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The next issue of the *South Central MIRECC Communiqué* will be published September 3, 2010. Deadline for submission of items to the September newsletter is August 27, 2010. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at Ashley.McDaniel@va.gov

South Central MIRECC Internet site: www.mirecc.va.gov/visn16

National MIRECC Internet site: www.mirecc.va.gov

TELEMENTAL HEALTH: A FRONTLINE PERSPECTIVE

By: Russell Smith, Ph.D.

Tele-Psychologist, Oklahoma City CBOCs

The purpose of this article is to describe TMH and the steps to implementing the program in CBOCs. Telemental health (TMH) is a great tool for providing care to Veterans living in rural communities. Typically, psychiatrists and psychologists who are located at VA medical centers (VAMCs) use distance video technologies to provide mental health care to Veterans at local CBOCs, removing the burden of long distance travel for patient and provider. The provider can see and speak with the patient and the patient can see and speak with the provider over special video screen. My own TMH work differs in that I provide TMH from my location at the Wichita Falls, Texas CBOC to Veterans at six CBOCs in Oklahoma City.

Although people talking through a television screen seems simple, the organization and technology behind TMH can be complex. My TMH team includes mental health (MH) providers, clinical chiefs and supervisors, and IT support. My teammate, Nilam Patel, M.D., provides psychiatry from the Oklahoma City

VAMC to eight of its CBOCs via telemedicine. Her practice is dedicated to the telepsychiatry portion of our program. Together, we receive strong support from our service chiefs and supervisors, Drs. Jeanne Morgan, Barbara Masters and Bill Leber, while Jrod Cunningham provides technical support. I would like to thank the many other people working in this effort, but I do not have space to name them all in this article. However, I especially want to mention the Patient Service Assistants (PSAs) and Primary Care physicians (PCPs) in all of our CBOCs. We rely heavily on their efforts to schedule Veterans and to be the initial positive face of the TMH program.

Two years ago, I joined the Oklahoma City VAMC after twenty years of private practice as a psychologist. My wife, Tracy, and I like living in small communities, and I have enjoyed providing MH care to rural communities for most of my professional life.

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Telemental Health: A Frontline Perspective continued...

Because telemedicine allows the provider to be in any location, Dr. Morgan offered me the telepsychologist position for Oklahoma City CBOCs while allowing me to remain stationed in Wichita Falls at a contract CBOC. Currently, I provide TMH to six Oklahoma City CBOCs and face-to-face care in Wichita Falls.

Implementing the TMH program in a rural CBOC presented some challenges, most of them logistical. When I arrived at Wichita Falls, there were no VA computers on station. As a result, I used my personal email account to communicate with Oklahoma City. Once the technological wrinkles were ironed out, I tackled my first step in establishing a TMH psychology program, understanding the telemedicine equipment. Starting with how to turn it on, Dr. Patel provided me with the basics of using the equipment to complete a session. Next, I learned the characteristics of the CBOCs with which I would be working. It is my policy to make an initial site visit to any clinic joining TMH to introduce myself and to educate the staff about the program. Although my current schedule does not allow regular repeat visits, it would be ideal to visit program sites at least annually.

My next step was to make sure every CBOC using TMH services had a written emergency/crisis response protocol that conforms to VHA requirements. In every case, Dr. Patel and I act as advisors to the CBOCs for Veterans in crisis. We must have a minimum of two methods to contact providers in each CBOC. Furthermore, every Veteran, no matter the level of risk, receives a VA Suicide Prevention wallet card and is taught how to call the suicide prevention hotline during crisis situations. As TMH providers, we make sure we understand the CBOC's logistics when dealing with an emergency/crisis patient. Each clinic is unique and understanding their differences makes the establishment of a new TMH program run smoother. Visit the Rocky Mountain Telehealth Training Center website at www.carecoordination.va.gov/index.asp for more information on emergency/crisis protocols and guidelines.

The best way to view a TMH program is to consider it as being embedded in Primary Care practice. PCPs simply

add TMH providers as a co-signer on the Veteran's medical record in the Computerized Patient Records System and ask their PSAs to schedule an initial visit. As the telepsychologist, I do an initial evaluation with Veterans at Oklahoma City CBOCs who haven't previously seen a mental health provider. To get over my initial discomfort with seeing patients over a video link, I remind myself that this is a patient who needs the service of a provider, a service that without TMH probably would not happen. My evaluation provides the basis for MH treatment and can give the telepsychiatrist insight into the Veteran's needs, which are no different from the needs of Veterans seen in person. I have found that the evidence-based therapies to which the VA currently subscribes work well using TMH. I have not had to vary any of the cognitive-behavioral therapy (CBT) techniques that I use with the Veterans in TMH. In fact, I believe that TMH is well suited for CBT approaches to care, which tend to be directive and goal specific.

Ironically, the greatest issue facing the program is our success. Dr. Patel and I find ourselves at capacity for providing TMH to patients. From January to May 2010, Dr. Patel has had 970 patient encounters, of which 951 were unique. I have had 644 patient encounters, of which 597 were unique. We would like to increase efficiency by centralizing scheduling. Currently, we rely on the PSA at each CBOC to control that CBOC's TMH schedule, which can lead to some scheduling conflicts for the providers. Because each clinic has limited time slots, these schedules have no leeway and we cannot schedule a Veteran in an unused slot. Centralized scheduling would allow us to give unused appointments quickly to Veterans from other CBOCs. We also need to increase the number of TMH providers in the program. Presently, I cover seven clinics in 5 days while Dr. Patel covers eight clinics in 5 days. As a result, new and return visits can be spread out over extended time periods. However, our schedules fill quickly and patients often need to wait for openings. Therefore, I shamelessly conclude this article by asking readers to become telepsychologists or point us in the direction of more funding! – *For more information about TMH, contact Dr. Smith at Russell.Smith3@va.gov.* ■

SC MIRECC ACKNOWLEDGEMENTS

The SC MIRECC congratulates John Fortney, Ph.D., SC MIRECC Associate Director for Research, and his study team for the “Telemedicine-Based Collaborative Care” intervention's designation as an evidence-based practice by SAMHSA. The intervention is now listed on SAMHSA's registry of evidence-based practices. Dr. Fortney was the principal investigator for the study.

Congratulations to the SC MIRECC researchers who presented talks and/or posters at the “Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans” national VA Mental Health Conference in Baltimore, MD, July 27-29, 2010:

Assessment of Sexual Health of OEF/OIF Veterans as Part of Routine Care (Poster)

Drew Helmer, M.D., MS, Andrea Bradford, Ph.D., Heather Honore, Ph.D., Michael Kauth, Ph.D., David Latini, Ph.D.

An Intensive Weekend Treatment for Panic Disorder in OEF/OIF Veterans with Comorbid PTSD (Poster)

Ellen Teng, Ph.D., Sara D. Bailey, Ph.D., Nancy J. Petersen, Ph.D., Nancy Jo Dunn, Ph.D., Angelic D. Chaison, Ph.D., Melinda A. Stanley, Ph.D.

Connecting in Cyberspace: How to Create a Community of Practice (Presentation)

Mary Sue Farmer, Ashley McDaniel, M.A., Kimberly Arlinghaus, M.D.

Developing Innovative Clinical Research Approaches with Returning Veterans (Presentation)

Ellen J. Teng, Ph.D., Carrie Dodrill, Ph.D., Kimberly Arlinghaus, M.D.

Factors Predicting Psychiatric Inpatient Mortality in a Long-term Follow-up. (Poster)

Wright Williams, Ph.D., ABPP, Justin Springer, Ph.D., Melissa Beason-Smith, M.A., Mark Kunik, M.D.

Implementing Telemedicine-Based Collaborative Care for MDD in Contract CBOC's (Presentation)

John Fortney, Ph.D.

Sexual Health Needs Assessment in a Primary Care Sample of OEF/OIF Veterans (Poster)

Andrea Bradford, Ph.D., Drew A. Helmer, M.D., Heather Honore, Ph.D., Michael Kauth, Ph.D., David Latini, Ph.D.

Which Psychological Factors Predict the Long Term Development of Heart Disease in Psychiatric Inpatients? (Poster)

Wright Williams, Ph.D., ABPP, David Graham, M.D., Mark Kunik, M.D.■

AUGUST CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

| | ACCESS CODE |
|--|-------------|
| 9 MIRECC Site Leaders, 11:00 AM CT | 27761# |
| 10 MIRECC Leadership Council, 3:30 PM CT | 19356# |
| 12 National MIRECC & COE Education Group, 1:00 PM CT | 28791# |
| 17 VISN 16 Mental Disaster Team, 11AM CT | 76670# |
| 18 MIRECC Program Assistants, 2PM Central | 43593# |
| 23 MIRECC Education Core, 3:00 PM CT | 16821# |
| 24 MIRECC Leadership Council, 3:30 PM CT | 19356# |
| 26 National MIRECC & COE Implementation Science discussion, 2:00 PM CT | 59066# |

MEET THE MIRECC RESEARCHERS: GINA EVANS, PH.D.

Interview with Gina Evans, Ph.D.

Assistant Professor, Baylor College of Medicine
Chronic Disease Prevention & Control Research Center

What is your area of research?

As a behavioral interventionist, my overall program of research focuses on decreasing physical and mental health disparities among obese underserved persons with coexisting mental illness. My initial area of research investigated contextual factors that contributed to obesity related eating habits. These findings highlighted the need to tailor strategies to improve maintenance of healthy eating habits and the variability in eating responses associated with negative emotions. The findings from this study prompted a deeper exploration of the impact of mental health symptoms on obesity self-care. Subsequently, I created and tested an enhanced brief stroke self-management intervention among obese and underserved racial ethnic minorities. The results from this study detailed how depression and anxiety impact fruit and vegetable consumption, exercise, tobacco usage and medication adherence. The next stage of my work will investigate how to translate these findings to improve obesity self-care among rural Veterans with co-morbid mental illness.

What active studies do you have going?

Negative social determinants of health significantly impact disparities in obesity related health outcomes. I was awarded a National Institute of Diabetes and Digestive and Kidney Diseases Diversity Supplement to examine the effects of social determinants of health and mental health symptoms on type 2 diabetes self-care among obese African Americans and Latinos. Specifically, I am examining how community resource utilization, social networking and depression impacts weight management and exercise. This study is in the data collection stage and will conclude in 2011. The findings from this study will inform a pilot study that examines the feasibility of a self-care behavioral treatment for obese rural Veterans with coexisting symptoms of anxiety with a specific emphasis on increasing community resource utilization.

What are the implications or potential benefits of your research?

My research has educational, clinical, and policy relevance. I have developed educational self-care materials that have been used in patient and clinician-focused health education workshops. This dissemination has allowed chronically ill persons with limited access to health services to receive needed self-care instructions. It has also increased clinicians' understanding of the systemic patient barriers to implementing their clinical recommendations, thus, allowing clinicians to tailor their treatment recommendations to patient lifestyle and health care needs. My translational research will have policy relevance by detailing the need for adopting culturally appropriate and community resource integrated health care services.

How did you get started in this area of research?

My dedication to building a research program and providing clinical services to improve poor self-care habits in underserved groups was first evidenced in my doctoral program. As a doctoral student in Counseling Psychology at Ball State University, I learned how to examine racial differences in mental health outcomes. My health psychology internship at the University of Missouri Hospital and Harry S. Truman VA Medical center provided a deeper understanding of the relationship between physical and mental health outcomes. I gained a broader understanding of how social determinants of health impact physical and mental health outcomes in my combined Baylor College of Medicine and MD Anderson Cancer Center sponsored Kellogg Health Scholars postdoctoral fellowship training. As a junior faculty member, I have been continuously honing my content knowledge and research skills to become an independent obesity health disparities researcher.

What person or experience had the most influence on your research career?

Witnessing the effects of poor health habits among my family members and patients influenced my research career.

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Although there are physical and mental health resources, access and affordability issues cause many of these services to be underutilized. As a result, I wanted to build a research program that would decrease access barriers and improve clinical practice and outcomes.

What advice would you give to junior investigators and to people who are new to research?

It is difficult to establish a successful research career. This becomes an even greater challenge for racial ethnic minority researchers and those who adopt a health disparities research agenda. Receiving strong mentorship is perhaps the most important factor to successfully beginning a research career. A mentee should identify a senior mentor who: (1) is accessible, (2) can provide consistent feedback, editing and networking opportunities, (3) has a successful track record of securing large grants,

(4) provides opportunity to work with them on their projects, and (5) helps the mentee develop a unique research niche. In addition, a new investigator should become familiar with federal and foundational funding institutes and program officers. Having a relationship with the program officer can help you identify funding priorities. Mentees should spend a significant amount of time fine-tuning manuscript and grant writing skills. Building collaborative relationships with other investigators is also highly important. Collaborative relationships allow you to complete more projects and expand your research agenda.

How can people get in touch with you if they have questions about your work?

I can be reached at ginae@bcm.edu for any questions about my research agenda or areas of potential collaboration. ■

RECENT MIRECC PUBLICATIONS

THE LINK BETWEEN PTSD AND PHYSICAL COMORBIDITIES: A SYSTEMATIC REVIEW

Qureshi SU, Pyne JM, Magruder KM, Schulz PE, Kunik ME

Psychiatr Q, 2009, 80(2):87-97

Introduction by Salah Qureshi, Ph.D.

This systematic review was my first research project as a MIRECC fellow. It was also the first step towards exploring the association between PTSD and co-morbid physical illnesses, particularly dementia. I want to focus on this topic because PTSD is on the rise in returning OEF/OIF Veterans, and we know very little about physical comorbidities associated with it. This review confirmed that only a few studies have examined the link between PTSD and specific physical disorders. Arthritis was the only disorder that was consistently found to be associated with PTSD in three of four studies, followed by gastric ulcers with two positive studies. The remaining associations were found in only single studies or the results conflicted. The most surprising finding to us was that no one had examined the relationship between PTSD and dementia, despite the fact that PTSD is associated with cognitive impairment.

This led me to my database study in which I explored the association between PTSD and co-morbid physical illnesses, particularly dementia. With the help of my mentor, Dr. Mark Kunik, I was able to put together an excellent research team across various disciplines from VA hospitals in Houston (Paul Schulz, Nancy Petersen),

Little Rock (Teresa Hudson, Jeff Pyne, and Tim Kimbrell) and Charleston, SC (Kathy Magruder). It includes faculty members with backgrounds in psychiatry, neurology, biostatistics, psychopharmacology and epidemiology. We have biweekly telephone conference calls where we discuss the progress of our research projects. Initial results from these projects have been very interesting, and I am hoping that they will improve our understanding of PTSD and its comorbidities. I believe these are under-appreciated, but appropriate attention could have a substantial impact on Veterans' quality of life and the use of VHA resources.

Abstract

Returning Veterans from Afghanistan and Iraq will show increased frequency of post-traumatic stress disorder (PTSD). Little is known about PTSD's impact on physical health. research reports focusing on PTSD and its association with physical health were selected for the study.

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Studies investigating only PTSD symptoms, trauma and physical disorders classified at the organ-system level were excluded.

The objective of this study was to complete a systematic literature review focusing on the association between PTSD and specific physical disorders. Data sources included an electronic search using PUBMED and hand search of four journals with an anxiety focus for studies published between January 1981 and July 2008, plus a manual search of article bibliographies. Original

Eighty studies were reviewed and seven selected for final analysis. Specific physical-health diagnoses were organized by system and tabulated. They were considered positive only if results were statistically significant. The total number of positive and negative studies for each diagnosis were then calculated for review. We found seven studies that examined the relationship between PTSD and specific physical disorders. Arthritis was associated with PTSD in most studies. Data conflicted regarding diabetes, coronary heart disease, and stroke. We concluded that few studies have examined the relationship between PTSD and physical health. Large, prospective epidemiological trials are needed. ■

RURAL HEALTH RESOURCES UPDATE

Challenges for Improving Health Care Access in Rural America

In the discussions leading to the passage of the Patient Protection and Affordable Care Act, the U.S. Department of Health and Human Services' Office of Health Care Reform requested research and policy analysis studies on a variety of key rural health care issues from some of the Rural Health Research and Policy Analysis Centers. This compendium is a collection of those twenty-four research and policy analysis studies.

Challenges for Improving Health Care Access in Rural America presents the studies according to subject matter from health insurance and its financing to health workforce. The Office of Rural Health Policy is releasing this compendium to fuel continuing discussion of the challenges facing rural communities as they implement health systems reform generated by the Patient Protection and Affordable Care Act and by other policy changes. For more information contact Joan F. Van Nostrand, DPA, Director of Research, Office of Rural Health Policy at jvan_nostrand@hrsa.gov. For a copy of the compendium visit: http://www.raconline.org/pdf/research_compendium.pdf.

The Patient Protection and Affordable Care Act: A Summary of Provisions Important to Rural Health Care Delivery

This paper provides a consolidated summary of legislative provisions contained in the Patient Protection and Affordable Care Act of 2010 (PPACA) that have particular meaning to rural residents and to the delivery of services in rural areas. Changes from the Health Care and Education Reconciliation Act of 2010 are incorporated. This paper serves as a rural roadmap of the PPACA for use by advocates, analysts, practitioners, and policy makers focused on rural health as they continue the important task of improving the system as it affects rural interests. Included in the paper are rural-relevant highlights of the legislation and detailed tables for each section. For more information contact Keith J. Mueller, Ph.D., Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis at 319-384-5120 or keith-mueller@uiowa.edu. For a copy of the paper, visit: http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06_08_10.pdf.

RECOVERY CORNER

EMERGING INTEREST IN COMPASSION FATIGUE/BURNOUT WITHIN THE VETERANS HEALTH ADMINISTRATION

By: Jennifer Halter, LICSW, DCSW
Social Worker/Local Recovery Coordinator
Oklahoma City VA Medical Center

The role of helper can be stressful, even if the helper really enjoys the work. This is called eustress, which is a healthy kind of stress. It gives people energy to continue to work well. The opposite, distress, is what makes the news. Distress contributes to people feeling less well or overwhelmed. Distress among health care providers, like those in the Veteran Health Administration (VHA), occurs in the form of compassion fatigue and burnout. These are people who want to help but find that personal resilience to distress and/or the systemic resilience is low. The research on burnout supports addressing individual as well as systemic factors, which may play a part in the development of or resistance to burnout.

Burnout is the result of chronic stress (Cushway et al, 1996). It was once thought that only those of weak constitution got burnout. The only response was to weed out the weak. More recent research on burnout identifies that even seasoned professionals will experience symptoms of burnout during a career. "It's not a matter of *if* a provider will develop burnout. It's a matter of *when* a provider will develop burnout." (Boniello, 2010). The mental health field recognizes that working with people can be stressful to the provider. Providers working in the area of trauma normalize the development of symptoms in providers as vicarious trauma (Pearlman & Saakvitne, 1995). The vicarious trauma research recognizes that providers are mentally affected by the work they do. On the positive side, helping people with mental health symptoms can be rewarding, it gives us energy and a sense of purpose. On the negative side, we're at risk for developing mental health symptoms ourselves.

Research on medical care providers, including nurses, often uses the Maslach Burnout Scale. It is used to measure burnout in human services professions. Maslach defines burnout as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity (Angermeyer, et al, 2006). It is a continuous variable with varying degrees of intensity and effect. This is the reason burnout can be insidious; it can creep up on you.

The research on nurses and physicians reveals that a two-pronged approach to building resilience to burnout is most effective. Organizations intending to manage the effects of burnout can help individuals build resilience to stress or burnout by encouraging adequate support, stress management, and personal care. However, when providers try to implement personal resilience into their lives, the organization in which they work might push back. Some organizations continue to feed the message that being a team player means working without compensation, working through lunch, being available whenever the organization needs that person – even expecting cancellation of vacation time. This type of dilemma tends to contribute to burnout and poor morale, which has an adverse effect on health care organizations' care and resources.

Fortunately, research studies are exploring the impact of organizational policy on its workers. Recommendations include making changes in staff to patient ratios, improving training, team building, reducing administrative tasks, clarifying roles, attending to toxic co-workers and leaders. There is recognition in this field of research that unhealthy organizational policies and unhealthy leadership behavior can contribute to burnout. These factors create a situation in which even mature professionals may experience burnout despite their best personal resilience behavior. Recommendations include training administrators and staff concurrently about burnout (Boniello, 2009).

The VHA National Local Recovery Coordinator Compassion Fatigue Work Group identified early efforts within the VHA to buffer medical staff from the effects of burnout. The Zablocki VA Medical Center (VAMC), Palliative Care Unit in Milwaukee, Wisconsin takes time out of the schedule weekly to remember the Veterans who died and openly discuss the effect that Veterans and the Veterans' families had on the unit staff (Smith, 2009).

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Anecdotally, the staff feels supported in their grief, which allows them to continue their important work with other Veterans and families. Also within the Zablocki VAMC, Dr. Heather Smith and Dr. Zoua Chang undertook a survey of mental health staff using the Mental Health Professional Stress Scale (Cushway, Tyler, & Nolan, 1996) as well as measures of staff attitudes, perceptions, knowledge, and behaviors regarding their self-care strategies for coping with job stress. The primary purpose of the study is to document levels of burnout, organizational and occupational factors affecting stress among staff, and self-care strategies of employees in VA mental health settings. The data are collected and are now in the analysis stage, and it is hoped that the results of the study will inform the development of interventions to reduce perceived stress and enhance coping among VA mental health providers.

As the Local Recovery Coordinator work group shares information among our colleagues in mental health, we learn that there is growing awareness of the impact of burnout on VA personnel. Our mental health services are changing to better serve Veterans and may also have the effect of building resilience among mental health care providers. For example, the shared caseloads of the Mental Health Intensive Case Management program may serve as a resilience factor for staff working within these programs.

The Office of Mental Health Services at VA Central Office directed the development of a subcommittee this year to explore the impact of burnout on VA personnel. Further, there is interest in the South Central Mental Illness Research, Education, and Clinical Center (MIRECC) to investigate burnout/resilience in the VHA (McDaniel, 2010). Clearly, the energy around the topic of burnout and staff resilience is building.

As we work toward helping Veterans build resilience and continue their journeys of recovery, might we also attend to the resilience and recovery journeys of VA personnel as well? After all, roughly 25% of VA and VHA employees nationally are Veterans (US Office of Personnel Management, 2007/2006). There is virtually no research on the extent of burnout among VHA providers. Perhaps it's time to collect data to determine if burnout is a factor affecting the VHA. With the increase in demand for VHA services, the data might provide a richer context with which to guide organizational decision-making.

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