Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar Series

"Combating Compassion Fatigue"

August 25, 2016 1-2:30 p.m. (ET)

Operator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. Today's conference is being recorded, if you have any objections, you may disconnect at this time. Now I would like to turn the conference over to your host, Dr. Vladimir Nacev. Thank you. You may begin.

Dr. Nacev: Today's presentation and resource list are available for download from the files pod below. Before we begin, let us review some webinar details. Live close caption is available through Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Should you experience technical difficulties, please visit DCoE.mil/webinars and click on the Troubleshooting link under the Monthly Webinar's heading. There may be an audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with those speaker's comments.

This continuing education activity is provided through the collaboration between DCoE and Professional Education Services Group. All who wish to obtain continuing education credit, or a certificate of attendance, and who meet eligibility requirements must complete the online CE evaluation. After the webinar, please visit dcoe.cds.pesgce.com to complete the entire CE evaluation and download or print your CE certificate or certificate of attendance. The evaluation will be open through Thursday, September 8, 2016.

Throughout the webinar you're welcome to submit technical or content related questions via the Q&A pod located on the screen. All questions will be anonymous. Please do not submit technical related questions via the chat pod. Participants are encouraged to chat amongst each other during the webinar using the chat pod, but please refrain from making or promoting your organization or product in the chat pod.

I will now move to today's webinar, Combating Compassion Fatigue. The negative impact of traumatic events can extend beyond those who directly experience the trauma. Healthcare professionals who provide services to traumatized individuals are also at risk for a phenomenon called compassion fatigue. This compassion fatigue can lead to impaired social and/or occupational functioning. This presentation will introduce attendees to the concept of compassion fatigue, it's hard to see symptoms, and discuss crutches to minimize the negative impact.

At the conclusion of this webinar participants will be able to: formulate a clear preconception understanding of compassion fatigue, including how it is similar to and different from related constructs; identify the symptoms in compassion fatigue in oneself and others; differentiate between the risk factors and protective factors associated with compassion fatigue; and lastly, identify best practices and self-care to prevent or diminish compassion fatigue.

I would like to introduce our presenter, Dr. Brian Bride. Dr. Bride is a distinguished university professor and director of School of Social Work at Georgia State University. He's currently serving as the Editor-in-Chief of Traumatology, an international Journal published by the American Psychological Association. Dr. Bride's research and teaching interests are in the areas of behavioral healthcare, primary and secondary traumatic stress, health services research, HIV/AIDS, and workforce well being. His work has appeared in several leading journals. He has received funding support from the National Institute of Health, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Children's Bureau.

Dr. Bride is a developer of the Secondary Traumatic Stress Scale and has received a number of honors as a result of his research on secondary traumatic stress, including a Creative Research Medal from the University of Georgia. He was named a Distinguished Scholar by the Center for Social Research at the University of Buffalo, and had an article identified in the British Journal of Social Work as the sixth most influential social work article in the prior decade. Welcome, Dr. Bride.

Dr. Bride: Thank you. Welcome everyone. I know it's afternoon for some of you, morning for others, evening perhaps for some of you as well. I'm grateful for the opportunity to present to you to talk about compassion fatigue. Let's go ahead and get started. I'm sorry I'm bouncing around, on the slide, I'll get it right in a moment. Just trying to get an idea of who's in the room, so to speak, I have a little questionnaire, What's Your Professional Identity? I know that I'm missing some here, for instance, I saw a couple of chaplain's note themselves, in the chat room, but this is our first polling question. All right, excellent. I see we have many of my people, social workers out there, and many of the other categories. I'm love seeing all these different professions and responsibilities down there.

I will tell you this, obviously, I'm a social worker. That's my background. I'm a clinical social worker. I will likely, I'll try my best not to, but I will likely lapse into social work piece from time to time. It's not meant to marginalize any other professions, but that's just who I am. Let's get started.

Let me also get an idea of how familiar you all are with some of the contents before I get going. Okay, great. It looks like most of you have at least some familiarity, some of you know a lot about it. We'll see if you agree with me or not. Let's go ahead and get started here.

We've gone over the learning objectives, so I'm going to skip over that slide and just get started here. For some time now, for several decades at least, we've been aware that individuals who work with those who've been traumatized themselves can experience some difficulties, sometimes very similar symptoms and a variety of other challenges.

Just like with PTSD in the early days, there were lots of terms bandied about to describe this, and this slide demonstrates a number of those. Indirect trauma, emotional contagion, savior syndrome, the cost of caring. The four concepts on the right, in yellow, are the ones that I particularly want to talk about today, because these are some of the things that we really gelled around as the concepts that we're discussing.

What I'm going to do first is talk about each of these constructs, how they're similar or different from each other. Then, we'll move into some research around prevalence and risk factors and then talk about what to do about this problem.

I think the first thing to really address is who is vulnerable to compassion fatigue? I listed family members and friends, spouses, partners, children, parents, and family and friends of individuals who are traumatized are susceptible to compassion fatigue. In fact, there is a pretty decent amount of research on this issue, some of it comes out of the military, in terms of military population, there's been research showing that children, close friends and spouses of Vietnam veterans demonstrate PTSD-like symptoms, so they did not directly experience trauma themselves. In fact, part of that research has demonstrated children re-enacting in their play combat scenarios, for example.

There's also research around holocaust survivors, the children and now grandchildren of holocaust survivors, demonstrating PTSD symptoms related to the concentration camp survivors experiences. Researches certainly beginning now to emerge around veterans of the efforts in Iraq and Afghanistan, and so forth.

What we're going to talk about today is really you all, the service providers, and people who interact professionally and para-professionally with traumatized individuals. I think it's important to realize that compassion fatigue can affect those who are not professionals, really about anyone who is in close contact with individuals who experienced trauma themselves.

I'm going to first start with the first construct I've put up there, which is secondary traumatic stress. Chuck Figley, who's now at Tulane, was one of the first who started talking about secondary traumatic stress in the early '90s. These quotes are from his book that came out in 1995. These are two definitions, two that I think is important to discuss.

One is that, "Secondary traumatic stress is the natural consequent behaviors and emotions resulting from knowledge about a stressful or

traumatic event by a significant other." I highlighted there "natural" to underline something that I'll probably repeat throughout this webinar, is that, it's important to note that secondary traumatic stress or compassion fatigue happens. It's really an expected possibility. It's an occupational hazard of doing work with individuals who've been traumatized. We really like to point this out to kind of beat stigmatize, or normalize the experience for those who are experiencing it. Just as with PTSD, with individuals who've been directly traumatized, we know that many of them may experience symptoms related to PTSD or full-blown PTSD, and it's not about a weakness inherit in that individual. That's an important piece of this construct that I want to convey.

Dr. Bride: Secondly is that, "Secondary traumatic stress is a syndrome of symptoms identical to PTSD except that exposure to traumatizing event experienced by one person becomes a traumatizing event for the second person." Secondary traumatic stress really is post-traumatic stress and that is important to remember. We're going to talk about that a little bit more when I go into the diagnostic criteria. I have those parentheses around the D purposefully, that's part of the original quote. The reason for that is I think it's important to focus on the continuum of experiences for secondary traumatic stress. One could certainly experience secondary traumatic stress to the point of meeting the diagnosis of PTSD, but really our goal is to recognize the experience long before it gets to that level, to that severity, to that intensity, so to disconnect it completely ... to disconnect it partially from a diagnostic process.

The second construct is compassion fatigue. Charles Figley also introduced the term "compassion fatigue." He did so really as a way of having a more user-friendly term for secondary traumatic stress. When he fist started talking about secondary traumatic stress and writing about it, he typically used the term "secondary traumatic stress disorder," noting that people can experience symptoms to the degree that they have a diagnosis of PTSD.

What he found and what he noticed was that clinicians were sometimes reluctant to acknowledge their experience with secondary trauma or compassion fatigue because it was a pathologizing term or that it carries some stigma. He really introduced compassion fatigue as a substitute for the term secondary traumatic stress.

In his view, secondary traumatic stress is compassion fatigue, and compassion fatigue is secondary traumatic stress. That's really the perspective that I hold and the one that I'm going to proceed with for the rest of this webinar. I will vacillate between compassion fatigue and secondary traumatic stress as I go through this.

I will also note that other people use compassion fatigue in a slightly different way. Beth Stamm, for instance, refers to compassion fatigue as a overarching umbrella term that includes both secondary traumatic stress and burnout, which is another one of the construct we're going to

talk about. If you're reading about it or hearing about some others, that may be the direction that they're coming from.

I think really for you on the front lines and for your own experiences those two, how you define that may be slightly irrelevant because the experience of the experienced and burnout often comes along with secondary traumatic stress for a big number of people.

The third term is vicarious traumatization. Vicarious traumatization is a term introduced by Laurie Pearlman and her colleague right about the same time that Chuck Figley started talking about secondary traumatic stress. Really what we're talking about are two groups of people that noted and began writing about and conceptualizing an experience at the same time, but they were coming at it from two different angles.

Figley viewed the phenomenon of secondary traumatic stress and compassion fatigue from a trauma-theory perspective, really tied into the Diagnostic and Statistical Manual of Mental Disorders, really from a DSM perspective of PTSD. Whereas Laurie Pearlman and her group came at it from a different perspective, something called constructivist self-development theory, which is really a combination of a number of psychological theories: constructivism, psychodynamics, ego-psychology, and attachment theory.

What Laurie Pearlman described vicarious traumatization as the transformation in the clinician, the therapist, that's a result of the empathic engagement with the traumatic material that's provided by a client or a patient. I have "empathic engagement" highlighted, but we're going to come back to empathy in a little while. The issue is that empathic engagement is believed to be the mechanism by which someone becomes secondarily or vicariously traumatized. It is having that interpersonal relationship with the individual, as well as hearing of the traumatic events.

Some of the key aspects of vicarious traumatization, so again vicarious traumatization from Pearlman's perspective focuses less on PTSD-like symptoms, though she certainly acknowledges that can be part of the picture. She focuses more on changes that occur with the, she uses the term "therapist" because that's where she comes from, but the clinician, the therapist, the social worker, the physician, and so on. That there are changes in the individual's frame of reference and whether they're able to meet certain psychological needs.

I'm going to talk a little bit more about those specifically. The core of vicarious traumatization is that over time in working with someone who's been traumatized, and I guess I should probably mention that Laurie's work was in a group practice clinic that primarily focused on survivors of childhood or adult sexual assault. They were coming from that sort of framework. They were hearing stories primarily of women, but certainly not solely women, being sexually exploited, sexually molested, sexual

abused, raped, and so forth. Their stories that they heard, the trauma that they heard, largely came from that perspective. The idea was, what they saw within themselves some changes that occurred over the course of their careers in working with these individuals.

Dr. Bride: One way that changes is it's frame of reference, that is being how the clinician views their identity, their worldview and their spirituality. There may be changes in one's identity, that identity may be either/or or both professional identity, how I view myself as a social worker, as a clinician, as a professional, and how I view myself as a person or an individual, being in my case, a man, a husband, a father. There may be changes in how we view ourselves in terms of our we meeting our role, obligations, do we see ourselves positively in those roles, and so forth.

Worldview has to do with how we view the world. This kind of goes back to, many of you may be familiar with Ronnie Janoff-Bulman's work "Shattered Assumptions." It's really this idea that we all, at some point, have some basic assumptions about how the world operates. To be very reductionistic about it, at some point many of us have this belief that the world is essentially a good place. Good things occur to good people. If we do good things, good things will come back to us. Bad things happen to bad people or to people who've done bad things.

That the world is essentially just a place to a certain degree. That when we're faced with hearing of these traumas that these individuals have experienced, those assumptions about the world are shattered. Over time our worldview shifts from one of, to be very simple, the world is generally good to the world is generally bad, and there are bad people in the world, and so forth.

Then there's also changes around spirituality. Pearlman and her group defines spirituality very broadly, really meaning that spirituality is a connection to something other than one's self, and that life has meaning, that there's a meaning to what we do and a purpose to what we do in life. That over time our spirituality in that sense changes. We begin to have less of a connection to the world and to others and to something outside of ourselves and we begin to question the meaning of life and the meaning of our place in life.

That's one piece of VT, of vicarious traumatization. The other piece is that we all have some basic psychological needs around safety, trust, esteem, intimacy, and control. Those needs are two-sided, those have to do with having a need, for example, our own safety, as well as, the safety of others.

For instance, I have a need to feel safe in my environment and in the environment that I find myself, both psychologically safe as well as physically safe. I also really have a need to feel that my family, my wife, my children, those who I care about are safe as well. When those needs aren't met, that's what begins to cause some distress and some

dissonance. You can go to each one of those terms and apply that, Safety, we have a need to trust ourselves, we have a need to trust others. As we hear of these traumas, that we begin to lose that trust of others or lose that trust of ourselves and safety. We have more difficulty holding others in high esteem, for instance, or to have intimate relationships. The idea is that over time in hearing these traumas and what goes along with them changes, it makes it more difficult to have these psychological needs met. By not having those needs met, we introduce some distress and emotional problems.

Before I move to burnout, I also want to highlight, I mentioned that secondary traumatic stress is compassion fatigue and compassion fatigue is secondary traumatic stress, and also of the view ... I've had discussions with Laurie Pearlman herself around this, she doesn't agree with me completely, she agrees with me partly. Really I see secondary traumatic stress, compassion fatigue, and vicarious traumatization, they really are the same thing that we're talking about. We are talking about an individual's reaction, largely negative reactions, to hearing about the traumas of others. Vicarious traumatization, and secondary traumatization, or compassion fatigue differ really only in the way you look at them. To me, it's kind of two-sided thing point. If by experiencing secondary traumatic stress, you're not just experiencing the DSM symptoms of post-traumatic stress, you may also experience all those associated features that come along with it.

Then others, I've also pointed out that one of the negative aspects of working with traumatized individuals is a higher rate of burnout. I hear this much less frequently now, but certainly earlier on when I was doing this around secondary trauma, I would see comments, "Isn't secondary trauma just a particular type of burnout?" or, "Aren't we just repackaging burnout?" I understand that perspective, but I think we've largely come to the conclusion, both conceptually as well as there's research out there supporting, that these are two distinct processes that occur though they're not completely independent.

Burnout is "a prolonged response to chronic emotional and interpersonal stressors on the job," particularly in human services, healthcare, those sort of things, dealing with people and their care. That is largely marked by dimensions of exhaustion, cynicism, and inefficacy. It's really this construct of emotional exhaustion, which most point to that hallmark of burnout. Certainly, working with traumatized individuals can be challenging and can be emotionally draining and exhausting.

There's a couple of differences between burnout and secondary traumatic stress. One of the pieces is looking at what's the cause of the issues. For secondary traumatic stress and compassion fatigue, the causal mechanism is being exposed to other people's traumas, so trauma has to be present. If you're doing work with individuals who aren't traumatized, then you're not going to experience secondary traumatic stress, but you might very well experience burnout because it goes beyond working with

traumatized individuals. You can experience burnout in your work with all sorts of populations.

Dr. Bride: Another aspect is that burnout is really caused, not by the one-on-one work though that may increase it, that's the initial part of that, but it's really the causal factor, we largely believe, has to do with the resources that are provided. Burnout really is a function of having excessive job demands in light of diminished job resources. Resources being time, money, support, and various aspects. That's the piece that really seems to be the core feature of burnout that increases or decreases burnout, addressing that. You can have burnout in working with any population; secondary traumatic stress, you have to work with traumatized individuals.

Another aspect I like to point out between burnout and secondary traumatic stress is burnout is largely confined to the work environment. You're burnout around your work, but largely it does not impact your families. Sometimes that may be with burnout, but it can also increase depression. Secondary traumatic stress, if you go back to those things we talked about vicarious traumatization and what we know about how trauma affects interpersonal relationships, you can see how secondary traumatic stress certainly can impact one's life outside of the work environment. You don't leave the secondary traumatic stress as the work environment becomes home with you. It can impact your relationship with your spouse or partner, with your children, with the people that you interact with. As we go on and talk more specifically about the symptoms you'll see some other ways in which that occurs.

Okay. For the next few slides, what I'm going to do is I'm going to go through the symptoms or the criteria for PTSD, as they are in the DSM. I know that, I would imagine everyone on this webinar is quite familiar with these criteria. My goal is to just highlight how that manifests secondarily and as a reminder that these are the sort of things to really look for and how it's experienced. The first, of course, is exposure, as I mentioned secondary traumatic stress and compassion fatigue requires that one be exposed to trauma and requires that one be exposed to the trauma of someone else. Again, these are the diagnostic criteria straight from the DSM.

For post-traumatic stress disorder there has to be exposure to a trauma. That trauma can be either directly experienced or it can be witnessed in person. The latter two mechanisms of exposure speak directly to secondary traumatic stress and compassion fatigue and that one can be exposed by learning that the traumatic event occurred to an exposed family member or friend, or it can be exposed through first-hand repeated or extreme exposure to the aversive details of the traumatic event of another. These last two that is really what we're talking about when we're talking about secondary traumatic stress.

What's interesting about this to me is, in previous versions of the DSM and in a lot of the writings that you see there in the last few years, will

note that secondary traumatic stress or compassion fatigue are not codified in the DSM and now they really are through these exposure criteria.

Secondary traumatic stress, you're indirectly exposed to the traumas of others. One of the core symptom clusters is re-experiencing or intrusion symptoms. I'm not going to read through all of these. Really they parallel for secondary traumatic stress and compassion fatigue, what those have been directly experienced trauma will be. Our research on the epidemiology of secondary traumatic stress shows that the re-experiencing or intrusions are the symptoms that tend to be reported most frequently and most often by people experiencing secondary traumatic stress. One of the most common of the intrusion symptoms is dreams, distressing dreams about one's clients, patients, or the experiences that they've had. Also, the notion of intrusion of thoughts, reminders, triggers about the clients or patients that we've worked with in ways that are not intended. I like to give the example of pushing my shopping cart down the produce aisle and then the image of a particular patient or client, or a thought comes in, or simple just a shudder or an increased physiological reaction, heart rate, or sweating may occur.

There's also avoidance symptoms. Efforts to avoid a memory, thoughts, or feelings that are associated with the traumatic event, so the event of being with the people that we're working with, the people that we're providing services with, and traumatic events that they've experienced. As well as avoidance or efforts to avoid reminders of people, places, conversations, activities, and so forth, that arouse distressing memories associated with those individuals that we work with, or the events that they've experienced.

One of the things I'd like to point out, too, is a lot of these symptoms, especially if you work with a significant number of traumatized individuals or, for many of us, that's our entire caseload, or exclusively who we work with, it may not be a particular client or patient or individual, but a more generalized notion of being unsafe or being in a situation where someone else might be in danger or that we have been in danger, and so forth. It becomes this kind of global generalized trauma or event. Then we have negative cognition and mood ... I'm sorry there's actually two up there in that first bullet. Inability to remember an important aspect of the traumatic event, amnesia, a loss of detail around a case. For instance, it might be one that occurs, a persistent and exaggerated negative believes or expectations around ones self, others, or the world. We change in how we view those things.

I'd like to point out that almost straight from how Pearlman describes vicarious traumatization in the changes in frame of reference and worldview. To me, it's interesting that from the vicarious traumatization notion, although they were initially intended to be separated out from a PTSD perspective, are now being incorporated into the PTSD literature.

Because we recognize that as part of what occurs, not just as secondary trauma, but with primary trauma as well.

Dr. Bride: Persistent negative emotional state, diminished interest or participation in significant activities, a feeling of detachment or estrangement from others, and inability to experience positive emotions. Some aspect of depressive mood, social isolation, loss of pleasure, all can occur with secondary traumatic stress. You can see how that might then begin to impact one's interpersonal relationships.

Going back to the first of these, perhaps impacting our professional function if we're forgetting important pieces of our clients or patients stories, or what needs to be done with them. Or, going back to the previous slide, we're engaging in avoidance behaviors around this content or the individual that we work with. You can see how it might impact our occupational effectiveness and presence.

Arousal symptoms, so becoming more irritable, having angry outbursts, being reckless or self-destructive. With secondary trauma and compassionate fatigue, that latter one, it can occur in many ways, but the most commonly reported is increased substance use, alcohol or other drugs. I'm sure all of you know about hypervigilance and exaggerated startle response. Those certainly can occur, jumping at sounds or at movements, excessively on guard for any danger, and so forth. Having problems with concentration is also an arousal symptom.

I'll take a moment to also mention that it's important to note that there's a range of experiences with all these symptoms. Some of them certainly can be very functional and adaptive. One would argue that working with, for instance, from Pearlman's perspective, working with a lot of sexual assault survivors, of course you begin to be a little bit more vigilant about your surroundings and people and strangers, and that's okay and that's adaptive. It becomes a problem when it causes additional problems, when it causes distress and impairment and becomes kind of overbearing in our lives, many of these symptoms you could say that same for.

All right. Let me ask you at this point, of those symptoms that we've talked about for secondary traumatic stress and compassion fatigue, for you, how frequently, let's say in the past week, how frequently have you experienced some of these symptoms? All right. I'd like to see that there's not a huge percentage of people in the often, very often section, but there are some. That's important to note. One fifth of you say not at all. Eighty percent of you have experienced some symptoms in the past. That's important to note. Again, I will highlight that secondary trauma symptoms, compassion fatigue symptoms, are a natural byproduct of the work that we do. You would expect to experience some symptoms occasionally. The issue becomes, how are those symptoms impacting you?

Are they causing clinically significant distress or impaired function. The last of the DSM criteria for PTSD. Of course, clinically significant distress

is very subjective, it's really defined by the individual. Are the symptoms bothering you? Are you concerned about them? Are you receiving comments from your spouse or partner, children about them? Those sorts of things. There also may be impaired functioning, impaired functioning on a social level, so with family and friends and how we interact that way. As I've mentioned there's often a lot of social isolation and withdrawal from social activities. It may impair functioning occupationally. I've mentioned a couple of ways in which that might occur, but certainly the impacts are affecting this in our delivery of services.

Then there may be impaired functioning in other areas. For instance, we just have a completed study, a manuscript out there right now where we looked at the impact of secondary traumatic stress on health perceptions. This was amongst a sample of social workers and higher levels of secondary traumatic stress were related to lower levels of perceived health. Definitely those who had secondary traumatic stress viewed their health as more poor than it had been in the past or in comparison to others. There appeared to be this relationship between secondary trauma and health. The next step was then to really look at, are there objective measures of those impact as well?

All right. With that, to what degree you've experience the symptom? For those of you who experienced symptoms, let's poll to what degree have you been distressed by or impaired due to compassion fatigue, secondary traumatic stress?

Okay. About a third of you have not been bothered or distressed or impaired at all due to symptoms. That's great. I think some of the things to point out here is that percentage is much higher than the percentage who said they didn't experience symptoms. What that tells me, certainly, that there's quite a few of you out there who have experienced symptoms of compassionate fatigue in the past week, but have not been largely negatively affected by that.

That really kind of underlines, I hope, my point that it's a normal process and the symptoms are going to occur. Our goal is to allow you to identify symptoms and identify ways to address those symptoms and prevent a progressing to distress and impairment. Also, 60 to 70 percent of you said that either somewhat or to a great degree. There's certainly some impact negative in terms of the stress and impairment that's occurring amongst you.

All right. I'm not going to read all of these, I'm going to point out some. The next 2 slides are looking at a number of prevalent studies on secondary traumatic stress. All of these use the same measure, which is the Secondary Traumatic Stress Scale that I mentioned before, it's one that I've developed. I will point out that it's one of the files that are attached. You can download that and use it freely to monitor your own levels or pass it out to colleagues. You could post it on the telephone pole down the street for all I care, I don't make any money off of it, but it's a

tool that you can use to do some of these measures. The scale is tied to DSM or criteria for secondary traumatic stress, it hasn't been updated. I do have an updated version, I haven't distributed yet, that's type DSM5. All these studies were done with DSM4 version.

Dr. Bride: There's an item on that for each of the 17 criteria in the DSM4, PTSD diagnostic criteria that are specifically focused on traumas or experienced a piece of traumatic stress related to work or traumatized individuals. About half of the items will specifically say, for instance, had distressing dreams about my client or their traumatic experiences. The goal is not measuring one's own directly experienced traumatic stress, all that certainly that it can occur. You can experience trauma directly yourself, as well as experience secondary traumatic stress.

The key that I'm going to hone in here on is, the first and last pieces on these, the first one being, for instance, the top along with social workers, over half of the social workers surveyed met at least one of the core criteria for PTSD, based on the secondary traumatic stress. Half of them are experiencing some level of secondary traumatic stress that's pretty serious. Fifteen percent met the core criteria for PTSD, based on the frequency of the symptoms that they were experiencing.

Another survey of social workers, generally a little bit lower, 11 percent met the core criteria. Substance abuse counselors, 19 percent met the core criteria. Other substance abuse counselors, 13 percent. Domestic social violence social workers, 13 percent. Child welfare workers, 34 percent met the core criteria for PTSD.

I wasn't able to locate ... There certainly been studies that have included physicians, psychiatrist, psychologists, but they haven't presented the epidemiological data in a manner that allows us to compare all of these.

There is an article attached as a file that a colleague of mine and I did, looking at healthcare providers, primarily mental health, but there were some primary healthcare providers in the military. Actually, what was interesting about that for you all is that the levels of secondary trauma were lower than we might have anticipated given what we've seen with other professionals, organizations, and populations. That may be good news, but there was still plenty of it.

The key takeaway from these prevalence studies is that most service providers experience some symptoms of compassion fatigue. Most of those have relatively low levels of compassion fatigue. But there is a significant amount of providers who have high levels of compassion fatigue that impair them or cause distress.

The other thing I want to point out here is these numbers, 34 percent, 13 percent for core criteria for PTSD. Most of you are probably aware of the numbers. The prevalence of PTSD in the whole population is about 7 to 8 percent. These numbers are higher than that. More importantly, the 7 to 8

percent prevalence is based on lifetime prevalence of PTSD. Seven to 8 percent of people in the general population develop PTSD over the course of their lifetimes, or have over the course of their lifetime.

This measure of secondary traumatic stress, these were asked just as I did with you guys earlier, asked for symptoms in the past week. This is measuring current prevalence rates, people who were experiencing secondary traumatic stress at the time that they completed that surveys or in the past week. Lifetime prevalence of secondary traumatic stress meeting the core criteria for PTSD is likely to be much higher than this as well.

Okay. Let's talk about some risk factors. An obvious one that we've talked about is exposure to traumatized populations. You have to be exposed, but there are different ways that exposure matters, and different studies look at it differently. There are some that have to be with overall caseloads. Larger caseloads leads to higher levels of secondary traumatic stress. Overall that certainly is more important among people whose primary client or patient population are traumatized. With this audience, with you all who are attending this webinar, a higher caseload likely used to be more so. You could have another ... In other studies, the caseload that high, but there's very few traumatized individuals on that caseload and that might counteract the higher level.

Exposure also has to do with the percentage of caseloads that are traumatized. Most importantly is exposure has to do with not just who you're serving but how you're serving. You're exposure has to do with how much you are engaging in trauma material, either through assessment or treatment or engaging that information with the individual as well as your own processing of that information, documentation of traumas, talking about them in supervision, those sorts of things. Exposure has to do with how much you're really engaging with the traumatic material that patients are presenting.

There's some demographics that are related to secondary traumatic stress. Age is one. Higher age is related to lower levels of secondary traumatic stress. The same finding goes along with years of professional experience, so those who are more experienced in the field have lower secondary traumatic stress. We used to think that those were, maybe just measuring the same thing, but actually both of those finding tend to hold in controlling for the other. I think there's a couple of things going on here.

One, nearly all the studies at this point of secondary traumatic stress have been cross-sectional. There hasn't really been much in the way of longitudinal studies of secondary traumatic stress or compassion fatigue. What may be occurring is those that are at higher risk and have the higher levels of secondary traumatic stress are leaving their jobs, they're leaving the field. We're not necessarily capturing those. By virtue of that, those who are older or more experienced are the ones experiencing secondary traumatic stress. I think that's a part of it.

Dr. Bride: Also the fact that having more life experience and having more professional experience allows people to develop better coping skills and coping mechanisms over time. I think there is something about age and experience as protective factors, as well. As well as it being kind of an artifact of the measurement.

A number of these have shown a relationship between gender and compassion fatigue and that women are more likely to experience secondary traumatic stress or have higher rates of secondary traumatic stress. Some studies have not shown that. I'm very skeptical of this finding because, as you probably know, in the past that same finding has emerged with primary trauma, PTSDs are primary trauma. Most studies began to control or types of trauma, specific traumatic events, the severity of them, the intensity of them, the gender that washes out. The issue really is there are certain types of traumas that are more likely to result to PTSD. Two most likely are sexual trauma and combat trauma or combat-like trauma. They're most likely to lead to PTSD compared to things like the motor vehicle accident, or diagnosis of life-threatening illness, on robbery, those sorts of things.

The reality is that in a lot of the samples of secondary traumatic stress, first, there's a whole lot of women in number and most of them half of percentage is of men participants, so that may be skewing it. Also, women are more likely to work with sexual assault survivors. If you follow the logic of secondary trauma being indirect manifested, if they are more likely to work with those traumas and more likely to emanate in PTSD, then they may be more at risk. It's not really about a gender issue, it's who we're working with and what we're hearing.

Age, gender, there had been no findings related to socio-demographic factors related to salary, related to professional discipline, even related to level of education. Undergraduates degree, graduates degree, masters degree, PhD, all seem to have the same risk factors. We haven't really looked at individuals with less than a bachelors degree, however. There may be something there that we need to look at. So far that hasn't been an issue in terms of professional discipline or level of education. There's been no racial or ethnic differences noted.

Another risk factor is trauma history. Early on we identified trauma, having a past trauma as a potential risk factor for developing secondary traumatic stress. The research has been very mixed on this, so it's kind of the law of third, or it seems to be a third of the study shows that indeed a past history of trauma in the professional is related to higher levels of secondary traumatic stress, or higher risk to it. About a third of the studies have shown kind of military association. About a third of the studies have shown the opposite, that trauma history sometimes is a protective factor, those with past trauma have lower levels of compassion fatigue.

What's going on here is, it becomes a measurement history. We ask these questionnaires about past trauma history in a number of ways.

Some of which has simply been, "Have you ever experienced a trauma in the past?" Others go into so much more detail about it.

What we're now finding through our researches is that it's not simply having a trauma history that's the risk factor, it's how the professional is currently impacted by that past trauma. Individuals who continue to have a negative impact with a trauma that they're directly experiencing in their life have high risk for secondary post traumatic stress or have a higher level of secondary post traumatic stress. Whereas those who are not having negative reactions to the past trauma, those who resolved their past trauma are perhaps even experienced some post traumatic growth have less risk of secondary post traumatic stress or lower levels of it.

It's really about where we are now with the trauma and those who resolved their past trauma, who aren't negatively impacted, you can imagine, likely developed social support network and coping skills and ways to deal with the trauma in their life that they've then generalized to their work life as well.

Burnout, you can look at this two ways. Researchers are beginning to look at this more closely. Does burnout put one at risk for secondary traumatic stress or the secondary traumatic stress put one at risk for burnout? There are definitely a couple studies that have emerged showing that burnout is a risk factor for secondary traumatic stress.

As I mentioned, there aren't too many studies which is what we really need to determine whether it could be a cause of it. There is certainly a high association between the two, that you can experience both burnout and secondary traumatic stress at the same time. There are also groups of people who can experience burnout and not secondary traumatic stress and vice versa.

Empathy, as I mentioned before, empathic engagement is the way to be kind of the key methods by which the trauma is transferred from the person directly experiencing it to the professional. That emphatic engagement, therapeutic relationship and alliance, and that's the mechanism to change. Having empathy is a risk factor. I'm going to talk about this more on detail. We're going to parse out a little bit because I definitely want to tell you ... Okay. I'll just go ahead do that because empathy is also a protective factor. Again, I might parse out a little bit more.

My goal is not to say stop being empathic, don't care about your patients or clients. That's a necessary part of what we do. But there are ways that we can engage and deal with that, the way that that puts us at risk, or actually protect us. Again I'll come back to that in a minute.

Social motivational support is a protective factor. I have slide that talks about that as well. Then, self-care, we're going to talk about that in a little bit, towards the end here.

Dr. Bride: I also want to mention compassion satisfaction. Compassion satisfaction is somewhat analogous to post traumatic risk. It's the notion that we do not ... In addition to having experiencing negative impact from our work with traumatized individuals, we can also experience positive impact. We can grow professionally, we can grow personally, we get a lot of satisfaction in the work from helping others and so on.

The idea is not that compassion fatigue is on one end of spectrum and compassion satisfaction is at the other end. They're certainly related, but they're kind of what separate mechanisms. That having higher levels of compassion satisfaction can occur as having greater levels of compassion fatigue, but they help intervene in that relationship between the secondary trauma symptom, in the distress, in the impairment. It kind of moderate that aspect of it.

All right. Let me talk about a particular model of empathy that helps shed some light. Traditionally, most of us think about empathy as these two factors, these first two factors here, is that empathy has to do with taking the perspective of another perspective, putting yourself on another person's shoes. Having empathy is putting yourself in their shoes, taking their perspective or understanding their experience from that perspective. Also, aspect of sharing. Having empathy for aspects of their emotional responses to others and what they have experienced. I think that's what most of us think of as empathy and often that's where it stops. Empathy is putting ourselves in their shoes and feeling what they feel. Right?

Then, B, you can imagine how that might be the mechanism by which secondary trauma occurs [inaudible] and therefore can put us at risk. It puts us at risk because it's part of exposure that occurs.

However, Decety and Jackson down here, who developed this mode of empathy, stated that there's also two other processes that occur through the empathic engagement process. One is something called self-other awareness. It says, "the ability to temporarily identify between oneself and others." It's kind of temporarily taking the other person's perspective temporarily, they can pull back from that. We can get back out of that. It's not becoming the other person, but it's joining with them to a degree of it.

Kind of going along with that is that there's a process of emotional regulation. Whereas up there talking about the fact of sharing, we also have the ability to regulate the emotions that we experience while we're taking the other's perspective and sharing their emotion.

I think of self-other awareness and emotional regulation as something that's controllable. I like to think of that as a dimmer switch on a light or volume switch on stereo where you can turn it up and turn it down. The skills that you've developed and engaged in more consciously so that you really have to take a perspective and share emotionally, but you have to also pull back from it at times, certainly at the end of the day when you

get home, but also even as we're experiencing or engaging with our client.

Social network, organizational support. We've listed at least, in research, looking at two different things. Social and organizational support is kind of a broad umbrella. We can look at this two ways. One is social support from the peer support in the workplace, so your colleagues support. Then, organizational support, having to do more with kind of supervisory support. When we looked at people's experiences with peers and then definitely with supervisors, some key pieces emerges as to what reduced level of secondary traumatic stress.

For instance, you hear that first line, NS, it just means nonsignificant. There's really no impact negatively or positively on secondary traumatic stress in terms of having an attachment or friendship with peers or supervisors. Right? That's not to say that's not important. That becomes the attachment of friendship are necessary components of having the other pieces that I'm going to talk about.

Another aspect that in the process that there is a positive relationship. Reliable alliance is a construct from the work around peers that we have a reliable alliance with our peers and our colleagues, really that we feel that our peers and our colleagues are there for us. They provided help. They provided resources. We feel like they've got our back and we have their support, and they ours.

Relational quality is analogous to that with supervisor that talks about relationship between one and your clinical supervisor. That individuals who feel or report having a strong relationship and a positive relationship with their clinical supervisors have lower levels of secondary traumatic stress.

These other three, these kind of parse out different aspects of these alliances and relationships. One is there's a notion of believing that the peers or supervisors, depending on the study, are helpful. Not just that they're there and that we have an attachment or friendship, but they provide some tangible assistance, support and health. It may be in terms of ideas, processing cases, providing ideas about coping, and how to take care of oneself, and those sorts of things.

Another piece is proving that important piece of organizational and social support is having a mechanism to discuss the challenges of this work with contacted individual. It's not just being helpful, but having someone that you can talk to about what you've heard or what you're engaging or what you're struggling with in engaging this traumatic material. Having a safe place to be able to address this and discuss this.

The third is being satisfied with that helpfulness and that ability to discuss and kind of the overall relationship we have with our peers and our supervisors. You can imagine there's a lot of overlap between all these

concept, but the idea that it's more than just having a supervisor that you like. It's about the supervisor being engaged with you, being helpful, providing the opportunity for you to discuss, providing some feedback, providing some tangible support, and you being satisfied with that relationship.

Dr. Bride: What I think is really an important finding that becomes emerged from this organizational support is that it's not that you need to have those peer support and organizational or a good clinical supervisor, either one can be helpful while controlling the other. Many of us don't really have the opportunity to choose our clinical supervisor, right? We may have a supervisor that's just not a good fit for us or really not very effective. That may not be very helpful in terms of mitigating that secondary traumatic stress, but we can choose and we can develop peer relationship that do that.

Even if we don't have a good clinical supervisor relationship or that we don't engage in clinical supervision, if we engage in kind of a peer supervisory process or having a peer connectedness around these issues, it provides as much protection as a clinical supervisor might. Certainly, I would imagine that both together are the ideal way, but the reality is that's not often the case.

Some of you may operate in very confined or isolated environment where it's hard to engage regularly with peers and colleagues. Certainly, they make it more difficult to develop this. We're going to talk about how to overcome that in a moment. I'm aware that I'm running out of time, but I will get there.

This is a slide from, going back to compassion satisfaction and then including the resilience there some way that people reported positive aspects of their work. Observing experience client-patient, recovering growth, increased empathy, appreciation of life, personal growth, appreciation of relationship, improved relationships, and so forth.

I think I have another polling question coming up here. Yes. Take a moment to indicate, "To what degree have you been positively impacted by the work that you do with traumatized individuals?"

Okay, good. Thank you so much. I'm happy to see the not at all, very low, though there are so many of you out there. Many of you said somewhat. Almost two-thirds of you said to a great degree.

Again, that piece can really moderate that connection between having a symptom and having a negative outcomes as a result of this. It's really important. I'll talk about it as we got to self-care aspect to really kind of hold on to that piece.

Okay. Let's talk about what you can do. I'd like to present ... What you can do is really take care of yourself, self-care. There are things that

organizations can do in providing us support, but I'm here, I'm talking to you all as providers, you have control or you may have not control of how the organizations respond, the resources that are provided, but you do have control over so many things.

I divided it into kind of aspects of awareness, balance, connection on both the personal and professional level. Outside of work as well as inside of work we have to really maintain awareness balance, connection. What do I mean by that? As you'll see there's overlap or connection between awareness, balance, connection, things go back and forth there, as well as between the personal and professional.

Awareness has to do, at the very basic, to understand that compassion fatigue and secondary traumatic stress exist, That's a phenomenal that occurs. That is normal and is expected. That we can begin to recognize it and identify what those symptoms are. Awareness has to do with kind of being aware of your own symptoms over time and how they're changing.

One thing that we've found in secondary trauma really can fluctuate a great deal in a short period of time because part of it has to do with continual exposure. Vacations become very important because that exposure tends to diminish, hopefully completely minimize, but certainly I know that many of us take some of our work on vacation with us both formally and mentally. Monitor, it is to note if they're increasing over time. If they're increasing over time or there are changes in functioning, if they're functioning in distress or changing over time and getting worse, then that means that we might need to do some of the other things that we're going to suggest to self-care as well to help bring those things down.

I did a talk once to a group of, at Schools of Social Workers, psychologists here in Georgia. In those presentations, I often will give them the Secondary Traumatic Stress Scale so they can assess their levels. Typically, there are very high levels at social workers schools in psychologists. One time I went and there was very low level. I asked, "What's going on? This is strange." They pointed out that they have just come back from spring break, they were off the week before that, and that if we had given them the survey two months ago or a month ago that the levels would have been much higher. They recognized that that was happening. That shows getting away really helps. It's an important aspect of it.

I also like to speak up with on traumas if you're having concerns or troubles or negative impact of those. Recognizing the importance of supervision and consultation and peer relationship. Then, know your triggers. This is something that ... Part of my professional life has to do with substance abuse treatment and triggers being part of the relapse prevention plan.

Dr. Bride: What we've found and what I've heard from a lot of people all the time is their particular clients or patients or particular aspect of their lives or their traumas that can be particularly troubling to us individually based on what we bring to the table. I see that there are triggers or red buttons for us that are more difficult for us to deal with or may flare our secondary trauma symptoms more. Know what those are so that when they're confronted with that in the workplace you know that you might need to keep an eye out so you they can deal secondary trauma symptoms.

Balance. Balance between your personal and professional life at the very basic that you have to have a personal life, not just a professional life. Everything can't be about work, about serving traumatized individuals. You have to shut things down at some point to be able to lessen that exposure and allow yourself to recover. Protect your time. Protect your personal time. Have balance in terms of your physical and mental health. Engage in activities that support those. Find things that allow you to take time for relaxation or reflection.

Do whatever you need for stress management. Whether that be exercise, whether that be playing music, listening to music, spending time with kids, spending time with dogs, walking on the beach, walking along the lake shore, walking on the floors. You know what works for you in terms of stress management. The balance means making a commitment to doing this. As secondary trauma symptoms increase they tend to do less of that, so monitor. Going back to where it's monitoring how much you're doing those things that are positive for you. If that's decreasing, then you need to increase those.

Connection is maintaining connection in terms of family, having an effective social support network. It's easy to begin to withdraw from that with secondary traumatic stress symptoms, part of that being in social isolation I talked about, so engage in that. Be connected to your community, whatever you may define as your community - your neighborhood, your friends, your church, your workplace. It's part of that as well.

Revitalize your sense of professional purpose and connection. Remember why you do what you do and refocus on the rewards of your work. Going back to that is your compassion satisfaction as protective factor. This is one of the most important things.

Having peer and/or clinical supervision that's supportive and helpful, as well as having a sense of compassion satisfaction and identifying what is good about the challenge in the work that you do are two of the most important pieces that help prevent secondary trauma and deal with it when it occurs.

Kind of coming off that professional purpose and connection, develop professional connection especially if you work in isolation. Reach out to

people who do the work that you do that they can become a supportive network. Develop and utilize professional support network.

All right. Let me ask you this, a new polling question, how good are you at some of these things that I talked about in terms of self-care?

All right. Great. Some of you are doing great. Most of you need some improvement. Someone is preaching that I need some improvement myself. That's an important piece of that, it's recognizing that there's ways that you can increase your self-care and I strongly encourage you to do that.

The key takeaways, compassion fatigue is normal and expected experience. The negative impact of compassion fatigue can be minimized or prevented. It occurs, don't occur, but there's way to deal with it and to minimize it's effect. Self-care and social support are important ways to minimize to do that.

The biggest takeaway for me to provide you is to care for others you must first care for yourself. In the profession that we're at they're often self-sacrificing and certainly, do that and it's part of who you are as a professional, but you have to know that there's limits to that and if you're not taking care of yourself you can't continue to do the work that you're doing.

Here's some references. I assume that the PowerPoint will be provided. Thank you.

Dr. Nacev: Thank you very much for your presentation, Dr. Bride.

Dr. Bride: You're welcome.

Dr. Nacev: Now it's time to answer questions from the audience. If you've not already done so, please submit question via the question pod located on the screen. We will respond to as many questions as time permits.

We'll start off with the first question, if you will, Brian. "What is the secondary trauma and primary trauma, or what's the difference between the two?"

Dr. Bride: The difference between primary and secondary trauma is the way that ... Primary trauma is trauma that is directly experienced. It's an event that we personally witnessed. A physical assault or combat situation that we are there and it hurts us or [inaudible]. Secondary trauma is having someone tell us about their experience with this.

Dr. Nacev: Okay. Thank you. Next question was, "Is there a biological difference between burnout stress response and secondary trauma stress?"

Dr. Bride: That's a great question. I'm not aware of any research that actually look at the biological response. Certainly, secondary trauma actually has, I would say, some more of the hyperarousal type physiological responses - increased heart rate, sweating, heart palpitation, increased blood pressure. Burnout tends to be more depressive in nature. It occurs more in terms of tiredness and fatigue and dragging and all sorts of things. I would imagine there's some physiological part of it.

Dr. Nacev: Okay. Next question, "What might you recommend to organizations and/or peers in organizations to do to address compassion fatigue or vicarious trauma and burnout?" It's more I guess at the organizational level, what could one do?

Dr. Bride: I think there's a couple of things with the organization, one is it's most helpful for there to be an organizational culture in which compassion fatigue is acknowledged, it's believed and seen as a potential problem for the organization and the workers. The organization must send a message that, "It's okay, we know this is being experienced. We're going to support you in dealing with it and providing tangible ways to have those supports."

Those supports would be seen by providing for clinical supervision or group support, having adequate time off and vacation, and importantly around that encouraging people and supporting people in taking their time off in vacation. Not all organization do that, but that's an important piece of it. People are using that time and they're not getting the recovery they need.

Dr. Nacev: I'd say that's a very good point to highlight, was the notion for the organization to encourage people, to support people taking the balance. I liked your slide about balancing life, balanced life, and so forth. It's important to have perceived, support that notion and practice that notion in real life.

Dr. Bride: Absolutely.

Dr. Nacev: Okay. Next question that was posted was, "Can you identify the top three techniques with developing, enhancing resilience and possible proactive factors for secondary trauma stress?"

Dr. Bride: One would be developing and maintaining a peer or some sort of social support network, whether that would be peer, organization, or family, or friends, and actively using that. Another piece of resilience or preventive aspect is developing a self-care plan. There are exercises out there that I use. Sometimes I have participants sit down and identify what do they do and come up with kind of commitment to themselves [inaudible] those activities. Those are two. Then, the third is maintaining that balance. Having downtime and relaxation and stress-management plan that are preventive and active.

Dr. Nacev: Okay. Last question for today. "Is there a relationship between compassion fatigue and moral injury?"

Dr. Bride: There are researches that are beginning to emerge around this, very little, but there are a couple of people out there that are working on this. Empirically, that's not all I can say, but certainly, we think and some of the researches started to support that increased moral injury is significant risk factor for secondary traumatic stress? If you go back to kind of think about the vicarious traumatization in terms of the issues of world view and spirituality that it kind of plays into that.

Dr. Nacev: Thank you very much, Dr. Bride. After the webinar, please visit dcoe.cds.pesgce.com to complete the online DCoE evaluation and download or print your CE certificate of certificate of attendance. The online CE evaluation will be open through Thursday, September 8, 2016. Again, thank you very much to our presenter, Dr. Bride. This presentation will be archived in our Monthly Webinar section of the DCoE website.

At this point I want to take a few minutes of personal closing remarks. After 38 years working for the Department of Defense, it's time for me to move to my next phase of life - retirement. In addition, I have been a moderator for these webinars on psychological health for almost three years, I want to express my gratitude for your consistent interest, support, and participation. Although today we reached a major milestone, the most registered participants we ever had for this series. I hope and wish you will continue to participate.

Over the years, we have covered some topics of major importance to you, suicide prevention, new developments in the treatment of PTSD and depression, use of technology in psychotherapy, and evidence-based treatments to name a few. In addition, we have matured from providing only presentations to attaching CE credits for these presentations. As the commercial goes, we made it possible for you to double your pleasure. Next question is: which commercial?

I also wish to take a minute and thank the Protection team, behind-the-curtain people whose work has been invaluable because they made it all possible, they make it all look seamless. None of this would have happen, would have been possible without them. I thank Megan, Katrina, Mitchel, Tina, Alicia. Thank you very much.

Again, thank you all for your participation. I wish you much success in your professional developments.

To help us improve future webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To access the presentation and resource list for this webinar, visit the DCoE website at dcoe.mil/webinars. A downloadable audio podcast and edited transcript of close caption text will be posted to that link.

The chat function will remain open for additional 10 minutes after the conclusion of the webinar to permit attendees to continue to network with each other.

The next session, DCoE psychological health webinar, Gender Differences and PTSD, Symptoms and Treatment Approaches is scheduled for October 27, 2016 from 1:00 to 2:30 p.m. in the afternoon. The next DCoE TBI webinar, Unique Perspective For Women with Mild TBI: Gender Differences and Coping Strategies, is scheduled for October 13, 2016, again from 1:00 to 2:30 p.m.

2016 DCoE summit, State of the Science: Advances and Diagnostics and Treatments of Psychological Health and Traumatic Brain Injury in Military Health Care, is scheduled for September 13 through 15, 2016. Summit registration and continuing education information are available at the listed website.

Thank you again for attending. Have a great day.

Operator: Thank you for your participation in today's conference. Participants, you may disconnect. Speakers, please stand by.