

NAADAC

THE WOUNDED HEALER: HELPING THE HELPING PROFESSIONAL

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[Live captioner standing by to caption event].

>> The broadcast is now starting. All attendees are in listen-only mode.

>> SAMSON TEKLEMARIAM: Hello, everyone. Welcome to today's webinar on the wounded healer, helping the helping professional, presented by Sarah Buino.

It's great that you can join us today. My name is Samson Teklemariam and I'm the trainer at NAADAC, the association for addiction professionals. I'll be the organizer. The permanent home page is www.NAADAC.org/webinars. Make sure to bookmark this page so you can stay up to date in the latest in addiction education. Closed captioning is provided by CaptionAccess. Please check your email or Q&A and chat box for the link to use closed captioning.

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And speaking of the different tabs you have access to in this webinar, we're using go to webinar for this live event. You'll notice the control panel that looks just a little bit like the one on my slide here. Here are some instructions. You've entered into listen only mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have trouble hearing the presenter for any reason I recommend switching to a telephone line using the audio option which is right next to the orange arrow in your go to webinar control panel. You can use that orange arrow anytime to minimize or maximize the control panel. If you have questions for the presenter, just type them into the questions box. We'll gather the questions and pose them to the presenter during our live Q&A. Any questions that we don't get, we'll collect directly from the presenter and post those questions and answers on our website.

Let me introduce you to today's presenter. Sarah Buino is the founder of head heart therapy. She is a licensed clinical social worker, certified addiction counselor, certified facilitator. Shame resilience curriculum and adjunct professor at Loyola university and Fordham university. Holds a masters from Fordham University and specializes in substance use disorders. She uses music, yoga, and Chakra System to help clients enhance their authenticity. She's also has a podcast which examines the role of your own healing while being a health care professional. Presented to you by this accomplished trainer. So Sarah, if you're ready, I'll hand this over to you.

>> SARAH: Thank you so much, Samson. Hello, everyone. Thank you so much for joining us today. I'm excited to talk about this topic to you as it's something I'm very passionate for myself and my staff and my and the people I work with. First, we'll take a look at the objectives. We'll be discussing about compassion fatigue and vicarious trauma and I'm guessing that that information is not necessarily going to be new to a lot of folks. So we're not going to spend a great deal on that but talk about what it is we need to actually do to care for ourselves. And then we'll talk about the eight areas of wellness and how they can support a healthy therapist or counselor. And finally we're going to analyze the self-care strategies from the eight areas of wellness and I'd encourage you to think about how to create an individualized plan for yourself.

So who is a wounded healer? In my opinion, everyone, not just people who are in professions, but literally everyone. And especially if we have chosen to go into this work, I believe we have the capacity to heal. When we're able to be in touch with our own pain and be able to continue to work on ourselves to be able to heal -- I put up my podcast logo here not just to gain new fans but -- I've been doing it for two years now and have reached 100 interviews and asked everyone do they consider themselves a healer? And it's interesting, you know, the answers that you get when you ask the same question over and over. And essentially what the answers boil down to is usually that if we're in some sort of caring profession we find ourselves being a conduit or being someone who holds space for somebody to do their own healing work, and so that's

one of the reasons why I'm so passionate about this topic because I get to talk about it a lot.

Next, I wanted to let you know this webinar is really a call to action. It's not that same fluffy self-care seminar that you may have heard in the past. What I want to do is create an invitation to openness and curiosity because I'm going to say some things today that potentially may challenge what we've learned before about self-care and how to do it. I may be saying things that inspire you and make you want to essentially change the way that you relate to yourself and relate to your clients. And so I just want to make sure that we're on the same page about openness and curiosity so that we can examine the ways we're showing up to help people in this field.

So why do we become helping professionals? I ask this question of myself a lot and continue to get different answers and I ask this of my students and there's so many answers that we come up with. And usually one of the No. 1 reasons is that we have this desire to help others. And when I think about where that comes from, I think about for me personally, I think about my childhood and what was it in my childhood that created this desire to be of service to other people? And truthfully I grew up in a home where my mother was the daughter of an alcoholic and was what I would call an untreated Al-Anon. So the way that influenced the way I needed to show up in the world was quite profound to feel this not only desire to help others but this need to get my own cell worth sometimes from that desire to help.

The second reason, the desire to do meaningful work. I can use my husband as an example here. He worked in PR for almost 20 years and one day just said, you know what? I can't do this anymore. I really want to do something more meaningful with my life. I was so proud of him that at almost 40 years old decided to go into grad school to switch into doing meaningful work. I think our culture has such a focus on success and success being driven by work. So we really think about our work as almost -- sometimes it's the way we define ourselves. It's definitely one of the things in my life that I used to define my life is who I am in my work.

And then the third, recognizing that our values match well with our work, just like my husband going back to school, he recognized that when he was working for a food company essentially and he's, like, you know what? Mac and cheese is not really within my value system [chuckling]. And I want to do something that actually helps people. So when we're able to align our values with our work, generally we have a healthier sense of well-being in our lives. And I'm curious if you can think of other reasons, too, why you got into this field.

So now, I saw this quote on Instagram and I absolutely loved it so I had to make my own image and post it. If you never heal from what hurt you, you'll bleed on people who didn't cut you. So one of the spaces of inviting openness and curiosity is have we put ourselves in the position to bleed on our clients based on something that maybe we haven't worked on in ourselves? I can give you a recent example of something that happen to me. I've shifted more from addictions work into a lot of trauma work. And

truthfully, as most of us know, we can't really separate those two because everybody who has addiction usually has an underlying trauma as well.

And I've recently found myself needing to give -- send people to a higher level of care, specifically for trauma. And I've been working in addiction for ten years so I've essentially built up this callus to knowing my internal stopping point when I begin working harder than the client and I can realize that and set that boundary when it came to addiction. But when it came to trauma that internal boundary wasn't there. I didn't have that same sort of off switch that I can employ to take care of myself when a client is really, really struggling. So I found myself bending over backwards, going above and beyond for a client who wasn't willing to do that for themselves. And it was a very painful lesson for me to learn.

So the invitation here is not just self-care in, oh, I'm going to, you know, make sure that I lower my stress and I go to the gym and that sort of thing, but really self-care, including the way we're working with our emotions and our mental health. And the question that I pose is, why might we struggle to do our self-work? What gets in the way of our desire to be the healthiest version of ourselves so that we're able to support and care for our clients?

So the first one is fear. And often, I will hear from people who are essentially a little bit resistant to going to therapy themselves, it's really a fear of pain, a fear of if I uncover something, I'm afraid I might not be able to tolerate it or I'm going to hurt for the rest of my life then. And for those of us committed to doing our own healing work, we know that it's actually true [laughing]. I think it's not -- it's not an unfounded fear that we will be experiencing pain if we attempt therapy, you know. I know that some of us have told our clients that sometimes you're going to leave sessions and leave treatment and you'll feel better but sometimes, you'll feel worse, and the feeling worse doesn't mean it's not working. It means we're uncovering really important areas that we need to do our healing work.

So then shame, also getting in the way -- and shame truly is -- it's under the same umbrella as fear. And shame, if you define it in terms of Brene brown's work, shame is the intense feeling that we're not worthy of belonging. So shame, if we're in this field of a helping professional, it can be fear of not being not good enough. One of the interesting things as a result of my pod cast is I find a lot of my listeners are people who aspire to be in the field but felt they were too broken or -- their childhood was too messed up or something like that and that's what prevented them from getting in the field. But with the honest conversations we have with my guests on the pod cast, people are able to recognize, oh, therapists are humans too [laughing]. We're not -- we didn't get our stuff all fixed and are sitting on top of our thrones with our perfect lives, that we actually struggle too. This shame, if we can shed light on it and share our struggles in a more compassionate and public way, it can be really helpful in normalizing that we still struggle as humans even when we're in helping professions.

And then the third, pride. When I think about pride, I also kind of think about it on the narcissistic spectrum. And not everybody who has a level of narcissist -- doesn't

mean they're on the spectrum of course. But it could be a cover for fear. People with narcissistic disorder, they have to utilize defense mechanism of denial in order to not be present with that feeling, and I think that that can happen in our field, too. I know that I have a friend who recently has been suffering from some depression and it took her a while to recognize that she was actually experiencing depression. And it wasn't -- it wasn't narcissism from this grandiose, but this inability to look at that part of herself for fear that then she would be an impostor and not be a good enough therapist in the field.

And then the fourth, not valuing the importance of inner life. This one, I see this with my students and folks who are new to entering the field that sometimes there's illusion of wanting to be in a position of power over clients. Truly we can recognize that comes from our childhood wounding. If we have this desire to be the person who knows everything for our clients, we can really get in the way of working on our own healing and noticing the places where -- what happens when we allow ourselves to be equal to our clients? And for a lot of folks, that brings up the fear. And of course I'm sure there are multiple others.

So empathy and the therapist. I want to first share, I completely stole this slide from Neuro Effective Relational Model. I'm in training -- we call it NARM, and it's essentially a trauma modality that really focuses on complex developmental trauma. So differentiating that from shock trauma, shock trauma is a one-time actual life threatening event whereas complex developmental trauma is really relational trauma that happens in our family of origin usually with our primary care givers. So I got this from NARM.

So empathy and the therapist, we want to be thinking about -- as we move through the rest of the slides here -- when is empathy moving us towards connection and towards healing with our clients and when is it potentially moving us away from our goals with our clients. And truthfully, the client's goals themselves. The goals and therapy really should not be driven by the therapist. They should be driven by the client. And so when we are experiencing what they're calling here as unmanaged empathy, it can be empathy on over drive. Empathy on really again coming from this place of wounding that we haven't worked on ourselves and therefore are spilling on to our clients. And that emotional contagion and blurring of boundaries is this not knowing where I end and the client begins. And it can get really complex. If anybody here, which I'm sure many of you have worked with clients with personality disorders, I had actually a situation recently where I was setting boundaries, what I considered appropriate boundaries and worked with a supervisor to talk about those appropriate boundaries with the client, and then the boundaries kept getting knocked over and punched through and doors kicked in and then I found myself continuing to question whether I was unreasonable because the client kept saying that I was unreasonable. And so it was really difficult for me in the heat of that. And I'm so grateful for the good supervision that I had. It was difficult for me to kind of sort out what was mine and what was the client's.

And then this risk of feeling triggered, frustrated, distressed, hopeless, I don't know about you, but that's something that I can go to pretty quickly. Addiction is such a debilitating disease for so many people, and it can be heart breaking. And I've had my

heartbroken countless times. And there are times when a client will sit in front of me and either their circumstances are really difficult or there are some barriers that are in the way and there are things that just feel so, so hopeless. Actually, I have a great example for that.

I have a client who I sent to treatment, and he has a benefactor who he's lucky another that benefactor paid for his treatment. And we also work with his wife, and the wife does not have IOP benefits. And I got so hopeless. I just tipped right into hopelessness so easy because whenever I get faced with a macro problem, I recognize how insignificant it is in my feelings and my ability to make changes in that situation. And so I can tip to hopelessness so easily. But what I've recognized with looking at unmanaged empathy when I'm sitting in a place of hopelessness I'm not empowering myself to take any sort of action and that hurts me and it hurts the client, which then leads straight into this feeling overly responsible or overly burdened. I cried with my supervisor last week about not having IOP benefits. I was, like, I'm going to take on the insurance industry all by myself. And that's unrealistic and that carrying that burden all by myself is unfair to me and it's just -- it's just harmful and hurtful.

The other thing I wanted to share as we move on to the next slide is that clients with a particular developmental trauma, sometimes they actually don't respond to empathy very well. I don't know if you've ever noticed that with a client that when you try to provide empathy and connection, that actually creates a barrier. That's something to consider, too.

And the next slide, so how do we sit with the suffering of another person? This can be really challenging and I find for myself and especially for a younger therapist that I work with, there's often a desire to fix. Right? We have our clients come to us and they're asking for solutions. They're asking for relief. And our culture has set us up for failure in this idea that we should be able to relieve someone's symptoms in six to eight sessions because, I don't know about you, but in my experience, it doesn't happen often, at least especially when addiction and trauma are at play, that that's not really enough time. But we have this idea in our society that there should be a pill to take to get over something or I should be able to do six to eight weeks of physical therapy and have all of my physical ailments be fixed. So why shouldn't I be able to do that with mental health? But really, what is actually transformative in therapy is sitting with the suffering of another person. And are we able to truly stay present with that pain? Or do we try to compulsively change a situation? The presence that we have with our clients, we really want to cultivate an idea of just being and not doing. And if we're able to connect with ourselves, that then in -- in forms that we can connect with our clients. We can create the space of just being instead of doing. That's where an engagement can grow out of that.

Now I'm going to turn it back over to Samson here.

>> SAMSON TEKLEMARIAM: Thanks, Sarah. Yes, everyone, this will be the first of a few opportunities to connect with your presenter. You will see a polling question pop up on your screen where you can interact and answer the polling question.

The question is asking: What were you taught about countertransference? You'll see five answer options there. Please select the one that best reflects your experience. What were you taught about countertransference? Almost a quarter of you have quoted. I'll give you about ten more seconds.

Great, thank you so much, everyone. Keep those answers coming in. Before we turn this back over to the presenter and close the poll, thank you for sending in the questions in the question box. Any questions you have for Sarah, please go ahead and click on the questions tab which is in the go to webinar control panel. And any questions you put in there we'll ask towards the end of the webinar. Any questions we don't get to, we'll be sure to send it to her and post them online on the same page you used to register for the webinar. About three quarters of you have voted, 75 percent. I'll share the results and turn this back over to Sarah.

>> SARAH: All right. So we've got a pretty interesting spread here. So it looks like most people were taught that countertransference should be avoided. And actually before I even go into that, just noting that -- if anyone was questioning what is countertransference, we didn't learn that at all because we got 9 percent there, it is essentially a fancy way of saying what are our emotions in reaction to the client.

Most of us -- the majority thought that countertransference should be avoided. About 29 percent thinking that it was normal and good. 13 percent that it's my problem. And countertransference means I'm working harder than the client. It sounds like to me that for the most part, we were essentially taught that countertransference wasn't normal and it wasn't good. And so I'm really glad that I asked that question so we can examine it.

Countertransference is not bad or wrong. It's something that comes up. It comes up in our sessions because we're human, right? I think earlier training in this field, we are essentially expected to be a blank slate. I was mostly taught that in school and I graduated over ten years ago. And it's just not possible. I don't know about you, but it's not possible for me to completely shut down my emotions when it comes to being with other people, especially when it comes to being with other people who are in pain. And so the idea that countertransference is something to be minimized or something to be avoided is actually taking out a lot of information because I know for myself that whenever I'm having a feeling come up and I do a lot of checking in with myself during sessions, whenever I have a feeling come up, I have a running dialogue in my head. Is this mine? Or is this the client's and sometimes when it's appropriate, I would actually say to the client, you know, as you talk about this X, Y, Z situation, I'm experiencing a lot of anxiety right now. And I'm curious if you're experiencing anxiety. And that's an example, one way we can use countertransference in a session and recognize that that's when empathy is about connection rather than shifting into this unmanaged empathy.

And again, unmanaged empathy can look like we're being caring and supporting and attuning but when it's fueled by our countertransference, we need to be able to focus in a different way. So using this example of anxiety, if I'm feeling anxiety while the

client is talking about something and I don't acknowledge that it's happening for me, I won't go to savior mode. I might try to problem solve or focus things for a client and we know that's not usually the most effective way to support our client and could get in the way of the client's own goal. So unmanaged empathy really points to places where the therapist needs to heal themselves.

And so again, this is just continuing on this idea of being the wounded healer.

So now, hazards of the helping field, these are things that I'm sure we've all heard about. I know our supervisors, especially early in training say, oh, don't get burnt out. Don't get compassion fatigue but it's a real risk, especially when we work with high need population like we do with addiction. I got this image from -- you'll see the citation there, proQOL.org. You can go and take a test on there and look at information about the professional quality of life. You'll see the umbrella here. Professional quality of life contains compassion satisfaction and compassion fatigue. And then under compassion fatigue, we have both burnout and secondary trauma.

So they don't include rust out on here, and rust out is something one of my mentors whose name is Bob Carte, he talked about rust out as essentially being an experience when you've been in the field a really, really long time and you've lost the passion and the fire to do the work. And I don't know about you, but I have certainly seen this in all areas of my career when working in community mental health, working for a treatment center, and I also see it in private practice sometimes too, which you may think, what? In private practice, you shouldn't be rusted out, but it absolutely happens to many of us. And if we don't have that continued hunger to keep learning and changing and growing along with the field, we can really -- we can really suffer and hurt ourselves.

So professional burn out. I love this quote by Bill White. Deterioration in job performance due to continued contact in high stress work environments. And this is one place I want to kind of zoom out and think of things from a macro aspect because symptoms of burn out, I've got some listed here, but we have a tendency to isolate and hypercritical self-talk. When I think about why these things happen, they happen because of high caseloads, increased documentation demands, unmanageable pace of change, limited training on complex issues, inadequate professional support, ineffective self-care practices. When I look at all of these listed here, there's only one that I think is actually an individual problem, and that would be the ineffective self-care practices. All of the other components listed here are structural issues. Right? And if we pull back and look at the big picture of who is informing how many -- how many clients are on our case load or how quickly we have to do documentation, those are really informed by the payer. Whoever is paying for the services often is going to determine -- or the organization that is structuring the care is often going to determine these things. And so some of what we're talking about today is personal, and some of it is more global. And we need to be honest with ourselves. If we are leaders in this field, we need to be honest with what is -- what is possible for our workers to be able to do? Unmanageable pace of change. I really think about this when I think about the treatment center pace of life [laughing].

I worked in a PHP IOP which also had housing, so it felt residential even though it wasn't technically residential. And the pace with which, you know, those six to eight weeks would go so, so fast and it was difficult to keep up with all of the demands going on at the same time. Truthfully I loved working there so much. I just love that level of care. But I became burnt out because of the unmanageable case and the high caseloads and documentation. And the limited training on complex issues, when I think about that, I think about our education system. If we are getting -- maybe we're getting a masters in some sort of counseling social work or therapy field. When I'm working with social workers, I can tell you that we don't get adequate training on trauma. It's something that is supposed to be information that we get once we've graduated. I'm also guessing that people who are at the counselor level also don't get adequate training on trauma, and I know that -- I think we're on this precipice where the field is starting to tip over to recognize how integral trauma work is to healing addiction. So I'm hopeful that that is going to change in the future.

And then I also think about this inadequate professional support as, you know, my hope is always to lift up my fellow counselors, therapists, social workers and really support each other in this difficult work. But sometimes, we're placed in positions where we're competing with one another, and that I think is also a structural thing that can get in the way of really being able to help our clients.

So vicarious traumatization. So again, just remember that this is really under the umbrella of compassion fatigue. Right? Burn out on one side, secondary trauma or vicarious traumatization on the other. So what is it? It is caused by exposure to reports of trauma given to us by our clients, and it's essentially just hearing horrific and awful stories over and over. And then on the other side here, what are the symptoms? The symptoms are similar to post traumatic stress disorder. So essentially, we are taking on the trauma of our clients and experiencing all of these different symptoms here.

So we're going to move to the next poll question here, and I'll give it back to Samson.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. Yes, everyone, you'll see the second poll question pop up on your screen just asking at what point in your career have you experienced some level of compassion fatigue? You'll see four answer options here, which is different points in your career where you have experienced some level of compassion fatigue. I'll leave the poll open to interact with the presenter and give you about 10 more seconds or so to answer this question.

Thank you so much, everyone. As a reminder, any questions you have for Sarah, make sure to send them in the questions box. About 75 percent of you have answered the polling question we see on it screen. I'm going to go ahead and close the poll and share those results so that our presenter can take back over and speak to those results.

>> SARAH: Thank you, Samson. So it looks like early in my career is the winner here. And then of course circumstances unrelated to work and not surprisingly, you are all on trend because newer clinicians are the most likely to burn out. And so we can

attribute that to of course inadequate training or not even inadequate training but essentially not having as much time in the field can -- prevents us from having all of the confidence that we need and all of the tools that we need at our disposal. One of the things I think about when I think about compassion fatigue and this unmanaged empathy, when I was early in my career, I worked for community mental health, and one of my jobs was to see a health center at school. I had a student come in once and I can't remember what it was they were sharing. They shared something very painful and I had such a hard time sitting with the pain of that student. And what slipped out of my mouth is I just want to put a band aid on your heart. While that's a sweet thing to say, it's pretty silly [chuckling]. I didn't know at the time but it wasn't received very well. I had a student who was friends with that person see me later and told me that what I said was cheesy and they thought it was very unhelpful [laughing]. And I found myself getting in that position a lot and that the demands in commune tale mental health and the high acuity of pain that happens in that level of care can be really, really difficult and move us towards compassion fatigue.

So speak of all of that, we're going to talk about our own potential experiences of trauma. And what I've got here is an image of the adverse childhood experiences questionnaire. So this is something that we didn't actually spend a lot of time on in grad school because it was newer information, I think. But I put it up here because I think this quote is really important. Multiple studies report that the more ACEs a therapist has, the more susceptible they may be to burn out and secondary trauma. If you don't know the back story of -- what the ACEs study is, Vincent [indiscernible] was a physician and he was working for Kaiser Permanente and they were doing a study on weight loss. And they found -- it was for clients -- or patients who were morbidly obese and they were trying to help these people really save their lives and change their lifestyles. They found that patients would get within five to ten pounds of their goal weight and there would be this contraction and back sliding and sometimes even gaining all of the weight or more back. When they looked at who was having that back lash, it was mostly people who were -- who had experienced some level of trauma in their childhood. And so they came up with these categories, abuse being physical, emotional sexual, neglect category physical or emotion. Household dysfunction having a parent with a mental illness, having a parent who is incarcerated, seeing your mother being abused physically or emotional, substance abuse of a parent and also divorce.

And this -- the ACEs don't really cover every single experience of trauma, but it's a really good picture to think about how this shows up for us. So compassion fatigue in folks who work in the field of addiction -- so actually, the study was done with you all, with folks who are members of NAADAC. And it was in 2009 and they essentially found that addiction counselors, 59 percent of addiction counselors met at least 1 criteria for PTSD and then you can see 28 met 2 and 19 met the full criteria. So we go into this field because we have a connection to it. Right? I was telling my clients, you know, there's wink, wink, nudge, nudge, there's a reason we go to our particular specialty. And if we're going into the specialty of addiction, chances are your lives have been touched by addiction in some way and that has created some sort of wound in us. And so again, we need to really think about healing ourselves.

And then the other piece I want to talk about here is PTSD as a diagnosis does not capture everyone who has experienced trauma because as I mentioned earlier, trauma can be shock trauma or it could be developmental and relational trauma. And conflicts post-traumatic stress disorder is a diagnosis that is on the forefront and will be coming out. I believe it's already been accepted for the ICD. And we know that once ICD accepts it, then the DSM will come out with it later on. How do we heal?

Post traumatic growth, I really think about it in terms of how we make meaning from our traumas and it's a little different from resilience because resilience is a set of qualities that really help us adapt and transform. And then post traumatic growth is really how do I make meaning out of all the things that happened to me? And one thing I wanted to share with you, I'm so excited for the fact that our culture seems to be really shifting into this place of non-binary language. And what I mean by non-binary language is instead of thinking in black and white terms, I see us starting to think in more and more of the gray area. And the way this shows up with resilience in trauma, I saw a post in Instagram where somebody said the idea of what doesn't kill you makes you stronger, when we say those things to a person that experienced trauma, it might be helpful if that's the way they make meaning of their trauma but it actually can be really harmful if they're not in a space to receive that yet.

I know for my own pain, there are certain times where I've been just in the place of struggle where I don't want to make a positive meaning out of it. I don't want to think about the plan that my higher power has for my life. That's just not where I am. And so when we're thinking about supporting our clients' ability to make meaning of their trauma, have we done that for ourselves? I find if we haven't done it for ourselves, it's difficult to support our clients going through this.

I also want to make note here that we really need to consider how marginalized people need to cope despite the fact that trauma doesn't end. Post traumatic care supports that there's an end to the trauma. But how do we support the people who continually experience trauma?

So now we'll move on to social justice and self-care. This is again where it might get a little bit challenging because I want to pull back and look at the bigger picture instead of just looking at what we can do personally for ourselves on the individual level.

And making self-care an individual practice actually puts an unbalanced responsibility on us and that takes away the challenge to the bigger system that can be very oppressive. Just be thinking about this as we move through the slides. Self-soothing activities that provide distraction and/or comfort in difficult times. If anybody utilizes DBT in your work with clients, I'm sure you know how to teach people distraction skills. And TV binging, bubble baths, singing, getting massages, exercising, cuddling, these are things that all feel really good and can really soothe us when we're experiencing difficulty. But not necessarily making big changes for us.

And then self-care, if we kind of think of going a deeper level underneath the self-soothing, these are activities that help find meaning and support growth and

groundedness. We see up on the top left there, going to therapy, my personal favorite. Also meditating and then exercise is on here too because exercise can certainly be distraction, but exercise can also be supportive of growth and groundedness. Right? I love this, taking ownership of your finances. That's something that I tend to avoid and I'll tell you more about that later [laughing]. Setting boundaries, saying yes and no when you really mean it. That can certainly support our growth and groundedness, getting our medical care, eating well for our body and yoga. Who doesn't love yoga?

Community care, now we're going even a more macro level. And these are work arounds for systems that don't inherently lay support care. So we've got childcare here. And I know that in Chicago, I hear the cost of childcare is just astronomical. And when people are making decisions whether or not to have children, the childcare cost is one of the things that can really come into play to that. So the work around here they're sharing educational collectives where people can share in the responsibility. Let's see here. Intimate relationships outside of traditional couple hood norms. I think about this in terms of connection with childcare as well because when we look at the dawn of humans, we weren't in four to five person nuclear families. We were in communities. We were in tribes. And I can't remember what the name of the tribe was, but I heard this story about a child's feet didn't touch the ground until the age of three. And thinking about how loving and caring that would be to experience community in that way. And so when we have really close relationships with people who can create that tribe with us, that can be a work around for this lack of support. And you can see the other ones here. Worker owned coops. Free cycle and buy nothing groups. Cohousing and sharing in mutual aid.

And then finally here, structural care. So these are systems that support community care, self-care and self-soothing and these are extraordinarily big, big pieces that individually we cannot change. But I guess the call to action here is really thinking about when we're voting we want to vote for politicians and policies that are supporting our ability to care for ourselves and that are actually supporting our values here. My husband and I were having a conversation recently about the upcoming election and thinking who's going to win. I'm not going to get into all our politics, but what we recognized is regardless of who wins, our day-to-day lives are not going to change because we are afforded a certain level of privilege. And we have that privilege and one of my values and one of his values, too, is to share in that privilege and use our privilege in order to lift up people who may not have access to all of the things we do. And so that's -- that's one thing that we think about when we are going to vote.

I do want to note there, it has capitalism in the bottom and this is one place where I imagine people will have lots of questions about it. I'm not an economist so I'm not going to go outside my scope and tell you what is the economic system that is most supportive. But what I've been leaning into recently with a lot of antiracism training, I've learned that capitalism draws from white supremacist values that are oppressing many Americans and of course disproportionately people of color. And so I'm really thinking about how do I utilize my privilege in order to support a system that's actually going to support health, healing, and caring for most folks.

So that leads us to the eight areas of wellness. And when we go through each of these individually, what I'm thinking about here for our learning today is that my hope is we can create a culture of healthy therapists. And if we have healthy therapists and counselors, that means we have clients who have more support and care. I also just want to mention too -- this is not really the scope of what we're talking about, but I'm always thinking about the folks who I work with who are parents. And if we're supporting people to be healthier parents, then we're supporting healthier children, potentially. Before we go to the next slide, I want you to really think about what is healthy and in our training, we spend a lot of time talking about pathologies, but we don't really talk about what comprises health. That's what this initiative by SAMHSA was really asking us to look at.

We're shifting from looking at illness to looking at wellness. And these are the beliefs that underlie the concept of wellness. The belief that recovery is possible. If you're a person who works with addiction -- I know you know this is true as many miracles have walked through your door as I have. Underlying trauma or anxiety affects our mental and physical health. The whole mind-body thing we're getting into right now, there's never been a separation and we're trying to shift to recognize that mind and body have always been interconnected and we thought we can separate them, but we're wrong. Recovery involves balance. So I sometimes see clients who come into recovery and then they go -- they go hard and they go all into it. And then they find themselves getting burnt out on all of the recovery activity. I'm trying to slow them down. Recovery requires community support and this is something -- I know I'm preaching to the choir here -- but we absolutely need to be recovering through community whether it's eating disorders, trauma, mental health issues, having other people to be able to talk about these issues with are really what can help that growth.

And then finally, routine and regular habit support recovery. I like to tell my clients that it's always a practice. We're not going to wake up one day and be healed. But everything we do in recovery should be supported by routine.

We're about to dive into all the specific areas of wellness, but before that, I want you to think about these things for yourself. So it's problem. If you are a new-year resolutions setting, I'm curious where those resolutions ended -- or maybe they haven't ended, but they're still going. But if they have ended, why? When setting a self-care goal for ourselves, if we fail to reach that goal, then I'm guessing we set it up in a way that we were setting ourselves up to fail. So think about have your goals been too big? So if I am, you know -- if I've got this goal to lose a certain amount of weight in a short amount of time, that's probably too big of a goal and I may set myself up for failure.

Did a goal actually belong under community care or structural care? So with this, this client that I have that doesn't have the IOP benefits, if she has this goal for herself that she's going to heal from her trauma in a specific way, she's setting herself up for failure because this is really structural care that the insurance company is really failing her in this way. Are there barriers to your goal that are outside of your control? So again, just like this last piece that I talked about with the IOP, there are barriers we don't have access to IOP for her and that's outside of our control. And then lastly, I think this

piece is interesting. Was your goal actually your goal, or was it based on someone else's idea of what you should do.

I have a client and we talk about the way his family views as success and what he should do with his life. His story is really, really awesome. He was in the finance world and when he ended up getting sober it was because he finally quit trying to get a job in the finance world and he decided, well, I'm just going to work for Uber. And he was able to recognize that this goal of -- specific career and financial success wasn't his goal but his parents' goal. Once he was able to shift that, he was able to take away that pressure and maintain a really positive recovery.

So looking at these areas of wellness, first one being physical, the things I do to take care of myself, my body in healthy ways. We've got sleep, nutrition, exercise, sexual activity, and regular health care visits. One of the things that I've historically had in my head is I have to work out a certain amount of times a week to be healthy and be fit and weigh a certain amount. And I unfortunately had health issues in the last year and my body wasn't able to perform in the way that I wanted it to perform. And so now I've started to shift my goal instead of being -- I'm going to work out X amount of times per week, I'm going to listen to my body and I'm going to try to intuit what it is my body needs on any given day. Like, just for instance this morning, my intention last night when I get to bed was I'm going to get up early and go to the gym tomorrow and I ended up being up two hours in the middle of the night last night so when the alarm went off at 6:30 this morning I made the decision to turn it off and go back to sleep for a couple hours. So listening to our body instead of forcing it to conform to an outside goal can be a way to take care of it.

Emotional, the things I do to take care of my feelings in a healthy ways. Maintaining personal and professional support systems, counseling, journaling, talking about feelings. One of the things I'm working on this year is creating the space for the vastness of my emotions, especially the negative ones. We want to avoid suffering as much as possible but that's unavoidable. Suffering and pain kind of comes with the job of being human. What I'm finding for myself recently is I'm really, really trying to be at peace with the fact that I have really overwhelming emotions, overwhelming painful emotions sometimes.

I was reading -- I'm still reading Pema Chodron, a Buddhist monk. Her book, *Welcoming the Unwelcomed*, I was struggling with negative and painful emotions and what she was suggesting was essentially sitting with them and just seeing how long can you sit with a negative feeling? And in the book she writes that, I guess, some folks have said that three minutes is the absolute longest we can sit with a painful emotion which is pretty interesting considering that we naturally have them. So thinking about our emotions is a great way to support our wellness.

And then cognitive, the things I do to care for my mind and understand myself better. So examples are reading for pleasure or for work, writing, taking a class, engaging in continuing education, gaining new skills and knowledge. For me, this is probably one that I need to dial back on because I do spend so much time learning

because I'm just a voracious learner. As we're going through these, not only are we looking at -- weir.

Wanting to develop healthy and supportive goals for ourselves but we also want to think, which ones do I need to dial up and which ones do I need to potentially dial down?

Next three, we've got social. So the things I do in relation to others. Spending time with friends, family, colleagues, having fun, belonging to groups, communities. So for me, this one is one that I really need to dial up. My husband and I went out to dinner the other night and I started talking about something work related and he said, can we talk about something other than work and I said, this is all I've got, buddy. Hmm I need to find more time for fun and social things. So this is one that I really need to deal with -- there's an underlying fear of if I'm not working and not being productive then my worth is affected by that. So if I can sit with that fear, create space for the vastness of that emotion, that fear, that pain of the fear, then I may be able to turn up the dial on the social piece here.

And then financial, the things we do to spend and save responsibly. So this is also an area where I can use some work. And I want to note hereupon that my privilege actually affords me to not have to think about it that much and I know that there are a lot of people who don't have that luxury. And so what am I doing this year to really think about the way that I approach money? And one of the things I'm trying to do is not just putting things in the Amazon cart and sending them off but being intentional when I decide to spend money on something.

Next, we have spiritual, the things I do to gain perspective on my life. Prayer, meditation, contact with nature, connection with a higher power. So medication is absolutely huge for me and it's a practice that for almost four years now, I've been a daily meditator and it's going to change my life. I'm a big proponent of medication. But one of the goals I have for myself this year is I'm working in my 12 step program, really thinking about the cultivation with my higher power and what does that look like for me on a day-to-day basis?

And then the last two areas of wellness we have. Environmental. How do we create a livable space or environment? Creating space to engage in activities free from distractions, noise pollution, clutter, allowing ourselves to disconnect from screens or down time to cultivate space for play. So this one can certainly be affected by where we live and what's going on around us. I live in Chicago and so noise pollution is kind of a given, though I live on a quiet street where I can retreat to my backyard if I need to. But I've got this area of wellness extraordinarily challenged this fall because we had mold in our house and the house next door was being gut rehabbed. So I had jackhammers outside. And then I had people digging in my basement and doing all kinds of crazy stuff to get rid of our place of mold downstairs and there was literally no space where I can go where I was freed from noise for about two and a half months. Let me tell you, it affected the rest of my areas of wellness and I did everything I can to try to take care of myself in that space. And it also just made me think about our clients who don't have

access to a calm environment on a regular basis if they're living with roommates or if they have a very large family or -- I also think about my clients with kids. Kids make a lot of noise and we can't just -- kids aren't just supposed to be seen and not heard these days. So it can be really difficult to cultivate wellness in our environment. And then finally, occupational, the things I do to make sure I'm aligned with my work/life purpose. So do I allow myself to take breaks? Do I notice when I'm experiencing burn out and talk with a supervisor? Do and ask for help with difficult tasks? So I really find that a lot of the folks that I work with, when they struggle to be aligned with their values and their occupational life, they seem to struggle really feeling that sense of wellness and sense of ease in their lives. And so we want to be aligned with what we love instead of with what we're obligated to do. Those are the areas of wellness.

And I'm going to turn it back over to Samson for our last polling question.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. You'll see the areas of wellness here. We'll ask you to share which area of wellness you struggle most to balance. Let me launch the polling question. You should see it pop up on your screen with four answer options here. Oh, answering really quickly there. A quarter of you answered. The area of wellness I struggle most to balance is -- you'll see two of them on each row. We'll give you ten more seconds to respond. Excellent questions, so far, by the way. You guys have some great questions coming in. We'll go ahead and get them in the queue. If you had a question about wellness or about the wounded healer helping the helping professional, please go ahead and send those into the questions box and we'll ask them in the order they are received. Or we'll pose them to Sarah in a Q&A document that she'll post online later. 75 percent of you have responded to the poll. I'm going to go ahead and close the poll. I'll share the results and turn this back over to your presenter.

>> SARAH: Thanks, Samson. It looks like we're very balanced in our struggles, huh? So physical/cognitive seems to have the most. But also social/environmental. We had to put these together because we couldn't get all eight as individual answers, which is why we had to lump them together. But it's interesting that emotional spiritual is the area where people are struggling the least, which is very affirming for me, and I'm excited to hear that since that's the area that we are doing most of our deep work in. Thank you, folks, for answering that. I hope going through those all specifically are giving you a way to really think about what areas you'd like to target for yourself to support creating a different plan and what that might look for you.

So one of the suggestions that I have when we're thinking about how we're practicing wellness, how we're caring for ourselves is utilizing self-compassion. And I talk a lot about after working with Brene brown and her team, they talk a lot about empathy being the antidote for shame, but what I found is really empathy is great and super important and absolutely needed but if I'm not practicing self-compassion and creating space for myself for self-love, ain't no amount of compassion going to do anything with that. So just a little bit about what that means. So compassion really means to live with. And what essentially we're asking is to recognize that we're experiencing suffering and be kind to ourselves in that moment. Like I told you the

other night, I was experiencing really strong, painful emotions. And I said to my husband, like, wow, I'm experiencing this emotion right now. And I went to bed and was starting to read Pema Chodron's book, and I felt that was a practice of self-compassion for myself instead of continuing with the running thoughts in my head and beating myself up about not being good enough.

Self-compassion is a practice of good will and not good feelings. Again, we're trying to sit with the feelings, not trying to make the feelings go away or pretend they're not there or invalidating there. We want to hold loving space for ourselves when we do experience negative -- I don't want to say negative because that's still in the binary. But when we experience painful emotions.

What self-compassion is not. Whenever I present this, especially to folks in early recovery -- every single Monday I do a detox group, my favorite thing to do in the week and when I present the idea of self-compassion a lot of times they say, well, I shouldn't -- if I tell myself that I'm a good person, that means that I get away with my quote unquote bad behavior. Or I can't say that to my wife. She'll tell me I don't deserve any self-compassion. It's not self-pity. We're not wallowing in the fact that we're experiencing pain. We're acknowledging it that it's there. It's not self-indulgence. We're not letting ourselves off the hook. Kind of the paradox is once we're able to create some space for self-compassion, then we're able to do the work that we need to do in order to change our behaviors that may have put us in this feel of feeling defensive in the first place.

And then self-esteem, self-compassion and self-esteem is different. Self-esteem is especially what we think, while self-worth is what we feel. If we have decent self-esteem, essentially, we are able to list things that we're good at. Right? So I can tell you I'm a good singer, I'm a good therapist, a good friend, and I know these things are qualities that I have. But shame kind of gets in the way sometimes of my self-worth. So even though I quote unquote know all of these good things about myself, my self-worth can be affected. And unless I practice self-compassion and recognize that that is a normal experience, then I'm not supporting myself as much as I can.

And then finally, self-compassion is not weakness. I know oftentimes it's the men who will tell me, well, I can't be compassionate with myself, that's weak. And weakness is the -- the definition is that we're flawed or broken. And vulnerability is really what we are looking at here when looking at self-compassion. Do we have the capacity to sit with our own vulnerability and not judge it?

And then finally, what is self-compassion? So all of this work comes from Kristin Neff. Her website is self-compassion.org. If you go there there's a place where you can test your own self-compassion and it's going to list out these three different areas. And so the first area is mindfulness or over-identification. So if we're engaging in mindfulness when it comes to self-compassion, we are able to recognize in the moment when we are experiencing pain and suffering. If we're engaged in over-identification, that means that we're really struggling to recognize our emotions and we might get

carried away with them. So the hope is that we increase mindfulness so that we're able to create some sort of intervention of self-compassion.

And then the second, self-kindness versus self-judgment. Self-kindness is just the way that we talk to ourselves. Am I talking to myself like I talk to someone I love? Or am I talking to myself like a jerk? [Laughing]. And that's where we go to the self-judgment side. And from most of the clients that I work with, especially in early recovery, a lot of the way they're talking to themselves is extraordinarily judgmental. And it's not necessarily -- we don't want to eradicate self-judgment. We want to know it's there. Then can we invite something a little more kind? And I often joke about Stuart Smalley. If you might remember from Saturday night live. I'm smart enough, and gosh darn it people like me. Affirmations we find is probably helpful for self-esteem but not helpful for self-worth because what we're doing when we are just focusing on the affirmative, we're not acknowledging the pain. And so self-kindness is really, how it I honor the fact that there might be something I'm judging myself over and something I'm really unhappy about? My folks who are in early recovery when I talk to them about self-kindness, yes, maybe I acted really poorly under the influence of my drug of choice and I'm a person who is worthy of love and belonging. Because if we're not somebody who is worthy of love and belonging and kindness and compassion then what's the point of even trying to go through recovery?

And No. 3, common humanity versus isolation. And so common humanity is the idea that we're all connected and all in this together and all verses pain and suffering. Isolation, the term terminal uniqueness comes to mind. I'm so screwed up and I get the award for being the most screwed up person and that really, really truly separates from the experience that we have a shared humanity with others. And what I recognize for myself, one of the places where I've begun to do a lot of healing is my experience with putting myself in the victim role. I think of terminal uniqueness and victim role intertwined. What I realized I'm doing is I'm not showing up to do the work that I need to do in order to heal. But when I'm a victim, I'm still playing into this binary of good and bad. If somebody has to be good and somebody has to be bad -- I'll tell you in my childhood it was better to be oh, I'm the victim, I'm small and that's the big, bad person and that kept me on the side of quote unquote being good, but that actually is avoiding the healing. So test your self-compassion on Kristin Neff's website. It's interesting and the way I used it with clients is I'll have them test themselves and we'll talk about which areas do they feel like they want to intervene the most? Like, where is the area that's really standing out for them, where they're experiencing the most pain and want to take a look at shifting?

So we've come to the end here so we can get to some questions. I'm really excited to hear what your questions are. So in conclusion, I just want to drive these three points home. Wellness takes commitment to a practice. We tell clients we're not going to show up one day and be recovered. We're not just going to magically heal. We have to be engaged in something on a regular basis that is supporting and helping us. And then No. 2, we can help your clients more effectively when we help ourselves. And so I hope that you've really resonated with this idea of an invitation to look to our own wounds to be the best counselor, therapist person you can be with your clients.

And then No. 3, wellness takes a combination of individual agency and collective support. So I also hope that this potentially inspires you to look at the systems of power that are interplaying with some of these areas of wellness and where can we make changes in our agencies? Where can we make changes in the treatment industry? Where can we make changes in the health care industry? I hope we can make these changes so everybody gets the same opportunity to recover like those of us privileged do. With that, I'll turn it back over to Samson.

>> SAMSON TEKLEMARIAM: Thank you so much, Sarah. And everyone, here's Sarah's resources and references. And Sarah, before we get to the Q&A, one question that just showed up, a lot of people just asked, what was that website again? You just mentioned a website for self-compassion. And quickly, a bunch of questions came up for it.

>> SARAH: Yeah. Self-compassion.org. And even if you just did a Google search for self-compassion, Kristin Neff's website would come up most highest on the list and her last name is spelled N-e-f-f.

>> SAMSON TEKLEMARIAM: Thank you so much, Sarah.

>> SARAH: Uh-huh.

>> SAMSON TEKLEMARIAM: So we'll go to our Q&A. Denise Harrison from North Carolina asks: I had a severe loss many years ago. And I sought counseling for grief. I made it through two sessions and realized all I was doing was comparing the counselor's techniques to the ones I use. It was almost impossible for me to switch hats from therapist to being a client. Any suggestions?

>> SARAH: Honestly, I probably have more questions than I have answers at this point. So I do the same thing. So first of all, thank you for calling attention to that. And especially I'm in that NARM training right now so I'm seeing a NARM therapist. And I'm consistently in the experience and analyzing the experience at the same time. So I think it's really hard for us to completely step out of that role. But when I think about my own experience in that, what am I valuing most importantly? If I'm putting the value of education and learning above my healing why am I doing that? And for me, often times, it's fear of truly sitting in the pain. And for your question, I kind of hear this too where if you're comparing yourself to the techniques of the other therapist, then comparing so that either you can be better or you can be worse. And that goes back again to this binary idea of good, wrong, black, white, yes, no. Work on the outside of that. Something I try to remind myself of that when I'm in comparison mode is what is the benefits of being the winner or loser here? Why am I engaging in that thinking? How is that serving my wounds? How is that serving my healing? When we ask these mindful questions, it gets us out of the actual comparison and creates an area of exploration. So that's a really awesome question. Thank you for that one.

>> SAMSON TEKLEMARIAM: Thank you, Denise. Sarah, thank you. And yes, it is all too common that helpers are the worst at getting help.

>> SARAH: [Laughing].

>> SAMSON TEKLEMARIAM: They say doctors are the worst patients, counselors are the worst clients. Denise, sorry for your loss. Grief and loss is a long term struggle. Julissa asks: What is the difference between rust out and burn out?

>> SARAH: So rust out is essentially somebody who's been in their career for a really long time and has just kind of lost passion over time. And burn out is really more of a result of either the clients you're seeing or the systems at play that are not supporting the day-to-day work that needs to be done. So one of them is just for folks older in their career, essentially.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. Another question comes from Josie. Josie asks: How do you avoid the isolation of heavy caseloads and work demands?

>> SARAH: Hmm, I avoid it by creating community. So that kind of goes back to the different types of care, right? Community care versus self-care. I am a private practice owner. I have nine employees and I found that when I was talking with other practitioners who had their own solo private practices, they didn't really understand what I was going through, and I needed to create a community of other practice owners so that I could talk with people who share the burden that I shared. So I reached out to ten friends who have practices and said, hey, would you like to create a collective, a community? If you find yourself in isolation, are there people that you're able to reach out to build community if one doesn't already exist for yourself or for whatever particular, you know, facet of the field that you're in. I think we do have a lot of community support out there, but sometimes, we have to create it ourselves.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. The next question comes from Zoey. Zoey says: I'm a current student in mental health and addictions in northern Ontario, Canada. I've been taught a lot about how to not encounter countertransference with clients. Do you think it's because we are in different areas with different laws and ethics? Or is this a subject that different professionals have views on?

>> SARAH: Well, I think that kind of speaks to the shift in the way that we are showing up with clients. So I think that -- actually, I'm going to give credit to Brene brown and her work on vulnerability and authenticity that invited a change in the field really to start looking at utilizing our vulnerability with our clients as a strength instead of keeping it completely out of the room. I think most training places are going to continue to say that countertransference is something that you keep out of the room. And I don't want -- I don't want to tell you that your professors are wrong. But also, I really think as an adjunct professor, I try to keep current instead of keeping to the textbooks. Because the textbooks were written a while ago and then took time to print. And yes, they do new editions but I don't know if that's current in what's happening in our culture and also in research. It would be interesting to ask that question other Canadians and ask it of other Americans because I'm certain that there is also a cultural difference, too. So thank you, Zoey. That was a really interesting question.

>> SAMSON TEKLEMARIAM: Yes, thank you, Zoey. Sarah, thank you for that answer. Kelly asks: Can you give suggestions about how we can cope with our difficulty and stressors that come from largely structural issues, the feeling that we're powerless to take positive action.

>> SARAH: Kelly, this is something I wrestle with on a regular basis because I really feel mobilized to create change on a bigger level and yet I also feel really isolated because I know that me as one person cannot take it on. So this is where I go to my support systems and I -- you know, I told you guys last week I was crying with my supervisor about some issues and feeling like it was my personal responsibility. And when I'm -- what I'm personalizing something that's bigger than me, I also try to think about how am I -- how am I making myself more important than I actually am? And if I am putting the expectation on myself that I should single-handedly be able to change the health care system that's narcissistic. [Laughing]. So I try to recognize that that's the mechanism that's in play. And I try to essentially give myself a break and recognize that I as one person can only do so much. But on the other hand, I give webinars like this because I want to create this conversation. I want to find other people who want to change the system. And I want to find people who are really motivated to take action. I've been thinking about, you know, how do I encourage my staff to do these things? Because oftentimes my staff really want to see clients and don't want to engage in the larger system. So those who have a passion for it, I think we need to continue to find each other and support each other so that we can create that structural change.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. And another question from Patricia from Atlanta. Patricia asks: I'm good at working with people, but I really feel tired when I'm working with my friend who wants to tell me all of her personal problems. Is this a different kind of compassion fatigue?

>> SARAH: Oh, that's such a good question, Patricia. And my guess would be -- if I'm thinking about when that happens for me, what I've learned with boundaries is that whenever I'm feeling resentful at someone or something, it's because I either haven't set my boundaries appropriately or I let my boundaries be crossed. And what I've come to -- truthfully, most of my friends are in the field so I don't have this issue because we're respectful of each other's boundaries and we're very -- when my husband has something that he needs to talk about, he says, are you available? Are you available for this right now? And so that's one way I've supported myself. But how can you invite a conversation with your friend or your friends around, you know, when you need to take off your work hat and when you need to just be a human and just be silly or complain about something or whatever rather than this expectation in this relationship for you to continue to show up as a therapist? Because that sounds really unfair to you. And it may not be that that's your friend's expectation as well. What I'd be curious about is how much is the expectation you're putting up on yourself to show in this way? That's why we go into this field. Why did you decide to become a helping professional? And if it's because you have this insatiable desire to help people like I do, sometimes we put ourselves in the helping role when people haven't even asked for it. Those are the things I think about with that question. But that's a doozy. That's a good one.

>> SAMSON TEKLEMARIAM: Thank you, Sarah. We're going to squeeze in two more. A lot of questions flooded in just as you were answering them. I'll try to squeeze in two more. As a wounded healer, how should I regulate the use of self-disclosure.

>> SARAH: That's a good question. The way that I think about it for myself -- there are two things. So if I -- if it's an issue that's in the past and I'm working on healing it, I only self-disclose issues that I have done a lot of work around. Right? That's usually my rule of thumb. Though there have been times -- and actually really recently, when I was going through this mold issue in my house in the fall, I was just a basket case and I had incredible struggles taking care of myself. And there were times my clients would ask me how I was and I'd say I'm feeling a little crazy and yet I'm here for you right now. And so we're just going to sit in this space together. And it was interesting. Most clients -- truthfully, most clients didn't care very much what I was going through so it didn't faze them. But one client said they canceled a session because I said that I was struggling and we actually had a really beautiful conversation about that because they canceled their session and then they were resentful at me. So it goes back to the last question I answered, when we're resentful, is it because we allowed someone to cross our boundaries? So those are the things to think about in terms of self-disclosure. In terms of what I've been experiencing in the room, I tried to cultivate kind of a Spidey sense with my intuitive therapist gut, and I just know what it feels like when something is not mine and when it's somebody else's? And I felt that took a lot more fine tuning. But using my childhood wound to know what people are going through was a -- but we can talk about that for hours.

>> SAMSON TEKLEMARIAM: I'm probably doing the wrong thing. I'm going to squeeze in this last one because I'm curious. The last question I'll ask here is -- Catherine is asking: Can you speak a little more to the NARM training.

>> SARAH: Yes, I can [singing]. NARMtraining.com if you want to go to the website. And Lawrence -- Dr. Lawrence Heller was the developer of the model and it's -- how do we describe it? It increases mindfulness. It helps people look at the ways that they had to survive as children and how we carry that into adulthood and it creates space for our most adult authentic selves to show up in life. And it's changing my life. It's changing the lives of some of my clients. It's super-duper cool. And so you can find information on NARMtraining.com. And we also released a pod cast called transforming trauma. And that's where you can find more information about NARM but I'm super excited about it.

>> SAMSON TEKLEMARIAM: It will be on your Q&A documents. Everyone's questions that came in are so valuable. Thank you for sending them. We'll get them all on a Q&A document to Sarah and she'll get to write out the responses, including some information pointing you to NARM. She'll get to write that out. It'll be posted on the website, the same one you used to register for the webinar in about two weeks. So you may be wondering about your CE quiz for this webinar, how to access the recording after the event, et cetera. Every NAADAC has its own web page that houses everything you need to know about that particular webinar. Immediately following the live event you'll always find online CE quiz on the same website you used to register for this

webinar. Everything you need to know will be permanently housed at www.NAADAC.com/wounded-healer-webinar. Please tune in if you can for our upcoming webinars. Really interesting like today. In collaboration with [indiscernible] NAADAC is proud to announce our new peer recovery support series. We brought together some of the best experts and speakers covering topics about building successful support culture in your ocean from hiring, on boarding, integration, all the way to peer recovery supports specialist supervision, advanced skills and techniques and so much more. This series is free to view and attend. There will be a processing fee if you are wishing to get continuing education credits after the live events. However, you can go now to the website to register and learn more from world renowned speakers like Kris Kelly. We'll also have Jenna Neasbitt, CEO of [indiscernible]. Dr. Carlo DiClemente, co-developer of the behavior change. Does he need an introduction? John Shinholser, pioneer in the peer recovery movement; Phil Valentine, author/speaker who also appeared in the documentary, Anonymous People. So many talented people. Make sure to register for this free series by visiting the web page you see at the bottom of this slide www.NAADAC.com/peer-recovery-support-webinars. More importantly, if you are a NAADAC member, your CEs will be free. There's no processing fee or continuing processing fee. There's a small fee for those who are not members. Please note that a short survey will pop up at the end. It will be emailed to you from GoToWebinar. Please take some time to complete that survey, share your feedback, your notes on the presenter, how we can improve and do things differently. Your feedback is super important to us as we continue to improve your learning experience. Thank you again for participating in this webinar. Sarah, thank you for your valuable expertise. I encourage you to take time to browse our website and learn how NAADAC helps us. You can stay connected with us on Facebook, Instagram, and Twitter. Have a great day, everyone.

[End of webinar].