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When Self-Care Is Not Enough: Reflections on How to Make Trauma-Intensive Clinical Work More Sustainable

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Abstract

As a psychology resident on the psychiatry consultation-liaison service at a trauma center, I was asked by another trainee how I cope with the devastating cases of traumatic injury and abuse that we witnessed regularly on the service. This trainee's courageous question about how we as providers cope sustainably with bearing witness to trauma coincided with my own reflection on the limits of "self-care" as it is often discussed and practiced in human service professions. In this article, I argue that an activity-based approach to self-care is not enough for providers in trauma-intensive service settings and must be complemented with an ongoing, self-caring engagement with the existential impact of bearing witness to trauma. Part of this impact is the "unspeakable" nature of trauma, which is most profound for victims, but is also an important consideration for bystanders, helping professionals, and larger systems of care. Major dialectical tensions of bearing witness to trauma as a provider (such as between denial and awareness, problem solving and acceptance) are described, with reflection on ways that trainees can practice the integration of caring for both self and others in their encounters with trauma survivors. Concluding recommendations are offered for a trauma-informed theory and practice of self-care for trainees, training programs, and the field.

WHEN SELF-CARE IS NOT ENOUGH: REFLECTIONS ON HOW TO MAKE TRAUMA-INTENSIVE CLINICAL WORK MORE SUSTAINABLE

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ABSTRACT

As a psychology resident on the psychiatry consultation-liaison service at a trauma center, I was asked by another trainee how I cope with the devastating cases of traumatic injury and abuse that we witnessed regularly on the service. This trainee's courageous question about how we as providers cope sustainably with bearing witness to trauma coincided with my own reflection on the limits of "self-care" as it is often discussed and practiced in human service professions. In this article, I argue that an activity-based approach to self-care is not enough for providers in trauma-intensive service settings and must be complemented with an ongoing, self-caring engagement with the existential impact of bearing witness to trauma. Part of this impact is the "unspeakable" nature of trauma, which is most profound for victims, but is also an important consideration for bystanders, helping professionals, and larger systems of care. Major dialectical tensions of bearing witness to trauma as a provider (such as between denial and awareness, problem solving and acceptance) are described, with reflection on ways that trainees can practice the integration of caring for both self and others in their encounters with trauma survivors. Concluding recommendations are offered for a trauma-informed theory and practice of self-care for trainees, training programs, and the field.

KEYWORDS

trauma, burnout, self-care, indirect trauma, vicarious trauma, secondary traumatic stress, clinical training, acute care, emergency medicine

A medical student on our psychiatry consult team approached me as the team disbanded from our meeting after afternoon rounds. The student, on the second of a three-week rotation, said, "I wanted to ask you - how do you cope with 'ugly' cases like this?"

It was an average day on our consult service. I had updated the team about another patient admitted to the burn intensive care unit (ICU) after a suicide attempt by self-immolation. The young woman poured gasoline on herself and her partner's car and lit a match. In her life, she had been hurt deeply by others and had also hurt others. In rounds, we discussed ongoing legal and personal questions about whether and to what extent the woman's family would maintain contact with her in the aftermath of the self-immolation. This was a complex, heart-breaking situation that one provider described matter-of-factly as 'ugly.'

In the course of my clinical training, I had been asked periodically by supervisors what I did for self-care. But I had never been asked this question from someone who earnestly expected me to have coping skills that I could share. The medical student added, "Because you are from psychology, I thought I would ask you- that you would have thought about this."

In this article, I offer reflections that I hope do justice to the courageous question asked by this student. Although he did not yet have the language for it, I took his question to be one about trauma and how we as providers cope sustainably with bearing witness to trauma—its brutality, horror, and anguish. I write these reflections particularly for psychology and psychiatry trainees and their supervisors, while anticipating that providers of trauma-intensive services across a range of disciplines—such as social work, nursing, medicine, and emergency first response—might find a kernel of value in this work.

The reflections in this article emerge from my clinical science training and my former position on a Psychiatry Consultation-Liaison service at a Level 1 trauma center.[1] I should note that in this capacity as consultant, I did not provide psychotherapy per se, but rather met with hospitalized patients in the context of responding to specific consultation requests from the patient's primary medical or surgical team (e.g., burn surgery, orthopedic trauma surgery, neurocritical care). As consultants, our clinical "intervention" was then to provide relevant recommendations to the primary team (Leigh, 2015). The format of a consultation encounter involves an initial interview and assessment with the patient at bedside, with any number of follow-up bedside visits depending on the patient's needs and length of hospital stay.

Before addressing the issue of self-care in this article, I grapple with the question of what trauma is, and consider its many guises in the setting of a trauma hospital. I uneasily embrace the paradox of speaking on behalf of myself and others about experiences that are by definition "unspeakable." I connect this clinical and rhetorical experience of the unspeakable to the existential impact of trauma-intensive work and to the need for an expanded practice of self-care. As part of the reflections, I describe some of the patients I met and worked with in the hospital and tell parts of their stories. I have omitted and changed details of people's identities and taken care to tell these stories not gratuitously, but because they are part of the fabric of my own story. In this article's conclusion, I consider the power and privilege inherent in telling the stories of those whose voices are silenced and marginalized.

The Unspeakability of Trauma

> The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word 'unspeakable.' Atrocities, however, refuse to be buried... (Herman, 1992, p. 1)

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[1] In the United States, trauma hospitals are designated with Levels 1-5 based on the specific capabilities and services they offer to patients. "Level 1" trauma centers provide the highest level of surgical care to severely injured patients, along with 24-hour specialized services for both adult and pediatric patients suffering from traumatic injuries.

> Who can find a proper grave for such damaged mosaics of the mind, where they may rest in pieces? (Langer, 1991, as cited in Van der Kolk, 2014).

When I first learned that I would be completing part of my internship at a trauma hospital, I imagined serving patients with physical wounds. While we serve people who are critically injured: by falls, motor vehicle collisions, guns, knives, fire, assaults, poisoning, and the list goes on, we also consult to inpatient medical and surgical teams treating adults with serious illnesses: liver cirrhosis, end-stage renal disease, diabetes, HIV/AIDS, hepatitis, necrotizing skin infections, and that list goes on and on, as well. We serve vulnerable populations that include individuals who are homeless, who are refugees, who are international survivors of torture, slavery, and war. And yet even in a medical setting where the primary mission is to heal trauma as "a wound, or external bodily injury" (OED Online, 2017), I marveled each day at the ways that trauma remains unseen—an internal anguish—and unspeakable—that which cannot be put into words in a satisfactory way.

As a clinical psychology doctoral student, I completed most of my training in outpatient and residential treatment settings where my clients and I could have face-to-face conversations about their distress. Clients shared their personal histories in a narrative way as part of the assessment process. Sometimes these histories included experiences of interpersonal trauma and violation. In a typical therapy setting, words are the currency of the realm. Back-and-forth interactions are how connections develop. In the setting of a trauma hospital, I was initially stunned to meet with patients who were too ill or critically injured to communicate, either because they were intubated, medicated, delirious, or traumatically brain-injured. And yet, I wanted my interactions with these patients to be healing, or at the very least, not to increase their stress. How to do that without the typical ways that therapists communicate?

Another adjustment as a clinician was working with patients who had been brought to the hospital due to grave physical injury—often physical and sexual assaults—who were unwilling or unable to describe their experience in a narrative way. This could be due to acute psychosis, developmental disability, cognitive impairment, traumatic brain injury, or memory loss (due to brain injury or acute alcohol/drug intoxication during the assault). Reluctance to share one's story could also relate to understandable mistrust of healthcare institutions resulting from centuries of racial and cultural oppression and violence by individuals and institutions in the U.S. (Cromer, Gray, Vasquez, & Freyd, 2017; George, Duran, & Noras, 2014).

In her clinical work with sexually abused girls, Annie Rogers has captured this phenomenon of the unspeakability of trauma, and its implications for both survivors and witnesses:

> I saw that what is so terrible about trauma is not abuse itself, no matter the brutality of treatment, but the way terror marks the body and then becomes invisible and inarticulate. This was the case even when someone could tell a story or reconstruct a memory. There was always something unsayable, too. (Rogers, 2006, p. 44)

Many of these most vulnerable survivors in the trauma center were women.

- One woman who appeared in the emergency department periodically under different aliases, with multiple fractures all over her body including her head

and face, who refused to discuss what happened or to be examined for sexual assault despite physical evidence of rape;

- A woman who disclosed that her children were being sexually abused by a male relative but who was also psychotic and so these statements were dismissed as 'delusions';

- A young mother with a long history of trauma, criminal justice system involvement, and substance use who alternated between terror and laughter (in conversation with the voices she was hearing) during the interview and was not able to explain how she ended up injured.

As a hospital provider, a temporary bystander to these women's journeys, I felt sadness and grief for their lost stories and their risk for further harm. I also felt anger at the injustice of our social systems that enable and perpetuate harm against discarded populations (Levin, 2015).

Another way that the unspeakability of trauma manifested in the hospital was its unspoken presence in the childhood histories of adults with severe somatic conditions and frequent hospitalizations. One young woman had been admitted to emergency departments more than 75 times in the past year complaining of seizures and paralysis in her limbs. Despite many exams and diagnostic tests, no "organic" origin for these problems could be determined. She did not volunteer information about her trauma history, but her medical chart alluded to a childhood history of chronic interpersonal trauma (in one study, 88% of outpatients with electroencephalogram (EEG) documented pseudoseizures had histories of severe sexual and/or physical abuse; Bowman, 1993).

In these and similar cases, the hulking machinery of the healthcare system was slow to recognize somatic symptom disorders. This created a kind of institutional amnesia where each patient visit, each inexplicably paralyzed limb, was like the first of its kind, submitted anew to the diagnostic process. The institutional narrative about why the patient was there and what would cure the problem itself became fragmented. Without a shared, coherent narrative, the patient's symptoms—the intermittently paralyzed limbs and "pseudoseizures"—kept repeating.

Defying simple categorization, with any patient there was often not a reassuring line between medically unexplained illness versus "real" illnesses. For instance, someone might present with an orthopedic injury and related pain, accompanied by diffuse pain unexplained by the injury; another patient might have a history of a defined neurological problem or of neurosurgery, but along with that have medically unexplained "pseudo-seizures." Being the judge and jury for what is a medically unexplained versus "real" illness is an invitation for providers to invalidate the patient's experience, a form of institutional betrayal (Smith, 2017). Adults with childhood abuse histories, who have experienced traumatic invalidation, may be particularly sensitive to or harmed by this institutional invalidation (Delker, Smith, Rosenthal, Bernstein, & Freyd, 2018; Salter, 2012). Personal histories of betrayal may also intersect with marginalized identities in a way that further compounds invalidation—as in the well-documented phenomenon that healthcare providers underestimate and disbelieve the pain of patients who are racial and ethnic minorities, relative to patients who are white (Anderson, Green, & Payne, 2009).

The Urge to Tell

> I began to hear the 'unsayable' as something that moves toward speech and away from speech at the same time (Rogers, 2006, p. 57).

In her landmark work *Trauma and Recovery* (1992), Herman named a core dialectic of psychological trauma: "the conflict between the will to deny horrible events and the will to proclaim them aloud" (p. 1). As Herman noted, both victims and witnesses are affected by this dialectic of trauma.

I perhaps should not have been surprised when, bearing witness to the trauma of patients at the hospital, I found myself having the urge to tell my loved ones what I witnessed at the hospital each day. I wanted to describe the horrors that brought my patients to the hospital, or tell the more extended stories of a lifetime of struggle, or recount the whole constellation of challenging issues that emerged around each hospitalization. I wanted to share an unknowable assumption that the trauma history of one patient had "surface[d] not as a verbal narrative but as a symptom" (Herman, 1992, p. 1), one that neither the patient nor the whole medical system was willing or able to recognize as such.

There is a way in which trauma moves through people and systems. Despite or perhaps in dialectical relationship with the powerful force of denial, trauma has a will to be expressed. This may be especially true when powerlessness, real or perceived, is at stake. As a consultant on the Psychiatry Consultation-Liaison service, I was not a therapist and I was not tasked with treating patients. The patient's primary medical team was responsible for delivering care to the patient or changing the environment of care to make it more therapeutic. Etherington, writing of her experience as a researcher working with survivors of childhood sexual abuse, named a special "danger" for people who bear witness to trauma but whose role is "*not* to intervene therapeutically" (Etherington, 2009, p. 182).

Many traumatic experiences of betrayal that patients have shared with me are so horrifying for those who told them that it is hard to imagine, confidentiality aside, telling them to a loved one. In and of themselves, some stories could vicariously traumatize a listener. I could create a composite or representative story for public consumption, an illustrative case. And yet each person's story is so remarkably individual, it is hard to imagine telling a satisfying example. Any story, if told, risks being told sensationally, with a voyeuristic lens turned on the pain of an individual or a cultural group. And one person's story, even if it were mine to tell, would not convey what makes a given day in this job so impactful: it is the crescendo of stories, of suffering, hyper-saturated with terror and also with the wonder, the inscrutability, the defiance of the human spirit.

Self-Care

When the medical student approached me with his question about how to cope with "ugly" cases, I was feeling the existential impact of trauma-intensive work and struggling with cynicism over the concept of self-care. The following sections explore how self-care is commonly defined for human service trainees in psychology and psychiatry; consider the limits of a purely activity-based approach to self-care (e.g., take a bath, exercise); and propose that the practice of self-care be expanded in ways that acknowledge the existential impact of trauma-intensive work.

The concept and common practice of "self-care."

Over the years of clinical psychology training, supervisors posed the question periodically: "What do you do for self-care?" During my internship, friends and family asked me the same question when I shared about the intensity of the work. The phrase "self-care" seemed like a buzz-word, an obligatory nod in the direction of trauma's vicarious impact on witnesses, rather than a thoughtful consideration of the existential dimensions of trauma work. A medical resident, Rachel Pearson, has written of a forceful disillusionment with "self-care." In "When Doctors Can't Afford to Feel" Pearson (2017) argues that "medical residents don't need ice cream and wellness weeks to survive grueling schedules and the deep trauma of patients and families." They need to survive the "profound grief" and "many smaller griefs" of their work. In order to do that, she argues, they need an emotional distancing and focus on service to others that draws from "the wisdom of the Stoics" (2017). Pearson writes: "I function best as a resident when I check my inner life at the hospital door, and ready myself to serve others. I reject the notion that I need to focus on some necessarily vain effort of cultivating my own 'wellness'" (2017). Although my personal ideas about what is needed to make trauma-intensive clinical work sustainable are somewhat different from Pearson's, I identify with her dissatisfaction with the ways that self-care and wellness are represented in the field.

Limits of activity-based self-care.

The familiar question "What do you do for self-care?" tends to pull for a list of distinct self-care activities. The implication is that these activities occur off-site or separate from the clinical work itself. On some consult days- 9, 10, 11-hour days when I worked back-to-back with traumatized, high-complexity patients, I waited in darkness for the hospital shuttle bus and considered what "self-care" activity I could do when I got home. I could get some ever-elusive exercise, practice yoga or meditation, take a bath, watch trashy TV. But somehow, on certain days, none of these activities seemed adequate. Yes, they might relieve some tension. They would be more nourishing than the many vices available to numb a spirit ill at ease. But this activity-based approach to self-care assumes that once tense muscles are relaxed the mind will follow. And yet one of the major demands of trauma work— bearing witness up close to the agony and sorrow of others—is the images and stories that linger long after the day's rounds are complete. It is more than an image of the ravaged body of a gravely injured patient, or a story that someone tells about the horror of a traumatic event. It's being left alone with the existential questions raised by trauma: what it means that humans intentionally devastate each other, and why and how we can go on in the wake of the overwhelming cruelty and indifference of which humans are capable.

Existential impact of bearing witness to trauma.

In an article in this journal, "Doing Sustainable Trauma Research," Salter (2017, p. 1) writes: "Whether I'm in a professional or social setting, one of the most common questions that I'm asked is how I 'cope' with or 'manage' the emotional impacts of the research." He continues:

> Trauma fragments and disrupts systems of meaning, leading to feelings of nihilism and emptiness. The emotionally corrosive effects of trauma affect witnesses, such as researchers, as well as those more directly impacted [...M]any people's view of the world as predictable and orderly depends upon assumptions that other human beings are basically benevolent and good things happen to good people. The violation of these assumptions

gives rise to a profound sense of injustice that can, at least initially, be the impetus for action and intervention. However, when these assumptions are rendered untenable by overwhelming evidence of human malevolence, bystanders and witnesses are plunged into existential crises that imperil their own mental health and well-being (Salter, 2017, pp. 2-3).

Before working at a trauma hospital, I did not consider myself naïve to the existence of trauma. I did not believe that good things happen to good people, and bad things happened to bad people. I had felt that "profound sense of injustice" in response to violence directed at individuals and at whole groups, as with oppression and cultural trauma. But nothing brought me to the feeling of "emptiness" that Salter describes like bearing witness to trauma on the consult service hour by hour, day after day. It lifted a veil on human suffering that shrouds most of us, lest we be unable to function, to go on living and loving. It is this experience that belies an activity-based approach to self-care, and one that invites more attention to making trauma-intensive work sustainable for clinical trainees.

Expanded definition of "self-care."

To support clinical trainees in trauma-intensive settings—clinical psychology practicum students and interns, medical students, psychiatry residents, social work, and nursing students, although I can speak best to my own discipline, clinical psychology—we need an expanded definition of "self-care." Self-care includes, of course, those activities that self-soothe and distract us depleted providers when we return home from work. But these activities must be complemented by an ongoing, self-caring engagement with the existential dimension of bearing witness to trauma. Writing about sustainable trauma research and advocacy, Salter describes this as an "ethical commitment":

> In my experience, making trauma-intensive research sustainable is not solely a methodological issue. Rather, it is an ethical undertaking, in which the research process involves the development and disclosure of clearly articulated frameworks of meaning that are capable of holding, and making sense out of, traumatic material and affect. [...]The ideal is an ethical framework that not only withstands ongoing exposure to human pain and violation but is actively renewed by it. Nobody is born with such a framework. It is a project that is built through conscious effort, and, I would argue, one that is considerably strengthened by drawing on the resources of diverse philosophical, religious, and cultural traditions (Salter, 2017, pp. 2-3).

The self-reflection needed to develop this framework over time calls for institutional support from trauma-intensive training programs. Programs can build time into the curriculum for structured reflection, and into the work week for trainees to connect with contemplative, cultural, and spiritual or religious traditions. They can support and encourage students as they experiment with different means of metabolizing the violence in their midst. *At the end of which days this week did you feel energized rather than depleted by the work? What was different about yourself (what you were doing, thinking, feeling), the relationship between you and the patient, or the context itself on this day?* In addition to asking trainees "*What* are you doing for self-care?" supervisors and colleagues can ask, "*How* are you making sense out of the violence and suffering you witnessed today?"

The way that each individual provider responds to the stress of trauma-intensive clinical work will be a unique reflection of their own personal, social, and cultural history, including of course their own trauma history (Butler, Maguin, & Carello, 2017; Dworkin, Sorell, & Allen, 2016). Given the uniqueness of reactions to trauma work, different systems of meaning may resonate with different trainees. There will not be a one-size-fits-all for this self-caring approach to bearing witness to trauma. Below, I reflect on components of an approach that worked for me.

The Dialectic of Caring for Both Self and Other

> There are properties of things that we call dialectical: that one thing cannot exist without the other, that one acquires its properties from its relation to the other, that the properties of both evolve as a consequence of their interpretation (Levins & Lewonton, 1985, p. 3, as cited in Linehan, 1993).

> The spirit of a dialectical point of view is never to accept a final truth or an undisputable fact. Thus, the question addressed by both patient and therapist is 'What is being left out of our understanding?' Linehan, 1993, pp. 34-35.

Institutions and individual providers of trauma-intensive care are "functioning under conditions of chronic stress, repetitive trauma, and chronic crisis" (Bloom & Farragher, 2013, p. 15). Burnout and vicarious traumatization, or secondary traumatic stress (Balu, 2017), are issues that resonate across human service professions, from the local to the global (Beck, Cusson, & Gable, 2017; Günüşen, Wilson, & Aksoy, 2017; Kinker, Arfken, & Morreale, 2018; Lee, Gottfried, & Bride, 2017; McCain, McKinley, Dempster, Campbell, & Kirk, 2017). Under conditions of stress, actions and thinking can be pushed to all-or-nothing extremes. Tensions of human service work are heightened, such as all-or-nothing extremes between denial and awareness, between the need to help solve patients' problems and to accept the limits of our helping, and between the urgency of other-care versus self-care. Sticking to either side of these extremes can lead to unmanageability and distress for providers, in turn reducing the quality of patient care.

An example of extreme thinking around self- versus other-care is the assumption that caring for patients occurs at work, while caring for the self occurs only at home or leisure. What is left out of this all-or-nothing understanding of professional care? For one, trainees who have worked hard caring for patients at the hospital may return home from the hospital and need to care for other family members, including young children, or they may moonlight at other locations to support themselves or their families. Even with all the post-work leisure time in the world, it is possible to care for patients in an all-consuming way that disregards one's own emotional needs, hastening burnout. It is also possible to participate in recreational safe-care activities while being disengaged from important questions about the existential impact of trauma.

As a trainee (and person) with high expectations of how helpful I could be to others and a skeptical understanding of self-care as activities to do at home, I was stuck in high-gear, hurtling toward burn-out. Part of what helped me get unstuck was lessons from the elective clinical training I was doing in Dialectical Behavior Therapy (DBT). DBT was developed by Dr. Marsha Linehan in the 1980s and 1990s to help treat adults who were chronically suicidal, but who were not responding to

standard cognitive and behavioral therapies. Linehan recognized that the life-or-death stakes of chronic suicidality could create a crisis-driven urgency that was toxic for both patients and therapists, leading to unhelpful extremes in thinking and doing (for example, for the patient, seeing suicide as the only solution to a conflict; for the therapist, seeing involuntary hospitalization as the only solution to keep the patient safe). Instead, DBT advocates that both therapists and patients practice walking the middle path between all-or-nothing extremes. Linehan called this practice of moving away from extremes in thinking and action "dialectics."

Doing suicide risk assessments as a psychiatry consultant was an opportunity to practice walking this middle path, in a way that felt more caring for both myself and others. For suicide risk assessments, we interviewed severely injured people at bedside as soon as possible after they survived a suicide attempt. The interview might be a single occasion for an hour or so, or an ongoing conversation over days, weeks, or even months depending on how long the person needed to recover from their injuries (such as traumatic brain injury due to self-inflicted gunshot wounds or jumps from bridges and buildings, or burns due to suicide attempt by self-immolation—at one point, my caseload consisted entirely of survivors of self-immolation). Based on interviews with the patient and consultation with team members in psychiatry, we needed to advise the person's medical team about whether they could be safe if discharged from the hospital, or even if they could be safe in the hospital without a one-on-one monitor or restraints.

The pull between extremes that I felt when doing suicide risk assessments was between my clinical task to gather personal information from the patient about their history and their suicide attempt, and the patient's own needs. Acutely, the adult or teen who survived a suicide attempt may need relief from an extreme degree of emotional anguish. They may also want to conceal private aspects of their lives and details about what they did that are unacceptable to their loved ones. And they may need—and to a greater or lesser degree, want—to solve the problems in living to which they had seen suicide as a solution. How to fulfill the job mandated by medical ethics and the hospital (the suicide risk assessment), and be of service to survivors in a compassionate way that provides some seeds for empowering people to make changes to their lives? What is the "middle path"?

First, I set an intention in the hospital, no matter how hurried, to practice listening actively to patients. Although therapist readers might find the need for active listening to be obvious, I found that it was easy for this practice to be sacrificed in such a high-stakes, time-limited environment. Listening is active in that it seeks opportunities to understand and affirm the speaker based on what is said and left unsaid. This effort to understand and affirm the person who I was speaking with was, I hope, its own "intervention," and way of caring. Second, I started to do suicide risk assessments using the format of a guided discussion that nonjudgmentally explores, step-by-step, the causes of a person's suicide attempt (in DBT terms, a "chain analysis"; Linehan, 2015). A person describes the events, thoughts, and emotions that lead up to their attempt, while the interviewer uses questions and active listening toward the goal of mapping out why the person made the attempt at that particular point, on that particular day, in that particular way. This step-by-step process can itself be validating in its acknowledgement that that all behavior is caused and is understandable in the context of a person's history and current life situation (Linehan, 1993). The "chain analysis" approach to suicide risk assessment has also been found to improve the formulation of risk in acute settings and can be used to guide problem-solving and treatment planning (O'Connor, Comtois,

Atkins, & Kerbrat, 2017). Ultimately, I found that an active listening approach in caring for patients was part of my own "self-care," in that I personally was less vulnerable to burnout when I could believe that I was being of compassionate service (even in some small way) to suffering patients.

Another approach to the middle path of caring for both other and self at work emerged in cases where I perceived that the healthcare system's approach to treating chronic/complex PTSD in female-identified patients was a harmful capitulation to uncritical biomedical models of trauma. An example of this was two women with chronic/complex PTSD related to long histories of sexual and physical victimization who were hospitalized after suicide attempts. Each (unrelated) woman's outpatient PTSD treatment was limited to long-term, heavy use of prescribed benzodiazepine medication (e.g., alprazolam, clonazepam, diazepam), despite consistent evidence that long-term benzodiazepine use is not only ineffective at treating PTSD, but harmful (Guina, Rossetter, DeRhodes, Nahhas, & Welton, 2015). Each woman's medical chart included a statewide alert due to her multi-sourcing benzodiazepine prescriptions in quantities of thousands of tablets from different providers in the past 6 to 12 months. Increasing their vulnerability, both women were unable to work and were alienated from loved ones. Finally, the women were adamant that benzodiazepines were the only acceptable, effective treatment for their trauma-related distress, and requested these in the hospital.

What did it mean to provide care for these women as a consultant, when the care they so desperately wanted was a form of further harm, and when I was powerless to change their beliefs about their suffering? As a provider, I felt the tension between my powerlessness to change these women's (and the whole system's) approach to their suffering, and my willful urge to nevertheless problem-solve on their behalf. I also feared for their safety; each was at risk to make another high-lethality suicide attempt. I stepped back and sought consultation from my team. My colleagues and supervisors on our interdisciplinary team helped me to clarify my role as a consultant and to recognize how far I had tipped toward the extreme of wanting to help change these women's circumstances. This is where—as part of my self-care—I committed to a DBT-based mindfulness practice focused on acceptance. For me, this involved a continual *at-work* practice of turning my mind toward the humble boundaries of my role as a consultant. I framed my interactions with patients such as these two women as part of a larger fabric of care in this mission-driven hospital. When the ways that I could make a difference for people felt minimal, I savored the privilege and significance of working among hospital colleagues who were deeply committed to providing the best care to anybody who came through the doors, turning no person away. I tried to meet patients' needs as best as I could, and I also radically accepted that the care I offered would never be enough in a social system with so many inequalities.[2]

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[2] In DBT, "radical acceptance" is both a concept and a set of dialectical coping skills grounded in mindfulness and Zen Buddhist traditions (Linehan, 2015). Part of what makes an acceptance practice "radical" is the letting go of struggle with reality as it is, not from a place of resignation or dismissal but from a place of openness "to the facts of reality as they are" (Linehan, 2015, p. 451). Radical acceptance also involves practicing acceptance "all the way"—"in your mind, your heart, and your body" (Linehan, 2015, p. 453). Interested readers who are unfamiliar with DBT can refer to Linehan's DBT skills training manual for descriptions of such reality acceptance skills as turning the mind, willingness, half-smiling, willing hands, and allowing the mind (2015).

With this ongoing self-care practice at work, I found myself more "capable of holding, and making sense out of" the traumatic material and emotions that I encountered day by day (Salter, 2017, p. 2). Rather than urgently problem-solving in response to repeated crises, I could turn my mind continually to an intention to be of service. This involved a large dose of humility, as I could not know in advance whether and how I would be able to be of service to any given person. This element of the unexpected is part of the joy and challenge of clinical work for me. In one case, the form of service might be concrete, instrumental support such as connecting a mother who wants to see her children in another city with a hospital case management program that can get her a bus pass after she recovers from her injuries. In another case, it might be a simple statement that acknowledges why a patient is wary of hospital providers, when they have a history of betrayal by hospital institutions. This stance was more self-caring for me, and I expect, ultimately more caring for the people who I worked with, than if I had made assumptions about what was best for them in their state of crisis.

When I was working at the hospital, a few times a patient would offer an unsolicited apology to me and my colleagues that our job was to work with people "on the worst day of their lives." Some people believed, for various reasons both personal and contextual, that they were placing a burden on their healthcare providers at the hospital (a study with trauma survivors in outpatient treatment found that "clients themselves overwhelmingly agreed that their trauma *was* difficult to hear, and more than 60% felt a desire to protect their therapists" Dalenberg, 2000, p. 71). Although I understood why someone would feel that way, I found that on the contrary, for myself, working with people on their worst days was not a burden, but an enormous privilege—deeply significant, profound, moving, humbling, challenging, and surprising.

Conclusion

> The study of psychological trauma has a curious history—one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion [...] Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed (Herman, 1992, p. 7).

Bearing witness to trauma day by day in trauma-intensive service settings raises profound existential and practical questions with implications for patients, providers, systems of care, and society itself. In this concluding section, several implications and recommendations relevant to the topic of self-care are highlighted. These comments are particularly for providers and trainees in trauma-intensive settings that may not yet have institutionally supported, trauma-informed practices for managing vicarious trauma.

1. *Normalize both avoidance and the pull toward over-involvement*: Normalize for trainees that avoidance—the urge to leave, withdraw, stay home, shut down or numb emotionally—is a common reaction when bearing witness to trauma at the level of intensity of acute care. More than one trainee has disclosed such reactions to me. In "Speaking trauma: The inadequacy of language in trauma treatment," Dalenberg notes that even hearing about trauma that others have experienced can qualify as a trauma if an emotional reaction occurs; indeed, in the DSM-5 diagnostic criteria for PTSD, "experiencing repeated or extreme exposure to aversive details of [...] traumatic events"

constitutes a Criterion A trauma (American Psychiatric Association, 2013). Dalenberg continues: "[...]t would be understandable, and in fact psychically healthy, for therapists to resist a closeness that would leave them vulnerable. There is good reason, then, not to hear trauma" (2000, p. 58). On the other extreme of the avoidance-approach dialectic, some trainees may be pulled toward over-involvement when serving high-need populations in crisis. Given that both avoidance and over-involvement are normal, expected responses, trainees can be taught on-the-job and through supervision to observe these reactions and to practice self-care accordingly.

2. *Increase the depth and breadth with which self-care is taught in clinical training programs*: For the purposes of writing this article, I looked at the indexes of 10 treatment manuals on evidence-based psychotherapy that had formed the core of my predoctoral clinical training material. Only 2 out of 10 books included any mention of self-care. In one book, it was a single paragraph of about 150 words, "Enhancing Self-Care," in a broader chapter called "When therapists have dysfunctional reactions to patients" (Beck, 2005, p. 120). The other book offered a one-page section called "Therapist 'Fatigue' or 'Burnout,'" which provides practical suggestions for spreading out "difficult clients" in the schedule and encourages trainees to "ensure that you have and use a set of self-care activities, such as regular exercise, personal care, hobbies, social activities, and holidays" (Dobson & Dobson, 2009, p. 220). As discussed in this article, trainees can be supported and encouraged to move beyond an activity-based approach to self-care. Supervisors can coach trainees on the evidence-based skills needed to effectively serve challenging patients (Riddle, Meeks, Alvarez, & Dubovsky, 2016), who likely have histories of interpersonal and institutional invalidation. In so doing, quality of patient care improves and trainees are less likely to elicit "difficult" patient reactions that increase risk for burnout.

3. *Teach all providers, including trainees, to listen for what is left unsaid*: For trainees who rotate in trauma-intensive settings but do not have formal training in trauma theory and treatment, settings may need to help trainees develop the willingness and skills to listen to patients in a new way. Given trauma's unspeakability, it is essential for bystanders to listen for what is left unsaid. Referring to this intentional listening practice within a research context, Smith and Freyd (2014) write:

> It takes dedication, energy, and bravery to purposefully research and report on phenomena—interpersonal violence, human rights violations, and other forms of trauma—that many wish did not exist [...] When studying a topic that we wish did not exist, it is necessary to listen for what is left unsaid as individuals try to share their experiences. Noting these gaps in understanding of traumatic events often signals the need for research, as individual accounts of trauma often reflect societal norms of what 'counts' as traumatic (Smith & Freyd, 2014, p. 521-522).

To take the case of medically unexplained symptoms: empirical research has established a connection between interpersonal trauma and increased rates of healthcare utilization (Gawronski, Kim, & Miller, 2014) and functional somatic syndromes such as irritable bowel syndrome, fibromyalgia, and chronic pelvic pain (Afari et al., 2014; Chiu, Lee, Chen, Ho, & Wu, 2017; Spiegel et al., 2016). These syndromes disproportionately impact women relative to men, at rates as high as 3:1, 13.7:1, and 10:1, respectively (Canavan, West, & Card, 2014; Jones et al., 2015; Clemens et al., 2015). In practice, the role of

interpersonal trauma in these conditions is rarely discussed or acknowledged. "Betrayal blindness" (Freyd & Birrell, 2013) to the prevalence of interpersonal violence and its role in the etiology of adult health conditions persists at multiple levels- patient, provider, healthcare system, and society. There are surely practical reasons for this. Nevertheless, far more work is needed to understand how systems of care can take a trauma-informed lens on working with adults with somatic conditions, and with injuries whose causes are otherwise unspeakable.

4. *Construct a narrative, even when any storying seems impossible or unsatisfying*: The reason for this was best-said by Fivush: "experiences that are silenced lead to a sense of existential despair" (2004, p. 83). As elaborated by Salter in this journal, trauma disrupts and dismantles systems of meaning. As systems of meaning are undone by interpersonal trauma and violation, so they can be re-constituted—through hard, intentional work that is facilitated by a supportive community. One way of meaning-making is to make sense of disruptive experiences by telling the story (Breen & McLean, 2016; Park, 2010). Developing a coherent narrative of past traumatic events is often part of the trauma recovery process (Anderson & Hiersteiner, 2008; Briere & Scott, 2015). As a former provider in a trauma-intensive setting, writing this article—however inadequately it captures the experience—is one parallel, self-caring effort to make meaning of what I witnessed. It is an effort couched in considerable privilege, to have the power to give voice to my experiences and those of others, creating a version of our shared reality.

To heal from the collective grief of trauma and loss—both the acute and that inflicted over time, by individuals and institutions—we need to empower more witnesses and survivors (especially those on the margins) to tell their stories, and we need to encourage those with the power to heal to listen in a new way—to the unspeakable, to that left unsaid. With this, we can create a new story.

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