PTSD 101
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COURSE TRANSCRIPT FOR:
Vicarious Traumatization: Towards Recognition & Resilience-Building
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Slide 1: Vicarious Traumatization: Towards Recognition and Resilience-Building

Hi, this is Fred Gusman. I'm the Director of the National Center for PTSD-Education Division and Clinical Laboratory at the Palo Alto VA Healthcare System.

Slide 2: Overview

Today's topic is vicarious traumatization. You might be wondering, why are we talking about vicarious traumatization as it relates to providers? Well, it's been my experience over the last three decades that many of us who provide immediate care, whether it be as emergency workers, first responders in disaster, or working in an outpatient setting or an inpatient setting (a specialty program dealing with victims who have been traumatized) that there is potential there for the healthcare providers also to suffer from some sort of vicarious traumatization.

So today, what we're going to do is get a better understanding of what is vicarious traumatization and what can we do about that, what kind of preventative measures can we take. So first, we're going to look at recognizing vicarious traumatization and related concepts. Second, we'll describe how vicarious traumatization changes basic assumptions about self, others, and the world. Third we'll recognize variables that increase the risk of vicarious traumatization. And fourth, recognize when vicarious traumatization is interfering with self or the provisions of care. And last but not least, identify methods to support and increase resilience and positive coping for those of us who care for victims of trauma.

Slide 3: Traumatic Stress: Recognition

Let's take a look at some major terms in regards to traumatic stress so that we can differentiate between what victims experience and what primary care providers and other healthcare professionals experience. The major terms we're going to look at will be: primary traumatic stress, secondary traumatic stress, vicarious traumatization, and compassion fatigue.

Slide 4: 1. Primary Traumatic Stress

Most of us are very familiar with primary traumatic stress. That is the direct exposure to or witnessing of an extreme event and one is overwhelmed by the trauma.

Slide 5: Primary: Experience the Trauma

Here, you're seeing a photo of some Marines from Falujah where we have four Marines who are tending to, rather three Marines, who are tending to a fallen Marine. Each one of these men will have a different experience as regards to this particular situation. We have to keep in mind that trauma is a violation of self, and is an individual experience, not a group experience even though in this photo we see them as a group.

Slide 6: Secondary Traumatic Stress

Secondary traumatic stress. What is that? Well, that's the direct exposure to extreme events directly experienced by another and one is overwhelmed by the trauma.

Slide 7: Secondary: Witness to Trauma

Again, we're looking at that same photo of the four Marines, one is wounded. As you can see, two are providing care and the other is observing. So each one of these folks, these Marines again, depending upon their activity in regards to this particular scene, will dictate whether or not it's primary traumatic stress, or they're witnessing the trauma.

Slide 8: 3. Vicarious Traumatization (VT)***

Vicarious traumatization. The definition for that-- that we're using today is the phenomenon of the transmission of traumatic stress by bearing witness to the stories of traumatic events. So vicarious traumatization can be experienced from once to numerous times. So now we're really talking about us – those of us who interface every day in our professions with victims of trauma.

Slide 9: Vicarious: You Hear About the Trauma

So again we're seeing this photo for the third time but in this regard, think of this as you being told the story of what happened and getting the sense-- depending upon which Marine you're experiencing it from will sort of have some sort of connection with you, not only clinically but possibly impact some perception of yourself in some regards.

Slide 10: VT: Natural Process

So vicarious traumatization-- consider it as a natural and inevitable response to spending significant time working with or studying trauma survivors. So in other words if you're seeing in your caseload a number of veterans, or if you're with the Department of Defense in uniform you're seeing a number of active duty reserve and guard, then you, you are inevitably/possibly going to have some kind of natural response to hearing these stories over and over and over again.

Slide 11: VT: Soul Weariness

Soul weariness. That's something that might not be very familiar to many of us, but here's a definition. There is a soul weariness that comes from caring, from doing business with the handiwork of fear. Sometimes it lives at the edges of one's life and at other times it comes crashing in overtaking one with its vivid images of another's terror with its profound demands for attention, nightmare, strange fears, and generalized hopelessness.

What comes to mind when I think of soul weariness is a therapist who is in uniform or working at a military base dealing with men and women who are being redeployed to Iraq. And, because of the tremendous caseload-- this particular therapist is hearing these stories without very much of an opportunity to have a break or distance himself. And, it's only natural that because they also have some identification being in uniform, in other words being in the military as well, that it can have an effect on him. Another way to describe what they're experiencing is that there's a sort of a soul weariness which comes from caring, sort of identifying and its very much difficult not to be able to identify with the people they are serving.

Slide 12: VT of the Provider: Definition

Okay, let's take a look at vicarious traumatization of the provider and take a look at a definition here.

Vicarious traumatization is the transformative effect upon the provider of working with survivors of traumatic events. So what we're really saying is that because one is working with survivors, there is a potential for transferring over some of the effect that we're hearing from those who are telling us their stories.

Another is a process through which the provider's inner experience is negatively transformed through empathetic engagement with the client's trauma material. Some people might confuse that with transference and counter-transference. We'll get into that a little further.

Slide 13: VT: What it Isn't

Okay let's take a look at what vicarious traumatization isn't. One, it's not counter-transference, the process of over identifying with the client or of meeting one's needs through the client. It's also not burnout, a state of physical, emotional, mental exhaustion caused by long term involvement in an emotionally demanding situation.

Slide 14: 4. Compassion Fatigue (CF): Cumulative Trauma

It's also not compassion fatigue, which is basically the cumulative buildup over time of primary traumatic stress. (Remember primary traumatic stress is the direct trauma experience of the provider.) And, Secondary traumatic stress, which is the indirect witnessing of other's trauma. And third, vicarious traumatization (bearing witness to other's traumas through listening to their stories).

Slide 15: Traumatic Stress: Types

Here you see a graph of traumatic stress types. You see primary, secondary, vicarious, and compassion fatigue. And what we're trying to illustrate here in this graph is that, primary, secondary, and vicarious traumatization can actually add up to or be very much a part of the overall spectrum of compassion fatigue. What we've done in the last few minutes is try to break this down for you.

Slide 16: Compassion Fatigue: Symptoms

So let's talk about compassion fatigue, and its symptoms.

One, is the preoccupation with the client's traumatic events.

Two, avoidance and numbing of events.

Three, an increase of negative arousal.

Four, lowered frustration and tolerance.

Five, intrusive thoughts of client's material. What comes to mind there is we've heard at times and in some of my supervision of other therapists-- particularly junior therapists where they listen to so many stories and are so diligent about their work, but yet have some difficulty in finding a way to breakaway from their work and find themselves having dreams, if you will of some of their client's material. This confuses the therapist because they know that they haven't personally had this experience and start to wonder why they're having these dreams that seem to have pieces and bits of the client's stories that they're listening to.

Another is dread of working with certain clients. We see this often as well too, when folks are working with most veterans or military personnel who have a comorbid diagnosis. It's generally not just combat-related stress or PTSD. And some folks have difficulty with some comorbid issues such as substance abuse and struggle with: "Well, do we treat the substance abuse first, or are we treating PTSD" or combat related stress? Or, there sometimes are other ethical or some principles that a particular therapist has about dealing with patients who might be viewed more as not treatment ready or characterologically affected. And so, it gets a little complicated sometimes, so sometimes we just dread working with certain clients.

Another is the decrease in a subjective sense of safety. We see this increasing over time as we hear reports of some of our clients, some of our veterans or active duty personnel, reserve or guard, showing up to clinics and we find out that they have a weapon in their vehicle or that they've been accruing weapons at home. And then we hear the story that, it doesn't happen that often, but you hear where there was a violent act committed in the therapist's office. This kind of subjective, if you will, information-- without having an opportunity to discuss this with the supervisor or to do some sort of reality check—can, over time, create a subjective sense of less safety.

Another is feeling of therapeutic impotence. And that comes often too when we feel that our client, our veteran, our active duty personnel is not taking any responsibility for change. And we

start to sort of get wary at session after session when we see that there doesn't seem to be any forward movement. Another is when we're faced with some realities of other kinds of obstacles. These obstacles might come from the reality that the person we're providing treatment for is also being seen by other providers and there might be some sort of barriers or obstacles that are affecting what you might believe, as a clinician that, the client, veteran, active duty person should be addressing.

Another is the diminished sense of purpose. I think we see this when caseloads become so heavy and there doesn't seem to be any sense of relief or doesn't seem that there are any clinical gains being made. That some therapists begin to feel that diminished senses of purpose.

Another is the decreased functioning in a number of areas. We're going to get into that in a minute.

Slide 17: VT: Ecological Model of Trauma

Let's look at an ecological model of trauma. Traumatic events have the greatest impact on the immediate survivors as well as those around them (Harvey, 1996). I believe what she was talking about at that time we could illustrate by thinking about a stone being thrown into a pool of water. At the center where the stone hits we see, we could sort of visualize, that that's where the immediate survivors are. And then concentric rings around the survivor, these are the rings of flow when you throw a stone into a pool that you see sort of moving away from the center. That's where we see folks like family members, caregivers, friends, and the community.

Slide 18: VT: Like a Stone Thrown into Water

Here's an illustration of what I was just talking about. Like a stone thrown into water, as you can see, that the circle expands and as it expands and this is a way that we can sort of visualize how people are effected throughout. And that includes the providers as well. It's impossible not to be effected. Another way of thinking of this is, if you take a boulder or a rock that's close to water or where there's a lot of rain overtime, that rock starts to whittle away a little bit. It changes its shape. A positive note is for some of those rocks if you will, the shaping and that, reshaping that comes from being weather beaten. It's sort of like that for us therapists to see so many clients-- sometimes we just get better, or if you will, our template of interventions grows. But for others it goes the opposite way where they start to feel less potent in how to deal with the cases that they're faced with.

Slide 19: VT: Like a Stone Thrown into Water

Like a stone thrown into water those in the rings closest to the survivor are likely to have the greatest risk for developing secondary traumatic stress disorder or vicarious traumatization. The reality is for many of the people that we see in treatment, we are the second person. Some of them don't have family members. Some feel distant from friends. So it's only natural that in many ways the energy if you will, think of it as the energy when they're sharing their experiences with you, their concerns, their fears, their anxieties, their frustration, their anger, it's

sort of like, if you will, that water hitting that rock. It just keeps coming, keeps coming, keeps coming. It can and will have an impact on us if we don't take some sort of preventive measures.

Slide 20: VT: "The Intruder"

We'd like to think of vicarious traumatization as sort of another name that we'll give-- it is called "the intruder". It intrudes on and disrupts four main areas of functioning, cognitive, psychological, memory, and worldview.

Slide 21: VT: "The Intruder" – 1

So as an intruder, in regards to cognitive schemata, it decreases trust, a sense of safety, self-esteem, intimacy, and connectedness to others. And basically, what we're saying is-- these constructs that we have in our head already about life, in regards to trust and safety and self-esteem, start to-- sometimes can be whittled away a little bit, and in that regard, it starts to maybe shape these areas in a different way, sometimes in a negative way. It also can shatter frames of reference in worldview and as well, issues related to power.

Slide 22: Common Cognitive Distortions

The common cognitive distortions that occur in regards to vicarious traumatization are catastrophizing-- sort of the worst case scenario. You hear that-- sometimes from therapists when they're feeling overwhelmed and where usually you kind of chalk that up sometimes to, "well this person just overreacts". And I think that that is a problem, because if we don't really look thoroughly at what's going on in this particular individual's practice, we might in fact, be labeling or pathologizing this therapist when in fact they might be experiencing the sum total of vicarious traumatization and compassion fatigue.

So besides catastrophizing, it also goes the other way minimizing-- minimizing issues in situations is sort of discounting, if you will, the overall impact or seriousness of the things that one is challenged to deal with, especially when we are faced with dealing with clients that are exposed to trauma and have comorbid issues.

The other is discounting the positives. I think this also can occur in a natural way because we're hearing a lot of negative things time and time and again from our clients. They don't usually tell us a whole lot of positive things that are happening for them. Hopefully that happens over time as they start to take to heart and put into practice some of the tools that we're providing for them. But for the most part usually when we start with our new clients we're always hearing a lot of negative feedback if you will and a lot of discounting. And, if we're kind of having some sort of work experiences other then just a client, I mean just our work setting where we feel that we're not heard or that things never change-- those kind of things trigger what's going on with us, separate and apart from the client, but they end up making a connection.

Then there's the all or nothing thinking. I'm sure that you know many folks that get into that all or nothing thinking and it's sort of the black and white concept-- very dangerous, particularly

when we’re charged with dealing with people who have had very serious life changing experiences.

Then there’s our favorite person that does the mind reading, that is, assuming you know. That kind of person can actually create a lot of problems in a practice because they’re assuming they know everything. Let’s face it, all of us generally are well-schooled in clinical practice. Most of us understand that we need to continue to have supervision or peer support because we need to be able to bounce things off people so that we can check our own realities. But, if somebody doesn’t have those kinds of resources, there is the tendency to become sort of a “mind reader” and not really sort of looking at the bigger picture, or, going in the other direction-- that is focusing or narrowing in the focus to understand really what’s going on.

And then last but not least, the self blame. We see this more so actually with disaster responders where they felt sometimes they should have done more, could have done more. True, we see this with, interesting enough, corpsmen and medics. And corpsmen and medics have a similar role such as us. We are therapists and sort of sometimes feel we don’t have all of the tools. Corpsman and medics sometimes feel they don’t have the right equipment when they’re dealing with battle wounds and so on. And sometimes they feel like their caseloads have just too many wounded all at one time. For us as therapists, sometimes we feel like our caseloads are just too overwhelming and we’re struggling. And so, for some of us, we can get into that position of sort of looking at ourselves and blaming ourselves for not being efficient or effective. Not a healthy thought.

Slide 23: VT: “The Intruder” – 2

How about psychologically-- what occurs when vicarious traumatization affects our psychological needs? Well there’s a decrease of self-worth, self-depreciation, hopelessness, and helplessness. We sort of talked about that earlier in the other slides.

Slide 24: VT: “The Intruder” – 3

Well, how does vicarious traumatization affect the memory system? There are five ways that that occurs. There’s the internalization of the client’s memories. And that generally happens, again, when we have a lack of support in our critical settings where we can review our cases and take a look at what our role is and how we’re proceeding. In looking at the treatment plans, there is a propensity to sort of internalize some of the client’s memories because we’re not getting any distance. And by having the supervision and the peer support, it allows us to have that distance-- sort of a preventive measure.

Another is that the therapist may experience flashbacks of client’s materials. This is rare but can occur.

Dreams similar to the client’s material. I spoke earlier of a therapist who was experiencing dreams that clearly were related to the client’s material and the therapist could not understand why that was happening. We’ll get into why that was happening a little later.

Intrusive thoughts of client's material. That's similar to the dreams only obviously, you're not in a sleep state of any sort, but you're having these intrusive thoughts. And it's confusing because part of you recognizes that these intrusive thoughts are not yours per se, in terms of the material, but they are there.

Another is a powerful emotional state upon reminders of traumatic material. So these emotional states that occur sometimes can be experienced as sadness and anger. And we see this, and this might be a little confusing, but we call it "emoting". Sometimes when we're working with a client and they're telling their story and sometimes we want them to experience that emotion and they might cry, they might get angry. They become very verbal at that moment sometimes or at other times, it's more careful, but they're expressing themselves.

And I've seen this happen with therapists who have been exposed time and time again without any kind of support, without any kind of supervision. The therapist has a tendency to emote when they make some kind of subconscious connection with other materials unrelated specifically to that particular individual case. So for example, the therapist can find themself watching television and seeing a story that maybe there's some little connection, but most likely not, but the story is sad and the therapist then finds themselves crying, or finds themself getting angry, or finds him or herself being frustrated. And this might be normal, but on the other hand, if it's happening frequently and it's happening in a way that when we "step back", doesn't make any sense as to why this is happening-- it's beyond the norm of emotional response. Then we have to take a look at whether or not there are powerful emotional states occurring that are related to the material that the therapist has been hearing day in and day out.

Slide 25: VT: "The Intruder" – 4

Another way vicarious traumatization can intrude on us is our frame of reference. It can be disrupted, our basic identity challenged, spirituality questioned, and worldview maybe shattered. So, let's take one of these for example, spirituality is questioned. We hear stories from our clients, veterans, active duty, reserve and guard folks where they talk about how they felt betrayed by God, or they felt that they betrayed their belief system in God. And, they talk about the situations that put their mind in that position. And we hear that time and time again.

We're exposed to some horrific stories that can, in fact, start to impact on our frame of reference and we possibly might begin to question, is that really something that God would support or not support? Well, you know, it's kind of a very complicated issue on the surface, but most of us are, whether we believe in some particular religion or not, because of the fact that we're in the healthcare business, we all have some sort of spirituality. And that spirituality, if anything, reflects more on things of the well-being of people, kindness, and caring.

When we hear these stories, horrific stories of actions taken by men and women that go beyond what would be considered the norm, even beyond what our fantasies would be considered, war begins to challenge some of our own belief systems. So again, if you're hearing a lot of cases that have to do with, let's say, spirituality questioned, it could trigger some questions in your mind about your own spiritual belief system. And for sure, your worldview may be shattered. You know, we who have not been exposed to war or some particular traumatic events,

sometimes as we try to rationalize and help the clients make meaning out of their experiences, we generally can do that but on the other hand, when they leave our office sometimes we're left with you know "Gee is the world really going to pot?" Is it, is it really that, or is it, things really that crazy? And so again, we can become affected and it's really important that we understand that, that a variety of things can affect our well being.

Slide 26: VT: Contributing Factors -1

So, what are some of the contributing factors to vicarious traumatization? Let's review those again. There is the proximity to the situation, how close you are. The relationship with the person or persons involved. The element of surprise or shock. The presence of an interpersonal violence. Having witnessed or experienced trauma-- particularly similar traumas in the past. Unresolved personal issues. And then of course, the rekindling of subtle issues that seep into therapy.

So all of these are there in our daily practice, and for the most part, we're able to separate ourselves from our clients and not take to heart, or not incorporate, or we're very aware of some of our own life experiences and we try to keep our boundaries. But we are vulnerable. We are human. So for example if, let's say that we've been through a horrendous divorce and we've worked it through. We've gotten past it. It's now a couple of years later. We're feeling fairly grounded. But now we're working with these Iraq, Afghani returnees and we're hearing of the high incidence of divorce and domestic violence.

Initially we're able to deal with this and keep our boundaries, but you know, after we hear so many stories, it's bound to happen that there's going to be a story that's similar to your own experience even though you might not have been deployed to Iraq and Afghanistan and that's where there's the potential for that sort rekindling, if you will, of your own stuff. That can sort of confuse matters in terms of what type of intervention. Even though you might do a fantastic intervention in this situation, after the client leaves, you're left with the residue and maybe you're not in the best mood later or you're feeling you need to distance yourself from your peers. It's really important that we pay attention to our predisposed factors because there isn't a human being that hasn't been exposed to some kind of trauma in their lifetime.

Slide 27: VT: Contributing Factors – 2

There's a few other contributing factors. One of the most obvious is the provider's lack of skills. So, if you have somebody that for example, relies on let's say, best practice models but they haven't really had the opportunity to be observed by a supervisor or had the pleasure of a supportive peer group to help them look at how their practice is going-- it might be that they might not be, they might not have all of the skills that they are perceived to have and be relying too much on a best practice model. And in fact, they may make themselves vulnerable to vicarious traumatization, and at minimum, not provide the best possible clinical service that we really intend to give to our clients.

Another is affect tolerance of self and others. We see this with providers when their caseloads are just almost overwhelming and there seems to be no endpoint. That's when we start to notice

things about affect with the providers and it's another red flag that says it might not be vicarious traumatization, it just might be workload but we need to take a look at it as a potential flag, if you will.

Another is awareness of trauma impact on self and others. And I already gave that example a therapist who's gone through a horrendous divorce. The therapist, even though they've worked it through and it's been a few years, that things can be rekindled and there can be a connection that gets made there and so on.

Then there's how it affects self-awareness. You know, if we're buried into our work and we don't really have a life, then most likely we're not going to be very aware of our own self and how we deal with our clients, let alone deal with everything else.

So vicarious traumatization can, in fact, set up blinders for the providers and one of those is self-awareness, another is their professional identity, and then even things like starting to question. We have it listed here as administrative support but we're really talking about any kind of support in a clinical setting whether for those who are starting to experience vicarious traumatization.

Remember these are only some of the elements. You don't have to have all of these. In any of the material we've discussed thus far, it only takes a few of these issues that should trigger us as, as supervisors, as managers, as providers, that we need to be alert and examine ourselves in terms of how we're doing and making sure that we're not sort of overexposing ourselves by being the best we can be taking care of our clients.

Another potential problem is whether or not the individual has competent supervision. We find this sometimes where you have settings where there isn't a specialty clinic for, let's say, PTSD or combat-related stress. It's more in a general setting and the supervisor has very little understanding of best practice or evidence-based treatments. It makes it really difficult then for the provider to feel supported or to be able to go to somebody and get some sort of direction. So competent supervision-- if you don't have it at your own site, then you need to seek that out.

There are a tremendous number of competent clinicians and supervisors in the VA system nationwide now, and I believe that all of these folks are very caring individuals and support our fellow peers and are open to working with people, be it in a peer fashion or to actually provide some kind of training and supervision.

Slide 28: VT: Effects on Provider

So what is, or can be, the overall vicarious traumatization effect on the provider? The greater the percentage of trauma survivors in the provider's caseload, the greater the number of vicarious traumatization symptoms reported. Now in that study, it was real clear that the folks that were seeing more traumatic survivors and hearing these stories clearly were susceptible to having some vicarious traumatization symptoms. So the lesson learned there is, if there's a way to spread your caseload out and not just see all trauma victim, or to have your practice divided between group and individual work where you're co-facilitating a group with another therapist or

finding a way to break up your daily activities by going for a walk or taking or doing some kind of fun thing for yourself, some way of nurturing yourself you need to break up the impact. And for some of us, where we work in small clinics or we work in a residential program or we're in private practice, that becomes a major challenge. But it's something that we have to take on otherwise we can become a victim of vicarious traumatization.

Slide 29: VT: Reactions/Symptoms

So here's some of the symptoms or reactions to symptoms that may appear soon after the event or can be triggered at a later time by a reminder of the event. And when we say event we're talking really about the clients we're seeing-- the veteran, the active duty person, reserve or guard, that after seeing them or seeing so many, some of these things can occur for us. Shock or disbelief. Irrational guilt and self-blame. Intrusive symptoms. Numbing and avoidance. Increased hyperarousal. Irrational fear for the safety of loved ones. Feeling isolated and misunderstood. Low energy. Disrupted sleep and nightmares. Anger. Risk taking and rule breaking.

Let me take one of these right now and give you an example of how listening to a concern, a valid concern, of a returnee from Iraq could impact on us and create sort of an irrational fear because we hear the story over and over again. In the war today, and over the last couple of years, many of the men and women who have been exposed to the war zone talk about how unsafe it is. How you can't predict where safety is, or where it will not be safe. It's sort of a risk situation all of the time.

So you have a person you're seeing who tells you that (at first blush, you're thinking they might have a problem with intimacy because they say), "You know my wife always wants to hold my hand when we go into the market, into the grocery store, and I love her, but I don't want her holding my hand and I don't understand why she has to hold my hand." So at first you might think, well, maybe this person is just struggling with, you know, a male identity issue, or the lack of understanding of nurturing relationships or whatever. But as you dig further, you find out that he or she is really reacting to their combat experience where they thought some areas were going to be safe, but turned out not to be safe, that the enemy can be anywhere.

So, when this individual isn't safe, when his wife tries to hold his hand, he releases her hand, pushes her hand away because he feels unsafe. And then when he tells you these stories about how these things can happen anywhere, in your backyard, in a store, that when you look at Middle Eastern people (since we're talking about Iraq right now and that they work in fueling stations, gas stations or grocery stores or whatever) and the client says to you, the returnee says to you, "How do I know that person isn't sending money over to Iraq to support the insurgents and, and so on and so? How do I know that this person isn't Al Qaeda or something like that?"

So, it becomes irrational in some ways if we start sort of saying yeah how do we know that? How do we know we're not safe? And of course, the fact that we were attacked here in our country, it's sort of not too hard to go that way in some ways. So, this is an example of how, by listening to the client's stories that are factual, and finding that they've taken that experience and brought it back here to the US, this can sometimes create an irrational fear for us even though we

might not have been exposed to Iraq or whatever (the traumatic event is). On the other hand, for those of us who were exposed to 9/11, we can make this kind of connection and we might not think it's so irrational, but we need to really examine and take a look at whether it is or not.

Slide 30: VT: Provider Case Example #1

Let's take a look at a case where a provider's history can, in fact, create a situation where vicarious traumatization can occur. This particular person was an intern in mental health and the history of the provider was that his parents divorced at an early age. His father was a World War II veteran in the military with a long history of alcohol abuse, sort of a very stoic person. The provider, being the oldest male at eight years old when the parents divorced, became sort of the surrogate adult or father image. He grew up in a way where in some ways, some very positive things occurred for this person in terms of his resiliency. But on the other hand, there was a lot of denial that occurred in a natural sort of way. You know, they say time heals everything.

And so this particular intern went into the military, did quite well in the military, has no history of being incarcerated or substance abuse, has been successful, sort of a self-made person, and finds himself at a VA medical center doing an internship. Eventually he is so successful in the internship that he gets hired in that particular clinic in the outpatient setting. This particular provider was one of these sort of "dyed in the wool" type folks who like I said had been in the military, so there was a propensity for him to take on as many cases as possible. Of course he was very young and, still in the stage of developing the rest of his life.

But anyway, he had a very good supervisor who actually had an office directly across from his. And the supervisor noted that it seemed like the clients that this young new mental health provider was seeing-- the ones who had a diagnosis of alcoholism-- he seemed to be sort of like cutting them short if you will. He gave them a lot of time for the appointment, but yet at the same time it was right on the dot that he would stop that session. Yet, when he was seeing other clients with other types of disorders, he would extend their sessions or allow those sessions to continue. Or, if that client came in late, he would allow that client to still continue on past the fifty minute hour.

So the, the supervisor called him in and asked him what was going on, was he aware that maybe he was providing a different type of treatment by diagnosis? Well the young therapist went into denial and struggled with that but after the supervisor said, "Well, let's take a look at the cases, let's look at these diagnoses that you seem to be like "right on time" and stopping the session and so on, and let's look at the other ones." And so what we found was that the diagnoses that he was stopping on the dime, on the minute, were those who carried a diagnosis of alcohol.

It was, in summation, clear that this particular provider still had some unresolved issues and they were, if you will, in a subtle way, being projected out by cutting off the clients. Somebody might not think that's a big deal and say, "Well wait a minute, the client only gets fifty minutes and he's stopping it at fifty minutes, that's okay." Well no, because we need to take a look at how he's treating the other clients. If he's letting his other clients go over the fifty minutes then there's something here that can be problematic.

Slide 31: VT: Providers – Case Example #2

What we found and we were discussing in the previous slide about that young provider was that when he went into therapy for himself it became evident that he had some unresolved issues related to his father's alcoholism and abuse. We're very happy to say that that particular therapist, the young therapist has become, if you will, an expert in dealing with substance abuse patients with comorbidities. And I think that illustrates how when one has support and supervision and that the therapist is open to taking a look at his or her practice and the role they play in it, that there's a lot of potential for growth and a it's a nice way to take a proactive action to avoid continuation of some sort of vicarious traumatization.

Let's take a look at another case example. Just prior to Desert Storm, the VA held a number of trainings around the country because the VA and DoD, Department of Defense, were getting ready-- working from the assumption that we might have a number of casualties from Desert Storm. Well, as part of that training, at one particular setting, there were about two hundred and fifty mental health providers, some of those were DoD folks and the rest of them were VA providers who worked either at hospitals or clinics or at the Vet Centers. One of the tasks that was required (in order to sort of sensitize the providers as to what maybe the warriors that they might be engaging with as they return home had experienced) was having to wear what they called mob gear. This is basically the sort of protective uniform or clothing and gas masks that one puts on to protect themselves from some sort of poison gas attack.

Well, these two hundred and fifty providers were given about the same amount of time that somebody in a war zone was given to put this gear on. And what we became acutely aware of was that some of the providers actually had an onset of a panic attack. That concerned us.

So what we decided was that we needed to survey those two hundred and fifty folks to determine what was really going on there. Was this just an issue of being unfamiliar with the gear and that that was creating some kind of discomfort, or was there really some sort of genuine panic anxiety going on? And what we found was that approximately thirty percent of the group, I'm sorry, less than thirty percent of the group that were in this particular Desert Storm situation (where they donned the gear) had been exposed to combat in Vietnam. And that this sort of, even though they did not use this kind of gear in Vietnam, it sort of rekindled some discomfort.

At the same time, there was another workshop that was going on, and again related to Desert Storm, and what we found was that about thirty percent of the providers were pretty angry about having to attend these workshops even though we were about to go to war. When looking further and questioning the therapists as to why they were angry about being at this training, almost every one of them mentioned that they felt they had abandoned their current caseload. That the patients that they had left to come to the training were not going to have anybody else to see them.

Again, that sent up a red flag for us who were supervising this situation, saying-- we've got a problem here and we need to sort of try to understand what's going on with these therapists because they've been called forward because we're expecting the possibility of lots of casualties. And, we're trying to train them up so they can be better-prepared, yet they're really angry

because they have to leave their clients back at their local facility. And it was almost like in some ways some sort of major league conflict between a practice, there they work in the VA and they work for the government, but it was almost like it was a private practice model to them. And so looking back now on some of the interchanges we had and some of the assessments they did with these folks, that we can safely say that they were already experiencing-- back home prior to Desert Storm-- vicarious traumatization.

Slide 32: Provider Self-Care

So here is a photo again of Marines courtesy of Camp Pendleton in California. And these Marines, as you can see if you closely look at them, most of them are moving forward in a particular direction. And you have one Marine who is covering the back door, if you will, on your left side of the screen at the very back of it. But you notice that all of these Marines are, even though they're sort of moving in the same direction, are having a different experience.

You can notice that by looking at their eyes and their facial expressions. And that's kind of like us. You know, if you think about it, we're all different. We might all see PTSD cases or combat- related stress cases, but we're not all the same. We're different and we're all affected as we know our clients are-- independent of a group experience. So, we don't want to generalize that every therapist has vicarious traumatization or compassion fatigue, but on the other hand, we can have variations of that kind of exposure.

Slide 33: Perspective/Reactions to Trauma are Unique

So we have to keep in mind that, like the victims we deal with, the same is true for us that perspectives, reactions to trauma are unique and they're unique to the individual.

Slide 34: Risk/Resilience: Self-Assessment

So let's take a look at some self-care tips here. First, we need to be able to make a self-assessment. And the question you might ask, "Well how can I know if I'm at risk for, or am I experiencing vicarious traumatization or compassion fatigue?"

Slide 35: Risk/Resilience: Self-Assessment – 1

Well, here's a few questions that we can ask ourselves by doing a self-assessment. Let's start with work. Am I enjoying my work? Is it as fun as it used to be when we started working in our setting? Or has it continued to be sort of a place that I enjoy, that I look forward to coming to? Are there certain clients that are too stressful for me?

Are you feeling as a clinician that there are certain clients that just create a tremendous amount of anxiety for whatever reason? If there are, then we need to start to note that. Again, that does not mean that if you're not enjoying your work, or if there's certain clients that you'd rather not see, that that right away means that you have vicarious traumatization, but it might be an indicator.

So let's keep going down this list. How do I feel when I arrive at work? You know some of us come to work and, we immediately get grounded into our jobs and move forward and we're very focused. Some of us might come to work and be carrying some things from home. Maybe there's things that are not going well at home. Your mortgage rate has been increased, or you found when you went to your car in the morning that you had a flat tire, or there's a particular medical problem that one of your family members experienced and so you're preoccupied. So you know, we need to ask that question, taking the temperature. How do I feel when I arrive at work? If you're arriving at work and because of a situational thing like I just mentioned, that's understandable, but if you keep arriving at work feeling the same way all the time, then that is a red flag that we need to consider.

How do I feel when I leave work? Well, do you leave work feeling exhausted? Do you leave work feeling unfulfilled? Do you leave work feeling frustrated? Do you leave work feeling like you don't want to come back tomorrow? Again, all of these are signals that we need to look at in more depth.

Do I dream about work-related things? Well, I think most of us have done that, particularly when we're faced with some uncomfortable work-related issues-- whether we're dealing with management or supervisor or some kind of issue with a particular client. We can have some sort of fractured dream, and pieces of that that come into play. And the other is that we can have some intrusive thoughts related to that, of course not necessarily invited intrusive thoughts but it can occur.

Do I over-identify with or distance myself from certain clients? Well, that's a question that I think we all struggle with because there are obviously clients that we enjoy working with and there are others that we find really a struggle. Again, this doesn't mean that you are suffering from vicarious traumatization or compassion fatigue, but if it's happening frequently then we need to pay attention.

Slide 36: Risk/Resilience: Self-Assessment – 2

So, let's take a look further-- more on the physical side. Have I noticed changes in my health? Are you getting more colds? Are your allergies (seem to be) kicking up more than eve? Sometimes we just want to chalk it off to the season. (Some of these things sometimes get stimulated by emotional issues.)

Have there been any changes in how I spend my leisure time? In other words are you spending any leisure time or are you feeling too tired from work to do anything? Are you being affected by so many stories that the things that gave you pleasure now don't. [For example] a lot of people like the Fourth of July. They gather together. Depending upon the community, there might be a parade in the local community. There's usually a picnic or a barbecue. And then there are the traditional fireworks. For a number of people that we see in our practice, a number of them have problems with attending large events or particularly fireworks. [This is] particularly true for those that have been under fire in a war zone-- sometimes they feel that going to the fireworks places them in an awkward position where they're going to feel that things get rekindled and they feel unsafe. They can have a panic attack and so on. So they start to say

you, “You know, I don’t think the Fourth of July is an important holiday. It’s, not really relevant. People don’t really care about the country. Gee everybody just goes shopping on the Fourth of July.” So after a little bit of hearing that over time we might start incorporating some of those thoughts and ideas in how we deal with our leisure time. We start saying, “Well, I don’t want to do Fourth of July. So again this is one of those subtle ways that we might be affected and not be aware unless we do this inventory that we’re doing right now.

Am I drinking, smoking, overeating, not getting enough sleep etcetera? You know, some people want to chalk up those behaviors, the increase in those behaviors to: “I’m getting older so I don’t need to exercise and I’m going to train myself because you never know where you’re going to go. You know life is really short so I’m going to enjoy myself. So I’m going to eat a lot of those steaks and drink more beer and whatever.” I think we need to sort of again take a look is there an increase in that behavior? And is that increase in that behavior of overeating or drinking or smoking, or having problems with sleep related to our work?

And is my body showing signs of stress? The most common signs are muscle spasms or tightening of the shoulders, headaches that come certain times of the day, or right after a client leaves. So I think we need to take a look. Maybe in our minds we’re feeling not feelings anything, but our body is sending us signals.

Slide 37: Risk/Resilience: Self-Assessment – 3

Here’s a few more in terms of self-capacities. Has my sense of myself changed?

Do I feel worthwhile? Sometimes that one comes up when we start to feel that we’re just a cog in the big wheel of clinical care and that nobody is listening to us. And we’re trying to impart, we feel, relevant information about how we can provide better clinical practice to the management and we feel like we’re not being heard. And, then we start to feel like we’re not very worthy. And that kind of “fit” if you will, or draws a parallel-- sometimes with the victims that we’re seeing. Because, sometimes they have those same issues related to authority, or they tell the stories where, “I was trying to tell that Lieutenant that we were going to be in harms way but he wouldn’t listen and he put us in harms way.” So you can see how in some subtle ways we can be making some connections and, in part, those connections might be coming just because of the sort of the wear and tear of hearing these stories over and over again—it starts to reshape us to a certain degree.

So the next question is, how am I managing my stress? So if I’m experiencing tight muscles and those headaches, and how am I dealing with that? Am I taking an active response to this? Am I being responsible? Am I taking care of myself? Am I going and getting that massage that I need? Or am I taking a walk, giving myself a break?

Am I under stress? Well, we probably would all say we’re under stress. But you know, there’s a difference between just feeling a little stressful, which is kind of normal, to feeling overwhelmed with stress.

Am I making good life decisions? Has the way you make decisions changed? Are you becoming more impulsive? Are you procrastinating more then ever? Those might be indicators that something is going on, that possibly could be related to the clients that you're seeing over time.

Should I be making big decisions right now? That's a good question. You know, I think that there are many times that we don't ask that question to ourselves. And I think the worst time to be making a big decision is when you've had a horrendous day at work. You heard a lot of stories. And you, have to make a big decision like maybe you're going to change your mortgage rate or you're going to make a decision about a relationship.

I think you need to give yourself some distance from your work before you start to make some of these big decisions because remember, we're dealing with people's life stories, and their stories are not out of the norm. We can identify sometimes with some of these stories, or we know people in our own life circle, if you will, that are not our clients or patients that have these experiences. So we need to work hard at being able to separate our work and our personal life.

Slide 38: Risk/Resilience: Self-Assessment – 4

Okay here are a few other ones to ask yourselves. Do I like or enjoy being with others? Do you find yourself-- are you now pulling away at work, not socializing? Or even after work, do you find yourself doing that?

Do I spend meaningful time with my family? You know, I've had many, many students and both junior and senior therapists that I've had the privilege of mentoring, and one of the things that does come up is this feeling of conflict that they just don't have the energy to listen to the story at home. You know one of the family members, I have some issues going on and they look to us sometimes because we're supposed to be objective and we're supposed to be the kind of person that everybody else comes to for help, to look for assistance, to help clarify and so on. By the time we get home, sometimes we don't want to do that anymore. We've just had enough. If you're feeling like that, and your family can't have an interchange with you, or you don't feel like you want to participate because it's too much work, then that is a serious sign that we have to consider the possibility of vicarious traumatization working there.

Do I feel close to others?

Do I share myself more, or less?

Do I feel understood by others?

And, have I changed in the way I think and feel about others who are close to me?

So that all goes back to that illustration I gave about work, coming home from work and dealing with families or friends. I think it's a good way to take your temperature. You know are you changing? Have you shifted? Were you this gregarious person before but now you're different, and people are giving you that feedback and saying, "You know, you don't smile very much

anymore. You don't seem to have fun. Gee you don't come to lunch with us anymore." Or your family says, "Gee, you never want to go over to grandmas….and we used to go kayaking but now you don't want to go kayaking. What's up with that?" Well those are all signs that we need to pay attention to.

Slide 39: Resilience: Red Flags

Okay here's some red flags to pay attention to again: being overwhelmed, agitated, irritable, nervous, uptight, isolating, depressed, lack of interest in things, a general negative attitude, problems falling and staying asleep, low energy, laying awake and worrying about things, you're not doing the things you'd like to do. Work intrudes on home and personal life, and feeling helplessness, like you can't cope. Well, we've talked about all of these things and I just wanted to go through that list to sort of give you a quick reminder that these are all potential red flags.

Slide 40: Resilience – Personal

So what do we do about this? How do we deal with this? Well, we all have a built in resiliency. And what we need to do is utilize our own resilience to better-understand what's going on with us and how to deal with it and how to take preventive measures from becoming our own victim, if you will, of vicarious traumatization. So, one must have an awareness of one's limits, emotions, and resources and having a balance among personal and professional activities. And of course, it's very important having that connection not only with other, but with our inner self. Then break the silence of unacknowledged pain. What we're saying there is that if you have relationships and you can have those support groups, it allows you not to walk around if you are carrying this load of issues of uncomfortableness. Also, it helps to offset the isolation and it increases validation and hope.

Slide 41: Resilience: Helpful Hints – 1

Here are some helpful hints-- using your resiliency.

Acknowledge the trauma.

Maintain a normal schedule. That's sometimes hard for us to do, but I find myself having to sort of send the therapist home at four thirty when they're supposed to go because, there are some people that just keep going even though they're not seeing clients. And so we have to look at how are we managing our time. So maintain that normal schedule.

Create a balance and separateness between work and personal lives. We have a rule even at work. When we get together we have some social gatherings even sometimes scheduled at least once a week during the week, during their work time, where we see this is an opportunity to nurture. And the golden rule if you will is we can't talk about work. We can talk about anything else. We can talk about things we like to do. We can talk about things that are going on with our family. You know usually they're fairly positive things. We sometimes bring food to share. And even though it's only for forty-five minutes to an hour, it's rejuvenating. It's a way to

nurture ourselves and it's a way to maintain that balance so that we don't let work become our whole life.

Pay attention to basic good self-care. I don't think I need to teach all of you that. I think you all know because you're all in the healthcare business. You know what you need to do in terms of health. We just need to apply it. We need to do what we tell our clients to do. We're constantly giving them direction about: here's how you deal with your anxiety, different stress management techniques, and telling them they need to go for walks, and they need to eat right, and they need to sleep, and get their appropriate sleep. We need to do the walk, and just not the talk.

Do not numb out with excess. In other words, watch out for an increase in the alcohol or substances. Or sometimes, with fun things like gambling, eating, shopping, TV, and even exercising, there are some people that just go overboard with that and they're not really clear why they're doing that. And what we might find out is, if we can sit down, slow them, slow this movie down a little bit, we might just find that there is, in fact, some kind of vicarious traumatization living alive in that individual.

And minimize your exposure to traumatic stimuli. This includes violent movies or TV and news. We are not really good at that. We are good at telling our clients, because we know that if they can be rekindled if they watch certain programs and news events over and over again, well we can too. We need to take our own feedback and minimize that traumatic stimuli.

Slide 42: Resilience: Helpful Hints – 2

Here's a few more hints.

Engage in leisure activities.

Nurture the aspects of yourself with health and creative artistic and, and maybe spiritual activities.

Know your own red flags. And, a biggy is grief about the event- [share this] with colleagues.

And we've talked about supervision and peer support and that's all we're saying here.

If the symptoms persist for more then a couple of weeks seek further assistance. Do not wait. The sad thing for me is watching an excellent therapist, an excellent healthcare provider who did not take care of themself, did not pay attention to the red flags, and finds themself feeling the need to leave the field in a not happy sort of way-- feeling like a victim.

So please, if you are experiencing symptoms and they persist more than a few weeks, you really do need to sit down and talk with somebody and take a look. Are you experiencing vicarious traumatization? Or maybe it's something else. But you need to be responsible for yourself. How can we take care of our patients, our clients, if we don't take care of ourselves?

Slide 43: Resilience: Helpful Hints – 3

Again, I'm just going to go through these real briefly because we talked about these. Again these are just helpful hints, make a connection, avoid seeing crisis as insurmountable problems, accept that change is inevitable, set goals, and actively move towards them, take decisive actions, look at problems as triggers for personal growth, nurture a positive self-view, and don't blow things out of proportion. We're really good again at telling our clients not to do that, but sometimes we're susceptible to sort of blowing things out of proportion and usually we do that because we're feeling overworked or, or something related to work, that's going on with us. Remember and use past coping success and strengths.

Slide 44: Resilience: Professional

On the professional side, here's a few helpful hints. Know the type of clients who you can or cannot work with. Don't go beyond your ability, your skill level. Sometimes we're asked to pick up cases that we don't really have the background or training, and it needs to be done because the clinic (or whatever treatment setting you're working in) is being overrun. But you need to go and get the appropriate education and training, because otherwise, this will take its toll on you-- and it really doesn't help the client.

Refer certain clients to others. Manage your caseloads. Continued education is essential. Self-disclosure with your colleagues. Continue to express emotions, don't be shy you know. We sometimes set up unrealistic behavioral expectations on ourselves, like because we're therapists or healthcare providers, that we're not supposed to have any emotions. Well, we do have emotions and we need to let those out at times. Just find an appropriate place to do that and with the right folks. Seek support. Obtain supervision. Obtain consultation. And take mental health breaks.

Slide 45: Resilience: Organizational

There is one last area I want to cover, and that's organizationally. And for those of us who are not in the management level, sometimes there's very little we can do about some of the stresses that occur from an organizational perspective. But, it's important for those of you who are today going through this course that you consider these. That we all have to consider these, whether we're in management or we're at the hands on level.

Reduce the feelings of isolation.

Provide or offer adequate funding, space, and supplies. There's nothing worse then sticking a clinician in an office-- I know we'd all love to have windows that have a view of the ocean or the mountains and that's not usually available. But we need to make sure that our clinicians, and you as a clinician create, an environment that nourishes you and nurtures you and the client. Now that doesn't mean bring in a couch and a bed and all of that in there, but it means to make it reasonably comfortable for a workspace. I think it's important that management and supervisors make sure that the providers understand what their access to mental health benefits are. Balance the management of caseloads and so on. I'm not going to go through this whole thing. I think

that you can all read through that and some of this you'll be able to relate to, and some of these things are not in your domain.

Slide 46: Common Obstacles to Building Resilience: Not recognizing Problems and Not doing your own self-care

So there are common obstacles to building resilience, not recognizing problems, and not doing your own self-care.

Slide 47: Vicarious Traumatization: Summary

So in summary vicarious traumatization can be insidious. Vicarious traumatization can be a natural consequence of empathetic listening. You are your equipment, maintain it. Developing resiliency can support you both personally and professionally.

Slide 48:

So as we see in this last photo with these Marines sitting around. You see them with a smile. They're taking a break. And yet they're still aware of their mission and their purpose. And that's what we have to do. We're usually pretty good about being aware of our mission and purpose, but we're not necessarily very good at taking care of ourselves.

So in closing, I'm hoping that you seriously consider this exposure to the subject of vicarious traumatization that you just had with me and that you share this with other providers. Because, we're only as good in the kinds of services that we provide as we are in terms of the shape that we're in as providers.

So take care of yourself. Thank you.