Shared Trauma and COVID-19:
When the Professional is Personal

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Professional Quality of Life Scale (ProQOL)(5)_(B.H. Stamm, 2012)

- Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

- **1=Never**

- **2=Rarely**

- **3=Sometimes**

- **4=Often**

- **5=Very Often**

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my private life from my life as a helper.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
9. I think that I might have been affected by the traumatic stress of those I help.
10. I feel trapped by my work as a helper.
11. Because of my helping, I feel "on edge" about various things.
12. I like my work as a helper.
13. I feel depressed because of the traumatic experiences of the people I help.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with helping techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a helper.

20. I have happy thoughts and feelings about those I help and how I could help them.

21. I feel overwhelmed because my caseload seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

24. I am proud of what I can do to help.

25. As a result of my helping, I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a helper.

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

Self-scoring Directions for ProQOL: Burnout, Compassion Satisfaction & Fatigue Subscales

- **Reverse the scores on 5 items**: 1, 4, 15, 17, 29

(i.e. 1=5, 2=4, 3=3, 4=2, 5=1)

- **Put an "X" by the following 10 items**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30 (CS)

- **Put a "+" by the following 10 items**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29 (B)

- **CIRCLE the following 10 items**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28 (CF/2ndary T)

PQLS Scoring

- **Compassion Satisfaction: Pleasure derived from work**

- <u>23-41</u> is average score

- 25% score <u>42 or higher</u>- good deal of professional satisfaction

- 25% score <u>22 or less</u>- job problems or satisfaction is derived from other activities

PQLS Scoring (continued)

- **Burnout: Negativity (gradual onset) which interferes with job performance**

- 23-41 is average score

- 25% score 42 or higher- perceived lack of effectiveness at work

- 25% score 22 or less- positive feelings/perceived self-efficacy

PQLS Scoring (continued)

- **Compassion Fatigue/Secondary Trauma:**

Work-related secondary exposure to extremely stressful events (generally rapid in onset & associated with a particular event)

- **23-41** is average score

- **25% score 22 or less**- general absence of CF symptoms

- **25% score 42 or higher**- consider feelings/fears/concerns re work environment

COVID-19

Experiencing, Witnessing, or Hearing About Traumatic Events

- Military Combat
- Sexual Abuse
- Physical Abuse
- Domestic Violence
- Torture
- Immigration
- Natural Disasters
- Man-Made Disasters
- **Subjective Perception of What Constitutes Trauma** (depends on existing mental schema)
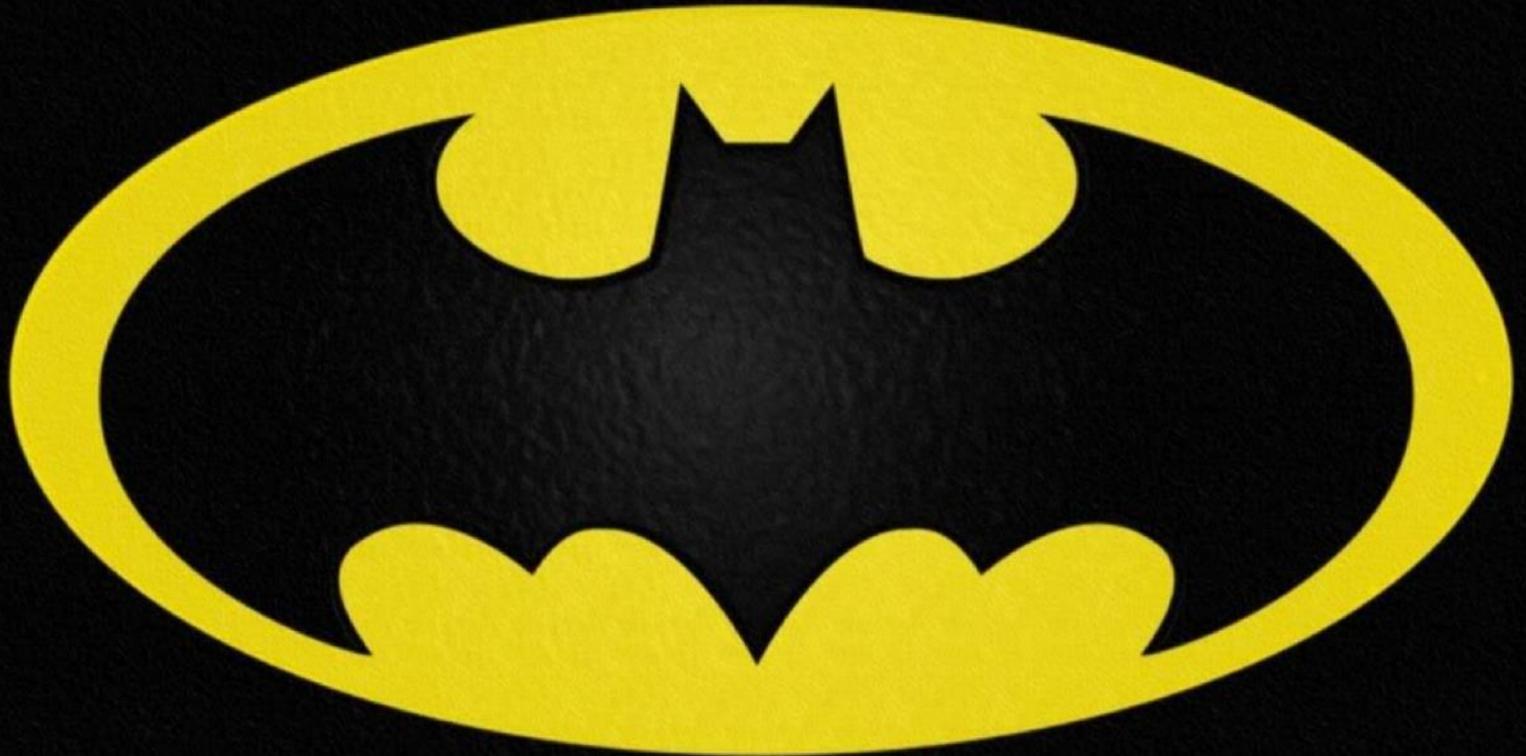
Why do traumatic memories persist?

Traumatic memories are dissociated from consciousness and are stored as sensory perceptions (visual images, olfactory, auditory, &/or kinesthetic sensations).

They are encoded differently (**non-declarative memory: emotional/sensory imprint**) than memories of everyday events (**declarative memory: symbolic/semantic processing**).

"**Fight-Flight**" encoding of information, **dissociated from linguistic expression**.

Sights, **smells**, **sounds**, **somatic sensations**, not symbolic level narratives.

Left and Right Brain Functions

Left-Brain Functions

Analytic thought

Logic

Language

Science and math

Right-Brain Functions

Holistic thought

Intuition

Creativity

Art and music
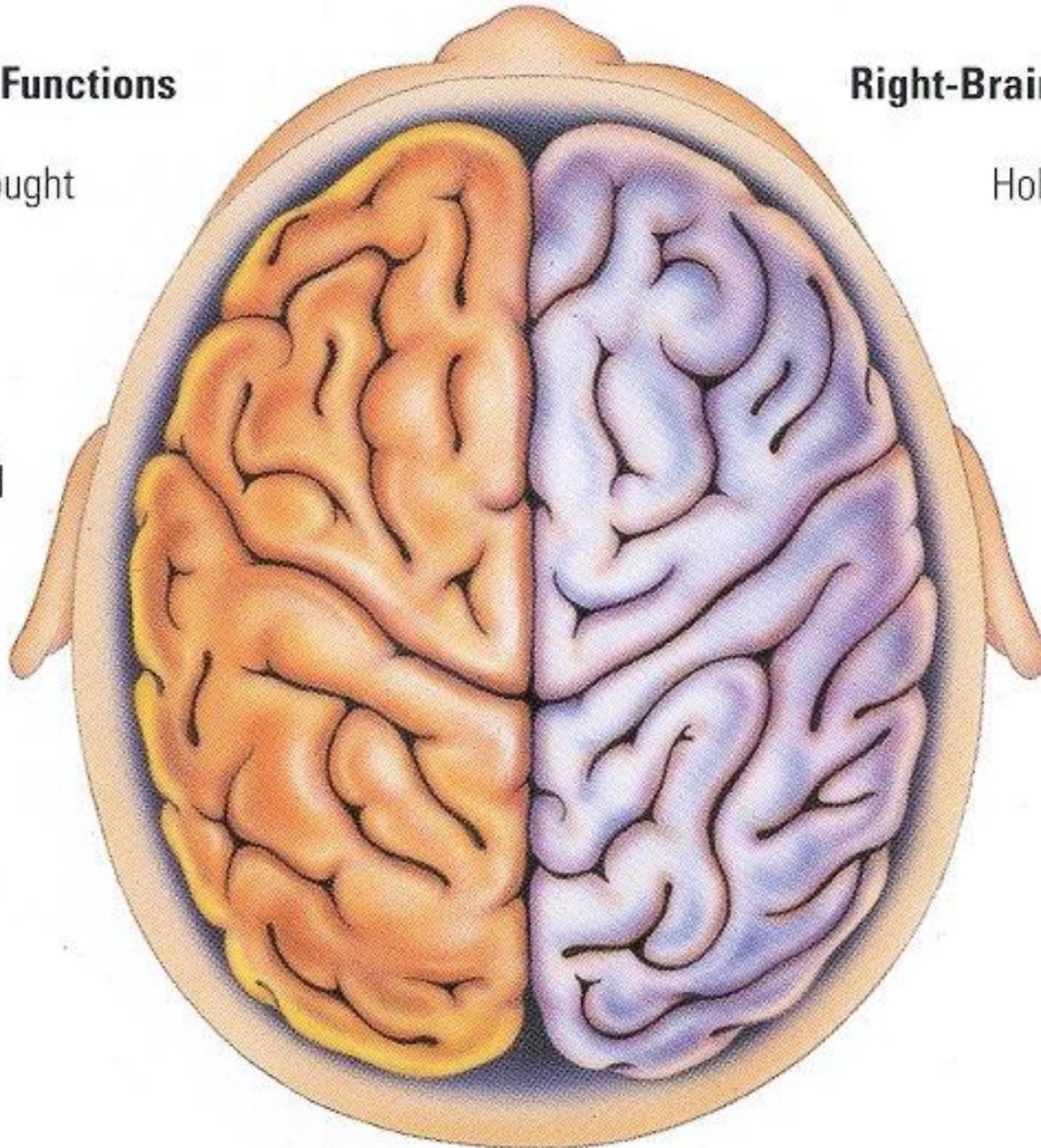
Differentiating Anxiety from Fear

- **Fear** is a response to a known external danger

- **Anxiety** is a response to a threat which is unknown, vague, internal, or conflictual.

Modulation Model

Ogden and Minton (2000)

HYPERAROUSAL

AROUSAL

HYPOAROUSAL

Hyperarousal
Hyper-orienting and defending
Emotional reactivity
Hypervigilance
Intrusive imagery
Obsessive/cyclical cognitive processing

Freezing
High arousal
Agitated immobility
Frozen defensive responses

Window of tolerance
Optimal Arousal Zone

Hypoarousal
Flat affect
Inability to think clearly
Numbing
Disabled orienting/defensive responses

When an individual is traumatized they experience such strong reactions that it overwhelms the brain, as a result distressing memories become frozen in time coming up intrusively and manifesting through emotional and physical distress.

The Relationship Between the ACE Score & Trauma

CANarratives.org

Trauma-Related Concepts Relevant to Clinicians

- Burnout

- Compassion Fatigue (comprehensive & intended to include burnout & secondary traumatic stress)

- (Traumatic) Countertransference (e.g. working with adult survivors if childhood sexual abuse)

- Traumatic Reenactments (context of psychotherapy)

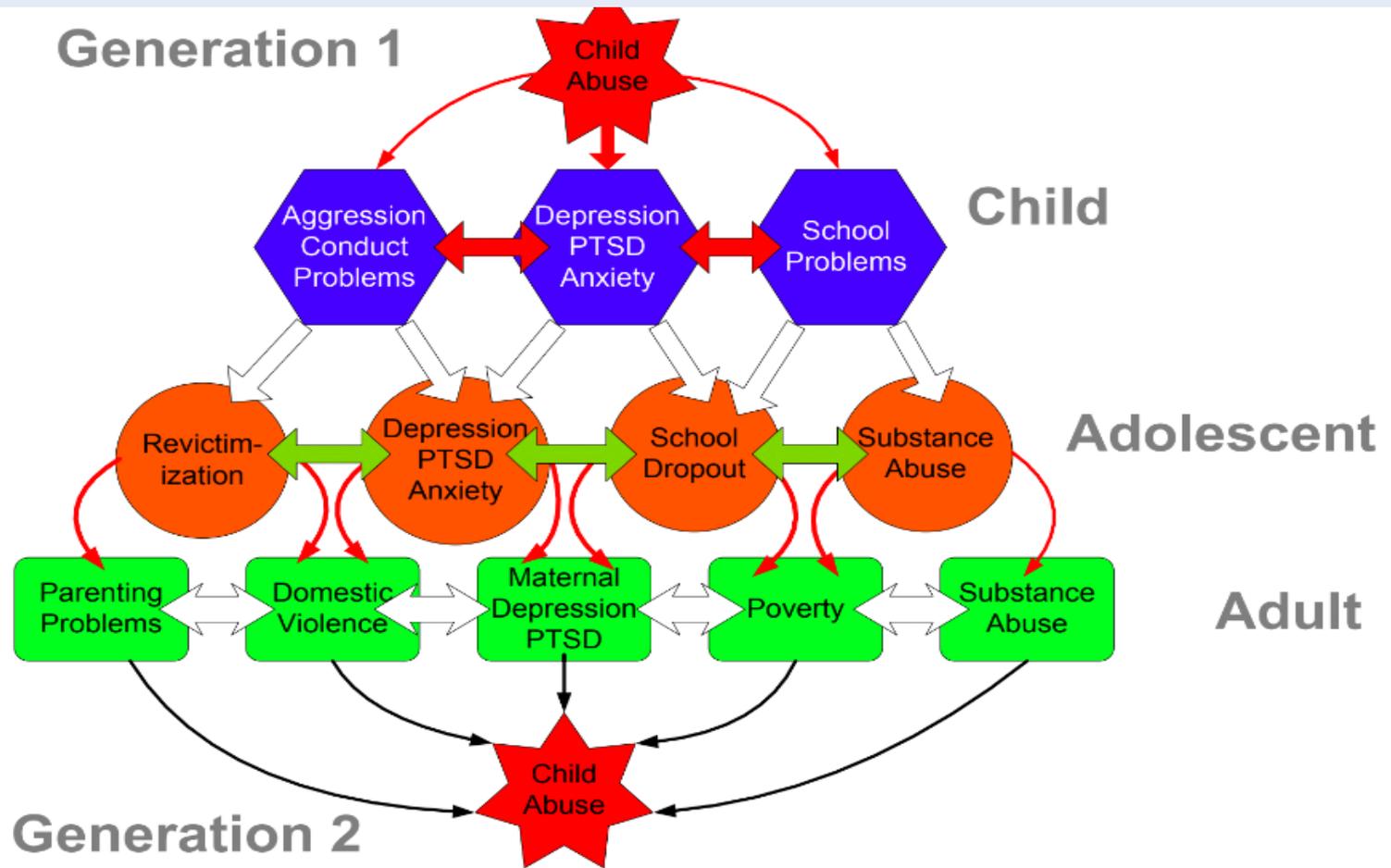- Secondary Traumatic Stress (affective, behavioral, cognitive, somatic, spiritual, personal & work relationships)

- Vicarious Trauma (emphasis is on transformative changes in relation to self, others, & world; neophyte & highly empathic clinicians, & therapists with a trauma history are most at risk; "have a life")

- Shared Trauma (underscores the symmetry of the therapeutic relationship; dual exposure to trauma)

Factors Predictive of CF/STS

- **Younger Age**
- **Cumulative Trauma**
- **Recent Exposure to Trauma in the Work Place**
- **Past History of Trauma, Depression, &/or Anxiety**
- **Post-Disaster Counseling Efforts**

September 11th

Shared Trauma

This is a new construct which developed

in response to the September 11th tragedy.

It contains elements of Compassion Fatigue & Vicarious Trauma, but the therapist is exposed

to the same trauma as the client. Both the client and the

clinician undergo transformations in the cognitive, affective, behavioral, and spiritual realms as a result of the shared traumatic experience.

ST underscores the symmetry

of the therapeutic relationship, and provides

opportunity for mutual reparation and

growth (Saakvitne, 2002; Altman & Davies, 2003; Tosone, 2006, 2012).

9/11 PTSD Risk Factors

- **Mass Violence** – **Most disturbing type of disaster** (Norris, 2001)

- **Gender** – **Women more prone to development of PTSD** (Norris, 2001; Silver et al., 2002; Galea et al., 2002)

- **Media Exposure** – **The greater the exposure to watching disaster-related media, the greater the development of PTSD** (Schlenger et al., 2002)

- **Concurrent Stressors** – **Presence of 2 or more additional stressors** (Galea et al., 2002)

Shared trauma and the boundary shifts that resulted

Provider

New Boundaries from Shared Experience

Shared Trauma/ 9-11

Client
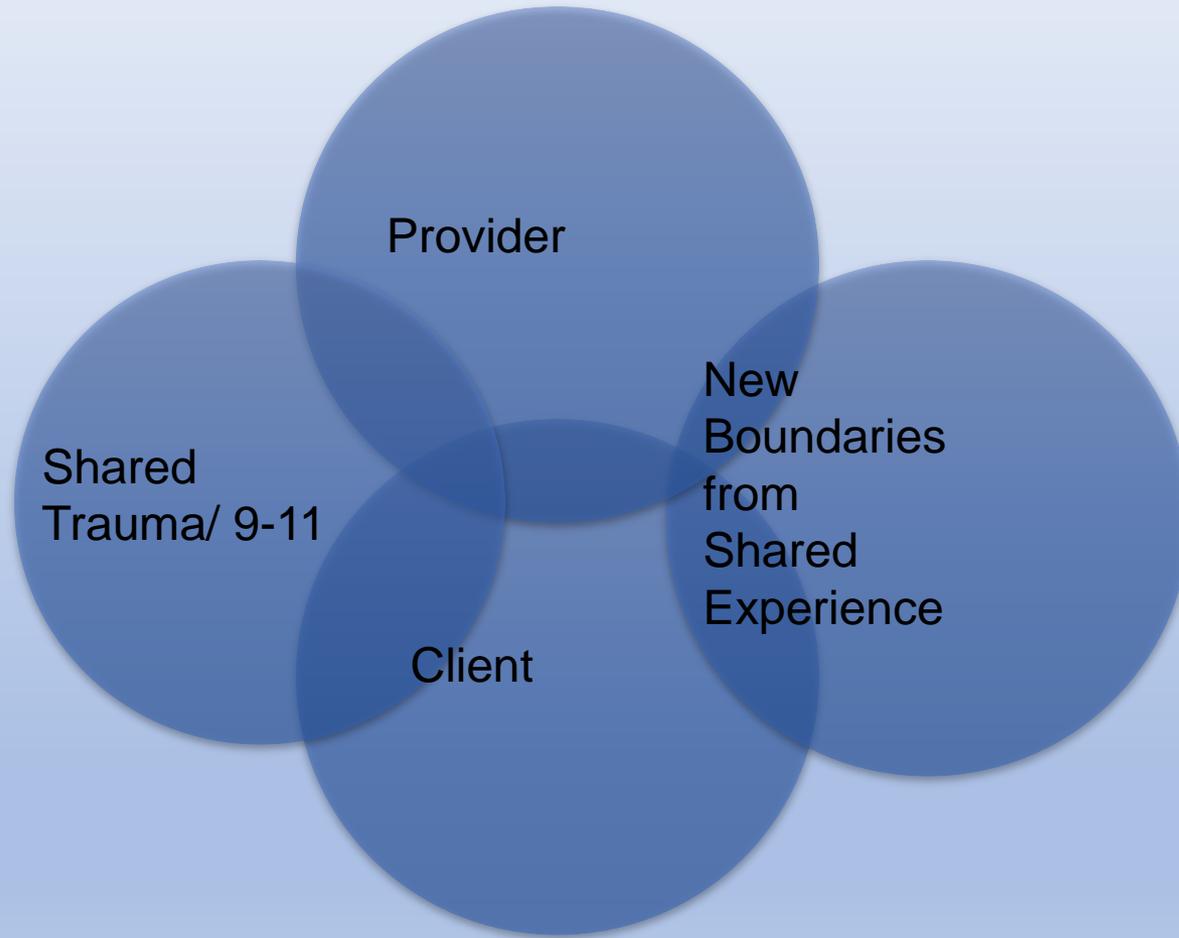
Boundary Shifts

Professionally, the boundaries between me and patients came down somewhat, as we were going through it together.

At the time of (9/11) I was more opened to talking about my feelings with patients. This has continued to this time.

In regard to September 11th experiences, there has been no other traumatic event of such magnitude in my 19 years of work that has so impacted my practice. By this I mean that my patients and myself were "in the soup" together, so to speak and both my patients and myself talked together about our experiences, thoughts, and feelings.

Negative Traumatic Reactions

- I was right in the thick of the 9/11 experience, living and working about one mile from the towers. I saw the second tower go down and was so traumatized that I had nightmares and repetitive thoughts related to the horror of it. I continued to work although it was very sad, cried a lot with patients, and felt for at least one year a great deal of anxiety.

- I have found being a therapist more burdensome and I have felt regret for choosing this field. The healthier I get the less I want to sit in a room all day listening to people's pain. What a place to find myself.

Responses with trauma history

Previous trauma viewed as a Resilience-builder

Having lived myself in Israel during the 1973 war and volunteering with the injured and staying on came back to me with full force on and after 9/11. My work with Holocaust survivors and their children also prepared me for what I would hear and how I would practice.

I am a combat Veteran who works with other Veterans (work for VA) on 9/11, my sense was that many of our patients dealt with 9/11 better than staff. Almost as if experience of prior trauma inoculated the Veterans to deal with present trauma. "Been there, done that, and can handle it."

As a survivor of World War II/Holocaust related trauma—I found that I didn't seem to feel as shocked by an event that challenges a basic sense of safety, already living with a reality that includes such occurrences.

Previous trauma was a Detriment

I found that 9/11 rekindled earlier trauma in patients who have experienced trauma in the past. The meaning of this horrific event was different for each person.

Patients with pre-existing trauma histories had more anxiety and fear...

Did a lot of personal work on relating the 9/11 trauma to early childhood terrors.

Hurricane Katrina after landfall.
2:15pm, August 29, 2005 from NOAA

Shared Trauma, Shared Reality, Shared Traumatic Reality

Shared Traumatic Reality

- Concepts developed after the 1991 Gulf War, Iraqi Scud missile attacks on Israel.

- Describes the experience of helping professionals who live and work in communities that are exposed to the same trauma that they address in their work.

Baum, 2012; Kretsch et al., 1997; Keinan-Kon, 1998

Sderot, Israel

Specific Studies of Shared Traumatic Reality

Lev-Wiesel et al. (2009):

- "Consistent with previous studies (e.g. Lev-Wiesel and Amir, 2003), the current findings revealed that the ***PTS symptoms and PTG co-exist.*** These findings provide further evidence that practitioners are at particularly high risk of vicarious traumatization yet they might also experience substantial growth."
- "… the findings of the current study showed that ***peritraumatic dissociation contributed to VT and to PTG among the social workers.***"
- "… when facing a succession of traumatic events, such as in wartime, ***the social worker might need to activate peri-traumatic dissociation in order to continue functioning.***"
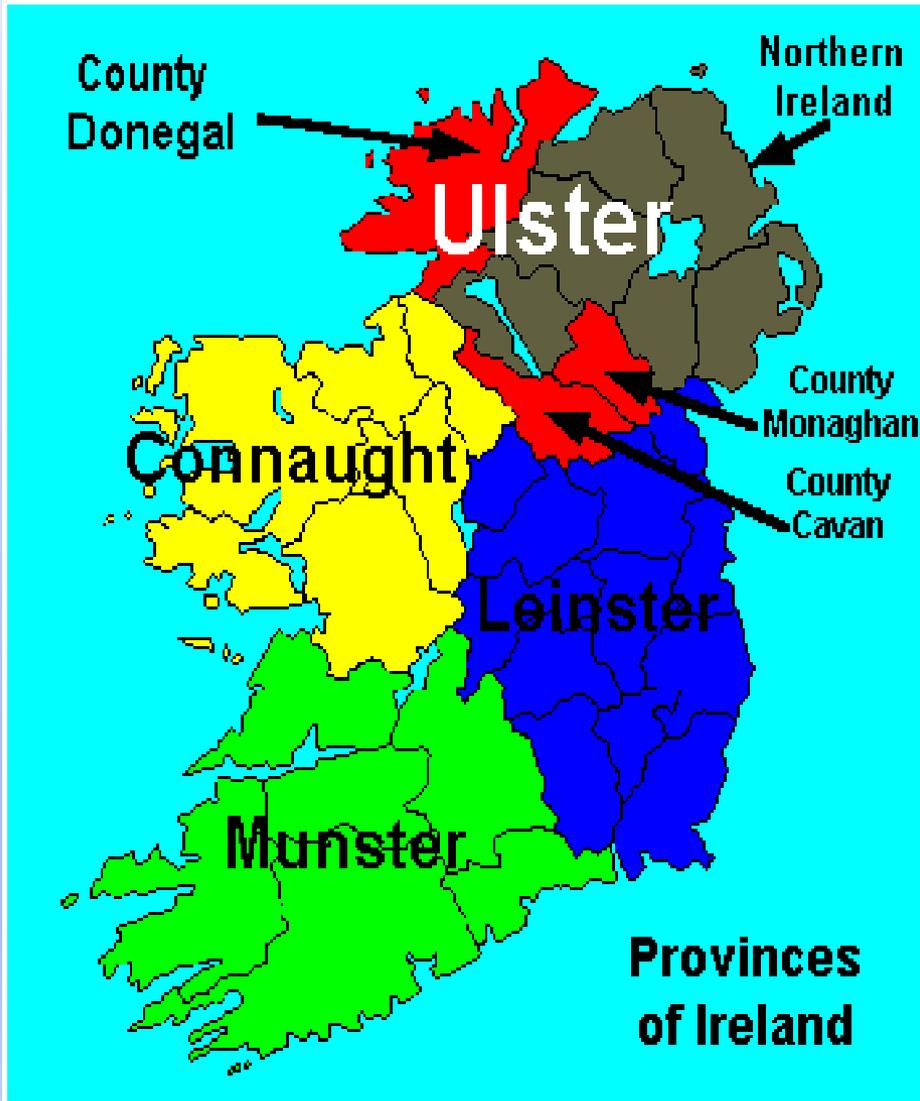
הסלמה בדרום

Taverna du Liban, a Lebanese Restaurant bombed in January 2014.

Car Bombing, 18 September 2012 in Kabul

Northern Ireland

Belfast "Peace Wall"

Shared Trauma of Politics
Rekindling past traumas

- Early in most sessions I introduced the idea that while we were all distraught, we were not all distraught in the same way. The events of November 8 (even now I apparently can't call it by name!) had brought up feelings and associations for each of us that were unique and specific. This proved correct of course, and very helpful in organizing the material of the sessions.

- Now granted, this is not an attack on our city as 9/11 was and not a natural disaster as Katrina or Sandy. But it does feel traumatic (even if labeled as a little t trauma) in the sense i**t feels like an attack on human rights as well as a loss of the perception of a country in it together striving for continued progress towards openness and acceptance**.

- One of the issues to come up most consistently was sexual abuse. **Trump's election evoked many of their original feelings of helplessness and betrayal, of there being nobody to protect them from the aggressions of the perpetrator. Two patients actually brought up instances of early sexual violation which had never been raised before in treatment.**

- While Trump's history of sexual aggression played a part, I had the feeling that **these patients were responding equally to the sense that there was nobody in charge to fend off the ominous perpetrator.**

Self-Disclosure related to 2016 election

I have never had to disclose my stance to my patients, since my demographic pretty much does the job. I am a Jewish, New York native, social worker/psychoanalyst who is partial to ethnic clothes and big jewelry. People take my affiliation for granted.

I disclosed to one client, also a social worker, who expressed profound anxiety and confusion about how this could happen. She said that she could not understand how any woman would vote for Trump. I agreed. Then she said- but women don't support other women. And I recognized the truth of this from my own experience. This client is a young woman, the next generation of social workers, and I think I felt compelled into a more "motherly" transference with her at the time.

- **I have found this to be an interesting moment in the treatment with all of my patients because it was a shared upsetting (to say the least) moment we were experiencing together.** It wasn't a patient's father died and I could offer empathy for their experience, **it was something happening in real time and the same event deeply affected the both of us. My decision to disclose was a tricky one, and I really wanted to make sure it was supportive and did not become about them having to care for me, which is why I decided to disclose the way I did.** But I found it to be a positive and connecting moment(s) helping them understand we were going through this moment together. **And it also allowed me to, I think appropriately, release a little of my feelings too and allowed me to be more present in the room by doing so - opposed to having to contain and push my experiences deep deep down.**

Posttraumatic Growth

Positive Changes:
1. Identity or sense of self
2. Relationships
3. Philosophical or worldview changes
4. Future changes
5. Political Motivation
6. Clinical and Professional changes

Affleck & Tennen, 1996; Tedeschi & Calhoun, 1998; Ai, Cascio, Stantangelo, & Evans-Campbell, 2005)

Positive Changes in Identity

- Such things as greed, small-mindedness and pettiness seem all the more irrelevant and unenlightened since 9/11—I feel more mature, more knowing, more human and more loving. It brought things to a common denominator for me and my colleagues and loved ones that is healthier—there is a sense of honesty and directness—we have a different and more compassionate approach since 9/11

- For myself, personally, it certainly brought home the shortness of life and, therefore, the necessity to make changes which will bring life more into alignment with one's true self.

Positive Changes in Relationships

- As a result of these experiences and increasing age, I treasure my relationships with family, friends, colleagues, and patients. My ability to connect with others and my capacity for compassion and humility has increased. I am grateful even as I feel anger at events I observe.

- On 9/11 my partner worked outside NYC and commuted by car…When he returned we discussed the experience, lack of contact, our fears. We discussed what else we wanted for our lives and decided that after 10 years of living together that we would marry. We did so 6 months later. We are very glad we did and wonder seeing 9/11 pushed us to do something that we found difficult before.

- The experience of 9/11 changed my personal sense of world (my sense of safety) and required that I work out a new, essentially more intimate relationship with my patients.

Philosophical or Worldview Changes

- I have more hope than ever now—because I realize how time is limited in ways we cannot predict, so enjoy & live in the moment; be kind to other people, don't hold on to grudges, forgive more quickly. Life is precious!

- I believe 9/11 had a profound effect on my life. I've become more spiritual, more existential, more solitary.

Future Changes

- I have become healthier since September 11th. I frequently exercise, I never skimp on my sleep and I eat very healthy. I am probably more healthy now than I have ever been. I am much more clear about my priorities and actively pursue things that are meaningful to me.

- I had always looked forward to some future day when I could work closer to home and not have to endure hours of stressful commute and the constant rushing home to pick up my son from school. I was always rushing. I decided to make the future now by shifting my practice from Brooklyn to Manhattan over a period of a few years. It was one of the best decisions ever for me.

Professional & Clinical Growth

- It made me live more in the day & relate more freely and share more directly my feelings with clients.

- A year after September 11th I received a diagnosis of advanced lung cancer with a very poor prognosis. The two events made me far more value my life and life in general. I am more open as a therapist—I do not work full time, and do short-term treatment now…Thus the value of life and human connection have been enhanced by these experiences.

- I reduced my agency work and built my practice as I did institute training…The attack of 9/11 crystallized for me how to better care for myself.

- 9/11 inspired me to educate myself in depth about trauma. This has deepened my work with patients in profound ways!

- It challenged me to grow as a clinician and work through what I needed to work through to better treat my patients.

Physical Symptoms of COVID-19

- People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.

  Symptoms appear 2-14 days after exposure to the virus & may include :
  - Cough
  - Shortness of breath or difficulty breathing/pneumonia
  - Fever
  - Chills
  - Muscle pain
  - Sore throat
  - **New loss of taste or smell**
  - Nausea, vomiting, or diarrhea
  - **Children**: multisystem inflammatory syndrome (Kawasaki-like disease)
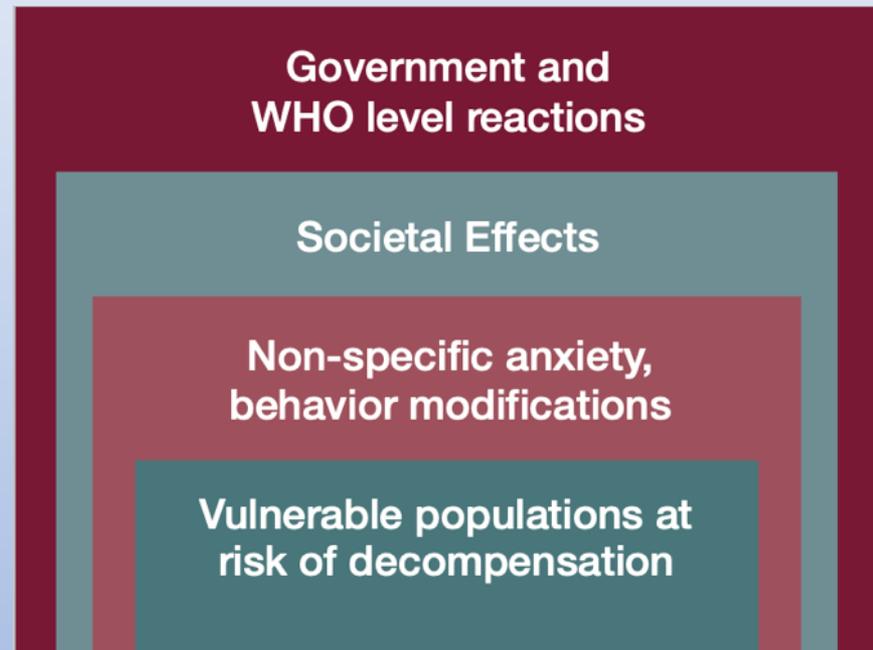
Psychological Impact of COVID-19

(Jiang et al., 2020; Chen et al., 2020)

- Stigma & Xenophobia

- Anxiety-related behaviors, sleep disturbance, impaired physical health

- Exacerbating of pre-existing mental health issues

- Mistrust of authorities > to belief in conspiracy theories

- Quarantine/Interpersonal Isolation > boredom, loneliness, anger, anxiety, negative coping & lifestyle (^ drinking, ^ smoking, ^ inactivity)

- **Social Support from family, friends, colleagues can counteract the negative psychological consequences/secondary psychological crisis**

Infectious pandemics can cause disruptions on social and individual levels; the impact on vulnerable populations can be magnified

Source: Moukaddam, N. (2020).

https://www.psychiatrictimes.com/psychiatrists-beware-impact-coronavirus-pandemics-mental-health

MSNBC

8:00 PM CT

COVID-19 Hospitalization Data by Race in NYC
(as of May 6, 2020)

Age-adjusted rates of lab-confirmed COVID-19 non-hospitalized cases, estimated non-fatal hospitalized cases, and total persons known to have died (lab-confirmed and probable) per 100,000 by race/ethnicity group
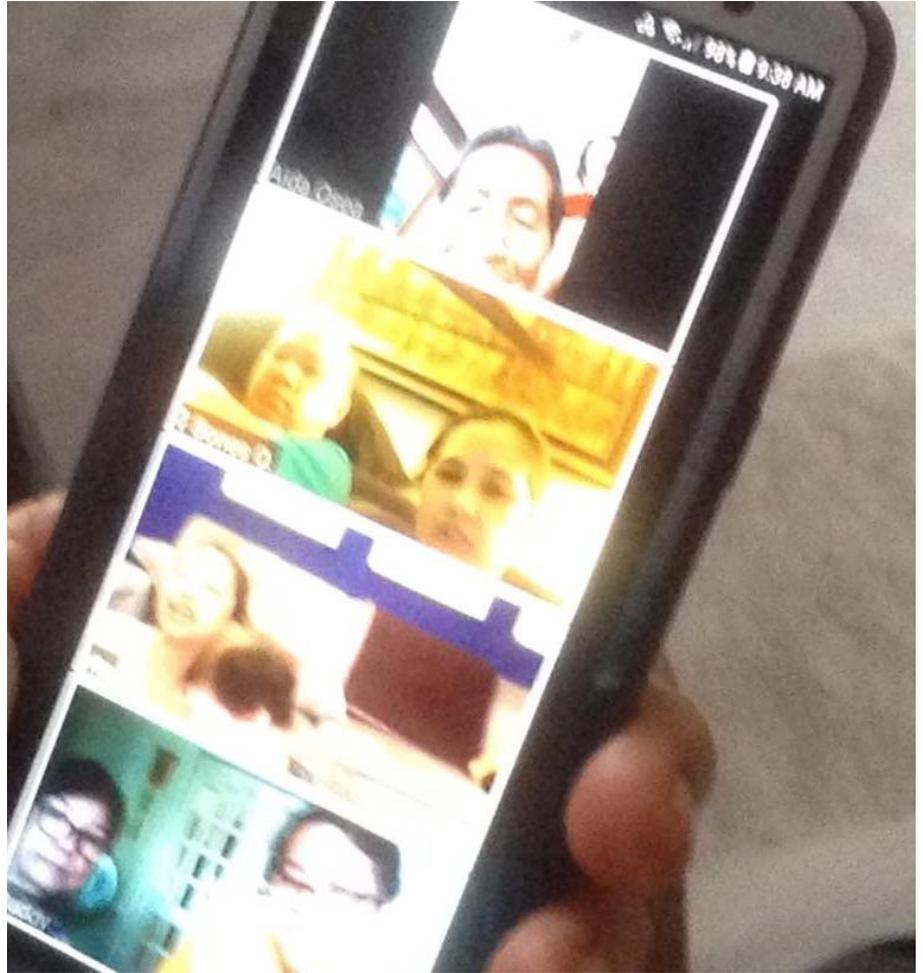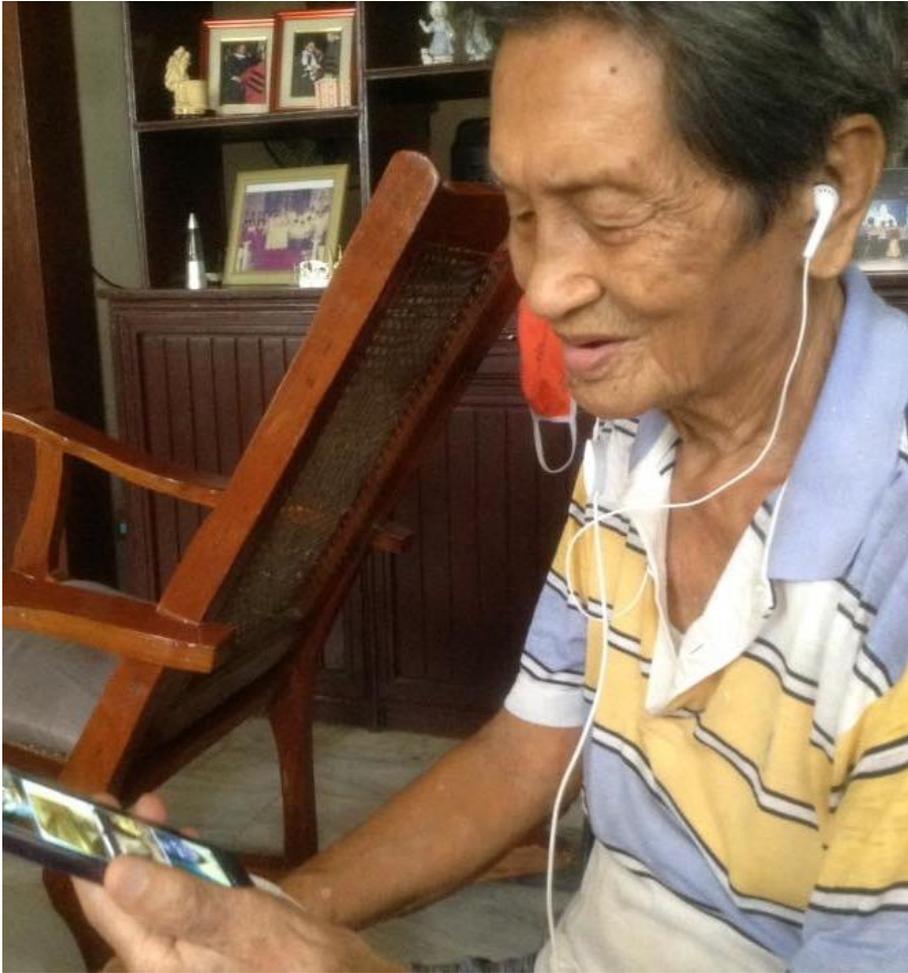
NYC Health

	Non-hospitalized	Non-fatal hospitalized	Confirmed + Probable Deaths
Black African American	806.0	395.1	243.6
Hispanic/Latino	667.5	341.8	237.7
White	618.7	163.4	121.5
Asian/Pacific Islander	303.3	137.3	109.4
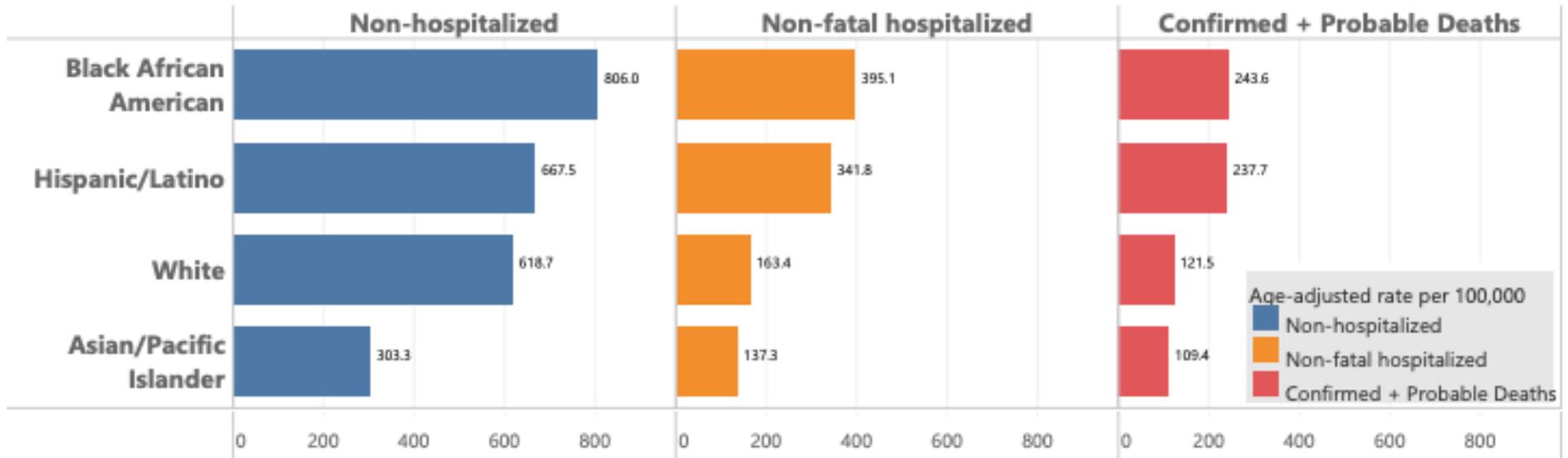
Age-adjusted rate per 100,000
Non-hospitalized
Non-fatal hospitalized
Confirmed + Probable Deaths

Source: NYC Health. (2020, May 7). COVID-19 Data: Rates of Cases, Hospitalizations and Deaths by Race/Ethnicity Group

Month-Over-Month Comparison of Unemployment Rates - March & April 2020
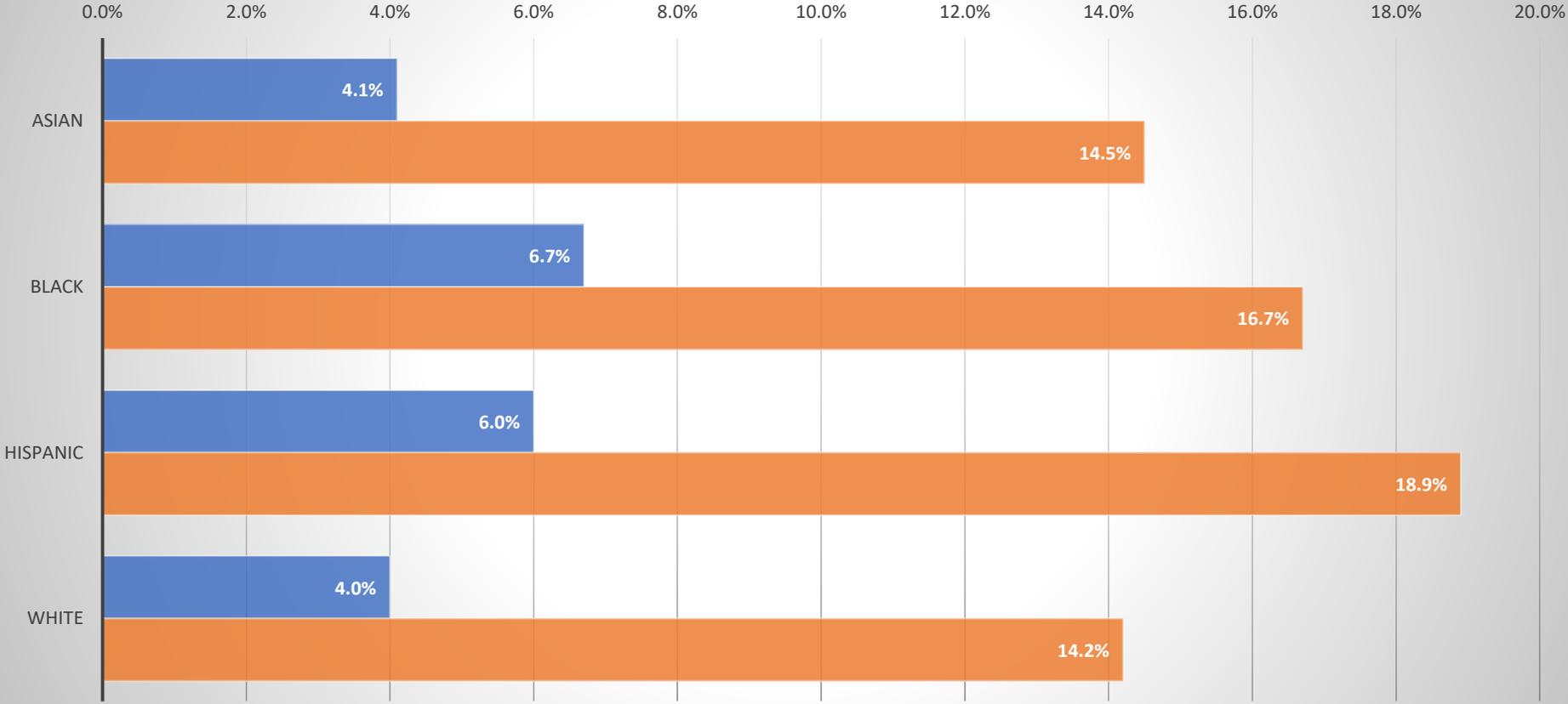
Group	Mar-20	Apr-20
ASIAN	4.1%	14.5%
BLACK	6.7%	16.7%
HISPANIC	6.0%	18.9%
WHITE	4.0%	14.2%

■ Mar-20 ■ Apr-20
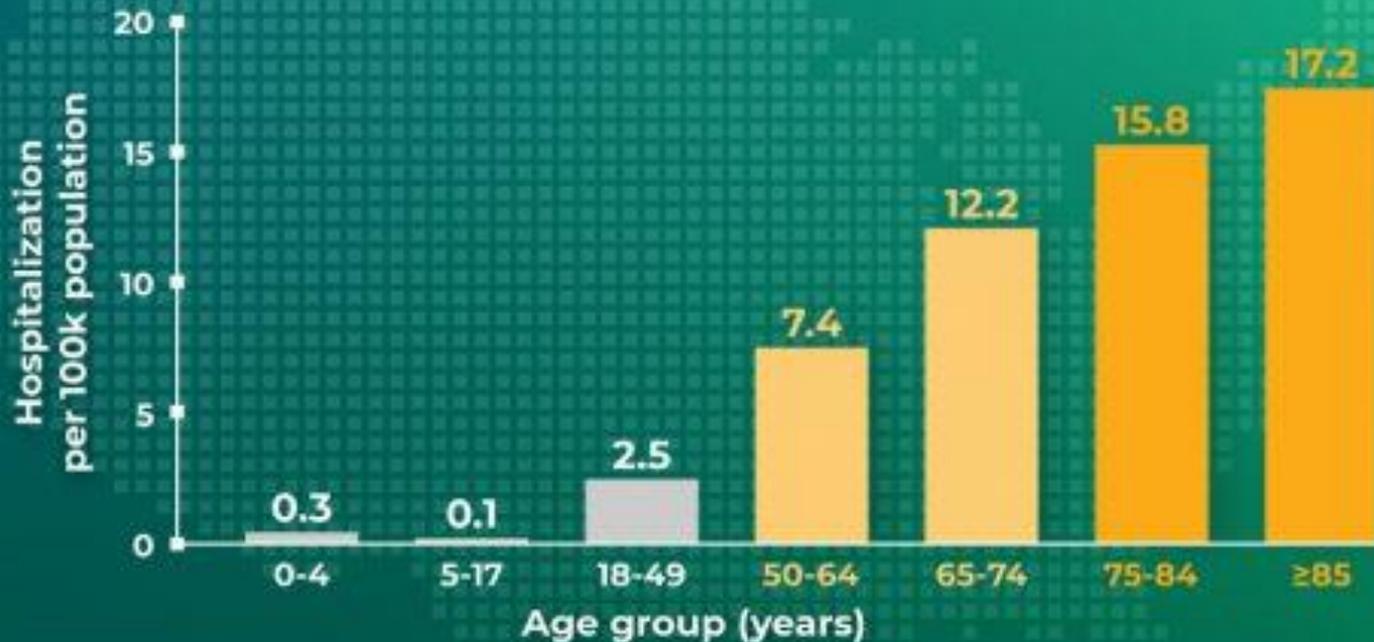
Coronavirus Lethality for Older Adults

A third of U.S. coronavirus deaths are linked to long-term care facilities.

Cases in long-term care facilities

All other U.S. cases

11%

Deaths in long-term care facilities

All other U.S. deaths

35%
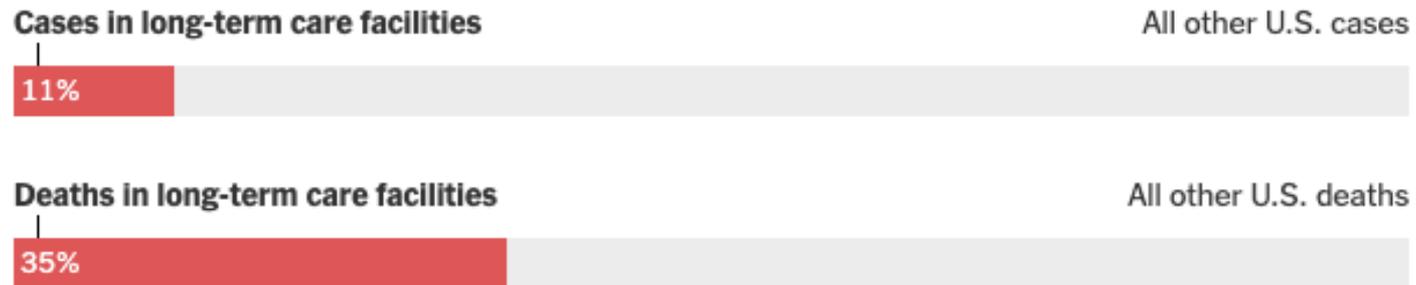
While just 11 percent of the country's cases have occurred in long-term care facilities, deaths related to Covid-19 in these facilities account for more than a third of the country's pandemic fatalities.

Source: New York Times. (2020, May 9). One-third of all U.S. coronavirus deaths are nursing home residents or workers

Attachment Theory

- "Attachment behavior characterizes human beings from the cradle to the grave."   John Bowlby

- Vulnerability to trauma is rooted in the attachment system

9/11 Cluster Analysis

- 294 are in a cluster showing the highest resiliency & compassion satisfaction, & the lowest compassion fatigue, posttraumatic stress, & ambivalent & avoidant attachment.

- 89 respondents were relatively high on resiliency & compassion satisfaction but showed the highest levels of compassion fatigue, posttraumatic stress, & ambivalent & avoidant attachment.

- 98 respondents had the lowest resiliency & compassion satisfaction, & were moderate on all other measures

Katrina Cluster Analysis

- Cluster 1 (N=108) was high on resiliency & compassion satisfaction & low on compassion fatigue, PCLC, ambivalence and avoidance.

- Cluster 2 (N=94) was high on resiliency & compassion satisfaction, & moderate on compassion fatigue, PCLC & avoidance, & high on ambivalence.

- Cluster 3 (N=24) was low on resiliency, compassion satisfaction & ambivalence, & moderate on compassion fatigue, PCLC and avoidance.

- Cluster 4 (N=16) was low on resiliency & compassion satisfaction, & high on all the others.

Potential Long-term Impact of COVID-19

- FOMO may be replaced with FOGO (fear of going out)
- Decreased international travel
- Global economic impact
- Masks, gloves, PPE may become part of social fabric
- ?

Psychological Crisis Intervention

- Best delivered in the context of a multidisciplinary mental health and health care team

- Provide clear communication and regular updates

- Establish secure and confidential counseling services

- Telehealth has inherent limitations (e.g. inability to read body language)

Self-care in the promotion of the well-being of mental health practitioners

Source: Posluns, K., & Gall, T. L. (2019). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, 1-20.
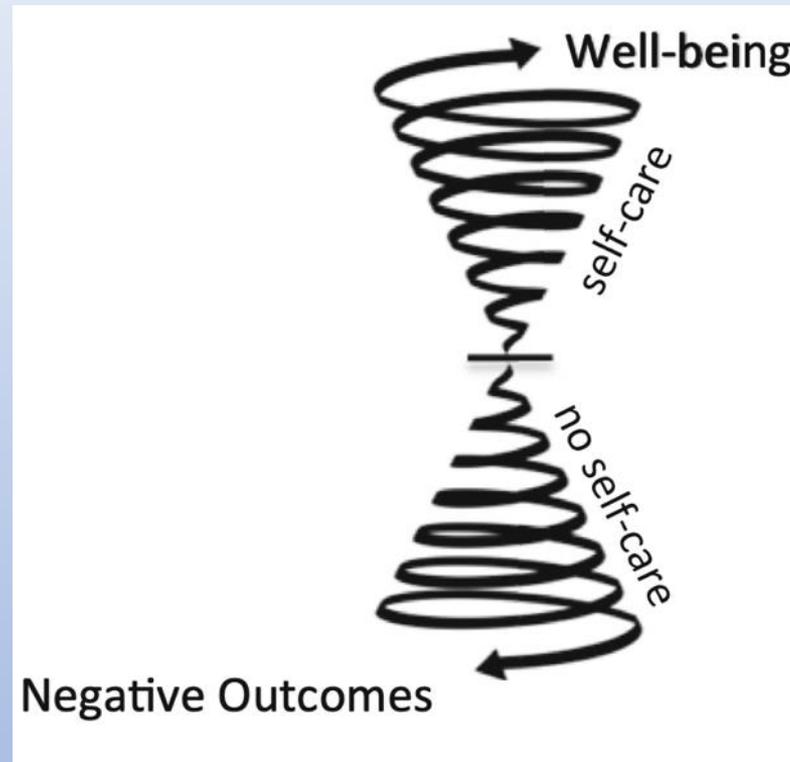
Self-care strategies for mental health practitioners

Self-care domains	Self-care strategies
Awareness	Acceptance and Commitment Therapy; Mindfulness and meditation training; Self-reflection; Creative writing
Balance	Leisure activities; Varied work activities (e.g., teaching); Non-work related passions; Non-work related relationships; Holistic approach to health; Professional and personal boundaries; Time management Taking breaks; Flexible work hours and locations; Realistic work goals
Flexibility	Effective coping strategies; Attitude of openness; Adaptability; Realistic self-expectations; Cognitive reappraisal; Self-compassion and acceptance; Setting and reappraising goals; Expressive writing and journaling; Acceptance and Commitment Therapy; Professional development
Physical health	Sleep hygiene (e.g., self-monitoring sleep habits); Balanced diet and hydration; Exercise
Social support	Personal (Family, Friends, Personal psychotherapy); Professional (Individual or group supervision, Professional associations, Colleague assistance programs, University faculty, Mentors/advisors, Peer consultation)
Spirituality	Spiritual connection; Prayer; Mindfulness; Spending time in nature; Practicing gratitude; Meaning-making (Positive reappraisal, Engaging in meaningful work, Setting goals with life purpose, Spiritual beliefs and activities [e.g., ultimate meaning of work])

Source: Posluns, K., & Gall, T. L. (2019). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling*, 1-20.

Ways to Cope with Stress

- Take breaks from watching, reading, or listening to news stories, including social media. Hearing about the pandemic repeatedly can be upsetting.

- Take care of your body.
  - Take deep breaths, stretch, or meditate.
  - Try to eat healthy, well-balanced meals.
  - Exercise regularly, get plenty of sleep.
  - Avoid alcohol and drugs.

- Make time to unwind. Try to do some other activities you enjoy.

- Connect with others. Talk with people you trust about your concerns and how you are feeling.

What is mindfulness?

- Mindfulness is defined as being aware of your thoughts, emotions, physical sensations, and actions – in the present moment – without judging or criticizing yourself or your experience.

- Origin: Mindfulness is linked with a set of cross-cultural principles and practices originating in Asia more than 2,500 years ago.

- Evidence suggests that mindfulness techniques promote a sense of purpose, the ability to self regulate, as well as increase resilience (Siegel, 2007).

- Rittenberg, S.
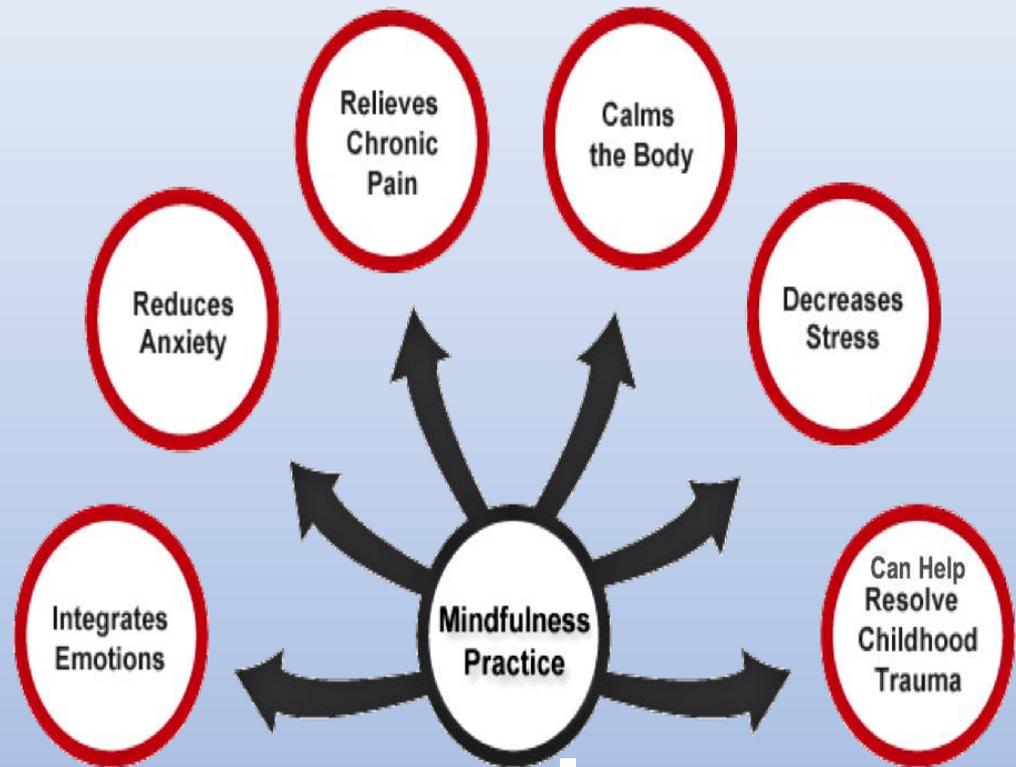
Mindfulness as a Form of Self-care for Clinicians

▶ Mindful self-care is a methodology for cultivating attunement among the internal aspects of self, within the context of external challenges (Cook-Cottone, 2016).

▶ Mindfulness has been shown to be especially relevant for helping professionals as a means of managing stress and enhancing self-care.

"Mindfulness explicitly teaches self-compassion, giving us permission to be "imperfect" or, put a better way, "perfectly human." Mindfulness helps us as clinicians recognize when we are not acting skillfully, without condemning or shaming ourselves. We are able to note with compassion those times when we are stressed or exhausted, holding ourselves with the same compassion and care we bring to our patients" (Shapiro & Carlson, 2009).

Rittenberg, S.

Supporting Research
for the use of mindfulness as a form of self-care for clinicians

▶ Research has shown that through the use of mindfulness techniques, clinical social workers are able to:

- ▶ increase emotional resiliency

- ▶ Be better aware of their own emotions, and in this way, hold clients pain without it creating compassion fatigue

- ▶ decrease the risk of burn-out

- ▶ decrease the likelihood of secondary traumatic stress

- ▶ decrease ruminating and distracting thoughts

- ▶ improve mood

- ▶ improve self-awareness

(Wisniewski, 2008; Garland, 2013)

Rittenberg, S.

Some Examples of Mindfulness Techniques for Self Care...
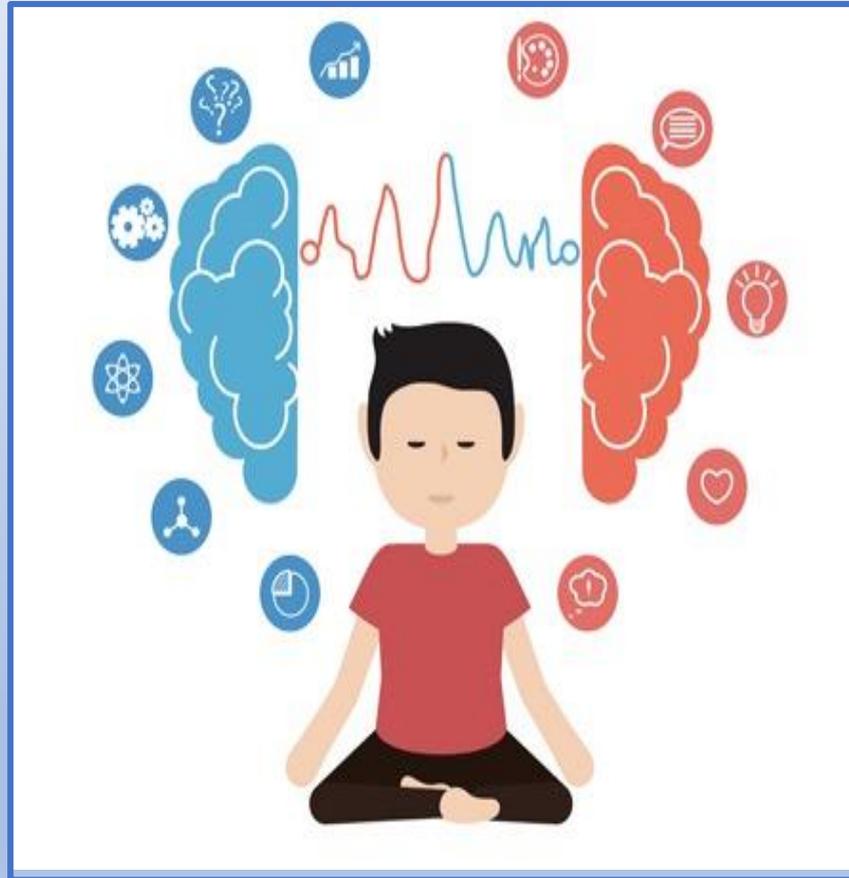
That can be easily integrated into a clinician's day

Breathing Exercise

*As this exercise can be done in about 1 minute, it can be easily integrated into a clinician's day. (ex: between sessions, etc.) Can be done sitting or standing up.

Directions:

- Start by breathing in and out slowly. One breath cycle should last for approximately 6 seconds.

- Breathe in through your nose and out through your mouth, letting your breath flow effortlessly in and out of your body.

- Let go of your thoughts. Let go of things you have to do later today or pending projects that need your attention. Simply let thoughts rise and fall of their own accord and be at one with your breath.

- Purposefully watch your breath, focusing your sense of awareness on its pathway as it enters your body and fills you with life.

- Then watch with your awareness as it works work its way up and out of your mouth and its energy dissipates into the world.
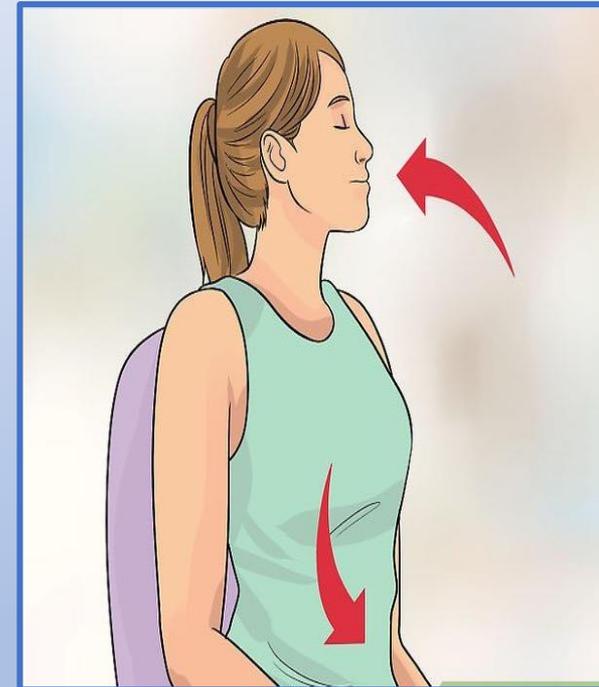
Body Scan

* While this body scan technique can be done over a longer period of time, there are also many quick versions that can be easily incorporated into one's day when there is not time for a lengthier exercise.

▶ This exercise asks you to systematically focus your attention on different parts of your body, from your feet to the muscles in your face. It is designed to help you develop a mindful awareness of your bodily sensations, and to relieve tension wherever it is found.

- http://elishagoldstein.com/videos/3-minute-body-scan/
  - This video gives an example of a three minute guided body scan exercise.

  - Rittenberg, S.

Body Scan Meditation

1 Set aside a time and place in your day where you can sit comfortably and you won't be distracted or disturbed.

2 Find a comfortable but attentive seated position, close your eyes, and bring your attention to your toes.

3 Working up from your toes, bring awareness to each body part in turn: your feet, ankles, calves, knees, etc. up to your head.

Health Benefits:
- Reduced stress
- Decreased muscle tension
- Increased pain tolerance

Why it works to reduce stress:
Body scan meditations encourage self-awareness of sensations we might otherwise be ignoring.

Self-compassion Pause

Directions:

- When you find yourself stressed out in a difficult situation, take a moment to pause.

- Reach up and touch your heart, or give yourself a hug.

- Take a few deep breaths.

- Acknowledge that you are suffering and see if you can treat yourself with as much kindness as you would a dear friend or child who was struggling.

- Offer yourself phrases of compassion, first by acknowledging your suffering

- For the final phrase(s), choose an appropriate phrase for your situation. Examples:
  - May I hold myself with compassion.
  - May I love and accept myself just as I am.
  - May I remember to treat myself with love and kindness.
  - May I open to my experience just as it is.

- Return to your daily activities, intentionally carrying an attitude of self-compassion and acceptance to your day.

- Rittenberg, S.

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