CASAT Podcast Network

Hello and welcome to season four of CASAT Conversations.

I am your host, Heather Haslem.

This season, we will explore the impact of trauma on those who work in human services.

You'll hear from researchers, authors, and people with lived experience.

We hope you enjoyed today's conversation today.

I'm thrilled to welcome back Kathy Kain. Kathy joined us in season two when we discussed the cost of the work we do.

You can check out Kathy's previous interview on season two, episode three of CASAT Conversations.

Welcome Kathy, great to be here.

So as we get started, please share with us about yourself and the work that you do.

Okay.

I've been in the field of physical care and trauma recovery for 42 years, which seems impossible.

Um, I started out as a body worker, which might be different than some of the sort of practice lineage that some folks have who participate in this program, but relatively quickly in my private practice experience, I moved into special realizing and working with people who had chronic symptoms, somatic symptoms specifically related to trauma.

And that's really been my work then for all of those intervening years, 30 plus years.

I've been working specifically with that.

Um, and at the same time, I've always been an educator.

My PhD actually is in education.

I closed my private practice seven or eight years ago and I've really been focusing on supporting the providers.

Um I've always offered education but by not having a private practice, it meant that I could offer more in terms of mentorship and support for people who work in a really difficult practice environment.

Working with trauma survivors is depleting, which is part of what we're here talking about.

Um So really for the bulk of my time I've been working in that field.

So um I hope that I have interesting things to share with people about how you navigate that for an extended period.

Yeah, I mean you've been doing the work of treating people with trauma for 42 years, which is really incredible amount of time.

And so I'm sure you'll have a lot to share with us on how do you manage that as a practitioner?

Yeah it's been in a private practice setting but I teach to people who work in a wide variety of settings, so have a fair amount of experience of how to support people um in very demanding circumstances.

Yeah.

And you've had a front row seat, I'm sure from a personal experience as well.

So can you give us a synopsis of what happens in the body when we experience trauma?

Yeah, the really simple way to put it is that what we think of as trauma physiology really originates as response physiology is how I would put it and specifically what we're talking about is survival responses when we talk about trauma really and I'll talk about that in just a moment.

So there's these different categories of physiology behaviors, ways of thinking, ways of seeing um that are very particularly tuned to survival effort and the things that were probably most commonly familiar with are things like our autonomic nervous system, turning on our sympathetic arousal system to get us ready for fight or flight.

Um That is very particularly what I call survival physiology.

I use that umbrella term when I'm educating clients in particular.

So we have these versions of physiology behaviors, all of the things I listed that are fairly specific to survival effort.

And what that usually means is we're kind of maximizing the conditions physiologically for that.

And that means we increase our heart rate typically and our breathing.

But then we do things like turn down our immune system, turn down our digestive system because we're starting to reallocate energy, so to speak physiologically we're reallocating attention.

So our vision changes.

For example we diminish our peripheral vision and we focus on central vision which help with depth perception and identifying what we're seeing.

We do something similar with our hearing and we start tuning our hearing to what are often called low tone predator sounds meaning deep sounds that have vibrate torrey quality.

So we lose our ability to hear high pitched noises or voices.

Uh and also we lose our ability to extract voices from background sounds because what we're trying to do is listen to our environment to identify potential threat and that might be humans but it also could be other things that are making noise.

So we can't afford to tune all of that out and only listen to the human voice.

So we imagine if we imagine that's only supposed to be happening in a short term basis.

What happens in traumatic stress is that whole series of survival systems not just physiologically but behaviorally.

Our sense systems, what I call our paying attention systems are really supposed to be tuned for short term response.

But imagine that becomes long term chronic systems now and so then we start looking at what is the effect that trauma has, the effect that trauma has is that we are in a long term circumstance with what's to be short term systems typically.

So now we have things like a suppressed immune response.

Potentially every person is a little bit different about which systems wake back up again and sort of come back to normal response and which stick over with survival activity.

For some of us that might be more behavior systems.

Our physiology might kind of go back to normal, so to speak, but our behaviors still organize around survival effort.

Um For some of us certain physiological systems go back to normal and others don't.

So for the client population that I've worked with we would typically see um immune response issues.

Um chronic inflammations, fibromyalgia, that kind of thing.

Sleep disturbances is another common one.

The sleep system we stay on alert more than is compatible with sleep or in a physiology that's more about wakefulness and alertness.

Um And the digestive system is another big one where we see poor uptake of nutrients because survival physiology says, what do we need to do for the next 10 minutes to stay alive and digesting lunch isn't one of those things on the list.

So the digestive system kind of gets turned down.

So that's another one.

And we know from the adverse childhood experience study of looking at the health consequences of chronic exposure to trauma.

Essential services like heart and lungs are also strongly impacted.

So for some people, their respiratory and circulatory system doesn't really go back to normal.

So we might see high blood pressure.

It's not very easily controlled by medication for some people, it's low blood pressure because one of the categories of survival responses that freeze catatonic collapse state.

If our efforts, active efforts at survival are unsuccessful that that active effort is mediated by the sympathetic system.

If that doesn't do the job, we revert to what's considered a more primitive survival system which is the kind of a shutdown system.

The freeze response.

Um Those who are familiar with steve purchases polly vagal theory would know it as the dorsal vagal system that causes us to move into collapse.

So if you imagine that your you have a modified version of that and you're trying to be out in the world, we affiliate that with things like low blood pressure, but we also affiliate with things like depression.

So the sympathetic system being on all the time.

We affiliate with anxiety, restlessness, agitation, lack of sleep and that frees dorsal physiology being used too much.

We affiliate with lower energy states, it's a conservation physiology um and depression apathy, that kind of thing.

And of course in terms of addictions, what we sometimes see is in someone using substances to try to counteract the influences that they're they're under the influence of their survival physiology.

And so we sometimes go into behaviors or the use of substances or things like food to try to counteract the effect that we're experiencing.

So that's why we often see this inter relationship between traumatic stress and things like addictions and eating disorders, that kind of thing.

I really um something that was highlighted there for me was under the influence of survival physiology as we think about, you know, the behavior systems and what takes over.

Um That's a really powerful way to think about addiction well and the thing about survival physiology is we're not meant to be able to resist it, We're not meant to sit there and think through whether or not we should run, it really is meant to pick us up and move us.

It's very potent chemistry.

We are secreted substances that have very powerful influences on us that we really don't get much opportunity to resist.

We have to be pretty active in our resistance talking ourselves down.

My heart rate is up, my breathing is escalated the kind of things that happen for people if they're having a panic attack and you might learn strategies to kind of talk your way down from that chemistry.

But really it's very, very powerful chemistry.

And we sometimes don't think about that when someone's escalated up into threat response.

Like in a mental health context, if someone's escalated up into threat response, they are under the influence of their chemistry and we have to be attentive to how we respond to them.

We have to have the right context for understanding what then is driving maybe the behaviors that we're seeing for that person, uh, and having some idea of what those physiology czar, so to speak can be really helpful for someone as a clinician, whether that's in medical practice, there's a lot of different professions where it's really useful to understand when someone is under the influence.

You know, we do that when they're under the influence of certain kind of drugs or medications, like don't sign a contract if you're taking this medication.

Um, but I would think being a little bit more trauma informed to understand that Sometimes people are under the influence of their own physiology and their brain is working differently.

They're hearing is different if you're sitting with a client or a patient who's moved up into stress response, particularly if you have a high pitched voice, they can't hear you and they have a really limited capacity to process language.

So complex instructions go out the window for someone who's in stress response, we have to take it down to be really simple in our communication because we have someone whose brain is working differently as a result of that survival physiology.

So, Kathy you've been in this field for 42 years now treating different types of trauma and I'm curious, you know, I think oftentimes when we think about trauma, we think about big T traumas um and can people experience the same physiological response or what does the physiological response with small T traumas?

And is there like a kind of accumulation of those small T traumas that then impact the body.

Does that make sense?

Yes.

And um there's some important windows of development that we need to consider for that uh small t traumas when we're Children have a different effect when we're an infant and a child.

Um what we might as an adult look back on and think is not something that would be categorized as trauma for Children, it can fit in that category.

So, if we look at the adverse childhood experience questionnaire, for example, it's really an inventory of lack of safety and belonging.

So in our early lives having no access to ready access to safety and that can be either within the family or out in the environment.

Um we're living in a crime ridden neighborhood for example, or we're in a school where we're being bullied all the time.

So those, those cumulative traumas where you don't have ready access to safety and interconnection belonging within your family, belonging within your community.

Um certainly we have lots and lots of evidence that say they accumulate to the point, they can change the way your brain develops, they change your stress response, they change your ability to make connection and recognize safety in the future.

So we really do need to pay attention to those in Children And then if that has been present and we have those cumulative effects that person will most typically not 100% of the time, but most typically have less resilience.

So then as an adult, the small tease become important because that person does not have to be exposed to something huge and significant to pile on to the pre existing trauma structures.

Often the language we use is they've got a system that's been kind of organized Around and by stress response.

So we know that those Children will have learning issues more typically.

Again it's not 100%, they just have a higher probability and also their stress response system is more attenuated so it will be easier for them to move into stress with a smaller stimulus.

By contrast, if we had the benefit of developing in the context of ready access to safety and belonging, then the small t traumas more would fit in the stress category where our recovery for them would be more readily accessible to us but even the healthiest person, you pile enough of those on at one time, you're going to see those cumulative effects or you give one big T trauma it's really you know the one is the cumulative effect over time and you need more than one exposure, so to speak.

And in the adverse childhood experience study we do the rating based on how many exposures of each of the things in their category.

So the more categories of exposures of little T you know, lack of safety or whatever and the more of them equals bigger structures of trauma and in adulthood the same thing would be true.

It's really you're talking about a measure almost of resilience.

What is your capacity to recover from the little ones or the big ones?

Even if you've had that benefit of that more supportive beginning your ability to recover from a single traumatic event is most typically enhanced.

You have greater resilience and you have a higher probability of kind of naturally recovering from the loss of a loved one or a significant event in your life.

Well that really makes me think about the window of tolerance.

Yeah, exactly.

And in the model that I teach with my colleague steve Terrell that um the book that we wrote, nurturing resilience is based on that we came up with this terminology that we call the faux window or the pretend window where when you've had that early trauma, the developmental trauma your window of tolerance essentially has developed in the context, that you have to work pretty hard to stay within a range that feels manageable.

And so you will create ways to do that.

And that again is where food maybe does that for you or um you have certain kind of habitual what might look like, obsessive compulsive things, you have rituals that you do for yourself, meaning that you have to actively get yourself into the window tolerance.

It's not that that will naturally occur as a consequence of the fact that everything is working well.

You will be working at that process in a way that someone who did not have those early challenges does not have to do.

And that will make the difference if you're working with adults, that's the population of people that I was working with, these people who had developmental trauma.

I didn't know that in the beginning when I was first working with that, I just saw these kind of health consequences and then it became apparent and until we address some of the underlying traumatic stress physiology, we weren't going to lift the load off of their system to free up some of that body energy, you know, the nutrients that they take in the rest they take in that kind of thing to to get well.

Um and that's important for those of us who know in a few moments we'll be talking about what is this in relation to those of us who provide care our own history makes that difference because for some of us were already pre depleted by our earlier survival efforts and we don't have as much gas in the tank so to speak.

When we then are working in stressing environments it's true for everybody but in the helping professions they're demanding professions.

Um And so if we're fueling that response to the demand from a shallow pool it's gonna have a different effect on us.

Then we're doing that when we're doing that from a deep capacity of resilience and recovery from stressors.

And I'm curious can you deepen your pool um say you have you know a number of aces.

In what ways can you essentially create more depth in your pool?

Uh There's actually a lot of different ways that you can do that and for quite fortunately but they do take a kind of a focused attention.

So um immediately what I think of is the experience that a colleague of mine had who works for the V.

A.

And she was working on developing um a wellness inventory uh almost like a research instrument of how do we assess wellness.

And they were thinking of it in terms of the returning veterans that they were going to be working with.

But as they were testing the instrument, they also had people who worked with the V.

A.

Filling it out, thinking they would kind of get a baseline and actually what they found is the care providers scored lower then did the majority of the returning veterans.

So here we're the caregivers trying to provide care to people whose wellness inventory seemingly was better.

And what they discovered is actually what was helpful is for those care providers to go through many of the same kinds of programs that we would think of as being for trauma survivors.

So there are the kinds of things that help us build our resilience and I'm a particular fan of doing that, including the body and including somatic approaches.

And I'll take a little detour because I want to explain why is one of the things that develops over time for everyone is our somatic referencing system.

What's called interception.

It's that combination of experiences that are generated by our own somatic systems, our skin and our digestive system that tell us how we are, how we are sitting still, how we are in relation to the world, how we are in relation to each other.

The thing is that that develops in the context of the feedback we're getting from the people around us in our environment and we can make mistakes in how we calibrate that.

So if we're living in a threatening environment all the time.

And one of the examples that I use is let's say around dinner time is when there's big arguments and fights that can escalate into violence.

We might affiliate our sensations of eating and digestion with something very stressing.

And so now we've linked together a kind of a usual needed physiological marker, what it means to be hungry, what it means to feel satisfied by our food.

But we've linked it with stress response.

So our somatic vet vocabulary isn't necessarily neutral.

So if we've had exposures to previous stressors, our interpretation of what's normal and what's resting state might be inaccurate.

And that would be true with many of the people that I work with.

They wouldn't know the markers of relaxation if they felt them because they've been in survival physiology forever.

So maybe they reduce stress chemistry, reduce heart rate and they think, oh, I'm relaxed, but they might still be at a level that is not really very healthy.

So one of the big things we can do for folks in whatever category they fit whether they're the care providers or people who've experienced trauma is to get them back in relationship to their body and recalibrate those somatic systems.

So we have what I call a reliable witness to our own experience.

Can I rely on those indicators that say that was a deep breath?

I call it reset to zero?

How do we actually know we've reset back to zero?

What does relaxation feel like?

What does a deep breath feel like, what does some feeling of some version of access to safety and connection feel like, what are the markers of that.

I can learn the social markers that's important, but I also need really physical somatic markers to say this is what it's like and that will improve my sleep, that will improve my stress response, not only my behavioral response to other people.

So other folks around me will begin to be able to notice the difference and give me that feedback to say, I notice that you are more resilient there.

That's what we do with our patients and our clients.

We help them learn how to do things differently, understanding your own threat response, understanding your tendency.

And I'm just giving you the list that I do with clients.

It's the same list that I do with clinicians with practitioners.

Do you have a tendency to do the flea?

So your way of getting out of stress is to either physically exit the circumstance or flee into having a glass of wine or flee into your phone and I'll just spend the whole evening scrolling and whatever and i it's too stressful to feel myself.

So I'm gonna exit somehow or are you more the kind of person that's gonna go into fight.

So you're gonna have arguments, you're going to respond to the circumstance with sort of verbal aggression, getting to know our survival habits and how they aren't serving us is helpful.

So that's what I mean when I say trauma informed, I mean right down to knowing what do we do when we're we feel our survival feels threatened in some way.

Getting to know our habits of that and then getting to know how we don't do that anymore.

What do we do instead of that?

How do I support myself when I feel that thing coming up that says, okay, that person just said something that I don't like and I'm going to come in to fight.

What do I do for myself to settle back and take a moment and notice that maybe that's not the best response here.

Maybe quiet conversation or maybe just sitting with myself and realizing I'm overreacting.

Um the other piece of the puzzle is when we need breaks.

So that same system is part of what we rely on to say I am way past my limit here, I'm running on fumes.

I call it flat battery.

I have lots of names for this because I talk about it all the time, not only with clients but with practitioners.

When am I hitting that flat battery syndrome where now I'm kind of spending resources I don't have, I'm withdrawing from my family.

I'm not going out and doing social stuff.

I'm not doing things that I enjoy because now I am so deeply fatigued by the work that I'm doing, that.

I'm conserving my resources to do it the next day and the next day and if I keep doing that for 30 years, it's going to be very unhealthy and I'm probably going to physically pay the price for that.

And so how do I start to know when I'm for myself?

I think about it is starting to nose in, you know, like as a boat starts to dig into the water and say okay, when am I starting to go in that I'm going to start having to push a lot more to even get the minimum done.

That's my information.

It's either break time in the sense of a day off, mental health day or two days or maybe I retool what I'm doing at work so that the higher stress task go to someone else temporarily or get put off into the future.

And I recharge my battery and identifying what is that for us?

What recharges, you know, for some people that's reading for some people that's going out with friends, it's each of us need to identify what helps rebuild us so that they were not paying that price.

So it's a kind of a recognition, have a vocabulary that tells us where we are and know that it's reliable.

Pay attention to it.

Get in the habit of noticing an inventory of noticing, finding out what helps us, what does that recharge, What helps us move out of those habitual survival responses physiologically behaviorally and noticing when we're going to our kind of crutches, so to speak, in the vocabulary with my colleague steve Carrell, we call him defensive accommodations, we're having to get more active now to get ourselves back in the window of tolerance and we can start to get to know those things that tell us, Oh right, I just sat down tonight, an entire bag of chips.

That's a marker for me that says I'm now kind of using food to try to get myself settled when there's healthier ways for me to do that.

So those defensive accommodations themselves, those management strategies themselves can become warning signs for us when I get into that behavior, when I start hearing myself say that when I feel this way that says back up and do a little inventory of where I am.

One of the things that I've noticed is really um, with these survival habits there.

Um like we might go into fight in some situations and flight in other situations, You know, home life work life.

I think sometimes we think of like, oh I just do this.

But there's a lot of nuances as you start to really pay attention.

And so, um you know, really like, I feel like you have to become a real detective in a lot of ways as you start to pay attention to your own survival systems.

Well, I'll just speak about my own experience of being this long in this profession.

The way that I have had to frame it for myself as a practitioner Is it's actually my mindfulness practice in a way you could call it my spiritual practice for the reason you said is when I was working on my master's thesis.

One of the things that I did was I interviewed practitioners who had been working in the trauma field and my criteria is it had to be 30 years or more that they had been doing that as practitioners and or as educators.

The majority of the people that I interviewed were ill, they were in very poor health and some to the point that they had to withdraw from the profession, they just could not, their health did not support it.

And that was extremely sobering for me.

And fortunately it was early in my work life and I realized that's me 20 years from now, if I don't start paying attention now to the ways in which I need to take care of myself because it's a high burnout profession and we lose our most experienced practitioners and educators really from burnout often.

Um they leave the profession.

So I fortunately got a bit of a head start on how did I need to do this?

And one of the first things I figured out is what you just said.

Um fortunately, almost simultaneously, I also had the experience with one of my first teachers in learning about working with trauma was Angwin Saint just who at that time was specializing in working with um domestic violence survivors and combat survivors.

She now only works with social trauma and one of the things she said is that when we're working with trauma population, we have to understand that every person who's experienced trauma holds terrible knowledge.

They hold the terrible knowledge of what humans do to each other and the horrible things that happen to humans.

And when we're working with that person, we're agreeing to share in that terrible knowledge.

So for me as a practitioner from the very beginning, I realized I'm making this decision to continually be exposed to the awful things that happened to other people and I see the consequences that can happen if I don't figure out how to do that in a way that's healthy for me and the way I figured it out, which may not be the way for everybody is to be mindful moment by moment and it was a self reflection process, what is this, what am I doing to myself to be with this person?

And my habit was at the end of every session I would do the reset to zero.

Am I actually done with this session or am I still feeling an after effect from having been sitting with that person in the moment with the person when they share something with me, I would take a moment and say to them, I just need a moment because what I want is to be with that person.

They lived through the terrible thing.

I'm here on the outside.

And so I'm feeling like I need to have a willingness to be with what they've lived through.

But I sometimes need a moment to find my way to how am I going to do that?

And then at the end of every session, did I find that way?

Or am I leaving this session with some after effect from this at the end of each day?

If I'm disciplined at the end of each week, am I starting to nose in, am I allowing this to accumulate to the point that the self care need is going to get bigger and bigger and bigger until a year off is going to be the only remedy.

So for me it was like a mindfulness nous practice moment by moment.

Am I here in my present with this person and my withdrawing with horror and closing my heart off to them because it's too horrible to hear if I do that.

I have to find a way to find my way back to openness.

That will be different for each person.

But that has literally been my practice now and I have particular things I do um sitting connecting to all of the other people who are out there in the world, helping other people.

I'm not the only one people can help the person I'm working with people can help me if I need it.

I have people I reach out to, I've developed a great network of folks that I can be with to say I'm struggling, I'm struggling with this client or I'm struggling in general with feeling like it's pretty hopeless to empty the ocean with a teaspoon when there's endless trauma it seems, who do I talk to to say I need somebody to help fill my battery, you know, um, including clients who are being successful in their healing and making sure I take that in.

It's not only about bad stuff, it's also recognizing that even when they don't get completely well, that people have improvements in their life and are better able to live the life they want to live or what they can live now from where they are.

I worked with people with spinal cord and head injuries.

They're not going to go back to the life they thought they were going to have, But that doesn't mean they don't have a good life.

And for me it's been actually a transformative process as a person.

I'm a very different person, that sense of broadness in my markers for what makes a good life.

I have really altered because I've watched clients do it.

I watched people get to a good life from what looked like severe limitations and no hope for having a good life from where they were.

And I watched people kind of claw their way back into having a life and being a person who is more of who they want to be and those are the people that bolster me a lot of the time is okay.

I can get back in there and help this person in this way, I can't do everything for them, but I can be kind and I can be responsive and I can maybe take the burden for a while of adapting.

I was just with a group of people this last weekend in a training environment, one of the things I said is the offer of adaptability is huge in our world right now because it's such a huge demand in marginalized communities to constantly be adapting.

It's the load that's there 24 hours a day to adapt, to be safe to adapt in order to belong, to adapt in order to get something to move forward in your life or your career.

And even if it's just for an hour or however long I'm willing to be the one who's doing all the adapting here and enjoying who you are and having you be able to show up and however you can not being afraid of you not thinking you're only the stuff that is hard for you and seeing in you, that other person who's still there longing for more in their life and more of how they are.

If I can just keep finding that person that's an awful lot to offer.

But I can't do that if I've exhausted myself if I've depleted myself so deeply that I'm just struggling for survival for myself and of course the pandemic has done that for a lot of us.

I mean we thought it was going to be shorter, but it's been a long time for those of us in the helping world to be helping so many people so much.

We all have pretty low batteries at this point well.

And I also think about it's really like I see it as like this emotional residue that can be left over if you carry it with you after sessions.

Unless you have some sort of practice or process of letting it go, which um, you know, you shared how you developed.

Yeah.

And my practice, the way I call it is letting it be.

So Um we I learned the original one of this in the somatic psychotherapy program that I was on the faculty for 12 years in the somatic psychotherapy program in Australia.

And we had a practice that we taught people at in the budding practitioner basic levels.

We found it was so important and we called it objecting without contracting, meaning that we could sit there and object strenuously to how unfair the world had been to this person we were working with and how much they've been harmed, but we needed to learn how to do that without harming ourselves and kind of moving into bracing contracting, not breathing, whatever that was.

And it was just a somatic practice to say, take a breath.

We used to have our three little things, movement, breath and sound, so you move you breathe, you make noises, you shake your arms, you do whatever you have to do to settle as a practitioner.

Over time it just made more sense for me to call it for myself letting it be.

So because I was so much working with people who probably are never going to be completely well, they're going to be living their life with some limitations.

They have chronic diseases.

Um, I don't work with a young population, so chronic diseases that have already taken their toll.

And so for me it was the practice of letting letting things that I can't change be So while simultaneously bringing interest and curiosity and energy to the possibility that we could change things that we didn't think we could change.

It's a really hard balancing act to stay interested and stay curious and keep exploring with someone while also not then creating this pressure that they have to be different.

Because that is also true with a lot of the people that any of us work with when we're working with trauma, they've had so many experiences of people telling them that what they are isn't good enough that sometimes the source of their trauma, but inadvertently in the treatment culture, we can create the same thing.

What are your symptoms?

How are we going to change and what are your symptoms?

How are we going to change them?

That in and of itself tells them how you are right now is not the place.

And it's certainly not the place we want to live forever.

But it's where we can start.

So part of the practice for me is to meet the person with kindness and hopefulness without making it feel like they have to be a different person in order for someone to meet this with kind meet them with kindness and hopefulness.

It's and it's again, that's where I go back to saying it's a mindfulness practice because it is a delicate practice.

I've been at it for 30 plus years that I've been figuring that out and I'm still learning ways to be at ease and permissible for the person and meet them and at the same time not overwhelmed moment, a simple thing, but it's how I know how to not have to leave the profession.

I mean those, that's what many of us come up against.

If I don't figure out how to do this, I have to do something else with my life professionally, which might be the thing for some people.

Um not everyone is cut out for this.

When I started working with um terminal cancer patients, I realized I'm not the kind of person who can do that.

I am so grateful for people who work in hospice settings and have the constitution to work with people with their dying process.

And I just had to admit it wasn't me, I just couldn't do it.

I was heartbroken and unhealthy and never found a way to get to a healthier relationship with what was happening with people.

And so it was just better for me not to work with that population.

I just, it just took too much of a toll on me and made me less available for the other people that I was also working with.

So I think that's a part of the self care is understanding which populations of folks we can work with and it feels relatively easy or doesn't take that much to be with them and who are the people that it's like loading ourselves up with carrying rocks.

You know, it's like we're gonna just keep drowning and drowning and slowing down because we don't have the capacity to recover easily when we're working with folks who have this kind of issue or disorder or what have you.

Yeah, it's really about intimacy of knowing ourselves and our capacities.

That's right.

And and being willing, you know, is the treatment culture sometimes says to us, we should be able to do all of that.

And some of it is just being willing to say, I can't, I'm just, you know, I'm just, my nature just doesn't fit that thing.

I work with clients in my practice.

I worked with people routinely.

Then I found kind of interesting and pleasurable to work with that had been referred to me by other practitioners where that client scared them or enrage them or, you know, and I was so grateful that they were willing to notice that and say, let's send you to somebody who can work well with you.

And I would do the same thing.

It's like, this is not a good fit for me with this client.

I just they leave and I feel like I was completely unhelpful and day after day, week after week is like, I am not figuring out how to be helpful to this person.

And it's just then I'm dreading seeing their name in my, in my appointment book.

Wouldn't it be good to send them to someone who says, oh, that person's coming, This will be fun.

I love that.

The ego doesn't always like that one.

It's like, no, I gotta, I gotta, I gotta figure this out.

And yet there's so much wisdom and just acknowledging like this is not a good fit and there's someone out there who there, who this is a good fit for.

Inevitably it might take some doing, but we're not the only ones that goes back to knowing we are not the only person who can be helpful to people and hopefully we're creating and finding a big network of other people to send our folks onto if we aren't.

And sometimes depending on our practice setting, there's someone right there in our the same environment with us and those of us in private practice sometimes have to work a little harder to find who those people are.

But that's another big piece of the puzzle for me was always having other practitioners of different modalities in a referral network to make sure I had someone that I could match clients up with to say, I think this person might be a better fit for you and we always, the whole community of people, we stayed in touch about availability is if I refer a client to you, you're just going to say no, that doesn't help who's available to take clients now and what programs are available to send this client to.

That's also an important bolstering for us.

That makes a lot of sense.

And there's an ethical responsibility there too.

Um, in not just saying, oh, you should go see this person, but like actually ensuring that that person gets to the next clinician.

That's right.

Um, you know, you talked about the trauma response on the body and I'm curious if um the body reacts differently to vicarious or secondary trauma or if it's similar.

What is that like for the body?

Well, it's a little bit of a yes and no answer because it depends the context.

So if you're talking about someone, say who's a first responder and they're in an environment that's physically dangerous for them or they're working in an environment with patients where there's potential for violence are at that point, our physiology is matching up pretty well with the trauma survivors, You know, we're probably in fear and vigilance and it's gonna be pretty similar, But if we're working in an environment where we have the capacity to do what we're doing, except maybe we don't have resources or there's rules in place that mean, we can't give those resources or somehow or another, the structure where we're working is contributing to the under care of people.

Then we go over into these things that are more in the category of moral injury, for example, or we go into perhaps our own responses of things like shame and helplessness and hopelessness.

And I mean, in the bigger picture, you can say, yes, we're going to have the same response.

Eventually, it's going to take a toll, but it it takes a toll in a little different way in that initial one.

When we're in that survival physiology that's around danger.

If we're out of the danger, we have a better probability then of getting ourselves back out of that survival physiology and a lot of the care that we now have in place for first responders and people that we know are going to have exposures to trauma are about that.

How do we come out of that that survival need when we're not in combat?

When we're not in in the dangerous moment, we don't have routinely, I don't think as helpful resources for people when we're working more with those issues of helplessness, hopelessness, certainly some of our clients have that.

But if you're working in a client population that's a marginalized population and those clients are out in the world every day being told that they're not of value and you're supposed to be there supporting them and you can't change what the world does every day with that person.

That's a kind of a recipe.

It is vicarious trauma in the in the what I think of as kind of the seed syllable, so to speak of trauma is helplessness.

That's one of the definitions of trauma is we're faced with something in the face of which we feel overwhelmingly helpless.

That's one of the definitions of trauma and we put it more in the context of survival.

I'm faced with a survival task that I feel help us to accomplish.

But now we're talking about that with someone whose job it is to help that person and if I feel overwhelmingly help us to make a difference for them, that pretty much equals potential trauma response, it's just probably gonna show up in a way that's less visible than it might for our clients.

Maybe it'll show up as things like anxiety more likely it'll be sleep disturbance and the kinds of things we talked about.

I need to work harder to get myself out of that feeling at the end of the day.

So what does that mean?

The same things I talked about before I withdraw, I have a glass of alcohol, right?

So I would still count those as trauma symptoms, but they're not always gonna look the same as we would see in the direct trauma survivor, because we're that next step back in our role.

So, the role we have and how effective we can be in that role is often where that trauma comes from.

Of course we have the other one that I spoke to about terrible knowledge, We might be sitting there listening to day after day stories of awful stuff, and that can be traumatizing, but in my experience, more on the burnout end than the likelihood that we're going to end up with panic and anxiety and the things that our clients are coming in with.

It, certainly it happens, but I think it's, for me it's more worrisome because it's usually less recognized, it fits a little bit more in that cumulative slow accumulation.

How do we know when we're over the threshold to say now it's too much.

Where is that threshold?

It's going to be different for different practitioners depending on their own history.

So, the vicarious trauma piece to me, and the secondary trauma piece is a little stickier question, because our own resilience makes a difference.

I've met people who work in this field happily without having that experience.

And when I asked them about these kind of questions, it's like, well, I just figured out a ways I want to be there for that story.

I want to hear that I understand it could be horrifying, but I'm actually feeling like, oh here, this person person can finally speak it without worrying about me when they tell their story and they there's a way they hold it that doesn't affect them in the way it does for other people, where it's just like another rock on the pile.

I can't listen to another horrible story of whatever.

Um, and so your treatment environment, the control you have on that people in private practice usually have a little bit more control about exposure, so to speak and balance your client population and who you take into your practice when you're in a more larger institutional setting or where you're really working with very specific populations of people.

Uh if you're specializing or your your delivery system is really geared towards sexual violence survivors.

For example, you're kind of hearing the same stuff all day every day and particularly if you have that in your history, that's a much harder thing in terms of maintaining health.

I think in what I hear from people who work in these different environments, that makes a lot of sense and the it's the importance of our environment and acknowledging, you know, do we feel safe in that environment and what is our ability to have control over that environment and how that impacts Um, even just how our bodies experiences the trauma.

Again, it just goes back to all those nuances, right?

Like I think our brains want an easy answer X equals, you know, but it's I find that with trauma and as we look at this, there's just so many layers and I think, you know, the last thing I would say on that is in terms of those institutions, um you know, it can seem like we're saying that we all have to do it ourselves but backed if we work in an environment where we don't have that much control over how the care is delivered or what our role is that places the burden on that institution of whatever kind it is to do some of the take some of the responsibility to do some of the caretaking in traditional cultures, in particularly collectivist cultures, it's really understood.

There's no such thing as one person experiencing trauma, if it happens to one person, it happens to everybody.

And that's true in organizations, whether they know it or not.

And we're seeing a very very high attrition now of people from the helping professions, particularly medical and mental health care professions.

And I think it's not only evidence of what's happened during the pandemic, but for many of those people, what you're hearing is it just was like that was the icing on the cake.

We were already not feeling supported and cared for.

And so there is an organization and groups of organizations that have missed the information that secondary trauma, vicarious trauma, a sense of helplessness and inability to feel safe in your work environment, not just physically safe but safe to make a mistake, safe to speak up and say something needs to be different, safe to say I'm struggling here and I need some help.

We we really limit the person's choice, then you have to leave or bear up under it.

And so I would really advocate for the organizational institutional level, even if it's small, even if we're talking about groups of practitioners doing some of the same things we've been talking about, just do the things you would do for your patients, you know, have programs in place that aren't external, that aren't like you go out there to go do this thing, we're gonna build it in here because we recognize it's important.

How do we support you in developing your resilience?

How do we have programs available to you here?

How do we make a way have access to green space which we know is so important have ways that we can find each other when we're struggling have mentorship programs for people um have buddies, you know, like who do you go to when you just had a really difficult time?

Who do you go and hold their hand and sit there and say, I just need to cry.

I just like, I just, it's one of those days, you know, I just need to let it wash over me and get myself back to myself.

How do we create that even at the smallest level would make a big difference because organizations are paying the price for that now and then everybody that those organizations help pays the price by not having access to providers to care providers in some way.

And we're really seeing that now rationing care, particularly mental health care.

Um it's starting to be rationed within different systems because we don't have enough providers.

Um and so we're kind of coming to what could shape up to be a crisis level of exactly the thing we're talking about, how do we care for the caregivers?

How do we care for the care providers?

It's not really that different about how we care for our patients.

We need the same things, we just need them delivered in a professional context rather than at that personal level that we do for our patients and clients.

How do we do that as a community of clinicians?

That's what the organ, I think those that those are the questions that organizations are really gonna need to answer.

Yeah, it's um as we look at the shortages and all of these different helping professions, um, and the first responder communities and it really um, is a question that needs to be addressed.

And unfortunately, yeah, there are people addressing it and I know that's part of what you're doing here is to ask the right questions, have the right conversations, hopefully have the right people listening that say it's not going to be retooling everything from the top down, we can start adding things in getting feedback from people about how it helped them or didn't use our community as resources, we have people who've been performing heroically in the face of huge challenges that have a lot of information about what is helpful for them and what's not helpful.

So even just tapping into the resources of the people who are presently in the system, so to speak, the folks who stayed behind um probably have some good information.

The folks who left have some good information.

So reaching out to people who have withdrawn from the profession might be useful.

Um And I hope that that all of these conversations contributes to that effort because it's really gonna be I think it's going to be one of the next places we have to be working is we're doing a better job of trauma informed care at the delivery face to face level with patients and clients where we aren't doing it really yet.

Is that next layer or two back with the people who are providing that care and the people who are supervising the people who are providing that care who need to understand what they're seeing.

So we need to understand what we're seeing with our patients of like oh that response is coming from survival response.

That's why that person is doing that.

I call it barking with my client.

So my client just barked at me.

That's because they're feeling threatened, huh?

So if the supervisors understand when I start seeing these behaviors and these patterns happening, I have a staff that's telling me they're really overdone.

And we better start paying attention from a different perspective that isn't just like disciplinary and put more pressure on, right?

That has the kindness built into it to say, oh God, it here's what we need to do and go and get some a meal together.

Do something that makes us feel like human beings again.

Well.

And it it brings me back to what you said really about mindfulness that requires us to really pay attention to our colleagues to, you know, everybody within the organization.

Um you know, how how are you doing?

And it's that how are you really doing?

Not not that I'm fine.

And then like moving along.

Yeah.

Yeah.

And I'm a big fan of people are okay with it?

Hand on the shoulder or something.

You know, we know from some of the research that when you're asking something from someone, if you touch them in a way that's okay with them a social, what I would call a social touch, you get a different response.

And when you stand across the room.

So when you're asking that question of someone, if they're okay, if you have a relationship with them to put a hand on their shoulder and you say how are you how are you really you're likely to get a different answer than when you're just sitting there at the table going and so how are you today?

You know, it's a really different question.

So it's also that learning to step forward, that's really kind of where I started with this for myself as a practitioner with clients, how do I not be braced in myself so that I stepped forward to them to let them know?

I'm actually interested, I'm interested in the real answer to that question.

How are you and what are you struggling with and then together, what can we do about that?

If anything, the worst thing we can offer is a good company, meaning the least effective thing we can offer.

So at worst we can offer good company and that's a lot.

We might not be able to change anything in the moment, but I'm willing to sit here with you and be with you and say, yeah, this is really hard.

Mhm.

And that's the what's really emerged or the theme that's emerged from the season is honoring our own humanity as practitioners.

And I feel like that's again highlighted here in today's conversation.

Um the way I put it to the people that I train is it's always in your scope of practice to be a human being, no matter what else, if you're sitting with somebody and you're thinking this isn't my job to be helping this person.

I don't have the skills to help this person, you can be a human being with them and be available as a human, if nothing else.

And unfortunately in our treatment culture, we've been sort of trying to get the humanness out in part so that we don't get the human mistakes, but sometimes we go so far in trying to not have human mistakes that we make it hard to be a human, we make it kind of hard.

I used to have a colleague who was a nurse midwife and she would cry when babies died and she got reprimanded repeatedly for being over emotional and eventually she left the profession because she said, I refused to stop being sad when someone loses a baby.

I want to be with the parents in their moment of grieving and I'm going to do that as a human being and they're telling me to stop being a human being when I'm helping people bring their baby into the world.

I'm not willing to do it.

It was a very unfortunate circumstance that she got placed in and I always thought it was one of the most powerful things she had is her willingness to grieve with people when it was necessary.

She celebrated with people when it was there.

But also she was willing to grieve with parents whose Children that they thought they were welcoming arrived, either not living or with different circumstances than what they had hoped for.

I think those kind of things require human response.

So that's another thing at an organizational level is supporting people and being human would be nice and you know, finding that balance as being careful about the human mistakes, but also being careful about maintaining humanness as one of the basic standards of care.

I I whole heartedly understand that I actually left an organization because I felt like they were asking us to be robots and I I'm not and I won't be and we don't provide the best care.

That's what's actually true.

If you talk to the recipients of the care, they would rather I know this from hearing from my own clients.

They would rather have someone sitting with them being genuine saying, I don't actually know the answer to that than someone who separates themselves and doesn't let themselves feel bad thing that says, I don't know how to help you.

I don't know how many times I've had to coach a client to say when someone did that thing to say, oh, you have this thing that nobody knows what to do with.

I said, all you heard them say to you is I don't know how to help you.

And that person didn't know how else to tell you that they couldn't help you than to say to you, you can't be helped.

And they said it that way and all they were actually talking about was themselves.

So if we can't let that human side of us come in to admit when we don't know can't no, don't have the tools or whatever.

We're not providing the best care and I think we're underestimating our clients and patients that they probably are more willing to hear us and see us being human than we think.

I wholeheartedly agree with you.

You know, as you've given us so much to think about or me personally so much to think about today.

I really love this conversation.

Is there anything else that you want our listeners to know or understand as we wrap up?

I think we've kind of covered the waterfront on this one.

I think so too.

I'm really, I'm taking away with me.

It's always in your practice to be a human being.

That's pretty simple.

It's not going to be so simple in actual practice.

But yes, it's a simple but not easy.

Well thank you Kathy, it was a joy to have you back.

It was great to have a chat.

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