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Sharevision: A Collaborative-Reflective, Expressive Arts Intervention to Address Secondary Trauma

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SHAREVISION: A COLLABORATIVE-REFLECTIVE, EXPRESSIVE ARTS INTERVENTION TO ADDRESS SECONDARY TRAUMA

A DISSERTATION

(submitted by)

ELLEN M. LANDIS

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

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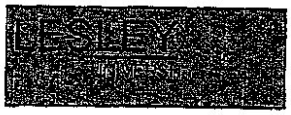

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In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

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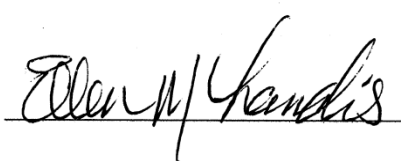
SIGNED: 

DEDICATION

For Betsy & Donald Landis who taught me about the importance of offering, asking for, and receiving help.

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Lisa Thompson you are everything that is inspiration, wisdom, courage, integrity, generosity, laughter, beauty…

My Crew: Lisa Thompson, Maggie Landis, Gigi Troy, Linda Thompson, Tuti Scott, Dick Baldwin, Joy Breneman, Lynn Carlson, Marta Martinez, Krisiti Nelson, Linda Hannum, Rebecca Davis, Audrey Troy, Daryl Beattie, Troy Beattie, Lynn Hoffman, David Landis, Becky Chamberlain Landis, Ruth Landis, Miriam Landis, Martin Landis, Carrie Mathias, Grandmothers, Grandfathers, Aunts and Uncles, Carol Drexler, Lenore Grubinger, Carolyn Sadeh, Marlena, Collette, B.B., Charlie, Pepper, Rickie, William & Sylvia, Sue & Allan, Leon & Merle, Liz Ringrose, Julie Buldoc, Nanci Newton, Donna Burhoe, Sally Stuart Christian, Debja Steinberger, Stacie Stewart, Betty Osman, Peggy Melanson, Dassie Hoffman, Bertha Josephson, Margaret Kierstein, Connie Kruger, Susan Tracy, Ruth Levy, Michelle Forniash, Irit Halprin, Dale Mintz, colleagues at Lesley, Sheila Weinberg, Betsy & Donald Landis

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Abstract

This study examines the impact of a collaborative-reflective, expressive arts intervention on secondary trauma among mental health clinicians. Clinicians met at their workplace over a three-month period, on alternating weeks, in six expressive arts-integrated workshops. They learned a particular collaborative-reflective format called Sharevision. Clinicians also met independently using Sharevision, on non-workshop weeks. Participants completed a four-part survey on compassion fatigue (Figley, 1995 & Stamm, 1995-1998; Gentry, 1996; Baranowsky, 1996; Gentry & Baranowsky, 1998) at the onset and conclusion of the study period. Findings from the survey, transcripts of workshops, and exit interviews indicate the collaborative-reflective Sharevision model correlates to a decrease in these clinicians' perceptions and practices as related to secondary trauma. During this brief program clinicians repeated cycles of reflection and action in both expressive arts integrated collaborative-reflective workshops and their independent Sharevision meetings. Clinicians developed confidence in an active rather than passive approach to addressing secondary trauma. Participants' sense of isolation decreased as their creativity, hopefulness and community increased. Future research should address the long-term impact of this program.

Chapter 1

INTRODUCTION

Introduction

Statement of the Problem

Statistics show a high degree of distress among mental health clinicians working in a wide range of work settings and with a variety of client populations (Adams, Boscarino, & Figley, 2006; Figley, 1989, 1995, 2002; Figley & Stamm, 1996; McCann & Pearlman 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995b, Stamm 1995, 2002; Valent, 1995, 2007). Research demonstrates that many clinicians struggle along with clients who have experienced primary trauma such as medical issues, natural disasters, domestic violence, bullying, sexual assault, human trafficking, and the impact of war (i.e., Adams & Riggs, 2008; Baranowsky, Dunning, Gentry, 2002; Brady, Guy & Poelstra & Brokaw, 2007; Wee & Myers, 2002; White, 2002). These troubles often coincide with structural trauma, such as poverty, racism and homophobia (Christie, Wagner & DuNann Winter, 2001). The impact of regular exposure to others' traumatic experiences is problematic for psychotherapists' health, their practice, and the organizations in which they work (Bloom, 1997). Research on interventions for these problems is minimal, though there is a resounding call for such research (Monroe, 1995).

Currently, there is little support in the workplace for psychotherapists whose clients are traumatized (Bell, Kulkarni & Dalton, 2003; Bober, Regehr, 2006). Meetings where psychotherapists can address their experiences along with questions about the serious issues of their clients are devastatingly rare. Support for psychotherapists is

traditionally focused on clients and the context they exist within (Barlow & Phelan, 2007). Many organizations do not require all clinicians to participate in regular conversations about their client related work (Hormann & Vivian, 2005).

Both collaborative-reflection and expressive arts have been researched and used for professional development in education, business and nursing to address job-related stress among professionals (Byers & Gere, 2007; Dewey, 1933; Schon, 1983, 1991). This study seeks to explore the impact of a particular collaborative-reflective, expressive arts intervention with mental health clinicians experiencing secondary trauma.

Purpose of the Study

In this collaborative inquiry study, I aimed to engage mental health clinicians in an expressive arts-integrated exploration of secondary trauma as a means of learning about the alleviation of that burden. I sought to understand how a collaborative-reflective, expressive arts intervention might be useful in clinicians' presentation of their perceptions and practices of this phenomenon. The collaborative-reflective design is called Sharevision. This collaborative-reflective expressive arts intervention provides participants an opportunity to present their experience or a question and get responses from others in the group. Time is divided among each participant equally. The intent of the responses is for participants to share associative ideas rather than to be directive. In this seminar I hoped to introduce the collaborative-reflective format and ask participants to use it without my being present. My goal was to develop an engaged and sustainable meeting format that was not dependant on me as a leader.

History of the Collaborative-Reflective Model

The collaborative reflective model utilized in this research study is based on the work of family therapists Lynn Hoffman (1981a, 1981b, 1985, 1993, 1998, 2002, 2009) Richard Baldwin, Lisa Thompson, and myself along with the other members of our Family Service Outreach Team (the "Team") at People's Bridge Action (PBA). The format developed at PBA is the immediate predecessor to the format used in this study (Baldwin, 1999, 2004a,c, 2005, 2008, Baldwin & Thompson, 1989; Fontes 1995; Hoffman, 1985, 2002; Landis, 2004, 2007a, 2010).

PBA, located in Athol, Massachusetts began in 1972 as a grass roots community action agency providing services to people who were unemployed, having difficulty with housing, and who had drug problems, as the local mills closed in the North Quabbin area. From 1976 until 1982 the Team provided outreach family counseling funded by the State Department of Public Welfare (DPW) to families at risk of child neglect. In 1982 contracted services changed from the DPW to the Department of Social Services (DSS). All cases were then referred by DSS, and accordingly were more serious, involving child abuse, child sexual abuse, domestic violence and drug and alcohol abuse. Since reports of child sexual abuse were being handled openly by DSS and the courts, cases referred to the Team presented a major challenge to staff and to their clinical supervisory structure. The traditional form of clinical supervision by a single supervisor no longer met the needs of staff. What was needed was a combination of supervision, education and support. The Team developed a process wherein a consulting clinician was hired by staff to meet weekly with the Team for a period of one year, providing training and supervision in family therapy. To meet educational and other specific supervisory needs,

staff met monthly with area practitioners with expertise in dealing with specific issues with which staff were working.

In 1987, team member Lisa Thompson introduced Lynn Hoffman, as a consultant to the Team. Hoffman, who was on the lookout for an unusual clinical setting, offered an entirely new approach to supervision. Rather than conducting supervision as usual by becoming "the expert," answering all questions with authority, she introduced a collaborative and nonhierarchical process. In this format, each person on the Team was asked to give a personal response to whatever issues a staff member presented. What was unique about this process was that discussion between people was eliminated. Rather, each person took a turn responding to the initial presentation with the initial presenter responding to this larger, group narrative at the end. Hoffman, Baldwin, Thompson and team members have begun writing on this approach and its development (Baldwin, 1999, 2006, 2007, Fontes, 1995; Hoffman, 1985, 2002; Landis, 2007b, 2008, 2010; Thompson, 2000). This process took hold over time and was further refined by staff at PBA. (Appendix A).

In 1989, Baldwin, the Team Leader, suggested that this process the Team developed was as a new form of group supervision, and be named "Sharevision" after the term "shareware" (Knoph, 2009). The latter referred to open structure software freely shared via the Internet with all who were interested. "Shareware" matched the process staff had created with Hoffman. The intent of Sharevision was to share everyone's knowledge with one another through a participatory process that was, for the most part, non-hierarchical. Indeed, Sharevision fit perfectly with Baldwin's enthusiasm for helping

establish a generative working environment that incorporated reflexive and creative processes.

In the past twenty three years Sharevision has been further developed and introduced in a number of settings. Examples of six such settings are: (1) departments of government in Massachusetts e.g., Department of Social Services; (2) non-profit organizations e.g., Rural Housing Improvement, under Housing Urban Development, or HUD, contracts; (3) hospitals, e.g., Arbour Hospital; (4) higher education classroom studies e.g., Lesley University; (5) private businesses e.g., Imagine Philanthropy; and (6) foundations which are part of the Women's Funding Network. Based on the experience of this researcher and anecdotal evidence from participants, Sharevision, has proven to be a highly effective group process. However, to date there has been no published researched data on the utility of the Sharevision, and the integrations of expressive arts.

Definition of Terms

Secondary Trauma: Negative effects of repeated exposure to an other's traumatic experiences (Stamm, 2010).

Vicarious Trauma: A negative change in:

- How one perceives the world, oneself, and spirituality
- Feelings of trust and safety
- How one takes care of one's self, such as maintenance of a positive self image and self soothing behaviors
- Sensory stimuli such as intrusive thoughts of clients' disturbing imagery and an increased startle response (Pearlman & Saakvitne, 1995)

Compassion Fatigue: Post Traumatic Stress Disorder (PTSD) symptoms in therapists, which are the result of exposure to another person's primary trauma (Figley, 2002)

Secondary Traumatic Stress Disorder: Severe physical and emotional responses of secondary trauma (Figley, 1983, 1995)

Burnout: Emotional exhaustion resulting from a gap between one's expectations, aspirations and accomplishments leading to a loss of interest and investment in related activities (Maslach, 1978).

Aesthetics: Study of sensory emotional values. Judgments of sentiment (Zangwill, 2008).

Creativity: Combining elements in novel or unprecedented ways, radical change. Design mixed with openness and spontaneity (Bateson, 2004).

Expressive Arts: Inherent to expressive arts therapies is an interdisciplinary approach in which multimodal expressive arts processes are used for personal and community transformation which may be psychological, physical and spiritual wellness, I include social action.

Social action: When people move from private to public action to raise public awareness, change policy and law.

Aesthetic action: Aesthetic action is a process wherein a group examines existing patterns and builds ideas about new ones, then realizes these ideas through action in different contexts. Diverse communication media are used in this process to support non-linear connections. The focus is to evolve a pattern that feels "right" or "fits" the group and the context. Once the aesthetic action is accomplished the group gathers and reflects

on the results. In this way an esthetic loop can be developed (Baldwin & Landis personal communication, 2005; Landis 2008, 2010).

Contribution of Study

My interest grows from my experience as the Clinical Director of Women and Children's Services at the YWCA of Western Massachusetts. Sixty professionals plus volunteers serving women and children affected by violent crimes such as sexual assault and domestic violence ran this component of the agency. These highly competent and dedicated individuals often put the well being of clients before their own. Watching the health of my colleagues decline turned into a mission to closely examine the situation. In 1997, I began running trainings on secondary trauma. Over the next few years, I learned about what worked and didn't work. I came to believe that I could not tell people what they should be doing, but rather needed to provide a workplace opportunity to practice suggested ideas and interventions.

Healthcare research concerning the restorative capacity of expressive arts therapy approaches is recognized as valid and valuable to recovery from primary trauma (Benson, Amir, Wolf, 2008; Byers & Gere, 2007; Callaghan, 1993; Gantt, & Tinnin, 2009; Glassman, 1991; James, & Johnson, 1996; Johnson, 1987; Klingman, Shalev, & Pearlman, 1990; MacIntosh, 2003; Malchiodi, 1990; Miller & Boe, 1990; Serlin, Berger & Bar-Sinai, 2007; Schulberg, 1997, Talwar, 2007; Trowbridge, 1996). Creative and embodied approaches have grown beyond the field of expressive arts therapies (Shapiro, Brown, & Biegel, 2007; Kisiel, et. al., 2006; Rothschild, 2003; van der Kolk, 1994). Still, little research has investigated the options for transferring findings into workplace strategies on behalf of clinicians. There are three current trends in efforts to minimize

secondary trauma: go to a training, go to therapy, and try to build new structures into clinicians' current setting. Each of these approaches comes with drawbacks. When clinicians go to training, they are generally isolated in their effort to manage secondary trauma when they return to their job. When clinicians go to therapy they are isolated from their colleagues (Munroe, Shay, Fisher, Makary, Rapperport & Zimering, 1995). Even when there are recommended structures to remedy secondary trauma in the job site, many organizations have been unwilling to take the time to develop policy and procedures to include approaches that encompass care of the clinicians. Moreover the cost of secondary trauma on the organization and clients, as well as the clinician's family appears to be misunderstood, if not undervalued (Brown & Pearlman, 2004; Madsen, Blitz, McCorkle, Panzer, 2003; Fay, Kamena, Benner & Buscho, 2006).

While there is growing documentation on efforts to address the needs of the people who offer themselves to others in times of great pain and suffering, there is far less research into workplace interventions. Therefore my research question is:

- **How does the application of a collaborative-reflective, expressive arts intervention, "Sharevision," impact the nature of secondary trauma among mental health clinicians?**

Chapter 2

LITERATURE REVIEW

Introduction to the Literature Review

This dissertation research concerns the alleviation of secondary trauma. The purpose of this literature review is to understand the research on efforts to ameliorate secondary trauma among psychotherapists as well as to examine the recommendations for future research to identify the gaps in the field. The researchers of the seminal studies represented in this literature review have afforded the field valuable information. I have based my research on their findings and suggestions for future investigation. Moreover, I have been inspired to fill in the gap in the literature through investigation of a program that includes the following elements: education about secondary trauma, arts responses to clinical practice, building community support for the personal and professional components of clinical work, and collaborative action to diversify clinicians' focus and improve their working environment. This literature review reveals support within the field for my doctoral research, which will be addressed in the third and fourth chapters of this dissertation.

I will begin with a brief orientation to primary psychological trauma and the critical relationship it bears to secondary trauma. Elements of psychotherapists' workload, (Chrestman, 1999; Cunningham, 2003), working environment, (Cacioppo & Patrick, 2008; Farber & Heifetz, 1981; Boscarino, Figley & Adams, 2004; van der Vennet, 2003), personal histories (Adams & Riggs, 2008; Pearlman & McCann, 1995) and coping mechanisms (Schauben & Frazier, 1995; Racanelli, 2005; Bober, Regeher &

Zhou, 2006) have been identified as either increasing or decreasing the potential for secondary trauma.

Research on the impact of secondary traumatization among psychotherapists demonstrates change in perception and practices at both personal and professional levels. Alterations in trust, safety, intimacy and esteem for self and others (Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995) coincide with silencing clients, (Baranowsky, 2002, Danieli, 1984) angry outbursts, (McCann & Pearlman, 1990) a sense of isolation, (Wee & Myers, 2002), restrictive coping styles (Herman, 1997) and ethical violations (Gentry & Figley, 2007). Secondary trauma has also been found to impact the working environment. It lowers moral and productivity, and increases absenteeism and staff turnover (Levin, 2003; Osofskym, 2008; Meldrum, King, Spooner, 2002; Woodard, Meyers, Cornille, 2002).

There have been many recommendations for further research made by those who have studied the nature of secondary trauma. They arise from the fact that psychotherapists who engage in self-care and particular institutional practices show less disruption of their cognitive schema and fewer signs of secondary trauma. Still further, creating art-responses to their clients' material (Good, 1996; Samoray, 2005), using active solution-focused coping mechanisms (Traue, 2002), and incorporating innovative coping styles (Figley, 1995; Borkovec, Roemer & Kinyon, 1995) are all recommended. Institutional policies and practices are recommended for implementation, such as developing the worksite so that it is perceived to be a supportive environment (Pearlman & Saakvitne, 1995; Woodard, Meyers, Cornille, 2002), providing psychotherapists with trauma-specific supervision (Borkovec, Remer & Kinyon, 1995; Pearlman & Saakvitne,

1995), engaging psychotherapists in on-going training and evaluation (White, 1995, Chrestman, 1999), and ensuring that psychotherapists have a variety of professional responsibilities. The most frequent and consistent recommendation is that psychotherapists work with colleagues rather than in isolation (Harrison & Westwood, 2009; Monroe, 1995; Pearce & Stamm, 1999; Wee & Myers, 2002).

What follows is an examination of research on, and some specific programs to lessen the burden of secondary trauma among psychotherapists. Findings include the benefits of an individual approach (Gentry, Baggerly, Baranowsky, 2002; Shapiro, Brown & Biegal, 2007; Banks, 2007); the benefit of having a team (Barlow & Phelan, 2007; Figley, 1995; Fontes, 1995; Geller, Madsen, Ohrenstein, 2004), and the impact of organizational policies and practices (Bell, Kulkarni, Dalton, 2003; Blitz, McCorkle, Panzer, 2003; Boscarino, Figley, Adams, 2004; Fay, Kamena, Benner, Buscho, 2006), that address secondary trauma.

There are gaps in our understanding of how to lessen secondary trauma. These gaps are in part due to a lack of follow through on recommendations for further investigation into ways to alleviate secondary trauma. One such recommendation advises psychotherapists to engage in social action in an attempt to improve socio-political conditions for client populations as well as practitioners' working environment. Also nearly absent from the research literature is the integration of expressive arts modalities into professional development and peer supervision. These gaps call for studies of practice elements that could improve the education, engagement and evaluation of psychotherapists at work, efforts to which this writer hopes to add.

Primary Trauma

Trauma, or *traumat*, is a Greek word for wound or injury. Psychological trauma was defined by the American Psychological Association (APA) in the Diagnostic Statistical Manual, Edition Three (DSM-III), in 1980 when for the first time Post Traumatic Stress Disorder (PTSD) was included in the manual. APA describes the phenomena occurring due to events "outside the range of usual human experience" by either direct or indirect exposure to a traumatic event (American Psychiatric Association, 1987 p.146). However, acknowledgement of the frequency of atrocities due to war, domestic violence, sexual abuse, gangs, poverty, and natural disasters, brought change to the definition (Herman, 1992). Traumatic events were then understood to involve threats to life or bodily injury, or close personal encounters with violence or death (Herman, 1992). Someone who experiences a traumatic event may become overwhelmed and unable to join together long held beliefs and emotions about the world as they relate to the event (DePrince & Freyd, 2002).

A growing understanding of the inter-relatedness of the body and mind is exemplified in the concept that psychological traumas are also physiological traumas (Rothschild, 2000). Moreover, in 1994, the American Psychological Association redefined PTSD in the Diagnostic Statistical Manual of Mental Health Disorders Fourth Edition. The DSM-IV noted that PTSD included "persistent symptoms of arousal" (p.463) in the autonomic nervous system.

Trauma is also understood as a subjective experience (Allen, 1995; American Psychiatric Association, 1980; Creamer, McFarlane& Burgess, 2005; Pearlman & Saakvitne, 1995b). A 1979 seminal study of rape survivors by Burgess and Holmstrom

laid groundwork for understanding the individual nature of recovery from trauma. They found that the time it takes for rape survivors to recover from a traumatic event varies. Recovery response times varied from 37 percent of rape survivors reporting no trauma-specific problems at any time, to 37 percent reporting problems for approximately one year, to 26 percent reporting that six years after the traumatic event they continued to have trauma-specific problems.

PTSD is thought to be embedded in behaviors that are stimulated as a result of particular neurological processes, such as those that can lead to alexithymia (Simeon, Giesbrecht, Knutelska, Smith, & Smith, 2009; van der Kolk, 2006; Zlotnick, Shea, Pearlstein, Simpson, Costello, & Begin, 1996), which is defined as an inability to make appropriate meaning out of physical sensations. The resulting experience causes emotional and behavioral expressions that do not reflect an individual's needs and can also lead to difficulty in assessing the emotions and needs of others (van der Kolk, 2006). Thus, treatment of primary trauma is most effective when combining awareness of present day internal sensations and physical action patterns for both the client and the therapist, along with helping the client to build cognitive schema connecting relationships and events (Ben-Asher, & Koren, 2002; Foa, Keane, Friedman, Cohen, 2009; Gray, 2001; Horenczyk, Abromovitz, Brom, Chemtob, Daie, Peled, 2007; Johnson & Lahad, 2009; Lewis, 2003; Miller & Guidry, 2001; Moss, 2009; Shrubs, 2008; Stepakoff et al., 2006; van der Kolk, 2006).

Secondary Trauma

The nature of secondary trauma has been discussed since the third century C.E. In *Talmud Bavli, Tractate Nedarim* 39b the text reads: "R. Abba son of R. Hanina said: He

who visits the sick takes upon oneself or acquires a sixtieth of his pain." The number one-sixtieth is an interesting number in Judaism. It represents the ratio of what is and is not kosher. The explanation I was given about koshrut follows. When someone is making a kosher chicken soup and accidentally some milk spills into the pot of chicken soup, if the amount of milk is less than one-sixtieth of the total soup, then the soup remains kosher. If the amount of dairy that accidentally spills into the chicken soup is more than one-sixtieth of the soup then the soup would no longer be kosher. What the Rabbis of the third a century were addressing when referencing the number one-sixtieth in the discussion of healthcare was that by attending to someone who is suffering, the attendee and the community must address the issue with urgency because the impact is unacceptable.

It was not until the 20th Century that secondary trauma became a point in the research literature on health and education. For example, wives of World War II war veterans were found to experience some of the same symptoms as their husbands (Andur & Ginsberg, 1942; Gralnick, 1939). Exhaustion due to work-related stress was named burnout (Fruedenberger, 1974). The nature of burnout was researched (Maslach 1978, 1979, 1982) and found to correlate with cardiovascular disease and diabetes (Toker, Sharom, Shapira, Berliner, & Melamed, 2005; Melamed, Shirom, Toker, Berliner & Shapira, 2006). Research on burnout among therapists indicates that contributing factors include: professional isolation, the draining experience of empathetic engagement, indefinite success (Bermak, 1977) and failure to live up to one's expectations, regardless of whether those expectations are realistic (Deutsch, 1984).

The Emerging Field and the Growth of New Labels

At a family therapy conference in 1982, Vietnam veteran and psychologist Charles Figley, discussed the "cost of caring" (Figley, 1995 p.7) for family members attending loved ones suffering from primary trauma as "secondary victimization" (Figley, 1995 p.9). The term Secondary Traumatic Stress and the more severe, Secondary Traumatic Stress Disorder (Figley & McCubbin, 1983; Stamm 1999), were introduced to identify the experience of supporting family members who had traumatic experiences, as well as professionals attending to this population (Figley, 1999, 2002). The challenges these researchers recognized highlight the symptomatology of PTSD. Yael Danieli (1984) wrote a seminal paper, *Psychotherapists' Participation in the Conspiracy of Silence about the Holocaust*. She described how therapists limit Holocaust survivors' recounting of their experiences due to the psychotherapists' own discomfort.

In 1985 Hilfiker wrote about the personal impact of isolation experienced by physicians in training as an outcome of the lack of dialogue about their experience of closely witnessing disease. As examination of this phenomenon grew, Joinson (1992) introduced the term "compassion fatigue" (p.117). Joinson credits the term to Doris Chace, a crisis counselor, as it applied to nurses articulating their awareness of being worn down by their role as professional caregivers.

Three terms about the impact of witnessing clients' recounting of disturbing experiences have emerged, and are often used interchangeably regardless of their theoretical differences. These terms are: "vicarious trauma," "compassion fatigue," and "secondary traumatic stress." The one constant concept in each of the terms is the

practitioner's experience resulting from empathetic engagement with someone who is suffering.

"Vicarious traumatization," introduced by McCann and Pearlman (1990, p.137), emphasizes the interplay between traumatic life experiences, cognitive schemas and psychological adaptation. For therapists, traumatic experiences may include their own health issues, experience of natural disasters, or violence at the hands of others. To McCann and Pearlman, these experiences should be taken into account when considering therapists' reactions to their clients' traumatic material. This approach to vicarious traumatization incorporates Piaget's work on evolving mental frameworks, which he called schema. Schema expresses an individual's beliefs, assumptions and expectations about the world. Psychological adaptation refers to the therapist's identity and worldview expressed by "the ability to manage strong feelings, to maintain a positive sense of self and connect to others; and in spirituality or a sense of meaning, expectation, awareness, and connection; as well as in basic needs for and schemata about safety, esteem, trust and dependency, control, and intimacy" (Pearlman & Saakvitne, as cited in Figley, 1995 p.152).

Regardless of the type of trauma that clinicians work with, whether humanly induced or naturally occurring, a disruption of cognitive schemas in the areas of safety and trust in self and others was found (Cunningham, 2003). In a related way, research identifies isolation as both a predictor and a consequence of secondary traumatic stress (Figley, 1995; Bober, Regehr, & Zhou, 2006; Cunningham 2003; McCann & Pearlman 1990; Valent, 1995). Isolation is measured by the practitioner's negative sense of being understood by others (Wee & Myers, 2002), alienation from and under appreciation by

others (Dutton & Rubenstein, 1995), and the amount of time spent with family and friends (Stamm, 2002).

Researchers (Adams & Riggs, 2008; Brady, Guy, Polestra, & Brokaw, 1999; Pearlman & Saakvitne 1995; Rothschild, Rand, 2006; Saakvitne, 1992; Stamm 1999, 2002; Valent, 2007) suggest self-care strategies for clinicians to buffer themselves against the impact of their work.

Responsibility for care of clinicians leans heavily on the individual practitioner (Bell, 2003; April, 2009; Pearlman & McCann, 1990, Pearlman & Saakvitne, 1995b; Ringenbach, 2009; Sommer, 2008; Trippany, White Kress, Wilcoxon, 2004; Wood, 2009). An example of this focus on the practitioner being responsible for his or her well-being is in the American Psychological Association Code of Conduct (2002):

> 2.06 Personal Problems and Conflicts
>
> (a) Helpers refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
>
> (b) When helpers become aware of personal problems that might interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, to determine whether they should limit, suspend, or terminate their work-related duties. (American Psychological Association)

Recommendations from researchers also call for organizational participation in decreasing exposure to traumatic material (Bell, Kulkarni, Dalton, 2003; Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995; Salston & Figley, 2003; Sommer, 2008).

The status of responsibility for addressing secondary trauma, and especially the application of diagnostic criteria, has been found unappealing to employers and psychotherapists. They have been concerned about the stability and liability of their businesses (Stamm, 1999) as well as the liability of the practitioner.

Predictors of Probability of Secondary Trauma

Today a profile of psychotherapists most inclined to experience secondary trauma can be compiled based on researchers' examinations and findings on the nature of secondary trauma. Specific variables correlate with mental health clinicians' experiencing secondary trauma. These variables include: clinicians who are new to the field (Pearlman & MacIan, 1995); clinicians applying avoidant or emotionally focused coping mechanisms (Schauben & Frazier, 1995; Deighton, Gurris, Traue, 2007); clinicians who have high attachment anxiety (Racanelli, 2005); clinicians with years of education and experience in the field who do not participate in self-care and supervision (Bober, Regehr, & Zhou, 2006); women and ethnic minorities (Wee & Myers, 2002); and those with forty percent or more trauma clients in their caseload (Chrestman, 1999; Cunningham 2003). Difficult working conditions also produce more secondary trauma among practitioners (Farber & Heifetz, 1981; Adams, Boscarino, & Figley, 2008).

When clinicians first enter the field they have yet to develop the necessary coping mechanisms that go along with academic training for work in the trauma field (Pearlman & McCann, 1995). Therefore, therapists new to the field, and especially those with a personal history of trauma, are at the greatest risk of becoming negatively affected by their work (Pearlman & MacIan, 1995).

Adams and Riggs (2008) looked into the relationship between previous personal trauma history, clinical experience, and trauma-specific training. They also explored the relationship between defense styles and vicarious traumatization symptoms. Research participants completed the *Defense Style Questionnaire* (DSQ) (p.28). DSQ scale scores were used to group participants in one of four categories of defense styles.

(1) Maladaptive, representing those who have an inability to manage their own impulses and who withdraw, act out, and/or regress.

(2) Image-distorting style, representing those who split themselves and others into good and bad.

(3) Self-sacrificing styles, representing a need to maintain a self-image of being kind, helpful and never angry.

(4) Adaptive-style or positive coping style, representing those who are flexible and suppress, sublimate and/or use humor to manage their feelings.

Among their findings is that adaptive defense styles, such as positive coping strategies (suppression, sublimation and humor) are protective factors against vicarious trauma. This is true even when the trainee had a history of personal trauma. Schauben and Frazier (1995) concluded that psychotherapists with healthy, active problem-focused coping styles rather than with avoidant or emotion-focused coping styles, have less disruption to their self-trust schema and fewer PTSD symptoms.

Racanelli (2005) examined attachment as a potential mediating factor in compassion fatigue among mental health clinicians working with traumatized victims of terrorism. No significant correlations were found. However, in the same study, lower attachment anxiety was a predictor of compassion satisfaction. These findings support

previous research (McCann & Pearlman 1990) showing that those with positive self-esteem and esteem for others are more resilient in the face of the negative effects of exposure to trauma specific information.

Bober, Regehr, and Zhou (2006), applied the *Coping Strategies Inventory* (p.73) to clinicians. They found that those clinicians with more education and more years in the field were less likely to engage in leisure, self-care, and supervision. Shalvi and Luzzatto (2008), in researching clinicians who provided treatment to victims of terror attacks in Israel, also found that clinicians understand the importance of getting support but do not engage in trauma-oriented support programs. Furthermore, these clinicians believe that establishing a safe environment for themselves as well as their clients is impossible. The researchers describe passivity on the part of clinicians to care for themselves. Shalvi and Luzzatto (2008) also report that these clinicians describe a loosening of their personal and professional boundaries when, for example, they regularly discuss their professional challenges with family and friends, rather than at work.

Traue (1995) found that deficient social support corresponds with internalized coping strategies. This makes people more susceptible to muscle tension, pain and impaired immune functioning. On the other hand, Boscarino, Figley, and Adams (2004) found that clinicians who identify as having supportive work environments do experience an attenuation of the severity of vicarious trauma and compassion fatigue.

The research literature lacks a focus on race and ethnicity as it relates to secondary trauma. The literature does not address the fact that minority mental health practitioners are disproportionately represented within the field of mental health care. Initial findings (Wee & Myers, 2002) suggest that life as a member of a minority

population is itself a traumatic experience. This was expressed in higher rates of secondary trauma among minority clinicians. After the Oklahoma City bombing, Wee and Myers surveyed health care workers. Those workers who represented ethnic minority groups had the highest rates of distress. The researchers were unable to tell if this distress was present prior to the bombing. *Common Shock* is a phrase presented by Weingarten (2003) to describe the impact of exposure to violence on an everyday basis tied to experience of racism, classism, sexism, homophobia, anti-Semitism and ableism. This may also help to explain the disparity between ethnic minority practitioners' experience of their work and those who are white. Further examination of this phenomenon is needed to understand if higher rates of secondary trauma are related to an experience of isolation and/or discrimination and/or other factors (Wee & Myers, 2002).

When Pearlman and MacIan (1995) discovered high rates of vicarious trauma among psychotherapists, the participants in the study were 72% female and 28% male. Wee and Myers (2002) concluded that a predictor of vicarious trauma is female gender. However, this finding may contradict their claim that another predictor of vicarious trauma is having a personal history of trauma oneself. This would be challenged by the research showing more men than women experience potentially traumatic events due to war and street violence (Tolin & Foa, 2006). Tolin and Foa hold that a greater percentage of women who are symptomatic are diagnosed with Post Traumatic Stress Disorder.

Good (1996) hypothesized that art therapists witness a greater amount of trauma than other psychotherapists. They witness the verbal expression of their clients' traumatic experiences and also view images of those experiences in their clients' artwork. Research on the impact of witnessing art images by arts therapists did not increase practitioners'

secondary trauma (Good, 1996). In fact, those practitioners who engage in arts activities in response to their clients' expressed trauma undergo an amelioration of secondary trauma symptoms (Fish, 2007). Practitioners who have a creative orientation (Hatgis, 2006) and an innovative style of problem solving (Noworol et. al., 1993) are less likely than others to experience compassion fatigue. These factors provide a high sense of personal satisfaction (Fish, 2007; Hatgis, 2006; Noworol, Zarcynski, Fafrowicz, Marek, 1993). While compassion satisfaction can be a mitigating tendency in secondary trauma, it is not always the case. One can be both satisfied in one's work and also experience secondary trauma (Stamm, 1999, 2002). For example a mental health practitioner who is committed to helping her client through times of distress may also experience negative effects from witnessing her client's expression of distress.

In an empirical study of social worker clinicians, Cunningham (2003) found that they experience more disruption of their worldview when forty percent of their clients are recovering from sex abuse. In this study's findings, clinicians' self-esteem drops in direct proportion to the percentage of their work bearing witness to clients' trauma. Chrestman (1995) also found greater rates of trauma-related symptoms among clinicians with higher trauma caseloads. Among practitioners working for child protective services, a predictive factor for secondary trauma is the length of time one works with such cases. Also, the kind of trauma that clients experience is a correlate of stress among case managers working in Australia. Those case managers whose clients' lives were threatened have a greater rate of secondary traumatic stress reactions (Meldrum, King, Spooner, 2002).

Adams, Boscarino and Figley (2008) found the practitioner's work environment is a predictor of compassion fatigue. Work environments can contribute to producing or

reducing stress. Difficult working conditions produce more secondary trauma among their practitioners (Farber & Heifetz, 1981). When practitioners feel isolated as defined by their feelings of loneliness (Cacioppo & Patrick, 2008) or of alienation as defined as a sense of estrangement from community (van der Vennet, 2003), significant distress was experienced. If clinicians feel isolated from others at work, the probability of lowered self-esteem, lowered executive functioning and increased engagement in self-destructive behaviors emerge (Cacioppo & Patrick, 2008).

Effects of Secondary Trauma

Studies examine the impact of mental health practitioners' working in the trauma field. As previously stated isolation is both a predictor and a result of secondary trauma (Wee & Myers, 2002). Multiple changes occur among psychotherapists in the field, for example, their beliefs about safety, trust, intimacy and, esteem, (Pearlman & Mac Ian, 1995), an increase of restrictive coping styles such as dissociation and numbing (Herman, 1992; Gentry & Figley, 2007), minimizing and silencing clients' distress, (Baranowsky, 2002; Danieli 1984) and more sick days off from work than practitioners without secondary traumatic stress (Meldrum, King, Spooner, 2002).

In 1995, Pearlman and MacIan identified changes in psychotherapists' beliefs about safety, trust, intimacy, esteem, and power. Participants completed three questionnaires, one on avoidant and intrusive PTSD, the second on general distress, and the third on the practitioner's need for approval. They concluded that psychotherapists working with clients who have experienced trauma will inevitably be altered by their work. For example, a psychotherapist simply walking down a street may imagine the people she is seeing are experiencing violence in their home life or have in the past. Or,

when psychotherapists are in their own homes they may develop practices aimed at securing their safety such as pushing a bureau in front of a door before lying down to sleep. An example of a shift in intimacy among psychotherapists is a belief that since others are not able to enjoy the comforts of physical intimacy, the practitioner herself experiences a decrease in enjoyment in physical intimacy. This change in one's relationship to physical intimacy can, for instance, be due to intrusive thoughts of clients' negative experiences. These shifts in cognitive schema about trust, safety, esteem and intimacy have resulted in behavioral adaptations.

In "The Germ Theory of Trauma: The Impossibility of Ethical Neutrality," Bloom (1999) identifies feelings practitioners have of being ill at ease due to the incongruity of working to help their clients, countered by their own deep sense of hypocrisy about the origins of violence. Rather than seeing clients' distress as isolated events, practitioners struggle because of their deep awareness of our collective contribution to the problems at hand. Such a decrease in self-esteem appears to correlate with a decrease in creativity and therefore practitioners experience a waning ability to find logical, clear solutions to the clinical, organization and social challenges they face (Noworol, Zarcynski, Fafrowicz, Marek, 1993).

Steed and Downing's (1998) findings support conclusions that vicarious trauma correlates to negative effects on the psychotherapist's professional as well as personal life (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Pearlman & Mac Ian, 1995). Pearlman and McCann (1990) interviewed 12 female psychotherapists on their responses to hearing clients' traumatic material. Psychotherapists negatively responded when clients' experiences triggered a personal response in them. The therapists' sense of safety,

identity, and intimacy were disrupted. An example of a change in one's identity is a psychotherapist who realized she became numb in meetings with clients. Therapists discussed changes in their responses to people other than their clients as well, reporting that they found themselves getting more angry at others. They also have more intrusive and overwhelming images of violence. Practitioners reported becoming desensitized through repeated exposure to a client's history of abuse. Fifty percent of these therapists believe they are more suspicious and distrusting of others. Psychotherapists also reported decreased energy levels, somatic complaints, and sleep disturbance as a result of their empathetic engagement with trauma survivor clients.

Herman (1992) suggests that practitioners with restrictive coping styles such as denial, dissociation, numbing and over-involved and intrusive caregiving, can be a reaction to vicarious trauma. Baranowsky identifies sixteen signposts of a silencing response by therapists toward their clients, such as minimizing clients' distress, changing the subject of discussion, and feeling agitated and avoidant prior to sessions (2002, p.163-164). Danieli, in her work with holocaust survivors, called such behaviors a "Conspiracy of Silence" (1998, p. 298). Baranowsky (2002) and Danieli concur that the struggle on the part of the practitioner causes additional distress to clients. Baranowsky says these responses shut down therapy. Danieli finds that clients who already feel isolated further shut down and distance themselves from people. A correlation between compassion fatigue and ethical violations has been found (Danieli, 1984, 1988; Gentry, 2008, Monroe 1995).

In a study comparing professionals exposed to clients' traumatic material to the general public's reactions to traumatic material, both groups showed signs consistent with

vicarious trauma such as a heightened sense of vulnerability to harm (Luster, 2005). However, in 2002 Woodard, Meyers and Cornille found that practitioners are more symptomatic than the general population.

A sign of secondary trauma is the sense of becoming more isolated. Wee and Myers (2002) illuminate the isolating experience of practitioners in Oklahoma City after the bombing. Forty-seven point one percent of the practitioners felt that other people frequently rejected their experience or thoughts about the bombing. Seventy-nine point four percent of these practitioners believed that others did not understand what they were experiencing as a result of their role as counselors. Those who were administrators and supervisors experienced a high degree of secondary trauma due to their sense of responsibility for improving or fixing problems. Levels of concern by practitioners and administrators are largely a result of unresolved events that lead to worry, anxiety and fear (Borkovec, Roemer, Kinyon, 1995).

In *Humor as a Moderator of Compassion Fatigue* Moran (2002) explains the use of gallows humor as a recognition of the severity of the job of attending to those who are distressed, and says that this reaction can occur in addition to the distress of clients. Gallows humor, as a term, comes from the jokes made by the very people who were condemned to be hanged. Humor can allow practitioners an outlet for processing catastrophic events without becoming overwrought. The use of humor is seen either as a positive coping mechanism (Schauben & Frazier, 1995) or as negative when it is an expression of callousness or a perceived change in one's identity (Pearlman & McCann, 1990a; Pearlman & Saakvitne, 1995). It becomes more of a concern when

psychotherapists struggle with conflict between the values they developed in graduate training and their actual work in the field (Pakman, 2006).

In contrast Brady, Guy, Poelstra and Brokaw (1999) surveyed 446 female therapists and found that cognitive schemas about themselves and others as well as their sense of spirituality were not significantly negatively altered by trauma. In fact, they found that therapists with greater exposure to trauma felt they had more satisfaction in life than those with less. However, the authors found higher levels of post traumatic stress symptoms were present among therapists exposed to a greater amount of sexual abuse material. This research supports other findings that practitioners' exposure to specific stressors was associated with the severity of their secondary trauma symptoms (Figley, 2002).

While there are many questions about the impact of secondary trauma on organizations' profitability, evidence is mounting which supports the call for organizational initiatives to address it. Practitioners with secondary traumatic stress took more sick days off than practitioners who were experiencing subclinical secondary traumatic stress and asymptomatic practitioners. This study by Meldrum, King, and Spooner (2002) applied DMS-IV PTSD criteria to 300 practitioners through modification of the Florida Secondary Traumatic Stress Scale (Florida Scale) and added to the Queensland Mental Health Case Manager-Secondary Traumatic Stress Survey (QMHCM-STSS). Along with absenteeism, organizations and the work environment are also impacted by secondary trauma resulting in low motivation, lower productivity and higher staff turnover (Levin, 2003; Osofskym 2008).

Recommendations for Addressing Secondary Trauma

There are many research studies on the nature of secondary trauma, but comparatively few on the effectiveness of strategies to manage and prevent it. Therefore, included in this literature review is a compilation of recommendations by those who have researched the nature of secondary trauma in addition to related articles on primary trauma. These recommendations can be placed in six categories: self-care, social support, training, supervision, organizational policy and procedures, and activism.

The lack of empirically demonstrated means of prevention is of concern to Monroe (1995). He therefore begins his recommendations with practitioners' ethical responsibility for self-care. He raises two points for action: (1) to recognize the effects of secondary trauma on oneself and colleagues, and, (2) to limit isolation by making arrangements to work with others. The Green Cross Academy of Traumatology was established to train and deploy psychological trauma specialists around the world. Their *Standards of Self-Care* (Figley, 1997, 2003) includes guidelines for physical, psychological, social and professional wellness initiatives, (Appendix B). For example, adequate sleep, rest and relaxation are indicated. Building relationships with at least two people at work for emotional assistance is also necessary. Social justice work to prevent injustice is another standard of self-care. In 1999, Pearlman described the need for both intrapsychic and organizational interventions to prevent vicarious trauma. She recommends that practitioners develop themselves outside their work in ways that foster assertiveness, creativity, engagement with the arts and doing social justice work. Shields (1991) also advises sustainable social activism as part of practitioners' responsibility for their own self-care.

Valent (2002) is a child survivor and psychiatrist who has researched both primary and secondary trauma. He recommends that therapists engage in training that combines educational and heuristic approaches to compassion fatigue, and to examine adaptive and maladaptive survival strategies**.** Traue (2002) asserts that adaptive coping behaviors are developed by emotional expression in a supportive environment. To this end, Harris and Linder (1999) advise practitioners to enhance their communication skills and limit their isolation by using their visual, auditory, and kinesthetic senses. For example, a practitioner could say to colleagues, *I saw a client who described a man on a tractor hitting something that sounded to her like an explosion. When I heard this I felt choked up and my back got instantly tight.*

McCann and Pearlman (1990) note the importance of not pathologizing the practitioner's response to a client's traumatic material. Rather, as a means of self-care, they recommend normalizing it. This action parallels the social and clinical understanding that blaming victims of primary trauma is not helpful. In 2006, Sabo seconds this mandate to shift away from pathologizing the practitioner and instead emphasizing what protects her. Wee and Myers (2002) add the importance of positive self-talk for practitioners, as well as taking notes on a clipboard to help with memory problems during stressful times. As a result of their research on coping strategies among 259 trauma psychotherapists, Bober and Regher (2006) found that there is far too much attention paid to individual focused rather than structural approaches. They suggest shifting efforts from education to advocacy for improved working conditions.

Pearlman and MacIan (1995), in *Vicarious Trauma: Empirical Study of the Effects of Trauma on the Therapist,* make recommendations based on their study of 136

self- identified trauma psychotherapists. The participants completed three questionnaires: assessing avoidant and intrusive signs of Post Traumatic Stress Disorder, general distress, and participants' need for approval. They recommend supervision where confidentiality and support enable therapists emotionally to process the horrific information from their clients. Pearlman and Saakvitne (1995a) recommend trauma-specific supervision, making sure therapists are clinically prepared with appropriate skills for doing trauma work. Pearlman and Saakvitne (1995b) also state the significance of sharing rewarding aspects of the work in supervision and at other opportunities.

Figley (1995) advises practitioners to experiment with different methods for lessening compassion fatigue. An important distinction is made between experiences that offer superficial support and deep group support (Borkovec, Roemer & Kinyon, 1995). Borkovec, Roemer and Kinyon advocate group experiences that engage multisensory emotional expression to decrease worry, fear and anxiety and increase adaptive emotional behavior.

The importance of professional peer groups to provide "consensual perceptions of reality" (Catherall, 1995 p. 87) to deter isolation, share information, and provide social companionship is best obtained when a formal organization is applied to the gathering. Catherall also suggests that no member of the group should be exempt from sharing his or her personal reaction, especially in times of crisis. Also, Terry (1995) shares his experience with the benefits of employing traditional native values to collective learning in support of practitioners. He clarifies the values of collective learning practice as promoting meaningful re-connection to each other and the environment, collective wisdom, and social support.

For those practitioners who work in isolated areas or in private practice, Stamm and Pearce (1999) recommend the use of technology to limit isolation. Creating a virtual community where a practitioner does not have to leave her office but can use email, telephone, fax and other current means for staying in communication with colleagues is advised. They also recommend the use of online libraries to ensure practitioners are well versed in the subjects necessary for their responsibilities. Today, online social networks would be among the recommendations made for decreasing isolation and increasing practitioners' information and skills for psychotherapy practice.

Wee and Myers (2002) advise mental health practitioners doing disaster work to function as a team and to listen to each other's feelings. However, they maintain that it is important to preserve a distinction between personal and professional roles. Meldrum, King and Spooner (1995) concur, explaining that roles and responsibilities ought to be clear to avoid secondary traumatic stress. They also suggest that consultation groups, where practitioners represent a range of disciplines, may cause more stress for those accustomed to traditional supervision practices. On the other hand, creating a culture that values socializing, fun, humor, and relaxation time as a group are among the recommendations made by Shields (2006).

Woodard, Meyers and Cornille (2002) propose that practitioners who work with traumatized children should establish a safe place to release their own emotions and talk about their fears and regrets. This recommendation is made because practitioners often minimize the severity of secondary traumatic stress symptoms. Rosenbloom, Pratt, and Pearlman (1995) also highlight the importance of a respectful atmosphere when building safety for exploring difficult issues in supervision and training. The importance of such

an environment extends beyond supervision to the organization as a whole, especially in times of intrapersonal and interpersonal stress. Furthermore, regular time for staff meetings to address feelings and issues related to trauma work may limit vicarious trauma (Brady, Guy, Poelstra & Brokaw, 1999). Stamm (1999) recommends that practitioners break their isolation and develop experiences with nurturing communities. She proposes that what moves hope forward is often nurturance and wisdom from a sustaining community.

Organization policies that prevent vicarious trauma are strongly recommended (Hatgis, 2006; Pearlman & Saakvitne 1995; Rosenbloom, 1999; Woodard, Meyers, Cornille, 2002). Organizations have the responsibility to see to it that practitioners have a mix of client issues as well as a balanced day with meetings on varied subjects such as conducting research and public speaking (Catherall, 1995). There should also be time for lunch, walks and phone calls with friends. Providing flexible hours, vacations, and time-off are among the recommendations for improving psychotherapists experience as they attend to traumatized clients (Rosenbloom, 1999).

Institutional policies need to allow practitioners to process disturbing material (Figley, 1999). What is required is on-going professional training that addresses the personal growth of practitioners whose jobs require that they witness the suffering of clients (Sork, 2006). However, Sork recommends training and policy that will decrease the negative stigma associated with practitioners' need in order to get help early, especially for graduate students. McCammon (1999) advises graduate school educators and clinical supervisors to be prepared for students' vulnerability in discussing trauma, due to the significant percentage of students who have personal experience with it. She

further recommends that educators clearly maintain the distinction between their roles as educators and supervisors versus students' therapists. McCammon (1999) offers educators further guidelines for teaching about trauma.

White (2002, 2006) is adamant about the need for on-going training and evaluation, which is too often left out of project planning and implementation. He developed this approach through his work bringing Eye Movement Desensitization and Reprocessing (EMDR) training to clinicians and staff of several refugee camps in Bosnia and Croatia. Chrestman (1999) recommends on-going training for a number of reasons. One is that a function of educational programs is gaining more knowledge and skills. It is also an opportunity to meet colleagues, build a referral network, and develop social supports. Attending training programs raises the opportunity for contact with colleagues, and thereby decreases isolation (Brady, Guy, & Poelstra, 1999; Chrestman, 1999). Chrestman (1999) also recommends that practitioners seek non-trauma-specific continuing education units (CEUs) as a means for decreasing stress and anxiety.

Addressing Secondary Traumatic Stress: Programs and Research Studies

While research findings have led to a call for individual, team, and organizational strategies to prevent and ameliorate secondary trauma, only a small number of studies have focused on these growing efforts. For instance, research has been done on educational programs to relieve and prevent secondary traumatic stress. Another hopeful area is the appearance of meditation and mindfulness programs for stress relief for clinicians. Finally, expressive art therapists have introduced group therapy to the literature on treatment for secondary traumatic stress.

Researchers have determined factors that mitigate secondary trauma even when clinicians have a personal history of trauma. For example, mental health clinicians experience less disruption as a result of their work with traumatized clients when they can describe their workplace as supportive (Devilly, Wright, Varker, 2009; Deighton, Gurris, Traue, 2007) and employ the following: active problem-focused coping mechanisms (Schauben & Frazier, 1995) a creative orientation (Hatgis, 2006); innovative coping styles of problem solving (Noworol, Zarczynski, Fafrowicz, & Marek, 1993); and arts responses to their client's material (Fish 2007).

Gentry, Baranowsky along with their colleague Dunning (1997, 2002) developed a five-session educational program called the *Accelerated Recovery Program* (ARP). The program combines information on compassion fatigue with a focus on the personal experience of using self-regulation strategies, imagery, and personal goal setting. Between the first two meetings participants bring homework projects; a personal mission statement, and a professional timeline. ARP developed into a training program called *The Certified Compassion Fatigue Specialist Training*, (CCFST) which originally was a 17 hour event and expanded to 20 hours (Gentry, Baggerly, & Baranowsky 2004).

In 2000, Gentry published a research study, *Certified Compassion Fatigue Specialist Training: Training as Treatment* showing a clinically significant successful development of participants. The CCFST utilized the ARP and also built in training as a treatment approach. Multiple principles were built into these programs. One principle was intentionally to acknowledge the symptoms of compassion fatigue while allowing participants to address the issues. Moreover, a greater connection to self, facilitators and relationships with colleagues help participants acknowledge symptoms of compassion

fatigue. Third, anxiety management and self-soothing practices for the body and mind helped to attune people to levels of arousal that could support awareness of compassion fatigue symptoms. Fourth, self-care that includes exercise and artistic pursuits it seems might be the best self-care regulators. Gentry identified significant challenges among clinicians working with clients and in situations beyond their level of skill. Desensitization and reprocessing is applied through a variety of means that employ exposure and relaxation, such as Eye Movement Desensitization Reprocessing (EMDR). The *Certified Compassion Fatigue Specialist Training* has been found to reduce practitioners' compassion fatigue (Gentry, Baranowsky, Dunning, 2002; Gentry, Baggerly, & Baranowsky, 2004).

Pearlman and Brown (2004) developed *Risking Connection Training*, a three-day, twenty-hour, educational program geared towards professional mental health providers working with clients who have experienced trauma. The program trains practitioners through didactic and experiential activities in collaborative approaches to working with traumatized clients. This approach also includes educational material on the effects of trauma on the practitioner. The researchers hypothesized that clients and therapists who used the *Risking Connection* approach to trauma recovery would find that their sense of well-being was enhanced. However the study reports insignificant improvement in vicarious traumatization among participants after the training compared to before the training.

While the twenty-hour *Risking Connection Training* did not report improvement of vicarious trauma, group psychological debriefing has proved to be more effective in alleviating vicarious trauma indicators (Everly, Boyle, & Lating, 1999). One of the

differences between the educational format of the *Risking Connection* training and the debriefing methods appears to be that in the psychological debriefing format participants are invited to talk about their personal experience with traumatic events along with appropriate emotional expression.

Cohen, Gagin and Peled-Avram (2006) assessed correlates of secondary trauma in helping professionals who were involved in multiple terrorist attacks in Israel. Fifty-three social workers volunteered for the study. Participants were offered group supervision for one and a half hours every two weeks with two senior social workers and weekly individual supervision. Both supervision modes combined educational and supportive elements such as crisis intervention techniques and attention to participants' self-awareness. The group supervision methods included simulations, role play and experiential exercises. Peer support, group cohesion and mutual learning were objectives of these group supervision meetings. After terrorist attacks in which participants served community members affected by the incident, practitioners were offered two debriefing sessions, which were based on the *Critical Incident Stress Debriefing*, CISD, model (Mitchell, 1983, 1988). Findings show that forty eight percent of participants were in the extremely high range of secondary traumatization. Eighty percent were in the low levels of burnout. There were no differences found in levels of secondary traumatization among social workers who received either group or individual supervision or participated in debriefing sessions. However, participants of the group supervision meetings reported significantly lower burnout than those who did not receive group supervision. Dalton (2001) found that the greater frequency of non-evaluative supervision of licensed clinical social workers correlated to lower levels of secondary trauma.

Debriefing across cultures requires culturally specific practices (Dwairy, 2005). Dwairy studied Palestinian-Israelis after several murders in that community. An Arabic method of reconciliation called *Shulha* was successful in attending to the needs of this collective society in the case of both mental health practitioners and students. On the other hand, *Critical Incident Stress Debriefing*, CISD, (Mitchell 1983, 1993) emphasizes the individual, and therefore failed to include the important development of reconciliation within the community. During the early phase of CISD, students met together in their classrooms to discuss their personal experience with the program. However, fathers, as heads of households, forbade children to talk with classmates from families the parents were fighting with. In this collective society, relatives from the same family who have different heads of households and were in the same class needed to meet in separate rooms in order to work through initial phases of recovery.

Several expressive therapy groups have explored the experience of health care practitioners who self-identified as experiencing secondary traumatization. For example, an Italian oncology team, (Belifiore, 1994) which sought preventative measures against secondary traumatization through an art therapy program, found a decrease in isolation and an increase in supportive communication among doctors and nurses working with terminally ill patients. In this program, an art therapist met with the oncology staff for three hours each week for six months. During the first meetings participants sculpted "inner guides" (p.119) for themselves and the group as a whole. The eight sessions that followed were developed from the themes of each participant's inner guide: e.g., professional self versus hidden self.

The Effects of Music Therapy on Compassion Fatigue and Team Building in Hospice Caregivers (Hillard, 2006) is a study of two different kinds of music therapy sessions, one ecological and one didactic. In this study, each group met six times for one hour each and completed pre and post program surveys. Surveys included the twenty-question *Compassion Fatigue/Compassion Satisfaction Self Test* and the seven-question *Team Building Questionnaire*. The formless music-making in the ecological music therapy sessions, as well as the facilitated didactic group, showed increases in team-building, with the didactic group showing a greater degree of success. However, neither group demonstrated a significant difference in compassion fatigue scores.

Samoray (2005) sought to identity whether a correlation between compassion fatigue and creative expression could be made among practitioners who self-identify as experiencing compassion fatigue. She interviewed eleven practitioners in eleven states. Practitioners represented the fields of psychology, law, government and medicine. She found that lower levels of compassion fatigue correlated with the greater frequency of their creative activities. In another art therapy study of mental health workers whose clients were domestic violence and sexual assault survivors, van der Vennet (2003) found a decrease in participants' sense of isolation and an increase in their sense of creative imagination after eight sessions. Results were analyzed from both interviews with participants and pre and post-program surveys. The *Traumatic Inventory for Trauma and Burnout* (TSI) and *Symbolic Profile* were applied.

In a heuristic study, Banks (2007) applied her own training and personal application of expressive arts therapy and meditation to her recovery from secondary trauma following the bombing of the Pentagon and her professional involvement in

disaster recovery efforts. Murrant, Rykov, Amonite and Loynd (2000) developed an arts therapy workshop to enhance self-care for caregivers called *Creativity and Self-Care for Caregivers*. An objective of the program was to support practitioners shifting their perspective that the management team should "fix things" (p. 44) for them. The one-day program, for the 75 professionals and volunteers of a hospice, included three two-hour sessions of writing, art and music. They discovered that participants found that no one modality stood out as being more useful for the participants. Participants' evaluations also concluded that the supportive, non-judgmental environment the therapists facilitated was an important element that led to increased awareness of self-care.

Seasoned traumatolgist Ayalon (2006) traveled to Thailand after the 2005 tsunami and facilitated two five-day workshops for 100 mental health and education practitioners. While not a formal research study, his report of the program is an excellent example of a description of the program's success. This included arts-processing of practitioners' personal experiences and neurological, psychological and social signs of traumatic responses, and methods for professional intervention with others. Ayalon emphasized positive psychology's view of the natural coping and healing abilities within everyone. Ayalon introduced a model where practitioners considered their own and their client's well-being after a crisis, called *BASIC PH* (Lahad, 2000). *BASIC PH* is an acronym for evaluation of shifting beliefs, affects, social responses, and included areas like, imagination, cognition, physical activity and relaxation. Lahad notes the responsibility of a team leader for the emotional and physical health of a team.

In a study with graduate school students in counseling psychology, those who were newest to the field and professional role, were introduced to a mindfulness-based

stress reduction program to alleviate and prevent secondary traumatization and burnout, (Shapiro, Brown & Biegal, 2007). The offer to participate in the study was made to students who registered for one of three graduate courses. One class participated in the *Mindfulness Based Stress Reduction* (MBSR) (Kabat-Kinn, 1982) curriculum. Participants were trained in sitting meditation, body-scanning, *Hatha* yoga, loving-kindness imagery-meditation and mindfulness practices for day-to-day life. Two control groups were surveyed, as well as the *MBSR* course participants. Findings show a decrease in *MBSR* participants' experience of perceived stress, negative affect, rumination, plus an increase in positive feelings.

Organizational Initiatives to Decrease Secondary Trauma in the Workplace

Secondary trauma may have roots in the organizations where practitioners work (Hormann & Vivian, 2005). Stress can become part of an organization's culture and be passed onto generations of workers through a de-socialization process. Language, explanations of where stress comes from, and how it is perpetuated contribute to the way workers perceive their individual experiences. For example, social justice work can involve turmoil that can become embedded within an organization. People may find that the difficulties of such work may bring up questions and doubts about their abilities to support organization initiatives because they perceive changes as opposing needed improvements in their personal lives. Hormann and Vivian recommend open communication with practitioners within organizations to address the difficulties of social repair work and to do so with other organizations as a means to limit isolation and build critical dialogue.

Efforts led by Herman and Harvey at the Cambridge Health Alliance (CHA) (Harvey, Mondesir, Aldrich, 2007; Herman 2002, Herman, 1992) inspired countless studies and creative approaches among clinicians within the trauma field. *Sources of Expression of Resilience: Ecological Theory and Multicultural Practice* (Harvey, Mondesier, Aldrich, 2007) is an example of the work that has come out of this innovative facility. After a disaster in a community, their team of clinicians meets with key community members and offers training for providers, which includes peer support and didactic material on secondary trauma. They focus on lessening PTSD through community education, which includes emphasis on self, family, friends' support, available resources, and collective membership in a caring community. Members of the communities themselves are the evaluators of these programs.

HOPE NY (Lukens et al., 2004) brought immigrant groups together in New York City after the September 11th terrorist attacks to support resiliency. Researchers who facilitated a twelve-hour training for agency-based practitioners on compassion fatigue and vicarious trauma, brought six community agencies together. These practitioners then facilitated six to twelve people in four weekly or alternating-week meetings in the participants' primary language. The curriculum was structured with a focus first on care, rather than self-care, as many immigrant groups are members of collective societies. Then they focused on areas like grief, on-going effects of stress and trauma and future planning. The program purposefully included socializing time after sessions to help participants develop greater networking opportunities. Outcomes of the study include a manual on open learning across cultures and feedback from practitioners and participants requesting an on-going program instead of the four-session limit.

Teams within organizations have developed structured practices to enhance the well-being and the skills of practitioners. In 1995, Lisa Fontes wrote *Sharevision: Collaborative Supervision and Self-Care for Working with Trauma*. In this article, she describes the process that emphasizes narration of clinicians' perspectives of the family situation, building a culture of respect, sharing positive developments within client families, and collegial support while proposing differing perspectives and different ideas about the issues at hand. She identified the significance of a temporary flattening of hierarchy among professionals to facilitate clinicians hearing from one another. In 1995, Monroe, Shay, Rapperport and Zoning also described their experience with creating a structure for a collaborative team model to prevent compassion fatigue. In their work they also validate clinicians' affect in regard to their work. They build into their structure identification of trauma patterns in clinicians such as exploiter/exploited, allies/enemies, aggressor/aggressee and rescurer/rescuee (p.219). They pose alternative approaches to these patterns in their team discussions. However, they identify one limitation of teamwork: the tendency of participants to establish uniformity of thinking and approach to their work.

A similar format was introduced to clinicians in New York City after the terrorist attacks on September 11, 2001 (Geller, Madsen, & Ohrenstein, 2004). The authors found that these meetings "…enhanced the ability to work with difficult cases, restorative, renewing, safe environment." (p.428). This program was called the *Clinical Risk Management Team Approach*. Through this structure they helped team members to propose questions and develop a "shared ownership" (p.421) of the issues at hand. Their format included a time for practitioners to talk about their feelings. The study found that

practitioners do not always feel safe to do so. The researchers did not identify the origins of their practice in the way that Fontes, (1995) Monroe, Shay, Rappaport and Zoning (1995) did.

In a study of peer collaboration, counselors developed self-awareness that led to more intentional and improved management of their workloads (Barlow & Phelan, 2007). Six groups of three counselors each met six times over five months. Facilitators met with practitioners at the first, third, and sixth meeting to support the program goals. Their instruction was to simply, "Talk about their work and reflect on their practice" (p.7). Participants were to create the structure for their own groups. They reported to facilitators, in the third and final meeting, that they had experienced a sense of safety in their small groups that led to more open discussions and greater trust.

Sanctuary in a Domestic Violence Shelter: A Team Approach to Healing (Libbe, Blitz, McCorkle, & Panzer, 2003) describes the positive impact of this approach after it was brought into a twenty-two bed adult psychiatric unit in a four-hundred bed general hospital. Practitioners reported increased satisfaction with patient interaction, and there was a decrease in the number of seclusions and restraints patients received. In 2008, at a drop-in center for homeless women, after two years of on-sight individual supervision focused on alleviating secondary trauma, staff reported that there had been fewer incidences of violence among the women who stayed at the center (Landis, 2008).

Literature Review Conclusion

The research literature on secondary trauma among psychotherapists provides consistent agreement that there is a health risk to psychotherapists who attend to clients in extreme distress, either due to natural or man-made events. Those at greatest risk are

psychotherapists with their own histories of trauma; those whose client caseload includes a significant percentage who are experiencing trauma; those working with clients whose lives have been threatened; and those who are isolated and lack personal and professional support. The research literature demonstrates that psychotherapists who have secondary traumatization symptoms experience changes in cognition and behavior at personal and professional levels. Alterations in trust, safety, intimacy, and esteem coincide with silencing clients, angry outbursts, sense of isolation, numbing, and restrictive coping styles. Psychotherapists who engage in specific self-care and institutional practices show less disruption of their cognitive schema and fewer signs of secondary trauma. Self-care methods include creating art-responses to their clients' material, using active-solution focused coping mechanisms, and employing creative orientation and innovative coping styles. Important institutional criterion for limiting secondary trauma are experiencing one's worksite as a supportive environment, having a variety of professional opportunities, and most importantly includes working with colleagues rather than in isolation.

Research on interventions to ameliorate secondary trauma among psychotherapists has spanned investigation of several different kinds of approaches. These approaches consist of: education through intensive professional development training; mindfulness techniques taught and practiced in graduate school; individual and group supervision; art therapy; music therapy; peer support and group psychological debriefing. However, there are gaps in the literature. Absent are studies that explore the recommendations by researchers for social action to improve socio-political conditions for client populations as well as practitioners' working environment. Also absent from

the research literature is the integration of arts modalities in professional development and peer supervision in efforts to alleviate secondary trauma among psychotherapists.

Chapter III

METHOD

Rationale for Research Method

I chose *collaborative inquiry* as the method to research this expressive arts-integrated professional development program on alleviating secondary trauma. Collaborative inquiry establishes participants as inquirers in the study. As inquirer-participants, we are responsible for our choice of inquiry, meaning-making and action with concerted attention given to the role of affect (Heron & Reason, 1995). This model is often applied to small groups in work settings as "professional development" (Kasl & Yorks, 2002). Collaborative inquiry counteracts professional isolation through engaging participants in on-going cycles of action and reflection (Bray, 2002; Heron & Reason, 1997; Kasl &Yorks, 2002, Wherrett & et, al., 2002). In the collaborative inquiry process, participant-inquirers explore their perceptions and practices, using the research process to establish new knowledge based on their personal experiences (Bray, 2002; Heron, 1989). Desired changes in the professional lives of participant-inquirers are an indicator of inquiry validity (Bray, 2002; Heron, 1996).

Collaborative inquiry is consistent with the collaborative-reflective format called "Sharevision," which is described in this study. Aspects of the research design include clinicians as inquirers in ongoing cycles of reflection and action. The focus of the study is on participants' reflections on their experience of secondary trauma and on designing and performing a group action aimed at improving the community in which they work. Collaborative inquiry addresses participants' professional goals in terms of developing new understandings and practices for managing, as well as decreasing, secondary trauma.

Collaborative Inquiry: Expressive Arts Therapies and Adult Learning Theory

Collaborative inquiry is congruent with expressive arts therapies which assert that participants have the opportunity to alternate between verbal and non-verbal group and individual processes (Belanger, 1998; Braud & Anderson, 1998; Byers, Calisch, Gregoire, Peterson, 1994; Byers & Forinash, 2004; Byers & Gere, 2006; Cruz & Berrol, 2004, Feder & Feder, 1981; Forinash, 2004; Hervey, 2000; Johnson, 1999; Levy, 1988: McClelland, 1993: McNiff, 1998, 2004; Ristock & Pennell, 1996; Serlin, Roskin, Bar-Sinai, 2007; Stark, 2002; Stralen, 2002). Both adult learning theory and expressive arts theory welcome the diverse knowledge and experience of participants (Angus & Langsdorf, 1993; Argyris & Schon, 1989, 1996; Brookfield, 1995; Byers, 1991; Cranton, 1994; Falk & Dierking, 2002; Gordon-Giles & Zidan, 2009; Gray, 2001; Hoffman, 1985, 2003; Koch, 2004; Lahad, 2000; Malchiodi, 2005; Merriam, 2001; Mezirow, 1991, 2004; Rogers, 1993; Schon, 1983, 1991). Collaborative inquiry is composed of on-going reflexive dialogue, which is necessary to move the learning from the research process into the clinician's professional milieu. (Glennie & Cosier, 1994; Kasl & Yorks, 2002; Paulus, Woodside, & Ziegler, 2008; Smith, 2002; Veroff, 2002, Wicks, & Reason, 2009; Zelman, 2002).

Collaborative Inquiry: Born of Action Research

Collaborative inquiry is rooted in action research. However, collaborative inquiry departs from such research in that the emphasis of learning in this type of study is on the context in which a particular problem is embedded (Creswell, 2009; O'Brien, 1998, Torbet & Reason, 2001; Wicks & Reason, 2009; Stringer, 1999). While with collaborative inquiry the emphasis is on change within the individual, such change may

subsequently lead to efforts to change the frame, paradigm, policies and institutions of influence (Kasl & Yorks, 2002).

Exploring cycles of reflection and action in communities was introduced as "action research" by social psychologist Kurt Lewin in the 1930s as a four-part process of planning, acting, observing and reflecting (Creswell, 2009 p.597; Stringer, 1999 p.9). A cornerstone of action research is meeting "appropriate standards of rigor without sacrificing relevance" for "practitioners' demands for usable knowledge in the field" (Argyris & Schon, 1989, p. 612). In both the research methods of collaborative inquiry, and the collaborative-reflective practice described in this study, the continual cycling between observation, reflection, planning and action is supported by Winter's (1987, 1996) description of a set of six principles of action research.

1. Reflexive critique; a process of becoming aware of our own perceptual biases.

2) Dialectical critique: discussion is used to understand the relationship between the elements that make up various phenomena in our subject [in this study it is compassion fatigue] and the context in which it is experienced.

3) Collaborative resources: everyone's views are taken as a contribution to understanding the situation.

4) Risk disturbance: an understanding of our taken for granted processes and the willingness to submit them to criticism.

5) Creating plural structure: developing various accounts and critiques rather than a single authoritative interpretation.

6) Theory and practice internalized: seeing theory and practice as two interdependent yet compatible phases of the change process. (Winters, 1996 p.13-14)

Stringer (1999) elucidated the process of action research. He developed a three-part process of inquiry, "look, think, act," which he termed the "action research interacting spiral" (Stringer, 1999 p.19). Stringer applies a metaphor of vision to develop the concept of reflection. A group gathers information about the subject of inquiry in an effort to stimulate a new way to think about the topic. Thinking, analyzing, interpreting are means by which to clarify and extend the parameters of understanding it. For Stringer (1999), action is the intervention or attempt to weaken a problem that holds people oppressed or constrained. However, the "lines of action and reflection are often blurred" (Bray, 2002 p.87). At times, a group's action and reflection, such as involvement in an arts project, may take place within the group meeting.

Intervention: Congruence of Method and Model

Collaborative inquiry is an appropriate method through which to explore the impact of a collaborative-reflective, expressive arts intervention on the nature of secondary trauma among clinicians. Both collaborative inquiry and the collaborative-reflective practice, Sharevision, are designed as democratic processes wherein power is shared among the participants (Argyris & Schon 1989, 1991, 1996; Baldwin & Thompson 1989: Baldwin, 2006, 2008; Creswell, 2009; Fontes, 1995; Heron & Reason 1997; Hoffman, 1993, 2002; Kidd & Kral, 2005; Stralen, 2002; Stringer 1999). Emphasis is on continuously building understanding of beliefs and patterns, and developing a new awareness that helps clinicians plan, carry out and reflect on ways to improve their lives and often the lives of

others (Baldwin, 1999; Heron & Reason, 1997, 2001; Huizer, 1997; Landis, 2010; O'Brien, 1998; Rosenwasser, 2002; Stoecker, 2009).

Several other aspects are similar in the research method and the collaborative-reflective Sharevision model being explored here. In each process the participants are self-reflective. The process of improving their own lives often leads to improvements in the lives of others (Argyris & Schon, 1996; Baldwin & Thompson 1989; Creswell, 1998, 2009; 1993, 1996; Heron & Reason 1997). Participants are also co-inquirers. They take responsibility for their own choice of inquiry, meaning-making and action (Baldwin & Thompson, 1989; Heron & Reason, 1995).

Collaborative inquiry and the collaborative-reflective model applied in this research are founded on the principle that multiple perspectives are valuable in building sustaining groups (Fontes, 1995; Hoffman, 2002; Heron & Reason, 1997; Landis, Baldwin & Thompson, 2004). Using multiple perspectives means including people with differing ideas and a variety of means through which their ideas can be expressed. This is valuable because participants can then engage in a dynamic dialogical process (Creswell 2009; Hoffman, 2002; Landis, 2010; Veroff, 2002; Yorks & Kasl, 2002). The dynamism of collaborative inquiry is itself emancipatory in that participants are free to identify restraints on their perception and practice; and also to take action with the support and strength of fellow participant-inquirers (Yorks & Kasl, 2002).

Role of the Researcher

While Heron and Reason expect a research group to form and to agree on a focus of inquiry, develop their set of questions for the inquiry and "devise and agree on the set of procedures for gathering and recording data" (Heron & Reason, 1995 p. 4), I offered a set

of procedures for the meetings. There is, however, considerable literature on the parameters of collaboration in the decision making process. Researchers, educators, trainers and consultants have explored the range of decision-making options for collaborative inquiry (Heron, 1999; Marshall & Reason, 2007; Seel, 2005; Zelman, 1995; Reason, 1999). One criticism of all action research, including collaborative inquiry, is that it can take a very long time for a group to make decisions and the process can thereby lose momentum and participants (Bray, 2002). Stralen (2002) made use of her role as an organizational consultant by facilitating eight meetings of collaborative inquiry with six nursing managers. She gradually transitioned leadership to the participant-inquirers beginning with their third meeting. Bray (2002) cites his experience with initiating multiple yearlong collaborative inquiry groups within a school system. He found that participant-inquirers looked to him as the authority to resolve conflicts. He, however, would leave his position as a perceived authority by stepping out of the facilitator role as early as possible in the yearlong process. In this research study, I intend to facilitate the first meeting with the clinicians and ask them to meet without me on alternating weeks using the collaborative-reflective design. I refer to the role of the researcher in the Workshop Template as the facilitator and the Sharevision facilitator.

Study Design

This research is designed to explore how the application of a collaborative-reflective model for clinicians correlates with the nature of secondary trauma. As stated in the Informed Consent contract, participants' involvement with the study was a commitment of twelve consecutive weeks. The design is based on a pilot study (Landis, 2007).

The objectives of the workshops were to:

1. Discuss the program, read and choose whether to sign Informed Consent Forms
2. Fill out a questionnaire on the first and last days of the study
3. Engage in six workshops meeting every other Friday morning. In these workshops participants:
    - Learn the collaborative-reflective design
    - Explore their own experiences of secondary trauma
    - Communicate through expressive arts materials
    - Develop, perform and reflect on an arts-integrated group action project representing their design of a collective effort to interrupt the cycle of violence.
4. On five alternate Friday mornings clinicians employ the collaborative-reflective, Sharevision process in meetings without the researcher/ Sharevision facilitator present. In these meetings the clinicians focus on their clinical work with clients.
5. Clinicians meet individually with the researcher if they would like to have the results of their pre-and post-program surveys.

Workshop Template

Workshop # 1: Introductions, Ownership and Awareness of Change

1. The researcher/Sharevision facilitator greets clinicians and introduces the research program including Informed Consent forms.

2. Clinicians are invited to introduce themselves.

3. Survey: The researcher gives an orientation to the survey. Clinicians are asked to choose their own pseudonyms as part of completing the survey.

4. Presentation: The facilitator offers an overview of secondary trauma among clinicians.

5. Expressive Arts Project: The facilitator describes the purpose of integrating expressive arts activities into the course. The first activity is introduced with a question.

Question: When did you recognize that you were experiencing a negative impact from your job?

Purpose: This expressive arts activity is designed to engage clinicians in a cognitive and multi-sensory experience through which they can gain:

a. Ownership of the topic:

b. Awareness of the shared phenomenon

Rationale:

a. A few simple materials which may be familiar and easy to use supports decision making and requires no advanced skills.

b. Engaging in multisensory creative projects stimulates imagination both broadly and quickly.

c. Assembling metaphors and prompts in the shared group context provides multiple perspectives and expanded awareness.

d. Clinicians can reflect on their assumptions embedded within their actions.

Materials: Paper, markers, stickers, scissors, glue, string confetti

6. Introduce the collaborative-reflective format based on Sharevision (See appendix A). Each participant is invited to talk about her or his expressive arts piece and her or his experience relating to the chosen topic within the design. One person introduces her piece

then others respond. The person presenting has a moment to conclude. This process is repeated for each person.

a. Speak through "I" statements.

b. Share associative ideas, feelings and accompanying movement.

c. Unusual and surprising ideas are encouraged.

d. Time is shared equally among each participant.

7. Review collaborative-reflective format for participants to use during week to talk about their clinical work with clients.

8. Invite clinicians to contribute their ideas on secondary trauma for the next workshop and for any expressive means that they may like to explore.

9. Closing remarks from each participant.

Question: What is something you wish was different, and something that you liked about the meeting today?

Workshop # 2: Perception and Practices: Puppet-Making

1. Greetings

2. Check-in.

3. Review experience of using the collaborative-reflective, Sharevision design for their first independent clinical meeting. The Sharevision facilitator coaches participants on variations of the design and their purpose. The aim is to create a fit among the organization, the participants and their clinical meeting.

4. In the event a clinician brings up a pressing concern in the check in, apply the collaborative-reflective design on the subject. For example, a clinician may feel disturbed due to learning of the loss of funding for a program that will impact her clients and her job, right before the meeting.

5. Presentation: The facilitator offers examples of negative changes in one frame of reference such a change in one's sense of identity (Pearlman & Saakvitne, 1995a & b). Clinicians' requests and suggestions for thematic material from previous meetings are woven into the talk. ("Fear & Creativity")

6. Expressive Arts Project

Question: When did you notice yourself questioning your identity, your self-assumptions, especially as they relate to fear and creativity?

Purpose: This expressive arts activity is designed to engage clinicians in a cognitive, emotional and multisensory experience through which they can focus on their own shifting identity (as it relates to their chosen theme: fear and creativity).

Rationale:

See Workshop 1, Rationale: a-d.

e. Providing puppet-making materials offers an opportunity to externalize one's thoughts and emotions, giving form to one's feelings.

Materials: Fabric, thread, yarn, needles, glue, staples, paper clips, clothes pins, glue on eye balls, different colored fluff balls, ribbon, scissors, colored markers, paper and rulers.

8. Apply a Sharevision-based, collaborative-reflective practice. See Workshop 1 description.

9. Review of collaborative-reflective, Sharevision design for participants to use during week to talk about their clinical work with clients.

8. Closing remarks by each participant.

Question: What is something you wish was different, and something that you liked about the meeting today?

Workshop # 3: Worldview: Costumes

Greetings

2. Quiet Moment.

3. Check-in.

4. Review experience of using the collaborative-reflective, Sharevision design for their first independent clinical meeting. The Sharevision facilitator coaches participants on variations of the design and their purpose. The aim is to create a fit among the organization, the participants and their clinical meeting.

5. Presentation: The facilitator offers information and examples of negative changes in one's frame of reference in the area of one's worldview (Pearlman & Saakvitne, 1995a&b). Clinicians' requests and suggestions for thematic material from previous meetings are integrated into the talk (Fear & Creativity). The facilitator includes an example from her or his personal experience of a behavioral change.

6. Expressive Arts Project

Question: How do you manage your current relationship to violence and hopelessness as it relates to your job?

Purpose: This activity was chosen for this workshop to support clinicians' embodied awareness and expression of sensations, emotions and thoughts. It provides the opportunity to evaluate one's current patterns and consider investing in new practices for the future.

Rationale:

See workshop 1, Rationale: a – d

e. Providing costume-making materials is designed to bring attention to one's physical sensations, emotions and thinking, and to consider the relationship to one's body.

Materials: Fabric, glue gun, staples, pipe cleaners, doilies, scissors, rulers, markers, yarn, ribbon, stickers, needles and thread

7. Apply Sharevision based, collaborative-reflective practice. See the description in Workshop 1 description.

8. The facilitator introduces the group action project to interrupt the cycle of violence, "hopelessness"

9. The facilitator openly appreciates of the organization for allowing this research to be conducted.

10. Confirm meeting time for their independent collaborative-reflective, Sharevision meeting the following week.

11. Closing Remarks

Question: What is something you wish was different, and something that you liked about the meeting today?

Workshop IV: Aesthetic Action: Planning the Group Action Project

1. Greetings

3. Check-in.

4. Review experience of using the collaborative-reflective, Sharevision design for their first independent clinical meeting. The Sharevision facilitator coaches participants on variations of the design and their purpose. The aim is to create a fit among the organization, the participants and their clinical meeting.

5. The facilitator describes the rationale of the group action project. Components of the project include:

a. Identification of a shared concern among participants.

b. Effort to improve the situation

c. Aesthetic action: The use of expressive arts means to fulfill their goals.

6. Expressive Arts Project.

Question: Given what you know about violence what message would you like to pass on to others?

Purpose: Each participant can articulate his or her ideas and contribute to the group discussion of the plan of action they would like to take.

Rationale: See Workshop 1, Rationale: a – d.

e. Quiet, individual time to consider what is important, brings greater clarity.

Materials: Paper, colored markers, scissors, glue

7. Apply the Sharevision collaborative-reflective practice. See Workshop 1 description of the process.

8. Brainstorming discussion of their arts action project and supplies needed.

9. Confirm meeting time for their collaborative-reflective Sharevision meeting the following week.

10. Closing remarks.

- Question: What is something you wish was different, and something that you liked about the meeting today?
- Invite participants to bring supplies for their aesthetic action.
- Remind participants they do not need to spend time working on their group project outside of the workshop or their independent collaborative-reflective, Sharevision meeting.

Workshop V: Aesthetic Action

1. Greetings

3. Check-in.

4. Review experience of using the collaborative-reflective, Sharevision design for their first independent clinical meeting. The Sharevision facilitator coaches participants on variations of the design and their purpose. The aim is to create a fit among the organization, the participants and their clinical meeting.

5. Open discussion of their group arts action project.

6. Perform their chosen expressive-arts action project.

Purpose: Working together on a project of their choosing offers participants an opportunity to join together and amplify their efforts to improve upon a situation.

Rationale: See Workshop 1, Rationale: a – d.

e. Participants gain active and creative problem solving experience in the work setting.

Materials: Participants are welcomed to bring and utilize materials of their choosing. Program leader brings all material necessary for the project to ensure participants do not need to spend time outside of course on homework, such as gathering supplies.

7. Confirm meeting time for their independent collaborative-reflective, Sharevision meeting the following week.

8. Closing remarks by each participant.

Question: What is something you wish was different, and something that you liked about the meeting today?

Workshop VI

1. Greeting

3. Check-in.

4. Discussion of the Aesthetic Action experience

a. What happened since their performance?

b. What have you observed about your thoughts, sensations and emotions related to the performance?

c. What next steps can be taken given the performance outcomes?

5. Questionnaire

6. Discuss possibilities of continuing independent collaborative meetings.

7. Discuss individual exit interviews

- Survey results
- Written reflections
- CEUs

Individual exit interviews. 1. Review pre- and post-program survey scores and discuss any questions and thoughts each clinician has about them. 2. Clinicians are asked write a few sentences on their experience of the a). workshop, b). Sharevision meetings, and the c). group arts action project.

Setting

The setting of this research project is one of the many buildings of a community human service organization in Massachusetts. This building housed three floors of therapist offices, two group rooms, two conference rooms, waiting rooms and several administrative offices including a reception area that is the hub of the site. The research workshops were held in a small conference room with a large table and large comfortable chairs. The room was always cold but had a portable heater that made it bearable.

The organization has offices in four counties of Massachusetts. Its roots are in advocacy work, serving adults with mental illness since the 1960's. In the mid 1970's, when state-run hospitals for the mentally ill began closing, halfway houses, residential programs and support services were opened. The organization then merged with another organization that also had a history of serving adults in psychiatric residential programs and homeless people. Another merger brought crisis services, day treatment and additional residential programs under the auspices of this one organization. It has continued to grow and now offers services for people with brain injuries, intellectual disabilities, substance abuse challenges, as well as psychotherapy for a broad range of issues. To maintain confidentiality, I will call this organization Commonwealth Human Services (CHS).

In an August 2008 meeting with the CHS Vice President of Clinical Services I learned more about the organization. CHS has 125 licensed mental health clinicians working within the organization and hundreds of other personnel. Most of the clinicians work on a fee-for-service basis. Clinicians get paid only for the time they see clients. Therefore clinicians schedule meetings with many more clients than they think will show up for appointments. They do not get paid for the time they do paper work, such as insurance billing or referrals, nor do they get paid for conversations to coordinate care with other professionals. They receive no benefits, no healthcare, vacation, pension or sick days.

In an effort to support clinicians, the agency sponsored sixty-three Continuing Education Credits (CEUs) of programming over the past year. Most of these programs were free to those who work in the organization. There are also several consultation

groups designed to provide supervision, but the clinicians, who work on a fee for service basis, do not get paid for their involvement in these meetings. The Vice President of Clinical Services explained that there is one team of fulltime clinicians who are paid for time given to supervision.

CHS is a member of a national network of large behavioral health organizations called Mental Health Corporations of America (MHCA). Membership is by invitation only. The MHCA mission statement reads as follows. "MHCA is an alliance of select organizations that provide behavioral health services. It is designed to strengthen members' competitive position, enhance their leadership capabilities and facilitate their strategic networking opportunities" (http://ww.mhca.com/2AboutUs.asp). The history of MHCA is included as Appendix C. MHCA is relevant for a number of reasons. For instance, it has helped CHS be one of the first behavioral health organizations in the state to go paperless. It has also been instrumental in driving a corporate approach to this not-for-profit human services organization. The Vice President of Clinical Services attributes the organization's ability to stay in business in part to the guidance and support from MHCA.

Time Line

My entry to CHS began at a lunch meeting on July 31, 2008 with the incoming chairperson of the board of directors. She is someone I had previously met on approximately three occasions through mutual friends. By the end of our discussion she offered to forward an introductory letter from me about this research idea to the Vice President of Clinical Services. She also asked that I email her what she called an "elevator speech" about my research design for her to share with the Board of Directors. I

soon heard from the Vice President of Clinical Services about scheduling a meeting to discuss the research.

On August 13, 2008, I received an email from the Vice President of Clinical Services saying that my proposal had reached him and that he was happy to take a call or email. In the meeting we set up, the CHS Vice President of Clinical Services answered many of my questions about the organization. In return, I clarified my research goals and objectives. The Vice President of Clinical Services said he was interested in the project and explained the numerous steps involved in initiating a new program. He intimated that many people might not feel "burnt out" in the month of September because of having just been on vacation over the summer months. He suggested I emphasize the concept of resilience in the research announcement. The organization's culture and language tended to focus on techniques for clinical practice. I believe that out of courtesy he also explained how busy people are and reminded me that most people would not be paid for their involvement, so staff enthusiasm may be low. Aside from these reservations, he thought this research project would complement their other professional development programs.

The Vice President of Clinical Services suggested applying for Continuing Education Units (CEUs) for this program. Room space would be made available. My tasks were to draft an announcement to be placed on the organization's intranet. I wrote the necessary CEU application material which included a brief description of the program, three overall learning objectives, a paragraph answering how the program content would enhance clinical practice and included a reflection on theories and practice skills. However, before an announcement could be made, the proposal and CEU

application would need approval from the clinical management. Once approved, I would work with the Director of Out Patient Services who would administer the CEU application, room scheduling and any other such issues. Most of this planning with both the Vice President of Clinical Services and the Director of Out Patient Services was negotiated in emails. More information on the organization will be presented in the Sampling Procedures section of this paper and ensuing chapters.

The Vice President of Clinical Services also suggested a time line for the program with an ending date in mid December 2008. He believed that the December holidays would interfere with the continuity of the program. Once there was an agreement with the organization to offer this research project to clinicians, I applied to the Lesley University Internal Review Board (IRB).

The original design of the research was intended to take place in three months, beginning October 10, 2008 and ending December 12, 2008. Due to schedule conflicts the final individual exit interview with a clinician was on February 5, 2009. Each clinician chose to participate in an exit interview and discuss his or her pre-and post-program survey results. A positive outcome from these meetings being spread over a longer period of time than originally planned was that each person had approximately forty-five minutes for an exit interview to discuss the results of his or her survey scores and time to write about the program. This material will be presented in the Results section of this chapter as well as later chapters. I remained in regular contact with the people at CHS until April 2009 while finalizing CEU distribution.

Sampling Procedures

An announcement was sent through the organization's intranet to all 125 licensed clinicians. I was hoping to have a large enough pool of applicants to fill several programs with 6-8 people each. The announcement said that clinicians could choose Monday or Friday as meeting times**.** However, only six people responded within the first week and a half, four women by email, one man and one woman by phone. In trying to accommodate everyone's schedules, one program was set for Friday mornings. However, one of the six respondents could not make that time. Another respondent asked to see something I'd written in order for her to get a sense of my orientation to the work. I sent her a letter explaining my history with this research project along with two chapters I had co-written for a book called *Innovative Teaching Strategies in Nursing and Related Healthcare Professions* (Landis, 2007) and guided her to an article in a family therapy magazine that I had also written. She considered participating in the program, then later said that this was not a time that she could do it. This left four people who were interested and able to make the scheduled times. Ten days before the start date I received an email from a woman who was an intern at the agency. In the email she wrote that her supervisor suggested that she join the program. It turned out that her supervisor was one of the people already signed up for the research project. I spoke with them both about their working together in the course. Each believed they would benefit from the course. I approved their both being in the course because the collaborative-reflective model was designed to include people with different clinical backgrounds and years of experience, as well people with similar clinical backgrounds and years of experience.

Demographics of the Study

There are five participant-inquirers in this research study. I did not survey clinicians for standard demographic information. The participants in the study appeared to be Caucasian. Four were female, one was male, and all appeared to be between the ages of 30 and 60. The fifth chapter, Discussion, will present all survey responses. Further information is available on each participant in the transcripts of the study, (Appendix E).

The youngest person was an intern in her early thirties. Her pseudonym for the study is "Nona Gal." She had worked in human services for eight years before returning to school for a Master of Arts degree in Counseling Psychology. On the Trauma Recovery Scale, Nona Gal reported "No" on Part II, meaning she had no exposure to traumatic events where her response "involved intense fear, helplessness or horror" (Gentry, 1996, 1999).

The one male clinician was in his mid to late thirties. He called himself "Belgium" in honor of a family member. He had managerial responsibilities within CHS along with a clinical caseload. Belgium also reported having no exposure to traumatic events on the Trauma Recovery Scale (Gentry, 1996, 1999).

The oldest woman was approximately fifty-nine according to her response on the Trauma Recovery Scale (Gentry, 1996, 1999). She gave herself the pseudonym "November." She reported four traumatic occasions during her adult life. November wore two hearing aids that were covered by her hair. She told me that she wore hearing aids during our exit interview.

The next oldest woman, "Karen," was in her fifties. In the Trauma Recovery Scale, Karen reported having "too many traumatic experiences to count during her childhood" (Gentry, 1996, 1999).

The next oldest woman, "Francis" reported she was forty-nine according to her response on the Trauma Recovery Scale (Gentry, 1996, 1999). She also identified herself as having "countless childhood and early adulthood traumatic experiences."

Belgium and Francis are fulltime employees of CHS, which means they have a benefits package that includes healthcare and sick time. They also are members of the same treatment team that serves people who have experienced multiple traumas. They have weekly team meetings and supervision for which they are paid for their time.

The four clinicians are all Licensed Clinical Social Workers (LICSW). They live within approximately half an hour's drive from the location of our meetings, which is where their offices are located. Nona Gal walks to work. Each of the clinicians has a partner of the opposite sex. Francis, November and Belgium are all married with children. Karen referred to her partner being male and did not mention having children. Nona Gal identified herself as having a boyfriend and also did not mention having children.

Ethical Considerations

As the facilitator and researcher, I was aware that these roles were potentially in conflict. I therefore clarified my intent during the first workshop about these dual roles. I explained that I wanted to offer material on secondary trauma, resilience and Sharevision, and to learn from the participants how I could understand these phenomena better so that

useful information could be made available to others. In that regard we were collaborators in the investigation and shared the investment in providing useful information to others. In this respectful approach I invited my co-inquirers to choose pseudonyms.

Intervention: Workshop and Sharevision Meetings

The research entailed six workshops that the researcher facilitated and six meetings we called Sharevision meetings that the participant researchers facilitated on their own without the researcher present. Each workshop met on a Friday morning for an hour and a half between 9:00 and 10:30 a.m. During the first workshop, after a brief welcoming and overview of the study, participants reviewed and signed the Informed Consent Form and completed the surveys. They then each chose a pseudonym for themselves.

The workshops were designed to begin with a moment of silence followed by a brief check-in. In the check-in, participants were invited to take two minutes to say anything about their day or week that might help them transition into the meeting. Another purpose of the check-in is for participants to directly inform their colleagues of their status, rather than leaving their status up to the assumptions of others. Frequently, casual conversation when people arrived led into discussion about their Sharevision meeting. During each workshop I acted as the timekeeper, beginning each meeting, breaking the moment of silence after the amount of time participants requested, which was either a minute or two minutes. I also inquired about their experiences with the weekly collaborative-reflective team meeting, offered information on compassion fatigue (which was their term of choice for secondary trauma), on arts activities and the

collaborative-reflective format, to further address the topic that they had been focused on in their arts pieces and initiated discussions.

Workshops one, two and three focused on aspects of compassion fatigue, vicarious trauma, and the disruptions to the therapist's frame of reference in regard to their identity, worldview, and their spirituality, intimacy and hope (Pearlman & Saakvitne, 1995). Workshop four focused on planning a group action project to interrupt the cycle of violence. Workshop six was dedicated to reflecting on the group's action project. Because this is an unusual format for a research project I have included the transcripts of all six workshops (Creswell, 2009).

The Sharevision meetings were originally planned to alternate with Friday morning workshops. However, because clinicians were required to be at two organization trainings on Friday mornings and the office was closed the day after Thanksgiving, the actual workshop schedule was very different. The first two workshops were held before the first Sharevision meeting. During the third workshop participants discussed their experience of their own meeting. I also asked questions of them about their meeting and offered ideas on how to proceed for their next independent Sharevision meeting. More information on the workshops and collaborative-reflective Sharevision meeting is presented in the Method Rationale section of this chapter, in other chapters and in the transcripts of the workshops.

Instrument: History of the Questionnaire

Charles Figley, Ph.D., has been a leader of the movement to research, write and teach about how people become traumatized and recover from their experience (Figley, 1995, 2002). He has developed the Florida State University Traumatology Institute at

Florida State. Beth Hundall-Stamm, Anna Baranowsky and Eric Gentry developed the questionnaires used in this study (Figley, 2002). The questionnaire is made up of four parts: the Compassion Satisfaction/Fatigue Self-Test for Helpers (CFST), the Trauma Recovery Scale (TRS), the Silencing Response Scale (SRS), and the Global Check Set (GCS) (Appendix F).

I used these instruments because they are used in the Accelerated Recovery Program (ARP). ARP is one of the world's premier secondary traumatic stress, training-as-treatment programs (Gentry, Baranowsky, Dunning, 1997; Gentry, 2002; Gentry, Baggerly, Baranowsky, 2004). It was also the first known effective intervention for ameliorating compassion fatigue in mental health professionals (Gentry, Baranowsky, Dunning, 1997; Gentry, 2002, Gentry, Baggerly, Baranowsky, 2004). ARP is widely applied in a variety of fields such as healthcare, law enforcement and emergency response personnel (Baranowsky, 2002).

Validity and Reliability of the Questionnaires

Compassion Satisfaction/Fatigue Self-Test. *The Compassion Satisfaction/ Fatigue Self-Test for Helpers*, CSFST, developed by Figley and Stamm between 1995 and 1998, is comprised of sixty-six questions that are scored in three different subheadings: compassion fatigue, burnout and compassion satisfaction. It was revised from the original Compassion Fatigue Self- Test, CFST, that had two subcategories: compassion fatigue and burnout (Figley 1995a). It has a reported internal consistency and reliability alphas range from (.86) to (.96) (Figley & Stamm, 1996; Jenkins & Baird, 2002). The revised CSFST questionnaire has been tested multiple times for reliability (Stamm, 2002; Zimering, Munroe, Gulliver, 2003). The psychometric properties consistently scored with

good evidence of reliability and internal consistency alphas for each of the three subscales of the instrument (Bride, Radey, Figley, 2007; Stamm, 2002). The alpha reliability on the compassion fatigue subscale is (.87) with (16.04) standard variation. The burnout subscale alpha reliability is (.90) with (10.78) standard variation. The alpha reliability of the compassion satisfaction subscale is (.87) with a standard deviation of (13.15) (Stamm, 2002).

The survey asks respondents to rate their experience during the past workweek on a Likert scale of 0-5. Zero refers to "Never," one to "Rarely," two to "A Few Times," three to "Somewhat Often," four to "Often," and five to "Very Often." The introduction to the survey states the following.

> "Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: This includes your risk for burnout, compassion fatigue and satisfaction with helping others. Consider each of the following characteristics about you and your current situation."

Example questions in the CSFT are: "I am preoccupied with more than one person I help." "I feel connected to others." " I have felt weak, tired, run down as a result of my work as helper." "I feel like I have the tools and resources that I need to do my work as a helper."

One of the authors of the CSFT, Stamm, no longer supports the use of this survey. In August 2009 she recommended the use of a revised edition of CSFT called the

ProQOL5. ProQOL stands for the professional quality of life. It is a shorter survey having thirty questions (Stamm, 2009).

Trauma Recovery Scale. Gentry wrote the *Trauma Recovery Scale* (TRS), in 1996. It is made up of three parts. It has high reliability and validity ratings (Sprang, Clark, Bass, 2005). The TRS utilized a sample of convenience made up of 91 university students and 56 mental health professionals for a total of 146. The first part asks the respondent if she has directly been exposed to traumatic events to see if respondents meet the criteria of PTSD. If the respondent answers "Yes," she is directed to complete Part II and then go on to Part III. Part II asks which of twenty listed traumatic experiences they have experienced, the number of times these experiences happened and the dates and age of the respondents connected with those events. For example, question seventeen asks about "Accidental physical injury." Question seven asks if the respondent has experienced "Combat Trauma" and question nine, "Childhood Physical Abuse." Respondents are directed to check a box next to the event named and say how many times they experienced these events, as well as the dates and the age of the respondent at the time of the event. The validity of Part II is questionable according to Dubi and Marcus (2006). If the respondent answers "No", on Part I she is directed to Part III. Part III of TRS poses ten statements and asks the respondent to mark a perforated line to identify the percentage of time the respondent feels she is represented by the statement. Examples of statements in TRS are "I am able to concentrate on thoughts of my choice" and "I have a sense of hope about the future." Reports indicate significant evidence of validity for Part III with an alpha score of (.88) (Dubi & Marcus, 2006).

Silencing Response Scale. Baranowsky wrote the *Silencing Response Scale* (SRS) section in 1996 and revised it in 1998 (Baranowsky, 2002). Early research on the silencing response shows a strong correlation to compassion fatigue (Baranowsky, 2002). It has been used in hundreds of studies and is believed to represent high reliability (Ortlepp & Friedman, 2001). It is designed to identify selective listening and active avoidance on the part of the therapist. The silencing response is a reaction based on assumptions that she has limited ability to help clients through their difficulties, that discussing the difficulties will not help the clients, and because hearing about the clients' difficult experiences is too uncomfortable for her. The silencing response leads clinicians to redirect, shutdown, minimize, or neglect the traumatic material clients bring to counseling. The SRS contains fifteen questions rated on a Likert scale of one to ten with one representing "Rarely/Never" and ten as "Always." Two examples of the SRS questions are: "Are there times when you are unable to believe what your client is telling you because what your client is describing seems overly dramatic?" and "Are there times when you feel numb, avoidant or apathetic before meeting certain clients?"

Global Check Set. Baranowsky and Gentry wrote the *Global Check Set* (GCS) section of the survey in 1998. The questionnaire is designed to evaluate aspects of clinicians' mental health in order to identify any significant psychopathology (Gentry, 2010). The GCS presents thirty-five questions about the respondent's experiences over the last two workweeks. It also asks the respondent's date of birth and gender. Answers to the questions are made in the form of a mark in one of four boxes. The 0 box is "Never," 1 "Rarely," 2 "Sometimes," 3 "Frequently," 4 "Almost Always." Example

statements are, “My body is usually pain free” and “My concentration is good.” “I am fairly relaxed and do not startle easily.”

Data Collection

I chose to collect data through both quantitative and qualitative research methods. Creswell (2009), and Kasl and Yorks (2002) identify both quantitative and qualitative data collection in action research as viable means to work towards improvements. This study is designed to apply a sequential transformative strategy (Creswell, 2003) allowing for the collaborative-reflective theoretical approach and pre and post-program quantitative analysis. The collection and analysis of quantitative and qualitative data is applied to provide both private and public reflection on secondary traumatic stress. The quantitative four-part questionnaire gives participants the opportunity to reflect on a broad range of experiences privately. While, the qualitative collaborative inquiry research design offers a public forum for discussion, the quantitative approach of this study is less dominant due to the specificity of the research question. How does a collaborative-reflective program correlate to the nature of secondary traumatic stress? The quantitative data is implemented toward the inquiry of individual participant’s identification of change in secondary traumatic stress during the course of this pilot study.

The qualitative data gathered for the study include the transcriptions of digital recordings of each workshop that I typed out. They are included in their entirety for full transparency (Creswell, 2009; Heron & Reason, 1997). My notes from exit interviews with clinicians, which were not digitally recorded, are also included. Finally, each clinician wrote feedback to three questions about the program during his or her exit interview.

Triangulation. To present participants' experiences most accurately, I used data from multiple collection sources (Key, 2010); pre- and post-program survey results, transcripts of the workshops and exit interviews. I also participated in cross examination discussions with several colleagues about the data from this study (Key, 2010).

Chapter IV

RESULTS

Introduction to Results

There are three sources of data in this study: the transcripts of the six workshops, the survey results and the exit interviews with clinicians. The transcripts provide significant information about the workshops, clinicians' independent collaborative-reflective Sharevision meetings by themselves, and the group action project. This research group designed an interactive piece for their colleagues at their worksite. Their action project was aimed at breaking isolation by extending the sense of "safety" and "trust" developed during this research study and to invite others in the agency to "open up." The action project materialized as a colorful bulletin board with encouraging phrases nestled in decorated envelopes that were to be hung up in the staff room.

The sheer quantity of raw, qualitative data necessitated a selection process dividing clinicians' statements according to emerging themes. I emphasize the subjective nature of the statements. I alone chose to include them as representative of the emergent dialogue. These themes are also congruent with the literature on secondary trauma. The order in which they will be presented here is as follows: opening up, isolation, connection, hope, fear and creativity. Three statements by each clinician provide a sense of these topics over time and each statement is pulled from the beginning, middle and end of the program. I have included statements I myself made during the workshops as well, because of the influence they may have had upon the results.

The survey (Figley, 1995, Stamm, 1995-1998) results demonstrate that clinicians decreased their risk of compassion fatigue, generally lowered their risk of burnout, and

increased their compassion satisfaction. Full survey results are presented in Section II of this chapter.

In the exit interviews, each clinician received his or her survey results and discussed their scores with me. Also, in each exit interview clinicians were asked to write a few sentences in response to the workshops, Sharevision meetings and group action project. Generally, clinicians wrote that they found the workshops to be helpful in decreasing their sense of isolation and that they enjoyed the arts experience. The Sharevision meetings were generally meaningful in that each person had the same amount of time to speak, and be listened to on "relevant" topics of their choosing. The group action was universally appreciated for its intent, while the experience of offering end product to CHS was a disappointment. My notes from the Exit Interviews also provide insight into clinicians' investment in ameliorating secondary trauma. These notes give specific information on what was happening in their clinical practices and how clinicians worked to balance their clinical practices with their own lives during the week when they took the survey a second time. An analysis of the responses to three questions I asked participants, and my notes from exit interviews, comprise Section III of this chapter.

Section I: Emergent Themes

The process of coding the transcripts from the six workshops, and discussing them with colleagues, gave rise to four themes: opening up, isolation, connection and hope. I also include two themes that were spontaneously introduced in the first week by a clinician and corroborated by others: fear and creativity The six themes will be presented

in three parts, with the beginning being Workshops I and II; the middle was Workshops III and IV and the end was Workshops V and VI.

Workshops I & II

Theme I: O*pening up.* Clinicians in the study opened up about their lives at Community Health Services (CHS) and their lives away from the office. During the workshops, they addressed their aspirations, challenges and past experiences. Mention was made of their children, husbands, wives, boyfriends, partners, animals and hobbies. They also talked about their relationship to their clinical work, how they felt about coming to work and in some cases, they shared their thoughts about changing their work environment.

***Opening up* in the beginning.** These statements were made during the first workshop after using arts materials to respond to the question: "When did you first notice that your work as a clinician was having a negative impact on you?"

November: *I had a client, probably in the early 80s, who was a peeping tom. Sitting with him I started to have panic attacks.* (Quotations of participants are in italics throughout.)

Karen: … a*nd as I found myself working with more women who have those histories, I realized I didn't really want to do this work because it is too triggering for me. So I think that is when I first started to feel like this negative impact.*

Francis: *I'll do mine since mine is pretty simple. I didn't think about the first time but more recently. I have a really difficult history myself. And I've done a lot, a lot, of work.*

Nona Gal: *I think I needed more time to think about this. I ended up going with the first thing that came to me. Avoiding certain places where I know clients will be at. Not like the obvious places but the general places like the mall.*

After the first workshop Francis stayed with me in the room for a few minutes to talk about her experience of doing the survey and questioning whether she fit in the course. I listened and talked with her.

Ellen: *So many of us are in the field because of personal experience and desire to do something for someone else so others don't suffer as we have*.

Belgium was not able to make the first meeting but joined the course at the second workshop. He arrived early and took the questionnaire. His statement was made during the second workshop after using the art materials provided to make a puppet in response to the question: "How do you relate to the topic of fear and creativity and you and your identity as a clinician?"

Belgium: *At first, when you pulled out all the stuff it felt very familiar because my wife is an arts and crafter, a sewer. "Oh, I know this world."*

Theme 2: i*solation.* Isolation was a theme throughout this study. The saliency of these clinicians' experience of isolation was demonstrated as they commented on the novelty of talking with each other about their personal experiences of clinical work. Phrases they used include, "not fitting in," "not feeling safe," "not being okay" and "holding back." They discussed their experiences within the organization as emphasizing productivity. Reference is made to clinicians being product focused and not reflection focused.

***Isolation* in the beginning.** During the first workshop the clinicians had just a few minutes to create an arts response to the question, "When did you first notice that your work as a clinician was having a negative impact on you?" They responded with the following statements.

Francis describes the isolation she experienced when she realized how difficult her work was for her personally.

Francis: … a*nd all of a sudden not quite knowing how I was being affected in the environment where I work. And not knowing if those two things where going to be okay.*

November described a moment of grave isolation while working with a client.

November: *I started to imagine falling on the floor in the therapy room. And him sort of doing something to me. And it was shattering to me.*

Nona Gal: *I picture myself staying in this* [isolated] *place and the world is happening around me.*

After the first workshop Karen stayed in the room for a moment. It seemed to me that the following exchange between she and Francis might have been why she lingered in the workshop space.

Karen: *I'm so glad you're in this*

Francis: *You are?*

Karen: *Yes*

Francis: *That's nice.*

Karen: *We hardly ever get a chance to interact*

Francs: *Even though we're on the same floor*.

Karen: *We were two people who ran a grant together*.

When Karen left the room Francis stayed and talked about what she called a misunderstanding that she and Karen had in the past. She explained that she never told Karen that she had struggled with their relationship. Rather, she went to their supervisor for help and hid her upset from Karen. She also said she questioned if, because of her own "… difficult history," whether she was feeling different from others in the workshop…. "Am I a person who just has trouble with people?"

I responded as follows:

Ellen: *I'll try and keep the course structured enough so you can feel like there is room for you to have your experience, and also support and containment. There is room for you to address what is in the past, and what in the present relates to the focus of the workshop… The opportunity here is to be an integrated person and have support.*

Belgium shared his experience with isolation as it related to creating an arts piece in the workshop when he had only 10-12 minutes.

Belgium: *Another experience that came up was a thing about work, the time frame. Intuitively* [I question] *maybe it's the building; maybe it's this part of the work. It's the product* [focus]. *I got 12 minutes to come up with a product. How familiar is that in this building? On some level, what are you going to do?*

Theme 3: c*onnection.* Connecting to one another, and to the world outside the room, was addressed in different ways throughout the study. Clinicians also identified their experience of connecting with each other using a variety of terms such as intimacy, collective energy and "being right there" for each other. Their enthusiasm for a sense of connection with each other led them to choose a group action project that was aimed at building a bridge that would connect them to their colleagues at CHS.

Connection in the beginning. Belgium described his experience of not being able to connect with the world as he had in the past.

Belgium: *My mind wandered to my daughter. In the end the bells* [that she likes] *connected me to here and now. That combination of work and domestic is a constant right now in my life.*

Nona Gal described her connection to Belgium while in the workshop.

Nona Gal: *My sense, because I was working right next to you. I sensed the entire time that you were going at it, you knew what you were doing.*

Francis responded to Belgium's arts piece by introducing her relationship with Belgium, with whom she works on a clinical team.

Francis: *I don't always have a sense of who you are. I realized that as I'm sitting listening and that makes it hard for me to look at it* [the puppet you made]. *Because even though I know you, I felt like I don't. However that happens. As I look at it, there are a lot of elements there. They're all put together on this beautiful soft defined background. I still feel like I know those elements. I guess you are a little unknown to me still.*

November described the connection she had with a supervisor in the past as she introduced her first arts piece.

November: *It was too scary. So, my supervisor helped me find a way to transfer him to a better place.*

As the first workshop is coming to a close, I asked the group what they would like me to focus on in terms of compassion fatigue at the next workshop.

Ellen: *Is there something you would like to start with next time? I'd like to follow up on your ideas.*

Francis offers the words “fear and creativity,” Karen concurred.

Karen: *That sounds really good. I really resonate with that.*

Theme 4: *hope.* Hope emerged as a theme in language about hopelessness as well as hopefulness. Hope is expressed in arts pieces and in words. Hopelessness was introduced as a term synonymous to the term violence and related to how clinicians perceive secondary trauma. Hopeful was also how clinicians identified the concept and design of their group action project.

Hope in the beginning. During the first workshop clinicians addressed their experience of hope. Francis told the group about having felt hopeless about her life due to her experience working as a clinician.

Francis: *I worried that I’m not going to get well, or as well I want to get. Working with the same kind of people I’ve been working with. That was a kind of a hard moment. But, I think I slipped past that.*

After November referred back to the difficulty she had with a client who was a peeping tom, she explained how that difficult situation holds hopeful possibilities for her.

November: *It’s something I’ve wanted to write about. There was creativity in all that.*

Nona Gal speaks her inner thoughts of hopelessness about her life being limited because she has eliminated going to certain place.

Nona Gal: *Well, I can’t go do that anymore.*

As the first workshop was coming to a close I expressed my feelings about the change in the workshop schedule.

Ellen: *I'm delighted we'll be getting together next week so I'll have more time to go over it* [the collaborative-reflective model, Sharevision].

During the second workshop Karen made a puppet and described her process as follows:

Karen: *Sure, I realized in the beginning it was really important for me to make a head, a real recognizable head shape. Then it felt super important to make arm shapes, recognizable arm shapes. It was real important for me to be pleased with the color and patterns. I paint and I'm always thinking about color. I love this color combination. And I really wanted to put legs on it, but I became okay about not having legs. I wanted there to be a joyful celebratory thing so I made her have jewelry. I really like her.*

Belgium responded to Nona Gal's expression of her creating an arts piece during the second workshop.

Belgium: *The thing that struck me is that during this time in your life when you're all over the place and living in a bag, that when you started you knew one thing, you knew one thing, that you wanted to be able to put your hand in. In relation to things in life being just what they are right now. And you had one thing clear; that is pretty cool.*

Fear & Creativity

Fear and creativity were introduced during the first week together as a theme. Here these terms will be addressed individually. In the following chapter they will also be discussed as a unified theme.

Theme 5: *Fear*

Fear was mostly described by thoughts and actions clinicians take rather than their words. Fear is described in terms of tension in peoples' bodies. It is related to how their lives

have become constricted. Fear is associated with being seen as being too strong, loud or troubled. It is also expressed through the concern of being mocked by colleagues.

***Fear* in the beginning.** During the first workshop, after making the first arts piece Francis identified fear and creativity as themes to be addressed in the next meeting.

Francis: *I'm sitting with something that feels a little intense. The words that come up are 'fear and creativity.'*

During the second workshop I brought fear and creativity into the discussion about the arts making activity. Nona Gal showed the puppet she made, then took it off while she talked about what it meant. In my Sharevision response I had said I was curious about why she had taken the puppet off her hand while she was talking. In her closing statement she said:

Nona Gal: *I'm not sure why I took it off. Maybe I was a little bit uncomfortable holding it up and showing it off.*

Karen responded to Francis's arts piece by saying:

Karen: *I think that it's really neat that you were able to come to terms with not putting anything together today. That you decided to take the piece home with you. 'Cause I would have felt like that is not okay.*

Belgium also responded to Francis's presentation about not finishing her piece that day. It explained something about his inability to do that now that he has a young child.

Belgium: *The idea of taking it home and continuing on it is great. And, it's loaded for me.*

November heard Karen describe her piece and explain that she had forgotten about the fear part of the arts project once she got started working on it.

November: *Maybe it's what happens with fear when you start being creative.*

At the end of the first group I asked the clinicians what they are going to do with the arts pieces they made. Francis, Karen and November joked about other clinicians wondering what they were doing in this course if they saw what they had made. November said she was going to throw hers out. I expressed my fear that they would be destroyed before I at least took pictures of them.

Ellen: *I'd be happy to take pictures. Would you like me to hold onto them? …* (November said she was going to throw hers out.) *I'd like that not to happen yet. I would be happy to hang on to them.*

Theme 6: *creativity*. Creativity was generally recognized as an enjoyable endeavor for this group. They expressed pleasure in "doing art" and in sharing ideas with one another about making this arts piece together. They also found enjoyment in the act of collaborating in making their arts action piece. One of the determinants of their experience of creativity was time, or the lack of it.

Theme 6: *creativity in the beginning*. At the end of the first workshop Francis demonstrated her fear about her creativity by mocking the unlikely appreciation within CHS for their artwork.

Francis: *I don't think we're going to put them out on the wall and have a show.*

During the second workshop, November shared her reservations about her own creativity when talking about her arts piece.

November: *I did have the wish that I had done something like somebody else. Stopping to look around and be creative. Maybe I'll get past it. … Because I was wishing I had done something like others here.*

Nona Gal responded to Francis's decision making process about the arts materials and notes the importance of recognizing one's choices as valuable while also reflecting on her own creative process.

Nona Gal: *I'm really impressed that you wanted to take in all these things and see what there was on the table. To really look and make your choices rather than just grab.*

Karen briefly described insight into her creative process.

Karen: *At the end, just now, you mentioned the fear and creativity thing. I had forgotten the fear part as I got going* [making the arts piece]*…So, maybe that's a good thing.*

Belgium also identified the importance of cone's intention in the creative process as he responded to Karen in the Sharevision process.

Belgium: *I was thinking about how things* [words] *were important. Early on head, arms, legs. Then you shifted to likes. Those words are important, 'I like what has happened.'*

In describing the reflective aspect of the Sharevision approach, I gave an example of sharing unusual ideas.

Ellen: *Although very often the strangest things that pop into your mind are the most helpful. You may find yourself thinking; 'This is the strangest thing. I don't know if I should share that.' The seemingly strange ideas can actually be the most helpful. We are*

intentionally setting up a simple and intimate forum where people can actually address their creative ideas.

Workshops III &IV

Opening Up **Midway.** Francis described her experience of the group's first independent Sharevision meeting.

Francis: *As people were talking I realized it was very dense. Each person said what they really needed to say.*

November described the puppet she made during the second workshop. It is more of a sculpture or a doll than a puppet.

November: *This is my person…I really wanted to give myself permission to not be planful because I'm so bloody planful.*

Karen described her experience after the first independent Sharevision meeting and the two workshops.

Karen: … p*articularly in the afternoons after we met. I somehow felt, it's really hard to describe, but I did feel different with my clients. I felt less resentment and a different kind of energy.*

Nona Gal described her thoughts during a session with a client.

Nona Gal: …s*he was expressing her overwhelming life circumstances that every year of her life something bad happened and how is she ever going to feel better. And I was sitting there thinking, I don't know. How can this have happened to one person?*

Belgium described his experience of the first Sharevision meeting.

Belgium: [There was] *a lot of willingness in the room to give it a shot*.

During the third workshop I presented an element of vicarious trauma: shifting identity.

Ellen: *I can relate an experience. I remember years ago when I was in a car with a friend, and she wanted to turn on the radio and listen to the news on NPR. I said, 'No thanks.' She said, 'Oh, just for a few minutes,' and then she turned on the news. Then, I caught myself crying. Now, this was a really unusual experience I was watching myself have.*

I couldn't handle hearing one more piece of terrible news. I knew they would run an article on people experiencing something horrid. It was going to happen if we had that radio program on.

Isolation midway. In discussion about Francis' experience of her first independent Sharevision meeting, Francis described how she felt before it was her turn to present her topic of choice.

Francis: *I was like a balloon about to pop. I was holding all these pieces for myself and I didn't know if it was going to be okay to have people look at it with me.*

November described how she felt after that first collaborative-reflective meeting.

November: *I do remember feeling excited and happy, probably until the end of the week. When my mood went down I tried to remember that we were going to have this meeting, and things felt better again.* [Ellen: *Over the weekend, later in the week, this week?*] *... My mood went down over the weekend. It has a lot to do with isolation. During the week I felt a little more isolated. When I come here I don't feel so isolated.* [Ellen: *when you come here, meaning...?*] *Here, this meeting.*

Midway through the course Karen talks about how she now felt different in her meetings with clients.

Karen: *I didn't have to protect myself and hold myself back*.

Nona Gal, through an explanation of an arts piece she made during a workshop activity, shared her experience of packing a bag to go to the variety of important places in her life.

Nona Gal:*... I feel like I'm carrying around all this stuff. One day maybe I'll be able to unpack and stay.*

Belgium described a shift in his attitude about the violence he experiences through his work since having a child himself. He reiterates Karen's thoughts which are within quotation marks.

Belgium: *I find myself more aware of the violence. ... 'I've got to care differently or else.' Or even if its not be around as much. Something's got to shift that feeling.*

I described my thoughts when witnessing violent or aggressive behavior in public as it shared my sense of being alone.

Ellen: *I've thought I'm a bad person because I don't know what to say, and I didn't say or do anything…*

Connection **midway.** After the first independent Sharevision meeting clinicians discussed their experience of the meeting.

Francis: … a*nd I think everybody listened well and everybody got something. So everything felt of importance somehow. It wasn't wasted time. It was dense.*

November: *I thought it was fantastic…. I felt just terrific afterwards…I felt it was very well organized. Karen was the timekeeper. Everybody had enough time. Everybody shared something that was really meaningful. And we got great feedback.*

Belgium: [There was] *... a collective energy. It was nice to go for it.*

Karen described her awareness of the impact of this course on her and her ability to connect with her clients.

Karen: *It felt very smooth and very supported. It felt very cohesive. ... [and later] I've noticed after each of these sessions, two we had with you, and one where we met last week, I felt lighter, lighter. ... Maybe I was leaning forward more to my clients. I mean figuratively and literally.*

Nona Gal expressed the way she managed the difficult issues that come up for her when working with her clients through her arts piece during the third workshop.

Nona Gal: *There's all this stuff. They're all colorful and textured. Sometimes I take them out and use them and connect them to things. So it's about connecting. Sometimes keeping things safe.*

As I followed up with clinicians about their independent Sharevision meeting I explained the use of a tool to support feeling connected to oneself and others during the meeting.

Ellen: *I find that I take notes, because there is so much material that I'm trying to be present for. I don't want to be distracted by asking myself did I get all the information. Granted when someone is talking about personal material it may not be a time for note taking.*

***Hope* midway.** At the beginning of Workshop III when we discussed their first independent Sharevision meeting, Belgium sought guidance on doing Sharevision. He asked:

Belgium: *So, can it be about good news as well? …Good news is allowed? It tells you something that it was a question.*

About her first Sharevision meeting Francis said:

Francis: *It felt like everyone had something of equal resonance but from their own perspective. Oh, it was so nice. I felt from each and every person. It was really wonderful.*

After discussion of their independent meeting I presented material from Laurie Ann Pearlman and Karen Saakvitne's work on vicarious trauma (1995, 2007) (See Chapter III, Workshop Template).

Ellen: *Hope is at the core of our spirituality and goes along with all levels of intimacy.*

During this discussion Nona Gal talked about her awareness of how she was seeing the world differently.

Nona Gal: *I think I do carry a lot of hopelessness that I hear from clients, from people. And, I look at people's circumstances and wonder how can they possibly be having a good day? How can they overcome this?*

Then, after the presentation the group constructed costumes in response to the question: "How is it that you manage your current relationship to hopelessness, violence, despair, whatever your words are for it, to your current job?"

November: *This is a heart shield. This is my sword. To fend off* (long pause) *I'm not sure what it's fending off. But, it's definitely fending something off. This shield is my heart. The appearance is that of not being affected. But, underneath is this black heart, and there is this blood dropping down. The black heart is the hopelessness. But, then there is the vulnerability. The red is the vulnerability. The blood is dripping.*

November had tied a strand of beads to the sides of a doily and wore it around her neck. She turned it over and on the other side there was a dark tangle of threads glued to the center of the shield. From the tangle of dark threads November uncurled another row of red beads representing her bleeding, her vulnerability.

Karen: *So I'll go. All I could think was what happens when I'm with a client and they start talking about their traumatic experiences. So what happens is I get triggered, and this is what goes on in my mind. So I get memories. And this is what it feels like in my mind. My eyes are opened. I'm able to continue to talk with the client, but I feel like I have to not hear what they are saying. And these represent my ears. I've actually said to clients, 'You don't have to tell me the details. We don't have to talk about that.' I've actually said that. And this represents that I'm still able to talk with clients, and I feel I am still able to help them. So this is like pearls of wisdom. There are still things coming out of my mouth but I'm trying to block what I'm hearing, and I'm very disturbed. So that's my piece.*

***Fear* midway.** During the third workshop the discussion turned to the clinician's shifting worldviews by going back to the themes of fear and creativity.

Ellen: *In talking about fear of sharing* [thoughts and feelings] *we are returning to this theme of creativity and fear, fear of considering what the options are, and also limiting the questions being asked, [Such as,] 'What can I come up with for options?'*

Karen identified a change in her life related to her clinical practice.

Karen: *Oh yeah, when you [November] said you're a much more serious person I can totally relate to that. It's harder for me to be light or relate to people in a light way, and I feel like I'm a kind of a downer for my partner.*

During the third workshop the group made costumes representing how they manage their current reaction to violence or hopelessness in terms of their work as clinicians. After first hearing from each other about their arts pieces they each had a moment to talk about the experience of creating the costumes. Francis described a decrease in her sense of fear.

Francis: *I was struck by everyone. I had thoughts I wanted to share back. I'm having an experience that I am not as focused on as November and Karen are about the impact* [of violence and hopelessness], t*rying to hold the impact, for today there is more room. So maybe I'm not doing as badly as I thought about moving around and discharging it. Right now I'm not having problems in the room with specific traumas, being in the present moment with somebody who's trying to process that. It's the accumulated effect for me of going from one to the next. So I'm going to pay attention to what I'm learning here. It's communicating to me about how I'm doing and what I'm doing. And maybe I should trust that. I was profoundly moved by all of them and especially you two and what you expressed about how you're holding that. Really.*

During the fourth workshop November identified her concern that the group project she suggested for the homeless shelter is going to take too much time; and her fear that it would be draining for others.

November: *I guess I wouldn't want to do something there that we couldn't really follow through on. As we're thinking about it, it's beginning to sound like more work and time.*

Belgium contributed to the brainstorming during the fourth workshop by adding his concern about people in CHS making jokes about the group's project.

Belgium: *This could be part of the project, finding a way to explain it to people. Because really, what is it? Fast forward to someone asking "What is it?" In my mind, the answer is, "It's something positive." That's how to explain it at this point Then you get all sorts of people responding with their 'that's great', or 'that's stupid,' and everything in between, including the jokes. I'm thinking about what we are creating. There is a blend here. It's a positive piece. It's something on purpose, an effort to be supportive. Maybe we'll get a better sense as we create it.*

During the brainstorming session for the group project Nona Gal broke out of her earlier inhibition to share some of her ideas.

Nona Gal: *I have a couple of ideas. One is, if it is in the staff room, one of the components or things in a pocket could be a coupon. We could make a little card that says something like "random acts of kindness" but something like that, and every once in a while stick it in somebody's box, so that they're their going through their mail and it just says 'Yes' or 'Hello, You're not alone.'*

***Creativity* midway** During the third workshop Francis described her arts-making process of building a costume and related her creativity to how she balanced her life. She pointed out different colors and fabrics as she spoke.

Francis: *I was looking for something for a background that's kind of dark but still beautiful. I know its navy blue but I like blue and it's kind of like the sky. Down the middle of me it's where I try and find some kind of balance. And then I suppose this is more like spirit and this is earth. And that's how I find balance in my work and in my life, to move back and forth between those two and have something in the middle. I suppose if I was looking at chakras, this is the lower chakra color and this is a higher chakra color, and I try and find a balance. It was interesting, because last time it was so much to do to try and create what I wanted. And then I found this piece and it all came together.*

In describing the group arts project that will be developed during the fourth workshop, I had been asked to give an example of something another group has done.

Ellen: *A group designed a poster that went out in a mass email. They designed a special email address from which they sent the text of the poster. In the email was an explanation of their project and directions to use the text to make a poster, decorate it anyway one wants, and post it in the world. We got word from people who had seen it in their doctor's office for instance, so it went out into the world.*

November: *What did it say?*

Ellen: *Vertically written was D.O.V.E. Then there was a word across*

> ***D****on't*
> ***O****verlook*
> ***V****iolence*
> ***E****merging'*
>
> *Then below was written:*
> *'Say Something'*

During the fourth workshop individual arts pieces led to group brainstorming, and a decision about a performance piece they would create together. At the end of the group I invited everyone to say something they liked about the meeting and something they wish was different.

November: *I really like the resonance of the projects we all did alone. … For instance, Belgium has, "Yes" Francis, 'Be kind,' You* [Karen] *were working with the pockets, and it's all about community*, *and it's nurturing therapists.*

Nona Gal shared her closing thoughts on this fourth workshop, which included her reflections on the impact of creative engagement.

Nona Gal: *I was thinking on my walk here this morning I was really excited about doing art. Yea, someone is going to be there and we're going to do art! So, I like that we got to do our piece. I also liked that this was a really a productive meeting. At the start I couldn't imagine what we would come up with. So it feels really productive to me, and energizing.*

Karen's final comments on that day also include what she wished was different about the meeting.

Karen: *I love the collaborative creativity. I love the sharing of ideas. I would wish for a space with more atmosphere and lighting*.

Belgium also included what he wished was different about the meeting along with what he liked about it.

Belgium: *Like Karen, I like collaboration. I like formalizing it a bit. I like the idea of it. We're going to collaborate. So that's the part that really sticks out in our creative process and I really like it.*

Workshops V & VI

***Opening up* at the end.** During the fifth workshop they worked to build a colorful, interactive bulletin board to expand their web to include their colleagues working in the same building. While the group constructed the piece, I asked if they had considered a title that could help introduce the piece to their colleagues. Francis was the first to offer her ideas.

Francis: '*Take One, Make One' is kind of obvious. or 'Take One, Make One, Share One.'*

In Karen's reflection on the action project she said:

Karen: *It wasn't powerful enough because this experience has been more powerful than what we ended up with.*

After discussing his disappointment with the action project, Belgium shared his feeling about the challenge of conveying the intent of the action project.

Belgium: *I felt it got bogged in the grade school, in-between thing, with trying to explain it.*

I reframed some of the thoughts and shared some of mine about our disappointment in our project. It ended up not being hung up in the staff room but instead sitting on the floor in our room leaning up against a chair.

Ellen: *And not that anyone did it intentionally. The guy who was to put it up could have, God forbid, got in a car accident that day. But, the emotional experience sounds like backlash? Your effort to humanize the corporate place is in question. You've all but said, 'Why was I even thinking this could fly?'*

Nona Gal listened quietly through much of the conversation during the final workshop in which others described their disappointment with the culture of CHS and the action project. Then she offered:

Nona Gal: *I'm listening to people's perception of the culture here and I'm new to this culture. I can't say it's any different than I expected. I knew people operated doing individual therapy with the doors shut. It's about productivity.*

During the final meeting, November shifted the group focus from the action project to her feelings.

November: *I am already mourning this group. I'm wondering what will happen next, because it's been such a gift to me.*

***Isolation* at the end.** At the onset of the fifth workshop Francis explained that she had spoken with the appropriate people in management at CHS about hanging a bulletin board in the staff room. She was given a bulletin board and was told that it would be hung after the fifth workshop by the maintenance staff. Later, during that workshop she said:

Francis: *I remember in grad school someone saying that his,* [Carl Rogers'] *star pupil and the person that really carried on his tradition worked so differently from him. Their styles were so different and yet the content is the same. So I was thinking there is some kind of overlap but it doesn't need to look the same. There is a kind of dialectic…*

And there can be a continuity between people. You can learn something and carry on something. You're not isolated. You do this. You do this.

During the final workshop November addressed the problematic nature of feeling alone or isolated while trying to make their piece together.

November: *Thanks for saving us from a moment of being paralyzed.*

During the final workshop Karen identified her struggles to break from her experience of isolation with both other clinicians and her clients.

Karen: *There is this constant pull in me between really wanting to get into the work and really feeling good about it. And the other part is just wanting people to come see me so I can make my productivity that's all. Yeah. I think that really affects my relationships with people and how I talk to clients.*

During the final workshop Nona Gal explained to the group how she is more isolated at CHS than at her internship the previous year.

Nona Gal: *Last year I had the experience of being in a smaller agency. When I was in a crisis* [with a client], *we used to get together with the out patient staff at a weekly meeting, almost everybody attended. We could all sit around the table. So that doesn't exist here. I don't know half the people here. …my experience* [here] *isn't that cold or that unaccepting.*

Belgium responded to my asking the group about their experience of safety during the sixth workshop. Karen had just said that her motivation in the action project was extending the safety she felt in the research study to her colleagues in the organization at large. Belgium was the first to say he did not feel safe and then othered agree with him.

Belgium: *Yes, in a harmless way.* [Yes, I do not feel safe but in a harmless way.]

During the conversation about what Karen's interest in continuing to work on their group project, I proposed the possibility of meeting with each other outside this program's time frame.

Ellen: *You did your group project. Now you're in another domain. You have different options. It* [meeting together] *doesn't have to be during group time.*

***Connection* at the end.** Clinicians' enthusiasm for a sense of connection with each other led them to choose a group action project that was aimed at bridging their isolation to community with their colleagues at CHS.

At the conclusion of the fifth workshop, when the group worked together to create a supportive action for their colleagues, Francis reflected on her experience of working on the project.

Francis: *It was a little hard for me because there were so many parts to what we were doing. You know I thought about getting the materials but I didn't think about it past that. So I didn't feel as connected with everyone today or about the end product as I might have imagined.*

Nona Gal presents thoughts that emerged about the group action project during a conversation after their independent collaborative-reflective meeting.

Nona Gal: *We were talking about the purpose of the final project. …We're just beginning to think about it and, we need to reach out to colleagues. ... So we're just beginning.*

Karen identifies what she wanted the group action project to accomplish within CHS.

Karen: *Sharing with colleagues but with a sense that you could trust colleagues and be safe with what you shared. …and encouragement for people to open up more and share their experience.*

After talking about a culture clash between the arts medium of their action project and the productivity focus of CHS, Belgium recognizes the support he gets from CHS administration.

Belgium: *I was just thinking it's* [you, November, Karen and Nona Gal are] *coming from, this place of hope as opposed to just cynicism. I touched on this last week about being a new Dad here. And how one can get unofficial supports. You take some of the bosses. It's on the fly, it's quiet. They'll say, 'I'll take care of it.' Right, you know what I'm talking about. 'Let me take care of it. You go bill. You do your job.' It's not too touchy feely. There is an element of people in charge doing it their way. There is some support. It's not as formalized. It may tie into the idea of really taking it to the next level. It's not just a bunch of coldhearted folks. But, it's not a bunch of talky, feely people either.*

After November applied a family therapy template to the feelings she was experiencing about the group action project not going in the direction she had hoped it would go, I respond.

Ellen: *What do we do next? Do we forget it? Do we bond together and try and do something again? Usually it has to be that way in family settings. Right, because we're in therapy in this analogy. We would coach each other along, maybe the therapist or whoever would say, 'If Mom or Dad is drunk on the kitchen floor we wouldn't just leave it at that.' What is next?*

Later during the sixth workshop November addressed what she saw as creating the connection she felt to others in the group and how she would like to see it carried on by creating an action project that would take place over time.

November: *What we haven't talked about here is this particular kind of sharing, the format of it, the associational aspect of it. That has created more intimacy than most of the groups that I have been in. A more ready intimacy. …It would also be a wonderful thing to have this group spawn other similar groups. For somebody to take this model and take it around. That would be a way of doing the project.*

***Hope* at the end.** At the closure of the fifth workshop, when the group manifested their idea for breaking isolation and building collegial support within CHS, Francis described her experience.

Francis: *I like that we actually did something with what we imagined and experienced and are able to share it now. We actually formed it. People outside will get the benefit of it.*

In the sixth workshop the group talked about their disappointing experience of offering up the their project in CHS. There was also a surprise ending when Karen said she would like to continue to work on the project.

Belgium articulated a contrast between the CHS culture and the piece they wanted to present to their colleagues as it relates to hope and the use of humor.

Belgium: *There is something childlike about it. But, that doesn't have to be a problem. It certainly doesn't present the gallows humor that is part of what is here* [at CHS].

November addressed her sense of hope when the group project did not go as planned.

November: *I feel a sense of hopelessness about translating this experience, and communicating it and including other people. It feels like something you have to experience. And this is the way to experience it.*

Karen was interested in continuing to discuss vicarious trauma when this program is over. Belgium recognized Karen's interests and said:

Belgium: *Maybe what you're saying is tying into the hope as opposed to this total hopelessness*.

Karen: *Yeah, except I'm not sure it would feel that safe here. I don't know if I would feel particularly safe really, talking about real specific experiences of working with someone with a sexual abuse history. It almost feels like you'd have to do it outside the clinic.*

I asked about the history of the expressions of hopelessness.

Ellen: *Did you have more hope about it* [the group action project] *after choosing your group project, and making it, than after the Share One board didn't get up? …were you more hopeful the week before?*

Nona Gal found a reason to be hopeful about CHS, citing possibilities and opportunities.

Nona Gal: *Even though the bulletin board doesn't exist or we just made them. There have been opportunities in the past. Or even the fact that there are some good notices, and there are all these little teas and it's hard because this is a large agency.*

***Fear* at the end.** During the fifth workshop that was devoted to the group arts project, Belgium appeared to be joking about the silver fabric Karen suggested as a backdrop for the bulletin board, but his humor may have come from fear.

Belgium: *Whoa, there you go, Subtle as a blow-torch*

Francis made many small cards with the same phrase written on each one. She then crafted a nest-like pocket for them to sit on the bulletin board. The phrase by Ithimcthisis said:

Francis: '*Be patient even in time an egg will walk.'*

During the final workshop the disappointment people felt about what had happened with their project led into talking about feelings of fear.

November: *It's kind of embarrassing actually. It feels like something that nobody understands what it is.*

Karen: *I didn't explain too much about it to anyone. I found explaining it in an apologetic way. We only had forty-five minutes to do it.*

The discussion continued to evolve about their sense of a disconnect between their experience in the group, their objective in the piece they made together, and the difficulties of sharing within the organization. I then returned to the issue of fear or lack thereof, and asked about their motivation.

Ellen: *The fact that you all made yourselves available to improve things here, I understand it was critical for you. No one said, I don't want to do it here* [perform their piece]. *You were all quite clear. You wanted to do it here. And believe me, I've done this in other places and they don't want to do it in their work place. So I'm particularly curious about your chutzpah, your courage.*

Nona Gal's did not overtly describe feelings of fear but she did describe her trepidation about how she wanted to be represented in the group piece.

Nona Gal: *Belgium, Karen and I after* [our Sharevision meeting] *went back and forth about whether the purpose was to have something very obviously written* [about the piece] *to direct people or is it about experiencing it your own way. We were all over the place in our ideas about it.*

***Creativity* at the end.** During the fifth workshop, while Francis was working on the group arts project she described wanting to build ways into their project that invited creativity by others.

Francis: *I'd like to leave a little space to put some things I think we talked about, leaving space for other people to create things. So, I'm not sure how much space we have.*

During closure of the fifth workshop Karen reflected on building the group project.

Karen: *This was cool, actually, creative brainstorming together.*

November identified elements of the collaborative creativity during that fifth workshop.

November: *I really like the end product. I like the moments when ideas sparked other ideas and people picked them up and went with them…*

Nona Gal spoke about working with other clinicians on the project.

Nona Gal: *Something I liked was the project we did, the collaborative project. Something I'd like different* [is] *not feeling rushed.*

At the end of the sixth workshop Belgium was excited by Karen's interest in continuing to work on the arts project they started together. He implied wanting to join her in furthering the project.

Belgium: *We all know where your office is to brainstorm with you.*

Karen said she was considering using the board with clients. I responded:

Ellen: *You can make a board with your clients. Who knows, one of you may get the gumption, once you've worked with it and you've thought about it, once you've had more time. You may decide you want to try to bridge the heady approach by explaining how you've developed, its history and offer it to the rest of the staff. Because, hey, why not? Everybody deserves some support, some creativity, some connection. Maybe it needs this incubation time.*

Section II: Survey Results

Each clinician scored at extremely high risk of compassion fatigue on their first day of the program (Figley, 1995; Hudnall-Stamm, 1995-1998). The survey asks responders to rate the frequency at which they experienced each question over the course of the past workweek. When they took the same Compassion Satisfaction/Compassion Fatigue Self Test a second time on December 19th, it was after six workshops and four independent Sharevision meetings. Each of their compassion fatigue scores went down during the program. Belgium, Nona Gal, and November all scored at extremely low risk of compassion fatigue when they took the survey a second time. Karen and Francis remained at extremely high risk of compassion fatigue.

Chart #1: Compassion Fatigue Pre & Post Program Survey Results

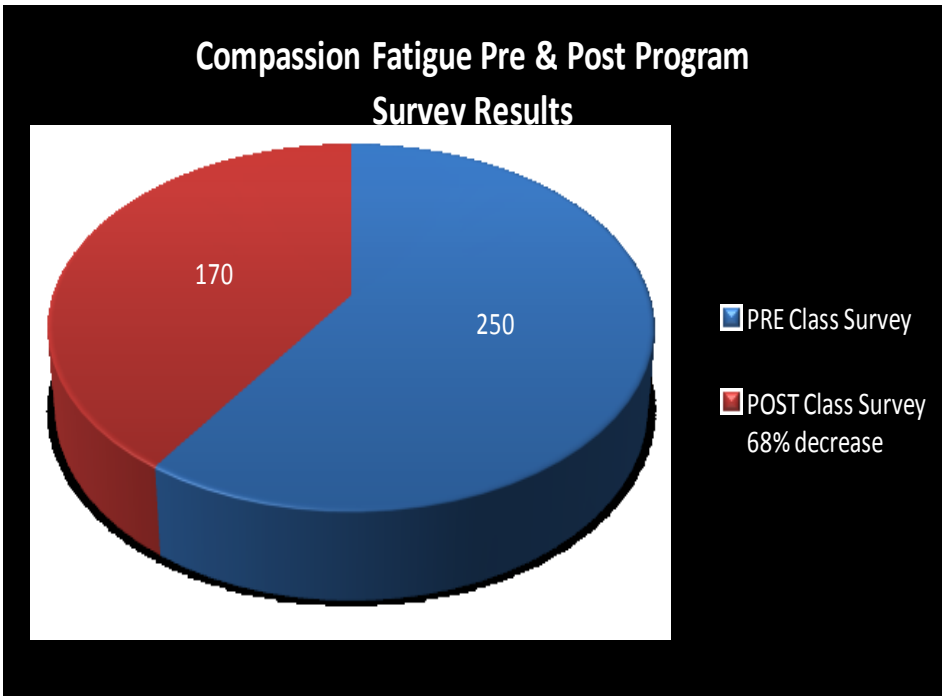
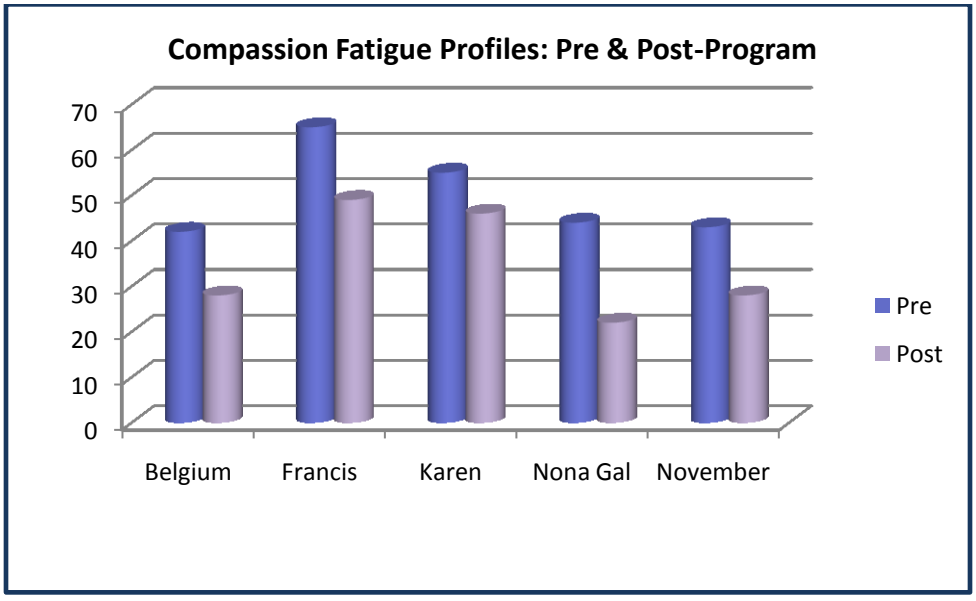


Chart #2: Individual Compassion Fatigue Profiles



Compassion Fatigue Risk was measured using a likert scale on twenty three questions. I have divided these questions into two categories: perceptions and practices. Clinicians' pre- and post-program ratings are shown in three questions representing these two categories. The lower bars in each chart are clinicians' pre-program rating of their experiences. The upper bar is the post-program rating. In some cases there is only one bar representing someone's self-rating. In each of these instances the clinician answered the question by saying he or she "Never" had that experience during the past work week.

Chart #3: Likert Rating on Perceptions

PERCEPTIONS
Compassion Satisfaction / Fatigue Self-Test for Helpers

0 Never	1 Rarely	2 A Few times	3 Somewhat often	4 Often	5 Very Often

Chart #4: Question 4. I feel estranged

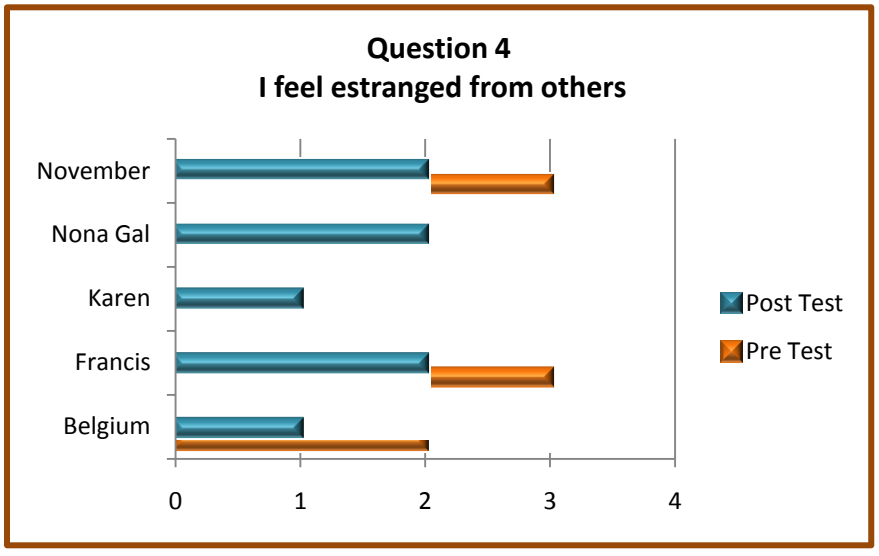


Chart #5: “Infected” by Traumatic Stress

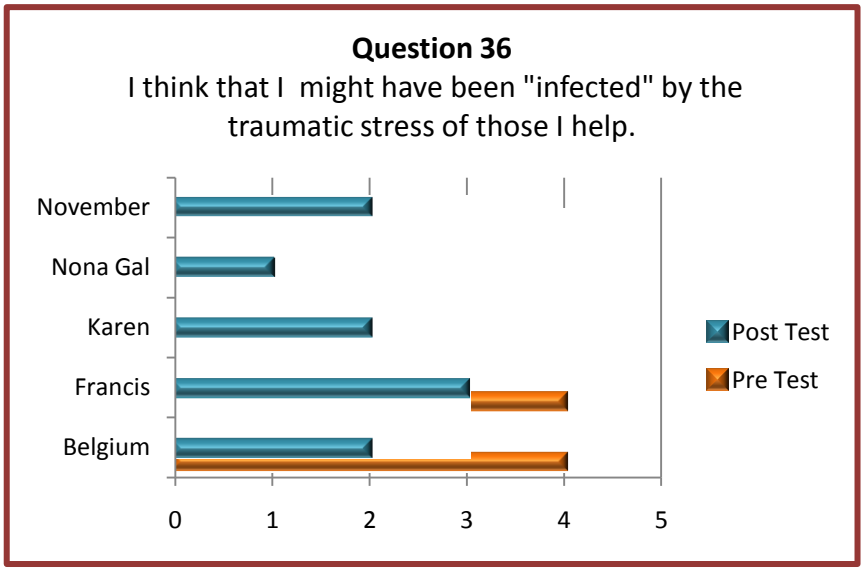


Chart #6: Trapped

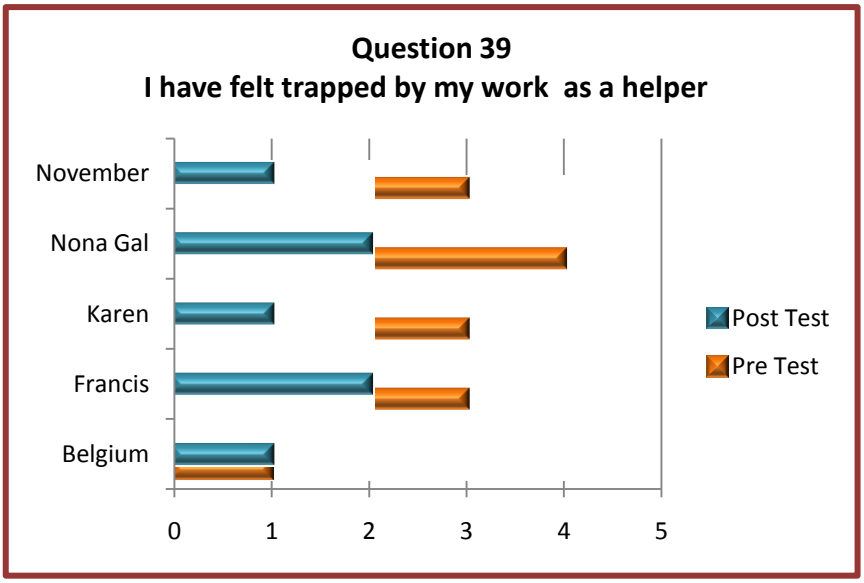


Chart #7 Sense of Hopelessness

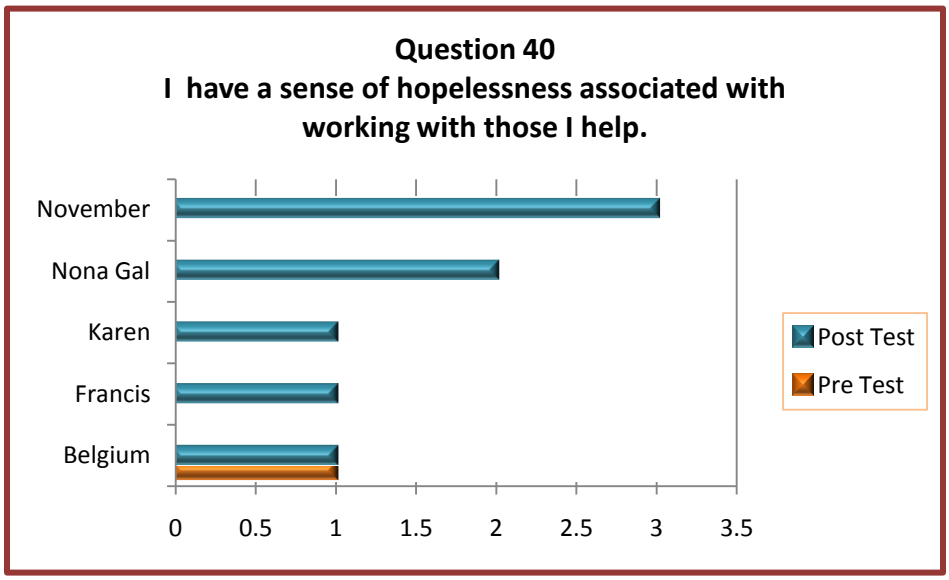


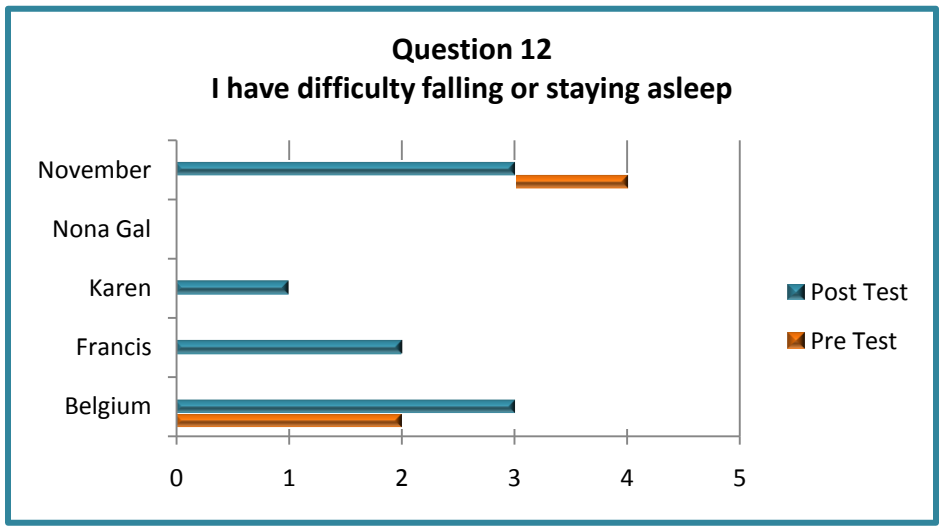
Chart #8: Likert Rating on Practices

PRACTICES

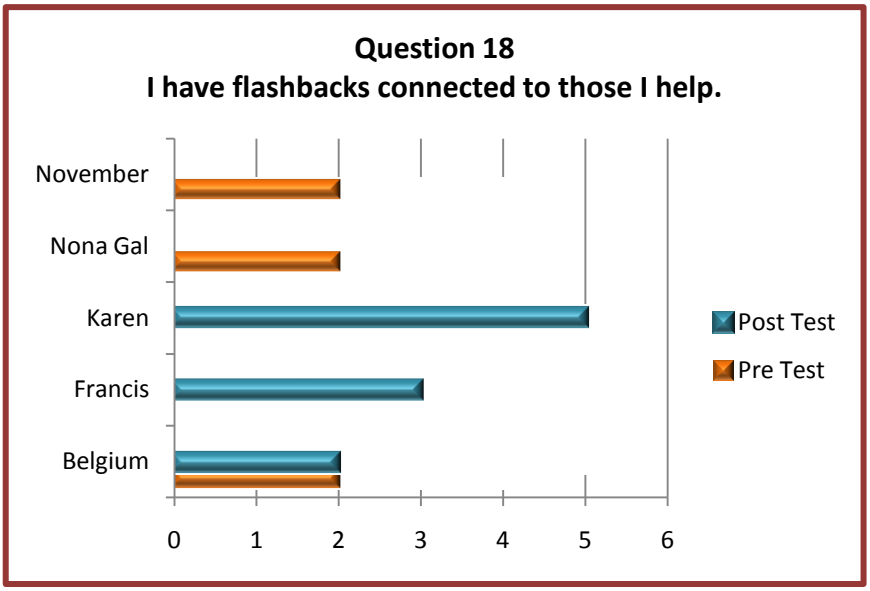
Compassion Satisfaction / Fatigue Self Test for Helpers

0 Never	1 Rarely	2 A Few times	3 Somewhat often	4 Often	5 Very Often

Chart #9: Falling or Staying Asleep



Question #10: Flashbacks



Charts #11: Intrusive Thoughts

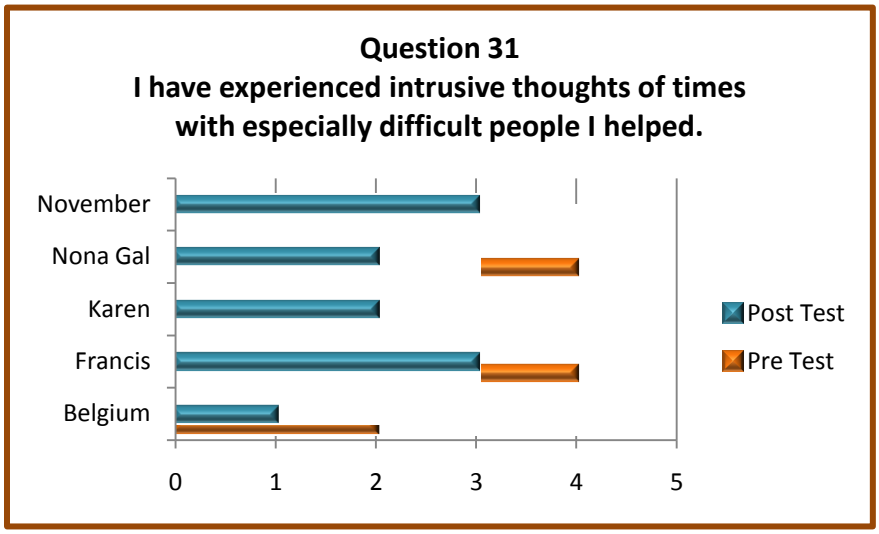
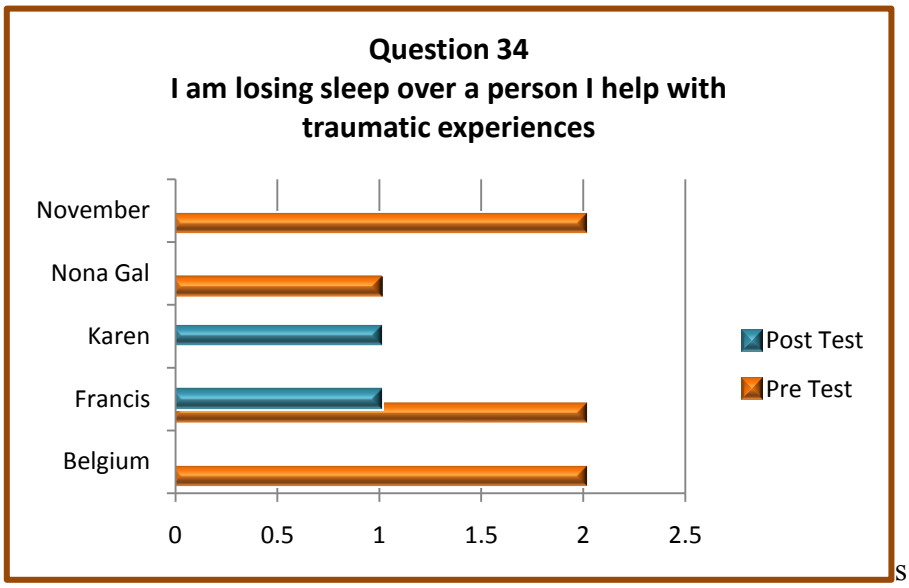


Chart 12: Losing Sleep



s

While the purpose of this study does not relate to other elements of the survey, the results are presented with less discussion. Each clinician's *Burnout* score went down. All but Belgium's *Compassion Satisfaction* score went up. *Trauma Recovery* (Gentry, 1996) scores went up for Belgium and Nona Gal. The Trauma Recovery score stayed the same for November. It went down for Francis. Karen did not fill out her pre-program *Trauma Recovery* survey so her second one could not be measured against an earlier score. Everyone but Karen's *Silencing Response* (Baranowsky, 1996, 1998) scores decreased.

Chart #13: Burnout

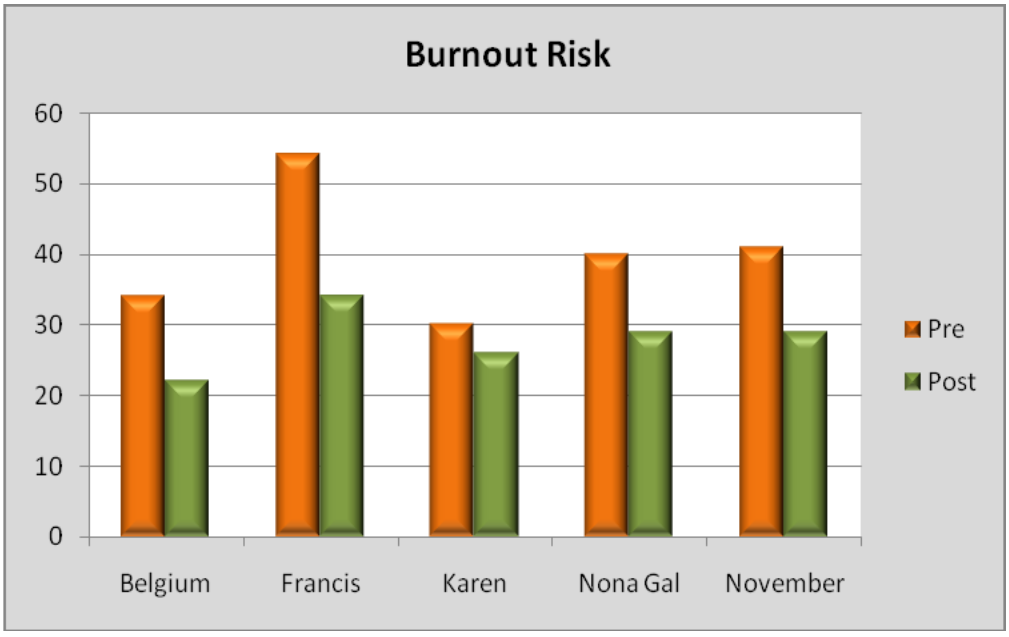
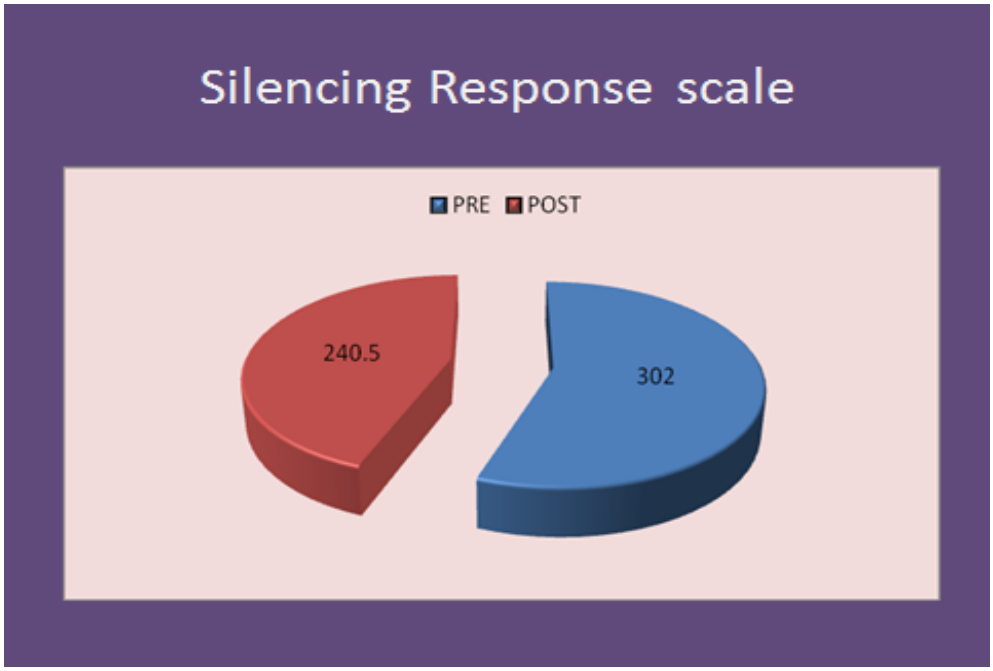


Chart #14: Silencing Response



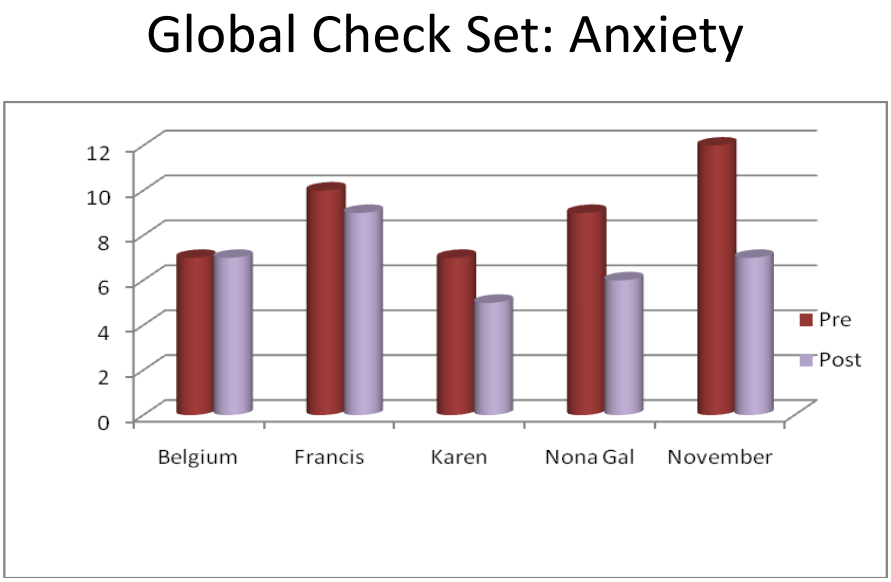
While the Global Check Set (Baranowsky & Gentry, 1998) component of the survey says that it measures psychological disorders, depression, substance use, suicidality, post traumatic stress disorder, generalized anxiety, and somatization, it explicitly states that the survey scores are not to be used for diagnosing anyone. The highest scores among the group were on generalized anxiety with the lowest pre-program score of 7 and the lowest post-program score being 6.

Table #1; Global Check Sets

Global Check Set

	Belgium		Francis		Karen		Nona Gal		November	
	pre	post	pre	post	pre	post	pre	post	pre	post
Depression (d)	5	7	9	8	5	3	6	1	6	5
Substance Use (a)	0	1	1	0	1	3	0	0	3	3
Suicidality (s)	2	4	8	8	4	4	6	1	4	2
PTSD (p)	2	3	7	9	7	11	8	3	4	5
Somatization (l)	4	3	6	4	2	2	5	3	4	2
General Anxiety	7	7	10	9	7	5	9	6	12	7
Dissociation	5	4	5	3	2	2	2	1	5	1

Chart # 15: Global Check Set



Section III: Exit Interviews

I met with each clinician for approximately forty-five minutes to go over his or her survey results and ask them to write a few sentences about their thoughts on the workshops, their Sharevision meetings and the group action project. Their comments are italicized.

November's comments during discussion of her survey results: 1/16/2009.

When looking at the Compassion Fatigue Assessment scores, November said: *Community and creativity provided by Sharevision are the missing link between my Compassion Fatigue scores. I'm quite devoted to self-care. I'm interested in test scores of those continuing* [Sharevision] *and those who are not in six months.*

When looking at the Global Check Set (GCS), I asked November about her thoughts on the rise in scores from 4 to 5 on PTSD questions. November said: *I've had two clients whose symptoms have gotten worse and that has been concerning to me.*

About the GCS General Anxiety score of 12 to 7, November said: *One, this is a personal vulnerability for me. And two, the agency banned group and individual supervision 3-5 years ago. No personal supervision. You must seek someone out. It's hard to find someone. There is no consistent oversight. If I get any supervision at all its for 10 minutes. That is true for everybody but the DBT* [Dialectical Behavioral Therapy] *group; they do have weekly supervision. The consultation groups go from a little bit personal where I can say I have a client who is driving me crazy, to other consultation groups that are not at all personal.*

[Consultation groups are optional supervision meetings that are unpaid time for participants. The leader may be paid.] When I asked November how she feels seeing the survey results she said: *I'm pleased that it shows significant difference where it does. I'm pleased to know.*

When I asked November how she feels seeing the Trauma Recovery Scale results November said: I do feel satisfaction in my work and I do recover well. When looking at the Silencing Response Scale, November said: *I have certainly noticed my silencing myself as a result of depression and anxiety. I do a lot of silencing myself about what worries me about my work. Sharevision gave me a venue for relieving myself.* (She makes a gesture with her hands as if moving something off herself.)

I'd like to get one of my informal group supervision meetings to use Sharevision.

I first realized that I really did know how my work was affecting me when we were in your group. The difference really shot out at me. Being in your group felt fantastic. Like I'd found my element. I'm a fish and this is water. Responding by association and putting things into symbolic form made me realize I've got a lot to say. And it was fun to say it. I loved doing it. Someone pulled the cork and all these lovely things came out. Instead of all those messy things. I'm going to take these test scores to my old supervisor here and show him what a difference a little bit of time doing this has made.

Nona Gal's comments during discussion of her survey result: 1/16/2009.

When looking at the Compassion Satisfaction scores, Nona Gal said: *I like my work. I'm surprised to see that it says I only have modest potential.* When looking at the Silencing Response Scale, Nona Gal said: *I am trying to be present more. I'm learning about this. I feel I've had huge growth here at work and at school. I wonder if my learning how to do structural work with families. Instead of digging up the past I'm more focused on restructuring relationships and boundaries. With clients who are anxious I'm learning about cognitive models. I understand more about choosing moments from the past to talk about, not to dredge it all up.*

We talked about whether the survey was model specific. I said that I was learning about the survey from her changing approach to clinical work. The decrease in her Silencing Response score supports the survey validity. The survey found that even though she was less frequently following her clients into conversations about their past, she was attending to them more.

When looking at the Global Check Set, Nona Gal said: *My personal life is different in a good way. The down part is I do feel more stress, hopelessness and am*

dwelling on things more. The up part is that I can shake these things off more easily. I feel more accomplished and more assertive.

When looking at the Compassion Fatigue Assessment scores, Nona Gal said: *I'm an intern in my third year of grad school but I've been in this business for 10 years. I'm going to pay attention now that I know I'm at risk. This program helped with personal growth. I do feel better. I've been looking at myself, where I was and what I've achieved, and I feel accomplished. We've been highlighting strengths. In the Sharevision groups we hear supportive things, similar stories, reactions: I'm not crazy or doing that bad. I'm not isolated. I entered a community. I became part of a community. I have started to exercise more, sleep better, have better nutrition. I found I wasn't doing all that enough.*

Karen's comments during discussion of her survey results: 2/5/2009.

When I arrived in Karen's office the Share One board was there. She said: *Numerous things happened this week that made me think: I really should be talking with someone about all this. But there was no one, no place, no way to discuss it. It's hard to talk with a supervisor midday. It's so draining to describe what's going on. To be questioning if I'm doing the right things then having to go back to work. The end of the day is better. Usually I'm looking for something else. I do have two supervision groups but I never present because it feels so stressful. I do have one person in the agency that I hit it off with. We can talk about clients and let it all out and joke about the situation.*

I shared my limited understanding of the neurological impact of expressing feelings through moving the body and making sounds to rejuvenate from stress and

trauma. I demonstrated "shaking it off," growling and laughing. Karen visibly lit up and said: *Yes, Yes I can see that!*

When looking at the Burnout, scores Karen said: *This is controlled because I have outside pursuits that are really satisfying for me.* She got up and went to her desk and took out printed note cards of her bright and colorful paintings to show me. *I also play the piano. I'm trained classically and am now studying ragtime.*

When looking at the Compassion Fatigue scores, Karen said: *I'm concerned I'm still at risk. I'm isolated. I don't feel welcomed, because others don't want to hear about my job. Even if they do it's unsatisfying, there's questioning and blaming.*

When looking at the General Check Set scores, Karen said: *I'm concerned they stayed the same. The PTSD went up. I get very overwhelmed because I don't handle stress well. On the job I have developed coping skills but in life in general I get really overwhelmed. When I get overwhelmed and stressed, I don't get more depressed, I get more PTSD.*

Karen discussed the week she filled out the post-program survey. *I had two clients with a father dying, and one client who was losing her children.* I said: Who knows if you had people to speak with, like a Sharevision group, if it might not have helped you.

Karen said she would like to join the Sharevision group that was starting as a result of this program. But when she thought about driving there from her home a few towns away she said: *I get too stressed. If it was right in my town and I could walk to the program, I'd be very interested.*

On my way out I thanked Karen for participating in my schooling. She said: *I liked being asked questions. I'm always the one asking the questions.*

Francis's comments during discussion of her survey results: 2/5/2009.

I met Francis at her new private practice office a few blocks from the agency. After welcoming me, she said that because she has not been at all the meetings that it is all right if I cannot give her CEUs for participation. She had missed the final workshop and three Sharevision meetings. Francis said very little about individual survey scores. She summarized the results by saying: *I'm going through a lot with my son who recently was admitted to TW* [a residential program for people with psychiatric conditions.] *My father died a year ago and I am going through a lot in trying to sell his house. Old stuff is coming up. My brother and I have three-way joint power of attorney with my uncle. My uncle is responsible for seriously downgrading the property. It's costing a lot of money and stress. I'll need to hire someone, which will freak my uncle out.*

Francis switches subjects to her new office and starting a new business. *The world is starting to come to me. Though, I'm aware I don't have the same buffers here that I have at the agency.*

When I ask Francis about her care of herself, she said: *I go out to the movies more, but I've learned through this course that I don't want to hyper-stimulate myself. That's a big mistake. I'm getting more consistent with exercise. I'm working on my food thing. I've also started taking drumming classes.*

Belgium's comments during discussion of her survey results: 2/9/2009.

When looking at the Compassion Fatigue scores, Belgium said: *In the fall I had some clients who were very intense, extremely intense. They were doing poorly, having suicidal ideations, and each had a history of suicide attempts. For instance one was manic and depressed and another was depressed and had PTSD. I saw them through the*

wave of depression. Both were right out of Hollywood casting. My job is to listen. I'm sure I was feeling all that. It's hard being around all that emotional pain.

When looking at the Burnout scores, Belgium said: *Maybe I do pretty well sharing. I seek out supervisors, then they have to hold my hand. Sharing, this is how we do it. I think it's stupid to hear someone's pain and hold onto it. It's validating to joke about how hard it is. I have a few supervisors. With one supervisor, when someone is having suicidal ideations I fill out a form and get a number and the person is tagged. With another supervisor I can think, review, get a clinical consult, have an emotional experience – when I trust that person. If I'm not getting the support I just keep going until I find another supervisor to talk to. I just keep talking. I'm a relational junky. I'm curious. I also studied photography, have a BFA. It was always something I would do. Now, having a child I don't have time for it. I also don't have to care about my clients in the same way. Now that I have a baby I have less room. I often have someplace I'd rather be.*

When looking at the Compassion Satisfaction, scores Belgium said: *When things are quieting down at work, I want to be home more. I got to be at home more during Christmas holiday.* (The final survey was after his vacation from work.) *It's less appealing to be at work. Belgium added: How I've been treated here at work is really good, great. They have been flexible. I am more vulnerable since having a baby. I'm also more savvy. More aware of the insidious. Being around suicide – I don't need any more of that. I have learned to be around emotional pain but my cup is full.*

When looking at the Global Check Set scores, Belgium said: *Depression, I get baby worry waves, worrying, "Oh my God how am I going to feed these people." It never*

ends. There is no "me" time and I get emotional. As for the January score, I had just had a week off for the holiday. Suicidality, I was reading about it. I'm a consultant on suicide prevention. I'd rather not be but I am. Its what other clinicians wanted to talk about. We had a group getting started [in January]. *Generalized anxiety, that's consistent. PTSD, it's all that reading on suicidality. Dissociation, I was more present on that day* [during the post program survey].

I asked Belgium about his over-all thoughts on reviewing these survey results, he said: *It's symbolic of a domestic year. Work came second to my life for the first time. Being on a team, getting paid to get together, being a middle management guy. Being paid to be around. There is room to cultivate what you're doing. Bean counters think we can't afford one hour a week. But, it's important. It'll be interesting to see the next wave of bosses. They'll come from a history of fee for service work with no teams, no salaries.*

Three Questions

I present clinician's written words in the format they hand wrote their responses.

November wrote.

1. Work with Ellen
2. Group w/o Ellen
3. Aesthetic Action

1. Loved our meetings with Ellen. Looked forward as high point of the week. Opened doors between me and other colleagues: opened doors to my pleasure in creativity. Brought hope for prospect of less isolation in the future: made me aware of need to share and pleasure of sharing that had been unmet. The format

itself facilitated more intimacy than alternative peer supervision groups and the creative part was pure joy.

2. Groups w/o Ellen: Format was easy to use and immediately effective even w/o Ellen! A pleasant surprise! I feel closer to those colleagues as a result. Felt I discovered my own voice in those groups, that I had something important to say for myself & to share. Enjoyed giving & receiving feedback/responses from group members. A transformative experience for self, and for connection & heightened the meaningfulness of our work.
3. "Aesthetic Action" – I love the concept and our intent. The execution – well, I didn't feel we really worked cohesively to create a shared vision that each would/could own. It seemed each of us put in our individual contribution & kind of worked in our own sphere. It started to seem silly to me during the creation project. Perhaps imagining colleagues observing it brought a sense of distance. Embarrassment was my main reaction when it was done & that increased when it sat ignored in the corner of the staff room.

Nona Gal wrote.

Workshops

The workshops brought a sense of connection and community to my experience as a member of this agency – very helpful as an intern and newbie!

Appreciated the component of art – I'd been "intellectualizing" content/material/groups for a long time & it was a satisfying experience to switch gears.

Group Meetings

The Sharevision process was a validating one. During another group I'm part of for consultation, I found myself missing it – particularly its structure of shared time & feedback.

Group Action

I felt more connected to the idea behind this than the actual product. I have some guilt about recognizing this as I'm usually game for putting in some effort to improve something I'm not particularly satisfied with, but I don't currently hold this motivation (due to many factors that place me in a realm of overextension.)

Belgium wrote.

1) Seemed more pressed for time – more "to do" – with the focus upon projects as well as discussion and reflection.
2) Sharing of more personal information – would like more time to do so – Structure was meaningful. Everyone having same amount of time to share
3) The effort to work together on a physical project was helpful, though my investment in the project itself was somewhat limited.

Karen wrote.

1. It was good to know that the group was a safe place to share difficult experiences. It seemed too short. It went by too fast. I can imagine it being more intensive if it was held over two days rather than 1 time a week.
2. The few times I met with co-workers opened up new possibilities for peer support and helped me to realize how important it is to not give advice unless the person asks for it, and to not interrupt when a colleague is sharing.

3. I enjoyed doing the creative segments and did enjoy doing the final project, but was disappointed in the results.

Francis wrote.

Workshop

Group Meetings

Group Project

Workshop was fun and unexpected. I never knew what would be created by myself or others. There was always a sense of relevance and aesthetics about the process that was fun and eye opening. Time was unfortunately short.

Independent group meetings were surprisingly helpful. I was truly amazed at how powerful it was to share and be heard in the format we used. The experience of that has made a permanent imprint in me and has not been matched in the same way by other group meetings or supports.

I was appreciative about the process of planning our group project with us learning to blend ideas and priorities to create a concrete project/outcome. The actual doing felt disjointed and not satisfying in the time period. We may have bit off more than we could chew in the time period. I think the end product reflected this.

Chapter V

DISCUSSION

Introduction to Discussion

Lynn Hoffman influenced this research. Her ideas inspired the creation of Sharevision. She met with me every week during, and since, the three month collaborative inquiry and has engaged in deep consideration of these transcripts. She coined the phrase "building a sustaining web" in reference to this research (Hoffman, 2010). In part, the phrase arises from the title of the program, which was named "Building a Resilient Practice," and in part, from a proposal I was writing with her help entitled "Leadership & Sustainable Resilience." In it, Sharevision is presented as a practice for enlivening and sustaining resiliency. Hoffman recognized that the project was not merely focusing on individuals so much as that Sharevision clears the way for people to connect with each other as the Internet does. I like the phrase for its simultaneous reference to what uplifts us, the arts, connection to others who are not physically in the room with us, to nature itself; to Bateson for affirming the intrinsic weave of human, animals and the environment, and for returning to the Internet, as did Baldwin in naming the collaborative-reflective design Sharevision.

The themes that emerged in this study suggest there is great significance for these clinicians in having the Sharevision process through which they could (1) *open up* (2) break their *isolation* through addressing topics of relevance (3) thereby *connect* with each other (4) and generate feelings of *hopefulness*. Multisensory engagement, through *expressive arts* activities was found to be key to the relief of *fears* associated with secondary trauma.

During the study I introduced the group action project as *aesthetic action* (See Transcripts of Workshop IV and V). I aimed to convey the importance of creative endeavors, wherein clinicians can express their sensory emotional values or their aesthetics and together communicate their commitment to their work through advocacy [See Transcripts of Workshops IV &VI]. (Ayalon, 2006; Barlow, Phelan, 2007; Belfiore, 1994; Biegel, Shapiro, Bober & Regehr, 2006; Borkovec, Roemer & Kinyon, 1995; Brown, 2007, 2008; Byers & Gere, 2007; Figley, 1995; Golub, 2005; Gregerson, 2007; Harris, & Westwood, 2009; Harter, 2007; Hillard, 2006; Hocoy, 2005; Junge, 1993; Kakkad, 2005; Klar & Kasser, 2009; Lett, 1995; Maxey, 1999; Musick, 1980; Nainis, 2005; Pearlman, 1999; Riley, 1996; Serlin, Berger, Bar-Sinai, 2007; Stamm, 1999; Traue, 2002; Ungar, Mackey, Guest, Bernard, 2000; Valent, 2007; van der Vennet, 2003) .

> "Aesthetic action is a process wherein the group examines existing patterns and builds ideas about new ones, then realizes these ideas through action in different contexts. Diverse communication media are used in this process to support non-linear connections. The focus is to evolve a pattern that feels "right" or "fits" the group and the context. Once the aesthetic action is accomplished the group gathers and reflects on the results. In this way an esthetic loop can be developed" (Baldwin & Landis personal communication, 2005; Landis 2008, 2010).

This study highlights the impact of clinicians' isolation in their workplace. These clinicians sought to improve conditions within the organization where they work. They had a short period of time to accomplish their goal to expand support for each other and their colleagues through their group action project. However, they were

discouraged when the project did not take off as they hoped it would. I have learned how important it is that such endeavors provide for greater attention to repeated cycles of action and reflection in order to accomplish the goals of the group.

Emergent Themes

Each of the six themes is discussed in light of both the study and the literature on secondary trauma. Arts pieces are looked at as artifacts in this chapter and not analyzed. Clinicians' narratives about what they have made are the focus of discussion. C*reativity* is presented first to give context to the discussion of the other themes.

Theme: *Creativity.* Creativity was a surprisingly joyful endeavor for these clinicians. It was a vehicle for transforming their angst. Creativity was freeing and intriguing. They liked making things, witnessing how their arts pieces turned out, and what was said about their creations. They described Sharevision as well as their collaborative action project as a creative process. They came together in their group action project by incorporating an element of each person's ideas. They recognized and were relieved by their courage to step beyond their previous perceptions and practices at work, and in finding new effective alternatives. They were creative from the onset of the first workshop's arts project. They became more verbal about their interest in Sharevision as it related to their positive associations with creativity.

The following exchange took place during the fifth workshop as the group completed its collective project. The project was aimed at decreasing the sense of isolation among colleagues at CHS and to extend the group's feeling of connectedness to others. Their use of a bulletin board to create community echoes Stamm's (1999) recommendation to use technology to limit isolation. They all recognize the proximity

and parameters of their work and apply an innovative approach to their problem solving (Noworol et. al., 1993). What's more, the group built a project to serve both others and themselves since they too would be able to use the interactive board. Being in a receiving role is critical for clinicians' wellness (Pearlman, 1999).

Example of *creativity*.

Karen: '*Try not to rush.'*

Belgium: '*No rushing.'*

Ellen: *As we rush to finish!*

November: '*Try something new'*

Karen: *Hey I know, 'End on Time.'*

Ellen: *What's fun is you guys can add to these whenever you think of a new one.*

November: *This is so beautiful!*

Belgium: *So textured.*

November: *Where are the kooky scissors?*

Ellen: *Is there anything else that needs to be glued down, the stars?*

Francis: *How about the glue gun?*

Nona Gal: *You have to press it here. I can do the stars.*

Ellen: *Are you just about done? Any other decorating for now?*

November: *'Choose your path.'*

Nona Gal: *Are all the stars down?*

Karen: *'Breathe.'*

Belgium: *'Breathe, Pause.'*

Karen: '*Pause,' yeah.*

November: *How about 'Your Own Magic'?*

Ellen: *What were some of the ones you liked? We could do some duplicates.*

November: *Duplicates? We haven't done "Try something new." I'll do that.*

Ellen: *Belgium, will you do some of those?*

Karen: *'Care For Your Body.'*

November: *Did you already do that Francis?*

Francis: *No, I didn't.*

Group: (quiet, writing by all members)

November: *Did anybody do 'Take a friend to lunch'*

Group: *Nope.*

Karen: *I did 'Take Yourself to Lunch.'*

I'm trying to think of all the things I don't do during the day and should. And like to do.

Ellen: *Yes, what would you like to do?*

November: This is fun!

Nona Gal: *'Stretch.'*

Belgium: *'Rest.'*

Figure #1 Make One ~ Share One

Figure #2: Help Support Colleagues

Figure #3: For You

Figure #4: For Your Journey

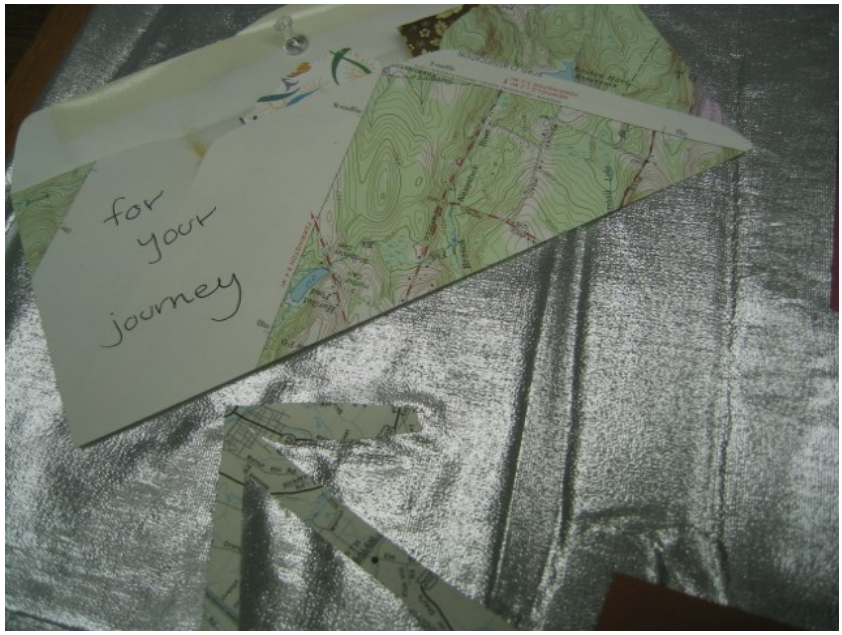


Figure #5: Something Special

Figure #6: Open Up

Figure #7: Help Yourself

Figure #8: Questions?

Figure #9: A Gift

Figure # 10: Choose Me

Figure #11: Be Patient In Time Even an Egg Will Walk

Figure #12: Add Some

The multisensory expression the group devised for their project mirrors recommendations to do so as a tactic to decrease anxiety, worry and fear (Borkovec, Roemer & Kinyon, 1995). Research has not shown any one arts modality to be better than another at decreasing secondary trauma among clinicians (Murrant, Rykov, Amonite, Loynd, 2000). It is arts activities, such as the colorful group project and arts responses to clinical work (Fish, 2007) that is relevant.

When clinicians do not have a creative orientation they experience more secondary trauma (Hatgis, 2006). Their self-esteem decreases (Noworol, Zarcynski, Fafrowicz, Marek, 1993). When one lacks a creative orientation finding solutions to challenges becomes more difficult and thus leads to lowered self-esteem. However clinicians who employ active problem focused coping strategies have fewer PTSD symptoms and less disruption of their self-trust (Schauben & Frazier, 1995). Inversely, greater frequency of activities of creative expression correlates to lower levels of compassion fatigue (Samoray, 2005).

Researchers believe that far too much attention is paid to individualistic approaches to secondary trauma rather than institutional and cultural approaches. They suggest shifting the focus from education to advocacy (Bober & Regher, 2006). The highly regarded Green Cross Academy of Traumatology includes social action work in its *Standards of Self-Care* (Figley, 1997). Shields (1991) reminds clinicians that activism ought to be sustainable. The clinicians in this study innately understood the importance of their multisensory creative social action project to improve their working conditions needed to not only offer them the opportunity to be in a receiving role (Pearlman, 1999) but also had to be sustainable rather something they could not follow through on.

Theme: *Opening Up*

Generally, in *opening up* clinicians explored new ways to address their individual and collective experiences of their work. They took risks in trying new behaviors, and shared aspects of themselves they had not opened up about before. *Opening up* was a positive, feel good experience. Clinicians sought to continue *opening up* throughout the program because they enjoyed how Sharevision *opened doors between colleagues*. In the Exit Interviews they identified Sharevision as generating effective means for them to *open up* due to equitable time-sharing, associative responses and a focus on listening. Their experience of working together on the group action project was an *opening up* of their concerns and their investment making things better in CHS, their worksite. They *opened up* as they performed their desire to offer and receive more support at their worksite through an innovative and simple group action design.

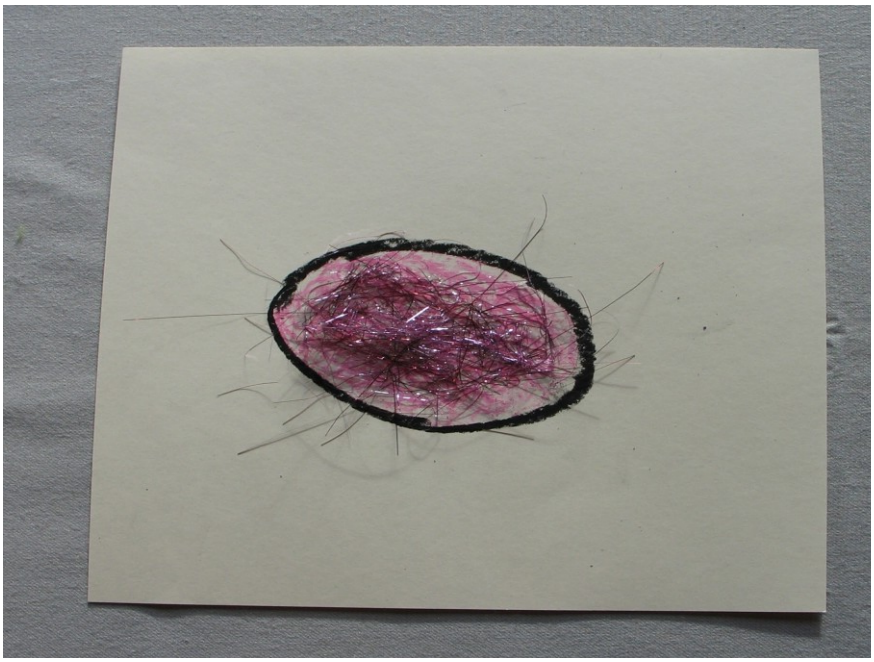
Example of *opening up.* Francis: *I didn't think about the first time but more recently. I have a really difficult history myself. And I've done a lot a lot, of work.*
There was a time last year or two that I thought, I realized that my healing process might not be going along as quickly as I want it to. Because I kept working with people with similar struggles. It worried me for a while. Besides the fact that the work I do informs my healing.

I worried that I'm not going to get well or as well I want to get working with the same kind of people I've been working with. That was a kind of a hard moment. But, I think I slipped past that.

But, it was hard because I thought I've worked so hard to do what I do and maybe I can't get well. I had to stay with that for a while.

So what I saw was this pink. Me, My healing and the tender parts of me. And all of a sudden not quite knowing how I was being affected in the environment where I work. And not knowing if those two things where going to be okay. So, this is what came out of it right now.

Figure #13: Pink Little Me



Francis broke her isolation of several years by describing her concern about her own wellness at it related to her work as a clinician. By keeping these concerns to herself, this example by Francis is amplified by Shalvi and Luzzatto's 2008 finding that while therapists understand the importance of support, they often do not seek support for themselves from their colleagues. Woodard, Meyers and Cornille (2002) found that therapists minimize the severity of their own unpleasant reactions to their work.

Throughout this study clinicians used the structured meeting format to express their personal experience of their work. Pearlman and Saakvitne (1995) highlight the importance of having a respectful atmosphere at work where clinicians' beliefs,

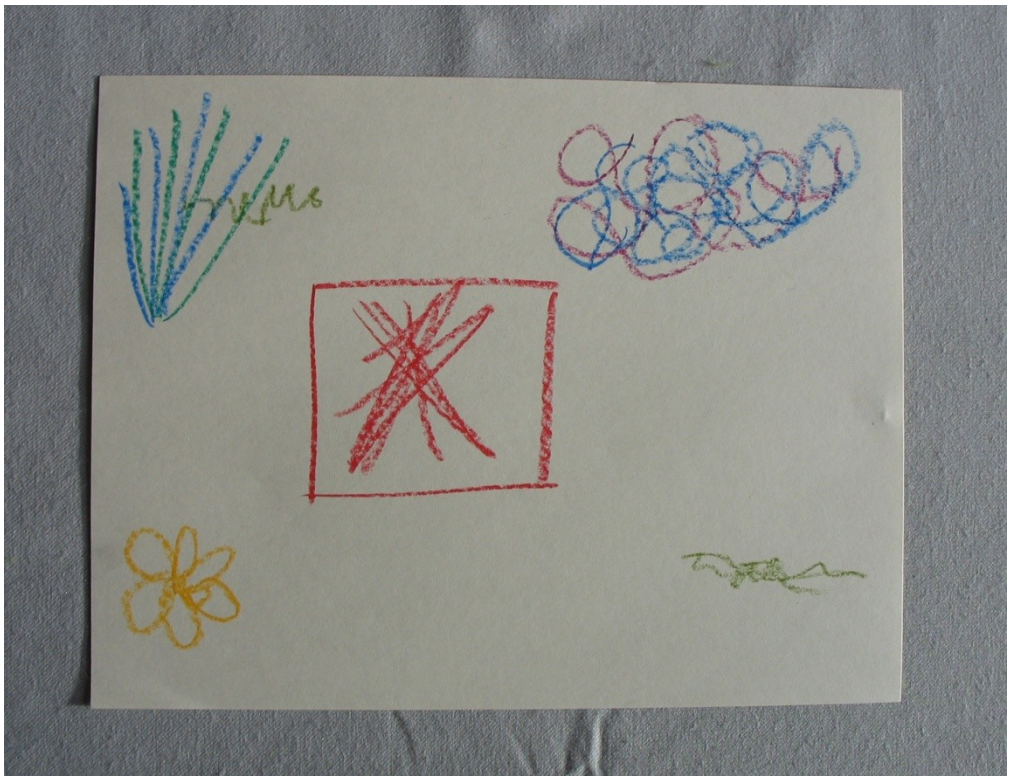
assumptions and expectations can be addressed. Hormann and Vivian (2005) advise open communication about of doing social repair work, both with people within the organization where they work as well as with others in different organizations as a means for gaining perspective and momentum for the work ahead. Woodard, Meyers and Cornille (2002) specify the setting needed as being one where clinicians are safe to release their emotions about their work with clients, as clinicians do in the study. Having such a forum where clinicians listen to each other has been found to decrease compassion fatigue (Everly, Boyle, Lating, 1999; Mitchell, 1983; Wee & Myers, 2002).

Theme: *Isolation.* *Isolation* was a term for feeling alone, of loneliness. It was a negative experience of depletion and sadness. They were especially expressive about not wanting to feel *isolated*. During the program clinician's sense of *isolation* decreased as they realized that they could find connection and community through both their workshop and their independent Sharevision meetings. However, their decreased sense of isolation was temporary, as it did not last from meeting to meeting. Some clinicians talked about feeling a sense of isolation in their home life. Though, at times when they thought about their involvement in this program their sense of isolation waned, as they looked forward to the next meeting. In Exit Interviews clinicians described their sense of loss at not having Sharevision meetings on a regular basis. They spoke about wanting to introduce Sharevision to others to help reduce their sense of isolation and felt it was possible to do so.

Example of isolation. Nona Gal: [I've been] *avoiding certain places where I know clients will be at. Not like the obvious places but the general places like the mall. Places that you are inevitably going to go to. I picture myself staying in this [issolated]*

place, and the world is happening around me. [I have] *thoughts of, 'Well, I can't go do that anymore.'*

Figure #14: Places I Avoid



Nona Gal presented her sense of isolation (Cacioppo & Patrick, 2008), of estrangement (van der Vennet, 2003), and alienation (Dutton & Rubinstein, 1995) in both words and in her drawing. Herman's (1997) experience working with many clinicians and clients brings insight to describing clinician's coping styles as representative of dissociation and numbing. The example of the places she no longer goes to is also described as a common defense style, of withdrawal (Adams & Riggs, 2008). During the program Nona Gal described her experience of having too little energy (Pearlman & McCann, 1990) to address these perceptions before they became life practices. During the

program she talked about being tired which is also consistent with the literature from previous studies on the impact of empathetic engagement with clients (Traue, 1995).

Nona Gal is representative of many interns and practitioners new to the field who struggle with these feelings of isolations (Pearlman & MacIan, 1995). While at the other end of the spectrum, those clinicians with the greatest amount of education and more years of experience also are less likely to engage in leisure activities (Bober, Regehr & Zhou, 2006) as was described by other clinicians during this study.

There were numerous examples of clinician's feeling isolated both at work and in their lives away from CHS. For example, they talked about not seeing or stopping to talk to each other as well as the lack of emotionally supportive supervision. Adams, Boscarino and Figley (2008) found working environments, such as practices described by clinicians in this study, are predictors of compassion fatigue. However, it was CHS which made this arts integrated research program available. Belifiore (1994) and van der Vennet (2003) found a decrease in clinicians' sense of isolation correlated to an increase in their sense of creativity.

Theme: C*onnection.* *Connection* was a feeling clinicians described as pleasing, uplifting and affording them a sense of aliveness. They presented happiness about *connecting* to themselves, each other and their clients. Clinicians' sense of *connectedness* increased markedly during the course of the study. Having time to participate in Sharevision increased their appreciation for each other due to the help they received in those meetings. They consistently remarked on their surprise at how powerful it was to share and be heard. They found that their increased sense of connection grew a feeling of community that was lacking prior to this study. They chose a group action project aimed

at spreading their connectedness to others in CHS. Although, in Exit Interviews they differentiated their intent to connect with colleagues in CHS from their disappointment that it did not happen.

Example of *connection.* Belgium: At *first when you pulled out all the stuff it felt very familiar because my wife is an arts and crafter, a sewer. 'Oh, I know this world.' It's a feeling like jump in. I don't jump with her to do it, so that's the difference, but it was familiar. All the stuff, the materials Oh, I know this. ... It took a little while, half way through before I went to the other end of the table to look at the other stuff. I got into the time thing thinking about my eight month old at home. She likes bells, I like bells. ... My mind wandered to my daughter. In the end the bells. A combination of work and domestic. Which is constant right now in my life.*

Figure # 15: Mr. Constantly On the Go

Belgium speaks of his challenge to be present at work when his focus shifted to his family at home. However, he was able to incorporate his thoughts into the decision-making about his arts piece, take action, and present his experience to the group. I believe that Belgium demonstrated that the non-evaluative (Dalton, 2001), collaborative-reflective meeting format was relevant to his lowered compassion fatigue score for a number of reasons.

Once he, as did others, *opened up* he was able to share rewarding aspects of his life (Pearlman & Saakvitne 1995). He experienced validation (Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995) from other clinicians about having multiple roles in life outside of work. Belgium found that the group provided a "consensual perception of reality" (Catherall, 1995 p.87). This is possible because of the feedback loop created through emotional expression in a supportive environments (Traue, 2002) where differing ideas are welcomed (Fontes, 1995).

Clinicians who report having supportive work environment have lower levels of compassion fatigue and vicarious trauma (Boscarino, Figley & Adams, 2004). The visual, kinesthetic and auditory descriptive language Belgium used, as did others, when describing arts responses was helpful in building vitally important communication among clinicians (Harris & Linder, 1999). Clinicians are then able to be more aware of compassion fatigue in themselves and their colleagues (Gentry, 2000).

Humor (Adams & Riggs, 2008) is another means for generating communication. It can be used to encourage clinicians to look at their own thinking and behavior, and that of others, from a variety or vantage points. Individuals within organizations can nourish a supportive environment through humor, and socializing. Reciprocally, organizations

benefits form valuing a culture that is fun and relaxing (Shields, 2006). This can be accomplished throughout the workweek by encouraging clinicians to take lunch breaks, walks and to contact loved ones by phone or email (Rosenbloom, 1999).

Theme: *Hope.* Hopelessness emerged with great clarity early in the dialogue about their lacking a sense of connection to others, their experience of isolation and feelings of fear. Throughout the program *hopelessness* transformed and was remarked upon in several ways. A transformation of *hopelessness* into *hopefulness* was related to an increase in clinicians' sense of intimacy due to the associative rather than directive responses in Sharevision. *Hopefulness* was reflected in their comments about their arts piece and having individual, collective and collaborative creative projects.

During the last meeting clinicians described how hopefulness dwindled when their attempt to transfer their positive feelings of connectedness to others in CHS did not succeed. They expressed hopelessness about being able to do that in the future without others having a similar Sharevision experience. Then hopefulness re-ignited in the group by the interest of one person's investment in breathing new life into the group action project. In Exit Interviews clinicians also shared feelings of hopefulness about being less isolated when they wrote and talked about continuing to participate in Sharevision.

Example of *hope*. November: *I'll go next. This is my person. I was struck by the time limitation. I also really wanted to give myself permission to not be planful, because I'm so bloody planful. I just grabbed things. I also knew I wanted a head. I just grabbed stuff and let it evolve. You know I don't particularly like this puppet, but she is kind of out there, and I like that about her. At a certain point in the process I looked around at what other people are doing. I thought, "I really like that and oh, I like that about what others*

are doing." And I started to have regrets about not doing this in a planful way. So I was really relieved that you said the time was up, because I didn't have to think about it anymore. So there she is.

Karen: *I think it's fantastic. I became curious when you said you didn't like it and wanted to know why. Because I love it.*

Nona Gal: *I like that you decided to go against your initial impulse to be planful. That is just a cool thing that you did.*

Belgium: *Like Karen, I really like what you did a lot and can identify with some of the process. And in terms of the product, I really like the work a lot, it's great.*

Francis: *Sure, I had thoughts before you spoke. Then I think I was surprised by some of the things you said. I felt like it was exuberant, multifaceted and integrated all at once.*

Figure #16: Kind of Out There and Not Planful

November represents both her hopelessness as well as her hopefulness in her description of her puppet-sculpture. Yet, she and her sculpture inspire rich expressions of esteem from her colleagues. It appears that November and everyone else in the group may have lower compassion fatigue risk scores at the end of the program in part because their self-esteem and their esteem for each other increased. Pearlman and MacIan (1995) found that those clinicians with positive self-esteem and esteem for others are more resilient to the exposure of the traumatic material of their clients'. Stamm (1999) concurs saying that what moves hope forward is often the nurturance and wisdom from one's community.

The term hope is at times used to describe aspects of spirituality (Pearlman & Saakvitne, 1995a&b), positive affect (Shapiro, Brown & Biegal, 2007), and satisfaction in life (Brady, Guy, Polestra & Brokaw, 1999). For example, clinicians with greater exposure to trauma reported greater satisfaction in life than clinicians exposed to fewer traumas (Brady, Guy, Polestra & Brokaw, 1999). The impact of private, shared and collaborative opportunities for reflection in this study, especially the arts practices, bring into question the multiple means for mindfulness stress reduction (Shapiro, Brown & Biegal, 2007).

Far more is written about clinician's sense of hopelessness than about hopefulness. It is somewhat complicated to discuss. Research shows that clinicians with higher exposure to trauma have a larger sense of personal satisfaction (Brady, Guy, Polestra & Brokaw, 1999). However, that greater exposure, when clients are sexual assault survivors, also coincides with a decrease in esteem for others. As a result, clinicians experience less enjoyment in life (Pearlman & MacIan 1995; Pearlman &

Saakvitne, 1995a&b) because participation in leisure activities, self-care and clinician supervision declines (Bober, Regehr & Zhou, 2006). A number of reasons account for these perceptions and practices, such as having intrusive thoughts about their clients' negative experiences. I speculate that November's negative thoughts about her process and product are a manifestation of a pattern of negative thinking represented in compassion fatigue scores (See Compassion Fatigue Scores in Section III of this chapter).

The impact of November's sense of hopelessness is addressed by Baranowsky's (2002) writing on the *Silencing Response*. November and other clinicians in this study expressed their feelings and behaviors related to the silencing response, such as feeling agitated and avoidant prior to meetings with their clients. Feelings of hopelessness can also coincide with a loss of humor and higher compassion fatigue scores (Moran, 2002). Loss of humor can also be an expression of clinicians' loss of hope because their real world experiences with their clients do not fit into the clinical models in which they have been trained (Pakman, 2006).

Theme: F*ear*. *Fear* was presented as an unpleasant experience that stimulated feelings and behaviors related to isolation. *Fear* correlated with the pressure the clinicians felt to maintain a level of productivity, their disappointing relationships with their colleagues, their lives away from CHS, as well as with themselves. Fear decreased with the movement of arts making activities, speaking about their experiences and with validation from the other clinicians. In Exit Interviews, clinicians described a decrease in their sense of *fear*. They wrote and spoke about the relief they felt due to Sharevision's providing for equal amounts of time for everyone to be the focus of attention and especially to be listened to. *Fear* also decreased in relationship to clinicians' shrinking

sense of isolation and increased experience of positive connection with others. Their *fear* lowered during the program along with their experiencing a heightened sense of "relevance" and "meaningfulness about our work."

Example of *fear*. Karen: *So I'll go. All I could think was what happens when I'm with a client and they start talking about their traumatic experiences. What happens is I get triggered, and this is what goes on in my mind. So I get memories. And this is what it feels like in my mind.*

My eyes are opened. I'm able to continue to talk with the client, but I feel like I have to not hear what they are saying.

And these represent my ears. I've actually said to clients, "You don't have to tell me the details. We don't have to talk about that." I've actually said that. And this (pointing to another part of her piece) *represents that I'm still able to talk with clients, and I feel I am still able to help them. So this is like "pearls of wisdom."*

Group: Laughter

There are still things coming out of my mouth but I'm trying to block what I'm hearing, and I'm very disturbed. So that's my piece.

In Karen's reflection about this piece she described the shift in her *fear* and the impact of this collaborative-reflective approach.

Karen: *For me it was great to be able to actually share what happens to me when I'm with a client and they're talking about trauma, because I don't think I've ever expressed it that freely. I knew exactly what I wanted to do. It just came to me, and, it didn't feel that scary to talk about it. I had thought it would be scary and that I'd cry. It wasn't really like that. It feels safe.*

Figure #17: Antenna & Pearls of Wisdom

Figure #18: Antenna That Tell Me Not To Hear

Karen presents the disruption to her cognitive schema, specifically in the areas of safety and trust through expressions of fear. In 2003 Cunningham found, that regardless of whether clients experienced human-induced or naturally occurring trauma, clinicians' sense of safety and trust would be altered. Not only do clinicians experience a disruption in their sense of safety and trust at work but outside of work as well (Pearlman & Saakvitne, 1995). In fact fifty percent of clinicians surveyed report they are more suspicious and distrusting of others (Pearlman & Mac Ian, 1995). Karen described that this perception of her safety and sense of trust being compromised relates to the practice of trying unintentionally to silence her clients (Baranowsky, 2002). Furthermore, some clinicians feel that they cannot provide a safe environment for their clients (Shalvi & Luzzatto, 2008).

Fear, anxiety and worry have been linked to the burden of unresolved issues among clinicians and administrators working on behalf of traumatized clients (Borkovec, Roemer, Kinyon, 1995). Think of how Karen might feel about her silencing her clients. Might her actions cause her further negative feelings? While, the general public as well as clinicians exposed to traumatic material show a heightened sense of vulnerability (Luster, 2002), the helping practitioners show more signs of vicarious trauma (Woodard, Meyers & Cornille, 2002).

Karen articulates the struggle she has managing her conflicted and incongruent practices. Both her individual behavior and her internal awareness of the collective contribution to the problems that lead to people being traumatized cause her distress (Bloom, 1999). Karen and the group apply gallows humor (Moran, 2002) at the recognition of the severity of the situation. For all these reasons Pearlman and Saakvitne

(1995a&b) recommend clinicians have supportive and confidential supervision wherein they can process the horrific material. It may be the small group setting that enabled Karen and others throughout the program to feel safe (Barlow & Phelan, 2007) enough to present what they had never done before.

Survey Findings

Findings from the four-part survey, which participants' took at the onset of the study and after their fourth independent Sharevision meeting, correspond to the qualitative data. These survey findings will be discussed as indicative of the five respondents and not as substantial findings. The Compassion Satisfaction/Fatigue Self-Test for Helpers (Figley, 1995 & Stamm 1995-1998) asked clinicians to consider their past work week when answering questions. The Trauma Recovery Scale (Gentry, 1996), the Silencing Response Scale (Baranowsky, 1996), and the Global Check Set (Baranowsky & entry, 1998) asks clinicians to complete to these surveys based on their experiences over the past two weeks. Their responses illustrate how the collaborative-reflective Sharevision model had a positive impact on decreasing their levels of secondary trauma as measured by the presence of compassion fatigue and burnout. In general it also lessened the impact of inadvertent silencing responses and increased the level of compassion satisfaction.

I examined the questions in the Compassion Satisfaction/Compassion Fatigue Self-Test in terms of practices and perceptions, which is customary within collaborative inquiry studies (Bray, 2002; Heron, 1989). Improvements in clinicians' perception of themselves and others appeared more often than with clinicians' practices, such as disturbed sleep patterns and avoidance behaviors like limiting the places they go because

they associate those places with running into their clients. This first section of the four-part survey measures risk factors for compassion fatigue and burnout, and also measures factors that further compassion satisfaction. Examples of questions that target clinicians' perceptions and practices follow.

Chart # 15: Perception: Question 36 of the Compassion Satisfaction/ Compassion Fatigue Self-Test

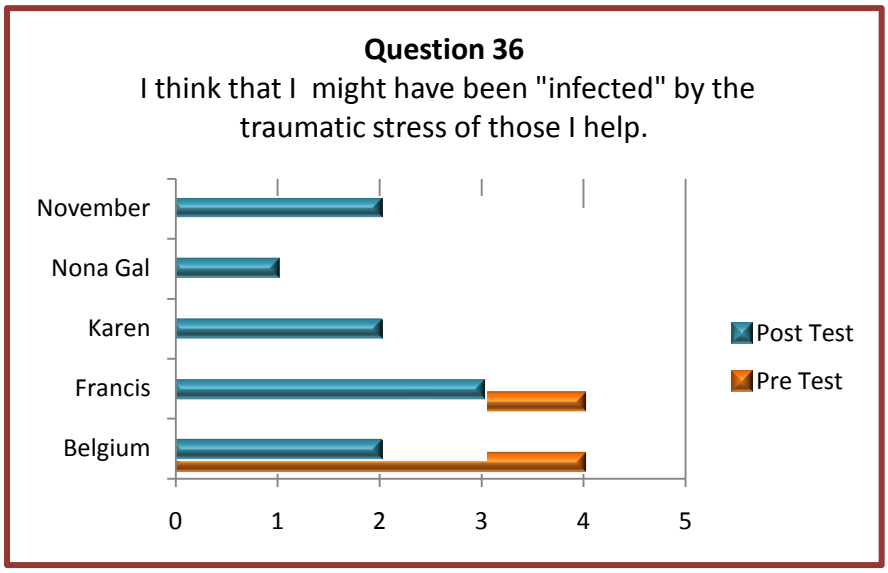
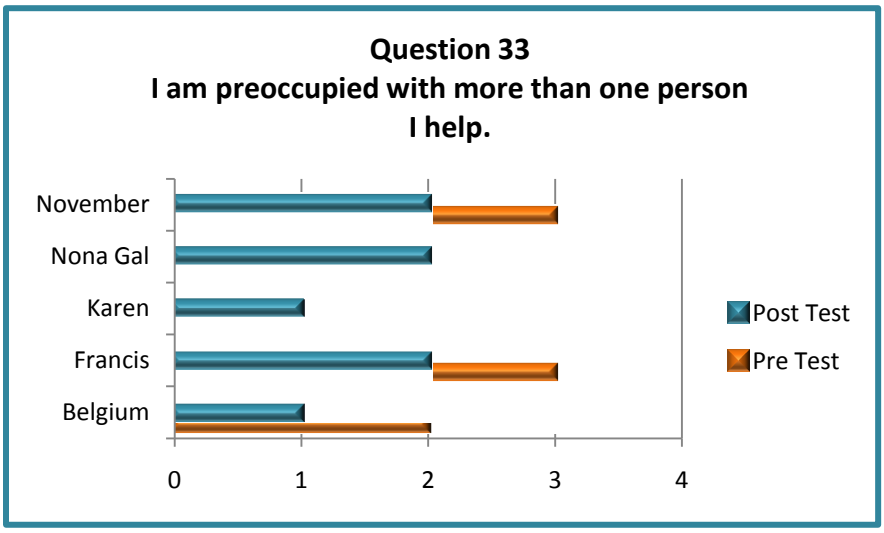


Chart # 16: Practice: Question 33 of the Compassion Satisfaction/ Compassion Fatigue Self-Test

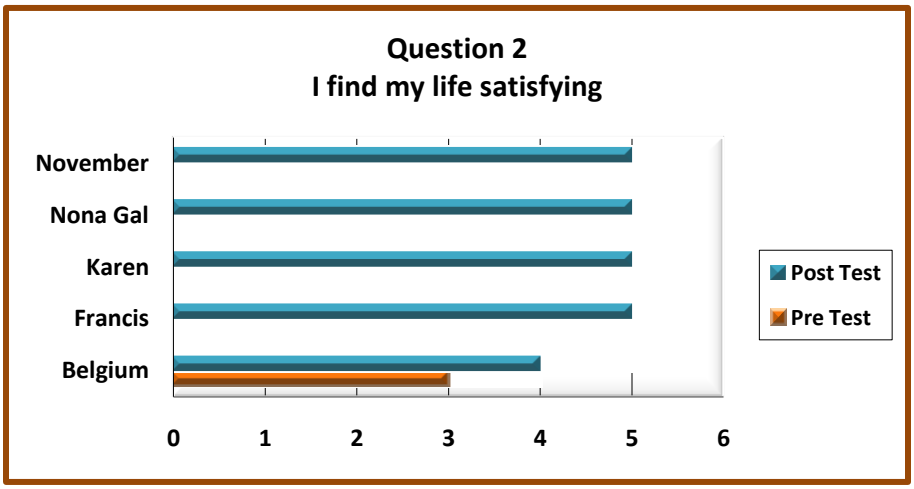


Each clinician experienced fewer signs of burnout at the end than at the beginning of this brief study. An example of how the collaborative-reflective model positively impacted these clinicians is revealed in their lowered scores on Question 24 of the Compassion Satisfaction/Compassion Fatigue Self-Test. These responses mirror clinicians' statements that the model being applied was "effective" for them.

Chart # 17: Burnout Measurement

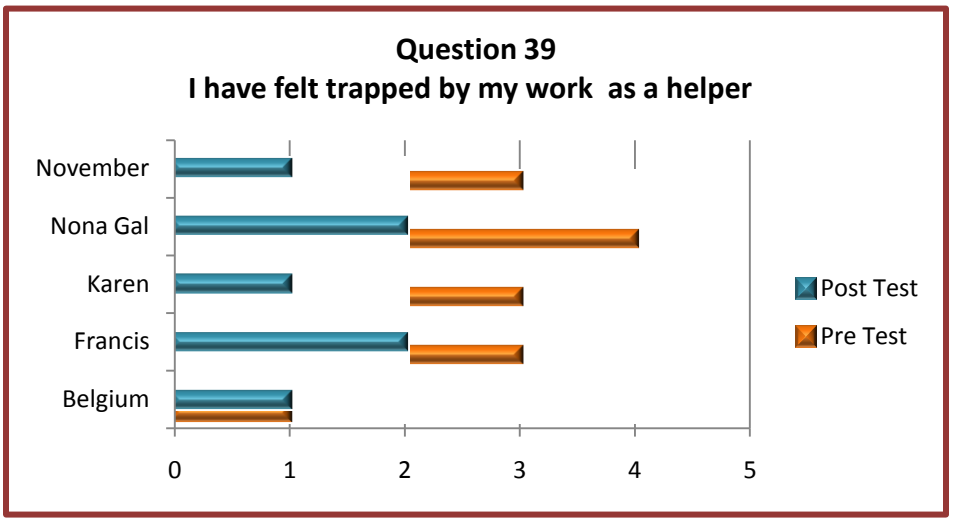
An increase in compassion satisfaction is the productive impact represented by Question 2 of the Compassion Satisfaction/Compassion Fatigue Self-Test. These findings are analogous to what clinicians said about their arts-based creations and their self-run, independent Sharevision meetings: that they were effective and satisfying.

Chart #18: I Find My Life Satisfying



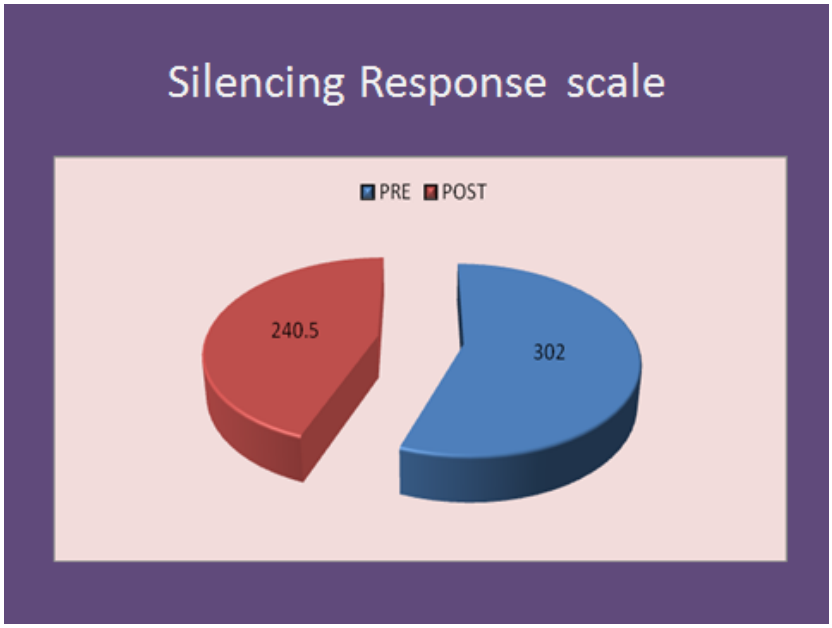
Question 39 of the Compassion Satisfaction/Compassion Fatigue Self-Test is an example of a question measuring compassion fatigue. This finding supports the importance of building community in the work place, according to clinicians' statements during the final workshop and in their Exit Interviews.

Chart # 19: Compassion Fatigue Measurement



The number of silencing responses generally dropped, a finding which appears to correlate with statements clinicians made about feeling more hopeful while participating in the workshops.

Chart # 20: Silencing Decreased



Limitations of the study

While measures were taken to support the legitimacy of identified emergent themes (Creswell, 2003; McNiff, 1998), by having three people code the transcript, and by including the full transcripts to avoid abstraction and serve as evidence (Eger, 1993), qualitative research is fundamentally interpretive (Creswell 2003). My status as a non-neutral participant-observer (Stringer, 1999) with a bias toward the collaborative-reflective Sharevision approach was made transparent from the onset of the study. It is possible that some of the participating clinicians may have censored or made an effort to please the researcher in their written responses during the Exit Interviews because of my presence in the room.

The small number of people involved also limited the study. The original design was to convene several small groups within one organization. Were that the case, survey

responses would be valid and applicable to the research question. However, in this instance the survey responses are in no way conclusive.

The overall structure of the research was changed. Clinicians were required to be in agency training and had a day off during times that were also scheduled by CHS for this research program. This led to the use of workshop time to reschedule several meetings. For these reasons, this collaborative inquiry into Sharevision as an intervention that could ameliorate the effects of secondary trauma was valid only for these clinicians. While the research can be used to inform theory, practice and future research, the findings cannot be generalized for other populations due to the limited size and scope of this study.

Recommendations for Future Research

The aim of this study was to bridge the gap in the research literature on workplace interventions for secondary trauma among psychotherapists. While these findings offer insight into the relationship between isolation and secondary trauma, and the usefulness of this collaborative-reflective, expressive arts intervention in the alleviation of secondary trauma for these clinicians, further research could provide new support.

This study was an exploration into six expressive arts integrated workshops and five independent Sharevision meetings. Benefits could be gained from additional meetings, in order for the group action project to have more time to be performed and the cycle of action and reflection to be developed further (Bray, 2002: Heron & Reason, 1997; Stringer, 1999; Yorks & Kasl, 2002).

Program evaluation studies with control groups are also recommended, wherein the number of participants is large enough for the findings to be generalized. Separating

the variables for comparison would be of value. For instance, it is possible that the expressive arts activities increased the speed of clinician's insight and ability to discuss these matters. Examination of Sharevision programs that do not include expressive arts activities alongside programs such as this study design could be informative as to the impact of expressive arts within Sharevision. Another area for investigation is the impact of Sharevision meetings without the clinician-focused workshops or the group action project? In each case neutral parties to disseminate and collect feedback from participants is recommended.

One serendipitous finding is the prevalence of high *generalized anxiety* scores on the Global Check Set survey. Future research into the normalization and acceptance of particular indicators of clinician's distress within an organization is of interest here.

Recommendations for Practice

The primary goal of this study was to explore a workplace professional development program for the alleviation of secondary trauma among mental health clinicians. This study adds to the research literature by examining the impact of a collaborative-reflective, expressive arts intervention called Sharevision in fulfilling those aims. In sum, the findings for practice include the following workplace suggestions:

1. Participate consistently in meetings to listen and act as witnesses for each other presenting on topics of relevance.
2. Include time to address personal experiences from work.
3. Share time equitably in these meetings.
4. Encourage innovation, surprising and unusual ideas.
5. Encourage differing ideas.

6. Participate in multisensory expressive arts integrated professional development.
7. Engage in individual and collaborative multisensory creativity as methods of problem solving.
8. Build connections that foster a positive sense of community.

In Summary

My aim in this research was to add to the literature on professional development by applying expressive arts and a particular collaborative-reflective approach called Sharevision to address secondary trauma in the workplace. Secondary trauma is described in detail in this dissertation through both the research literature and transcripts from this study. In essence, clinicians meeting with clients in extreme distress are at risk of experiencing negative effects due to their work. Their perception of themselves and others can decline. Both the quality of their professional and personal practices can unfortunately become tainted. Those who are most at risk are clinicians who are isolated and lack professional support for their work; have significant percentage of traumatized clients on the caseload or are administrators for these clinicians; are new to the field, and those with a personal history of traumatization. Clinicians in this study represent the population of at risk clinicians.

At the recommendation of other researchers studying secondary trauma and through my practical experience beginning in 1997, I developed a workplace intervention that integrates expressive arts, collaborative-reflection, community building and social action. I am particularly interested in the parameters of the worksite. For example, how much time can be allotted away from other responsibilities for such meetings, and clinicians' need for continuing education units, CEUs. Another concern for me was the sustainability

of practices introduced in the course. Therefore the study design is both brief, and includes clinicians' meeting independently as they might do after the research period.

The three month intervention represented by this research thesis began with clinicians completing a four part questionnaire on compassion satisfaction, compassion fatigue, burnout, silencing response and a global check of clinician's mental health status (Figley, 1995; Stamm, 1995-1998; Gentry, 1996, 1998; Baranowsky, 1996, 1998; Baranowsky & Gentry, 1998). Clinicians met six times, every other week in a facilitated workshop, for an hour and a half. During workshops they learned the collaborative-reflective design called Sharevision. On the alternating five weeks they were to meet independently with the aim of applying the Sharevision template to their clinical work. Due to scheduling conflicts within the organization the sequence of the design was altered. During the workshops clinicians engaged in expressive arts activities focused on addressing secondary trauma. In the fourth workshop they were asked to develop an idea for a group expressive arts action project. We (Baldwin & Landis, 2005; Landis, 2010) call such a collaboratively designed group intervention aesthetic action. During the fifth workshop clinicians put their ideas into action. The final workshop was dedicated to evaluating their group action project, coming up with ideas on next steps for their project, discussing the continuation of independent Sharevision meetings, planning for the completion of the survey for a second time and exit interviews.

Findings from the survey responses, transcripts and exit interviews confirm clinicians' ability to address and reduce secondary trauma in their lives. The qualitative data supports previous research showing a strong correlation between clinicians' sense of *fear* and secondary trauma. Clinicians' fear decreased during this brief intervention as

their *creativity* along with their *connection* to each other increased. Other emergent themes included their sense of *isolation*, their interest in *opening up* to each other and their experience of *hope*. All three sources of data demonstrate these clinicians' perceptions and practices as they relate to secondary trauma changed for the better. The survey results for these clinicians' show a decrease of compassion fatigue after three months in this course.

Findings from this study expose the potential of workplace interventions, which build on procedures and policy that decrease secondary trauma, were demonstrated here. The application of the Building a Resilient Practice professional development course was shown to relieve critical elements of secondary trauma. Clinicians found their independent collaborative-reflective Sharevision meetings were "effective" at addressing their concerns. During the final workshop clinicians discussed introducing others in their agency to the Sharevision format (see the Transcripts). In addition, the integration of Sharevision with expressive arts practices engaged clinicians in a process through which representative aspects of their clinical work were assembled into single unified pieces. Metaphors and prompts they conceived provided an incentive to share, explore, take risks and transform their perceptions and practices.

During this three month course, clinicians went through repeated cycles of reflection and action in both the workshops and their independent Sharevision meetings. These clinicians developed an active rather than passive approach to managing the effects of secondary trauma. Together they established a heightened sense of the "relevance" and "meaningfulness" of their work. An increase in their feelings of connection with both their colleagues and clients became apparent.

Sharevision Guidelines

Format

1. Moment of silence
2. Check-In
3. Create the agenda together
4. Divide up the time for each agenda item
5. Choose a time-keeper
6. First person presents her question.
7. The time she uses leaves the amount of time remaining for others' input. For example, if the presenter has 15 minutes and introduces her question/situation in 3 minutes, the group has 11 minutes to divide equally between them. The presenter always gets a minute or 2 of that time to make a final statement.
8. If there is time left over, divide up the time for a second go-round about the same question.
9. Next person with an agenda item presents her question, gets reflections (same as above) until all agenda topics have been presented and everyone in the meeting has shared their ideas, reflections, feelings about each topic, given the agreed upon amount of time.

Guidelines

- Be consistent about the time (time-keeper gives a warning, sharing time equally allows everyone a chance to be heard).
- Talk about yourself, tell a story or describe your own experiences or thoughts.
- Give examples of what you have tried and found rather than give advice
- Give each person her full time, rather engage in back and forth talk.
- Focus on listening not rehearsing what you are going to say ahead of time.
- Focus on understanding what others are saying while listening.
- Be brief, concise with what you have to say, practice saying things simply.
- The person who puts the topic on the agenda and/or presents the question is in charge of her section of the meeting and the process.

Variations

- When there is time left over, feel free to suggest a dialogue (if it is your time).
- If someone else's question is similar to yours, feel free to suggest that you combine the time and have longer go-rounds. (be sure both people have a chance to have a final word after the group has each shared their thoughts.)

Standards of Self Care
Green Cross Academy of Traumatology
Standards of Self Care Guidelines
Retrieved from:
http://www.greencross.org/index.php?option=com_content&view=article&id=184&Itemid=124 October 2007.

I. Purpose of the Guidelines

As with the standards of practice in any field, the practitioner is required to abide by standards of self care. These Guidelines are utilized by all members of the Green Cross. The purpose of the Guidelines is twofold: First, do no harm to yourself in the line of duty when helping/treating others. Second, attend to your physical, social, emotional, and spiritual needs as a way of ensuring high quality services who look to you for support as a human being.

II. Ethical Principles of Self Care in Practice: These principles declare that it is unethical not to attend to your self care as a practitioner because sufficient self care prevents harming those we serve.

1. Respect for the dignity and worth of self: A violation lowers your integrity and trust.
2. Responsibility of self care: Ultimately it is your responsibility to take care of yourself and no situation or person can justify neglecting it.
3. Self care and duty to perform: There must be a recognition that the duty to perform as a helper can not be fulfilled if there is not, at the same time, a duty to self care.

III. Standards of Humane Practice of Self Care

1. Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self care.
2. Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
3. Emotional Rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
4. Sustenance Modulation Every helper must utilize self restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since it can compromise their competence as a helper.

IV. Standards for Expecting Appreciation and Compensation

1. Seek, find, and remember appreciation from supervisors and clients: These and other activities increase worker satisfactions that sustain them emotionally and spiritually in their helping.

2. Make it known that you wish to be recognized for your service: Recognition also increases worker satisfactions that sustain them.
3. Select one or more advocates: They are colleagues who know you as a person and as a helper and are committed to monitoring your efforts at self care.

V. Standards for Establishing and Maintaining Wellness

Section A. Commitment to self care

1. Make a formal, tangible commitment: Written, public, specific, and measurable promises of self care.
2. Set deadlines and goals: the self care plan should set deadlines and goals connected to specific activities of self care.
3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self care.

Section B: Strategies for letting go of work

1. Make a formal, tangible commitment: Written, public, specific, and measurable promise of letting go of work in off hours and embracing rejuvenation activities that are fun, stimulating, inspiriting, and generate joy of life.
2. Set deadlines and goals: The letting go of work plan should set deadlines and goals connected to specific activities of self care.
3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self care.

Section C. Strategies for gaining a sense of self care achievement

1. Strategies for acquiring adequate rest and relaxation: The strategies are tailored to your own interest and abilities which result in rest and relaxation most of the time.
2. Strategies for practicing effective daily stress reductions method(s): The strategies are tailored to your own interest and abilities in effectively managing your stress during working hours and off-hours with the recognition that they will probably be different strategies.

VI. Inventory of Self Care Practice -- Personal

Section A: Physical

1. Body work: Effectively monitoring all parts of your body for tension and utilizing techniques that reduce or eliminate such tensions.
2. Effective sleep induction and maintenance: An array of healthy methods that induce sleep and a return to sleep under a wide variety of circumstances including stimulation of noise, smells, and light.

3. Effective methods for assuring proper nutrition: Effectively monitoring all food and drink intake and lack of intake with the awareness of their implications for health and functioning.

Section B: Psychological

1. Effective behaviors and practices to sustain balance between work and play
2. Effective relaxation time and methods
3. Frequent contact with nature or other calming stimuli
4. Effective methods of creative expression
5. Effective skills for ongoing self care
a. Assertiveness
b. Stress reduction
c. Interpersonal communication
d. Cognitive restructuring
e. Time management
6. Effective skill and competence in meditation or spiritual practice that is calming
7. Effective methods of self assessment and self-awareness

Section C: Social/interpersonal

1. Social supports: At least five people, including at least two at work, who will be highly supportive when called upon
2. Getting help: Knowing when and how to secure help – both informal and professional – and the help will be delivered quickly and effectively
3. Social activism: Being involved in addressing or preventing social injustice that results in a better world and a sense of satisfaction for trying to make it so

VII. Inventory of Self Care Practice – Professional

1. Balance between work and home: Devoting sufficient time and attention to both without compromising either.
2. Boundaries/limit setting: Making a commitment and sticking to regarding
a. Time boundaries/overworking
b. Therapeutic/professional boundaries
c. Personal boundaries
d. Dealing with multiple roles (both social and professional)
e. Realism in differentiating between things one can change and accepting the others

3. Getting support/help at Work through
a. Peer support
b. Supervision/consultation/therapy
c. Role models/mentors
4. Generating Work Satisfaction: By noticing and remembering the joys and achievements of the work

VIII. Prevention Plan development

1. Review current self-care and prevention functioning
2. Select one goal from each category
3. Analyze the resources for and resistances to achieving goal
4. Discuss goal and implementation plan with support person
5. Activate plan
6. Evaluate plan weekly, monthly, yearly with support person
7. Notice and appreciate the changes

Receive free CEU's for participating in a twelve-week course on *Building a Resilient Practice*. Licensed clinicians are invited to participate in a research project designed to help you assess the impact of your work on you and help you find ways to make your practice more personally satisfying. If you are interested in being considered for the study, *click here* for more information.

Building a Resilient Practice
9 CEUs
(APA approved, SW pending)

Limited Enrollment, register soon!
Choose a time that works for you.

Mondays mornings 9:00 -10:30
Friday mornings 9:00 -10:30
A third group is possible as small groups are ideal.

Beginning: The week of October 6, 2008

This twelve-week course offered to licensed clinicians includes a series of 6 workshops meeting every other week, which will cover the following topics:

- how to identify the signs of burnout and secondary trauma
- how to collaborate with colleagues to reflect on the impact of work with clients on the clinician
- how to address the needs of clinicians to feel more fulfilled in their work
- how to sustain yourself when working with clients is taxing and when it is invigorating
- how to support colleagues and use this support to build a more balanced life
- how to use the support of colleagues to be more creative at work

The program is designed to address vicarious trauma and to prevent burnout among clinicians. The approach to relieving the stresses associated with caring for others who have experienced profound pain, is creative, supportive and proactive. Integrated into the course are simple creative arts activities to make the experiential training informative as well as enjoyable.

Participants will be asked to complete a pre and post class survey. During the six workshops, participants will be taught, and practice a highly structured peer support model to discuss their unique and shared experiences of their work. In the five weeks

between the bi-monthly workshops, participants agree to use the group discussion model to focus on their client's and clinical issues, meeting at the same time and location.

Course Objectives

Participants will be able to:

1. Understand and identify signs of secondary trauma and burnout
2. Recognize research implications of secondary trauma and resilience
3. Develop skills to reduce isolation
4. Identify sustainable tools for resilience

Clinicians who have participated in this program have made positive changes in their practice and enjoy the benefits in their personal life.

Prior participants have reported:

"The format of meetings is so well structured that it gives space for our putting out information without being interrupted, making the conversation in the room so much safer and more valuable." Clinician, Boston MA

"I've deepened respect for my colleagues." Clinician, Brookline, MA

"The tools I learned in this program have been really helpful in extremely difficult situations." Clinician, Cambridge, MA

Ellen Landis is a licensed marriage and family therapist and Ph.D. candidate in expressive arts therapies at Lesley University. She has worked for over 20 years with people who have experienced primary trauma. The design of this program is based on years of experience as a clinician, clinical supervisor, educator and researcher. Ellen is offering this program for research towards her Ph.D.

To apply for or discuss any questions about this program, contact Ellen directly at her office 413.586.5800 x 2 or email her at Ellen@Sharevision.net

Appendix D

Compassion Satisfaction/Fatigue Self-Test for Helpers

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self -test helps you estimate your compassion status: This includes your risk of burnout, compassion fatigue and satisfaction with helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics **in the last work week**. Then follow the scoring directions at the end of the self-test.

0 Never	1 Rarely	2 A Few Times	3 Somewhat Often	4 Often	5 Very Often

Items About You

____1. I am happy.
____2. I find my life satisfying.
____3. I have beliefs that sustain me.
____4. I feel estranged from others.
____5. I find that I learn new things from those I care for.
____6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
____7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
____8. I have gaps in my memory about frightening events.
____9. I feel connected to others.
____10. I feel calm.
____11. I believe that I have a good balance between my work and my free time.
____12. I have difficulty falling or staying asleep.
____13. I have outburst of anger or irritability with little provocation
____14. I am the person I always wanted to be.
____15. I startle easily.
____16. While working with a victim, I thought about violence against the perpetrator.
____17. I am a sensitive person.
____18. I have flashbacks connected to those I help.

____19. I have good peer support when I need to work through a highly stressful experience.
____20. I have had first-hand experience with traumatic events in my adult life.
____21. I have had first-hand experience with traumatic events in my childhood.
____22. I think that I need to "work through" a traumatic experience in my life.
____23. I think that I need more close friends.
____24. I think that there is no one to talk with about highly stressful experiences.
____25. I have concluded that I work too hard for my own good.
____26. Working with those I help brings me a great deal of satisfaction.
____27. I feel invigorated after working with those I help.

Compassion Satisfaction/Fatigue Self-Test for Helpers - CONTINUED

0 Never	1 Rarely	2 A Few Times	3 Somewhat Often	4 Often	5 Very Often

____28. I am frightened of things a person I helped has said or done to me.
____29. I experience troubling dreams similar to those I help.
____30. I have happy thoughts about those I help and how I could help them.
____31. I experienced intrusive thoughts of times with especially difficult people I helped.
____32. I have suddenly and involuntarily recalled a frightening experience while working with a
person I helped.
____33. I am preoccupied with more than one person I help.
____34. I am losing sleep over a person I help's traumatic experiences.
____35. I have joyful feelings about how I can help the victims I work with.
____36. I think that I might have been "infected" by the traumatic stress of those I help.
____37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
____38. I remind myself to be less concerned about the well being of those I help.
____39. I have felt trapped by my work as a helper.
____40. I have a sense of hopelessness associated with working with those I help.
____41. I have felt "on edge" about various things and I attribute this to working with certain
people I help.
____42. I wish that I could avoid working with some people I help.
____43. Some people I help are particularly enjoyable to work with.
____44. I have been in danger working with people I help.
____45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

____46. I like my work as a helper.
____47. I feel like I have the tools and resources that I need to do my work as a helper.
____48. I have felt weak, tired, run down as a result of my work as helper.
____49. I have felt depressed as a result of my work as a helper.
____50. I have thoughts that I am a "success" as a helper.

____51. I am unsuccessful at separating helping from personal life.
____52. I enjoy my co-workers.
____53. I depend on my co-workers to help me when I need it.
____54. My co-workers can depend on me for help when they need it.
____55. I trust my co-workers.
____56. I feel little compassion toward most of my co-workers
____57. I am pleased with how I am able to keep up with helping technology.
____58. I feel I am working more for the money/prestige than for personal fulfillment.
____59. Although I have to do paperwork that I don't like, I still have time to work with those help.
____60. I find it difficult separating my personal life from my helper life.
____61. I am pleased with how I am able to keep up with helping techniques and protocols.
____62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
____63. I have thoughts that I am a "failure" as a helper.
____64. I have thoughts that I am not succeeding at achieving my life goals.
____65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
____66. I plan to be a helper for a long time.

J. Eric Gentry, MA, CAC, CTS **TRS**

T R A U M A R E C O V E R Y S C A L E

PART I

___yes ___no I have been exposed to a traumatic event in which ***both*** of the following were present:

a. experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, ***AND***

b. my response involved intense fear, helplessness or horror.

- If **yes** is answered please complete Part II & III;
- If **no** is answered complete Part III (omit Part II)

****

PART II

Directions: Please read the following list and check all that apply.

Type Of Traumatic Event	# of Times	Dates/Ages
□ 1. Childhood Sexual Abuse	_____ _	____ _____ _____
□ 2. Rape	_____	_____ _____ _____
□ 3. Other Adult Sexual Assault/Abuse	_____	_____ _____ _____
□ 4. Natural Disaster	_____	_____ _____ _____
□ 5. Industrial Disaster	_____	_____ _____ _____
□ 6. Motor Vehicle Accident	_____	_____ _____ _____
□ 7 Combat Trauma	_____	_____ _____ _____
□ 8. Witnessing Traumatic Event	_____	_____ _____ _____
□ 9. Childhood Physical Abuse	_____	_____ _____ _____
□ 10. Adult Physical Abuse	_____	_____ _____ _____
□ 11. Victim Of Other Violent Crime	_____	_____ _____ _____
□ 12. Captivity	_____	_____ _____ _____
□ 13. Torture	_____	_____ _____ _____
□ 14. Domestic Violence	_____	_____ _____ _____
□ 15. Sexual Harassment	_____	_____ _____ _____
□ 16. Threat of physical violence	_____	_____ _____ _____
□ 17. Accidental physical injury	_____	_____ _____ _____
□ 18. Humiliation	_____	_____ _____ _____
□ 19. Property Loss	_____	_____ _____ _____
□ 20. Death Of Loved One	_____	_____ _____ _____
□ 21. Other:_____	_____	_____ _____ _____
□ 23. Other:_____	_____	_____ _____ _____
□ 24. Other:_____	_____	_____ _____ _____
□ 25. Other:_____	_____	_____ _____ _____

Comments:

_____

_____

_____

_____

TRS T R A U M A R E C O V E R Y S C A L E
PART III
Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

2. I sleep free from nightmares.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

3. I am able to stay in control when I think of difficult memories.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

5a. I am safe.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

5b. I feel safe.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

6. I have supportive relationships in my life.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

7. I find that I can now safely feel a full range of emotions.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

8. I can allow things to happen in my surroundings without needing to control them.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

9. I am able to concentrate on thoughts of my choice.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

10. I have a sense of hope about the future.

._____._____._____._____._____._____._____._____._____._____.
0% 100% of the time

SCORE: _____

Silencing Response Scale (Baranowsky, 1996, 1998)

INSTRUCTIONS: This scale was developed to help caregivers identify specific communication struggles in their work. Choose the number that best reflects your experience using the following rating system, where 1 signifies rarely or never and 10 means very often. Answer all items to the best of your ability as they reflect your feelings over the previous two work weeks.

1=Rarely/Never --------2----------3--------4---------5--------6--------7--------8--------9------ 10=Always Sometimes

(1)____ Are there times when you believe your client(s) is repeating emotional issues you feel were already covered?

(2)____ Do you get angry with client(s)?

(3)____ Are there times when you react with sarcasm toward your client(s)?

(4)____ Are there times when you fake interest?

(5)____ Do you feel that listening to certain experiences of your client(s) will not help?

(6)____ Do you feel that letting your client talk about their trauma will hurt them?

(7)____ Do you feel that listening to your client's experiences will hurt you?

(8)____ Are there times that you blame your client for the bad things that have happened to them?

(9)____ Are there times when you are unable to believe what your client is telling you because what they are describing seems overly traumatic?

(10)____Are there times when you feel numb, avoidant or apathetic before meeting with certain clients?

(11)____Do you consistently support certain clients in avoiding important therapeutic material despite ample time to address their concerns?

(12)____Are there times when sessions do not seem to be going well or the client's treatment progress appears to be blocked?

(13)____You become negatively aroused when a client is angry with you.

(14)____Are there times when you cannot remember what a client has just said?

(15)____Are there times when you cannot focus on what a client is saying?

TOTAL = _____

GLOBAL CHECK SET (**GCS**, Baranowsky & Gentry, 1998)

Name:_____ Date:_____ Birth Date:_____ Sex: M, F

Instructions: Read through each statement responding to items in a manner that best describes your experience over the previous 2 work weeks. Some questions relate to the present and some to the past, respond accordingly.

	Never	Some	Almost	Rarely	Frequently		
					times		Always
1-a. I drink alcoholic beverages daily.	□ 0	□ 1		□ 2		□ 3	□ 4
2-d. I feel sad, empty or become tearful.	□ 0	□ 1		□ 2		□ 3	□ 4
3-s. I feel hopeless or worthless.	□ 0	□ 1		□ 2		□ 3	□ 4
4-p. I have been exposed directly or indirectly (i.e., family, friend) to a traumatic event.		□ 0		□ 1		□ 2	□ 3 □ 4
5-x. I worry and feel anxious.		□ 0		□ 1		□ 2	□ 3 □ 4
6-i. My body is usually pain free.	□ 4	□ 3		□ 2		□ 1	□ 0
7-c. I am unable to clearly recall past traumatic experiences.		□ 0		□ 1		□ 2	□ 3 □ 4
8-a. I use illegal drugs daily.	□ 0	□ 1		□ 2		□ 3	□ 4
9-d. My sleep is disrupted or I awake tired.	□ 0	□ 1		□ 2		□ 3	□ 4
10-s. I have a positive and cheerful attitude to life.	□ 4	□ 3		□ 2		□ 1	□ 0
11-p. I have frequent recollections to a traumatic incident. (i.e., thoughts, dreams, flashbacks).	□ 0	□ 1		□ 2		□ 3	□ 4
12-x. I seem to be unable to control my worries or fears		□ 0		□ 1		□ 2	□ 3 □ 4
13-i. I worry about my health.		□ 0		□ 1		□ 2	□ 3 □ 4
14-c. I do not know how I came to be at some place.	□ 0	□ 1		□ 2		□ 3	□ 4
15-a. Drug or alcohol use interferes with my work ability.		□ 0		□ 1		□ 2	□ 3 □ 4
16-d. I am no longer interested in the activities I used to enjoy.		□ 0		□ 1		□ 2	□ 3 □ 4
17-s. I think about ending my life.	□ 0	□ 1		□ 2		□ 3	□ 4

18-i. I have not been well due to diagnosed physical illness(es). □ 0 □ 1 □ 2 □ 3 □ 4

19-c. I easily recall important personal information about myself. □ 4 □ 3 □ 2 □ 1 □ 0

20-a. Drugs/alcohol have negatively impacted my personal life. □ 0 □ 1 □ 2 □ 3 □ 4

21-d. I have a lot of energy. □ 4 □ 3 □ 2 □ 1 □ 0

22-s. I have a specific plan to end my life. □ 0 □ 1 □ 2 □ 3 □ 4

23-p. I am quick to anger. □ 0 □ 1 □ 2 □ 3 □ 4

24-x. I always feel on edge. □ 0 □ 1 □ 2 □ 3 □ 4

25-i. I have frequent headaches. □ 0 □ 1 □ 2 □ 3 □ 4

26-c. I act out of character and feel I don't know myself. □ 0 □ 1 □ 2 □ 3 □ 4

27-a. Drugs or alcohol are a problem in my life. □ 0 □ 1 □ 2 □ 3 □ 4

28-d. I have lost or gained more than 10 lbs. recently. □ 0 □ 1 □ 2 □ 3 □ 4

29-s. I fear that my life will never improve. □ 0 □ 1 □ 2 □ 3 □ 4

30-p. I avoid people, places or things that are trauma reminders. □ 0 □ 1 □ 2 □ 3 □ 4

31-x. My concentration is good. □ 4 □ 3 □ 2 □ 1 □ 0

32-i. I am afraid I will become seriously ill in the future. □ 0 □ 1 □ 2 □ 3 □ 4

33-c. I feel outside of myself - detached like an observer. □ 0 □ 1 □ 2 □ 3 □ 4

34-p. I am fairly relaxed and do not startle easily. □ 4 □ 3 □ 2 □ 1 □ 0

35-x. I feel irritable most of the time. □ 0 □ 1 □ 2 □ 3 □ 4

_____ + _____ + _____ + _____ + _____ + _____ + _____ = _____
d a s p x i c TOTAL GSC SCORE

COMPASSION FATIGUE ASSESSMENT PROFILE

1. Compassion Satisfaction/Fatigue Self Test (Stamm & Figley, 1998, 1995)

Measures

- Compassion Satisfaction
- Compassion Fatigue
- Burnout

Scoring

- Circle the following 23 items: 4, 6-8, 12-13, 15-16, 18, 20-22, 28-29, 31-34, 36, 38-40, 44.
- Put a check by the following 17 items: 17, 23-25, 41-42, 45, 48, 49, 51, 56, 58, 60, 62-65.
- Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
- (Add the numbers you wrote next to the items for each set of items and note:)
- Add all circled numbers for your *Compassion Fatigue risk factor*: TOTAL = _____

26 or less=extremely low risk; 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

- Add all numbers with checks beside them for your *Burnout risk:* TOTAL = _____

36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.

- Add all numbers marked with an "X" for *Compassion Satisfaction factor:* TOTAL= _____

118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63-0=low potential.

2. Trauma Recovery Scale (Gentry, 1996, 1998)

Measures

- PART I: Respondent's belief whether or not they meet Criterion A. (DSM-IV) for PTSD. This refers to whether they have been exposed directly or indirectly to a traumatic incident.
- PART II: History of traumatic experiences
- PART III: Relative recovery and stabilization from traumatic experiences.

Scoring

- PARTS I & II do not require scoring.
- PART III: Take the mean of the two answers for item #5 and add to the scores on all other items. Divide by ten and you will arrive at a mean score. If score is < 50 then significant traumatic stress; If score is > 75 then significant recovery (or minimal traumatic stress).
-

- **3. Silencing Response Scale (Baranowsky, 1996, 1998)**

Measures

- The silencing response

Scoring

- To score total all response scores to arrive at the sum of scores.
- High risk = 95 - 150; Moderate risk = 41 - 94; Some risk = 21 - 40; Minimal risk = 0 - 20.

4. Global Check Set (Baranowsky & Gentry, 1998)

Measures

- Psychological Disorders - including **Depression (d)** (# 2, 9, 16, 21, 28), **Substance Use (a)** (# 1, 8, 15, 20, 27), **Suicidality (s)** (# 3, 10, 17, 2, 29), **PTSD (p)** (# 4, 11, 23, 30, 34), **Generalized Anxiety Disorder (x)** (# 5, 12, 24, 31, 35), **Somatization (i)** (# 6, 13, 18, 25, 32), and **Dissociation (c)** (# 7, 14, 19, 26, 33).

Scoring

- Total sum of scores as listed on scale items (Total GSC Score)
- For greater clarification total subscores for subscales above (d, a, s, p, x, i, c)
- Higher Scores signify greater psychological distress - compare scores over time
- Scores of $\geq$ 70 = significant psychological symptomatology
- This scale is not to be used for diagnostic purposes.

Retrieved from (http://www.mhca.com/2History.asp) January 12, 2010.

Mental Health Corporations of America (MHCA)

History

In the 1980s, a number of changes were occurring within the health care industry which directly impacted the mental health provider network. The emergence of new forces were determining where and how the health care dollar would be spent. The health care industry today is characterized by aggressive competition for that dollar.

- General and private psychiatric hospitals, due to increasing competition and decreasing bed utilization, were looking beyond their traditional inpatient, general medical model for new markets and a new array of income-generating services. In addition, other providers not traditionally involved in the provision of psychiatric care were entering the market.

- Insurance providers were being asked to consider mental health as a legitimate part of health coverage. The types of treatment being covered, and the duration and scope of treatment, were under constant review and revision.

- Government, insurance companies, and private employers were pressuring the health care industry to curtail rising costs. As a result, the economic structure of the health care industry made fundamental changes from cost-based reimbursement for health care providers to competitive market pricing. Those purchasers expanded their influence over how, where, and at what price the aggregate consumer would receive services.

- The public funding base for mental health was under increasing pressure, and a greater share of the responsibility being shifted to the private sector through contractual arrangements.

These changes created a number of potential problems for community mental health providers. Many mental health centers were experiencing an increase in competition either from private practitioners in their local community or from private organized care facilities. While some centers viewed this competition as healthy, or as meeting a need in the community, most were very concerned about the implications of these developments for their own operations.

Because of these and other factors, a group of executive directors of community mental health centers across the country met several times during 1984 to discuss solutions to the above described problems. They recognized that it was necessary for centers to re-evaluate their basic

mission. The inevitable conclusion was that centers could not continue to view themselves as solely a part of the mental health care delivery system, but rather a part of a much broader health care system.

Despite general agreement with this conclusion, the dilemma most centers faced was in finding a way to compete effectively in the marketplace. Limited funding, lack of marketing expertise, an image as public or quasi-public agencies for the indigent, relatively small size, and a history of operation based on humanitarian rather than economic concerns, left most centers ill-equipped to deal effectively with these problems.

However, strategies for dealing with the competition were already beginning to form; some directors adopted aggressive counter-marketing strategies, and others took a "wait and see" attitude. Those centers who made up the original group forming MHCA realized that a "wait and see" attitude would accomplish nothing more than allowing others to determine for them their future scope of activities, responsibilities and funding. From that realization emerged the Mental Health Corporations of America, Inc.

In September 1984, nineteen chief executive officers of community mental health centers met in Orlando, Florida for the purpose of forming the Mental Health Corporations of America, Inc. (MHCA). They hired a consultant to help them organize and search for a chief executive officer for the corporation. From that original 19 members, MHCA has grown to a 2006 membership of 139 members across the country.

Appendix F

Workshop Transcripts

Transcripts Doctoral Research
Building A Resilient Practice

Workshop #1 ~ 10.10.2008
Workshop #2 ~ 10.17.2008
Workshop #3 ~ 10.31.2008
Workshop #4 ~ 11.14.2008
Workshop #5 ~ 11.21.2008
Workshop #6 ~ 12.12.2008

Sharevision #1 10.02.2008 @ 12-1:00
Sharevision #2 11.07.2008 @ 9-10:30
Sharevision #3 12.05.2008 @ 9-10:30
Sharevision #4 12.19.2008 @ 9:10:30
Sharevision #5 01.09.2009 @ 9-10:00

10/10/08
Workshop One
Digital Recorder A2

Ellen: Are we really recording? That is fantastic.
(Nothing was recorded in the welcome and initial overview of the program or about the consent forms until they were signed. The group has told me they prefer the term "compassion fatigue" over all the others I mentioned that included the word trauma.)

Ellen: Let me tell you about the survey.
This is a pre and post program standardized survey that many, many people have taken. You are not alone. A lot of personal information is requested. It helps us to understand clinicians.

Take your time going through it. You can come up with a name, a pseudonym. Write it on the last page. You don't have to let anyone else see it. This is for you.

I have clipboards to lean against if anyone wants to sit back from the table.

Francis: That would be nice.

Ellen: We'll discuss what it was like for you to do afterwards.

(Quiet while participants complete survey.)

Karen: I have a question on no. 28. 'I am frightened of things a person I helped has said or done to me.'

Are you thinking of fear of violence or something more general?

Ellen: You can answer it either way. If it feels like it answers the question in terms of fear, for instance if a client made a come-on, or said, "I can't wait to see you in town," you can answer it about fear, about dread.

Karen: Okay, okay. The question is about fear not just about violence.

November: What was the question you were just asking about? Number 28? Now I'm up to it.

Karen: I thought it was about violence by a client, but Ellen said it's more about general fear, not just of violence.

Ellen: "I can't wait to see you at church next week." Do you feel fearful about that? Do you feel uncomfortable about it? It could be your client says something like, "How beautiful your sweater is." Something that creeps you out, and you don't want to hear again.

November: Okay, sure.

Francis: What's coming up is that I'm oscillating. I want to do 4.5's on everything. It's happening enough. Do I just make choices about it?

Ellen: I think that makes a lot of sense. I do.

Francis: I have a lot of contradictory things. I have supports, and then I have deficits, and they are both there.

Ellen: Right. That's standard for surveys. They ask questions a million different ways.

Karen: I'm having a hard time answering it about the last work week. I have to keep reminding myself.

Ellen: Don't worry about it. It's really about how you are responding today. How you feel today. It's generalized for the last work week. Some people would say that this week has been better because I got off for the holiday yesterday. But, in general, this is how I feel.

Ellen: I don't want you to feel that this is too strict in some way.

(Ellen's voice has softened, and is quieter during the survey.)

Francis: "Positively inoculate." I haven't heard that.

Karen: Yeah, I've never heard that one.

Francis: Me either. It's a really interesting one, number 37. A good question.

(Silence)

Karen: Number 59, are there some words left out? Because I'm trying to make sense of it. (No. 59:) "Although I have to do paperwork that I don't like, I still have time to work with those I help."

Ellen: "those I help."

Karen: Oh, you mean those "I help." Do you mean clients?

Ellen: Yes

Francis: Can you say one more time about what is meant by answering for this work week?

Ellen: I'm interested in you having a chance to respond to this based on your general experience of yourself at this point. People generally feel that by being ruthlessly honest they get the most out of it. So, there is not a sense of I should or shouldn't have said, "that is really me."

Francis: Number 58: "I'm working for the money and prestige."

Ellen: I see you smile.

Group: Laughter

Francis: Probably people working in different environments have this more or less.

November: What do we mean by "helping technology"? "I am pleased about how I am able to keep up with helping technology." Does that mean the system we use to do our paper work?

Ellen: Yes, it could be the system for doing your paperwork, the agency intranet, or how you have colleagues help you with online training vs. in-person training. For some people it's very frustrating that there is a lot of new technology, and they are concerned about keeping up with it.

Karen: On the trauma recovery scale, when they say "accidental physical injury", are they asking about falling and getting a bruise or something more serious?

Ellen: Any injury.

November: What are those voices? Are they from the parking lot?

Group: Yes, they are. You can hear it right through the building.

Ellen: I wasn't expecting a conversation about a teddy bear.

Group: Soft laughter

(Quiet)

Ellen: We will have a little debriefing time after this. This is very heavy stuff.
(Ellen senses the intensity increase as people consider the survey questions.)

(Quiet)

Karen: On the Silencing Response Scale, do you mean really getting angry at clients or feeling angry?

Ellen: You can respond to it about feeling and/or acting angry. What it is getting at is your recognition of your experience.

Francis: It's interesting because it's different with different clients.

November: I experience being more anxious that angry.

Ellen: Yes, that is all right to answer, too. It might be angry, despairing, anxious.

(Quiet)

Nona Gal: Ellen, did you want us to do the scores on the sheet?

Ellen: No.

Did you come up with your pseudonym? Write the pseudonym on the last page of your survey. I'll keep them in a confidential file until you do the survey after the program. I won't write your last names on this key.

Karen: Are we supposed to pick a name or a word?

Ellen: Either.

Karen: There are just too many.

Group: Laughter

Ellen: There are "Gloria," "Suzette," "Star Power" …

(Long silence)

(Ellen whispers to Karen, who finishes so that she can use the arts supplies that are out on the table to doodle with or make a piece expressing what she felt like doing the survey.)

(Ellen repeats this to the next person, November, who has finished. When everyone completes the survey Ellen accentuates taking a big full breath before starting to talk.)

Francis: "TRS" Is this over a lifetime or a specific amount of time?

Ellen: Points to explanation.

Francis: Okay.

Ellen: (Breathes, sighs before talking) I'll tell you about why we use art, and then discuss it. Then you'll get to make your first piece here. The reason we use the arts is not only because I find it helpful, but today through neuroscience we understand that by activating the creative centers of the brain, trauma is processed more quickly, rapidly.

We use the crayons and all to help in the processing of compassion fatigue: all the traumatic material of your clients, the poverty, racism and violence, and loss, death and dying, all the things that you deal with everyday.

Now of course I wish I had more time with you to discuss your experience of filling out the questionnaire. It's always very heavy for people. Is there a word you can put to it…? Okay, we have one grunt and one sigh.

Group: Laughter, Yeses

Francis: It's confusing to consolidate certain experiences into a form. I want to be coherent about it. To actually feel like I'm communicating clearly, given the form and my experience. That it is useful meeting and that it didn't just happen.

Ellen: Right, I wish we had our hour and a half from here to discuss the experience.

Group: Yeses

Ellen: We could do the survey and then have time afterwards. Actually, it would be good to have more time to lead up to it, to prepare yourselves for filling it. Especially because we don't usually talk about these things. Other feedback?

Karen: It helped me to focus on where I am right now in different places in my life. It was very focusing. Very revealing

Ellen: Powerfully revealing. You may feel the reverberations of this for a couple of days. Thank goodness we have a period of weeks to work on different aspects of all this.

Karen: Yeah, and we're meeting next Friday.

Ellen: I'm glad about that. We'll meet next Friday and get going about what to do about all this.

Nona Gal: As a student I feel survey-savvy right now. I'm taking a lot of them. I'm fresh at it. Of course they're all different. I have an attention span for about one page. I was questioning myself and noticing what I was saying as I was trying to be as accurate as possible.

Ellen: I have to ask, did anyone find any moment where they didn't want to say what their real experience is?

November: Yeah.

Ellen: Most of us have that.

November: It is hard to evaluate what number on the continuum.

Karen: It was more about saying more or less than would I tell at all.

Francis: It left me wondering. So I wanted to comply. But I had to compartmentalize myself.

Ellen: It is very difficult to do. It's six pages. It's a huge survey. Thank you so much for doing it. I hope you feel lifted by the thousands of people who have already done it. None of us would come into this room with such a collective understanding of compassion fatigue unless others had done these surveys.

Let's synchronize our watches. I'm thinking the clock is a little fast. There is always a mystery to the real time around here.

November: I have almost twenty after.

Ellen: I do too. Okay then it's just one minute slow then?

November: Yes.

Ellen: I'd like to give everyone time to do a very quick piece with these materials (pointing to the arts supplies on the table) about "when you recognized the stress of the job was having a negative effect on you."

Karen: Meaning words?

Ellen: It can be any form you want. Then we'll take three minutes to talk afterwards. You can use any of the supplies here to express in words or images when you recognized the stress of this work was having a negative effect on your life. Is 'negative' an okay word for you?

Group: Yeses

Ellen: I'll keep an eye on the time so we have a chance to come back and discuss the project.

I'm trying to not overwhelm you with too many choices on this first meeting. I'll bring some other things to work with next time. I'll be bringing different sorts of things each time.

November: I'm glad we don't have to do this in words.

(Quiet while people are assembling their pieces.)

Ellen: You don't have to. We have just one to three minutes left.

Francis: Mine is very simple, so I'm taking my time.

Ellen: It's amazing what you can do whether you have a lot of time or a short amount of time. Even if you don't get a chance to finish the piece, getting started is good enough. I do want you to be freed up for 10:30.

Take a last minute to finish up.

Everybody's got the idea of their piece? All right, I need to introduce you to the model we'll use throughout this course. I'm delighted we'll be getting together next week, so I'll have more time to go over it.

In this model each person gets a chance to share what their piece is about. Then usually we invite others to comment. They are not critical comments obviously. They are more associative, such as: 'I am reminded of…' rather than directive, such as, 'You should try'… responses.

I'll help you along with it as we get going.

I think we've got a moment to introduce yourself and your piece. Just a few sentences for today since we have to finish up. Does anybody want to start?

Francis: I'll do mine since mine is pretty simple. I didn't think about the first time but more recently. I have a really difficult history myself. And I've done a lot, a lot, of work. There was a time last year or two that I realized my healing process might not be going along as quickly as I want it to, because I kept working with people with similar struggles. It worried me for a while. Besides the fact that the work I do informs my healing. I worried that I'm not going to get well or as well I want to get working with the same kind of people I've been working with. That was a kind of a hard moment. But, I think I slipped past that. It was hard because I thought "I've worked so hard to do what I do and maybe I can't get well." I had to stay with that for a while.

So (showing her piece) what I saw was this pink Me, my healing and the tender parts of me, and all of a sudden not quite knowing how I was being affected in the environment where I work. And not knowing if those two things were going to be okay. So this is what came out of it right now.

Nona Gal: I think I needed more time to think about this (shows her piece). I ended up going with the first thing that came to me. Avoiding certain places where I know clients will be at. Not like the obvious places but the general places like the mall. Places that you are inevitably going to go to. I picture myself staying in this place, and the world is happening around me. Thoughts of, "Well, I can't go do that anymore."

Ellen: You all are amazing. You whipped off these incredible pieces in such a short time. (to Karen) Do you want to go next?

Karen: Mine was totally intuitive. I got into this field to work with sexual trauma victims, and as I found myself working with more women who have those histories, I realized I didn't really want to do this work because it is too triggering for me. So I think that is when I first started to feel this negative impact.

November: I had a client, probably in his early 80's who was a peeping tom. Sitting with him I started to have panic attacks. I started to imagine falling on the floor in the therapy room, and him sort of doing something to me. And it was shattering to me. So I tried to create a shattered piece (shows piece to group), and ultimately I had to stop working with him.

It was too scary. So, my supervisor helped me find a way to transfer him to a better place. But what ended up happening here is that I made something I really like. (laughter) So the good news is I felt very protected by my supervisor and very understood. I actually ran into that client 20 years later when he was the teacher of a class I was in. It was a really ambiguous experience. I didn't know if he knew who I was, and I wasn't sure who he was. It's something I've wanted to write about. There was creativity in all that.

Ellen: So you can see how we could have really interesting conversations about each of these pieces. Thank you for jumping in so well today. We'll have more time next time. We won't be doing the survey and introductions next time. I'll share more about compassion fatigue as it relates to our identity, worldview and spirituality.

Does any of this ring a bell? Is there something you would like to start with next time? I'd like to follow up on your ideas.

Francis: I had a thought that related to November's piece as well as my own. I'm sitting with something that feels a little intense. The words that come up are "fear" and "creativity."

Karen: That sounds really good. I really resonate with that.

Ellen: All right, that sounds good. I know what to do with that. Remarkable pieces! Now what are we going to do with them?

Francis: I don't think we are going to put them on the wall and have a show.

Karen: We'd really make people wonder.

November: The clinician walking down the hall looked like he was really wondering what was going on in there with all those crayons. Put them in his mailbox?

Ellen: I'd be happy to take pictures. Would you like me to hold onto them?

Karen: Would you hold on to them? Would you mind?

November: I was going to throw mine out.

Ellen: I'd like not to have that happen, yet. I would be happy to hang onto them. And if you do want to have a show at some point we can talk about that. Usually, we'll have more time for closing, but I don't want you to be late for your next meeting.

November: You can smash that (her own piece).

Ellen: I love how balanced it is. Out of that experience comes balance.

Francis: It's quite cohesive.

Ellen: I'm happy to take care of putting things away. I know you've got your 10:30's. But, I'm not pushing you out. You're welcome to stay as I'm cleaning up.

Nona Gal: Thank you Ellen.

Ellen: What an absolute pleasure to meet you all.

November: Yes, so we get to come back next week.

(Karen and Francis stay.)

Francis: If somebody still wanted to come to this class is it too late?

Ellen: What do you all think? I should have asked you all that.

Francis: A clinician's name came into my mind who was talking about needing something.

Karen: Oh, somebody that was talking about it?

Ellen: It works two ways. We could definitely fit somebody else in, but it also means that each person you would have a little less time.

Francis: She is somebody who goes well in a group. But it may be too late to ask her.

Karen: I don't know how I feel about it.

Ellen: If you're okay with a small group we can leave it at this. And if there is interest I'll do another group.

Karen: Is there still going to be a Monday group.

Ellen: No, not right now. If there is interest I can run another one.

Karen: So not that many people.

Ellen: Right. Out of one hundred and twenty-five licensed clinicians this is the group that could sign up. Others were interested but couldn't meet at the times that the agency could offer. I offered some other times but we went with the times when the agency could provide the space.

Karen: (To Francis) I'm so glad you're in this.

Francis: You are?

Karen: Yes.

Francis: That's nice.

Karen: We hardly ever get a chance to interact.

Francis: Even though we're on the same floor.

Karen: (To Ellen) We were two people who ran a grant together.

Ellen: I'm really glad you're both here. Bye Karen.

(Francis stays even later.)

Francis: I have a really hard history. That was the piece that stopped me. I didn't know how to do that. It was one of those moments when I started to think, 'Am I feeling different than others in the room?'

Ellen: It is amazing that we ask each other these things. We must decompress after these things. You don't have to leave right now if you want to stay for a few minutes.

Francis: Can I just sit for a minute? That would be would nice. To fill something like that out is big. When I have to put in a linear form and I can't. (deep sigh)

Ellen: (shuts the door.)

When I did the survey, I had a similar experience. I felt like, 'You've got to be kidding!' (The two laugh.)

Yet we know that there is a really high percentage of people with really difficult backgrounds that have chosen this work to essentially interrupt the cycle of violence. And, yes, statistics say we are at higher risk of compassion fatigue.

Francis: Can I tell you two different ways I've seen people who also have difficult paths. One time was my therapist, and one time was a teacher and therapist who did some work here.

I had a therapist whose father committed suicide when she was a child. By the time I met her she was a vital and compassionate and intelligent therapist. She had anorexia at one point and she went off to present a paper on it. She was taking the leap by talking about the fact that a lot of the people in the room had gone through difficult things. She was a model for doing that in the room in a responsible way.

The other was an extremely dedicated and passionate, bright psychiatrist But she brought in her history in a way that was not so good. She felt she needed to go to the edge to make it real. She hadn't integrated it in a way that was useful. You know…it was very wonky. In fact, some of the people in the room were in that with me. I come up against that edge when I'm in a professional group.

When my history, for one reason or another enters in, so I'm thinking "How do I do this? How do hold it in myself? How do I bring it in?"

Ellen: Absolutely, There is no expectation here that you would or wouldn't share it.

Francis: I come to this edge where I don't know quite what to do for myself. I think we just don't know. Its not like there is a way to do it or not do it. It felt okay what I did say, but even that, I'm questioning it.

Ellen: That's why I thought it was important for me to share something about me with you as well.

Francis: Yeah

Ellen: So many of us are in the field because of personal experience and desire to do something for someone else or not see someone else suffer as we have.

You know it's not just us as clinicians. We can think of people around the world who are in communities with a natural disaster, or war and people come together to help out. It's a given that the caregiver has had similar experiences of loss. But our western model has a shhh shhh thing.

Francis: Yeah

Ellen: We're even told we're unprofessional if we have feelings about our work. We've got to figure it out. I think its so interesting.

Why is it, I wonder, that there is much research confirming compassion fatigue and so little about what to do about it? So, you, we, are kind of on the cutting edge trying to figure it out. So many other professions deal with similar concerns. Some institutions know they need to do something for us clinicians and others, like intake workers who take the first call from someone who is still so raw: stenographers, lawyers, judges who hear terrible things in courtrooms.

So we're not stuck in isolation, going to therapists alone when it's a work related thing. I know exactly what you mean that stuff gets stirred up because of the work.

You can always stay afterwards.

Francis: Thank you.

Ellen: Look at November who has okayed her intern being here.

Francis: Right.

Ellen: What does that mean about what she can share? While different, it is still the issue of what can be shared on the job.

Francis: Right, I feel like its uncharted territory which is fun and important and a little scary too. There are people in the room now with whom I have had a little wonky stuff in

the past. It's not as big as some things. But I was thinking, "Am I a person who just has trouble with people?" I don't think that's true. But it can be. I'm a sensitive person, so how do I settle down in this?

Karen and I had unresolved stuff when we worked together that I took to my supervisor. We had a great supervisor, but Karen doesn't know the half of it. Karen and I never spoke about it.

Then there is all the stuff that came up with my traumatic past. And it's like okay, I am easier now. It's just like, damn, I want to shake it off.

Ellen: Well, we will do that.

Francis: It was just so nice for Karen to say something.

Ellen: We'll do the shaking off. I do that after a lot of meetings and session and things like that. I just have to go like (I move, shaking my hands and body).

Francis: That's probably it. I paid attention to your words. About what the focus was and that helped me a lot. You come into the work place where people have interacted over time and you bring the history with you.

Ellen: Remind me, what did I say was the focus?

Francis: It was compassion fatigue with our clients. That helped me to say, I'm not in the middle of something that happened back there.

Ellen: Good

Francis: There's no adversarial thing (with Karen). There is not a residual of that. It was kind of a feeling of misunderstandings that weren't always easy in the moment, and weren't really spoken of. And then my own stuff that was coming up, filling those pages and fitting it into the boxes.

Ellen: I'll try to keep the course structured enough so you can feel like there is room for you have your experience and also the support and containment. There is room for you to address how what is in the past and in the present and how it's related to the focus of the workshop. So you don't feel like we're trying to drum up the past. The opportunity here is to be an integrated person with support.

That's my job, to help create a supportivey environment.

So as the gal who's on the job all these years, you deserve time and support for creativity and decompressing from the job.

Francis: This helped.

Ellen: How are you doing now?

Francis: I'm doing okay. I feel just feel a lot in my body, so I need to go walk or something.

Ellen: That sounds like a good idea.

Francis: I also like teaching, and I like teaching therapists. I've started to move onto all this. So, when you're doing all this, I'm wondering if I'd like to learn to do this.

Ellen: That is part of the design of this program. Because when the neuroscience research came out that supported creative art therapies, we creative art therapists knew we couldn't just hand clinicians a technique for doing these practices without experiencing it yourself.

Ideally these workshops using different mediums, movement and all, can give therapists an idea of the power of the expressive therapies.

I'm wondering if it might be reasonable to integrate the arts into your work with clients.

Francis: I have this space that is kind of amazing that I found. It's just a few blocks away. I looked for a long time. I got something that way exceeded my expectations. I have room for a group, and I have room for movement. I have a neuro-feedback corner, and I have a treatment space. I would like different things to happen there over time. So, if you would like to stop by and see it sometimes. It would be fun.

Ellen: Yes, fabulous!

Francis: All right I'll see you next Friday.

Ellen: Okay.

Transcripts Workshop 2

10/17/2008
Digital Recorder A3

Ellen: Hi everyone, nice to see you.

Since we have Belgium beginning the program this week I'll do a very brief review. We did an introduction, consent forms, a survey, an overview of the topic and course and made art pieces about when people first recognized the stress of the job was having a negative impact on them. Then we had a little time to go over those amazing pieces. Each person got a chance to talk about what they found making their piece, and we contracted to meet this week in the workshop format because of the training next Friday. You'll get a chance to meet together after our final workshop. I'll come meet with you and go over your survey results with you on the 17th of December. And, let me say that I would be delighted to meet with you at the beginning of your first meeting next week, if you would like.

Let me do an overview for today as I did last week. We'll go over the process for your meetings. It's a collaborative reflective practice and we call it Sharevision. Where it comes from, the history and theories we will not be going over now. We'll do a practice round of it today, so you'll have experience with it for your meeting together.

Last week we said we would focus on a different aspect of compassion fatigue, called our 'Shifting Identity,' while bringing attention to fear and creativity. I'm very excited to be talking about it with you today. It is a topic that came out of our discussion last week.

Karen: I think it was Francis who came up with it.

Francis: It was kind of in the room. It's so apropos for talking about compassion fatigue.

Ellen: Then, without much ado, I think we'll do the Sharevision check-in later and jump into the topic now.

I hope you all are well. I know the survey was a lot last week and you've all probably been very busy this week, so I'll let you all just sit and listen to this material. We'll be doing an arts piece later and will have time to check in after that.

Ellen: As far as compassion fatigue goes, let me start with a brief infomercial to get us all thinking about fear and creativity and how it intertwines with our identity, which is an import element to attend to in compassion fatigue. All right?

With compassion fatigue we talk about the shifts that take place in our lives as we are emotionally there with people discussing and processing very intense things in their lives.

Other researchers focus on the biological changes we go through with compassion fatigue but I can't eloquently speak to all that.

That being said, as we engage with people processing such difficult things, our engagement with them has the ability not only to alter us physiologically but also psychologically. Our identity goes through a whole slew of shifts. For instance it is not uncommon for us to perceive ourselves differently.

Here's an example of a shift in one's view of self-care. We might hear ourselves thinking: "Well, somebody else had it so bad – what am I complaining about?" "Someone had it so bad, I don't really need time for myself, I don't deserve time."

On the other hand, many times when we end up at a holiday party with friends or with family and someone says, 'Hey how was your day at work?" and we start to tell them about just a single situation, it is not uncommon for someone to change the subject, turn away, run away pretty fast. Has anyone had that experience?

Group: (People nod, um huh, oh yes)

Karen: People say, "I don't know how you can do that."

Ellen: Yes, that's a pretty good way to close down the conversation isn't it?

Group: Oh, yeah, (people nod.)

Belgium: Or the opposite, "Really? (he leans in showing how others treat the subject with curiosity).

Ellen: Yes, they want us to tell them the worst things we've ever heard.

Belgium: "Well I have an uncle who…" I get that a lot.

Ellen: Then we're on the job again and people are seeking our services.

Group: Right, So true.

Belgium: "That must be so interesting".

Francis: We have a new therapist on the team who has a t-shirt that says, "I'm not your therapist."

Group: Laughter

Ellen: These experiences have shown up in thousands of people's lives who do this kind of work. It has been shown to really affect us by shifting our identity. For instance, we

think “I used to sit around and talk with people about what’s going on in my life but I can’t do that anymore.”

Group: Yeah, sighs

Ellen: This “who am I?” question can be something we don’t talk about. It can be a real challenge, because with shifting identity we lose important aspects of ourselves, often creative activities, movement, exercise, and socializing.

Now we may feel like we’re not doing things we used to do, that were important to us. We may recognize that we’re isolated in ways that we didn’t used to be. We may feel ourselves boxed in by other people’s needs, who want help from us but who don’t ask for it directly. And if they do, they may find it too difficult to maintain the conversation.

It often happens right at home with our families, with dear friends. That shift in a relationship, shift in dynamics is often isolating for the clinician.

When talking about compassion fatigue, we get to talk about the shift in ourselves from the heaviness of, and/or, the newness of the work. We discuss this process of questioning, doubting, wondering, judging, saying, “Who am I?” The questioning, doubting and judging is generally very hard to go through, let alone share with anyone else. We may question ourselves with thoughts like, “I thought I could handle this work.” Doubting our selves is very hard to talk about, hard to share.

Well we all know the professional domain says, “You’ve got the education, the skills, the license. You can handle it. You’re hired.” We don’t talk about our process of questioning, doubting, judging, anger, or our feelings of sadness and isolation. We talk about “How to Help the Other.”

This work on compassion fatigue came out of practitioners dealing with trauma. Now, what we call trauma work here may look different, and those labels or definitions may change. Some of us may call issues of domestic violence and sexual abuse trauma work while someone else may call work with homelessness and chronic illness trauma work. The list of what is called traumatic experiences and who experiences it is endless. It includes people who have experienced primary or firsthand trauma, be it racism, hate crimes, homophobia, poverty, chronic illness, bankruptcy, natural disasters, domestic violence, sexual assault, while some avoid the term trauma, and call their work something like “helping people.”

The traumatic experience has been called one where there has been an absence of creativity. The body’s frozen experience of being unable to recognize, or act upon, what options are there.

Group: uhuhmm

Ellen: There is a difference between a very hard experience and a trauma experience. One of the ways to differentiate them is this. The body goes through a number of processes that one often experiences as a freezing up. Your clients will tell you that that no one was there to either help them or come up with options that could halt the difficult or tragic experience. Often, no one was there saying, "I'd love to hear what your ideas are here." There may be a bleak, sense of stillness, silence, or racing thoughts that cloud out everything else, or a sense that things are moving impossibly quick, or a trance experience.

We can take the leap here to talking about creativity. Even if there were options there was often no way to act upon them due to the limitations of the moment.

By being with our clients hour after hour, week after week, month after month, year after year, decade after decade (laughter among group), this recurring story can become something we as clinicians find ourselves challenged by.

Is any one familiar with the term "mirror neurons?"

Group: (silence)

Ellen: This is sort of fun and amazing. In Italy a group of scientists had placed small wires in the brains of monkeys. The wires were connected to the monkey's region of the brain that involves planning and carrying out movements. One day when a graduate student came into the lab with an ice cream cone and ate it in front of the monkey, the wires registered movement even though the monkey had not moved. Years of research have gone into understanding that humans have these mirror neurons as well, though humans may have sets of more sophisticated mirror neurons.

It's not just imitation. We actually do feel the feelings of others that we are exposed to. Think of movies, television, or why athletes and dancers visualize perfect performances ahead of time? To help train the body to handle the desired experience. This explains how we learn as children to do not only what we're are told to do but what we perceive as the experience around us. We learn not just through thinking but through simulation or feelings. The environment we are in is often the environment we become. We can recognize our ability to sense by thinking about our ability to know if a room of people is happy or sad without needing words. We can sense a lot. We can feel it.

Group: Ah, sighs

Ellen: We sit with feelings all the time. As therapists we are exposed to, and therefore essentially train ourselves to experience, our clients' feelings, while our clients are trying to train themselves to develop some of our coping skills.

Let's pause for a moment to breathe deeply, and notice how you feel. How does your body feel?

Francis: While you were talking I was thinking about my experience. Over the years I've become acclimatized to working with people who are distressed, so that feels familiar. I don't recognize it as stress, but sometimes another colleague who doesn't work with such intense cases will have a reaction, and then I realize oh, this is a big deal. At the time I have no idea of the accumulated effect, because I am so habituated to a feeling of competency. But in one way it all goes over my shoulder, and I have no idea what is accumulating over there.

Ellen: I feel like what you brought up last week about creativity speaks to this experience. Let's talk about it. Your clients are talking about their distressing experiences to somebody who welcomes hearing about it. They're considering options, possibilities for the current moment. We put a lot of attention into trying to be in the present moment; evaluating the present moment. That is a big part of our work. Right?

So, if you do a mindfulness approach, you're asking people to pay attention to their sensations with questions like "how does your body feel?" "What are you experiencing now?" How can that be helpful? Attention is going toward how they would like their lives to be.

So, the parallel I'm trying to make is that as we are with people who are trying to get out of their confining boxes, so much of our time, we can find ourselves boxed in as well.

Of course not all the time. I can tell this is a very creative group from the pieces you all made last week. There can certainly be fear about going into the world of options, into creativity. What options? What colors? What shapes? What size? Which we use as metaphor to speak about our lives.

Karen: When you were talking about options, and welcoming our clients' stories, I was thinking, recently you know, I haven't felt welcoming. It's almost like, I don't want to hear this. (others nod their heads). Then the second thing, along with not wanting to hear it, is that often I'm totally in the box with them. I can't think of any options because I'm so drained. Well, you know not all the time.

Ellen: Yes, of course. It's a very real process. We find ourselves asking, "What do I do?" and, "Wouldn't it be wonderful if I had some colleagues I could talk to." But sometimes the box we're in is related to the fear we have about sharing our experience with our colleagues. We don't dare discuss our stuckness with our colleagues, or, say, "I don't want to hear what my clients are saying."

And again, as you saw from the survey questions last week, this is something thousands of our colleagues experience. And that's just the people who have taken the survey not the millions of people who feel the same way.

November: Are you saying that, "I don't know" is the beginning of the creativity?

Ellen: Yes, when you share that with each other, the "I feel stuck," you've already jumped over that professional discomfort. Or we can call it fear. We are a group that is experienced in the healthcare machine. We know not everyone gets a collegial meeting where you get to say how you are doing with your work and have time to discuss your experience and come up with creative options.

Group: Hmmms. Right.

Ellen: So this model that we are using to address compassion fatigue does that. It makes room for us as individuals in this work, and for our life experiences. It jumps us right into a collaborative model. It is a very different process than some of the traditional practices that have us acting like we can handle it all alone. Like our patriarchical, John Wayne, you know, "Leave me alone, I'm okay, I'm okay." The silencing of our emotions.

"Don't worry we don't think it's your fault." (to the one man in the room).

Group: Laughter

Someone: He's used to being the only man in a lot of meetings.

Group: Laughter

Ellen: This is a different model than having one authority teaching a group of helpers. This model has a base in ancient counsel practice and a feminist approach to working together.

There are a variety of sources that say, "We know each person has expertise that will be relevant, no matter what your age, professional experience, or gender. We have used this model with first year masters candidates, people without university degrees, with executive directors and those with every level of experience.

This is not a "telling you what to do" model; it is sharing our ideas with each other. It is saying "These are my ideas, this is what comes up for me when you share that." So instead of putting someone on the hot seat by asking, "Have you tried this, have you tried that?" The person whose turn it is to present gets to sit back and listen to what associations others have based on her presentation. So you might find someone saying, "You know I felt that too, and this is what I've done or thought about" which is not so likely in most supervision meetings. If someone would say "I'm stuck", people would jump in with problem solving.

Group: uh huh, yeah

Ellen: Have you tried to say something to someone who then puts you under an inquiring spotlight?

Group: uhmmm

Ellen: Okay, in this practice, one might say, "What comes to my mind when you share that is such and such." Very often, the strangest things that pop into your mind are the most helpful. You may find yourself thinking, "This is too strange. I don't know if I should share that." The seemingly strange ideas can actually be the most helpful. We are intentionally setting up a simple and intimate forum where people can actually address their creative ideas. While there is a lot of theoretical material underpinning this approach, now is not the time to go over it.

The simple process is this. We sit together, and because everyone comes from very busy lives, we take a moment of quiet together. For ten seconds, thirty seconds, a whole minute together, to center, to meditate. Some people pray, some people make an imaginary lists. So we articulate the "being here." We differentiate this time from wherever we were before.

Then we take another whole minute or two to do a personal check-in, one person at a time. This is not cross-talk. This is not a time for saying, "I don't agree with you." We do a lot of guessing about each other when we don't have relevant information. We start wondering. "Is she mad at me?" and then we start feeling uncomfortable. Well, often we're off. She might have just had a flat tire on the way here. Her child could have been throwing up all night.

We can see something is on people's faces, notice something about their body language and spend time and energy making up stories that are not always flattering, that can really muddy up our work time.

On doing Sharevision the check-in, we say whatever we want. We then have more personal agency in the story. There is no requirement about what you share. What do you want others to know? It doesn't have to be about work. It is just a minute for you to make the transition from where you've been to where you are now.

Karen: So it's kind of like the creative process in that you are letting whatever is on your mind to kind of come out.

Ellen: Yeah.

Karen: You're not censoring.

Ellen: Well, it's up to you. You can censor as you like.

Karen: Right, right, right.

Ellen: In other words we are not pulling from each other. We're not asking to be told more; we're not getting into each other's material like that. It's an opportunity, like you said, to get whatever you like off your shoulders that helps you be present. If you think it might be helpful for the group to understand you. It's really your choice.

This way of working is built on a horizontal sharing model. We all have multiple layers of experience. There are plenty of people who go back to school for a second and third career. There are all sorts of valuable experiences people bring to the meeting: age, profession, life experience, different kinds of family and relationship backgrounds.

I imagine you hear the idea of having a quiet moment and a check-in and you think, "There goes all the time." I know it's not a lot, a moment, a few seconds, but what we've found is that it is a remarkably helpful tool, even for a minute or two.

What we found is that by doing this check-in, compassion for each other grows. Things can then happen remarkably efficiently. No one has been shut out. Everybody is there doing the best they can given these parameters.

So what happens next in a regular Sharevision meeting is that everyone gets to put an item on the agenda that they would like. In your six meetings, we are asking that everyone does put an item on the agenda. A Time Keeper generally makes a list of topics, with a little bit of information about each subject can be helpful. Sometimes there are shared topics that can be great. I am going to ask you all to bring an idea of something you would like to talk about when you meet without me. Some case related piece, or something maybe you haven't wanted to talk about. Or, a situation in which you've tried everything and now are bringing the subject to this group.

And then we divide time equitably. Everybody gets the exact same amount of time. Say everyone has fifteen minutes. You are in charge of your fifteen minutes. You can talk for two minutes and use the rest of the time for feedback. Or you talk for six minutes. Then you divide up the rest of the time for feedback, again equitably. We need a time-keeper in these meetings. Each person has the same amount of time to respond, and then the person who presented; this person gets the final word, a reflective moment, to close.

Then the next person goes, presents, responds, closes; presents, responds, closes; presents, responds, closes. Each person goes and knows how much time she or he has.

We call it something of a turbo experience, because the creativity is amazing when you know you are going to get a turn to share something. Say another person says exactly what I was going to say then I am truly being challenged in that moment. I am truly being invited to be creative. What else comes to mind?

There is tremendous focus, of course, on listening.

All right, so we are going to practice it today. Instead of talking about your clients, we are going to talk about yourselves and your experience of creativity and fear.

I'm going to invite you to create a puppet. You'll be able to describe your puppet. Your puppet can speak if you like.

But first tell me how are you doing so far. Does that sound curious enough to get going? Is there any clarification you would like?

Francis: How do the two things go together, the working with the materials and the sharing?

Ellen: You're going to have the thing you make and you'll be able to share it or not.

Karen: So this is the practice that is going to lead when we are alone without you?

Ellen: Yes, you're not necessarily going to have the arts materials. This, right now, is workshop time for us to create a piece and then use the guidelines of Sharevision. You'll all have a worksheet that'll walk you through the Sharevision format to take with you for your meeting, but I will guide you today, and I may be there to guide you next Friday.

November: So today we will be doing something different than when we are alone together? Because today we a re going to be doing a creative project. But when we are alone together, it will mainly be talking?

Ellen: Exactly. When we are together in workshop, we get to focus on you and you will do a creative piece each time. We'll use the Sharevision format to talk about your experience. Then in your meetings, try using the format to address client-related issues.

This is doing something about compassion fatigue. I'm not telling you what to do about compassion fatigue. Rather we're practicing the what to do about it.

You could go to a workshop or course on compassion fatigue with a Power Point presentation that would tell you what to do. But this course is different. It's not: "Go do creative things." "Go talk to people." "Go do peer supervision." "Go share."

We're actually not doing that. We're doing a short infomercial from me. Then we're going to do a practice piece. In the sharing there is going to be more information and learning about different aspects of compassion fatigue as we talk about your experiences. Then the alternate week, you'll come in a little more experienced having done it without me once. You'll come in with more understanding of the practice, more ownership of it. You may say, "I'll go first." "Here's my piece." "Let's go around."

Okay? What other thoughts do you have?

November: Have we decided on a time we'll meet without you?

Ellen: As I understand it, we've asked for this same time and room 9-10:30. So we have the same time for these twelve weeks. No, it's not twelve weeks anymore it's ten weeks after today.

November: Except that can't happen next week because of the training that is scheduled.

Ellen: Got it. (this is the first I've heard of this training.) But we do need to meet next week at some point. So how do we figure this out for next week? The other option is to go a longer period of time into December, but you know December 17th is pretty late into your holiday season, which could get difficult.

Can you all imagine another time you all might be able to meet? Does anybody have a lunch break?

Group: (Silence)

Ellen: No?

Karen and November: Yeah, but not an hour and a half?

November: On Friday from 12-1:00.

Ellen: (They will all be in a day long training on that day.)

Group: Laughter

Ellen: Yeah, you're going to want to get up and walk around, right?

Ellen: I'm not opposed to taking a shorter period of time. Which would mean everybody gets about ten minutes.

Karen: And you're going to be there too?

Ellen: I'm going to be there if I can. If not, you guys can do it without me. Other programs have done it without me being there. They're at a long distance from me and they meet on their own. Because I'm local, it may be easy for me to come in.

So, here's the question, what are we going to do about next week?

Karen: Maybe we should figure out who is here on what days.

November: It's important because Nona Gal is here only Wednesday, Thursday, Friday.

Belgium: The training is Friday; that leaves us Wednesday, Thursday,

Ellen: Okay, this is just this one time, finding a time on a Wednesday or Thursday.

Belgium: You and I are in the same place Wednesday at noon. Does anyone have Wednesday at noon?

Francis: I might, but I'd have to move something.

November: I have that, Nona Gal and I could shift our time.

Ellen: So next Wednesday at 12:00. I won't be able to join you since I'm in Cambridge, but I know you can do it without me.

Francis: I am going to have to see if I can shift something.

Belgium: We can't meet on Thursday. They are giving us pizza then.

Francis: It's good when all but one can find the time.

Group Laughter

Ellen: And that quickly. Thank you so much Francis and all of you. October 22 it is.

Belgium: A scheduling miracle.

Ellen: Thank You. 12:00 Wednesday.

Belgium: We're back in the game.

Ellen: Why don't we figure that each of you will have about ten to twelve minutes. We have to do this realistically. This whole program is designed around what professionals can actually whittle out of their work worlds to do this.

Lets take out all these materials. If anybody has any questions or thoughts that they would like to run by me as you're getting started, let me know.

Why don't you give me some help here and we'll take out all these fun things?

(Ellen takes out a scarf) This was a sewing experiment of a scarf. Anything here you can cut up and use as you like. It could be part of someone's puppet.

Belgium: Materials, fabric.

Ellen: The reason why we do so much with materials is that not only is making things an ancient tradition, but a way people reflected on experiences such as storms, wars and dreams.

Today we know through neuroimaging that in doing so we activate the brain centers where trauma resides. These arts-integrated activities can move the process of trauma recovery along faster, more quickly.

I want you to think about the topic as you are doing it.

Think about your experiences, your thoughts and feelings as a clinician, about how you relate to the topic of fear and creativity and how they affect you and your identity as you work on building your puppet. This is very much about you.

Karen: What do you think about…(inaudible).

(November, Karen, Belgium can be heard naming some of the supplies…glue gun.)

Ellen: We'll have ten –twelve minutes today.

Group: Laughter

Ellen: Next time we'll have more time because we won't use some of the time for scheduling.

November: How much time do we have?

Ellen: A ridiculously short amount of time.

Group: More Laughter (lots of sounds of tearing and ripping, laughter, scissors, related chatter, then very quiet.)

Ellen: (after a few minutes) If anyone wants to bring any supplies they want to use feel free. I see there is a CD player here, so if you would like music you can bring it.

Group: (Quiet)

Ellen: (coming in from hallway) All the creative juices have made this room a lot warmer than out in the hallway.

Group: (More quiet. Start to hear bells jiggling from someone's project.)

Ellen: I wish we had so much more time, but I need to ask you all to start to bring this to a close.

Group: (More quiet)

Ellen: Alrighty then. Doesn't time fly when you have some stuff to play with? I really have to commend you for doing all this in this tight little space.

November: Thanks for all the terrific media.

Group: clapping

Ellen: My goodness you all are terrific. What makes sense in this time frame is that we'll skip the check-in because you'll get to talk about your piece. I'll do a demo for you about the quiet moment. One of the last groups changed the name. We had called it "the moment of silence." They called it "the moment." So we'll take ten seconds for quiet.

Group: (silence)

Ellen: Thank you everybody.

So as you come back we can review for a moment. I'll ask one person to go ahead and start with an introduction about fear and creativity, your puppet, your process. Anything you would like to address.

Let's say we have five minutes for each of these pieces, well, under five minutes, now we have three minutes each. I'll invite you to speak for a minute or two, and then if you're open to it we'll have a quick go-around. You will of course have more time when you're talking about your own pieces.

Any volunteers to go first? (to Francis) You're on, all right.

Francis: It was fun to see all the stuff. And I have a lot of thoughts. I work with clients who hoard and collect stuff. I used to have a ton of creative materials, and I gave most of it away because I couldn't figure out what to do with it. And now, maybe I'm going to figure it out.

I got excited about this (holds up a puppet). It's the color of my birthstone. This morning I woke up thinking about not liking the color of my birthstone. When I saw this I thought maybe I can figure something out.

For me the exercise became seeing parts of what I wanted to bring together, and trying to balance that with the time we have, and making a choice. Last week my project was very simple I did it like that (snap of a finger). Now I want to feel all these parts. And while we were here earlier I was thinking about some new endeavors in my life. They are kind of like that. They are so multifaceted. There are so many pieces.

So I made peace with that. I am not going to finish this puppet here. It's not going to be done now. But I really wanted to look around and check things out, and find what I want to have part of what I'm doing.

So, I had this little thing to do, and I thought, "Maybe I'll be able to do it all." And then I wanted to be easy with that, which is not always so. I kind of made my peace-piece, and I'll take it home.

So blue and green is really important to me. I like this and the stars, and, I was thinking about different things and about being a little bit more out there than I usually am in my life.

In talking to myself about it, I was saying, “It’s okay for me not to finish.” It’s more important to me to have the pieces how I want them.

Ellen: Great.

Francis: And I don’t know what is going to come next.

Ellen: Feel free to bring it back next time if you want.
(to Francis) I would be happy to go first, and you don’t have to model what you say after me.

I really hear what you’re saying about “I’m going to be a little more out there than I am used to.” I take that to heart for you as well as for me.

No order. (Gestures to everyone to go next.)

Karen: I think it is really neat that you were able to come to terms with not putting it all together today, that you decided to take the piece home with you. Cause I would have felt like that is not okay.

Ellen: You guys have the hang of this already.

Nona Gal: I’m really impressed that you wanted to take in all these things and see what there was on the table. To really look and make your choices rather than just grab.

Belgium: The idea of taking it home and continuing on it is great. And loaded for me. Francis and I have sat in a room together talking about how to be creative with our work. It’s all so familiar coming from you.

November: I was similarly impressed as was Nona Gal with the sense of time and planning you allowed yourself with this project. Going to look at what was available and not needing to finish it. It was just very impressive to me (laughs).

Ellen: So you get to have a final word.

Francis: I’m so appreciative. It’s nice to have these little things, because each one will stay with me. Like it’s okay to be out there. It’s a strength for me to check out my options.

When people said “different stuff” my anxiety went up. Part of me doesn’t think it’s okay that I didn’t finish it, so now I can notice when that comes up. Belgium and I laughed when it did because you don’t have any time to take anything home. (Laughter from Belgium)

Sometimes our life shapes our choices.

Ellen: Thank you so much, Francis, for going first. Does the phrase "turbo experience" seem fitting now? That was a lot and fast and doable. We get to make it up. Do we take a deep breath in-between?

(I lead group in one deep breath.)

(To Karen) Would you like to go next? Thanks, Karen.

Karen: Sure, I realized in the beginning it was really important for me to make a head, a real recognizable shape. Then it felt super important to make arm shapes, recognizable arm shapes. It was real important for me to be pleased with the color and patterns.
I paint, and I'm always thinking about color. I love this color combination. And I really wanted to put legs on it, but I became okay about not having legs. I wanted there to be a joyful celebratory thing so I made her have jewelry. I really like her.

Group: Sighs, laughter

Ellen: (to Belgium) Are you ready?

Belgium: I was thinking about how certain things were important. Early on head, arms, legs. Then you shifted into "likes." Those words are important. Also I like what has happened.

It kind of struck me that I like my piece too.

Francis: It is fun to listen to you, and I wanted to stay in the listening to you. I like this. I got curious about what you decided you couldn't compromise around, no matter what you were able to accept. The head. I'm taking it in, and don't know what the words are yet.

November: I love the way you wrapped it. It's cozy. And it is very likable.

Nona Gal: I like how you wanted it to be celebratory. That you made it esthetically pleasing to yourself. That you took pleasure in creating this.

Ellen: This piece about "what's important to me." It really speaks to me about informing our identity, to actually put "I" in the forefront, what is pleasing to me, what is important to me. "This is my life too."

Karen: You know when November said it is cozy, I immediately thought about my office here. I purposely made incredibly comfortable. I have a sofa and two really big comfortable chairs. I think my clients really like it. I really like sitting in a comfortable chair when I'm doing therapy. I like being cozy and like my clients to be comfortable too.

November: I'll go next. This is my person. I was struck by the time limitation. I really wanted to give myself permission to not be planful, because I'm so bloody planful!

Group: Laughter

November: That I just grabbed things. I also knew I wanted a head. I just grabbed stuff and let it evolve. You know I don't particularly like this puppet, but she is kind of out there, and I like that about her. At a certain point in the process I looked around at what other people are doing. I thought, "I really like that and oh, I like that about what others are doing." And I started to have regrets about not doing this in a planful way. So I was really relieved that you said the time was up, because I didn't have to think about it anymore. So there she is.

Ellen: Thank you. Are you open to a little group go-around?

November: Oh yeah.

Karen: I think it's fantastic. I became curious when you said you didn't like it and wanted to know why. Because I just love it.

Nona Gal: I like that you decided to go against your initial impulse to be planful. That is just a cool thing that you did.

Belgium: Like Karen, I really like what you did a lot and can identify with some of the process. And in terms of the product, I really like the work a lot, it's great!

Ellen: Do you want to go?

Francis: Sure, I had thoughts before you spoke. Then I think I was surprised by some of the things you said. I felt like it was exuberant, multifaceted and integrated all at once.

(Someone says "big words")

Group: Laughter

Francis: I like the brown and the green, the great colors the flair and it works. I think it's like you, because you're all put together. You're experienced. There is substance and flair. That's a little more out there than the way you dress, but I can see it.

Ellen: I like it so much that I'm over here wishing it were a reflection of me.

Group: Wows

Belgium: That's pretty good.

November: You know jealousy is a phenomenon here. I am contending with jealously. I am labeling that jealously.

Ellen: Oh, it doesn't feel like jealousy. It feels like, did somebody say "love?" Oh, it's your turn.

November: Okay?

Ellen: Okay it's your turn.

November: I did have the wish that I had done something like somebody else. Stopping to look around and be creative. Maybe I'll get past it. So, I appreciate your saying that you wish it were yours, because I was wishing I had done something like others here.

Ellen: Hey, how was that for an example of, "Do you share one of these unusual thoughts?" and then it turns out to be useful?

Group: yeses

Ellen: All right who's up next?

Belgium: I'm already thinking back to it. At first you pulled out all the stuff, it felt very familiar because my wife is an artist and crafter, a sewer. "Oh, I know this world." It's a feeling, like "Jump in." I don't jump in with her to do it, so that's the difference, but it was familiar. All the stuff, the materials. Oh, I know this.

Another experience that came up was a thing about work, the time frame, intuitively, maybe it's the building; maybe it's this part of the work. It's the product. I got twelve minutes to come up with a product. How familiar is that in this building? On some level. What are you going to do? But I was able to notice it and was able to let it go.

It took a little while, half way through, before I went to the other end of the table to look at the other stuff. I got into the time thing thinking about my eight month old at home. She likes bells, I like bells. My mind wandered to my daughter. In the end the bells connected me to here and now. That combination of work and domestic is constant right now in my life.

Karen: It feels really solid to me, maybe because it's a rectangular shape. Solidity.

Nona Gal: My sense, because I was working right next to you, I sensed that the entire time that you were going at it, you knew what you were doing, That you were comfortable taking the materials and seeing what would happen. You were very comfortable exploring.

November: I loved the bells, the bell noise. I guess it makes me think of how, in my work, the DBT group, they use the ringing of the bell.

Belgium: Wonderful! (laughter)

Francis: Of all the ones I've looked at, I've been sitting here thinking, "what do I think about this?" because Belgium, you're a person I don't always have a sense of who you are. I didn't realize that as I'm sitting listening, and that makes it hard for me to look at it. Because even though I know you, I felt like I don't. However that happens. As I look at it, there are a lot of elements there. They're all put together on this beautiful soft defined background. I still feel like I don't know all those elements. I guess you are a little unknown to me still.

Belgium: Mystery person.

Francis: You put all those there for a reason. They go together, but they're different. But I don't know all that much about you. I don't know what it all is: the man of mystery. That is what I said when you came.

Belgium: That's right you did.

Ellen: I have the same take. I wish we had more time. I am so curious to learn more about you and look forward to all that.

Nona Gal: (showing her puppet.) I wanted to make it so my hand would fit. (She slips it on.

Group: Ooos and ahhhsss, then laughter

Nona Gal: I don't know. I just went at grabbing material, colors that I like. I had a sense that I wanted to make my puppet holding a bag of things. Because I feel like right now my life is in so many different pieces and depending on where I'm going, I pack it up in a bag. I have things from school, home, you know, so on and so forth with me, and then they are spilled out once in a while. I wanted it to represent how I feel like I'm carrying around all this stuff. One day maybe I'll be able to unpack and stay. That's me.

November: I love the clothes pin, "There is something I need to remember; I put it there for a reason." It's so much about your life right now. It could also be about how in the bag there is stuff, not at all yucky stuff. It looks like fun stuff.

Ellen: I'm hoping it's okay that we go two minutes over today.

Group: Yes.

Belgium: The thing that struck me is that during this time in your life when you're all over the place and living in the bag, that when you started you knew one thing, you knew

one thing you wanted to be able to put your hand in. In relation to things in life being just what they are right now. And you had one thing clear. That is pretty cool.

Francis: Could I see it again? I found myself being amazed. When you put your hand in it, it's kind of like seeing a dress on a hanger and seeing a dress on a person. It comes to life because you've really shaped it. You've done the impossible, because you've really shaped it. It looks like it could have taken a lot of planning and the execution. I don't know if any of you have watched Project Runway. Because I have a love-hate relationship with it. To execute what you imagine. I'm thinking that's not possible what she accomplished because it all looks like it should be there. Then you're talking about your life. Okay, that's what you do everyday. You put all the pieces together, you carry it around and you make it work. And you act from it. So then it became clear to me that you've been practicing this. And I think it's amazing! Because I had the opposite experience. I couldn't accomplish the task in the amount of time I had. And you did something really amazing. So you must be doing that every day.

Group: Laughter

Karen: I thought it was neat that you started sewing in a way that seemed like you wanted to sew. I thought there is an incredibly playful humorous quality about it. So even though it seems like your life feels chaotic to you, it also seems to reflect a certain kind of lightness.

Ellen: With a theme of fear, I see optimism. "Someday I'll get done, unpack and stay," okay, maybe there's a little bit of fear. You know there will come a time when things are a little more even.

As someone else who is in school and doing a million trillion things, I hold some of that as well. I'll get through this with a lot of pep talks. I was curious why you took the puppet off your hand when we all were talking.

Nona Gal: I'm not sure why I took it off. Maybe I was a little bit uncomfortable holding it up and showing it off. I don't know what else to say, but thank you for your comments.

Ellen: Thank you everybody. I am terribly sorry we went over two minutes. I have a hand-out for each of you for your meeting. And, p.s. for anybody here who doesn't want to hold onto your little puppets, I promise I'll take good care of them for you. But, I can see them sitting in your chairs keeping you company. They are seriously great. I hope that you can play with them and encourage yourself with them. It is pretty amazing what you did in ten to twelve minutes. It's amazing! There was a big pile of stuff and you brought real life stories into the materials in just a few minutes.

Group: Okays

Ellen: Wait until you see what you can do with ten minutes per person instead of three minutes.

Karen: I have a question about today's process. At the end, just now, you mentioned the fear and creativity thing. I had forgotten the fear part as I got going. I was trying to figure out how we were supposed to incorporate that into this whole presentation and discussion. So maybe it's a good thing.

November: Maybe it's what happens with fear when you start being creative.

Ellen: That's right, and the fact that we weren't alone doing it makes it a very different experience, also having a small amount of time to do it in. When there is more time the critical voice has more chances get in there. There is something about having a short amount of time that supports you get started, and that can make the outcome feel all right.

So, I have no concern about you letting go of the thought. I'm available if anyone has any questions or comments. You can reach me by phone or email. You still have my contact information.

Group: (Cross talk; someone asks for my phone number, others talk about the Wednesday meeting, and when they will meet.)

Ellen: Yes, sure.

(Francis & Belgium talk between them about staying to help clean up

Francis asks if I have bag to put her things in to so she can work on her puppet at home.

More cross talk with Karen & Francis & Ellen about Karen's puppet)

Ellen: It's really great! I picture it in a chair in your office. Yes, your clients will want to touch her.

Francis: You spoke about a council. I've been reading about that. I'm kind of drawn to that. Is that part of the background to this. It has the feel of it.

Ellen: Yes, and it has a different feel to it when you're meeting without the fun, pretty stuff and focusing on clients. You're able to say whatever you need to say. Starting this way should be interesting because you're used to the regular professional way broken down by these arts processes. So hopefully starting this way makes it easier.

Ellen: Are you "August?"

Francis: Yes I am. Are you too? Do you like this green?

Ellen: I like it more now. I've always liked the deep emerald green more, but I'm having a new relationship with it. Now I realize it's like the spring's new bright greens.

Francis: Yes, I was just saying that it should be the color for someone born in spring. (to Ellen) All right, bye.

Ellen: (into the mike) Two people left their puppets with me, one man, one woman. I'll take pictures of them because they are amazing pieces.

Thank you.

Transcript Workshop 3

Friday October 31, 2008
Digital B 3

Ellen: Good Morning.

Okay, How was your group meeting? How was getting together last Wednesday?

November: I thought it was fantastic!

Karen: Yeah, me too.

November: I felt just terrific afterwards.

Ellen: What about it do you think made it terrific?

November: Let's see if I can remember.

Group: Laughter

Ellen: Remembering your feelings are also really fine. Does anyone else remember something about her experience?

November: I felt it was very well organized. Karen was the time monitor. Everybody had enough time. Everybody shared something that was really meaningful. And we got great feedback. And we ended on time.

Karen: It felt very smooth and very supportive. It felt very cohesive.

Ellen: What do you remember?

Nona Gal: I remember the same thing. It felt that way to me as well. I thought it went really well.

Ellen: (to Belgium) Do you want to add how you felt about it?

Belgium: Ditto. A lot of willingness in the room to give it a shot, a collective energy. It was nice to go for it the best we understand it.

Ellen: Were there questions you all had about it?

Francis: I wasn't able to switch my time slot.

Ellen: Oh, I'm sorry you weren't able to be there. Hopefully next week you can. So Friday next week at 9:00 in the morning.

Were you all able to bring a topic in and get feedback in that hour?

November: Absolutely.

Karen: Yeah yeah. We figured out how many minutes we each had. And I was a strict timekeeper.

Ellen: How did you do it?

Karen: We all had seven minutes.

Ellen: Oh my goodness. And you got something in seven minutes?

November: I thought I'll never fill seven minutes, and Karen had to cut me off. (Laughter)

Ellen: Did you speak for seven minutes and then got feedback?

Karen & November: Yes, each person did.

Ellen: Let see if I got this. You each spoke for seven minutes, and then there was still time for a go-around. So you had how much time each?

Belgium: About ten minutes tops.

Ellen: Sounds like you're doing a beautiful job. This is great to hear.

I can do a little coaching now, to support you in developing this practice. When you know how much time you have, say ten minutes, you can each decide how you want to use that time to present your piece. Say you each have ten minutes. When it's your turn you can choose to speak for three minutes and have time for two go-arounds. When it's your turn, you decide how you'll use the time.

Always leave time for the presenter to have the final word. The timekeeper's job can be tricky. Not only is the timekeeper looking after the presenter's time, the timekeeper also

makes sure all the respondents have the same amount of time. Because when respondents start, we respondents can get going and lose track of how long we're speaking.

There is something very nice about having the timekeeper get the meeting started and keep an eye on the check-in times as well. Did you do all that?

Karen: Yeah, we did a check-in too. Yeah, and since we'll have an hour and a half the other times, even though there will be more of us, we'll have more time.

November: But do people have an hour and a half carved out of their schedule every Friday regardless of whether it's just us or with Ellen?

Group: Yeses all around

November: Okay, cool, then we do.

Ellen: Wow! I look forward to hearing about your meeting. You're off to an amazing start in one shot!

Any questions about it?

(Silence)

Karen: We assumed that we were supposed to present a case that relates to our experience of compassion fatigue. My question is whether we are really supposed to present a case?

Ellen: The part about compassion fatigue is not required, but the clinical material I think is a good idea to do.

Karen: Okay.

Ellen: It doesn't have to be about you and compassion fatigue. It can be about you and whatever the issues are.

For instance, "what do I do with an eating disorder case?" You are in charge of how much you talk about yourself as it relates to the case. It's your time to talk and be heard, to get ideas and responses, and reflect with your colleagues. You can pick anything you want. By all means pick pieces about compassion fatigue. It's your time.

Belgium: So, it can be about good news as well?

November: Oh right, that was a question.

Belgium: Good news is allowed?

Group: Laughter

Belgium: It tells you something that was a question.

Ellen: It's a great question. Doesn't it feel different when you get some good news?

Belgium: Right.

Ellen: Sometimes we do get into a habit of not passing along good news. To address this we invite everyone to share one good thing that has happened over the course of the week before the meeting ends. So you can schedule in the time for a final go-around for a positive development that has happened in your week.

Again there is flexibility about what you share. You're in charge of what you share. You may want to share something from your clinical practice, about a collaboration with a colleague, catching up with paperwork or gaining something from new technology. You have options here about what you think would beneficial for others to know. Imagine coming to a meeting hearing from each other what you all feel great about. "I feel great about …"

November: Okay.

Ellen: Is there anything else?

Nona Gal: When we got together we weren't sure how to make the agenda so we just got going.

Ellen: That's fine.

Nona Gal: Okay, so how would it look to make the agenda?

Ellen: This would get us into advanced Sharevision, when you're bringing in administrative issues or shared clinical issues, or presenting together. For now, let's practice the agenda regarding who is going to go first, second third and on.

Nona Gal: Okay.

Ellen: Let's hear another question, anything else?

(Silence)

Ellen: Okay then, I'll ask one or two. In the feeling you described as "kind of fantastic," can you identify a physical sensation that goes with the feelings of being in the meeting? And next, what awareness do you have of how long that feeling lasted? Could you recall, or even call upon, that experience or the sensations related to this cohesive experience where people are willing to be together?

Karen: I can speak to that. Well, I've noticed after each of these sessions, two we had with you and one where we met last week, I felt lighter, lighter, particularly in the afternoons after we met. I somehow felt, it's really hard to describe, but I did feel different with my clients. I felt less resentment, and a different kind of energy.

(Karen leaned forward as she described feeling lighter and having less resentment.)

Ellen: You're leaning forward.

Karen: Yeah. Maybe I was leaning forward more to my clients. I mean figuratively and literally.

Ellen: What would that mean "figuratively?"

Karen: I didn't have to protect myself and hold myself back.

Ellen: Okay. I had the inclination to say, "Hey. if you're up for it, would you be interested in having other people respond to your gesture or even your words?" I'm so glad you spoke because I never would have thought what you just said.

Karen: Well only if people ~ you know.

Ellen: We don't have to do it today. This Sharevision practice can be integrated with the arts as we have used them but also with movement to have a whole person approach. Because, there are things that are hard to put into words which are kinesthetic, that can be shareable. Thanks for demonstrating this for us.

Karen: ummm hmm.

Ellen: Did anyone else want to chime in about their experience?

November: When Karen was speaking, I thought about moving forward in yoga. In yoga we are always being asked to be present in the pose in a very intense way. Or in a way that you can most be there at that time. So that's my association of what Karen said.

I'm not very good about translating feelings to where I feel them in my body, but I do remember feeling excited and happy, probably until the end of the week. When my mood went down I tried to remember that we were going to have this meeting, and things were going to get better again.

Group Laughter. Yeah.

Ellen: Over the weekend, later in the week, this week?

November: Ummm…my mood went down on the weekend. It has a lot to do with isolation. During the weekend I felt a little more isolated. When I come here I don't feel so isolated.

Ellen: When you come, meaning…?

November: Here, this meeting.

Karen: I have to say that this feeling of lightness doesn't last very long for me. I still have this over-arching feeling of well, I have many, many thoughts, of how can I spend less time here?

November: Laughs

Karen: "How much longer can I do this?" Constantly thinking things like that. Particularly, how can I spend less time here? How can I get through the day when I have eight clients scheduled. That kind of thing.

Ellen: That is a lot isn't it?

So we'll see if that sensation, that feeling lighter, increases with more time doing this practice. In the meantime we can hope and see what other ideas come up.

November: Does anyone else smell a burning smell?

Ellen: Kind of. Do you think it is our heater?

Francis: Sometimes when the heat goes on.

Karen: The staff room?

November: The heater does smell okay.

Ellen: I bet the fire alarm system works well here. If something's burning in the microwave over there, we will find out. Okay?

Group: Yeahs

Ellen: All right, feel free to bring questions and experiences back with you about how to make the most out of this opportunity.

So, here's a brief over-view for the rest of the workshop today. I thought we could continue on with this theme of creativity and fear when talking about compassion fatigue.

There is another piece I want to go over today before we do our arts piece. We will have time to do that and come back together for a Sharevision go-around. This next piece is

within the umbrella of our shifting experience. Laurie Ann Pearlman and Karen Saakvitne, in their work on vicarious trauma, discuss our "change of reference."

Last time we talked about identity and this week we get to talk about our worldview changes. I want to jump right in with the experience that so many people have, that is, of seeing the world as though there are horrible things, violent things almost everywhere. Many of us can notice that we have become accustomed to thinking that many people walking down the street are being abused or are abusing someone else.

I can relate an experience. I remember years ago when I was in a car with a friend, and she wanted to turn on the radio and listen to the news on NPR. I said, "No thanks." She said, "Oh, just for a few minutes" and turned on the news. Then, I caught myself crying. Now this was a really unusual experience I was watching myself have. I just couldn't handle hearing one more piece of terrible news. I knew they would run an article on people experiencing something horrid. It was going to happen if we had that radio program on.

Over the years I've discussed with many people their experiences doing similar work, you might be surprised at how many people put a chair up under their door at night because they had developed a concern that the violence they knew of from their work would come to them in their home.

The ramification, the side effect of doing this work, that we might have habituated to or become very accustomed to, we may think that we are the only one, or that there are just a few of us, and that we're incredibly unusual, and that there is something the matter, and we shouldn't share it. Given our education, our skills, experience and license, we think we should be able to handle the job, and that these things shouldn't be happening.

As we talked about last week, these questions are is something many people go through in their own way. And we know that holding personal material in is a severe and an understandable response but not the only option.

In talking about fear of sharing we are returning to this theme of creativity and fear, fear of considering what the options are, therefore limiting the questions being asked, "What can I come up with for options?" instead of thinking to ourselves: I should, I shouldn't, I can't, I'm bad, or whatever the self-depreciating, self-deprecating, judgmental, doubtful things are.

I find it outside in the street or in the supermarket, for instance, when there is a parent yelling at or physically hurting a child. Feeling like I want to say something. I should say something. I've thought I'm a bad person because I don't know what to say, and I didn't say or do anything, or some variation of all of this. Instead of continuing the cycle of violence by beating myself up, these are things we can talk about.

What are the questions that might get at how to handle the situation when you see something of such concern? What do I do with the feelings internally? These are great discussion questions that can bring out great ideas.

In the online introduction to this program I said that we get to do a group project together. We'll decide together on a project that speaks to your expertise of the impact of violence. You all have immeasurable experience and knowledge of the impact of violence and loss in people's lives. We couldn't count the hours of your work to interrupt, discuss, address and help heal the impact of social and physical distress.

This project is aimed at interrupting the cycle of violence by working together. We know you are doing that on your own every day as a clinician. This is an opportunity to work together. Granted we have an hour and a half on a Friday morning to execute the idea.

This aspect of the course incorporates research findings on people who have experienced primary trauma. We know that doing a social action piece is incredibly helpful for these people. Some of us are doing community action on our own, or with friends or family. Clinicians rarely get to come out from behind the mask of neutrality together in a group.

Given the understanding, that we have vast knowledge of the impact of violence, what can we do together to impact the cycle of violence?

Our jobs are for many of us a part of that effort to interrupt the cycle of violence. We don't want one more person to suffer, or certainly not as badly as maybe we have or as the people we have worked with. We are trying to do whatever we can to increase peace and safety in our clients' lives.

There are numerous studies that show no matter how much we do on our own, individually; there are still many cases of compassion fatigue and burnout. In this research project we are looking at: what happens if we do something together to address the mission of our work?

Yes, we have a number of components in this study. We have our workshop, your Sharevision meetings where you have a few minutes to collaboratively reflect on your work, and we have a project to design and perform for others outside this room.

So next meeting we'll talk about what we want to do given our expertise on the impact of violence. In the fifth meeting we'll do the group action. In the sixth workshop we'll reflect on the group project.

What's important is the neurological experience of expressive arts as I've talked about it previously. These projects are designed to be arts-integrated. We have lots of flexibility regarding what that means, which I thank the organization for welcoming this course.

November: Could you concretize what the group art project means?

Ellen: I will do a lot of that next week. We have workshop number four to come up with something we want to do together on the following Friday morning. It is essentially an opportunity to speak out beyond the room here.

I can give you a few examples. Here are two: A group designed a poster that went out in a mass email. They designed a special email address from which they sent the text of the poster. In the email was an explanation of their project and directions to use the text to make a poster, decorate it anyway one wants, and post it in the world. We got word from people who had seen it in their doctor's office for instance, so it went out into the world.

November: What did it say?

Ellen: Vertically written was D.O.V.E. Then there was a word across, "Don't Overlook Violence Emerging." Then below was written "Say Something."

Another group that was held during the summertime wanted to make the world a more beautiful place. They were sick and tired of seeing the ugliness of the world, so they brought perennials from their gardens, and went out and did plantings in a variety of places so people would be surprised by the new beauty in their lives.

That group had a few hours to do their project. They wanted to be vigilante beautifiers!

November: There is a group in Britain that does that.

Karen: Did you read that in the NY Times?

Ellen: I will help facilitate the conversation next week. We'll check in and get going. There is no requirement to spend time on this outside of here, but some groups have. They've brainstormed together and have ideas to tell me about when I return for the fourth or fifth workshop.

The group project is a great and exciting mystery for me. I never know what is going to happen. You can imagine that when I was starting to develop this course, I got concerned that people would come up with a group project that would jeopardize their jobs.

Group: Laughter

Ellen: You know I imagined groups might want to criticize the organization in which they work. So, we've refined the focus to speaking out about the mission of your job or the service of your job.

Group: Okays all around

Ellen: Any other comments or questions for this part?

Group: (Silence)

Ellen: Then I thought it would be good to take time to share about your shifting worldview I shared one: there I was in the car crying when the NPR news came on.

What is an experience that you are aware of in which you are dealing with a feeling around violence that may be incongruous with current events?

November: I have to define that a little differently. My clinical experience has not been as directly with physical or sexual violence. It's been more about sadness and hopelessness.

Ellen: Thank you. A lot of us define violence differently.

Group: Yes from group

Ellen: Some of us think violence is related to things like assault, and some of us believe violence is related to poverty, homelessness, chronic disability, because the experience can be traumatic.

November: Broadly defined.

Ellen: Absolutely, and understandably so. So when we talk about trauma and violence, it is not uncommon for people, like you, to define them as expressions of hopelessness. This is one of the really big categories within the discussion of compassion fatigue. We can certainly talk about it some today.

Hope is at the core of our spirituality and goes along with all levels of intimacy.

Francis: I'm comfortable defining violence in the way you opened it up. I think it can be even more difficult working with people in those conditions, because when working with someone who has had an event in their life that we would call violent, they have a reference point. Compared to when there weren't those isolated events.

And when someone has lived for a long period of time in a kind of hopelessness and underlying violent circumstances, a lot of time there is no other reference point for them. So you're dealing with this kind of chronicity. So it has a wearing quality that can take you down.

Ellen: The world can be a very unfriendly, traumatizing place.

Francis: Right, and there is no other experience in their life. It's tough. It is.

Ellen: So would you define given your experiences that the world is a hopeless place? Do you imagine sadness in people's lives as you look at them?

November: No, I wouldn't say that it goes that far. But, when I see someone that does look like that, showing that their life has been very severely impacted, I can certainly imagine nothing but hopelessness for them.

Ellen: Got it.

Francis: Do you then imagine them not having a different experience?

November: Yeah.

Ellen: Do you think there is an impact on your life related to that?

November: Yes, over time definitely. I think I'm a much more serious person.

Ellen: You think you're a much more serious person due to your years of work in this field?

Karen: Oh yeah, when you said you're a much more serious person, I can totally relate to that. It's harder for me to be light or relate to people in a light way, and I feel like I'm a kind of a downer for my partner.

November: Yeah, definitely. Not being a fun person to be with anymore.

Karen: Not as fun yeah, yeah, yeah! It's almost like you have something going on in the back of your mind all the time.

November: There are lots of preoccupations.

Ellen: Like what?

Karen: Can this be my part? It might just be with the last two people you saw that day, or a whole parade of people you saw during the week, like little snippets. You'll start thinking of one person's issues, then it just keeps coming and coming. It often seems like it's very hard to talk about it with people who haven't experienced it who aren't clinicians. Very hard to talk about it.

In fact sometimes its feels even worse trying to talk about it and not getting the response that you would like to get. So sometimes it's easier to keep it inside and process it in a different way, not with other people on the outside.

Francis: I relate to that. When I'm sitting with someone and something intense is happening. We're working through something, and I feel like I've done something well with them. Then I think, "That's it, I'm done" because it's my job, and I don't think "What do I do with this now.?" I don't frame it that way. I get my satisfaction from thinking "We did something there that mattered." And I was present and I used my skills or my person.

On the other side of that for me, is without realizing it, there might sometimes be some hopelessness. I actually don't know what to do with what I might be left with from all that hopelessness so I don't think about that too much. I just think, "That work was something good."

I don't feel as skilled at knowing myself in some of these ways. And I need to feel like I've accomplished something. At home I try and move around.

And I have some of the things that Karen said, and my body feels heavy or tired.

This is decaf coffee. But then I want to eat sugar, drink coffee, or can't fall asleep or this or that. Or I keep doing things, being active, finding things to do to discharge it, but not really thinking about it that way because I feel overwhelmed, and uncertain.

If I actually thought it was part of my job, for myself and my client, to do something with what I'm left with, I don't know, I wouldn't know what to do besides get some exercise and sleep. I don't know what to do. It doesn't feel as doable to me somehow.

The clinical feels doable, and the other doesn't. I watch other people and sometimes think the other people may be a little more skilled at it. I don't really ask questions or talk about it.

Ellen: Thank you Francis.

Belgium: I feel like I have a wildcard, because this is what is going on with this new baby. A while back there was a baby shower here. For those of you who remember, Esther tossed me a gift. She said: "It's great, now you don't have to worry about your clients anymore." That was her joke. The room, of course, burst into laughter because they had a sense of what she meant.

That shift of caring and carrying it is so palpably different now. There is no choice but to carry it differently. In some ways I've never been more present and more concerned for these folks. And (laughs) it can go away awful fast once the nature of, you know, flying out of here early on Friday afternoons

Theoretically I have a lot of feelings. It all ties in around being more protective. It's a wonderful world but then there are so many crazies in it.

There is a part of me that can find one more reason to not leave the house. I use humor. Mainly around holiday time I did not listen to the news for about a month. I said "Off with you; see you in the new year."

Group: Laughter

Belgium: I'm scattered but around the same issue I find myself more aware of the violence. I'm more into it with my family and in-laws, because they operate a little more aggressively than I do.

I always had a hunch I might feel differently about this if I had a kid. You see I'm walking differently these days.

I like what Karen said, I know that feeling, "I've got to have to care differently or else," or even if it's not to be around as much. Something's got to shift that feeling.

Nona Gal: I'm having so many thoughts here My first thoughts when you were introducing this topic were that I think I do carry a lot of the hopelessness that I hear from clients, from people. And I look at people's circumstances and wonder how can they possibly be having a good day? How can they overcome this?

This is very much on my mind because yesterday I saw a woman who came into my office and was shouting: "No, I don't want to be here!" "No, I'm not happy! I'm not happy!" Well she used a vulgarity, and I don't' want to go into it, but she was expressing her overwhelming life circumstances, that every year of her life something bad happened and how is she ever going to feel better.

And I was sitting there thinking, "I don't know. How can this have happened to one person?" Yet I have heard it has happened to other people. Just feeling that and wondering what it's really like to be her and have that. I don't know, I just have been thinking about it a lot. Even this morning, all I could say to her is that "Yeah, that's awful and I can't imagine it."

I think I'm caught up in what everybody else has said. I do tend to go to a place since that happened, thinking that person can't possibly get over it, because I hear so often that people can't get over things, and I know from my own experience that I can't get over certain stuff.

Then there are shifts in our lives like Belgium is talking about. There are windows.

Ellen: Thanks. (silence, breath)

Ellen: A show of hands: Is there anyone else here who is careful about what they take in terms of the media?

Group: Yeses all around. Several say, "Oh my God yes, movies, television!"

Ellen: What do you do about movies?

November: I screen movies for violence. I don't go see one that I know has violence.

Karen: Oh, totally, totally!

Belgium: For me it plays out more around news than the arts.

Francis: I used to not be able to tolerate the violence. I used to be in a movie group a few years back when Munich, the film, was out when other people were excited, and I was like, "Oh my God!"

But then I lost my sensitivity. Now in the past few years I've become obsessed with watching things like Law and Order, which can be pretty explicit. What I think it is, is this feeling that there are bad things happening, and there are people paying attention. Somebody's taking care of it. That makes for some resolution, or not, I feel like at least somebody else is holding it.

Ellen: Well said.

Francis: It became my unwinding. Nobody in my family wants to watch it with me, but they tolerate it. I never used to watch any of that stuff.

Karen: I have to tell you that the clock stopped.

Ellen: Oh, gosh, thank you for telling me. So let's go ahead and shift into making things. I do this project during the third workshop all the time, but this is the first time it's landed on Halloween. We actually make costumes during this workshop. Because it s a small space and a short amount of time, you are certainly welcome to make a costume for a part of you.

Part of the notion of these projects is that we begin with the flat piece we did on the first day, then it's a little more physical and body oriented with the puppets, then these costumes are to give recognition and expression of our bodies.

Here is the question to ponder as you build your costume: How is it that you manage your current relationship to hopelessness, violence, despair, whatever your words are for it, to do your job? Your costume is about how you manage your relationship with these issues.

Ready everyone? I brought another big bag of supplies this week, if you would help me take them out. The glue guns are warming up over here.

November: Oh, the glue guns are what I have been smelling so nothing is burning.

Ellen: I love coming in early to set these things up so people get to come in to these beautiful, colorful, fun materials. But I've decided for our group that we'll set them up together, rather than your having to contend with teasing by people who see you.

November: This is a very difficult question.

Ellen: Yes it is.

November: Can't I just play with the stuff?

Ellen: Yes, and make a costume.

Well go for ten to twelve minutes on this.

Karen: Really, only ten to twelve minutes?

(Quiet while people build their costumes.)

Ellen: You all have done a remarkable job in this short amount of time, absolutely remarkable!

When we have the go-around and share your pieces, you don't have to sit here. You may want to stand up and stage your piece in some other way. It's your time. As you know, we only have a brief moment for each piece.

Let's do this. Who wants to go first?

Belgium: I'll go first. This is supposed to be a hat.

November: Well put it on!

Group: Laughter, clapping

Francis: Even the tip to the side is just right.

Belgium: What happened was I first thought of a badge, then a hat, then I wished I'd gone back to a badge. That happens creatively for me, I just go with it or, oh, off in different direction.

Ellen: If you were to use it as either a badge or a hat how would you use it?

Belgium: It's interesting. I wasn't thinking of using this as a badge. It was one or the other. I wasn't going to give myself the experience of having to come up with a product.

Ellen: What does the hat mean to you?

Belgium: The costume piece. I think that way often. I put on a sweater and a shirt, and I literally use the words "costume for work." Literally. Sometimes I'll crack jokes about the "therapy sweater."

Ellen: Is there anything particular about your hat that relates to your job?

Belgium: Well I wear hats often, so it's comfort, warmth. I've always worn hats.

Ellen: So is part of how you do what you do is to take your comfort with you?

Belgium: Yes, there is some truth to that. Yes.

Ellen: Moving right along.

November: Do we respond to him?

Ellen: No, I want to make sure everybody has time. But if we have time afterwards we can share some thoughts about each other's work. First, we have to make sure that everyone gets to go.

Karen: So I'll go. (Karen stands while she speaks. She holds up the large mask she made over her face.) All I could think was what happens when I'm with a client and they start talking about their traumatic experiences. What happens is I get triggered, and this is what goes on in my mind. So I get memories. And this is what it feels like in my mind. My eyes are opened. I'm able to continue to talk with the client, but I feel like I have to not hear what they are saying.

And these represent my ears. I've actually said to clients, "You don't have to tell me the details. We don't have to talk about that." I've actually said that. And this (pointing to another part of her piece) represents that I'm still able to talk with clients, and I feel I am still able to help them. So this is like "pearls of wisdom."

Group: Laughter

Karen: There are still things coming out of my mouth but I'm trying to block what I'm hearing, and I'm very disturbed. So that's my piece

Ellen: Thank you Karen. Amazing how quickly you're able to figure out how to make these things that speak for you.

Nona Gal: I can go next. I'm not sure where I'm going completely with this. It could be a bag or a necklace. (Nona Gal stands up and demonstrates how she can wear her costume as either a necklace or a bag.) There's all this stuff. They're all colorful and textured. Sometimes I take them out and use them and connect them to things. So it's about connecting. Sometimes keeping things safe.

Group: Laughter. Several say "Fantastic!"

Ellen: Really amazing!

Francis: I really wanted to finish mine this time, because I haven't finished the stuff I took home. (Francis points to the parts of her costume which is laid out on the table.)

I was looking for something for a background that's kind of dark but still beautiful. I know it's navy blue but I like blue and it's kind of like the sky. Down the middle of me, it's where I try to find some kind of balance. And then I suppose this is more like spirit and this is earth. And that's how I find balance in my work and in my life, to move back and forth between those two and have something in the middle.

I suppose if I was looking at chakras, this is the lower chakra color and this is a higher chakra color, and I try and find a balance.

It was interesting, because last time it was so much to do to try and create what I wanted. And then I found this piece and it all came together.

Group: (loud sounds of praise)

Ellen: It is a great dress! The dress that is the earth, sky and balance. It's actually the kind of fabric that you could step into.

Francis: I think that I might. I don't know if I'd scare kids, but I do love to give out candy. I might actually wear this. It was fun. It came much easier.

November: This is a heart shield. (November models her costume as she describes it.) This is my sword to fend off (silence)…

Group: (Silence)

November: I'm not sure what it's fending off. But it's definitely fending something off. This shield is my heart. The appearance is of not being affected. But underneath is this black heart, and then there is this blood dropping down. (She turns the shield to reveal this other side.) The black heart is the hopelessness. But then there is the vulnerability. The red is the vulnerability. The blood is dripping.

Ellen: These are powerful and amazing. They're all fantastic. Okay we did this.
My clock says it's twenty-three after. What do you all have?

Group: Yeses

Ellen: So we have a whole seven minutes. Why don't we have everyone get a chance to talk about their experience of being part of this. You can use it to talk about what it was like to make it or be seen making it, or any other aspect. You'll each have another minute.

Karen: For me it was great to be able to actually to share what happens to me when I'm with a client and they're talking about trauma, because I don't think I've ever expressed it that freely. I knew exactly what I wanted to do. It just came to me, and it didn't feel that scary to talk about it. I had thought it would be scary and that I'd cry. It wasn't really like that. It feels safe.

Ellen: Great, amazing, incredible!

Nona Gal: Like I said before, I wasn't sure exactly what to do. I had a vision, cause you said, "How do you go out into the world carrying all this?" I was thinking I would make bows for my shoulder to hold up my shoulders. Then I was going to make a bag, and it wasn't going to be a bad bag, just stuff. So that's what was going through my mind.

Ellen: Thanks. It's wonderful!

Belgium: I was thinking in terms of trauma and triggers and ways I've worked with this, being the male therapist with mostly female clients. There are moments when that is difficult. Maybe I'll have a chance to talk more about this.

That piece, clinically, has really been something for me. I haven't thought about it in a while.

Ellen: Yes, of course.

Francis: I was struck by everyone. I had thoughts I wanted to share back. I'm having an experience that I am not as focused on as November and Karen are about the impact, trying to hold the impact, for today there is more room. So maybe I'm not doing as badly as I thought about moving around and discharging it.

Right now I'm not having problems in the room with specific traumas, being in the present moment with somebody who's trying to process that. It's the accumulated effect for me of going from one to the next. So I'm going to pay attention to what I'm learning here. It's communicating to me about how I'm doing and what I'm doing. And maybe I should trust that. I was profoundly moved by all of them, and especially you two and what you expressed about how you're holding that. Really.

November: Well it was a roller coaster ride, because I just get so excited when all this stuff comes out. I just get so excited! I just feel so happy. When I'm lucky and really engaged in the experience of creating something, it's just thrilling and relating it to the theme, it's so thrilling. I'm just so excited I'm practically delirious!

Group: Laughter

November: While I'm doing this I'm trying to contain myself, and not be too silly. And then I've made something that really is grrrr! I've learned it's hard to tell what's true and what's not true. What I learned is depressing and scary about the black heart and blood and stuff.

Now I'm exhausted.

Ellen: This is a big project. I wish sometimes we had a whole day where we could move with them.

What do you want to say with them while you have them on? Write about them? Engage with each other about them? Because they really are remarkable pieces, incredibly beautiful.

So, please take each other with you through the week. Use the metaphors that you've gained here. If you have a shield, bless that shield. Maybe it can help heal. What is it about the antenna? How can each of you use the elements of these costumes?

Part of the model engages. One, You are not so alone. You can take each other's wisdom with you, whether it's what people said, or the beautiful acknowledgement you give each other, or something about each others' pieces that might be helpful.

Another aspect of this arts-integrated Sharevision approach is that we're really trying to reconcile our theoretical models with our learning process and our actual experience. When there is a dichotomy among these experiences, and there often is, disharmony can grow. The idealization of theory, skill training and all that, along with what we actually experience can mess with us. That is why this is a practice. It is practice based.

That is why we ask, "What happened this week and what do I do with it? What are the different ideas about what to do with it?"

Okay, gosh, we've got to make costumes on Halloween! I have 10:30 unless anyone has a different time on a different clock.

November: Yeah, it's 10:30.

Ellen: I will absolutely be looking forward to seeing you in two weeks on Friday morning, and I'll be thinking about you next Friday when you meet. Where do you meet?

Karen: Last time we met in the upstairs conference room.

Ellen: Was that good?

November: Is there a DBT group going on there?

Belgium: At 10:30 there is.

Ellen: Should we plan that you meet here next Friday?

Group: Okays

Ellen: I'll go talk with them before I go so you'll know you can come back here.

Group: Okays

November: What are we doing with the projects?

Ellen: What are you doing with them? Would you like me to hold on to them?
Or would you like to….?

November: I don't have anywhere to keep it.

Ellen: How about I hold on to them for now?

Karen: Okay, great.

Ellen: If its alright, I'll take pictures of them too so they are lasting.

November: Sure, sure. We'll have the option of the picture and the piece.

Karen: Cool!

Ellen: And don't worry about any of the clean-up. It's my pleasure knowing I got you out of here on time.

November: Well I don't have anything right now.

Belgium: Me either.

Karen: I purposely left time between this and a client because I knew it might not feel good.

Ellen: Wow, you two don't have to run off!

Francis: Karen, can I hand you those to put in that bag?

Nona Gal: Does anyone see a plastic bag to put this in?

Group: (More talk in helping to clean up.)

Transcription Workshop 4

November 14, 2008
Digital A 16

Ellen: So I'd love to hear about your get-together last week, and we'll hope that Belgium is here any minute now.

How about this, because it's a workshop and we can be flexible with the form, how about we do our moment of quiet together, and then we'll use a directed check-in from the Wednesday meeting you all had.

November: Okay, that sounds good.

Ellen: How long would you like?

Karen: Three minutes.

Francis: Three minutes each or all of you ten minutes?

Ellen: I meant for the moment of quiet. I'll be the timekeeper if you'd like.

November: Three minutes is a long time.

Karen: Is three minutes too long?

Ellen: Would you like two?

Karen & November: Yes, two.

Ellen: All right we have a compromise here, two minutes.

Group: (Quiet. Door squeaks open and closed during quiet moment.)

Ellen: Okay that's two minutes. (Waits a moment.)

Hi everyone. We've just agreed to do administrative things first, besides negotiate how long for the quiet time.

Belgium: Oh, it's negotiable?

Group: Laughter

Ellen: Yes. Okay, because of the Thanksgiving holiday we'll meet next week. Same place same time.

Then we'll take a minute or two for each person in a focused check-in about people's experience of the Wednesday meeting last week. Who would like to go first?

Francis: It was big for me. I don't want to go first.

November: I remember it being very intense. It was very effective, and one of the things I really liked is that I felt like I got to know Francis better. That Francis really joined us. I got to say something that was very important for me and I didn't have any other place to say it.

Ellen: And did you feel like the response you got was…?

November: Oh, it was great.

Ellen: Oh, it was great?

Group: Soft laughter.

Ellen: For the sake of my being able to do some coaching, I may ask some questions today.

Karen: Well we had it in my office because we decided it was too cold in here, so it was kind of cozy. I thought it was also intense, pretty powerful. I had some self-doubts. I thought I was too impulsive in my responses. I was questioning whether we were supposed to respond specifically to what people asked for or if we were supposed to do a total free association. So that question was up for me.

Ellen: Okay, I can respond to that. You have that choice. All right? When we put something out we know that, given this format, the responses may or may not be in the answer or problem-solving genre. As in, "Here is my question. What is your response?" It may be, "Well I tried this or I felt this or I'm reminded of that." It may be somewhere on that continuum of what feels like an answer and whatever is popping up because it is a response to what was presented.

Karen: Is it okay to problem-solve? Because we were under the impression that it wasn't.

Ellen: I think its okay as long as we're talking about our own experiences or our own thoughts or own imagination.

Let's say I were to present something about a challenge I'm having with an issue x, y or z and I'd love some feedback or ideas from you all. The responder always has the choice about how she responds. It may be with an image or a metaphor. Or one might say, "I've tried this and it worked for me. I know it's a different situation but maybe there is something in it that might be useful for you."

Group: (Silence)

Ellen: Okay?

Francis: It's nice to think about how to do that. Because my assumption about not doing problem-solving is to kind of get into a different head space where you're advising somebody and you're talking about how to offer something that would lend itself to problem-solving but not to get stuck in that analytical box.

Ellen: We're not telling each other what to do. Many of us have been in traditional supervision where we are constantly being told what we should do next. What we're getting here is a slew of ideas. Then, it's up to the person who presented to apply the feedback as he or she sees fit.

Belgium: It goes both ways. How often have I wanted or have others wanted to be told "Give me some hints or something." I've experienced both. It's not what I'm looking for but I do want to be told what to do. Because I've wanted to be told. I have certainly had people come to me wanting to know what to do.

Ellen: Absolutely, We all want help and to be able to ask, "What do I do?"

Belgium: What do I do?

Ellen: One of the things that I think is great about this process is, instead of getting one response you're getting a bunch of ideas, responses. Even if it doesn't come out as a directive, it may be useful to you in being able to problem-solve how you're going to approach the concern.

Belgium: Well I'll go next. I apologize first for being a little late. It certainly doesn't help the group cause. As far as last week it seems like a million years ago. I do remember it felt pretty intense. Effective. We were working pretty hard, and I remember it felt quick.

Group: Laughter.

Belgium: Having thirteen minutes, "Let's go," which meant there was a bit of a rushing to it. Somebody not getting a chance was not an option. So I remember that kind of feeling. And it was powerful. That's what I remember.

Ellen: How did you like that experience?

Belgium: It's feels a bit like work when I feel that rush and that's just me and that's part of the deal sometimes. It was also us learning it, and the feeling of going for it. That is part of the thing I felt. That's just broad strokes.

Ellen: And effective in what way?

Belgium: It is effective on responding to me. November already said its effective for her. Whether it's all of us, or one of us, feeling it. Which means there is something going on here.

At another given time it might not be the feeling. It might not be as strong for me as somebody else. And it so obviously was. We worked hard. And it was necessary to do that on some level. And good work, hard work.

Ellen: I remember the experience joking about doing Sharevision when the process felt like a car in low gear versus when the car is in turbo.

Group: Laughter

Nona Gal: I have also been thinking about the format. How quick and how fast we really need to respond to get everybody in. It's a little bit against who I am. I'm very introverted. I like to think about things. I don't think out loud very well. It's a little challenging for me, but at the same time I think it's a good challenge, too. You have to respond right then. Sometimes it's harder than others. Sometimes the content, you know, I really want to take it in, but I also want to give, to contribute.

I also remember it went by very quickly. And I felt very connected afterwards, even though I had to race and respond.

Ellen: I sometime feel that, too. Remember once the material is on the table, so to speak, there is always the possibility that we can give each other a call, or talk in person to follow up on the subject. There might be so many ideas that get stimulated about the subject, and the time only allows for this brief experience.

November: You mean outside the parameters of the group time?

Ellen: Yes. One can always say, "If anybody has more ideas about this, feel free to talk to me. I'm interested in what you have to say." There certainly might be some follow up paperwork that somebody says they can give you later. Or "I didn't think about it at the time would you be interested in what I've thought about your topic." So, the Sharevision meeting is the springboard for collegial work and helping each other out.

Are you all set to go Francis?

Francis: Yeah. As people were talking I realized it was very dense. Each person said what they really needed to say, and I think everybody listened well, and everybody got something. So everything felt of importance somehow. It wasn't wasted time. It was dense. At the end I couldn't remember if Nona Gal hadn't had a turn. She said what she said and I thought, of course, I was so here when she was talking. Going from one to another. I felt bad that I couldn't retain it all. The pace was a part of it. I had to let go of this to go onto that.

I was like a balloon about to pop. I was holding all these pieces for myself, and I didn't know if it was going to be okay to have people look at it with me. But it worked really well. And it made such a huge difference, and everybody was right there with me. It felt like everyone had something of equal resonance but from her own perspective. Oh, it was so nice, I felt connected to each and every person. It was really wonderful.

I felt that way when on the other side, when I was responding, too. Everyone was so real to me, and I felt so real to everyone else. It was a very big blessing.

Ellen: I find that I take notes because there is so much material that I'm trying to be present for. I don't want to be distracted by asking myself did I get all the information. Granted when someone is talking about personal material, it may not be a time for note-taking.

Did anyone try bringing a case they are working on?

Group: Yes

Belgium: We brought questions and talked about experiences.

Ellen: You can see the "pearls of wisdom" and maybe it's something to jot down. You have the option to bring up the job, the job and you.

(to Karen:) Are you coming to the meeting with a question?

Karen: Oh you mean did we come to the meeting with a question? I did because I was asking a clinical question.

Ellen: During the course of your week you can make a note in your calendar about what you want to bring up. You have the choice to bring it up or not. There might be something more pressing when the time comes.

It is a lot to go through five people without a break. You may want to take a breather, stand up, stretch, take a deep breath together, shake your hands, get the blood flowing so you can come back into being present. That way the last people aren't getting the dregs of exhausted energy. So before person three and four, before wearing yourself out, do a little something.

Any other questions or comments?

Can you believe this is our fourth workshop and sixth meeting together already?

Group: Acknowledgments

Ellen: In this fourth workshop we bring it all together. We've had a remarkable experience of meeting each other here and sharing a great deal, in applying some of the basic principles here.

What happens next is we go into another level to actualize the work. We've talked about identity and worldview. Today we talk about spirituality. It is the umbrella term for hope, creativity, forgiveness, intimacy and faith.

For me a group project is a nice way of being able to approach this.

We'll start with reflective time for you to individually assemble something on the subject of what you would like to say or do given your expertise on the impact of violence and hopelessness.

Given what you know about the impact of social injustice. Given what you know about violence, despair and hopelessness. What would you like to say….

November: To others in the community?

Ellen: Yes, that is a big part of this project, not just to us in the room here, but out in the world. You have your individual impact in the world.

Right now we're joining forces to be able use that power of influence together. We know you do a great deal to interrupt these cycles of despair and violence alone. Yet, you know we work in this field together, so this is a very conscious effort to do something together, essentially to interrupt these cycles.

We'll start with making a personal piece on the subject. Then we'll come back and talk about it. Then we'll go into a different process, we'll be brain-storming about what we are going to do together.

November: So the piece we're going to make today is an individual piece?

Ellen: Yes, to start you have a little time to individually reflect on the question: 'What would I like to say in the world?' Then once we have time to hear from everybody about what is important to you, we'll see what happens in the brain-storming process. We'll see what comes up for the group project. What we want to say out in the world, or more precisely, 'What do you want to say to the world?'

Francis: So we just come up with a concept?

Karen: Or are we going to create something?

Ellen: We'll be doing both. First you'll have a chance to think about it yourself as you make something about: 'What you as an individual want to do to engage the world through an esthetic action?' Then as a group you'll come up with a project that you'd all

like to do for a broader audience. Then, during our fifth workshop we'll do this group project.

We are not necessarily going to use any one of your ideas. We are going to come up with something between everybody. But first you have time to reflect on the question: 'What you would like to say out in the world, see and do, or see someone else do?' Consider what you'd like to see be known. You could say, "I'd like the subject of apples to be addressed."

Don't worry about the practicality about how it would get done.

How does that sound so far?

Karen: I'm a little confused. Are we going to be expressing what we say to other clinicians or the community at large?

Ellen: You get to pick. It can be amorphous. If you have a specific population that you want to speak to, for instance, lets say I want to do a piece that speaks to people who beat other people up. Or, let's say Belgium wants to do a piece to the presidents of the world. That would be his piece.

This piece is for you to use your vast expertise to identify a topic of interest to you and an idea of how to address it and, yes, to whom would be great, too. We are talking about accessing the expertise you've accrued. You know a great deal.

This is not for your clients. This is for a shared audience. You can think of your piece as a potential jumping off point into a conversation. So if anyone has any questions feel free to check in with me.

I want to give you a little more time today. We only go until 10:30. Lets plan on coming back together at 10 because we'll need time to do our project planning.

So, I brought fewer supplies for you to make decisions with today.

November: So we're going to come back together at 10 of?

Ellen: Yup, so if we need a little more time we have it. I like to leave time if we need it.

November: Actually it feels better for me not to have big span of time. I can be creative more easily if I don't' have to think about producing "something."

Group: Laughter

Ellen: You all are welcome to go through here with me.
(sounds of people going through the purple supply boxes.)

Ellen: Grab any supplies you'd like.

(sounds of people talking about the suplies and what they are looking for, asking questions, e.g. 'Where is the tape?')

Ellen: These are wonderful! What you've been able to create in just a few moments!

(more silence and sounds of people working)

So, for today we are stepping out of the Sharevision format, in terms of how much time we have for each person and responses to each person. We do have time for everybody to talk about what they found in what you made.

So we have time for our brain-storming phase about what we are going to do next. Let me check to see if you would like to go overtime a little today.

Ellen: What time would like to go until?

Belgium: I have an 11:00, so about quarter of.

Ellen: Okay, so we are going to extend the time. Ah, it's all going to get done.

Okay who would like to start?

Belgium: I will. One piece was very clear, one piece not clear. Very clear about the big broad piece, very clear about what is inside, and that it would be in the envelope. Not clear what would be on the outside of the envelope, but I didn't know what I wanted to put on the outside.

Maybe I'll utilize the group for some of it. I was very cued into the idea that this was going to be part of a collaboration.

Francis: Does the envelope represent something?

Belgium: The envelope I think represents that I want my piece to be out there but in a quieter way, in an unassuming way.

Ellen: Is there a particular thing you want to say in your unassuming way?

Belgium: It's in the envelope.

Group: Laughter

Belgium: (He pulls out the card that says: "YES.") It's about an experience that I find myself in lately, experiences that are not pleasant, but bring a positive vibe.

Ellen: All right, we'll put that positive vibe on our list.

Group: More laughter

Ellen: Thanks, Belgium.

Nona Gal: I can go next . (Sounds of pleasure from group as Nona Gal holds up a string of paper dolls) I want to emphasize relationships and community, so I attempted to make paper dolls. Building strength with relationships and community.

Someone says, It's wonderful!

Francis: I'll go.

Karen: Would it help to hold it up?

Francis: Oh sure. I'm gathering my thoughts.

I had a couple of ideas about a group focus and what I might suggest we do. I was trying to figure out how to bring them together. This is an image of what came up.

There is this poem that I love. I don't remember who wrote it and how it goes, but it starts out with an Indian on the bus in a poncho. And in the end it says, "It's only kindness that matters." So what I thought about is that kindness takes different forms at different times. Sometimes its very organized and linear and we have to set limits and say what's what. And sometimes it's very fluid and being present.

The tic-tac-toe board came to mind. You know people are interacting with each other, and sort of someone wins and someone loses. And sometimes we don't even know what we're doing with each other. But we're just there, you know.

Then I had all these thoughts that are too simplistic. It's kind of like Belgium's, "Yes, it's so true."

Karen: (taking her turn) All right to explain this? Well, I chose the brown. I think the brown means groundedness to me. So I'm giving out a message. I don't know. I don't know what that says, but it seemed important that it represents groundedness.

And the yellow represents hope. And all these shapes are the shapes that we as people and therapists look through. And we're always looking at different things. Some of the things are soft and round, and some are jagged, and some are more flowing. And mirrors represent, as clinicians, we often see ourselves as clients. And sometimes what we see is really harsh, so you don't want to see all of it. So some of it has to be hidden.

Group: Hmmms

Karen: I guess that's it.

November: I'm torn between making something very big or something very little. Big seemed overwhelming, and I didn't know what it would be, so I decided to make something very little.

This is a packet to put in your pocket, with resources, with little messages. I picked the color pink because I think of it as the color of hope.

So here are my messages:
Remember someone you love.
Try something new.
Look at nature.
Choose your path.
Say "no."
Love someone.
Take care of your body.
Say "yes."
Find forgiveness.
Hold hope.
Remember someone loves you.
Give thanks.
Be kind.

Group: (soft Sounds oos and ahhs)

Ellen: These are all amazing!

I have a few ideas that pop to the top of my head. I don't mind getting the ball rolling with ideas. We can go around and brain-storm ideas unless somebody else would like to start?

November: I have an idea. My idea is we all go over and hang out at the Maple Street Inn and make a commitment to do that on a regular basis.

Ellen: What would that look like?

November: We would do that to show we represent that we are part of their community and they are part of our community. And we see them and care about them. And we have hope for them and don't want them to be isolated.

Karen: (to November) Just a response. As you explained your idea, I started to make a connection to your idea and what you shared in our group last time, because it seemed like you felt that you hadn't given enough knowledge or something to that person who was homeless.

Ellen: Does anybody else have ideas that came from doing this project?

Francis: I had an idea when you first mentioned it. I had the idea to do something for the people in the front office, because, so much happens here all the time. People come in all states of distress. They're the first place, the first hit, and then they come to us, when we call them in, and it just goes around and around.

Like Lynn stays smiling over many years. Then you see her out back reading her book voraciously over any moments she has. That's how she bumpers herself. And then sometimes people are very grumpy at the front desk, cause who knows how many times they've called looking for someone. So it is a point where the community comes together around everything we do and everything that's out there.

Sometimes people like to go back there and talk with them, and then they shoo people out. There is always this, "How do we come together in this building?" It fascinates me a little bit to think about what we could do at this meeting point and place. I don't actually know what that would be. I know there are people who, individually and collectively, try and take care of these people, help and support them, show appreciation.

If there were a way for that to be a little different for the people who work there and the people who come in. Not that what they do isn't good enough.

Ellen: Any other thoughts that came up while you were working on your piece or since then?

Group: (no response)

Ellen: I'll just share one or two. I certainly got the connection theme, the relationship theme, the gentle kindness theme. The manner in which you do it is sounding like subtlety.

I thought about presents

November: Presents?

Ellen: Presents. Beautiful envelopes with pretty things inside them, that you, we, make for x number of people that we pass on the street. Different than holding banners up, more like painting something on the side of a building. But with a 'Yes' kind of relationship building. You know how presents do that?

Karen: Building on that, I had this image of a piece of cardboard or whatever with pockets all over it, made out of different fabrics or paper and putting something in each pocket. Whether it s a word, object or an idea.

Ellen: It might be fun to build one for the front office and one for Maple Street, a note of inspiration to share with people. The "Thank you," the "Be kind." Then people could add or contribute or change.

Group: Ahhhs !

Ellen: Take one or put one in.

Francis: Oh that's an interesting idea! You could make ten of something like that, saying 'Yes' or 'Be kind.' Then there would have to be a way that the appropriate thing would end up in there.

Ellen: Yeah, maybe a pad of paper right there.

Karen: We could use it as an on-going project. We could take things out and add things to it.

Ellen: Oh yeah, oh yeah!

Francis: So it would look like yours but not exactly. This is different, but you could have something showing from behind. The little spaces to put things in, kind of like yours.

Karen: You could incorporate Nona Gal's people (paper dolls). You could have people on it, and have little pouches. People could be carrying tiny little pouches.

Ellen: So it's an on-going community-building project that affirms the generosity of spirit, how did you say it, "that builds relationship?"

Belgium: (continuing) Like an Advent calendar for all the time, a living one.

Group: (lots of positive affirmations)

Karen: An endless Advent calendar.

Belgium: You can open it and put things into it and change it.

Ellen: It's not just being done to you, and you're only finding out, you're contributing to the happy, surprise thing in there.

Belgium: You can contribute if you want or just be curious.

Ellen: You know how at some places at a front desk there is candy? Offering the welcoming spot? This is a different experience.

I think about the Advent calendar and how the person whose calendar it is usually gets to open the door. Only those special people get to open the door. This is something that says

everybody would be welcome to open the door. Look in the envelope. How to do the envelope?

Francis: We can call it "Take one and Make one."

Group: Laughter

Francis: The only thing is that I know is inevitable is that somebody's going to put in there a direction for what should not happen.

Nona Gal: Guidelines.

Francis: Maybe give what you make to your therapist, or to the front window to protect it from somebody having a bad day, or to somebody who is pissed off at the front desk or something.

Karen: Another obstacle is if it was actually placed in the front desk space, the women who work there don't want people walking in and out. So it would be hard.

Ellen: I was thinking about the wall next to it. There is a blank wall by it. There is almost a whole area down there that's by the window.

By the way I'm still thinking about simultaneously having one at Maple Street and one here. I don't know about the relationship between there and here. Do people from Maple Street come here?

Group: (nodding yes)

Francis: Could we make two though, one for here and one for there?

Ellen: We could make five of them. Think about other fun places you would want to put them. We could make a factory, one person can do this part, another person does this part, then we put them all together.

November: So are we going to complete this during the time of the workshop?

Ellen: Yes, that's one parameter I put on it. But if you all decide to put more time in it that's okay. The idea is that you don't have to. You're already doing a ton of things. It's not to make your life more complicated, but if you would like to, that's fine.

Nona Gal: I'm wondering if many clients might feel not comfortable stopping right at the front desk. They are checking in and checking out. There are people standing around. So it might not happen.

I don't know if the waiting room wouldn't be a better place. Then maybe the people behind the front desk would get something else. I'm not sure, maybe it would be fine and people would stop there.

Then I'm wondering if we could have a combination of what this pocket thing could hold, like some words and stories. Then there could be some pamphlets on self-esteem, and a couple of tea bags, for somebody who is not drawn to words.

Group: (enthusiastic, affirming sounds)

Ellen: I'm not thinking about it being for clients, I'm thinking about it for the community, the people who are here, so that you could go and get something.

November: It could go in the staff room then.

Ellen: You know what you were saying about community building. If we start being exclusive about who gets to work on it then, are we following through with the universality of what I think you all have presented here?

Karen: So if we did it in the staff room, then everybody in the clinic would get it.

Francis: It doesn't mean it has to be the way I first touched on it, the place where people come and go and meet and interact but it feels like it gets lost if you put in the back of the building.

Ellen: Do you think it could get put in the front of the building?

Francis: I think there could be a conversation about this. I don't know how everybody would treat it. It might be fine but it might not.

Karen: One of the head honchos would have to approve it. It might get a little complicated explaining it to people.

Francis: What pieces are essential, and what pieces can we let go?

Belgium: This could be part of the project, finding a way to explain it to people. Because really, what is it? Fast forward to someone asking "What is it?" In my mind, the answer is "It's something positive." That's how to explain it at this point. Then you get all sorts of people responding with their "That's great," or "That's stupid" and everything in between, including the jokes.

I'm thinking about what we are creating. There is a blend here. It's a positive piece. It's something on purpose, an effort to be supportive. Maybe we'll get a better sense as we create it.

Ellen: I'd have a few headlines next to it or right above it that say

‘Building Community.’ ‘It’s Something Positive.’ ‘Take One Make One.’

Francis: I want to go back to something earlier, because when I first expressed this idea, I didn’t know that it touched a sense November had about human presence at Maple Street. Because if this is written, maybe people would take it there or use it in talking to people.

Ellen: Or build a board there.

Francis: Oh, that would be interesting!

November: Say that again?

Ellen: Or build one there

Francis: I didn’t know if it had enough of that sense of being present with them there. That was part of your idea. I wasn’t sure if it missed that or included it enough?

November: I’m open to the evolution of this. It’s different, and it’s okay.

Ellen: I pictured us meeting there at Maple Street. Then I thought that‘s a lot of us to show up all at once. There are a lot of options of what we could do next Friday.

November: One of the things we could do is find out what they need. What they don’t have. In terms of staff time, we could be doing something and at the same time be an offering listening presence.

Francis: I can just say this right out, so it’s not a hidden thing. I can sit in a room with somebody and do the most intense work about the most horrific things. But I don’t do well when I go into soup kitchens and shelters. I don’t have the buffer I need when I go into some of those dense environments.

So I would like to be part of the spirit of what we talked about, but to actually interface in that way is not how I can take the best care of myself, and I don’t know if that is the best thing to do.

Ellen: On that note I will share that I was imagining making a series of those envelopes and of course some blank ones so people could add some of their own and pass them on. Keep them for themselves or pass them on. “I got this from somebody and give it to you,” in terms of including Maple Street.

Francis: Little prototypes? I was thinking a simple way to get a smaller one than that. (points to Belgium) We’d have to see if the organization would put up a cheap bulletin board. Then you could create little pockets by just tacking them on to do it as simply as you could. We could put paper on the back of it, and then create little pockets of cloth or whatever and have it be fairly simple where you do a heading and have stuff in the envelopes.

It could be as simple as sticking up an envelope and then you pull out the goodies.

"Thank you" (as someone hands an envelope with phrases in it to me.)

When thinking about Maple Street, having room to add would be just as important. That little pad of blank paper would be so you could add one.

Karen: We might be able to get cheap colorful envelopes, so it would be visually more exciting.

November: And different sizes too.

Group: (affirmations)

Francis: This might be nice for Maple Street because people come and go there. They sleep there then have to go out and look for a job. Then they could take something with them during the day.

Group: (affirmations)

Ellen: Yes, people will be able to evolve it. While people are in the intake process, or hanging out, there would be this interactive board available.

Karen: Now I have to put something out. While we're talking about Maple Street, what's coming up for me is compassion fatigue. I feel like I don't want to focus on Maple Street. I want the focus to be on helping clinicians. I want the focus to be more here.

November: Helping the helpers?

Karen: Yeah, helping the helpers.

Francis: Could we create this maybe and then have it be something that ends up in more than one kind of environment? Well, maybe you and someone else that wants to go with you. If I was with you I might do it actually.

Group: Laughter

Francis: Go a couple of times and see if the staff is interested and see if this could be developed over there.

November: I guess I wouldn't want to do something there that we couldn't really follow through on. As we're thinking about it, it's beginning to sound like more work and time.

Francis: I was imagining that if we worked with them a little, they would want it for part of their community, that they would sustain it, if we simplified it enough. In that sense it

might be transferable to other environments. If they would want to take it as we passed it over to them.

November: That seems more viable to me.

Karen: My boundaries are coming up. I don't want to add anything else. I don't want to have to do anything else, anything extra in terms of this group.

November: I think "Say No!"

Group: Laughter

Ellen: It's such fun to even imagine the phrases that could be put in each envelope. The things that everyone has said already, isn't?

Belgium: "Say Yes" and "Say No."

I'm not really sure about that world (at Maple Street); it's much more about survival. This is such a meat-and-potatoes place as opposed to the work there. It's just different.

Francis: Are you talking about the front space here?

Belgium: No, Maple Street.

Ellen: I think we're starting to narrow down and getting closer to what it is. Even though the idea started with Maple Street, it sounds like it's moved to this building. And the notion of helping to build community here, of giving it a positive, subtle, potentially private moment people can have for a refresher. It doesn't take more out of your day. It actually 'gives' time and it only takes 2 seconds.

Does that sound right so far?

Group: Yeses

Ellen: I am still hearing the idea about little packages that offer a little light, a little brevity, a little care.

The packages have a variety of ways in which they are distributed. Is it literally handing off envelopes of creative things to people, in mysterious ways, or is that it's on a wall and you can come and take a few or put a few in or just look? Or put them back? It's like a whole board game.

Am I close so far?

Karen: You know, I was thinking about the Advent calendar. What are they called? They

are calendars, but they aren't specific years. They just have the number and days of the month. I am possibly adding the calendar theme.

Belgium: So far, what I can imagine is it could be universal if it were on a wall in this building in a communal place on the first floor somewhere.

The themes are quite universal: Head Injury, Doctor of, you know, Chief Medical Director. Here it is something that is positive at least in these messages, in these themes -- soup to nuts.

It's great for the helper and the folks who come waltzing in. It's great for the med reps who might notice and have more time than anybody, sitting waiting for some doctor for forty-five minutes.

People can have a response to it, get into it, or have a negative response -- you can't control the response. Just as an example, hanging it in a shelter. It's a little different. It's just an issue of time and place, not that you couldn't to it.

Ellen: I'm sure we could do it. It's just a question of whether we can do it for next week or not.

Belgium: Yeah, the time thing. I'm with you.

Ellen: Can you imagine yourself going up to this wall and participating?

Belgium: Totally!

Ellen: Participating in the wall?

Group: Yeses

Belgium: Curious absolutely, responding to something positive.

Group: Yeses

Ellen: Do your clients come to you? Or do you come to meet your clients?

Group: It depends on your various floors.

Francis: I started to have some reverse feelings. Maybe it was from Maria's idea of really thinking about what would be self-sustaining about this, so it didn't create more complications, and figuring out who is going to do it. Maybe the staff room would be the place, if we set it up and there was an invitation and it truly engaged people.

Then there is a copier there, if we leave a few papers there, some scissors. People sit back there and eat their lunch and get their mail. If it drew people enough where it would be a

simple thing -- it would be for the people who go back there. In that sense it could be the perhaps the simplest self-sustaining thing. We wouldn't have to worry about monitoring it, so something inappropriate wouldn't be an issue.

Well, hopefully, we could all do that for ourselves. Someone could sit down with their lunch and create ten messages and pop them in there. It could be, "Take one, make one, share one," so maybe a clinician would grab a couple and share with their clients. Or somebody doing a group would take a few. So it seems maybe safer there and a little more sustaining.

Ellen: You could absolutely encourage people to make them with their families.

Group: Sounds of affirmation, ah… wows, interesting

Ellen: A directive could be, "This is an interactive bulletin board that we use to help to sustain us."
Could you imagine introducing this to a client to do with their family?

Nona Gal: I have a couple of ideas. One is, if it is in the staff room, one of the components or things in a pocket could be a coupon. We could make a little card that says something like not "random acts of kindness," but something like that, and every once in a while stick it in somebody's box, so that they're going through their mail and it just says "Yes," or "Hello, You're not alone."

Ellen: So it's not confined if you go to the board, but you're spreading the spirit.

Nona Gal: People could take them with them and give them out.

The other thing I was thinking is if we want there to be a changing theme, spotlight on a word, a quote of the week or month.

Karen: Yes, like a theme.

Nona Gal: Here's one that is very different. I saw it in a magazine. This woman has in her kitchen a big metal thing, and she's got fortunes all over it, so people stand there and read them or take them or add to them.

November: This reminds me that sometimes you go down to the staff room and there'll be something that just came out of the Zerox machine, and it'll be a poem. And it's just sitting on the table, and I'll read it and think, "Oh, I wish I'd be included in whatever group was getting this poem."

Ellen: And now you would be.

November: Yes, yes, yes!

Ellen: What a great way to pass along those inspirations in the room where you guys have a moment of down time for yourselves. The fun of sharing them at times – "Hey I just got this one" and again, you never know who you might be able to pass it on to. But you don't have to. You get to have a moment for yourself.

Karen: That is a subtle way people are sharing here, by leaving things once in a while on that table.

November: Well, it's not intentional.

Karen: Well sometimes it actually is. Today I'm putting something intentional on the table.

November: Okay, ahah.

Ellen: Okay, so we know who is the culprit.

Group: Laughter

November: So it builds on what already is trying to happen there, and tries to bring in what we have put together. Certainly what I have taken from here is the sense of connection that is so so needed here. So it builds on that.

Ellen: I think you've got it.

I'm so glad we have these extra minutes, because this is big discussion. What we're talking about is something for this building. Help me understand what supplies to bring. Is it based on soft fabrics or a hard board that could have soft pouches and pockets?

My concern is with something soft given the short time frame we'd need to glue it, and I'm not sure how long it would last. Does the glue hold if we hot glue fabrics on for pockets? The other thing is yuckies that sometimes gather in pockets.

Francis: If we had a board, a corkboard, we could staple onto it, and it's pretty firm and then you could reinforce it. But you could pull it off, shake it out or replace it. I think hot glue holds for a while, then all of a sudden it doesn't.

Ellen: Good, because with sewing we'd be sitting here going very quickly but we could get a number of boards. I definitely know I have a corkboard that is smaller than that.

Do you know what size would be ideal, that would fit next door in the staff room. Things might be able to dangle off of it, your bag, your doll, your hat. It could have pizzazz.

November: As I think about it, there really isn't any wall space in there.

Ellen: Oh come on, there has to be a little space. Are we allowed to go look?

November: Something free-standing.

Karen: We're going on a field trip.

Belgium: Checking out the wall space.

(Group leaves and returns)

Ellen: Do you think there is a permission process for using the space?

Belgium and Karen: Yes.

Ellen: How do you want to handle that? Do you want to ask for permission beforehand? Do you want to ask for permission after?

Group: Laughter

Ellen: It's a nice present isn't it?

Francis: It could look so impressive it could sell itself.

Belgium: Now you're talking.

Karen: We could go to Marge and say, 'Marge, look!'

Francis: And we'll be so glowing she won't dash it.

Group: Laughter

Ellen: It's in a little corner -- it won't stop the work, it'll inspire it.

So, you'd like me to bring a board?

Francis: I have a question about who pays for these things supplies?

Ellen: All of these things are paid for by me. At times these projects are grant-funded or someone sponsors a program such as the Northampton V.A. sponsoring a program for their staff.

Francis: Because I would be happy to ask for money from the organization.

Ellen: Sure, feel free.

Francis: I don't know if I'll get it.

Ellen: Do you want to say it's for art supplies or think about what you want to say it's for?

Would you like me to bring a staple gun if you want to put some fabric on the corkboard? And of course everybody can bring whatever she wants. It doesn't have to be just me having fun, looking through things to see what would be good. I can bring some colorful envelopes of different sizes and other fabric to make different pouches.

Karen: Push pins.

Francis: We need paper to do what Maria did. I go down and get paper on King Street all the time to make diary cards in different colors, so I can pick it up.

Ellen: Great! Sure, anybody who wants to bring stuff, feel free. I'll make sure I'll bring basics as well.

Karen: What kind of board are you going to bring?

Ellen: I think it should be a corkboard so you can put things on and off.

Karen: Oh good!

Ellen: I saw the size.

Group: Laughter

Karen: Maybe we can cover it with fabric.

Ellen: I'll bring some fabric. Then we'll work on building the board, and putting in key inspirations, notes, coupons, or different kinds of things that give it the jumpstart you'd like.

As I understand it the purpose of this is (pause) -- actually, Let's do a go-around about what the purpose of this is.

Belgium: Something positive.

Karen: Sharing thoughts and little feelings.

November: Connecting with colleagues.

Francis: Caring for colleagues.

November: Breaking down isolation.

Ellen: Keep going. Second go-around.

Francis: Humor.

Group: Laughter, agreements

Ellen: In closing today we have time for a quick go-around. What is something you liked about this meeting today and something you wish was different? I do like having time for a closing activity together.

Nona Gal: I was thinking on my walk here this morning that I was really excited about doing art. Yea, someone is going to be there and we're going to do art! So, I like that we got to do our piece. I also liked that this was a really a productive meeting. At the start I couldn't imagine what we would come up with. So it feels really productive to me and energizing.

Ellen: And anything you wish was different?

Nona Gal: I can't think of anything. Well, maybe the time.

Ellen: Okay.

November: I really like the resonance of the projects we did alone.

Ellen: I'm not sure I get it. What does that mean?

November: For instance, Belgium has "Yes." Francis, "Be kind," You were working with the pockets, and it's all about community, and it's nurturing therapists.

Ellen: Oh yes, thank you, and something you wish was different?

November: I can't think of anything.

Karen: A warmer room.
I love the collaborative creativity. I love the sharing of ideas. I would wish for a space with more atmosphere and lighting.

Francis: I like the way you helped us stay focused with gentle containment, your reflections. This thing that started out in all of us had a commonality, but we didn't know how it was going to meet and form. And you just kept helping us to keep going -- then it just happened. I really appreciate that.

I tend to come here rushed not having had decent food. So it would be great if we had food.

Group: Lots of laughter

Karen: Yeah, maybe for next week, since we'll be spending so much energy, we could bring some.

Francis: Could we bring something?

Ellen: Absolutely! It's fine with me. Are you saying you'd like me to bring it, because I could?

Group: Lots of oh no's and "You bring all the supplies."

Ellen: See this check-out process has been really productive in itself.

Belgium: Like Karen, I like collaboration. I like formalizing it a bit. I like the idea of it. We're going to collaborate. So that's the part that really sticks out in our creative process and I really like it.

One thing different: I wish I would have gotten here on time.

Ellen: We did it.

Group: We did .

Francis: I have a request depending on what Nona Gal thinks, but I really love what she made and if we include it as part of what we create next week, I wouldn't mind that. So you can decide about that.

November: How about Nona Gal's bags? Bring them back.

Ellen: I can bring back all your pieces. I took pictures of them.

Group: Lots of loud excited, happy voices.
(sounds of some people leaving… Others stay to help clean up.)

Francis: All of a sudden it's toasty in here.

November: It can happen, but you have to be in here for a long time.

Karen left her piece she made at the beginning…I'll bring it to her. She can do with it what she wants?

That was very powerful!

Ellen: Wasn't it? It was just amazing, great!

Transcripts: Workshop 5

Friday November 21, 2008
Digital File E 2

(Conversation among group members before starting.
Waiting for Francis who had come in earlier and brought a large corkboard that the agency had donated for this group project.

Talk about knitting and sewing coming back as a "fad" among Nona Gal's generation.

Ellen requests more push pins. Karen gets some from front office.)

Ellen: Since there has been a lot of hustle and bustle this morning would you like to have a moment's quiet?

Belgium: Sure thing.

Group: Laughter

Ellen: All right, I'll be the timekeeper.

(quiet)

Ellen: As you're ready come on back we can get started. Since we don't have one of your in between meetings to review, I'm wondering if you would like to use this time to look through the calendars to make sure you get your five meetings times together?

Funny thing is when I came in this morning there was a big calendar right here. So, my understanding is that you've met twice or three times?

Group: Individually twice.

Francis: I missed one.

Ellen: In looking at the calendar (late in December) my guess is next week none of you are around for a Wednesday get-together at noon again.

(quiet)

Ellen: Nada. So we'll skip next week altogether. It will be interesting to go for that longer distance and see what it's like to come back together.

Friday the 5th of January is good? Who can be here?

Group: Umm huhs (quiet voices saying they can be there)

Ellen: That'll be your third one. Then I'm scheduled to be back for the sixth workshop on December 12.

We talked about extending it because of the earlier agency training. Originally we were thinking we would have all six workshops and five Sharevision groups by December 12th. But we'll only have three of your Sharevision meetings done because of the earlier training and the Thanksgiving holiday.

We had said we'd have until the 19th but that'll only give you four. I don't think I want to stop at four if we can help it. I wonder if you'd like to go for all five?

Francis: Does that mean that on the 12th it'll be just us?

Ellen: No, I'll be back on the 12th for the 6th workshop.

Karen: Maybe we should try to meet one of those Wednesdays as our 5th one.

Francis: Wednesdays wasn't good for me.

Ellen: Right, that's when you couldn't do it. What can you do?

Francis: So are you talking about meeting twice in a week

Karen: Yes, I guess so.

November: It would make sense if you'll be here on the 19th.

Ellen: I can come back later on another date, if you would like.

Karen: You mean after the holidays?

Ellen: Yes.

Karen: Oh yeah, after the holidays.

Ellen: Would anyone like me to go over their survey with them, the before and after? I'll finish up the workshop with you on the 12th . We also get to say hi which is nice.

Karen: Yeah, yeah.

Ellen: We definitely have that option. You'll have had four of your own meetings by the 19th, but I wouldn't want to take up your group time. If you have a bit of time I would meet with one or two people about your compassion fatigue surveys after your Sharevision meeting.

Francis: You mean we would meet on the 19th?
Ellen: That would be your 4th time.

Francis: I could probably meet for one Wednesday. I'd have to move a client and I could do that once, if you all want. I guess I want to think about squeezing it all in, twice in one week and how it changes it as opposed to having it be ongoing.

Ellen: Is there some appeal in not having it be over and having one to look forward to when you could all get together again?

November: Oh yeah.

Karen: Yeah.

Ellen: Two yeses. How do you all feel about that? Do you have room in your life to do one more time?

Nona Gal: Sure.

Group: Yeah, yeah ,yeah, nodding

Ellen: Okay. This calendar doesn't go to 2009. I'll get out mine to take a look.

Karen: First Wednesday after the year is the 7th of January.

Ellen: Then there is also that Friday. Is anybody here on the second?

Belgium: I'm not.

Ellen: Would you prefer the following week? Help me with the math.

Francis: The 9th.

Group: several people say "I'd be here."

Ellen: All right, Friday the 9th will be the 5th meeting on your own. And I'll send an email to everybody about that.

Francis: So we won't see you after the 19th?

Ellen: Oh no you'll see me.

Francis: Good. That didn't feel good.

Ellen: Let's figure it out. What's works after the 9th?

Francis: The 23rd.
Karen: Is this your final?

Ellen: It's for my coming in and spending some time with people individually, to go over your survey results.

Karen: Oh great!

Ellen: So, I can break it up and schedule these meetings over time. And lets say it'll take twenty minutes

Karen: So we're not talking about the whole hour and a half.

Ellen: Now, look you all. You don't have to stop. You can decide you're going to keep going with all this. It's one of the things when I come back and we met, I'll be asking a few questions like: "Have you continued to meet and use the Sharevision format? Would you like to continue to use it? Do you use pieces of it?"

Group: Okay

Ellen: All right.

Let me give you a heads-up -- getting your survey back can be intense. No matter what we know about self-care and our work, people have still been kind of surprised by the results of their surveys. Our individual meetings can be a nice thing because people set goals for the next step in their lives.

Let's go over it (setting dates for individual meetings). I'll email you all this. Do you all meet for an hour or hour and a half when you meet?

November: Hour and a half.

Ellen: All right. Next, I brought a couple of readings and a few quotes for today. I thought about sharing them as we get going with our group project.

I'm curious if anyone thought about it during the week beside Francis, whom I understand got us a corkboard.

Francis: And the spot. I had to say what the board was for.

Ellen: How was that?

Francis: It was fine.

Ellen: Whom did you have to speak to?

Francis: I spoke with Marge, cause I asked for money and she said we have boards. Then I spoke with Alex (administrator). I think she thought Marge said it was fine. So she's having someone come afterwards to hang it up.

Group: Oh, that 's so exciting!

Ellen: Fabulous, we're safe. I was deciding should I bring my power drill or not. It's great that someone is coming with the sheet rock screws and everything.

All right. In thinking about the theme that came up from the first week, "fear and creativity", here's the first quote: by Mark Matuseck.

'There is a myth among amateurs, optimists and fools that beyond a certain level of achievement famous artists ['read therapists'] retire to a kind of Elysium where criticism no longer wounds and work materializes without effort.'

Group: Laughter from group, "oh my gosh!"

Ellen: Right, there is a professional norm, a myth that we're fine, we can keep on going, that we know everything about keeping on going.

Here's another one by Matuseck.

'To demand perfection is to deny your ordinary, your universal humanity as though you'd be better off without.'

Group: Hmmms, wows.

Karen: Wish I could give that quote to a client who wanted to fire me.

Ellen: How about we make it into a card and frame it in your office?

Group: Laughter

Ellen: These are from a book called *Art and Fear*.

And thirdly:

'Whatever they have is something needed to do their work. It wouldn't help you in your work if you had it. Their magic is theirs. You don't lack it. You don't need it.
It has nothing to do with you.'

November: Oh, that's wonderful

Francis: What popped into my mind as I'm trying to integrate it, was "Is that an absolute truth?" Because how does it all overlap?

Who is the guy who did humanistic psychology? I'm embarrassed.

Belgium: Carl Rogers

Francis: I remember in grad school someone saying that his star pupil and the person that really carried on his tradition worked so differently from him. Their styles were so different and yet the content is the same. So I was thinking there is some kind of overlap but it doesn't need to look the same. There is kind of the dialectic.

Ellen: Your uniqueness is your uniqueness, while having similar ideas your magic is you.

Francis: And there can be a continuity between people. You can learn something and carry on something. We're not isolated. You do this. You do this.

Ellen: Right. We love hearing from each other don't we – sometimes that is.

Remember our talking about jealousy? Oh I love what you did. I wish I had thought of what you did. I think this speaks to it a bit, an ability to step back and appreciate and admire. And certainly not beating up on ourselves because we don't have that thing that created that piece.

There's good reason for it. It is theirs. And we have ours.

Any other thoughts for here? Or shall we start building our piece for today?

Group: "Move on" says someone.

Ellen: So has anyone thought about our piece for today?

Karen: I just brought stuff.

Ellen: You have thought about it.

November: I brought envelopes.

Ellen: Great!

Why don't we work together? Do you want me to take everything out and you guys start building the piece together? Or do you want any conversation ahead of time?

Group: (Silence)

Ellen: Why don't we start playing.

Francis: Maybe we could have tasks, a background, and then a heading, and then little individual pockets.

I actually want to call someone to ask them about something I want to put on it.

Ellen: I have everybody's pieces that you made and hope they faired well in the journey.

Here are some larger pieces of fabric.

Karen: Oh right, because we talked about covering the back in fabric.

Group: Laughter

Ellen: Come on over and play. Where do you think we should put these arts supplies? Right out there?

Francis: Nona Gal, I don't know how you felt about putting your string of people up?

Nona Gal: I actually hung it up in my office. So we can make some more.

Group: (Sounds of others talking about supplies and ideas, standing and moving around the large table.)

Karen: Shall we put the board over there (on a table)?

Ellen: Sure, if you need the space we can put these supplies to the side.

Francis: (Makes a phone call from room, can hear for a minute talking before she steps out.)

Karen: Does anybody else feel like that wall isn't wide enough?

November: Should we take it in there and hold it up?

Karen: Yeah, yeah.

November: I think that's a nice background material -- it's flashy but not confusing.

Karen: Not so confusing, because we're going to put confusing stuff on it.

Group: Laughter

Karen: Look it even divided up into little squares.

Group: Laughter

Ellen: That's a positive reframe if I've ever heard one. Instead of the fabric being wrinkled.

November: Oh look, she didn't iron it.

Group: Laughter

Ellen: I had that thought in the middle of the night.

Group: Laughter

Karen: I brought a bunch of envelopes.

Ellen: Should we make an envelope section down there?

November: Sure, yeah.

Nona Gal: Seems like it's gonna work (…inaudible).

Group: "Goods" from group (sounds, movements going through identify supplies.)

Karen: November and I thought this would make a good neat backing. What does everybody else think?

Belgium: Whoa, there you go. Subtle as a blowtorch!

Group: "Okays" from group.

Karen: What if we folded it in and used the push pins to hold it on?

November: That'll be cool.

Belgium: I'll start in on the… (inaudible).

November: I like that Belgium.

Group: (more talking sharing ideas, questions, planning ideas, negotiating)

November: Looking for perfection?

Belgium: A linear moment, that's all.

Group: Laughter

Karen: It looks pretty good.

Ellen: It does look pretty good.

Karen: You brought back the words we did last week?

Ellen: You took those with you.

Belgium: We can create more anyway.

November: What were you thinking about those?

Karen: To put them in the envelopes.

Belgium: Snazz them up or put them in as is?

November: Snazzier!

Group: Laughter

Karen: That would be pretty cool if we could put them on those nice pieces of paper. Look at these stars. Can we put them in there or would you want them back?

Ellen: I don't need them back.

Karen: Look at these stars.

Belgium: They probably glow in the dark. They do glow. Even in the dark.

Ellen: We've got the glue gun warming up. If we use the stick up we've got plenty and can put another in to warm up. I think there's enough for a star in there.

Francis: Oh to decorate with also?

Ellen: Yes.

Karen: Look, guys. I brought hearts, and then this stamp rolls hearts but I only have this one stamp pad.

Ellen: It's got the right flavor, the gold and silver.

Have you considered a title for this board? How do you introduce the project to people?

Francis: "Take One, Make One" is kind of obvious. Or "Take One Make One Share One."

Belgium: Maybe it'll speak for itself when we're done, we'll see.

Francis: We could put something above it too. We don't have to fill it up.

Is there tape?

Ellen: Yes, here in this box.

Karen: Wish we had some little tiny envelopes. We could put one envelope down and it could say "Take One."

Nona Gal: Can't they just be opened?

Karen: Yeah, good one, Nona Gal.

Belgium: How about placing them for now and then commit to it later, as opposed to starting out committing to everything?

Group: (lots of cross talk negotiating, ideas, questions.)

Karen: Yeah, lets keep brainstorming ideas.

Francis: Do you think we can leave some paper for people to add their own?

Ellen: You could decorate the envelopes, draw on the envelopes, put words on the envelopes.

November: We don't have to have the envelopes like this. They could be on an angle. (She tilts them.) What do you think about putting some of our pieces on top as decoration?

Ellen: Delicate, very delicate.

Karen: Like on the top here?

November: Maybe they would be meaningless to other people and they would just take up space. Maybe they would think them silly.

Group: Someone says, "Never!"

Francis: Actually some might really catch other people's attention.

Karen: How about using this side like a map…oh… a map of your…

November: Hey look, here are some maps. We could cut them up and put sayings on them.

Group: (sounds of material, tearing , cutting, talking among each other)

Ellen: So, establishing a theme, an environment would make sense.

Belgium: The one theme of our group so far is envelopes with messages inside. Maybe that's a place to start.

November: There might be themes that structure it.

Belgium: People, I need some people (indicating paper dolls).

Ellen: Nona Gal, do you mind making some people?

Karen: It is kind of a cool idea if we put a map down and the sayings were a map towards something, towards wholeness.

Ellen: Like you make a board game out of it?

Karen: Yeah.

Ellen: Towards being kind.

Belgium: So a fancy envelope could be…

Karen: Hey I missed that.

Belgium: I was saying in following a theme you could have things step out and one says "Get a real job!"

Group: Laughter

Francis: If you put that out you'd have to put your name on it.

Karen: We could cut this up.

November: That's not a very colorful map.

Karen: If we cut it up. Or we could outline them in a color.

Belgium: Put a town in an envelope: "Conway."

Group: Laughter

November: I'm sorry… you're going to have to explain this to me.

Karen: Cut out chunks of the map, color them in a little. Maybe we can have arrows from one section to another. Going to "Loving Someone, " "Choosing Your Path," Going to "Giving Thanks."

(silence)

Ellen: I saw it. I just saw it. You have chunks of maps with envelopes. The look of maps, envelopes, you might cut out some arrows and on the envelope you might have name a theme.

November: How long do we have for all this?

Karen: Twenty minutes.

Ellen: Or a half hour. You can do that.

Belgium: We don't have to have it all done in twenty minutes or half hour?

Karen: We don't?

November: We don't?

Belgium: We have to have it on the wall in twenty minutes!?

Ellen: No, forty-five.

Group: Laughter

Ellen: What do you think about this idea "Map, Local, Directions"? This idea of locating yourself? Envelopes having themes? Things you may want to say yes to, statements of love. Just an idea.

I do like the idea of adding more color to some of the maps.

Anyone have another one they want to put out?

Karen: Yeah.

Francis: I like what Nona Gal said last week about tea bags.

One of the things I wanted was to bring something from a client of about five years ago. I gave her some information about a phone company. You can call anywhere in the United States for a dollar. She called me the other day and wanted to tell me she still uses it because she doesn't have the money to call her family.

So I'd like to leave a little space to put some things I think about and we talked about leaving space for other people to create things. So I'm not sure how much space we have.

Ellen: Well you have a lot of space. These are very small envelopes. So maybe somebody would like to come up with some themes for some envelopes.

You could cut up the map in any way you want, and then someone can create some more phrases for people to get when they go to the envelope.

November: More of them?

Group: Laughter

Ellen: Well more of the same ones, yes, multiples of them.

November: Okay.

Ellen: And how about you Belgium. What seems fun for you?

Belgium: Make some more of the things to go in them (the envelopes).

November: Thanks for saving us from a moment of being paralyzed.

Ellen: Somebody helped Nona Gal get a job earlier so I'll help you.

November: She didn't get paralyzed.

Karen: How about making arrows out of the map?

Ellen: Fun, I love it! You could put the map arrow on top of another fun colored paper.

Did everyone see the one Francis is making?

Francis: "Be patient, even in time an egg will walk."
It kind of goes with the map.

November: That's great!

Group: (talk of supplies, markers, cutting, placement of the project, scissors… quiet. Soft talking while working. All talk about the project) Laughter.

November: "Life is full of questions"

So the little sayings on the little pink paper -- are we going to use them as decoration or put them on the envelopes?

Ellen: Do you have a preference?

November: If we use them up outside (the envelopes) then they aren't going to be very much of a big deal when somebody picks them out.

Belgium: My preference is to put them on the inside.

Ellen: How will someone know to go inside the envelope?

November: 'OPEN ME.'

Ellen: That's good.

Group: Laughter

November: 'HELP YOURSELF.'

Ellen: This is for you.

November: 'CHOOSE ME.'

Ellen: Are these okay with everyone else? Karen, Nona Gal, Francis? Yes? November, will you put those phrases on the envelopes?

November: Sure, with your help remembering them.

Group: Laughter

November: How about we get these in other people's writing styles?

Nona Gal: Do we want to say something special on the map envelope?

Ellen: How about we say, "SOMETHING SPECIAL?"

Karen: I'm wondering if we should include some wording, that relates to the therapist, the helpers, more specifically for the helpers? Different things that we feel.

Ellen: "Help for Helpers" – it's something somebody said last time.

Karen: "Help the Helpers."

Ellen: What are some other fun ways of saying that?

Karen: How about if we have some kind of direction , or ask a question? "Where are you now?" "Where are you going?"

Ellen: “Where are you now, where do you want to go?”

Group: Laughter

November: Where are we going to put that?

Karen: Right on top.

Ellen: On top over it like Francis had said.

November: Oh, another project.

November: I can’t remember other things we said for the envelopes.

Ellen: What do you have already?

November: ‘Choose Me’” ‘Something Special’

Ellen: How about ‘For you?’

November: ‘For you?’

Ellen: I think addressing the purpose of connecting with your audience could be spelled out.

Karen: Connecting and maintaining resilience and nurturing yourself.

‘BOUNCE BACK’ ‘GO WITH THE FLOW’

Ellen: Keep going. I’ll help over here .

(To Nona Gal) I think these are beautiful papers.

Group: Talk of pinning or gluing the paper dolls.

Ellen: Belgium is busy with the presents for people.

I think it’s coming together.

November: Ellen, I think that’s an exaggeration!

Ellen: I think you’re doing wonderfully!

Group: (more work sounds, negotiation, “where do you want this to go?”)

Karen: Where do you want it to go? "You are here now." Do you remember that book from the sixties?

Group: Laughter

Belgium: "You are here."

Ellen: Nice colors might go well with those phrases. It's not too busy. I think it's welcoming. I think if you put too much on…

November: Yeah, we definitely don't want too much on.

Ellen: Right. There should be enough room for someone to add something.

Francis: Or we can leave some empty space for people to add something to it.

Belgium: I like that too.

Ellen: "A GIFT"

I think these need a little more color on them

November: We could decorate them.

Karen: How about putting it above "Do you need help, support??

Francis: Put a heart right there.

Ellen: "Help support colleagues"

Karen: Yeah, "HELP SUPPORT COLLEAGUES."

Ellen: That's nice, simple.

Group: (more talk about glue and its reliability)

Ellen: Oh, so you keep the envelope closed and then you open it?

November: Right.

Ellen: Nice.

Francis: What can we say like "Add Something" or "Share" "Leave Something" or "Share Something"? Because that's the interactive part. Are we going to make a heading?

Group: (talk of push pins)

November: Ooooh -- this is looking perdier on this side.

Ellen: What did you make over there Belgium? We have to keep you busy. You too Francis.

Francis: I did this little thing, and the other thing I want to add is the phone company information.

Ellen: Why don't you make a heading?

Francis: I need to write up the info.

Ellen: Unless we put it right here. "Take One, Make One," right over here.

Francis: Yeah!

Ellen: I'm amazed that that is going to fit right there. How did you say it last week?

Karen: "Take One, Add One, Share One"

Fancis: I'm thinking about "Sharing."

Belgium: And how about the message that "Where You Are Is Fine"?

Karen: "Where You Are Is Fine"?

Belgium: Yeah, it's the same theme as "You are here." "Where do you want to go?"

Ellen: Is this the general layout now? Things need to start getting put down so we can see what space we have left. Then we can design the two descriptive titles.

Francis: There are the themes of the messages and then there is the theme of the board.

Group: (silence)

Ellen: I was thinking about the theme of the gifts. "These are for you," and "You can add your gifts to it."

Francis: So will things get put into them?

Ellen: Yup, Belgium is working on those. (to Belgium) If you'd keep working away on those.

November: Work away on those Belgium!

Group: laughter

Ellen: Would you like to start pinning things to the board so we know where we'll put the directions? Or do you want to get the directions made first then tack them all down?

Francis: Are these spread out for us to look at or are they going to stay here?

November: No, these aren't going to stay here.

Belgium: Tack them on or put them in?

Ellen: I thought they were going in some.

November: Well, I said I'd rewrite them. This envelope needs a title and a decoration.

Francis: Can we pick them up and start writing them?

Belgium: Yeah, start filling up the envelope. Definitely.

Group: (more talk, negotiating the placement and roles, jobs, questions)

Francis: I'll do some of these.

Ellen: The directions can be as simple as 'ADD YOUR OWN' 'ADD MORE' "ADD TO THIS."

The word "GIVE" could be tired for some folks.

Karen: Yes!

Nona Gal: Yeah.

Ellen: Skip giving anymore and think of adding.

November: In terms of attaching the envelopes to the board, I think they'll be easier if we just use stickpins. Or have you decided that?

Ellen: Is that good? Open or closed?

Karen: Opened. Did we need anymore words?

Ellen: Yeah, this one needs a title.

Belgium: Just a question mark on the outside.

Ellen: Yes, isn't it fun when something is right? It really sticks.

Karen: Belgium your thing was 'YES.'

Belgium: "YES!" right in the middle, in the gold envelope, 'YES!'

Group: Laughter

Karen: We also need something that says "You are here now."

Group: More laughter, more talk of markers, pencils, sounds.

November: "FOR YOUR JOURNEY"

Ellen: That's nice.

Belgium: This is colorful.

November: Ellen, I made these little pieces, because they are really pretty.

Francis: Oh, that's nice!

Group: (sounds of paper being cut)

Francis: I think I made these small…But we could have different sizes.

Group: (talk about glue, supplies, colors. Belgium is joking about putting something in an envelope. Enthusiastic voices, "beautiful," "great!")

Ellen: I like the "Support Colleagues" on top.

Francis: Yes.

Group: Yeses

Karen: You know what I just thought of when you read an article and you think it would be helpful for other clinicians, people could put little articles in.

Ellen: Yes, little, miniatures, you'd read them through a microscope.

Karen: Oh Yeah!

Ellen: Or a resource pile if you all are co-opting the corner.

Karen: Oh, right, yes.

Ellen: Little spaces could grow.

Francis: Okay, I was thinking we could leave a few things on the table, but I don't know what that would be. If we took up too much space Marge would probably reject it.

Ellen: You're right. I think gradually is good.

Group: (quiet talk focused back on project)

November: Do you think that's too negative (a "No" card)?

Francis: No, I don't think so.

Karen: What does it say?

November: 'No.' I think it's important to say.

Francis: I don't want to be too cheesey but you could say 'No With a Smile'"

Karen: Set limits.

Ellen: 'Say No'

November: Maybe 'Set Limits" is better than 'Say No'

Francis: Well it makes you think, I don't know that we have to figure it out completely today.

Belgium: In my opinion it's okay.

Francis: What's the size of the envelope for when I cut the paper for these long ones? It's going to make it hard for people to get them out of the long envelopes. Maybe we can cut these in half and make two?

Ellen: Do you want to make some longer ones?

Francis: Yeah that's what I was wondering, how to do it for the envelope?

Ellen: It might be nice to write them on a long piece of paper for the long envelopes.

Karen: Nice, a nice idea. Can we put more than one in? We can put more than one?

Ellen: Oh yes, a bunch in each so that people can take it with them, and there will be others for the next person. You know people will want to take them.

Karen: How about 'Have coffee with a colleague'

November: ‘Take a colleague to lunch.’

Francis: ‘Take me to lunch.’

November: “Take yourself to lunch.”

Belgium: “Don’t forget to eat lunch.”

Ellen: Belgium, do you have enough paper down there?

Belgium: Yeah.

November: What is going on with this?

Belgium: It’s a question mark for the outside instead of words.

Ellen: We can use the other half of the paper for some notes.

November: Oh, that’s great!

Group: (more “where does this and that go”…talk)

November: I forgot what I was doing.

Ellen: You were working on the lunch thing. I’m going to do one on “Come out of your office for lunch!”

How many of you have lunch alone in your office from time to time?

Karen: Oh a lot.

November: A lot. At least a quarter of the time.

Ellen: I’ll be happy to cut long strip for the longer envelopes.

Karen: This envelope is hard for people, should I take it off?

Ellen: I was going to make some strips.

Karen: Oh, good!

November: We already said, “Say yes to lunch.”

Ellen: “Take me out for lunch.” What was another one?

Karen: What Belgium said, “Eat lunch.”

Ellen: And then “Eat lunch with someone.”

Group: (more cross-talk going on …”gorgeous,” “does anybody need glue…)

Karen: “Try not to rush.”

Belgium: “No rushing.”

Ellen: As we rush to finish!

November: “Try something new”

Karen: Hey I know, “End On Time.”

Ellen: What’s amazing is you guys can add to these whenever you think of a new one.

November: This is so beautiful!

Belgium: So textured.

November: Where are the kooky scissors?

Ellen: Is there anything else that needs to be glued down, the stars?

Francis: How about the glue gun?

Nona Gal: You have to press it here. I can do the stars.

Ellen: Are you just about done? Any other decorating for now?

November: “Choose your path.”

Nona Gal: Are all the stars down?

Karen: “BREATHE.”

Belgium: “BREATHE, PAUSE.”

Karen: “PAUSE,” yeah.

November: How about “YOUR OWN MAGIC”?

Ellen: What were some of the ones you liked? We could do some duplicates.

November: Duplicates? We haven't done "Try something new." I'll do that.

Ellen: Belgium, will you do some of those?

Karen: "CARE FOR YOUR BODY."

November: Did you already do that Francis?

Francis: No, I didn't.

Group: (quiet, writing by all members)

November: Did anybody do "Take a friend to lunch"?

Group: Nope.

Karen: I did "Take yourself to lunch."

I'm trying to think of all the things I don't do during the day and should. And like to do.

Ellen: Yes, what would you like to do?

November: This is fun!

Nona Gal: "STRETCH."

Belgium: "REST."

November: Oooh, I like that star on there! Put more stars on. They're wonderful stars. I just like them.

Ellen: While you're finishing up, because I know you have to go.

November: I don't have to go.

Karen: I have a 10:45.

Ellen: Okay, let's say we have eight more minutes.

November: I love it, "Water the plants." That is something I forget to do.

Ellen: Yes Belgium, a little paper that says "Add Some" right there.

November: How about we put the envelope down and write "Add Some" on it?

Group: (affirmations by individuals as each new idea comes up…sounds of craft supplies, negotiations, affirmations)

Belgium: How about "Feel Free" on the outside?

Group: (affirmations)

Belgium: Will any of the group projects fit on there now?

Karen: So you're going to write "Add Some"?

November: Yes.

Karen: How about if we have a sign down there? I think we need to say that down there too.

Group: (ideas, negotiating, affirmations)

Ellen: You can keep developing it over the months ahead. And, you can spread the idea verbally to others in the building.

Group: This is really special! (more design ideas, more questions about what goes in and the envelopes.)

Karen: I still think this "Help Support Colleagues" goes somewhere else because it's too much information.

Ellen: Do you want to skip the "Where are you now?"

Francis: Or do you want to put that on top?

November: I don't think we've really made much of the directional theme. Do you think we have made enough of that?

So I think it makes more sense to have "Support Colleagues."

Karen: Oh good!

November: I mean if we'd done more with the map theme.

Let's pretend we're all colleagues. Who do you want to be? I'll be Ben Ridge.

Group: Laughing

Karen: Do you mean him standing in front of this. Then he'll be analyzing it.

November: Then we need to write “Stop Analyzing.”

Group: (negotiating design and color ideas, something uplifting)

Ellen: Let’s use these last minutes for the same closing as last week. Something you liked about today and something you wish were different.

Karen: This was cool, actually creative brainstorming together. I wish that we had time for individual check-ins. I had a couple of really difficult things happen in the last couple of weeks, and I just wanted to verbalize it.

Ellen: Is it possible that you can find some time with somebody here to have a check-in?

Karen: Probably not today, but probably next week.

November: I could meet.

Karen: Okay.

Ellen: Would you set a time, or a call to set up time?

Karen: We could do an email.

November: Okay.

Francis: It was a little hard for me because there were so many parts to what we were doing. You know I thought about getting the materials but I didn’t think about it past that. So I didn’t feel as connected with everyone today or about the end product as I might have imagined.

Ellen: Anything you did like about today?

Francis: I like that we actually did something with what we had imagined and experienced and are able to share it now. We actually formed it. That people outside will get the benefit of it.

Ellen: Who would like to go next?

Belgium: What I like is our effort to collaborate.

Ellen: Something you would have liked different for today?

Belgium: For whatever reason, in my head, I didn’t see how much we had to have figured out in such a short amount of time. It is unfortunately a familiar experience at work. I made up that it doesn’t need to be finished up today. I got it in my head that we’d put it up when at the last time we meet.

Ellen: I understand, and we can talk about it next time.

Nona Gal: Something I liked was that the project we did was collaborative. Something I'd like different is not feeling rushed.

November: I really like the end product. I liked the moments when ideas sparked other ideas and people picked them up and went with them, and I would have liked more time.

Ellen: I'll go quickly too. I think you are all amazing! This is no small project. You ended up with a phenomenal project. And, I absolutely agree with you about the time. Wouldn't it be wonderful if we had more time!

So, having said that, I know we want to send you off in good shape for your next meeting. I'll stick around and help out with putting it up.

(To Karen) I'm also glad you worked it out to meet with November.

Karen: Okay, bye.

Ellen: I can't believe you all actually pulled this all off! It looks really good, and it's a work in process.

Group: Laughter

Ellen: Feel free to take a breather and not clean up.

November: Oh, it's alright.

Group: (sounds from group cleaning up, someone is whistling a happy tune, talk among group)

Ellen: Belgium, can I ask you about what you were saying in your check-out about the familiar experience of rushing?

Belgium: Oh, yeah, the focus on product and rushing is really something I know and don't like here.

Ellen: You know when I first developed this work into a workshop series, this group project was the final day. I learned that we really needed another meeting to reflect on this experience. It's very important.

Belgium: It was curious to me that my head decided we had more time.

Francis: Am I going to make things worse by putting all these supplies in this one box?

Ellen: It's all right. I can take care of it.

Francis: I can take these up to Karen since she brought them.

Group: (more sounds of planning, organizing, finishing up)

Ellen: What you all made is really clear, supporting colleagues, really nice.

Belgium: See you all in two weeks.

Ellen: Bye, Belgium.

November: What about hanging this thing?

Ellen: Somebody's coming.

Francis: We could just leave it in the other room and they'll hang it up.

November: Thank you, Ellen.

Nona Gal: Thank you, Ellen.

Ellen: You bet, shake it off! That was turbo experience, an Indy event!

Transcripts: Workshop 6

Friday December 12, 2008
Digital File A19

Ellen: (referring to the news that the board did not get put up) I'm so sorry to hear that.

Nona Gal: I'm not aware of anybody in the group inquiring again. I have no idea whether it's been followed up with, because I haven't.

Ellen: Would anybody like to? Would you like me to? How should we handle this?

November: Who did it originally?

Karen: Francis.

November: Maybe we should ask her to follow up on it, hoping she'll show up today.

Ellen: What's it like for you having it be in the corner there leaning up?

Nona Gal: I don't think it's the best place for it.

Ellen: How does it feel?

Nona Gal: Even if it was on the wall I'm not convinced it's the best place for it. It's a little out of the way. I'm not sure if any people have stopped and used it.

Ellen: Well, it's on the floor.

Nona Gal: It's not on the floor anymore. Once upon a time it was. But now it's on the table leaning against the wall. Basically it's in the spot it's supposed to be in.

Ellen: What's that like for you all?

November: It's kind of embarrassing actually. It feels like something that nobody understands what it is. There is no message about it. I think there should be a message about it on the table right there. People see the table when they come in. And frankly it looks a little hokey.

Nona Gal: Belgium, Karen and I, after our meeting, went back and forth about whether the purposes was to have something very obviously written or is if it's about experiencing it the way one should experience it. We were all over the place in our ideas about it.

I saw Karen earlier this week and she said, "You know, I never finished the write up and don't think I will."

We were talking about the purpose of the final project. Maybe we can accept it as about getting ideas on how to build a resilient practice and this was the first experiment.

We're just beginning to think about it and, we need to reach out to colleagues.
We tried this. We have some ideas of how to improve even that, like the write up and a better place to show it. So we're just beginning. This was an experiment. We only had a certain length of time to complete it.

November: (to Karen) Good morning. We thought it was going to be the hardest for you to get here.

Karen: It just took me longer to get all the junk (snow) off my car, and I drove slower.

Ellen: Yes, once we got out of the sticks.

Karen: Yes, you live in the sticks too?

Ellen: Yes, I had to cut my way out.

I was just hearing about the board, that it is down and against the wall. It's down and never got put up and how lousy that can feel.

Karen: Yeah, nobody knows what it is. Did you tell about our conversation?

Nona Gal: Yes, I don't know if I've talked about all of our conversation.

Karen: We had second thoughts about how it turned out. It seemed too busy. So we wondered if we could change it?

Ellen: Yes, why not. It's yours. Of course you can.

I was wondering if once it's changed if you would like something posted on the intranet to explain it? Then it's very clear.

Group: Yeses from group.

Karen: We can ask Marge.

Ellen: If you like we can write it up today so no one is left with that job, one more project outside of here.

Group: Yeses from group

Karen: I was going to write something but just didn't.

Ellen: Oh, of course, there is so much to do.

Karen: I saw Belgium. He is coming.

November: Oh good.

Ellen: Did you want to add anything? (Door squeaks open) About how you were feeling slightly embarrassed?

Karen: What did November say?

Ellen: Did you say that it was slightly embarrassing?

November: I find it embarrassing. I think it looks really hokey up there. I think its been completely ignored. I think if anybody asked about it, they would say, "What is that?"

Karen: I know I found myself, well, I didn't explain too much about it to anyone. I found explaining it in an apologetic way. We only had forty-five minutes to do it.

Ellen: (to Belgium)We were checking in about the board and it never being put up and how miserable that feels.

Belgium: It's true. It's just leaning there.

Ellen: Leaning in a sort of pathetic fashion apparently.

Karen: It looks sort of grade school. How did it end up that way?

Ellen: Yes, good question.

November: Yes, for such an inspired project.

Ellen: And for such an inspired group.

Karen: I think we said a lot, given we didn't have that much time to do it or think about it.

Ellen: It was very, very quick

November: No, I think it's a contrast in cultures. They didn't, our colleagues, go through what we went through.

Karen: Who didn't?

November: Our colleagues who didn't come to this class.

Karen: Oh yes.

November: I think having not gone through this experience, it would strike them as not having much impact.

Ellen: And certainly having it be on the floor for as long, then leaning on the table. It just didn't get its fair chance. I think if it were on the wall it would look like it's supposed to be here. As opposed to the apologetic…maybe there's a little room in here for us.

Belgium: I don't know, my bias. I'd ditto what a lot of people have said. There is something childlike about it, but that doesn't have to be a problem. It certainly doesn't present the gallows humor that is part of what is here. We talked about it a little last week.

Time was an issue for me. I felt a lot of it before leaving the room. I wasn't psyched on it at all and not all that excited owning it.

Karen: You made the point that there was too much going on.

Belgium: Yeah, I didn't get my way. Which is the flip side of the collaboration. Too many words, not much not letting it stand by itself.

Karen: It isn't powerful enough because this experience has been more powerful than what we ended up with.

Belgium: That's right. You came up with an explanation of what it is.

I was thrown off by the time frame. I thought we had this flowing time. Then this is it.

Ellen: Yes, this is the time we have.

Belgium: This is the curve ball. That I didn't know.

Karen: Do we actually have time today to bring it in?

Ellen: I don't think that would be very hard at all.

Group: Laughter

Ellen: It's not on the wall so we won't have to unbolt it to get it off.

Belgium: I don't think anybody will miss it.

Group: Laughter

Ellen: The thing is I didn't bring all the arts supplies today.

When you said it was the war room, I admit, I thought red background fabrics, darker colors. I don't know what you wanted to do with it.

Karen: I think we should take everything off.

Belgium: November said, "I have some of the same emotional experience."

Karen: What did you say?

November: I think I don't want to see it?

Group: lots of oohhh, gasps from group

Belgium: I get it!

Ellen: Do you not even want to go into that room because it's in there?

November: I can pretend I don't have anything to do with it…I don't know what that is?

Group: Laughter from some

Ellen: Aaawww

That is the question. Can we talk about this? When you know you've had a moment of integrity building something, then there is the being seen for your efforts. This is related to what Francis said at the very beginning: fear related to our creativity. Isn't it? It's a major concern. You've said what are people going to think having it be associated with us?

Group: Oooo, yeses from group

Karen: Oh, Yes it is related. Yeah. It seems odd because, well Belgium wasn't, but I felt excited while we were doing it. So there is also a disconnect between the excitement I think we were feeling or at least some of us were feeling about what we were doing and then how it ended up.

Ellen: Well, lets talk about that some more. I think we're partly talking about what you all or we have built in this room, versus forget about what the board looks like. The concept was your wanting other people to feel like you were reaching out to them. Right?

Belgium: Yes.

Ellen: Your names didn't' have to be attached to it. You were wanting them to get… What was it that you wanted them to get?

November: Well I think it was something of what we got in having this experience.

Ellen: Okay, What was it that you got that you wanted them to get?

Karen: Sharing with colleagues but with a sense that you could trust colleagues and be safe with what you shared.

Ellen: Are you talking about not feeling particularly safe at this point having shared with them? Is that one of the pieces?

You're nodding, you're smiling, you're also nodding. How are you feeling about it? Not too safe about it? Does that feel true for you too, not so safe?

Belgium: Yes in a harmless way.

Group: Yeses

Karen: In a harmless sort of way.

Ellen: The intention was clear. You wanted them to feel safe. And you want to feel safe in your extending this sense of safety?

Karen: And encouragement for people to open up more and share their experience.

Ellen: To open up and share their experience. What else?

I have certainly thought it was helping to acknowledge that people may be in a hard place but in a positive, uplifting and light hearted way. It's relatively colorless out there. You're looking for support, sharing, helping, connection.

Group: Yeses

Ellen: Instead there seems to be a retreat that's going on.

Belgium: We talked about this last week at some point, the timing and the medium is a stretch for this venue, for this crowd. Creatively, what is the medium of creatively here? It's the written word. It's a pretty heady kind of crowd we are in as opposed to the visual.

Ellen: Good point.

Belgium: I was thinking about my response to the time thing. The wind went out of my sails when it was, we've got forty minutes, as opposed to when we started thinking about what it looks like and coming back to it next week. Right, that was in my head. You know. Then it was we're not going to have the time to do that. We've got to make the decisions. To do it and put it up.

Then I thought about the medium being more of a stretch in a place like this, than, say, if we had written something up to put in their boxes, then all these heading people might get it.

Ellen: And put it on the intranet where people are accustomed to meeting each other.

Belgium: Yes, the headiness would be there. "Oooooo they wrote something!" People can wrap their heads around that.

Group: Laughter

Ellen: Yes, we talked about that at the beginning this morning. Making the link via the intranet system where you would have the classic introduction to the unusual piece.

Belgium: The stretch, right?

Ellen: That might help to make the link, as opposed to what you're saying, that there may be no bridge from here to this other world.

Group: (silence)

We might benefit if we were creating something text-based even if it's just a few words that would bridge these worlds from the verbal to the more auditory and literary.

Belgium: Which is also why it should be more distracting. Get people's attention, as opposed to somewhere in the middle. We put something freaky on the wall for everybody and stopped the same ole writing. The same heady people can get all heady about it, but it gets their attention.

I felt it got bogged in the grade school, in-between thing, with trying to explain it.

Ellen: And also it went up without an explanation. In a sense you did get a piece of your way, because it doesn't have the description of what to do.

Belgium: Yes, I'm sure I got my way….cause you know how that goes.

Group: Laughter

Ellen: I do remember the conversation of Karen and Francis wanting to post a description. There were also those wants. I understand wanting to make a bridge to other people. But in the bridging to this other world, you're describing a culture shock.

We might need to consider bridging the cultures. Is that what you said, a clash of cultures?

Karen: When you talk about how people respond more to the written word, it seems like in this culture, since we don't often have time to talk to each other, we could share in different ways like sharing articles or bits of information about systemic things. So there might be a way to use the board for that.

Ellen: As a jumping off spot?

Karen: Yeah.

Belgium: Since that's the way the culture operates. Generalizing.

Ellen: You could say "Look under the table at the box for articles." It could be part of this storied way to connect with people.

Karen: Or we could take everything off the board and pin on three big envelops and have three different categories and offer people to put information in them.

Ellen: One could be notes of encouragement that are personal, if you want to keep up the esthetic effort.

Karen: ‘Cause now people put articles on the table and sometimes they put stuff up on that other board. The stuff on that other board has been up there forever. It’s a big mish mash, you know.

Belgium: People work here fifty hours a week, and people work here an hour and a half a week.

Ellen: I have a big reaction to hearing your conversation about the culture and would love to hear what you have to say about your experience of this clash. Here you are in relationship with one another, you’re talking, laughing, crying together and beyond these doors, just next door… Is this is a major change in your experience here?

Although, you might be so accustomed to it, you might just say, yeah – its there.
But for me as somebody coming in, it would be important in helping me understand more.

Today we have time for a longer discussion. What have we learned by our collective work, the group project? The intention of the group project is multifaceted.
One idea is to break the isolation. On another level, it doesn’t necessarily mean something negative about your site.

Karen: Can I have piece of paper? I want to write some things down.

Ellen: Sure, Anybody else help yourself. Would you like a minute to reflect on this or are you ready to jump in? Are you ready to go?

November: Do you mean am I ready to speak right now?

I feel a sense of hopelessness about translating this experience and communicating it and, including other people. It feels like something you have to experience, and this is the way to experience it.

The only way I think about communicating it to other people is to present articles on secondary traumatization and antidotes, and have those in envelopes for other people. And that doesn’t really get it because it doesn’t change the culture.

Belgium: And are you saying it’s that way because of the culture?

November: That’s the only thing I can think of.

Belgium: I get it.

November: They only think to reach from here to there.

Ellen: Did you have more hope about it after deciding what you would do and making it, than after the Share One board didn't get put up? Because we can't evaluate what would have happened if it was up.

Do you have a sense that you would have felt less hopeless last week, two weeks ago when it was supposed to be put up?

I really do feel Francis' absence. I hope she is okay.

November: No, I think my hope began to slide as we were making it. The time frame wasn't what bothered me. I began to feel like it wasn't translating well.

Ellen: And in the design of it, were you more hopeful the week before?

Belgium: In the early stage?

Ellen: Yeah, in planning to put together a bulletin board that was put in the break room to reach out to other staff.

November: Oh I think I was excited about it then.

Ellen: Okay then, here is my next question. In going back to the purpose -- the purpose in part was to break the isolation -- it was welcoming, easy, yes?

One of the other pieces of the idea of the project comes from trauma recovery research: the idea that doing something for someone else can interrupt the cycle of violence.

November: Oh yes.

Ellen: So, that idea sounds like it was helpful in terms of the notion of doing it?

November: Yes.

Ellen: Until the actual making of the board?
How about others of you? Do you see that there are two questions here?

Karen: What are they?

Ellen: What is it like to recognize a culture clash given this experience? Five or six people shifted their experience. You're dealing with what once was so familiar and now experiencing a clash. Though, I'm sure you have felt personal clashes before this. That is question number one.

1. What is it like for you to experience this culture clash?
2. What was the idea of interrupting this cycle here like for you?

Was there ever the sense that interrupting this cycle of silence and isolation was helpful or useful for you?

Let's start with that one. So we go with one question at a time.

Karen: Did you notice, did we notice?

Ellen: Yes, did you notice your enthusiasm feeling different when you realized you were going to make a culture shift? You were going to bridge who you are with what you'd like to see in the organization?

Belgium: I'll start, and I don't know if Francis was here that she would say this too. Part of what I do is work on a team so there is a built in support and clinical philosophy around our work that is built in.

Ellen: How many are on your team? Is it eight?

Belgium: There are eight.

Ellen: So out of the one hundred and twenty-five clinicians there are eight of you that share that experience.

Belgium: Yes, so over the years it helps with the cause. It helps perspective. Because I still hear people say it, "Oh, you're one of those DBT people."

Ellen: Are you saying there is an 'us and them' dynamic?

Belgium: Yes, it could be someone else or I hold that. So, there is an hour and a half plus a week. Who else gets to do that? Who else has a team?

Karen: Well, we have the CBT team. Every other week November and I are on it, and it's a very supportive thing. But it's not as out there in the clinic as the DBT team, and it hasn't gone on as long. Then we have an every other week peer support meeting. So there is something; but I agree the DBT thing is different.

Ellen: What do you think about knowing you have these other places to meet with colleagues? Let's talk about the culture that these small groups are in for a moment.

Belgium: Well the organization one is that it is primarily a fee for service culture and if not fee for service it's a productivity culture. Part of the job is seeing each other for two minutes depending what floor you're on. Then you go into your own room. It's also the culture of individual counseling. There are all these clashes. We have talked about this.

Karen: Oh right we have.

Belgium: If you want to start a group. It's not set up where I can come in and offer to do the group. I'll be the talent and you guys bring everything else. Isn't that enough?

Ellen: Yes, the billing time and energy for following up on an individual as compared with a group can be seen as not cost effective to organizations.

Belgium: Right, there would have to be an effort to get together to face the multiple culture clashes.

Ellen: Would you like to add some more here Karen?

Karen: There is this constant pull in me between really wanting to get into the work and really feeling good about it. And the other part is just wanting people to come so I can make my productivity that's all. Yeah. I think that really affects my relationships with people and how I talk to clients. I don't know if that relates.

Ellen: That totally relates to your decision to do your group project here at CHS. You may never have made yourselves quite as public in this organization. But there is something about who you are, that you care. You recognize the environment that you're in and you put your hand into the ring and said, "I'm available to make this place, in an unobtrusive way that won't sabotage anyone's cost efficiency or productivity to help this situation." That's how I see it.

November: Yes.

Ellen: I think what you chose fits this organization remarkably well. It's not going to take away from anyone's productivity. It's not a big and threatening. It's a little beauty. It's what I call an esthetic action. Because, the potential is there to make a shift. The visual, kinesthetic, compassionate elements of the Share One board you created. It's yours. When asked to interrupt the cycle of isolation, hopelessness, violence and limited world view, your project was designed to do that. We know that doing some sort of social action to make the world a better place can make one feel better and also aware of the challenges involved.

Group: Hmms (quiet talk about project sounds like it is an emotional conversation for the group)

Ellen: Part of this work is exploring what happens when we get together to do an esthetic action, to make the effort to improve things.

The fact that you all made yourselves available to improve things here, I understand it was critical for you. No one said, "I don't want to do it here." No one said that. You were all quite clear. You wanted to do it here. And believe me, I've done this in other places and they don't want to do it in their work place.

Group: Hmms

Ellen: So I'm particularly curious about your chutzpah, your courage.

Belgium: The shift went from the front hall and for everyone, then to the back for the colleagues but, I didn't get my way.

Ellen: Yes, it shifted from the front but it was still for the organization.

Belgium: But what I was thinking, it was more public for anybody that came through the door but it shifted to the workers.

Ellen: Yes, but it's still this organization.

Belgium: Oh, right.

Ellen: You had hope. Other workers in other organizations have zippo, no hope for improvement, whether it's on this wall or that wall. Which means that this whole thing is well, not so fearful, and you've Anyone have another one they want to put out?
been willing to be seen. And it could have been anonymous. You even have the idea, "Could we change it?"

Yes, you have the capacity to bridge the world you are in to your ideal world

Group: Hmmm

Karen: Can I throw a couple of ideas out?

Ellen: Absolutely.

Karen: I didn't see this whole workshop so much as helping the…(organization), I really saw it as helping the helper with vicarious traumatization. What I can see coming from it is a small group of people continuing to specifically talk about it. Or a little bit more specifically than we are talking in our group together, a little more focused on vicarious traumatization.

Belgium: But that model is a little more within the culture and this is about helping the professional step out of the familiar and doing it.

Karen: Oh yeah, yeah!

Belgium: Maybe what you're saying is tying into the hope as opposed to this total hopelessness.

Karen: Yeah, except I'm not sure it would feel that safe here. I don't know if I would feel particularly safe really talking about real specific experiences of working with someone with a sexual abuse history. It almost feels like you'd have to do it outside the clinic.

Ellen: To meet at my Sharevision office, where we hold these groups.

Group: Laughter

Ellen: This is an agency based group where you can do a good introduction to this work. It is important to have a place where you can get what you want from the experience. The Sharevision Group has a place at nearby which offers other possibilities for meetings.

November: In another world?

Ellen: Using the same the model. It gives everybody a chance and everybody time to listen. So it's a constant gifting.

Belgium: I was just thinking it's coming from this place of hope as opposed to just cynicism. I touched on this last week about being a new Dad here. And how one can get unofficial supports. You take some of the bosses. It's on the fly, it's quiet. They'll say, 'I'll take care of it.' Right, you know what I'm talking about. 'Let me take care of it.' 'You go bill.' 'You do your job.' It's not too touchy feely.

There is an element of people in charge doing it their way. There is some support. It's not as formalized. It may tie into the idea of really taking it to the next level. It's not just a bunch of coldhearted folks. But, it's not a bunch of talky feely people either.

Group: Laughter

Karen: You've been trying it being a new Dad. Specific people have been unofficially really supportive when you've got to go. When it's more important than you being here.

Belgium: Yeah, there are moments when it's, "Do what you've got to do. As long as you just get your job done." It's not hugs and kisses and oooo ooo. That's not happening. It's not like they say, "You don't need to be here."

Karen: A few years ago when my dog died I took five days off of sick time. I told Marge and she said, you're not supposed to use it for that. She was understanding, but that would never have been public. It would never be put out in the clinic, "If a pet dies you can take extra time."

Belgium: Yeah, "Don't tell me."

Karen: Or even giving bereavement time.

Belgium: Right, Don't tell me again! Gallows humor comes down big time, but other times you hear, "We can tolerate that." I think there has been more of that over the years than it used to be.

Ellen: Do you mean the pendulum has swung?

I don't know how many of us here worked in grassroots community healthcare and human service agencies before healthcare became the complex world of managed care?

Group: Yeses

Ellen: Community care was very different before managed care.

Group: Yeses

Ellen: I remember when this organization was looking into taking on the domestic violence and sexual assault state contract for programming in the county. It was a really big deal. They didn't have the history but they did have drive because they were such a big organization.

I'm wondering if you've seen the swing to a corporate model and swing back to more human or community approach? Are you trying to humanize the corporate world by putting up a bulletin board that is warm and colorful and caring? Is that right? As opposed to shelves that have files.

Group: Right, right.

Ellen: In theory it's really a delicious project.

Group: Right.

Belgium: There is a fine line. What is the most effective way?

Ellen: Look, you may be experiencing backlash from trying to do something about it. Does that sound right?

Belgium: Yes, it's going against the grain.

Ellen: It was agreed that your project was going to be put up. Then for whatever reason it wasn't. Nobody told me. I didn't call to get the Share One board put up. Nobody here tried to get it put up. For all I know Francis tried ten times to get it put it up. I don't know because she's not here. But it didn't get put up. And not that anyone did it intentionally. The guy who was to put it up could have, God forbid, got in a car accident that day.

But, the emotional experience sounds like a backlash. Your effort to humanize the corporate place is in question. You've all but said, "Why was I even thinking this could fly?"

November: I wonder if there is an analogy to family therapy here. When coaching an individual to go back into their family system and to do something differently, to make an

intervention that's very different, an effort to change the homeostasis of the family. They try it and it doesn't seem to go anywhere and they want to retreat.

Ellen: Right, What do we do next? Do we forget it? Do we bond together to try and do something again?

Usually it has to be that way in family settings. Right, because we're in therapy in this analogy. We would coach each other along, maybe the therapist or whoever would say, 'If Mom or Dad is drunk on the kitchen floor we wouldn't just leave it at that.' What is next?

Nona Gal, do you want to put any thoughts out next?

Nona Gal: Sure, I'm listening to people's perception of the culture here and I'm new to this culture. I can't say it's any different than I expected. I know how people operate doing individual therapy with the doors shut. It's about productivity.

My experience here is that I don't think of this place as being able to operate just on the files and not having a warm bulletin board. I think that's definitely feasible. Even though the board doesn't exist or we just made them. There have been opportunities in the past. Or even the fact that there are some good notices, and there are these little teases and it's hard because this is a large agency.

Last year I had the experience of being in a smaller agency. When I was in a crisis and we used to get together with the outpatient staff at a weekly meeting with almost everybody attending. We could all sit around the table. So that doesn't exist here. I don't know half the people here.

So, I'm not sure I see it as a clash of culture to have a warm bulletin board here, because my experience isn't that it's cold or that unaccepting.

Ellen: How refreshing. Did you all get a little wash of that?

Karen: Yeah. It's nice to hear that you don't feel like it's cold here. We used to have weekly meetings for everybody. Remember, everybody?

Belgium: That's true, the place was a lot smaller. That's the fee-for-service culture.

November: That weekly meeting wasn't a warm and fuzzy one.

Belgium: It wasn't very warm and fuzzy. That's my point.

Ellen: How long ago was that meeting?

Karen: Oh, gosh maybe five years ago.

Ellen: Are you saying that economically there was a way to do it?

November: To have that big meeting?

Ellen: To have everybody stop making money for a minute and get together.

I understand what you're saying is to forget the large group meeting. Instead you're imagining a small group, a warm and cozy, fuzzy meeting.

Everybody stops, spends some time together. Then would you be more productive? That's one of my questions. When you've spoken about noticing that you're leaning forward with your client and thinking about your clients differently. Are you measuring your productivity in two different ways, the quality and quantity of your work?

Karen: No. If I'm really connected with a client I'm not thinking about productivity.

Ellen: Are you ever more or less productive in terms of how many clients you see?

Karen: Do you mean do you ever see less or more clients than you are supposed to?

Ellen: Have you noticed anything different during the course of our ten to twelve weeks if you're seeing more or less people?

Karen: No, I'm just as anxious. This week I'll see maybe four or five below my productivity. I feel just as anxious as I would have before we started this.

November: I'm not anxious about productivity in general.

I am already mourning this group. I'm wondering what will happen next, because it's been such a gift to me.

What we haven't talked about here is this particular kind of sharing, the format of it, the associational aspect of it. That has created more intimacy than most of the groups that I have been in, a more ready intimacy.

I forget the question, but that's what I'm thinking about.

Group: Laughter

Ellen: Would you like to pose it as a question to the group? Was there a question there? Does this group want to keep meeting?

November: Yeah. Well part of me is less worried about the culture here and more worried about me. (November laughs and others join her.) How am I going to keep this rolling a little more? It would also be a wonderful thing to have this group spawn other similar

groups, for somebody to take this model and take it around. That would be a way of doing the project.

I wonder what you are imagining?

Karen: Lets say you and I really want to spread this through the clinic. We could go to Marge and write up the whole thing. We could say, "Could we apply for CEUs and conduct this in the clinic?" Like you're conducting it here. I would have the energy to do that along with everything else here but that's the problem with the productivity thing. It so limits creativity.

Ellen: What if we think about November and not everybody else for the moment?

Belgium: Should we all look at November while we think about her?

Group: Laughter

November: Please don't.

Ellen: Okay, what happens when I go to an organization to do this is a variety of things. Sometimes the groups continue to meet without me. They choose how often they want to do that.

You might figure out how to do this every other week. That's not the same as doing it every week. It's not the same as doing it once a month.

Some groups have used this format when they have an emergency. They call a meeting. But that's harder when you're not part of the same team.

The format is called Sharevision.

I too have gotten so much out of the experience that I continue to do it. I never know if it's right for any group of people or any individual to continue doing it. It's really the people who are there who figure it out.

As I've said, I do Sharevision groups at my office. I find that it's more helpful when someone initiates it. Like what you're saying. When one person is part of inviting other people and those people invite others, then it's much more connected. Also, sometimes an organization lets us use their space. There are options.

This was a completely free program. Your organization and I worked out a deal, wherein you get CEUs and you're are helping me with my doctorate. Group fees, you know, are much less than individual fees if you decide to join a Sharevision group.

Karen: You mean there are Sharevision groups that are covered by insurance and have a facilitator like you?

Ellen: It can be part of therapy. It can also be offered it as pay-out-of-pocket so it isn't connected to diagnostic criteria.

Karen: Then is it a time-limited group, like this was?

Ellen: Not necessarily. It's like a yoga group that you sign up for x period of time. Then you can sign up again for it. We've done on-going Sharevision groups like that for years.

Karen: So the material you passed out for us to fill out at he beginning and end is part of you data collecting?

Ellen: Yes, Sharevision groups can go on for years. They are more or less arts integrated depending on the group.

In terms of the ending of our group, there are some important things to address here. This was the last day on our contract, but of course we all agreed to go on because of the training and the holiday being a day off. We were gong to do six workshops and five Sharevision meetings. This is the sixth workshop and you've gotten three Sharevision groups. So, I was thinking of not doing the final survey until after you've done your Sharevision meetings.

Karen: Yeah.

Ellen: Next week on the 19th is your 4th. January 23rd is your 5th one.

November: Why did we put that 5th meeting so far into the month of January?

Ellen: Part of it was me. I was going to be in a meeting on the 12th and 13th and now am not going to be. Would it be better if we tried for a sooner date?

Karen: Yeah, there is January 9th.

November: Yeah.

Ellen: Can you all do January 9th?

Nona Gal: I can. I've been a little desperate for this Friday morning time. I have a client that this would be the ideal time for, but I don't want to hold up the group.

Ellen: We all agreed on the six workshops and five Sharevision meetings. Who knew you'd want more?

Group: Laughter

Ellen: This first step is figuring out when the fifth meeting will be.

November: (to Nona Gal) You're the one with the biggest issue.

Nona Gal: Yeah.

Ellen: Is the office open or closed January 2nd?

November: It's open.

What if we made it 10-11 instead of 9-10? Would that make any difference?

Nona Gal: For me it's the 10:00 hour. Oh, no its not. Never mind. It's moving our supervision from Wednesday to Friday, so I have Wednesday morning with that person. That's what it is. So if you and I could do something with our supervision?

November: I think we're only talking about meeting from 9-10:00 anyway.

Nona Gal: Okay, right. I was confusing all that. Yes, yes. Okay.

Ellen: Yeah!

Now of course you all could meet at 8:30 if you want. It's really up to you. If you all met before the 23rd when would you want to meet?

November: I'll be here on the 2nd.

Karen: So will I!

Belgium: I won't be here.

November: How about the 9th?

Ellen: Will you be here on 9th?

Belgium: Yes.

E: Will you be able to meet on the 9th?

Nona Gal: Yes.

November: Then it will be our group, just us.

Ellen: That'll be your 5th. I can come on the 9th at 10:00 and do the survey.

Group: (negotiations for times for individual meetings to go over survey)

(In here I ask if people would like to plan a 6th meeting. Belgium says he isn't sure. Karen says she's not sure about it.)

Ellen: (to November) I'm so sorry we haven't figured out a group for you yet. But you never know, sometimes these things emerge later when people miss the meeting and want it back. Another thing we could talk about is whether you'd like to work with me to initiate another group on this topic. We can also talk about creating a group that serves your needs not here.

November: And are you also saying we can talk about creating a group here? Are you saying both?

Ellen: We could talk about that. I don't know enough about the agency. Does the agency want to figure out how to pay me to run them for everybody in the whole agency? Can I get a grant for the agency to see everybody? I just sent in a grant to do something like that earlier this week. You never know how these things get sponsored.

November: Steve Cain is the person who works here and writes proposals for grants.

Ellen: We could work on it together.

All right, we have five minutes before we have to go. We've gone through an enormous amount today and we should follow up on the group action project.

Karen: The Project!

Ellen: All right everybody let's take a deep breath.

I'm wondering how you feel about putting it up as is or doing the intranet connection for it, changing the board, throwing the bulletin board out. It's yours. You really have options.

Karen: I'd like to spend the next time we have together changing the board.

Ellen: And not doing the meeting? I think it's important to do the 5th go-arounds, because it's really a different kind of process.

Group: (quiet)

Ellen: One of you could say "I'm not giving up this project. I want to see it changed." You did your group project. Now we're in another domain. You have different options. It doesn't have to be during group time.

Karen: We could find another time, like over a lunch hour or something.

November: To redo the board or decide what to do with the board?

Karen: To face the board.

Group: Laughter

Ellen: I'm inclined to save your sense of humiliation and turn it around or something. I think we need to take initiatives, take your power back, and not suffer over this.

Belgium: I could let it go. That's me. Sometimes the project doesn't fly.

November: I understand.

Ellen: You're absolutely entitled. Nona Gal and Karen may have the strength. Nona Gal sees it as a possibility. Karen sees it as a possibility.

Nona Gal: I think I should say I feel like I don't.

Ellen: You're done too?

Nona Gal: I'm done too.

Group: Ooo noos from group "Oh, my Gods"

Ellen: So, Karen you may be the activist in the group.

Karen: Move it to my room.

November: That's a cute idea.

Karen: I wanted to take a couple of things off my wall anyway.

November: That's a great idea!

Ellen: Why do you want to put it in your room? What will that mean?

Karen: I'll be able to think about how to change it.

Group: Ooos from group

Ellen: She may do a gorilla surprise and you're going to be excited when she puts it up.

Karen: It could be a jumping off of something. Who knows? Clients will obviously notice it too.

Belgium: We all know where your office is to brainstorm with you.

Ellen: That's beautiful Belgium! She could be the hub

Belgium: You know what would be great is if Francis came back and she was all angry about what's going on here. That would be a great punch line!

Group: Laughter

Ellen: Why were you saying oh, that's a great idea?

November: Well, it redeems it. It preserves it. It gives it a different venue. It is a place where somebody will love it.

Belgium: It sounds like you're talking about Charlie Brown's Christmas tree.

Group: Laughter

Ellen: You know people could really get into it clinically.

Karen: That's true.

Belgium: Oh really!

Ellen: If you're giving up on doing for your fellow clinicians, are you going back into the client therapist domain?

It is what it is.

Karen: Right, I could really use it with my clients. (Excited)

November: I did think about that too. Clients might be really intrigued by it.

Ellen: So you can make one too. You can all make one

Group: Laughter

Ellen: You can make a board with your clients. Who knows, one of you may get the gumption, once you've worked with it, and you've thought about it, once you've had more time.

You may decide you want to try to bridge the heady approach by explaining how you developed it, its history and offer it to the rest of the staff. Because, hey, why not? Everybody deserves some support, some creativity, some connection. Maybe it needs this incubation time.

Karen: Yeah.

Belgium: I would agree with that.

Ellen: It speaks to what you started with this morning. It was the first thing you said this morning. There was something about the time factor. So you have time to reflect, and you may find that you connect over it.

Belgium: (to Karen) I'll be knocking on your door, 'Hey, I've got an idea.'

November: He'll be coming in with a ruler, some scissors.

Group: Laughter

Ellen: I'll bring you all the agency survey for your CEUs and the final survey in our next meeting.

So we've got you all free for your meeting.

November: Are we meeting next week?

Group: Laughter

Ellen: Yes, you all have your 4th Sharevision next week and I'll send you an email to confirm.

November: (to Karen) We'll meet in your room, right?

Karen: Yeah, and the board will be there.

Group: Laughter

Ellen: Good luck getting it up. Maybe this is just what was supposed to happen all along?

Belgium: Right!

Ellen: Good luck you all. See you next week and we'll do the surveys.

Belgium: Thank you!

Ellen: You're very, very welcome. Thank you all.

Karen: Bye now.

Group: Laughter as they leave

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