

NEW SELF-CARE PROTOCOL

Practice Guide for Healthcare Practitioners and Staff



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Self-Care Protocol

Self-care is a complex concept to define and operationalize in most clinical settings. Self-care has many dimensions that need to be integrated to create a safe, secure, and nourishing working and clinical environment. This environment must maximize clinical excellence by promoting science- and evidence-based medical care linked to a system of personal and physical wellness, resilience, and health in clinical providers.

Promoting resilience is a key element of self-care. Resilience refers to a good adjustment across the mental, physical, and spiritual domains in the face of adversity. Resilience consists of 5 major capacities:

- 1) Ability to experience reward and motivation in a positive and optimistic way;
- 2) Ability to work and be productive in spite of fear
- 3) Adaptation of social behaviors to promote altruism, social bonding, and teamwork;
- 4) Use of cognitive skills to see negative experiences in a more “positive” light
- 5) Development of meaning and spiritual purpose in life.

All resiliency research has demonstrated the importance of maintaining strong, positive social relationships. Traumatic life experiences including history of past and present violence, chronic medical and emotional illnesses, can lead to feelings of humiliation and social isolation. The current COVID-19 crisis, for example, can make a health-care practitioner feel alone and isolated even within a labor intensive and busy hospital clinic.

Stress, of course, is the greatest enemy of self-care. Stress is what the brain does to itself and the body when a life experience is perceived as a threat or challenge. Stress begins as anxiety when the fetus is separated from the mother. This separation stress never leaves us. As mammals our survival strategy is to achieve a safe and secure attachment to a person or place. War, violence, poverty, and the current COVID-19 crisis can threaten to separate all of us from our harmonious selves and our sense of well-being.

The stress response is now well-known. The central nervous system (CNS) is a complex matrix of physiologic and immune systems that is under the top-down control of our brains. This system works through *allostasis*. Allostasis involves all of those biological

mechanisms that protect the body and mind from internal or external stressors. But persistent and chronic stress can make allostasis difficult. The acute and chronic long-term unrelenting stress, called *allostatic load*, can break down and tear at the organism at the cellular and physiologic levels, leading to severe physical and mental health problems. Resiliency is overcome and our bodies and minds break down.

We must act quickly to enhance resiliency and reduce stress, especially in times of crisis. This Self-Care Protocol and 10 Point Toolkit provides a practice guide to help health-care practitioners and staff to achieve the latter. Self-care must move beyond rhetorical exhortations to a concrete system of clinical policies and practices. The health care staff and their patients are in a mirroring relationship. What works for a doctor or nurse can definitely work for a patient. The following principles presented in this Protocol and 10 Point Toolkit are based upon a new scientific model called “One Health.”

“One Health” is a holistic system of healthcare that integrates all aspects of a human life: body, mind, spirit, and environment. One Health recognizes the connection between the health of people, animals, and the environment. The Centers for Disease Control and Prevention One Health office leads this global scientific effort. As we are learning from the COVID-19 crisis, human beings cannot be healthy within an unhealthy natural environment.

The principles that follow are simple, easy to apply, and science based. Of course, they will have to be adapted to each healthcare practitioner’s medical culture and social world. These practices, working together in unison, can provide the medical practitioner and staff the sense of satisfaction of a job well-done—even in a time of crisis. And a job well-done cannot be allowed to harm or damage the medical practitioner, colleagues, and their family and loved ones. While there exists great risk occupationally in caring for the suffering of others, self-sacrifice leading to self-damage is an unacceptable outcome.

The work of medicine is an extraordinary cornucopia of job and achievement that began over 2000 years ago in the West under the Greek god, Aesculapius. As stated in a new Manifesto: Healing a Violent World:

“We sing of our healers and their patients who are the treasure of our world. Without health and well-being, people have no freedom to escape from the tragedies and

struggles of everyday life in order to create a new and better world. We are in need of our treasure.”

As the late priest Henri Nouwen explained, “We are all wounded by living in a wounded world.” So, we all must work together in solidarity to heal ourselves, our patients, nature, and our society.

The definition of self-care is:

Self-care is a natural state of wellness and wellbeing. The clinician works to create a healing environment that provides high quality and effective care to all patients while providing a healthy and nurturing environment for those working in the environment. The healing environment itself, through its beauty, provides a place of safety, security, and restoration to the clinician and patient. Self-care begins with the creation of a nurturing physical environment where the achievement of excellence is fostered. Self-care occurs when the physical and emotional health of the clinician and the patient overrides competing concerns for financial success, efficiency, and productivity. Clearly, a healing environment leads to healthy self-care which in turn leads to excellent clinical care. A healthy care system protects its workers by never allowing the system to foster physically and emotionally damaging self-sacrifice or to allow bullying and/or organizational abuse.

Self-care is ultimately an integrated and holistic approach to the promotion of resiliency and wellness in all patients and staff where a premium is placed on thinking freely and working imaginatively and creatively in a scientifically and culturally sound environment. The capacity to be a healthy and affectionate clinician, co-worker, and family member is maximized. Self-care is a system of clinical care that maximizes the health, and wellbeing of patients, staff, and the community.

Top Priority: Take Care of your Family and Loved Ones First!

A common situation exists in modern medical care that is rarely openly discussed. The occupational life of a doctor, nurse, psychologist, and/or social worker can have an extremely damaging impact on family members. While the heroic work of medical practitioners is truly laudatory and socially valuable, this effort can have a devastating impact on family members. In our Harvard Medical School course for physician self-care over the past five years, it has been discovered that the physicians and their families have been highly traumatized by the medical profession. This includes not only serious depression and the development of chronic illnesses in the medical practitioner (more than 50% rate of burnout in American doctors) but similar problems in spouses and children, including suicides.

There are many factors that account for these family-related problems. They include:

1. Little attention by medical institutions to the impact of medical care on family members;
2. Few scientific studies on this topic area; very little information in the medical scientific literature;
3. Shame and fear among medical practitioners to admit mental health problems in themselves and their families;
4. Lack of institutional transparency on physician suicide attempts, especially depression among interns and residents;
5. Increasing industrialization in medical care leading to brief visits, little quality time with patients, and increase in burnout;
6. Electronic medical records that have been shown to take away up to 15 hours per week from family time;
7. Access to medical staff by patients, day and night, so that their family time is frequently interrupted;
8. Increase in bullying and harassment by administrators and financial managers;
9. Lack of and/or loss of peer supervision;
10. Breakdown in co-professional teamwork;
11. High status profession and pay leads to little sympathy from non-medical persons;

12. Family has no access to making its needs known to the hospital and/or clinic.

Family members (spouses, children, grandparents) and close loved ones are suffering greatly. Yet all effective medical care emerges out of paying close attention to a healthy and thriving family life. Effective diagnosis and treatment begins at home. As the neuroscience discovery of the “mirror” neurons reveals, we all share a common ancestral history; and this ancestral and family history is embedded, as Carl Jung noted decades before, in our “collective unconscious.” Our family history is present in our doctor-patient and our health-care practitioner/client relationships.

Principle No. 1 - Mission Statement

Most clinical care environments have articulated inspiring and idealistic mission statements. Usually these mission statements focus on providing the highest level of clinical care to all members of society without regard to income, social class, gender, or ethnicity. The *Hippocratic Oath* is a foundation of Western medical care.

“I swear by Apollo the healer, by Asclepius, Hygieia, by Panacea, and by all gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture.

To hold my teachers in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician’s oath, but to nobody else.

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course...But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.

In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.

– Translation by James Loeb

In almost all countries the *United Nations Declaration of Human Rights*, established in 1948, states the scope and scale of the universal right to health care. Article 25 states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and the necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

The practical wisdom in medicine was summed up by Drs. Francis Peabody and Edward Churchill years ago in their famous statements:

Francis Weld Peabody MD (1927): *“The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in the **personal bond**, which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”*

Edward Churchill MD (c1940): *“Charity in the broad **spiritual** sense, that is, our desire to relieve **suffering**, is the most prized possession of medicine.”*

Of course, in many medical and mental health systems of care, organizations are not able to fully achieve these lofty goals. Sometimes the highest quality of medical care is also not obtainable. Major gaps in achieving high quality effective health and mental health care

for all persons in need of medical care, as described by Peabody and Churchill, leads to moral confusion, disillusionment, and even despair in medical providers. The lack of achievement and true commitment to achieving the mission statement can be a major source of distress in the health care team. When clinicians work in a system where they are forced to break their moral and ethical principles, all the features of “burnout” set in. Burnout was first coined in the 1970s by the psychologist Herbert Freudenberger (NIH Informed Health.org December 5, 2012) to describe the consequences of severe stress and high ideals in the helping professions. Burnout can be described as is a “state of physical and mental exhaustion as a result of prolonged stress or frustration” (Merriam Webster’s Dictionary). Burnout is usually considered to be caused by a healthcare system where clinicians feel “ideals are compromised” and where they experience lack of control, inadequate social support, and excessive workplace demands. These circumstances threaten the values of caregivers and may lead downstream to moral injury; resulting in prolonged anguish and burnout.

In a time of crisis (e.g. war, COVID-19) the health disparities and inequalities of the mainstream healthcare system become exaggerated and visible. Vulnerable groups become even more vulnerable to illness and disease. It is especially painful to the staff when these gaps in care are not addressed in times of crisis.

Principle No. 2 – Clinical Excellence

A self-care environment maximizes scientific and cultural excellence in providing clinical care. Many systems of clinical care exist based upon different cultural models of illness and suffering. Clinical ignorance and incompetency in any model leads to poor self-care. Clinicians must strive to provide the highest level of excellence to their patients. Lack of scientific laboratories, medications, and surgical instruments can be a major self-care challenge. Probably the most common and serious self-care issue is the lack of access to scientific journals, books, conferences, trainers, the internet, and other avenues of scientific and cultural knowledge. Clinicians are physically and emotionally distressed when they cannot provide the “best care” possible. The ongoing education of all clinicians in evidence-based

medicine must be a top self-care priority. This includes proactive medicine. For far too long medicine has only focused on reactive medicine, which performs heroically when our patients are seriously ill to return them to a level of health. We must now provide primary care physicians and nurses the world over with knowledge and skills in proactive health promotion and illness prevention, so that the gratifications inherent in primary prevention and secondary prevention may restore enthusiasm and balance in their everyday practice of medicine. Alternative health models such as those embraced by mind-body-medicine (MBM) can be a very effective set of skills that has the benefit of advancing self-care and resilience not only in patients who integrate it into their lives, but, if practiced, in caregivers as well.

Principle No. 3 – Peer Supervision

Clinicians cannot work in isolation. Even in large hospital settings clinical staff can feel isolated from their peers and co-workers. Medical problems are often involved with such complex medical decision making, that a single individual medical provider is not capable of adequately making medical decisions. Many medical and psychiatric decisions are heart-breaking to staff, patients, and family. No medical textbook can help us out. Some decisions are at a spiritual level (e.g. termination of life-sustaining care) and are way beyond the skill and knowledge of a medical person. Some medical and behavioral health decisions are transference-counter-transference issues touching the personal life of the clinician and leading to denial and distortions in care. Every clinician caring for those who are emotionally and physically suffering need frequent contact with their peers in peer supervision. However, peer supervision is not therapy. Rather, peer supervision is an element of self-care where trusted colleagues provide peer support in a non-critical and non-judgmental atmosphere to their colleagues. A clinician might not only be denying there is an “elephant in the room,” but might also be touching only part of the elephant, not seeing the whole animal. Peer supervision will help the clinician bring the whole elephant into view. An excellent example of peer supervision is the Balint group model. More than 50 years ago, Michael Balint, a British medical doctor, created a small peer group structure for physicians to safely reflect

and discuss their challenging cases in a supportive environment. Balint's premise was that the doctor-patient relationship was at the therapeutic center of medicine. He famously emphasized the "the doctor is the drug." Since then, Balint groups have been used in training programs to provide peer support, and they remain an important component of peer support. Balint groups are especially valuable for supporting the clinical work of interns, residents, and new medical staff.

Today, considerable peer supervision occurs online, to include Smart Phones, and in private encrypted groups on the internet. The latter can become an excellent self-care approach, if used wisely. Rules for online and Smart Phone use, such as, being HIPAA compliant are extremely important and have been established. Most importantly, rules and procedures must establish a safe and secure trusted space for empathic communication. Aggression, criticism, and bullying must be closely monitored and properly curtailed. The online group leader has to role model of proper peer supervision, yet allow for differences and freedom of expression. While conflict will almost always occur, proper resolution can lead to a stronger group and online learning experience. The group must create a safe space for self-care reflection without making interruptions of "unconscious" material or drifting into a therapy group.

Principle No. 4 – Empathy

Empathy heals. Empathy is a biological miracle of our "mirror" neuron system that leads to deep relationships and reflection across culture, race, gender, ethnicity, and social class. But empathy is a double-edged sword. As William James warned, "the pain of the patient becomes our pain." The clinician absorbs the suffering of the patient and accumulates more and more pain and suffering over-time. It is easy for clinicians working in extreme environments (e.g. emergency rooms, oncology, ICUs) to become empathically over-loaded and develop what Professor Charles Figley has called "compassion fatigue," that is, the suffering of our patients has taken us over and has overwhelmed us.

Empathic regulation, the down regulation of high empathic distress and the up-regulation of low-empathic response, is a key element of self-care. The clinician must not only monitor their own empathic responses but also those of the patient. Patients also have a range of empathic responses to their caregivers. Empathic regulation can be taught based upon the new knowledge of the neuroscience of empathy. For example, the use of compassion meditation to increase empathic regulation can allow further immersion in the care of those who are suffering. In essence, an effective therapeutic relationship consists of “two persons, working in a community, in a shared empathic partnership, to create a new world view.” While the practice of “evidence-based medicine” is crucial, this healing journey based upon an empathic partner is a key ingredient in the relief of suffering. Neither approach is commonly taught to clinicians. Empathic regulation can be taught based upon the new knowledge of the neuroscience of empathy.

Principle No. 5 – Reflection

Reflection is a wonderful, age-old form of human expression expressed through reflective writing, art, music, dancing, poetry, and conversation. The cultural and scientific value of integrating reflection into clinical practice has been well-established.

Reflection is one dimension of self-care. It comes from the Latin root, *reflectere*, which means “to bend back.” Jumping to conclusions, always knowing the answer, not pausing to consider the consequent of one’s actions stifles the learning process – and may lead to poor clinical outcomes. The reflective process, in contrast, takes time to appreciate deeply the context, meaning, and potential impact of a thought, an action, or personal behavior. Reflection heightens awareness, insight, creativity, and leads to a process of continuous learning.

Reflection can enhance resilience. The ability to adapt to experiences of stress or adversity and maintain a stable trajectory of healthy psychosocial and physical functioning benefits from a sense of coherence that includes the quality of reflection, which is the ability to consider different perspectives and understand the importance of connectedness

(attachment). Reflection helps us marshal adequate resources to meet demands of difficult (separation) challenges. It can also help us balance positive (attachment) and negative (separation) experiences. When reflection aids our navigation of stressful times, it may contribute to *equanimity*. Equanimity can be thought of as our ability to return from a stress response physically and emotionally to a stable baseline response, called *allostasis*. Allostasis is stability in the face of inevitable change. The brain does the work of allostasis in keeping our physiological systems within a healthy normative range. When stress is overwhelming or persistent, an allostatic overload occurs. This can lead to metabolic wear and tear and be a precursor of chronic stress-related diseases.

When a stressful experience is managed with reflection, this is called stress inoculation. Stress inoculation will lead to resistance to future stressors. Reflection not only improves the physician's diagnosis and treatment capabilities, it also reduces distress, worry and despair in the clinician. But insight into ourselves, our patients, and our medical system is not always pleasant or benign. As we gain insight into ourselves and our work through reflection, we often have to confront disturbing thoughts and face painful realities. Sometimes as with prayer and meditation we have to pass through a very painful process in order to arrive at a more enlightened state.

Reflection that devolves into rumination about past mistakes and future worries adds to the allostatic loading. Meditation with mindfulness can anchor our mind's attention in the present and help us dampen rumination. Additionally, keeping a daily diary of clinical care, writing a brief daily Haiku or poem, or writing to an important patient once a month (in our own private notebook, not to be sent to the patient), may be enlightening and lead to a greater understanding of oneself and enhance a sense of wellbeing in one's clinical practice.

Principle No. 6 – Mindfulness, Meditation, and Prayer

Mindfulness is the “awareness of one's internal states and surroundings” in which a person focuses attention on his/her breathing, thoughts, feelings, and sensations as they occur (American Psychological Association Dictionary). Mindfulness involves non-judgmental

attention to experiences in the present moment to achieve self-awareness and transcendence in everyday life. Practitioners start with **Focused Attention** (emptying the mind of everyday thinking to decrease mental proliferation and focus on a single point, e. g, breath, word, phrase, prayer) to elicit **relaxation response**. They then move to **Insight/Open Monitoring** (having no object of focus but receptive in a nonjudgmental way to all physical and mental phenomena that arise). Eventually they can then add **ethical value qualities** (loving-kindness, compassion, self-compassion, forgiveness); or can use **visual imagery** and add hypnotic suggestion for analgesia for example. Mindfulness practices are thought to enhance attention and the emotional regulation of fear and anxiety. As mentioned above, use of compassion meditation can increase empathic regulation and allow further immersion in the care of those who are suffering.

Meditation is to engage in mental exercise (such as concentration on one's breathing or repetition of a mantra) for the purpose of reaching a heightened level of spiritual awareness (Merriam Webster Dictionary). Meditation takes advantage of our innate ability to breathe deeply and slowly. When we attend to this type of breathing exercise and break the train of everyday thought, certain beneficial physiological effects can result. Integrated physiological mechanisms are entrained when a subject engages in a **repetitive mental or physical activity** and passively ignores distracting thoughts. These changes include reductions in heart rate and blood pressure as parasympathetic tone increases and sympathetic tone decreases. Oxygen consumption goes down as respiratory rate declines. A positive energy balance ensues. Many meditation vehicles to achieve this so-called relaxation response have been designed over the eons in many cultures.

Meditation and mindfulness have earned significant advances in clinical value due to extensive clinical research. Meditation and mindfulness not only are significant tools in relieving anxiety and distress in staff and patients, they are all daily practices to enhance clinical wellness and wellbeing, as well as to promote ethical and altruistic behaviors. One mindfulness practice that enhances empathic interviews with difficult patients with a significant trauma story is "deep breathing." Deep breathing exercises, easy to lead and practice, can be used before, during, and after treating a very difficult and stress patient. Other

cognitive behavioral approaches include focusing on a color card or mentally reflecting on the happiest moment in one's childhood when distressing thoughts occur.

All meditation approaches are very useful in dealing with the pain and suffering associated with clinical care. It is especially useful in dealing with secondary traumatization. Secondary Trauma is “the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder.”

Mindfulness and meditation are primarily concepts derived from Buddhism, which leads to a discussion of prayer and spirituality. In many self-care programs using mindfulness and meditation, the latter are taught in a secular manner. This was not the prescribed intentions of these techniques, which were used to enhance Buddhist prayer and spirituality. In some settings, Christian meditation, a form of prayer, is used in a structured way to become aware of the power and revelations of God (see the *World Community for Christian Meditation*).

The role of meditation as a spiritual practice in Western medicine is not well-accepted although the power of spiritual practices to affect the state of clinicians in a positive way has been well-established. Daily prayer based upon one's religious orientation (e.g. the Bhagavad gita, the Bible, the Koran), may be a valuable self-care practice.

Principle No. 7 – Personal Self-Care Practices

Personal self-care practices are scientifically well-established health promotion instruments for the prevention and treatment of medical illnesses, and the promotion of wellness and wellbeing. These practices build upon the resiliency of staff and patients, promoting increased self-efficacy and agency. Poor self-care and the clinical states associated with the latter can lead to negative personal behaviors such as drinking, use of prescription drugs, opioid addiction, cigarette smoking, and high-risk sexual behavior. These clinical states can also become manifested as a lack of meaningful time with family and friends. Indeed, a major threat in using substances to assuage the pain and anxiety of ministering to those with

suffering is that these substances tend to hijack our normal receptor mediated sources of pleasure and solace, leaving these normal healing attachment experiences relatively impotent.

Evidence-based personal self-care practices have been developed. One such program was created at the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital. It is called the Stress Management and Resilience Training (SMART) program. This program is a composite 8 week, 2 hour a week immersive program that engages the person, either individually or in a group setting, in the learning of eight different meditative ways to elicit the relaxation response while the major components of human resilience are enhanced. The emphasis in the SMART program, which has been shown to effect changes at the gene expression, physiological and psychological levels, has been on integrating the following into the lives of participants:

- ▶ Healthy Behaviors;
- ▶ Social Support;
- ▶ Pro-social Activities that create vitality and prosperity;
- ▶ Cognitive Skills to avoid negative thinking distortions;
- ▶ Positive Psychology;
- ▶ Problem Solving Skills as well as Acceptance;
- ▶ Spiritual Connectedness and Compassion Training.

The beauty of this program is that it can be taught to clinicians (SMART) and to lay people in an educational version called the Positivity and Resilience Training (PART) program. A virtual telemedicine version has been shown to be effective. And a train the trainers approach can be provided.

One major self-care rule is: *take care of your family and loved ones first*. Put the medical record in its proper place and do not spend valuable family time on the computer screen. The latter will not assist you with a marital problem or a problem with kids – but may help cause the latter.

A proper, healthy diet with mindful eating and being present with the family at the dinner table is crucial to a healthy, well-balanced life. Put aside all devices when talking to family and friends. In most cultures, “food is love” – So spend time eating delicious, healthy foods with your loved ones on a daily basis.

Exercise is the new “miracle” drug that has been shown to improve mood, healthy feelings, reduce depression and posttraumatic stress disorder and lead to an overall higher quality of life. Even limited exercise is beneficial at any age (e.g. a 20 minute walk a day).

Principle No. 8 – Natural Environment

There is no healing without beauty. The healing environment is most therapeutic and restorative if it is a beautiful environment that reflects the culture and local community of the patient. Often the actual physical environment is sterile, ugly, and depressing. The British nurse, Florence Nightingale, in 1884 defined a healing environment as fresh, full of light and clean air, spiritual, and full of nature. The four elements of a *Healing Environment* defined by Richard F. Mollica M.D. and his colleagues include: 1) the physical setting, 2) the relationships inspired by the setting, 3) healing forces activated and operating in the setting, and 4) demonstrated positive outcomes.

An extensive scientific literature review has revealed the therapeutic power of plants and pictures of nature to reduce the stress of clinicians and their sick patients as well as enhance the patient’s capacity to heal. The therapeutic impact of nature walks, office plants, and spending time with animals is highly recommended as a daily self-care practice.

Principle No. 9 – Evaluation

How do we know if our self-care efforts and protocols are helping to improve our well-being? The clinical team must establish realistic self-care goals and evaluate the impact of these goals on the staff. Evaluation would include the actual implementation of practices and procedures related to the self-care goals. The transformation of the administrative

worldview of the health care system or clinic to a self-care-friendly environment is always the most difficult to assess. Qualitative approaches and key-informant interviews can contribute to assessing transformative changes at the staff level. Simple quantitative methods and surveys can determine what self-care practices have been implemented, frequency of the practice, attendance, and staff motivation and interest in using these practices. In this way practice barriers can be overcome and the practices themselves strengthened. The actual impact of the self-care practices on, 1) knowledge learned, 2) behaviors changed, and 3) outcomes achieved, can be assessed. Outcomes can include improvement in healthy lifestyle, family engagement and prevention/reduction in the symptoms of burn-out, compassion fatigue, and secondary traumatization. While many validated scales exist to assess the latter, a self-care protocol is focused on more than disease prevention. A new self-care evaluation scale can be developed by each agency to assess each of the ten areas of self-care in addition to an assessment of the illness phenomena assessed by current scales.

Principle No. 10 – Restoring Human Dignity

Health care workers at all levels in mainstream and traditional societies (e.g. surgeons and traditional healers) are a key to the preservation of health and wellbeing in the community. They are a national, local, and community “good” that needs to be “treasured by society.” It is therefore mandatory that the health and wellbeing of all healers and their associates be protected and nurtured.

Illness and suffering in health care staff and patients can diminish a person’s humanity. Illness can be associated with pain, disfigurement, and disability. Illness and disease can lead to social withdrawal, social isolation, and stigma. For example, society can reject those who are seriously mentally ill. Learned helplessness and a lack of self-efficacy and personal agency to work and contribute to the family and a job can set in. Illness and disease can and often does have an enormous impact on a sense of wellbeing caused by feelings of despair, hopelessness, humiliation, and shame.

The damage and illnesses caused by impaired self-care in health care staff not only causes a loss of self-respect and human dignity in the individual provider, but also in the entire clinic, the hospital, and the society itself. Injury to our medical and mental health staff is a form of social violence. The negative cascading effect of this violence on the individual and the entire community of practitioners is enormous. Ultimately a self-care protocol must aim at maintaining and restoring all human health care workers and their patients to the highest level of human dignity.

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