question 27 (Figure 4.2 below) asked participants how often they participated in activities that supported their well-being and sense of wholeness. All participants took care of themselves regularly. 22% (13) have monthly activities that support their well-being. The majority, 53% (31), participate in weekly activities to care for themselves. 25% (15) have daily activities to promote their wholeness and sense of self.

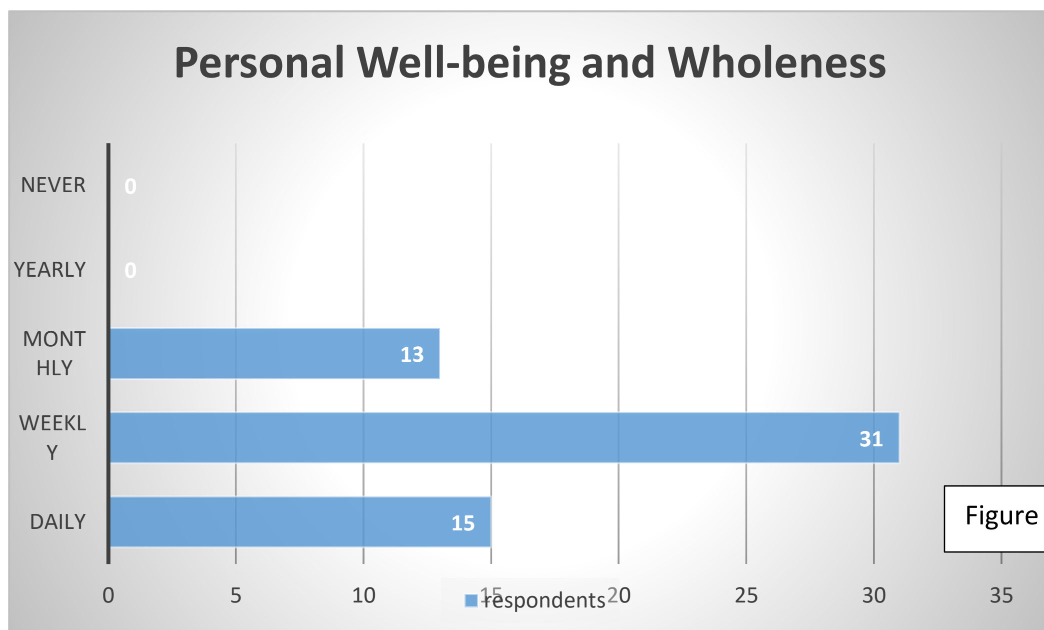



Figure 4.2

Question 28 was narrative, asking respondents to identify their activities that support their personal well-being and a sense of wholeness. There were no specific categories, and respondents could name as many activities as they wanted in their answers. The resulting responses could be divided into 10 categories. These included physical activities, spiritual and religious sources, socially related activities, nature and outdoor pursuits, intellectual pursuits, mental health, creative arts and crafts, family and intimate relationships, personal development, and miscellaneous activities.

Eighteen physical activities were identified, including exercise, working out, pickleball, cardio, and power walking. The next largest group of activities was related to spiritual and religious pursuits. Fourteen activities included prayer, church service attendance, listening to spiritual teachers, meditation, and "faith." A close third, with thirteen named activities, could be described as social activities within the community. Men's small groups, being with or talking with friends, social outings, and queer community organizing all fell into this category. Ten nature and outdoor experiences included everything from farming and watching the sky to caring for office plants. Intellectual activities included reading, learning, writing, puzzles, movies, watching television, and attending arts and cultural events.

The activities that fell into mental health and well-being included counseling and formal therapies, bodywork, and regular self-care routines. Creative activities such as drawing, painting, and music were identified. Family and intimate relationships were important; spouses, partners, children, and pets were significant sources of support. Personal development and miscellaneous categories include nutrition, bubble baths, and self-examination.

Many of the activities overlapped categories. These are illustrated in figure 4.3 on the next page.

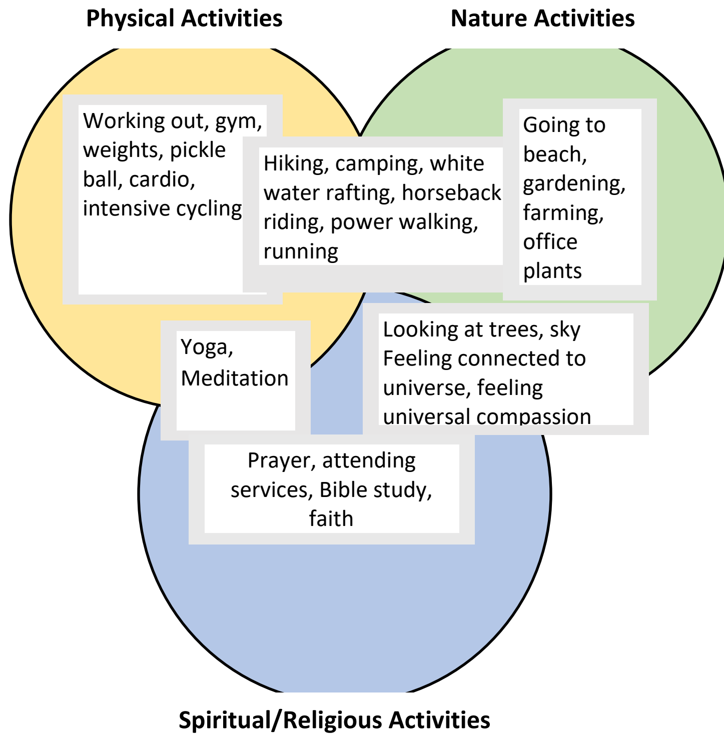



FIGURE 4.3

This variety of activities spanning numerous approaches toward well-being demonstrates that the participants are biological (physical), psychological (intellectual, mental health), social (relationships), and spiritual (religion, spirituality) beings, as purported by this

Question 29 (Figure 4.4 below) asked participants how often their spiritual, religious, or personal values influence how providers deliver care. 49% (29) answered "very much". 27% (16) state they influenced care "somewhat," while 24% (14) answered "not at all."

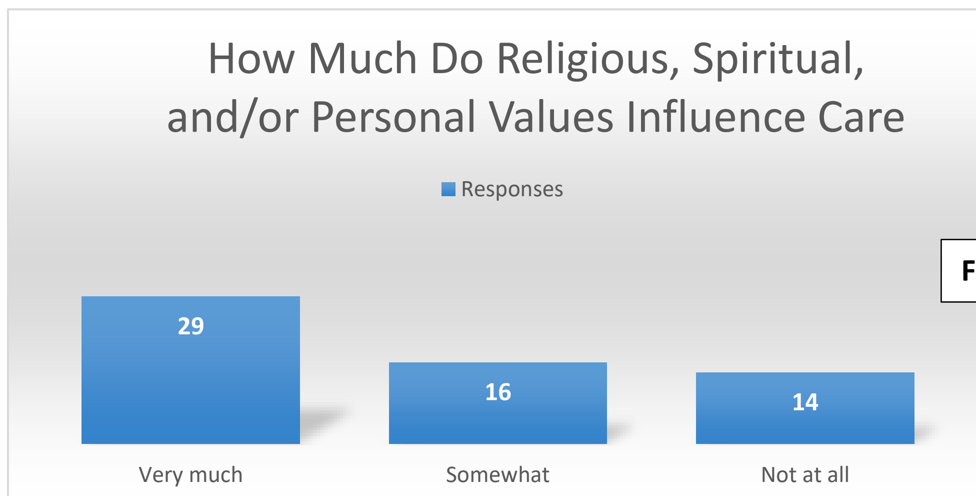


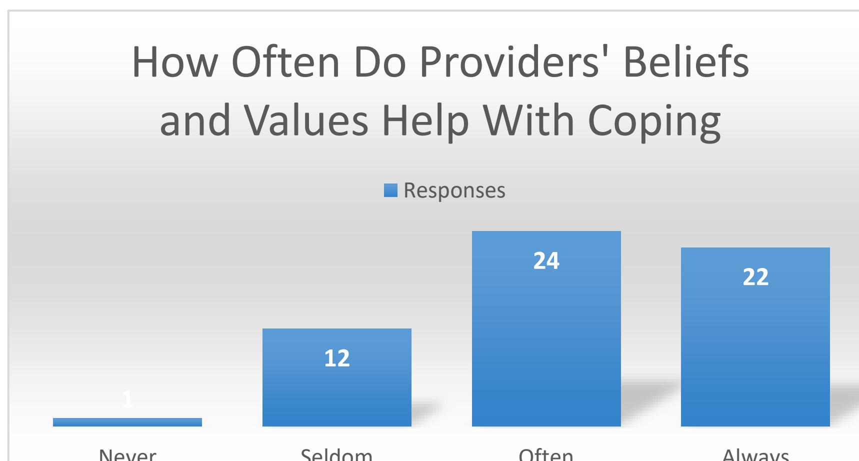

Figure 4.4

Question 30 (Fig. 4.5 below) asked respondents to rate their comfort in discussing spiritual and religious topics with their patients. Three percent (2) rated it as very uncomfortable. Seven percent (4) shared that they were somewhat uneasy. 37% (22) said they were somewhat comfortable discussing spirituality and religion with their parents. Most respondents, 53% (37), felt very comfortable discussing spirituality and religion with their patients.

**Figure 4.5**

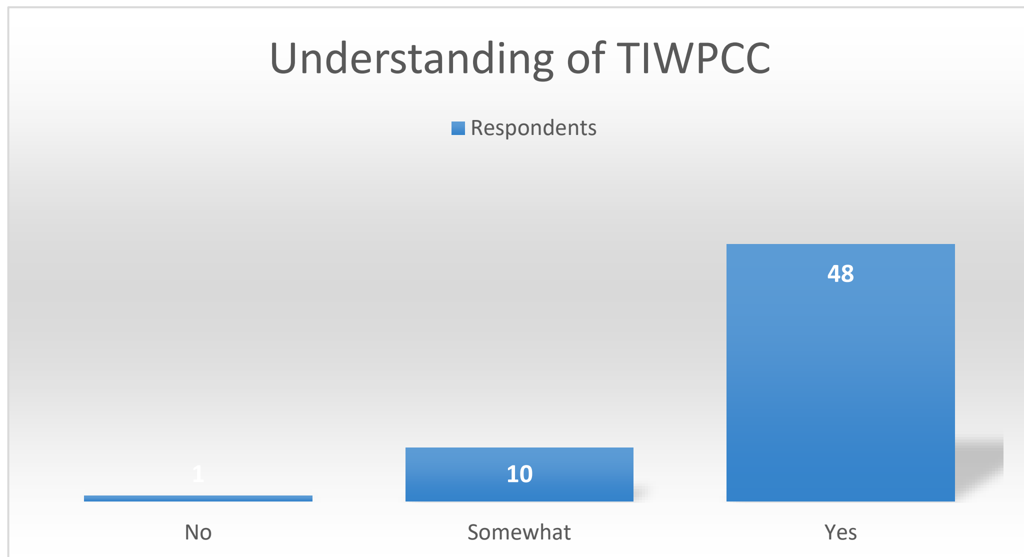
Question 31(Fig. 4.6 below) asked if religious, spiritual, and/or personal values helped providers cope with the stresses and demands of providing care to patients and families. One respondent (2%) said that these never helped with coping. Twelve (20%) said their beliefs and values seldom helped them cope. Twenty-four, or 41%, of participants revealed that their beliefs and values often supported coping, while twenty-two, 37 %, said their beliefs and values always helped them cope with the stress and demands of healthcare.

**Figure 4.6**



Question 32 (see Fig. 4.7 below) asked respondents if they understood trauma-informed, whole person-centered care as an approach that considers the context of a patient's life experiences as an important part of their care. This is a relational approach that includes the provider as an active participant. The large majority, 81% (48), answered yes. Ten (17%) answered somewhat. Only one (2%) responded with a no.

**Figure 4.7**




Question 33 (Fig. 4.8) was the final one in the qualitative portion. Participants were asked if they provide trauma-informed, whole-person-centered care to patients and their families. 75% (44) answered that yes, they do provide TIWPCC. 20% (12) were unsure. 2% (1) answered no.

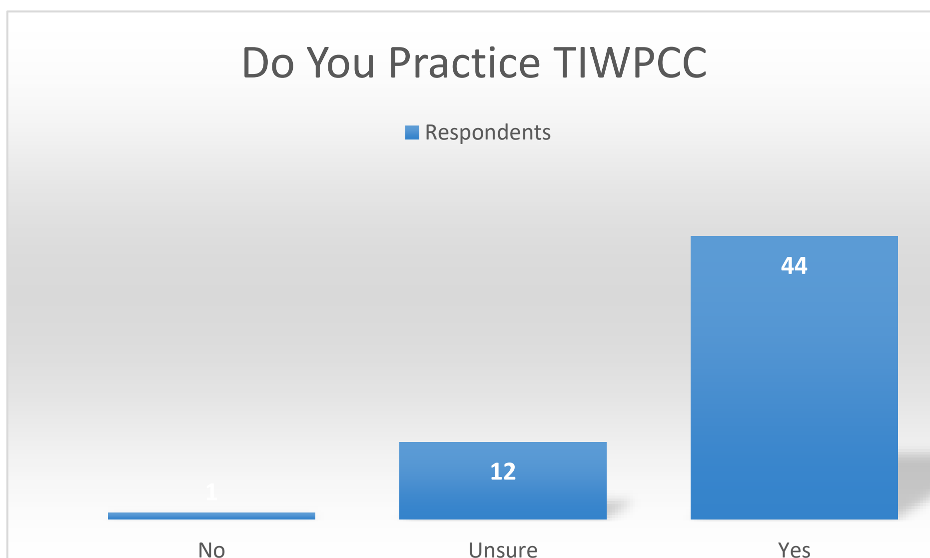



**Figure 4.8**

## Narrative Responses

Question 34 invited participants to share what would help them interact more effectively with patients in providing TIWPCC care. The following themes emerged.

Training and Education

*Practical Training*. More practice with trauma-informed care implementation through simulation sessions rather than just theory.

*Spiritual Care Training*. Increased training in discussing spiritual care with patients, as it is a common need.

Time and Resources

*More Time***.** The emphasis is on the need for more time to see patients and gather background information on them and their families.

*Lower Caseload***.** Reducing caseload to allow for more time to connect with patients.

*Supportive Environments*. There is a need for calm and comfortable meeting spaces for hard conversations.

Collaboration and Communication

*Interdisciplinary Team (IDT) Support* Better communication and endorsement from the IDT, especially the medical team.

*Joint Visits*. Collaborating with nurses or social workers during highly emotional patient/family cases.

Personal Approach and Self-Awareness

*Mindfulness.* Practicing being in the moment with patients and checking internal thoughts and feelings before encounters.

*Compassionate Presence*. Bringing compassion and empathy to patient interactions.

*Curiosity and Open-Ended Questions*. Ask open-ended questions and actively listen to patients and families.

Additional Resources and Support

*Printed Materials*. Providing printed materials for patients to share and give to them.

*Cultural Competence*. Education on cultural aspects to better address patients' and families' needs.

*Trauma-Informed Care Training.* Continued training on trauma-informed care to integrate it more fully into practice.

These suggestions emphasize the importance of practical training, sufficient time, supportive environments, collaboration, personal mindfulness, and access to additional resources in delivering holistic and compassionate patient care.

The last question, number 38, asked respondents directly to reflect on and share how TIWPCC benefits them. The major themes are categorized below.

Understanding and Empathy

*Understanding Patient Behavior*. Recognizing how past traumas influence patient reactions and behaviors.

*Empathy.* Enhancing empathy towards patients by considering their trauma histories.

Improving Patient Relationships

*Building Deeper Connections*. Strengthening relationships and improving patient engagement by acknowledging past traumas.

*Holistic Care.* Providing a more comprehensive and supportive approach by understanding the full context of patients' lives.

Personal and Professional Growth

*Self-awareness and Reflection*. Engaging in meta-cognition and reflecting on how caring for patients affects healthcare providers personally.

*Continuous Learning*. Ongoing education and understanding of trauma-informed care principles.

Communication and Safety

*Enhanced Communication*. Improving dialogue with patients through open-ended questions and active listening.

*Creating a Safe Environment*. Ensuring a sense of safety and trust for patients, thereby reducing re-traumatization.

Patient-Centered Care

*Whole-Person Approach*. Treating patients as whole individuals, considering their trauma, culture, and other life aspects.

*Non-Judgmental Attitude*. Maintaining non-judgmental and patient-centric attitudes.

Professional Collaboration

*Interdisciplinary Care.* Collaborating with other healthcare providers across disciplines to see a fuller picture of patients' lives.

*Support and Mentorship*. Seeking support and mentorship from colleagues to provide better care.

Out of the 59 responses, 19, or 32% of respondents, used the term "understanding" to describe the benefits of TIWPCC. According to Bloom's Taxonomy (Anderson & Krathwohl, 2001, pp. 97-98), "understanding" is the second level of thinking skills used to construct meaning from the acquisition and use of, in this case, TIWPCC skills. The word "understanding" was used in three ways, consistent with the cognitive processes of explaining (contextualizing), interpreting (gaining insight into internal states), and classifying (utilizing frameworks and best practices).

1. Six out of 19 (31.5%) state that TIWPCC care helps them (the provider) contextualize another's behaviors.
    a. #8: Allows me to know and **understand** my patients and their **idiosyncrasies**.
    b. #10: It helps me **understand why** people may react in a way that is not expected instead of feeling frustrated. Even if I don't know for sure if the person experienced a prior trauma, it helps me remember that the person could have experienced one, which helps me be patient, communicate better, and have empathy.
    c. #27: Greater **understanding of how** a patient interacts with their healthcare team.
    d. #29: It helps improve **communication and understanding** of patients.
    e. #34: It helps bring **understanding to the sometimes irrational choices** patients can make.
    f. #53: **understanding** motivation for **behavior**

2. The second use of *understanding* was that it offered insight into motivations for responses, behaviors or other internal processes. Seven out of 19 (36.8%) of respondents used the word as helping explore internal processes.
    a. #11: a way of **understanding people** more fully
    b. #12: Better **understanding** of people's experiences and how they **may influence** how they show up in your space and how to best help/provide care.
    c. #16: It helps to **understand where a pt is coming from** and what they have been through

d. #32: **Perspective** - if we can **understand someone at their core**, we can gain a better understanding of their thought processes and actions.

e. #38: Helps me **understand why** a person has a **specific perspective** and/or behaviors based upon an experience(s) they find they still are affected by. By recognizing this and validating their experience, hopefully they feel safer with me, which means we can have open and honest communication about hard things.

f. #46: It allows you the **understanding that there is history tied to what is happening in the room,** how the patient/family responds, etc. It allows for more compassion and understanding.

g. #48: more **comprehensive understanding** for the events and experiences that have affected people's lives and t**heir potential reactions to serio**us illness

3. Six of the respondents (31.5%) also used the word "understanding" as an intentional approach that informs the practitioner. "Understanding" became an active process that widened the scope of awareness by placing the patient-provider dyad in a broader cultural and institutional context.

a. #15: I believe it allows me to help **connect the dots for other medical providers t**o see a fuller tapestry of their lives. It also helps me **understand our patients and their families** better which allows us to provide better care.

b. #19: It helps me **understand how** a person's **whole experience, including trauma, culture, and other aspects of their lives,** can affect their current mindset.

c. #40: **Better understanding** of the patient which provides me better understanding **of which to counsel.**
d. #42: Gives me a **framework** to understand peoples' **WHY** - allows me to be supportive in ways that work for each individual. Also helps to prevent unintentional re-traumatization, which happens frequently in healthcare settings. Can be a **tool** to build trust.
e. #54: A way to **improve the care I provide** and ensure a patient-provider relationship based off respect, **understanding a**nd trust.
f. #55: Allows me to improve my relationship with my patients and have a deeper connection to them. It g**ives me understanding of concepts or topics that may be troubling for my patients** to discuss or that could cause harm to my relationship with my patients.

**Categories of Responses**

The table below (Figure 4.9) provides a visual representation of the responses to question 38. As documented above, TIWPCC is beneficial to providers in multiple ways. Seven out of 49 (14%) responses fell into an "other" focused category, meaning the use of TIWPCC helped gain insight into what may be occurring internally for someone else (in this case, patients, families, or colleagues). Most responses were dyad-focused in the context of patient interactions with the provider, accounting for 16 out of 49 (32.6%). 26.5% (13/49) of responses focused on self-preparation for patient interactions. Eleven respondents (22.4%) included a broader, cultural, and institutional viewpoint. Two out of 49 respondents (4%) included advocacy for patients when interacting with other providers.

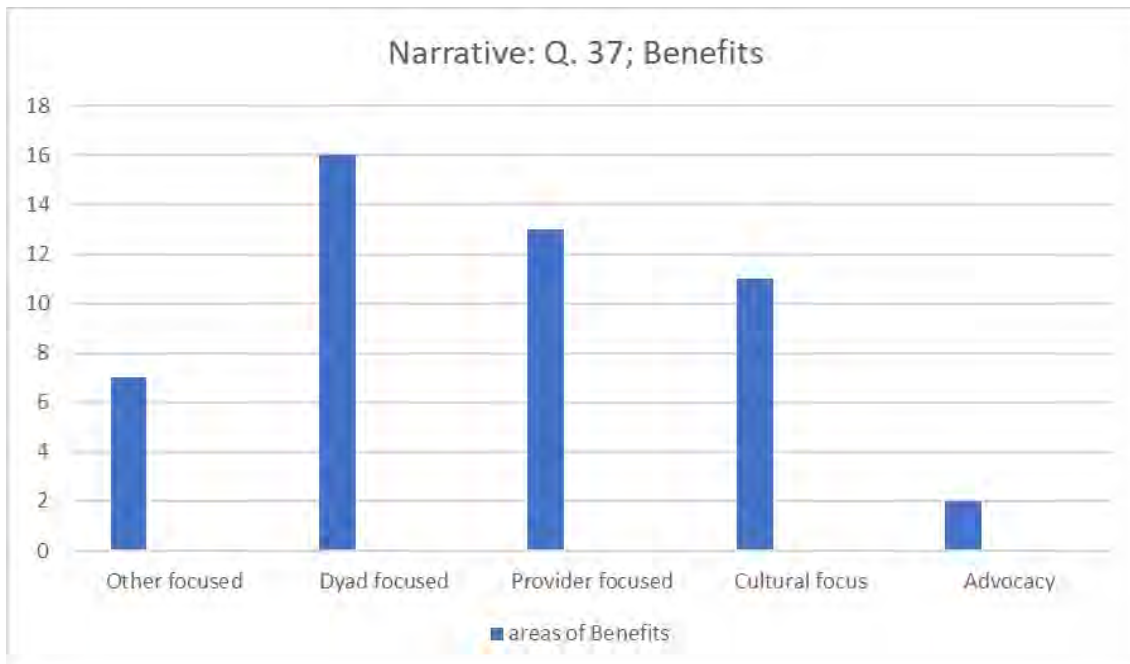



Figure 4.9

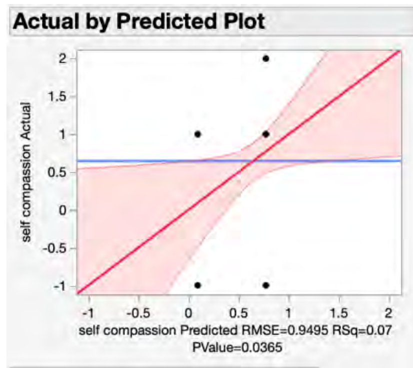
**Data Analysis**

When analyzing the "I practice trauma-informed, whole-person-centered care" question, several interesting relationships emerge.

***Self-compassion*** (Table 1 below) is positively associated with practicing TIWPCC. The term "compassion" was not defined for survey participants. The definition found in the Merriam-Webster Dictionary is that one feels empathy for another's suffering and is motivated to help relieve it. It appears that advocating and caring for oneself as a provider experiencing suffering increases for those who practice TIWPCC.

***Seeking collegial support*** for personally challenging clinical situations seems to have a positive correlation (Table 2 below) to practicing TIWPCC.

Table 1: Self Compassion




**Summary of Fit**

| | |
|---|---|
| RSquare | 0.074509 |
| RSquare Adj | 0.058273 |
| Root Mean Square Error | 0.949499 |
| Mean of Response | 0.644068 |
| Observations (or Sum Wgts) | 59 |

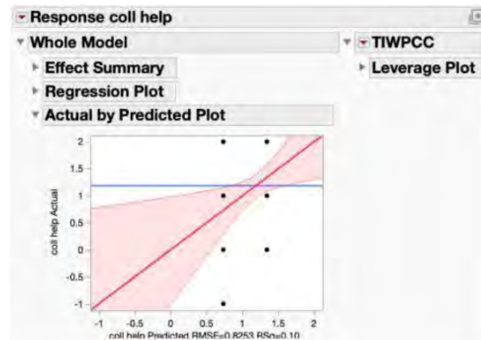
**Analysis of Variance**

| Source | DF | Sum of Squares | Mean Square | F Ratio |
|---|---|---|---|---|
| Model | 1 | 4.137166 | 4.13717 | 4.5890 |
| Error | 57 | 51.388258 | 0.90155 | Prob > F |
| C. Total | 58 | 55.525424 | | 0.0365* |

**Parameter Estimates**

| Term | Estimate | Std Error | t Ratio | Prob>\|t\| |
|---|---|---|---|---|
| Intercept | 0.0909091 | 0.286285 | 0.32 | 0.7520 |
| TIWPCC | 0.6799242 | 0.317398 | 2.14 | 0.0365* |

Table 2: Collegial Support




**Summary of Fit**

| | |
|---|---|
| RSquare | 0.096148 |
| RSquare Adj | 0.08029 |
| Root Mean Square Error | 0.825256 |
| Mean of Response | 1.186441 |
| Observations (or Sum Wgts) | 59 |

**Analysis of Variance**

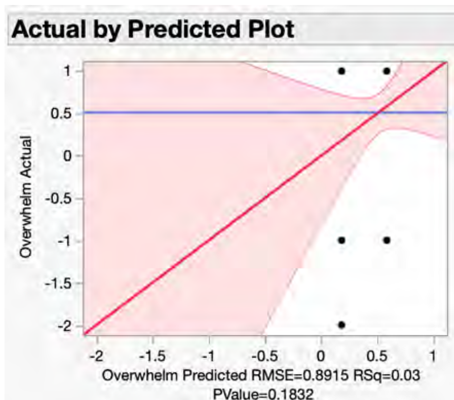
| Source | DF | Sum of Squares | Mean Square | F Ratio |
|---|---|---|---|---|
| Model | 1 | 4.129456 | 4.12946 | 6.0634 |
| Error | 57 | 38.819697 | 0.68105 | Prob > F |
| C. Total | 58 | 42.949153 | | 0.0168* |

**Parameter Estimates**

| Term | Estimate | Std Error | t Ratio | Prob>\|t\| |
|---|---|---|---|---|
| Intercept | 0.7333333 | 0.21308 | 3.44 | 0.0011* |
| TIWPCC | 0.6075758 | 0.246742 | 2.46 | 0.0168* |

**Effect Tests**

Table 3: Overwhelm




**Summary of Fit**

| | |
|---|---|
| RSquare | 0.030863 |
| RSquare Adj | 0.013861 |
| Root Mean Square Error | 0.89151 |
| Mean of Response | 0.508475 |
| Observations (or Sum Wgts) | 59 |

**Analysis of Variance**

| Source | DF | Sum of Squares | Mean Square | F Ratio |
|---|---|---|---|---|
| Model | 1 | 1.442732 | 1.44273 | 1.8152 |
| Error | 57 | 45.303030 | 0.79479 | Prob > F |
| C. Total | 58 | 46.745763 | | 0.1832 |

**Parameter Estimates**

| Term | Estimate | Std Error | t Ratio | Prob>\|t\| |
|---|---|---|---|---|
| Intercept | 0.1818182 | 0.2688 | 0.68 | 0.5015 |
| TIWPCC | 0.4015152 | 0.298013 | 1.35 | 0.1832 |

Table 4: Beliefs & Values

**Summary of Fit**

| | |
|---|---|
| RSquare | 0.300128 |
| RSquare Adj | 0.28785 |
| Root Mean Square Error | 0.98224 |
| Mean of Response | 0.915254 |
| Observations (or Sum Wgts) | 59 |

**Analysis of Variance**

| Source | DF | Sum of Squares | Mean Square | F Ratio |
|---|---|---|---|---|
| Model | 1 | 23.582956 | 23.5830 | 24.4435 |
| Error | 57 | 54.993316 | 0.9648 | Prob > F |
| C. Total | 58 | 78.576271 | | <.0001* |

**Lack Of Fit**

| Source | DF | Sum of Squares | Mean Square | F Ratio |
|---|---|---|---|---|
| Lack Of Fit | 1 | 0.356616 | 0.356616 | 0.3655 |
| Pure Error | 56 | 54.636700 | 0.975655 | Prob > F |
| Total Error | 57 | 54.993316 | | 0.5479 |
| | | | | Max RSq |
| | | | | 0.3047 |

**Parameter Estimates**

| Term | Estimate | Std Error | t Ratio | Prob>\|t\| |
|---|---|---|---|---|
| Intercept | 0.6082888 | 0.142153 | 4.28 | <.0001* |
| self influences numerical | 0.3937166 | 0.079635 | 4.94 | <.0001* |

Table 3 (on previous page) indicates that practicing TIWPCC does not alleviate or protect against feelings of overwhelm at work. This may be because of the pressures of Managed Care in a Westernized healthcare system. Further exploration is needed.

Table 4 (on previous page) indicates a positive correlation between practicing TIWPCC and the question, “My spiritual, religious, and/or personal values influence how I deliver care to patients.”

## Exploring Disciplines

### *Social Workers*

A. Social Work

**Correlations**

| | socail worker A | energized | spirtual, rel, value coping | compassion self | spirt, rel, values & care of pt | overwhelm | compassion pts |
|---|---|---|---|---|---|---|---|
| socail worker A | 1.0000 | 0.0285 | -0.0771 | 0.1268 | -0.2287 | 0.0128 | -0.0124 |
| energized | 0.0285 | 1.0000 | 0.1827 | 0.2258 | 0.0202 | 0.3150 | 0.4411 |
| spirtual, rel, value coping | -0.0771 | 0.1827 | 1.0000 | -0.0075 | 0.5269 | -0.0238 | 0.2250 |
| compassion self | 0.1268 | 0.2258 | -0.0075 | 1.0000 | 0.0149 | 0.0329 | 0.2229 |
| spirt, rel, values & care of pt | -0.2287 | 0.0202 | 0.5269 | 0.0149 | 1.0000 | -0.0876 | 0.0688 |
| overwhelm | 0.0128 | 0.3150 | -0.0238 | 0.0329 | -0.0876 | 1.0000 | -0.0714 |
| compassion pts | -0.0124 | 0.4411 | 0.2250 | 0.2229 | 0.0688 | -0.0714 | 1.0000 |

The correlations are estimated by Row-wise method.

**Correlation Probability**

| | socail worker A | energized | spirtual, rel, value coping | compassion self | spirt, rel, values & care of pt | overwhelm | compassion pts |
|---|---|---|---|---|---|---|---|
| socail worker A | <.0001 | 0.8302 | 0.5614 | 0.3386 | 0.0815 | 0.9233 | 0.9257 |
| energized | 0.8302 | <.0001 | 0.1661 | 0.0855 | 0.8792 | 0.0151 | 0.0005 |
| spirtual, rel, value coping | 0.5614 | 0.1661 | <.0001 | 0.9553 | <.0001 | 0.8578 | 0.0866 |
| compassion self | 0.3386 | 0.0855 | 0.9553 | <.0001 | 0.9106 | 0.8044 | 0.0897 |
| spirt, rel, values & care of pt | 0.0815 | 0.8792 | <.0001 | 0.9106 | <.0001 | 0.5093 | 0.6046 |
| overwhelm | 0.9233 | 0.0151 | 0.8578 | 0.8044 | 0.5093 | <.0001 | 0.5909 |
| compassion pts | 0.9257 | 0.0005 | 0.0866 | 0.0897 | 0.6046 | 0.5909 | <.0001 |

In Table A above, the correlation coefficient between "social worker A/role" and "energized" is 0.2288, indicating a positive association. Similarly, "energized" shows a positive correlation with "spiritual, religious, value coping" at 0.2269. This suggests that there is a relationship between energy for work and the use of one’s own spiritual, religious, and core values to cope with work.

However, "social worker A" has a negligible negative correlation with "spirit, religious, values used in care of patient" (-0.0016) and "overwhelm" (-0.0002). These findings suggest that while certain variables, such as "energized" and "spiritual, religious, value coping," are

positively related, experiencing feelings of overwhelm at work has a minimal correlation. This is consistent with the findings in the previous Table 3 above.

***Physicians/Mid-level Providers***

B. Physician, NP, PA

**Correlations**

| | physcian/provider | energized | overwhelm | compassion pts | compassion self | spirtual, rel, value coping | spirt, rel, values & care of pt |
|---|---|---|---|---|---|---|---|
| physcian/provider | 1.0000 | -0.3994 | -0.1275 | -0.3363 | -0.1802 | -0.3197 | -0.1247 |
| energized | -0.3994 | 1.0000 | 0.3150 | 0.4411 | 0.2258 | 0.2232 | 0.0202 |
| overwhelm | -0.1275 | 0.3150 | 1.0000 | -0.0714 | 0.0329 | -0.0076 | -0.0876 |
| compassion pts | -0.3363 | 0.4411 | -0.0714 | 1.0000 | 0.2229 | 0.2471 | 0.0688 |
| compassion self | -0.1802 | 0.2258 | 0.0329 | 0.2229 | 1.0000 | 0.0033 | 0.0149 |
| spirtual, rel, value coping | -0.3197 | 0.2232 | -0.0076 | 0.2471 | 0.0033 | 1.0000 | 0.5478 |
| spirt, rel, values & care of pt | -0.1247 | 0.0202 | -0.0876 | 0.0688 | 0.0149 | 0.5478 | 1.0000 |

The correlations are estimated by Row-wise method.

**Correlation Probability**

| | physcian/provider | energized | overwhelm | compassion pts | compassion self | spirtual, rel, value coping | spirt, rel, values & care of pt |
|---|---|---|---|---|---|---|---|
| physcian/provider | <.0001 | 0.0017 | 0.3359 | 0.0092 | 0.1721 | 0.0136 | 0.3466 |
| energized | 0.0017 | <.0001 | 0.0151 | 0.0005 | 0.0855 | 0.0892 | 0.8792 |
| overwhelm | 0.3359 | 0.0151 | <.0001 | 0.5909 | 0.8044 | 0.9547 | 0.5093 |
| compassion pts | 0.0092 | 0.0005 | 0.5909 | <.0001 | 0.0897 | 0.0592 | 0.6046 |
| compassion self | 0.1721 | 0.0855 | 0.8044 | 0.0897 | <.0001 | 0.9800 | 0.9106 |
| spirtual, rel, value coping | 0.0136 | 0.0892 | 0.9547 | 0.0592 | 0.9800 | <.0001 | <.0001 |
| spirt, rel, values & care of pt | 0.3466 | 0.8792 | 0.5093 | 0.6046 | 0.9106 | <.0001 | <.0001 |

The correlation analysis in Table B, above, highlights potentially significant relationships among the variables studied. The correlation coefficient between "physician & mid-level provider/role" and "energized" is 0.1827, indicating a negative association. Similarly, "energized" shows a negative correlation with "overwhelm" at -0.3113. This raises concerns for physicians and mid-level providers about maintaining both the energy for work and the feeling of being capable of handling work demands.

However, "compassion for patients" and "compassion for self" exhibit positive correlations with values of 0.1000 and 0.0026. This analysis suggests that medical providers who feel confident in their own abilities and the care they provide, create a positive feedback loop where compassion for patients enhances their own sense of well-being, and vice versa. This aligns with existing research that suggests compassion acts as a positive source for healthcare providers. (Meier, et al., 2001, p.3007; Miller, 2022. P.14).

***Chaplains***

C. Chaplain

**Correlations**

| | Chaplain total | energized | overwhelm | compassion pts | compassion self | spirtual, rel, value coping | spirt, rel, values & care of pt |
|---|---|---|---|---|---|---|---|
| Chaplain total | 1.0000 | 0.3745 | 0.0991 | 0.3358 | 0.0405 | 0.4359 | 0.4369 |
| energized | 0.3745 | 1.0000 | 0.3150 | 0.4411 | 0.2258 | 0.2232 | 0.0202 |
| overwhelm | 0.0991 | 0.3150 | 1.0000 | -0.0714 | 0.0329 | -0.0076 | -0.0876 |
| compassion pts | 0.3358 | 0.4411 | -0.0714 | 1.0000 | 0.2229 | 0.2471 | 0.0688 |
| compassion self | 0.0405 | 0.2258 | 0.0329 | 0.2229 | 1.0000 | 0.0033 | 0.0149 |
| spirtual, rel, value coping | 0.4359 | 0.2232 | -0.0076 | 0.2471 | 0.0033 | 1.0000 | 0.5478 |
| spirt, rel, values & care of pt | 0.4369 | 0.0202 | -0.0876 | 0.0688 | 0.0149 | 0.5478 | 1.0000 |

The correlations are estimated by Row-wise method.

**Correlation Probability**

| | Chaplain total | energized | overwhelm | compassion pts | compassion self | spirtual, rel, value coping | spirt, rel, values & care of pt |
|---|---|---|---|---|---|---|---|
| Chaplain total | <.0001 | 0.0035 | 0.4554 | 0.0093 | 0.7605 | 0.0006 | 0.0005 |
| energized | 0.0035 | <.0001 | 0.0151 | 0.0005 | 0.0855 | 0.0892 | 0.8792 |
| overwhelm | 0.4554 | 0.0151 | <.0001 | 0.5909 | 0.8044 | 0.9547 | 0.5093 |
| compassion pts | 0.0093 | 0.0005 | 0.5909 | <.0001 | 0.0897 | 0.0592 | 0.6046 |
| compassion self | 0.7605 | 0.0855 | 0.8044 | 0.0897 | <.0001 | 0.9800 | 0.9106 |
| spirtual, rel, value coping | 0.0006 | 0.0892 | 0.9547 | 0.0592 | 0.9800 | <.0001 | <.0001 |
| spirt, rel, values & care of pt | 0.0005 | 0.8792 | 0.5093 | 0.6046 | 0.9106 | <.0001 | <.0001 |

The analysis in Table C, above, reveals important connections between the various factors. For instance, the correlation coefficient between "Chaplain total/role" and "energized" is 1.0000, indicating a perfect positive association. Role identity and energy for the work are linked.

Additionally, "Chaplain role" shows positive correlations with "overwhelm" (0.3438), "compassion for patients" (0.4235), and "compassion for self" (0.4112), suggesting that chaplains who feel more energized also tend to feel more overwhelmed, compassionate towards patients, and compassionate towards themselves.

Conversely, "energized" has a weaker positive correlation with "overwhelm" (0.0994) and "compassion for pts" (0.0977). These findings suggest that while "Chaplain total" is strongly associated with various emotional and coping variables, "energized" exhibits weaker associations, implying these relationships are not as strong. Overall, it appears that chaplains have a generally positive sense of their emotional states at work.

# DISCUSSION

## Initial Reflections on Topics of Interest

This survey sought to identify the impact of trauma-informed, whole-person-centered care (TIWPCC) on healthcare providers. It explored TIWPCC's effect on providers when cultivating authentic, compassionate relationships with their patients. “Provider” was defined as any healthcare professional providing face-to-face patient or family care.

### *The Healthcare Providers*

The respondents represented a variety of healthcare roles which are most commonly part of the interdisciplinary team. However, TIWPCC is not limited to healthcare settings, as demonstrated by multiple formal nationwide programs aimed at building trauma-informed communities (SAMSHA, 2023, p.28). A small number of respondents felt they were not able to utilize a trauma-informed approach because they were in administrative roles or out in the community. This highlighted an opportunity for better education about the six guiding principles of a trauma-informed approach that anyone can adopt.[6]

There was a wide age range, ranging from their early twenties to their seventies. The majority identified as female at 72%. Religious and spiritual representation comprised 58% from various traditions and belief systems, including those of non-believers, atheists, and agnostics. Forty-two participants were a part of a Christian denomination, including Catholicism. There

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[6] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach | SAMHSA Library
1 – Promote physical and emotional safety.
2. Empowerment & Choice – Empower people and respect their choices.
3. Collaboration – Share power and decision-making.
4. Trustworthiness – Build trust and be transparent.
5. Diversity – Acknowledge, respect, and embrace diversity.
6. Peer Support – Value lived experience and peers.

was a representation of diverse work settings and providers from different parts of the United States. This variety of responses from a diverse population is crucial in assessing trauma-informed, whole-person-centered care because the experience of trauma and the impact of care practices are profoundly personal and culturally influenced (Herman, 1992/2022, p. 12; Howell, 2020, p. 29; Levine, 1997, p. 49).

Different provider roles highlight distinct challenges and strengths in patient and family care. The survey results, by gathering various perspectives on and approaches to care, may offer a more accurate assessment of the overall impact of trauma-informed, whole-person-centered care on providers.

A challenge of this survey was the limited number of responses. The survey questionnaire was not sent to specific individuals. Instead, it was made available to multiple healthcare teams and providers, who could choose to respond. Those who accessed the questionnaire could forward it to colleagues. While casting a wide and open invitation helped achieve the diversity of disciplines responding, I wonder what effect a more specific and intentional invitation might have had on the number of responses.

**First Topic of Interest: Job Satisfaction**

The first area of inquiry examined the quality of provider-patient relationships in relation to job satisfaction. The results indicate that most TIWPCC providers believe their work is mission-driven (questions 10-12), have collegial support (questions 15-16), and can cope effectively. It appears there is a positive relationship between compassion for oneself and seeking collegial support when needed, as reported by the participants who practice TIWPCC (see Tables 1 and 2).

The narrative portions, especially when directly asked about the benefits of practicing TIWPCC, suggest that providers actively seek to deepen their provision of trauma-informed care, and the majority recognize themselves as part of the dyadic healthcare relationship.

***Area of Concern***. Question 13, "I thrive under workplace stress", suggests an area of potential concern that requires further exploration. Twenty percent of respondents reported feeling neutral about workplace stress. Pursuing this further to elicit more specific information could significantly alter the results. On one hand, if a neutral rating is positive, it suggests that workplace stress motivates respondents in their jobs. Table 3 (see page 104) indicates that practicing TIWPCC does not influence feelings of being overwhelmed. Tables A, B, and C each suggest that some feelings of pressure boost energy for work at the 95% level, recognizing that some tension is necessary for growth.

On the other hand, being overwhelmed could mean that most providers are struggling to meet workplace demands. Feeling chronically overwhelmed by basic work demands is an indicator of secondary trauma (Miller, 2022, p. 17). Consistent "neutral, not sure, or uncertain" ratings may indicate healthcare providers are using defenses to avoid, repress, or dissociate from their uncomfortable feelings.

Given the potential for workplace stressors to lead to provider burnout and secondary traumatic stress, a thorough examination of contributing factors and the creation of effective interventions is warranted. Asking more specific questions about the relationship between being overwhelmed and workplace stress, and their impact on either motivating or discouraging provider output, would be helpful. Removing the option of answering with "neutral, not sure, or uncertain" is something to consider in future exploration of this topic.

**Second Topic of Interest: Self-Awareness to Boost Resiliency**

The second hypothesis explores provider self-awareness in response to increasing healthcare demands. Effective TIWPCC requires providers to recognize and address not just a patient's trauma but also cultivate a deep understanding of their own internal emotional states, reactions, and vulnerabilities.

***Awareness.*** In the narrative portion, question 37, "Are there things that could help you deal with patients and families more effectively?", asked participants to identify things that could enhance their interactions with patients and families. Thirty-six percent of the responses used the word "understand" to describe how practicing TIWPCC shifts perspectives and raises awareness of the provider's active participation in providing TIWPCC. One respondent put it this way: "It allows you the understanding that there is history tied to what is happening in the room." This awareness speaks to the respondents' ability to mentalize and be aware of their own perspective in the moment. This capacity aligns with Miller's (2022) "conscious narrative", which claims that being able to remember and tell our foundational story of why our work is important and necessary is a resiliency-boosting, career-sustaining tool (p.90).

***Seeking Professional Support.*** Providers' self-awareness was further assessed by examining their access to and willingness to seek professional therapeutic support. The vast majority had access (86%), and most said they would seek professional help if needed (78%). The survey revealed that a significant number of the responding providers were hesitant to seek professional help, with 20% responding as 'unsure' or 'no'. This raises the question of whether healthcare providers who practice TIWPCC are more likely to seek help than those providers who do not use this approach. Further exploration might reveal that providers who do not utilize TIWPCC

may be even less likely to seek assistance, potentially increasing their risk of negative consequences.

***Non-verbal Communication.*** Figure 3.1 (p.87) illustrates that most providers pay attention to the nonverbal cues and body language of their patients and families most of the time (69% always, 31% often). However, they report being less aware of their own nonverbal cues and body language (68% reported always, 25% reported usually). These findings suggest that bodily self-awareness and non-verbal communication are areas for further investigation

***Assessing the Whole Person.*** Question 22, "I ask my patients about other aspects of their lives," asked providers how often they addressed other aspects of patients' lives. While almost all providers do so regularly, two respondents (3%) seldom ask.

***Area of Concern***

When considering the questions about nonverbal cues and body language, one respondent reported being unaware of their own or others' nonverbal communication. Two respondents, or 3%, reported being unaware of any body language or nonverbal communication. One respondent indicated they rarely recognize their own or others' nonverbal communication, while two respondents (3%) stated they are unaware of body language and nonverbal cues. It appears that those who answered "never" or "seldom" are among the few participants who either do not practice TIWPCC (2% responded "no") or are uncertain about their understanding of it. This finding further suggests that participants need to receive a broader education about what constitutes a trauma-informed approach to include all the ways non-verbal communication influences interactions.

**Third Topic of Interest: Caring for Self**

This area of inquiry examined the use of well-being practices and holistic approaches to caring for oneself as a healthcare provider. There is a consistent, numerically positive relationship (at 99.9%) of compassion for oneself and the utilization of personal spirituality, religious beliefs, and/or core values to help healthcare providers cope with the demands of their profession (see Tables A, B, &C on pp. 105-107). All participants named more than one approach to self-care (see question 27 responses in Figure 4.7 on p. 96) that encompasses the needs of body, mind, and spirit (see Figure 4.3 on page 94). This suggests that for these participants, their personal well-being is understood holistically incorporating the domains of body, mind, and spirit.

Although the findings fall below the 95% correlation standard, it is interesting to note that a significant relationship (90%) exists between self-compassion and personal religious, spiritual, and value-based practices, incorporating the ability to feel compassion towards patients. These results suggest that when these providers prioritize their well-being, they may be better equipped to care for patients and patients' families.

**Fourth Topic of Interest: Articulating the Benefits**

The final area of interest asked participants to articulate how the practice of TIWPCC benefits them as providers. Based on both self-reported benefits and correlative data, findings suggest that TIWPCC benefits healthcare providers by fostering compassion for self and others (Q. 26 & 27; Table 1 on p. 104), enhancing patient relationships (narrative question 37), and supporting professional growth and well-being (see figures 4.2 & 4.3 on pp. 93-94). More specifically, the benefits identified by the participants are listed below.

***Benefit 1***. By understanding how past traumas influence behavior, providers report improvement their ability to empathize, respond compassionately, and build deeper connections

with patients, offering more comprehensive and holistic care (see narrative analysis of the term ‘understanding’ on pages 32 & 33).

***Benefit 2.*** Participants reported that a TIWPCC approach also promotes self-awareness and continuous learning, enabling providers to reflect on their practice and adapt to the emotional complexities of caregiving (see narrative responses to Q. 34 on pp. 97-98).

***Benefit 3.*** Additionally, participants reported that TIWPCC emphasizes effective communication and the creation of safe environments, potentially reducing the likelihood of re-traumatization and increasing the likelihood of building trust. Collaboration across disciplines was identified as supporting a more unified care model, while support and mentorship from colleagues strengthens professional relationships. These potential benefits were reported to enhance patient outcomes and may enhance healthcare providers' personal and professional fulfillment.

**Recommendations For Further Study**

This survey suggests that further research could better highlight the benefits of TIWPCC for healthcare providers by comparing those who practice TIWPCC with those who do not. Only 2-3% of respondents indicated that they did not practice or understand TIWPCC. The involvement of the few respondents without TIWPCC training led the investigator to consider including a non-TIWPCC providers group in future studies on this topic. In this case, comparing apples to oranges rather than apples to apples would provide a more accurate reflection of the benefits of TIWPCC for healthcare providers.

Well-being, job satisfaction, and self-awareness for social work/counselors and chaplains participating in this survey were comparable to one another across the board. However, physicians and mid-level providers, in this survey, differed by reporting less job satisfaction, less

reliance on their beliefs, spirituality, and values, and less coping ability. In the literature review for this survey, studies (Bagdasarov, Z., & Connelly, S., 2013; Denizon, A., et al., 2023; Meier, D., et al., 2001) consistently identified two areas lacking in medical school education: emotional awareness and coping with complex emotions. Building structures into the educational curriculum for personal formation, not just academics, in the way Spiritual Care education and Social Work programs do, may be helpful in bridging gaps in preparing medical providers for the nuances and uncertainties of patient interactions. "Human relationships, like the weather and economies, are inherently complex and chaotic systems" (Holmes & Slade, 2017, p. 154).

Physicians and mid-level providers also carry greater responsibility for the consequences of their medical management decisions. Considering these factors, there may be a benefit in looking at the educational models being used by social work and spiritual care programs to see if there are lessons and approaches to education that could benefit medical school programs. Unfortunately, there was not a significant number of nurses responding to the survey to reflect on their experiences. The literature review for this survey revealed that nursing programs also incorporate emotional wellness and cognitive teaching (Satran, et al., 2020, p. 486). This author recognizes nursing as vital to the interdisciplinary approach in trauma-informed, whole-person, centered care.

**Final Reflections**

Trauma-Informed, Whole-Person, Centered Care (TIWPCC) impacts providers by fostering a more compassionate approach to patient care. This survey suggests that providers trained in TIWPCC are better equipped to recognize and address the complex effects of trauma, resulting in improved patient engagement, treatment adherence, and overall health outcomes. Equally important is that this approach appears to contribute to the wellness of healthcare providers by

creating a supportive and respectful environment for both patients and staff. In TIWPCC, creativity and wholeness are found in the relational processes of human beings caring for each other. By integrating TIWPCC principles, providers can offer compassionate, holistic care that acknowledges the full context of everyone's experience, ultimately promoting healing and resilience for all involved.

While researching and exploring trauma-informed, whole-person-centered care, I followed the historical path away from ancient and early healing practices, steeped in the spiritual and communal domains, towards empirical and "factual" methodologies deemed hard science. Ultimately, I was led back to the foundation of (what has been labeled) primitive modalities. These early communities understood the importance of caring for one another in a holistic, spiritually grounded manner, recognizing the interconnectedness of everyone's life. This approach is a circle, where care is not linear but a continuous, inclusive process that honors the full context of each person's experience. The integration of TIWPCC principles fosters a supportive environment that nurtures healing and resilience, much like the communal and spiritually centered practices of our ancestors. It is enlightening to recall the early approaches to healthcare, appreciate their value, and examine how we can continue to connect with them in a modern context. As in the poem, Little Gidding, by T.S. Eliot (1943):

> We shall not cease from exploration
>
> And the end of all our exploring
>
> Will be to arrive where we started
>
> And know the place for the first time.
>
> Through the unknown, remembered gate
>
> When the last of earth left to discover

Is that which was the beginning;

At the source of the longest river

The voice of the hidden waterfall

And the children in the apple-tree

Not known, because not looked for

But heard, half-heard, in the stillness

Between two waves of the sea.

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**Appendix A: Invitation to Participate**

**12/2/2024**

**An email link and a QR code were sent to potential participants with this invitation.**

Thank you for taking the time to participate in this survey. There are 37 questions which are mostly multiple choice. It should take 15 minutes to complete.

My Doctorate of Ministry research project focuses on how healthcare providers experience patient encounters in the context of using a trauma-informed whole patient centered model of care.

**Description:** Trauma-informed whole patient centered care is an approach that believes the context of a patient's life experiences, by acknowledging the long-term health effects of trauma, is an important part of effective medical care. This is a relational approach that requires the provider to be an active participant in the provider-patient dyad.

Research demonstrates this approach can increase patient satisfaction, encourage compliance with medical care and positively influence health outcomes. Very little research focuses on health benefits and well-being of the medical providers providing this type of care. This survey seeks to explore healthcare provider's experience of providing trauma-informed whole person-centered care.

For the purposes of this study "healthcare provider" is defined as any professional involved in face to face provision of physical, emotional, and/or spiritual care of patients and families. This interdisciplinary model of care is an important component of providing trauma-informed whole person-centered care.

**CONSENT & DISCLOSURE:** This survey is managed by Survey King. It is completely confidential. Survey King does not keep emails, contacts or IP addresses. I will not receive any personal information. I will not know who is participating. By participating in this survey, you are giving your consent.

**Appendix B:**

**CONSENT & DISCLOSURE:** This survey is managed by Survey King. It is completely

confidential. Survey King does not keep emails, contacts or IP addresses. I will not receive any

personal information. I will not know who is participating. By participating in this survey, you are giving your consent.

**Appendix C: Survey**

**Trauma-Informed Whole Person-Centered Care - COPY**

*
My healthcare provider role is: (select all that apply)

Other

Social Work/Counseling

Student

Chaplain

Physician

NP/PA

RN/LPN

Other
*
Number of years in practice or role:

0-5yrs

6-10yrs

Over 30yrs

11-19yrs

20-30yrs

Area of specialty: (click box to type)

Healthcare is a second career for me.

No

Yes

If yes, what was your previous line of work? (Click box to type)

How many hours do you work in typical week?

What is your age?

What is your gender identity?

Male
Female
Non-binary

I identify with a particular religion and/or spiritual identity which is: (click box to type)

**Work Related:**

*

Healthcare is a career that is more than just a job. Helping people is more than collecting a salary.

Uncertain

Strongly Disagree

Disagree

Agree

Strongly agree
*
I am able to remember why I work in healthcare on my worst days.

Strongly disagree

Disagree

Uncertain

Agree

Strongly agree
*
I feel energized to come to work:

No days

Few days

Most days

All days
*
I thrive under workplace stress.

Strongly disagree

Disagree

Neutral

Agree

Strongly Agree
*
When I go home, I can leave work at work:

Most days

Few days

All days

No days
*
I have work colleagues with whom I can consult with on personally challenging clinical situations.

Never

Seldom

Sometimes

Frequently

Always
*
I have access to and take opportunities for interdisciplinary input as an approach to patient-centered care.

Not available in my setting

Never

Rarely

Sometimes

Often

*
How often do you feel overwhelmed with normal tasks at work?

Never

Seldom

Frequently

Always
**Self Awareness**
*
I am comfortable giving and discussing hard news with patients.

Never

Seldom

Often

Always
*
I am comfortable giving and discussing hard news with families.

Never

Seldom

Often

Always
*
I pay attention to my nonverbal cues and body language while with patients and families.

Never

Seldom

Often

Always
*
I pay attention to non verbal cues and body language of my patients and their families.

Seldom

Often

Always

Never
*
I think about how illness and disease might affect my patients' lives.

Never

Seldom

Often

Always
*
I ask my patients about other aspects of their lives.

Never

Seldom

Often

Always
*
Areas I ask about include (choose all that apply).

Personal interests

Work

☐

Coping styles

☐

Family background

☐

Religion

☐

Trauma history

☐

Other:

*

I have access to professional therapeutic resources and support.

○

Unsure

○

No

○

Yes

*

I feel comfortable reaching out for confidential professional therapeutic support if I need it.

○

Prefer not to answer.

○

No

○

Unsure

○

Yes

**Spirituality Section**

*

I feel compassion towards my patients.

○

Never

○

Seldom

○

Often

Always
*
I feel compassion towards myself.

Never

Seldom

Often

Always
*
I participate in actvities that support my personal well-being and wholeness.

Never

Yearly

Monthly

Weekly

Daily
The actvities that support my personal well-being and sense of wholeness are: (Click box to type)

*
My spiritual, religious and/or personal values influence how I deliver care to patients.

Not at all

Somewhat

Very much
*

I am comfortable discussing spiritual and/or religious issues with my patients when it is needed.

Very uncomfortable

Somewhat uncomfortable

Somewhat comfortable

Very comfortable
*
My religious, spiritual and/or personal values help me cope with the stresses and demand of providing care to patients and families.

Never

Seldom

Often

Always
*
I understand trauma-informed whole person centered care as an approach that considers the context of a patients' life experiences as an important part of their care. This is a relational approach that includes me (the provider) as an active participant.

No

Somewhat

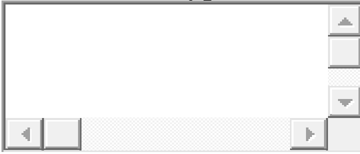
Yes
*
I practice trauma informed whole patient centered care.

No

Unsure

Yes
**Narrative portion:**

What are the things that could help you interact with patients and their families more effectively? (Click box to type)



What benefit does trauma informed whole person centered care provide to you? (Click to box to type)

Finish

Please answer required questions - Scroll to issue

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