PESI Grief Summit

Compassion Fatigue

4-30-21 11:45 a.m.

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>>> Welcome back.

I'm Zach Taylor.

I am so happy that you have come back and joined us.

Wasn't David unbelievable this morning?

I just want to take a few seconds to thank Donna who is here and our other incredible ASL interpreters who have been on with us now for almost two days.

As well as our captioners who you don't see, but who are faithfully captioning each of these for everyone who has those needs.

Thank you for doing this.

So here we are, session number two, on day number two.

Compassion fatigue has been referred to as the common cold of psychotherapy.

I'm sure someone said that at some point.

We'll see what Dr. Gentry thinks.

We are so fortunate to have one of the world's experts on this phenomenon of compassion fatigue here with us today.

And I'm going to allow him to jump right in because he has a lot to say and hopefully we'll have time at the end for some questions.

Please welcome Dr. Eric Gentry, president of the Forward Facing Institute and in private practice and consulting practice.

Thank you for being here.

>> Thank you, Zach, for introducing me.

>> Yeah.

>> Hello, folks, I'll just jump in.

That's what I'm going to do.

Perfect.

Howdy.

It is a privilege to do with this you guys, and it's a pretty big deal.

You know this is -- this is my job.

I do a lot of training, but this is also my mission and my covenant for the past 20 years I have been helping people that help people.

Who are traumatized or suffering or addicted and it's a privilege to get to sit in front of you and to help you be able to not have to suffer from your work.

You know, the 20 years of research and development that I have done on this material has left me with the ability to say with authority that you do not have to suffer to be a professional caregiver.

And to take that even one step further, if you are suffering from your work, you're doing it wrong.

That there are some things -- there are some simple skills and simple practices that when you put into place in your professional -- in the way that you professionally manage yourself throughout the day that you do not have to suffer from your work.

You do have to tolerate pain.

But you don't have to suffer.

So I want -- I have got an hour to do -- to highlight some of the features of a six-hour workshop.

One of the things I'm going to do here in about a couple of minutes is I'm going to give you access -- for any of you interested in doing a deeper dive into the processes that -- of how to put into practice those skills and principles of forward facing professional resilience, I'll give you access to that free.

It's on Youtube.

So that you can do a deeper dive.

And the last thing I want to say by way of introduction, the reason why I'm sitting here today is because when I started my doctoral program at Florida State in 1996, I was so sick with compassion fatigue that I almost died from it.

I lost a marriage as a result of compassion fatigue.

I relapsed in my recovery as a result of compassion fatigue and as I said, it took me to physical and emotional bitter ends.

So a lot of this material that got developed with Baranowsky and mine and Charles Figley at Florida State was necessarily being the mother of invention.

That it was really a selfish -- us trying to find a way not to have to suffer and, you know, I can't speak for Anna Baranowsky who runs the Traumatology Institute in Toronto, Canada, but here and I have been partners on this work for the past 20 years, but for me it's been kind of

stumbling forward and continuing to kind of accidentally discovering things that work and helping people not to suffer from their work.

But at the core of everything that I'm presenting is doing one-on-one treatment with people that were in the same place I was, who are struggling so much that they are prepared to give up their career of helping.

And sitting across from those folks, over 500 of them in the past 20 years and helping them to find their way back to joy and excitement and reconnecting to their mission, to have a genuine sense of mission and discovering how they do not have to suffer to be able to be a professional caregiver.

With that, I'm going to jump in and -- and oh, my host has disabled my screen sharing.

So I'm wondering if I might be able to get that repaired so that I can share my screen.

Is that possible?

>> I'll go back.

>> Wonderful.

So let me jump in with the disclaimers that the first half of this presentation is just -- just data.

There are no risks, no limitations to it.

It's just the present -- the presentation of data.

But as we get in to the second half of this presentation, that it is the exploring the principles and practices of the forward facing resilience workshop.

Now we have 11 peer reviewed articles nine of which are empirical demonstration in lots of different populations, with nurses, with faith leaders W animal care professionals and with law enforcement officers.

We have worked with a lot of people different people, we collected data, we published that.

But as of the present, we do not have any randomized controlled trials that demonstrate efficacy with this one-day workshop.

Although I'm working with a paramedic who is giving his doctorate in institutional and organized study and he's setting up a randomized trial as part of his dissertation.

I'm excited about that.

I can tell you with anecdotal reports as they put the material into practice that it works for them, but once again, I would invite you to use discernment as I continue through this presentation to bring forward the skills.

Take a look at them.

If they speak to you, engage some of them, see what happens with it.

Minimal risks are associated with this presentation.

But, you know, at -- at the centerpiece for any of you have been familiar with our forward facing work, at the centerpiece is developing the skills for interrupting the threat response or what we call self-regulation.

As people develop that capacity that it lessens all the way to eradication of distress.

For a short time, you have to develop the skill to continue the practice of it.

So there's just no danger in any of that.

But any time that you do any self-evaluation, there is the possibility of uncovering information and painful affective experiences.

So that's the warning and that is the -- really the only risk that's associated with any of this material.

So I think as I said this workshop, the whole six-hour presentation is available for free on Youtube and I just put the link in the chat.

So if you're interested in accessing any of that material, and taking a look at it, it's free.

Give it a look see and if it's valuable if you have any questions from it, then you -- my contact information is there and you are welcome to reach out to me.

So at the cornerstone of everything that I do professionally is Viktor Frankl and his work.

I have an ace score of nine and, you know, people with ace scores of nine don't end up on this side of the camera presenting to 15,000 people very often.

And part of the reason why I'm here is when I was 15 years old, I read man search for meaning for the first time in my life and it was my first conscious experience with hope and Viktor Frankl's work is that anything I do, I'm standing on his shoulders.

His spirit is infused in every single clinical or training activity that I do, for sure.

For those of you that have not read man Search For Meaning I can't think of a more important text to read than someone who is sitting across from trauma survivors than Man Search For Meaning and what was interesting to me is when I reread it.

And working on the compassion fatigue stuff and I'm reading all of his experiences in the Nazi death camp, 3 1/2 years.

And what I'm seeing this time is in my second read of it was this Mehta narrative of how he's able to find the peace and love in the Nazi death camp and continue to return to those states of generating and maintaining quality of life while being in a Nazi death camp and what emerged -

- bing, what popped in my head was if he can do this in the Nazi death camp, then I, Eric, ought to be able to do it while getting paid for it and he threw down the gauntlet to develop these materials that's where it comes from.

That this is a way -- this is -- as we unpack the materials in the second part of this presentation, it is a pathway to being able to navigate through a toxic environment.

Becoming increasingly immune to toxicity.

We can't do anything about the toxicity, well, we can gradually change it, it takes a while for the systems to change, but what we've discovered is an immunity process that helps you to grow the psycho spiritual immunity that you can -- you can exist in the toxic environment without being affected by that toxicity.

What we have used as the cornerstone of this program is this quote from Viktor, to give life must give warning and there's a warning embedded in the quote and the warning is if you like me, I have worked with a lot of physicians and the workshop I have done with physicians will say, how many of you have chosen to be givers of life?

No one raises their hand.

They spend half a million dollars to become physicians, but the environment is so toxic they can't raise their hand among their peers to own the mission of being a healer.

That's sad.

But I shame them a little bit and they do end up raising their hand.

But for those of you like me that have chosen -- that have dedicated your life to being a healer what Victor is telling with us the quote there's no way that we can avoid the pain of this work.

But the maturational process as a professional caregiver is to learn to tolerate pain without turning it into suffering.

And I hope by the end of this workshop I'll be able to show you how that what turns pain into suffering is not the experience of a lot of pain.

It is instead the threat response, the physiological response of our bodies, of our autonomic system that we have of perceiving threat in our work that mostly we're unconscious of, that's happening sub cortically, as we begin to become aware that we are perceiving threat, most of our day, and are able to interrupt that threat response intentionally, then what happens is we become able to tolerate the pain of our work without it metastasizing into suffering and symptom generation.

So that's exciting for me.

I'm a little bit of a geek about that stuff, but it's exciting.

And I love that Victor has set this, there's not a navigational pathway from sitting across from those who lost loved ones who are addicted, that are traumatized that you can't sit across from them without it being heart break at times.

And we have to kind of grow the resilience capacity to let our hearts break without hardening up, without becoming self-defensive around that, because it's not dangerous.

It just hurts and as we get -- grow the capacity to hear it without activating self-defense then what happens is that we grow the resilience and we can actually become more present, more engaged, more empowered as agents of change as we sit across from our clients and thank you, Viktor Frankl, for bestowing me and the rest of us with that gift.

So I wanted to just kind of -- where are we with studying and understanding?

Actually, let me rephrase that.

Where are we with treating and resolving the symptoms of compassion fatigue?

And, you know, what the research tells us we're not very far.

We have a long way to go.

That, you know, the study that was done last year -- well, no, I'm sorry, 2017, reported no effective treatments for compassion fatigue among nurses.

You know, I have to question their literature search because we have published four that shows significant lessening of those symptoms with the one-day workshop.

And it was -- you can kind of see I'm not going to read all of this out to you.

But we are still at best -- you know, we're a little bit beyond infancy but still at adolescence with finding things that work.

There's some really promising data with the mindfulness space reduction that there is significant lessening of burnout symptoms no several different -- in several different populations with mindfulness space stress reduction.

But not getting the secondary trauma distress piece.

So we have a ways to go.

I started my -- the reason I went to Florida State University to do my doctorate was to study with this man.

He and I started the Traumatology Institute at Florida state, the very first one on the planet.

And as I told you the compassion fatigue had -- had disintegrated, exploded my marriage and after that marriage dissolved in 1995, I did a year-long fellowship at West Virginia University in traumatology.

That was in May and I couldn't start my program until January.

So I hiked the Appalachian trail and I got down with the trail in December of '96 and I went on to Florida State and the first of January of 1997, I showed up to Charles' office as a brand-new, you know, first day graduate student, scared to death.

I walked into his office and when I walked into his office he did this.

He was on the phone.

He did this and he reached over to his bookshelf and he pulled out a book and he opened it up -- I didn't see the cover of it.

He handed it to me.

It was inscribed to me and it said, Eric, welcome, glad you're here.

Charles.

And I was touched by that.

But then I closed the book and the title of the book was Compassion Fatigue that Charles had written the previous year but I was on the Appalachian trail and I didn't read it, I never heard the term.

I never heard of the term compassion fatigue until I'm sitting in the office with the guy who wrote the book, getting ready to be his research assistant for next four years.

And tears came out of my eyes involuntarily and Charles is still on the phone.

He thought it was because you know, that I was touched by giving the book, but the reason I was tearful when I first saw that phrase on the text of the book, it gave narrative to all of those painful experiences that I had.

Yeah, someone got I into the language that's exactly what I had.

And I teared up.

You know, Charles is an ex-marine.

He's on the phone, he's trying to comfort me, I'm in tears.

It was really cringe worthy, awkward at that moment.

But it was really interesting to -- that's what kind of -- it was Kismet that I got to work with Charles and Anna was there also and we began to develop the Accelerated Recovery Program with Charles' blessing and support and administration -- helping us with that.

And that was how we generated the Accelerated Recovery Program.

Well, what Charles said that compassion fatigue was -- and he's still with us.

He runs the Figley Institute at Tulane University and he crafted the model of compassion fatigue and it's the combined effects of becoming secondarily traumatized by witnessing the traumatizing and plus the effects of burnout.

It's the union of those two factors that make compassion fatigue and that construct has stayed with us now for the past 25 years.

26 years.

And so I want to unpack a little bit about what it is and then spend the last half of our time talking about the resolution of it.

It's simply -- I mean, there's a deeper tap root that goes way down into exploring both of these phenomenon.

But to simplify it, secondary traumatic stress are the negative effects we get from people who are traumatized or suffering and/or their families.

It's the person to person interaction, whether that's in group, telemedicine, one-on-one interaction with people who are in pain.

And what that looks like is PTSD and the only thing different from traumatic stress and PTSD is criteria "a."

The cognition affect and cognition, and the arousal and reactivity, all of those symptoms are the same.

The difference is that secondary traumatic stress is almost always that criterion A, the event where somebody who has PTSD that can be one experience of combat or rape or domestic violence or natural disaster.

It's usually cumulative.

Usually you have lots and lots of those little experiences of witnessing trauma.

Which is -- it makes it really insidious because it's a gradual on set.

You don't see it happening to your own self.

That's contrasted with burnout.

And, you know, all the literature in burnout puts the locus of responsibility on the environment.

You know, it says that the -- that most burnout is -- that the primary cause of burnout is the environmental factors of our workplaces.

And what I'm going to argue with you here in a little bit is that it's not the workplace as much as it's the perceptions of the workplace.

But it is that -- it is the environmental engagement of a professional caregiver that produces burnout.

It's the schedule.

It's the overwhelming demands upon us.

It is the caseload that is way more than we -- people that we can see.

It's office politics.

It's the administration not being sensitive to the needs of the people who are in direct care.

It's those myriad of things, the gauntlet of painful experiences that we encounter in a day of our work.

And as I'll show you here in a minute, the reason why it's important to tease these two things out is the way to resolve them is different.

With secondary traumatic stress, it is a behavioral process of doing exposure-based treatment.

Either in vivo or natural.

Where with burnout, it is more of a perception, cognitive, where we evolve perceptions that it's nuanced but it's different.

Both of them require interrupting the threat response.

Both of them have it at the center to resolve these symptoms is developing the capacity for self-regulation.

But then with that done, with that skill developed, then we split off in two different directions to address secondary traumatic stress by confronting situations of perceived threat in a body that is relaxed and desensitizing those experiences where with burnout we use our neo-cortical functioning because we're not in a jacked up autonomic situation anymore and that's the way that we resolve burnout symptoms.

Now, to do a little illustration of the impact of secondary traumatic stress, I have a slide I want to show you, but I want to also -- I want to make aware that this slide is a potential trigger.

What's on the slide is a young boy who has been injured.

You can't see the injuries.

And he's in pain and he's scared and he's on a gurney it looks like and he's reaching out for help.

And I'm about to show you that slide.

If you do not want to see that slide, then now is the time for you to turn away from the screen.

And I fully respect you taking care of yourself in that way.

I wanted to not spring this on you.

So what I'm going to ask for the rest of you, those of you who are willing to look at this slide is I'm going to ask you to spend the next ten seconds looking at it.

Let's see if I can advance it.

Okay.

Stop.

I'll go ahead and take that away right now.

Now, I want you to -- those of you that just looked at the slide, I want you to notice what's happening in your body.

Scan your neck, your shoulders, your chest, your abdomen, your pelvis, your gluts, your thighs, your calves.

What are happening with those muscles in your body when you look at that picture?

That picture is gone for those of you that didn't want to look at it, you can look back now.

But for those of you that did look at the picture, what happened in your body?

And most of you, more than 90% in the workshops that I do, will report that they have constricted muscles in their body that they didn't know were constricted, just from looking at a two dimensional picture.

And, you know, when I'm working with physicians I say, what do you think happens in your body when you add the other sensory channels, when you're hearing the screams.

When you're smelling the smells, and you're yoked with the responsibility of making that screaming stop.

What do you think is happening in your body then?

You don't know, do you?

Because all of your attention has been focused on treating that child and you're going haywire and you don't know if you're in the response, it can interrupt it.

Part of the maturation of the skills development to become resilient to the effects of compassion fatigue is developing this capacity for discovering that we are in an autonomic nervous system that's jacked up and we'll talk about that later on.

The symptoms are a whole lot like PTSD.

It wasn't called compassion fatigue, but it was -- by Lisa McCann back in the late '80s where they worked with therapists that treated adult survivors of childhood sexual abuse.

Once they -- they found, once they elicited the symptoms that they were experiencing, if they didn't know which were which, they couldn't tell the difference from the symptoms list.

They thought that was pretty profound and they started all this process and wrote their first article in 1989 about vicarious trauma.

To take these two -- these symptoms to -- to cutting through the fog of them.

The primary intrusive symptom with secondary traumatic stress is perceiving the world as a dangerous and hostile place and that becomes more and more acute and more and more dangerous.

If you're perceiving a world that is more and more threatening, if you're working with people who have lost family members as a result of COVID, and you're seeing all their pain, what's gradually happening is that you're becoming more and more and more perceiving a threat about the impact that might have on you or your family and you have increased threat response becoming more and more sympathetic nervous system being on all of the time and that's what produces all of the symptoms.

In the beginning we usually see compassion fatigue as looking more like an anxiety disorder.

And on the end of it, it looks more like a depressive disorder.

It's more shut down.

More fatigue.

Front end, more activation.

Early in the career, later in the career it looks like -- it looks like depression fatigue shut down.

And with the DSM 5 what is really interesting in criterion A, you have to have encountered -- we witness it happening in vivo, we see it happening to a close friend or family member and then the fourth way which is repeated exposure with diminished consent usually in workplace, secondary work stress.

What is happening with the DSM 5 over the last eight years I have diagnosed a few physicians and nurses with PTSD proper as a result of their work.

That's intriguing and a whole new pathway for reimbursed treatment and being able to get people help.

So how do we heal secondary traumatic stress?

Well, there's two ways.

Just like any other trauma.

It's that we need to use reciprocal inhibition and use exposure and paired with relaxation.

There are two ways we can do that.

We can do that with an imaginable exposure and you can keep a therapist on retainer.

Consulting with -- you know, that you can PRN in with the therapist and make an appointment and share with them the painful parts of your work while staying in a relaxed body.

Or you can do that peer to peer.

But the important part is that you are using -- in the context of another person, you are sharing these painful work experiences while staying in a relaxed body and when you do that you desensitize and you integrate them in the same way that a combat veteran when they share with the therapist, the combat therapists in a relaxed body desensitize and extinguish the intrusive and arousal symptoms associated with traumatic stress.

But -- that's kind of -- that's all we have had for a whole lot of years.

But there's also a much simpler way to do it.

And I have these -- this slide here to talk to you about trauma genesis and I want to do that three pictures of how this process works.

That we have got a woman who's a dog lover who gets attacked by a German Shepherd.

After she's attacked by the German Shepherd, she's not just afraid of German Shepherds now.

That intrusion, the encoding of that experience with the threat response has turned into future perception of threat in every single time she's around any dog.

So there are three ways that a person could get traumatized.

We can survive it.

That we are the survivor of the -- I'm going to talk -- I'm going to do a presentation here in a little bit about traumatic grief and if you have a loved one that went through and died as a result of COVID, then that's post traumatic stress.

If you are a therapist and you hear stories from loved ones -- from survivors about their loved ones who died of COVID, then that's the secondary traumatic stress, is you hear it through story or witnessing.

But even more insidious form of traumatization, another way we can get traumatized by simply being around people who are anxious.

If you are around other people who are in a threat response, our neurons are attuned to read that in other people and when we read other people as anxious, as jacked up, then our threat

response kicks on and voluntarily, sub cortically, below our awareness, but we're still in that state of threat response.

So how anxious are your caregivers?

I'm sorry, how anxious are your co-workers?

You know, the environment that you work in, part of the toxicity that makes your work environment a painful place is that you are working with other people who are chronically activated and you simply being around them activates your threat response.

So those are the three ways that a person can get traumatized.

Survive it, witness it or being around other people who are in a state of anxiety.

Well, here's an exciting thing that we have rediscovered in the 21st century because we've found so many people who have complex PTSD and they can't tolerate doing narrative work very well.

So we have rediscovered in vivo exposure and it's become more and more central to the treatment of trauma in the 21st century and here's what that looks like.

Is if this woman came to see me for treatment, the very first thing that I'm going to do with and for her I'm going to teach her how to get into the relaxed body intentionally.

How to be able to recognize that she's having a threat response and then to interrupt it.

And then what that interrupted threat response in a relaxed body, I'm going to have her going out and encountering puppies and dogs in a relaxed body, and then this dog in a relaxed body, and she's scare stepping downward as she continues to pair exposure with relaxed body.

She's desensitizing the power of this experience intruding into the perceptual system of the present.

It's becoming less and less and less and finally she's able to go to the shelter and pet a German Shepherd or hang out with a German Shepherd and she's extinguished that threat response that came after she was attacked.

That's how we heal trauma in the 21st century.

We teach the people how to do that and then we send them back to work and staying in a relaxed body.

The more they do that, the more they are shrinking their -- the intrusion of all of those painful past experiences into the present.

They are lessening and lessening in potency and the person is having a better, better quality of life, gaining more resilience, functioning better, having less and less distress while being in that environment.

That's how we heal secondary traumatic stress.

But the best thing to do is prevent it.

And you cannot get traumatized either primary, secondary or tertiary in a body that's relaxed.

It's encoding the experience with a -- with a very jacked up autonomic fear system and it's the encoding that turns it into something that turns it into the present and as we are able to practice staying in a relaxed body, while confronting those situations of our work, then we don't get infected by it.

That's pretty cool.

And then finally, burnout, I don't want to spend very much time on that.

But this is Christine -- it's the emotional exhaustion and reduced accomplishment.

This is a study done in 2018 and look at what all of these causes that were identified as burnout.

And you see that they are all external.

They are all environmental.

Except for this one here.

This is what psychologists report as the reason why they have burnout.

That's what all of the research done -- does is it interviews people who are burned out and people who are burned out believe the reason they're burned out is because of the environment.

And if you believe the cause of your burnout is the environment, you are a victim of that environment.

And I took my anger at the field in 1998 and I made a different definition of burnout and it is the chronic condition of perceived demands outweighing perceived resources.

And when you have -- when you perceive, you have a whole truck load of demands upon you, and you perceive that you do not have the resources to fulfill those demands, then what happens is that you're in a chronic state of sympathetic nervous system dominance, in a chronic threat response state and that generates symptoms that's what Nadine Burke Harris calls toxic stress.

That it's metastasizing into debilitating symptoms and impairment.

So with burnout, the way that we resolve burnout is we help people once again to get in relaxed bodies and then we help them to change their perception of their workplace.

And these are some of the maturing of perceptions that we help people to do to resolve burnout.

And to develop an internal locus of control to help them distinguish the difference between a real versus a perceived threat.

To help them to bring choice to where previously they believed that some things were demanded of them.

To get out of outcomes into the present, doing the best that we can do.

As people begin to shift those perceptions, then what happens is the workplace becomes less and less toxic.

So in the workshop, I ask everybody is your job stressful?

And everybody says of course it is.

Try working in my shoes for a little while.

And then what I do is I elicit from them, okay, your job is stressful.

What are some of the negative effects of your work stress and they -- these are -- this is just a sample of some of the things that they tell me are the causes of their -- I mean, the outcome, the effects of the stress.

And then I say, okay, so what are some of the causes?

What are some of the things that cause you to have stress from your work?

And these are the things that they tell me that are the causes and I go through -- you know, 20 or 30-minute process that leads them to this where I tell them that their job is not stressful.

And here's the look that I get when I tell people that.

It's a shifting of perception.

And it's uncomfortable for a lot of people.

But what I help them to get to is that stress is actually your body's response to the perception of threat.

And when we perceive threat, these are the things that happen.

Energy goes up.

The part of our brain that manages that energy goes down.

So helping people to understand that what's really going on is with all of these things that we perceive to be the cause, there is a history of painful learning associated with it.

So in the same way that a combat veteran on the fourth of July when the fireworks are going off, they have exaggerated startle, we're having one of those things and every time someone asks us to do something, every time the administrator who writes an email, a patient says we're not helping them, that intrudes into the perceptual system here of the present and we're not doing anything about interrupting that.

We're just muscling our way, all the way through the day in the one perceived threat to another to another and we're in the state -- for a lot of us, we're in a state of a sympathetic nervous system dominance and it turns into all of these symptoms.

That's the true cause of the symptoms associated with compassion fatigue.

And it's pretty exciting because you can't have stress in a body whose muscles are relaxed.

Let me say that again.

You cannot have stress in a body whose muscles are relaxed.

That's elegantly simple.

Not easy, but it is simple.

So let's get to the solution.

And see if we can have a little bit of time for questions.

So using this old definition from CDC that disease is the absence of the effective immune system, not the presence of a toxic environment.

What do we do?

We build vaccines.

We don't fumigate the air.

And so in a whole lot of ways, what we have done with this workshop is to try to prepare a vaccination for you against the toxicity of the workplace environment.

And a whole lot of it is in this statement right here between stimulus and response, there is a space and that space is our power to choose our response and in that response lies both our growth and our freedom.

Beautiful quote by Viktor Frankl.

The more jacked up you are, the less space you have so you don't get growth and freedom.

What you have instead of space is involuntary self-defense.

I want you to -- Gemini wrote a book last year about this whole process and Gem was a physician who I consulted with the largest group -- practice in the United States on helping

them to practice medicine and not die and what we discovered pretty early on is that the physicians could not hear any of this stuff from the mental health professional.

So I had to train some physicians to be facilitators with me.

And Jim was the coordinator of that and he's a 36-year emergency physician, 16 years of that as a director of emergency medicine.

And I got a little three-minute video here of him describing what happens -- what resilience looks like from then till now.

>> There's an expectation placed on us as emergency medicine professionals and an expectation that we place on ourselves that no matter what they throw at us, no matter what happens during a shift we're going to handle it.

We're going to suck it up and handle it.

And what's really happening is that the more that gets thrown at us, the more distressed we're becoming.

And we perceive that, oh, the rack is still full.

There's that obnoxious patient over there.

There's that jerk surgeon I have to talk to.

The administrator said we have to get that patient upstairs within an hour and it's already an hour and 20 minutes.

And there are all these external pressures that are just -- that are heaped on top of just Mrs. Jones, how are you today, what can we do for you today?

I mean, I'm trying to talk to Mrs. Jones and I'm aware of all of these things that I'm supposed to be dealing with and I'm aware of the full rack that's right over my right shoulder, patients that need to be seen.

So I guess traditionally or from the way I used to look at it was I would just see all of those external pressures as being insurmountable piling up, creating more responsibility.

Feeling more stress.

Demands of this patient are so great, how will I ever meet them?

Demands of this environment are so great, how can I ever meet those demands?

They're asking me to do so much, that's this overwhelmed feeling.

Well, what has changed -- what has changed is that I realize that in fact there's not one of those things that's going to hurt me in the moment.

They're really not going to hurt me.

There's no real specific threat to my well-being in the midst of this crisis.

That Mr. Jones' demands or Mr. Jones' suffering is not my suffering.

The patients in the waiting room, they're waiting.

I understand that.

But I'm not suffering because they're waiting.

Well, I shouldn't be -- I don't need to suffer because they're waiting.

I don't need to suffer because an administrator may have expectations that I can't fulfill in the moment.

Those will all sort themselves out.

What I can control is my response to it all.

And by doing so, not only do I end up feeling less stress, less anxious, less intimidated, more connected, more impassioned with my work, not only do I feel that -- those ways, but I also -- I also sense that I'm not being damaged.

I feel like I'm going to be here tomorrow and the next day and the next day and be able to do it better.

>> My hope is that as you watched that, you get a little bit hungry for a little bit of what Jim is talking about there is there is no specific threat to me in the midst of this crisis.

As we begin to discover that in our work, we are able to be in comfortable bodies and we're able to maximize both our cognitive and our motor -- capacities and performance and our work no longer hurts us.

And in this process of for 20 years of developing -- this is the vaccination.

And there's a set of five skills that I'm going to go through these five skills.

I'm not going to get a chance to unpack them with you because I want to save a little bit of time for questions which I will do.

But I do want you do get at least an introduction to them.

And those are self-regulation that I've talked about, which is the ability to discover -- first of all, discover that you're having a threat response which is a felt sense awareness of your body and then the ability to voluntarily release your muscles and doing that a hundred times plus a day.

Discovering your type and releasing it, and discovering your type and releasing it and the more you do it the better quality of life you have.

After developing that capacity, we start helping people to discover how frequently they breached their integrity in word and deed and how far divorced the more compassion fatigued they are, the more divorced from their mission, their purpose, the reason that they went to graduate school in the first place turns into, you know, five or six or eight or ten years of a career of slogging through the day just to get a paycheck.

And what we help them to start to see is that by regulating their systems they can become aware of word and deed in their professional lives if they interrupt the threat response which is compelling them to act against their will and they start finding themselves able to perform their mission without having to suffer to do it.

And that lights people up.

And so people that were in avoidance of a lot of work related activities begin to come to work with a mission.

And that work becomes exciting again.

Because they don't have to suffer to perform this mission.

Then we help them -- as I talked a little bit about before, evolve their perceptions out of a victim stance into an empowerment stance.

And then the two things that sustain this resilience is the development and utilization of connection and support with peers and ongoing program of self-care and revitalization.

These five skills have been demonstrated in nine empirical studies to resolve the symptoms and enhance the professional quality of life.

We have got five minutes left of this presentation.

And instead of racing through the rest of the material I want to open myself up to any questions that anybody might have.

I think those are curated so if those questions want to get fired in my direction I will happily answer them.

>> How do we do that?

>> Help.

>> Eric, sorry about that.

We have got a lot of questions coming in.

Can I just summarize a few for you?

>> Certainly.

>> Great.

I would say the number one question coming in is how do you distinguish between your own reactions and perceptions to threat and real issues in your workplace?

So how -- you know, at what point do you call it quits, if you will, versus work on your own compassion fatigue?

>> Jim and I addressed that in the book and we asked -- we asked this question.

Whose responsibility is your professional quality of life -- yours or the administration's?

And the answer that we came up with is it's both.

That you the individual in that toxic environment, you are responsible for surviving today.

And performing at your peak capacity today.

But as you develop a regulated Anne anomic nervous system and as the administration begins to develop those capacities we can have collaborative engagement with both administration and with direct care staff to evolve more ergonomic and healthy workplaces that benefit the bottom line of the company.

And what's happened is that's become such an antagonistic threat-infused process that change is hard to make.

So it's on both of our shoulders for us to be as best we can, but we've got to start trusting that the administration has our back and in the short term, that's not going to happen.

That is a long-term process.

So, you know, it's discernment, it's one that what I would say is that as you get better and better at self-regulating, what you can find is that you're not suffering in those context where management is at best passive about your needs.

You can still have quality of life in those contexts.

But it is a discernment process and it's one that you need to have your full Neo cortex available and you're not leaving to get out of the distress because the next place you go it's going to be the same thing.

So it's really important that you get that autonomic nervous system regulated first and then find if you can find quality of life in that -- is the environment so toxic that there's no way then it's time to leave.

But you need to be in your maximal performing self before you make that decision.

>> I think a lot of people needed to hear that.

So thank you for that answer.

>> You're welcome.

>> Obviously, something you would go much more in depth on in your one-day.

So what about clients death or death by suicide?

And the clinical experience after the death of a client from any cause?

Can you talk about the kind of fatigue that comes on after that kind of loss?

>> Yes, I have had it happen to me twice and it's -- it is -- it's just like having a car accident and then driving afterwards.

You oversteer, and why is that?

It's because once you learned about the client's death, then what you did you encoded that with a lot of fear.

So it's intruding and the memory's intruding and it's producing a physiological response of a dysregulated autonomic system and the more -- we can integrate that memory, the more we can see that there is no specific threat to my well-being in the midst of this crisis.

And what happens then is normal organic grieving is that I feel sad about the loss, I feel sad about the quality of life that they had and their experiences and I have empathy and I cry for them.

I have genuine grief that resolves into melancholy instead of an ongoing process that is coming with all of this fear that's activating, not allowing me to process the grief of losing that client.

That thwarts it because there's a fear response every time that it comes up and I constrict and suppress it.

>> Thank you.

Eric, unbelievably our time is up.

But we're going to see you very shortly.

We're going to explore a different aspect of your work on traumatic grief.

So I know this is a question that's come up a lot so our next session is going to explore traumatic grief.

We will see you in about 13 minutes.

So we'll see you in the next session.

Thank you, Eric.

>> Thanks.

Bye.