

# Strategies for effective treatment of complex cases

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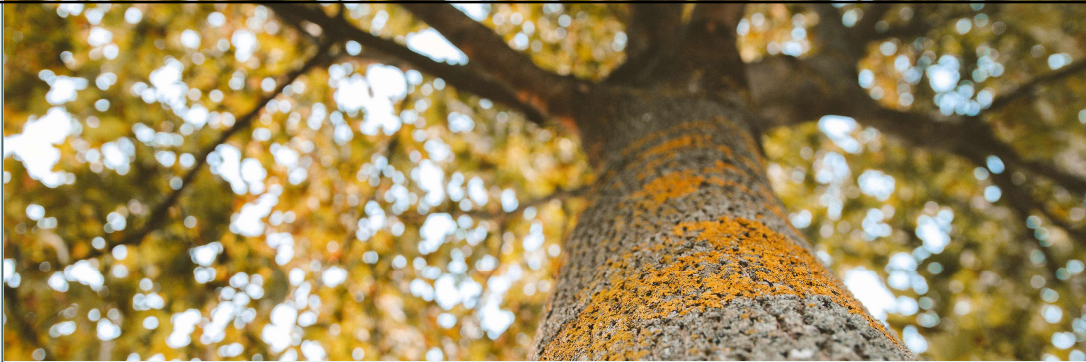
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## Goals

- Understand and conceptualize complex PTS
- Identify important considerations for the therapeutic relationship
- Identify appropriate staging of treatment for complex cases
- Identify appropriate interventions for each stage of treatment

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What doesn't kill you makes you stronger.

True or False?

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## Understanding brain structure; the triune brain



### Thinking Brain

Neocortex/Cortex

Information through thoughts, beliefs, language

Accessible when we feel calm and safe

Capable of long-term planning



### Emotional Brain

Limbic/Midbrain

Information through emotions, relationships, and intuition

Accessed when we feel strongly

Sense of time in minutes or hours



### Survival Brain

Brainstem

Information through our senses

Accessed in survival mode

Sense of time is in seconds

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## Polyvagal Theory

- **Social engagement** (Top Down)
  - Ventral Vagal
  - When here we are within our Window of Tolerance
- **Fight/Flight** (Mobilization)
  - Sympathetic Nervous System
  - Danger
- **Freeze/Fold** (Immobilization)
  - Dorsal Vagal
  - Life Threat

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## Social Engagement



Our first line of defense against threat

Heart Rate may increase or decrease

Breathing rates may shift up or down

Self-soothing and self regulation (i.e. top-down processing) is accessible which makes it possible for the individual to inhibit sympathetic adrenal influences.

The individual still has access to language and is able to seek support/ask for help

The individual is able to cry and/or grieve

When in our social engagement system, we may feel "bad" but we are still within our window of tolerance.

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## The Stress Response System

### Fight/Flight Response

- Adrenaline increases
- Heartrate increases
- Muscles tense
- Blood pressure increases
- The body prepares for action
- In fight/flight we are able to retain some power.
- The goal is to **ACT**. To **CHANGE** things or **DO** something.

### Freeze/Fold Response

- Heartrate and blood pressure drop
- Mind and body disconnect
- Avoidance
- Compliance
- Go Limp/Numb
- Common when situation is powerless or there is no escape.
- The Goal is to **ENDURE**

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## What is trauma?

Trauma is not an event or series of events but our reaction to the event. It is "stuck" processing.

It includes any experience that is overwhelming to the nervous system. It can be acute or complex, individual, transgenerational or cultural. It can have clinical or subclinical presentation.

Vulnerability to trauma is influenced by more than the event itself

- Age- "tree" example
- Support System
- Attachment style
- Intensity and frequency of the stressor or event
- Predictability of the stressor or event
- History of previous trauma

According to the World Health Organization at least 70% of Americans will endure at least one traumatic event in their lifetimes.

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## A few more considerations. . .

- Non-traumatization as a privilege (Baldwin, 2018)
- The trauma response is not a character flaw—you can do everything “right” and still suffer from PTS. We are designed to respond in a way that promotes our survival.
- Resiliency is not evidence that you are superior, more faithful, “stronger”, etc
- Many vulnerability and resiliency factors (such as social support) are out of our direct influence or control

“If knowledge is power, then wisdom is knowing what we don’t know.”  
Adam Grant

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## The Compliance Response



- Immobilization or an incomplete survival action/response is thought to be at the root of trauma. (Levine, 2010)
- The immobilization system is meant to only be engaged for brief periods.
- Case Studies:
  - “The Raven”, The Boy Raised as a Dog (Perry, 2007)
  - Compliance and repeated sexual abuse, APCC case study
- Considerations for behavioral and substance addictions
- Benefits of “Blaming the victim”?

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## Complex PTS

- Complex PTS can be thought of as trauma that is repeated, cumulative, and often beginning at a young age.
- Complex PTS impacts identity formation and attacks the sense of self.
- Many who suffer from Complex PTS do not remember life before trauma and therefore may struggle to establish an identity outside of suffering.
  - This can lead to ambivalence or secondary gains

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## Complex Post Traumatic Stress

- C-PTSD criteria includes the typical symptoms of PTSD (reexperiencing, avoidance, and persistent perceptions of threat) as well as 3 additional categories of symptoms:
  - Affect dysregulation/imbances in the ANS and PNS
  - Negative self-concept
  - Interpersonal disturbances
- "C-PTSD is associated with the sense that one has lost authority over the process of remembering"

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Schwartz (2021)

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## C-PTSD, Affect Dysregulation

- Chronic traumatization results in profound dysregulation of the ANS, which regulates functions such as our heart rate, blood pressure, body temperature, and breathing.
- Our ANS will either mobilize energy (SNS) or conserve energy (PNS)
- When the ANS is dysregulated, the individual will experience disruption in regulation and affect, which may include chronic hyper or hypo-arousal (fight/flight or freeze).

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## C-PTSD, Negative Self Concept

- Individuals may be prone to an impaired sense of self and struggle to form a coherent sense of self.
- Individuals may experience changes to their *systems of meaning* or core beliefs.
- There may be pervasive feelings of shame, guile, and despair.
- There may be profound loneliness and despair at the state of the world.
- These feelings may interfere with a sense of meaning, hope and purpose.

“I am. . . Others are. . . The world is. . . So I must. . .”

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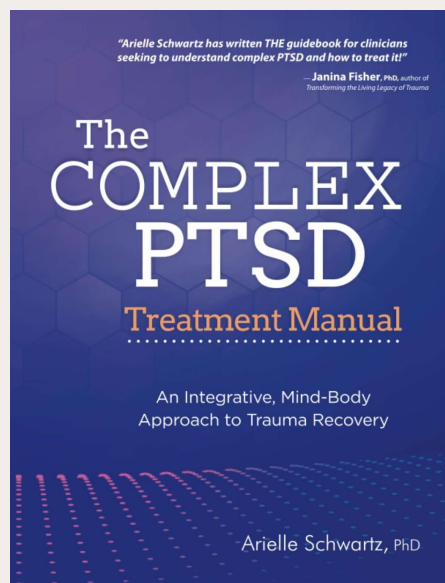
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## C-PTSD, Interpersonal Disturbances

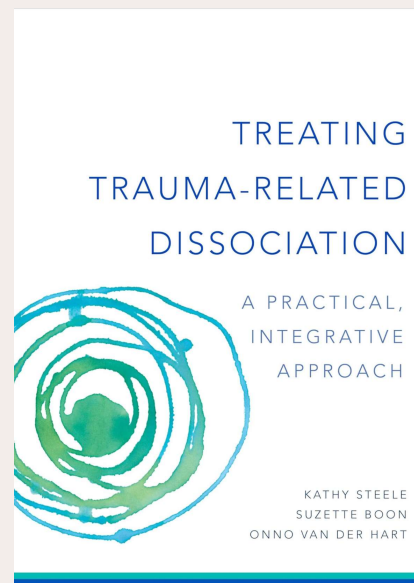
- There may be an inability to develop trusting relationship with others.
- There are often ongoing fears of betrayal, abuse, and abandonment.
- There may be avoidance and/or over-dependence in relationship.
- There may be a hyper-activated caregiving system, which is commonly referred to as *codependence*.

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## Assessment and Treatment Planning

The professional boards for both Licensed Professional Counselors and Licensed Social Workers requires that we have both an intake assessment and an up-to-date treatment plan.

Why does this matter?

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## Assessment in C-PTS

### What we need to know

- Acute v. complex
- Symptom presentation
- What are the contributing factors for the client's symptoms?
- What is the client's support system like?
- Can the client tolerate affect or state change?
- To what degree do we suspect dissociation?
- Are there any possible secondary gains?
- The client's overall readiness for therapeutic interventions

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## Objective and subjective measures



PCL-5

DES-II

Life inventory checklist

ACE inventory

Psychosocial interview

Others?

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## Common Symptoms of Dissociative Disorders

- Amnesia
- Depersonalization and derealization symptoms that refer to a division of the personality (distorted perception of body, not recognizing self or friends, being 'outside the body')
- Passive influence (different parts influencing behavior internally)
- Somatoform dissociative symptoms (unexplained pain or lack thereof, pseudo-seizures, numbness, conversion disorder)
- Schneiderian symptoms (symptoms of schizophrenia)
- Puzzling fluctuations in behavior, mood, and narrative

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Steele, Boon, and Van der Hart (2017)

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## False-Positive DID considerations

- “Cookbook” answers during diagnostic assessment
- Anger/defensiveness when asked for examples of their experience
- Clear chronological history
- Use of first person across of experiences and third person only when asked about dissociation or parts
- Dramatic shifts in the first session or during assessment
- Bringing “proof” of DID (timelines, maps or picture of parts)
- Reveal diagnosis to many people without fear or shame
- Obvious secondary gains.
- Heavily involved in DID community or chat rooms.

**All clients are suffering and deserving of compassion regardless of presentation.**

Steele, Boon, and Van der Hart (2017)

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## Treatment Planning

- Treatment of CPTS *MUST* be staged appropriately.
- Staging helps us ensure that we honor the client’s *window of tolerance*.
- Disclosure is NOT the goal
- Abreaction or catharsis is NOT the goal
- Ultimately, we aim to reduce symptoms and improve quality of life by establishing both internal and external safety.

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## Window of Tolerance

The **window of tolerance** is a term that describes to what degree an individual is able to stay in their social engagement system before their stress response system is activated into fight/flight or freeze.

In order for treatment of C-PTS to be effective we must be aware of our clients' limitations and tolerance.



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## Why this matters

- Standard protocols do not always work in complex cases and may actually cause harm.

Thoughts? Examples?

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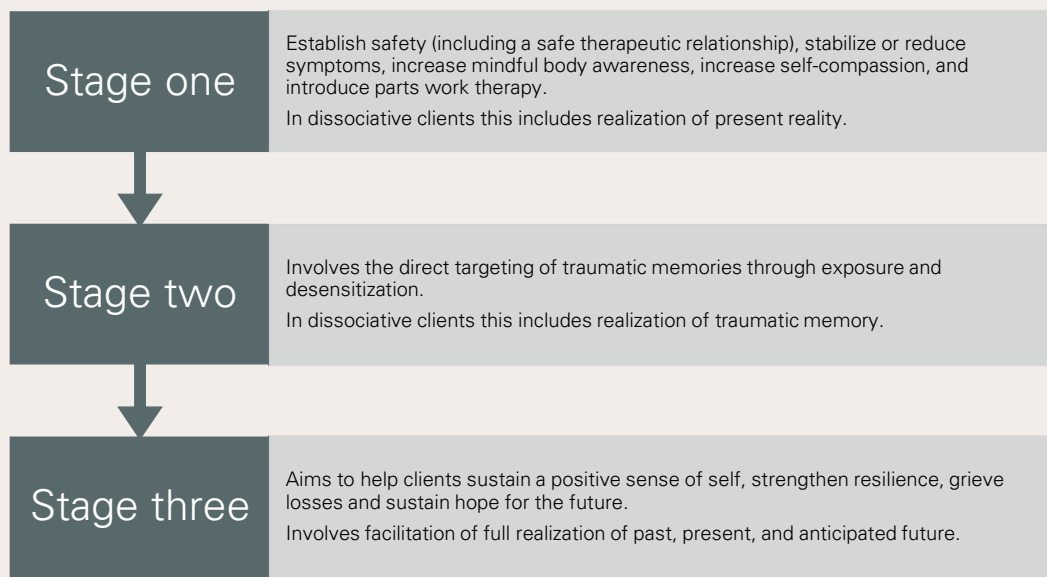
## Overarching Treatment Goals for C-PTSD

- Facilitating greater affect regulation and emotional balance
- Reducing avoidance symptoms, including dissociation
- Reducing the frequency and intensity of reexperiencing and heightened arousal symptoms
- Facilitating improvements in self-concept and sense of self
- Enhancing success with interpersonal relationships
- Enhancing sense of meaning, purpose, and hope

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## Staging Treatment



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# Stage One

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## Stage one goals and objectives



Establish a safe therapeutic relationship.



Increase affect tolerance to widen the "window of tolerance."



Educate the client on trauma and the stress response system in order to validate their experience and reduce shame.



Connect to and tolerate the body.



Establish collateral contacts, referrals to other professionals, and community support.

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## Stage one interventions

- Identify and practice safe boundaries within the therapeutic relationship
- Psychoeducation
- Identify and practice multiple regulation activities.
  - Regulation scheduling; “back to the basics”
  - Mindfulness practice and breath work
    - Connection to HRV
  - Coping skills of all kinds.
- Pendulation and/or titration to increase connection to the body and tolerance for sensation.
- Self-compassion work
- Parts work
- Resourcing
- Containment
- And many many more. . . .

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## The Therapeutic Relationship in Complex Cases



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## The value of the therapeutic relationship

- “Safety is the intervention” *Porges*
- Establishing a safe therapeutic relationship is one of the primary tasks of stage one.
- CPTS survivors will almost always experience disruption of attachment. Patterns of relationship are likely to be recreated/reenacted within the therapeutic relationship.
- Ruptures in the therapeutic relationship are difficult but can be considered opportunity for relearning and healing.

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## Therapeutic Relationship

- We must acknowledge our own experience and patterns of attachment.
- “*Manipulative* behaviors represent efforts to attain safety via caretaking and attachment by the therapist, a legitimate inborn tendency” (Steele, Boon, and Van der Hart, 2017).
- It is essential the therapist provide safety before attachment and curiosity and collaboration instead of dependency.
- Chronic trauma survivors will often have difficulty managing regulation of closeness and distance and may go between extremes depending on need, defenses, and parts of self.

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## Therapeutic Boundaries



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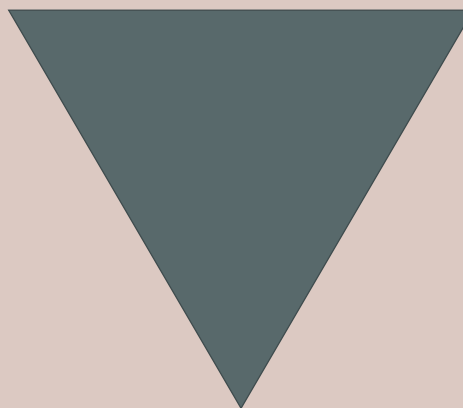
- We must carefully consider the boundaries we hold in the therapeutic relationship.
- The therapist is the one with the most power in the room.
- Clients who have survived through freezing or compliance are more likely to be over-compliant with therapy. This puts them at risk for re-traumatization.

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## Karpman's Triangle

**Bully or Perpetrator**  
"I must maintain control  
to stay safe"

**Rescuer**  
"I need you to  
need me"  
Desires worth



**Victim**  
Powerless  
"I cannot effect change"

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## Re-enactment and Re-traumatization

- Happens when an individual reenacts relational patterns of trauma. This is NOT a cognitive choice.
- Can happen internally through parts of self or externally.
  - Internal- aligning with the perpetrator in view and treatment of self
  - External- polarizing helpers (drama triangle)
- May point to underlying dependency needs of the client.
- Often involves the reinforcement of shame or immobilization.
  - Compassion counteracts this
- The therapist must recognize the re-enactment.
  - Habitual attention to roles and relational patterns.
- This can lead to resentment, guilt, or powerlessness in the helping professional.

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## Responding to Re-enactments

- Track your own experiences of the client and reactions in sessions, including your own fantasies and daydreams.
- Pay attention to anything unusual that arises in you (like anger or sadness); this may be evidence of reenactment.
- Be curious about the client's experience in the context of your relationship.
- Notice if dissociative parts are in conflict.
- Help parts accept each other with compassion or at least neutrality.
- Support the client in appropriate expression of concerns, feelings, and wishes about you. Accept these with compassion.
- Ask if the experience is familiar.
- When you feel defensive, notice it but do not act on it.
- Seek consultation and support as the therapist.

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Steele, Boon, and Van der Hart, 2017

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## Reparative Experiences

- A well-meaning but under-informed helper may inadvertently reinforce re-traumatization and shame, but a trauma-informed helper can provide opportunity for re-learning.
- Must take place within the context of a safe relationship.
- When communicating boundaries
  - I.e. the individual interprets boundaries as abandonment.
- When boundaries are violated
  - I.e the individual mistakes care for sexual interest
- A reparative experience may or may not translate into an observable change or outcome but is **ESSENTIAL** in re-writing the template.

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## Other considerations

- Therapist Disclosures (Steele, Boon, and Van der Hart)
- Collaboration v. caregiving
  - The therapist must be mindfully aware of their responsibility
- Relational problems often stem from a lack of compassion for self and others as well as unrealistic expectations. (*What is a reasonable expectation of you as therapist regarding availability?!*)
- Focus on seeking to understand the client's experience in the moment rather than focusing on the content or trying to "fix" the problem.
- Focus on creating a "felt sense" for the client to carry with them rather than being available 24/7.
- We must engage in attunement *and* clear limit setting, flexibility *and* consistency, support for the learning of skill *and* insistence on skills practice.

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“The therapist’s job is to stand relatively still no matter which part of the patient is prominent, without pursuing or distancing too much, without becoming too enmeshed or too detached, while being engaged and present to the greatest degree possible”.

Steele, Boon, and Van der Hart (2017)

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## Boundary interventions

- Explore what consent means to the client.
- Establish a “stop sign” for therapy.
- Practice mindfulness to help the client identify when they are outside their window of tolerance.
- Create a physical boundary.
- “We are not taking away anything you need”
- May include re-framing of responsibility



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## Connection to the Body



Trauma survivors often experience disruption in body connection.

- Hyper-arousal may result in “flooding”
- Hypo-arousal may result in dissociation.

“Gut instincts are guardian angels.”

We cannot process information we cannot tolerate or do not have access to.

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“The single most important issue for traumatized people is to find a sense of safety in their own bodies.”

Bessel Van Der Kolk

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## Interventions to connect to the body (and increase affect tolerance)

- Often must begin with an “island of safety” or tolerance for positive or neutral sensation that can be resourced. (Laurel Parnell’s *Tapping In*)
- Sensory exercises
  - Sensory checklist—increasing vocabulary and neutral feelings/sensations
  - Levine shower exercise
- Nurturing touch (Neff)
- Body scan and/or mindfulness work
  - *No Mud No Lotus*
  - MSC Workbook
- Trauma-informed Yoga
- Somatic therapies

Often will require titration or pendulation to maintain window of tolerance

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## Self-Compassion Work

- Compassion is directly opposed to shame or judgement
- 3 components of Compassion (Kristin Neff, [www.self-compassion.org](http://www.self-compassion.org))
  - Mindful acknowledgement over minimizing or overidentifying
  - Shared human experience over isolation
  - Kindness over judgement
- The 3 components can also be followed up by a boundary if necessary.
- Compassion is NOT pity. Pity isolates and compassion connects.
- Self-compassion work is often paired with parts work to repair internal systems. It is modeled by the therapist.

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## Parts work

- Through the lens of Internal Family Systems (IFS) we all have parts.
  - Protectors (Managers and Firefighters)
  - Exiles
- Protectors are often the “gatekeepers” to traumatic material. We (the therapist and client) must earn the trust of protective parts in order to access traumatic material.
- Exiles (or wounded parts) are often stuck in “trauma time” and store/hold trauma memories and “burdens”.
- During stage one of therapy, we aim to establish trust with parts of self.
- During stage two we aim to *unblend* and *unburden* the parts.
- The ultimate goal is **Self-Leadership**.
- Parts work is woven throughout all stages of therapy.

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## Qualities of Self Leadership: 8 C's of and the 5 P's of IFS

- Compassion
- Creativity
- Curiosity
- Connected
- Confidence
- Calm
- Clarity
- Courage
- Patience
- Presence
- Persistence
- Perspective
- Playfulness

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## Aligning with Protective Parts

- Protective parts may repeat abusive messages internally.
- Practice *curiosity* and *compassion* (and all Cs!) with protectors.
  - What is the protector's job?
  - Explore the protector's positive intention (PPI)? Be curious.
  - What does the protector need? Practice acknowledging this with "I get that".
  - Work to reduce the shame of the protective part by extending compassion/self-compassion.
  - Work to align with the protective part by acknowledging their important role in survival and a common PPI.
  - Change the "job description".

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## Working with dependent parts (child parts)

- The most important concept in working with child parts is to ensure these parts remain the responsibility of the client. The adult self must become responsible for all parts.
- The therapist is not the primary caregiver and is not responsible for re-parenting.
- Clients with high dependency needs often will project needs onto the therapist.
- Child parts are often disliked or reviled by other parts as they often represent what the client desires to avoid.
- Child parts may serve to hold memory, avoid responsibility, preserve ideal view of parents or perpetrators, express dependency needs, hold intense emotions.

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## Other concepts

- Some parts may act in ways that are not safe or socially acceptable. Examples may include over-sexualized parts or perpetrator-imitating parts.
  - We must be curious while also setting limits.
- We aim to understand each part and their role in survival. We are not aiming to get rid of any part.
- Conflict between parts may signal internal reenactment.
- If parts hold intense emotions our work may include helping the client express these verbally (rather than physically acting out), in appropriately contained ways, so they can be heard by others.

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## Working with anger

- Anger is experienced physiologically as a part of “unfreezing”.
  - *In an unspoken voice*, Levine
- Anger is an appropriate response to injustice and often represents an important shift in responsibility. It is a bridge from shame to self-compassion.
- Anger is a stage of grief. Anger and grief often go hand-in-hand.
- If an individual has learned anger is wrong or unsafe there is a temptation to *refreeze*.
- Working through anger (and grief) is often woven throughout of all stages of therapy.

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# Secondary Gains

Ana Gomez Coat Metaphor

Change is HARD and feels very RISKY.

- It may require we sacrifice the benefits of staying stuck.
- APCC Example- "K"

The Healing Crisis

- i.e. in "unfreezing" and individual may feel the "energy" of fight/flight which can be expressed as rage.
- The experience of trauma-related grief

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# STAGE TWO

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## Stage Two Goals and Objectives:



The goal of stage two is to process and desensitize traumatic material.

But what does it mean to “process”?

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## Processing Traumatic Material

- Separate past from present cognitively and somatically— what was true then is not true now.
- Reframe unhealthy beliefs about the self regarding the traumatic experience.
- Move toward *Self-Leadership*, continuing to foster connection between all parts of self.

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## Stage two interventions

Stage two may include a number of evidence-based therapies to process traumatic information. Including but not limited to:

- EMDR, ART, Brainspotting
- Somatic therapies
- Exposure therapy
- Narrative therapy
- TF-CBT
- IFS

What are your favorite therapeutic interventions to process trauma?

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## Readiness factors for trauma processing; things to consider

- Ability to be aware of one's own experience—Mindfulness
- Containment and state change
- Connection to the body and dissociation
- Presence of blocking beliefs
- Self-compassion
- Secondary gains
- Window of tolerance—can the client tolerate traumatic material?

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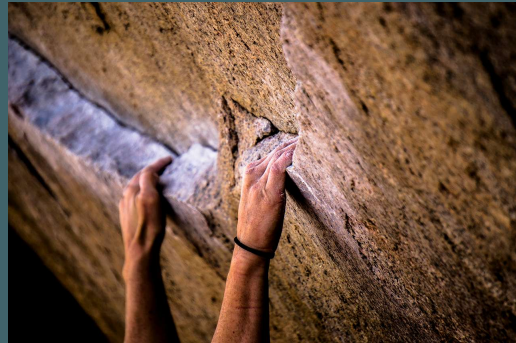
## Helpful interweaves for trauma processing

- Redirection to the body to nurture; or “what would your body like to do?”
- Benefit question
- How do you feel about (or toward) the part of you that survived this?
  - For EMDR, follow up with desensitizing LUP or resourcing POS (Bruce Hersey).
- “Are you aware (or is this part of you aware) that it is over and you survived?”
- “Through the eyes” (Sandra Paulsen); Grounding
- Self-compassion (Neff)
- “We are not taking away anything you need OR You will not lose anything you need”. (Roger Solomon)
- “Imagine that” (Laurell Parnell)
- Compassionate truth-teller/Allies
- Taxing the Working Memory
- Offering psychoeducation

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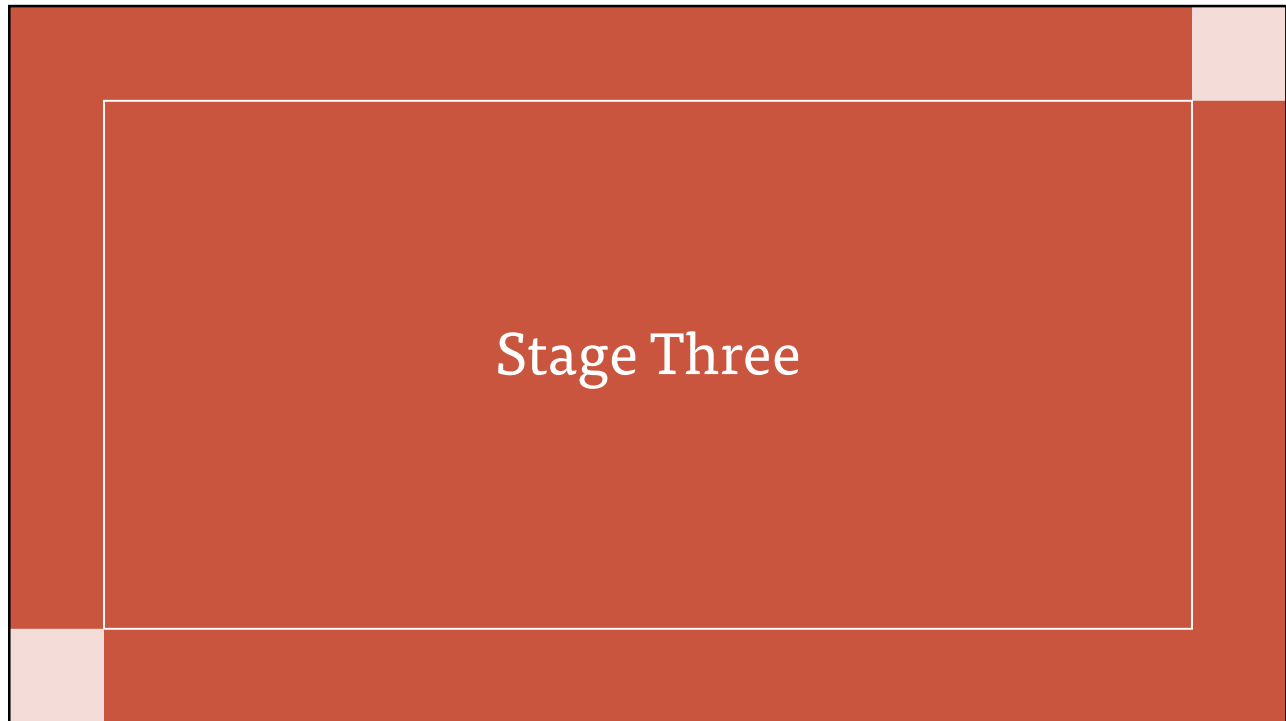
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Where do you  
feel stuck in  
processing  
with clients?



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**Stage three goals and objectives:**

- Process post traumatic grief
- Practice new boundaries and behaviors
- Establish meaning and act according to values that are important to the survivor.
- Establish and maintain healthy relationships

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## Trauma Related Grief

- Grief does not always include trauma, but trauma ALWAYS involves grief.
- Grief is the experience of loss.
- Grief is a universal experience. It cannot be fixed. It must be experienced.
- Trauma-related grief cannot be addressed until there is a distinction between past and present. This may delay the process of grieving in the case of Trauma.
- Example: The desire for a “re-do” is a barrier to living in the present and delays grief. This leads to possible re-traumatization.

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## The difficult practice of new boundaries and behaviors

- Honoring innate wisdom from the body now that the body is safe.
- Action where the client might have frozen before
- Action according to new information, resources, and power.
- May still feel innately risky and require support.

Like physical therapy after a surgery, clients must learn how to apply new skills and resources. This often requires ongoing therapeutic support.

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## Improving Relational Health

- CPTS survivors may not have a template for healthy relationship (this is partly why the therapeutic relationship is so important).
- Secure attachment may feel “boring.”
- Shared responsibility in relationship may feel dangerous to the client who survived through fight/flight or distant and uncaring to the client who survived through freeze.
- Improving relational health will include psychoeducation, increasing tolerance, and skills practice.

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## Value work



Identifying/Knowing our values can motivate meaningful action and positively influence affect tolerance.

ACT therapy identifies four categories of values:

- Relationship
- Work
- Leisure or recreation
- Health

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## Strategies to create meaning

We create meaning when we connect to our “Something Bigger” (transcendence).

In their book *Burnout*, Nagoski and Nagoski identify 3 strategies to foster meaning:

- Pursuit and achievement of ambitious goals that leave a legacy
- Service to the divine or other spiritual calling
- Loving, emotionally intimate connection with others

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## Transgenerational Healing

- Healing from complex trauma may create distance with the family of origin, bringing additional grief.
- In order to continue growth, the client must identify new boundaries and behaviors in existing systems that may or may not be on the same trajectory of healing.
- Concepts of transgenerational healing, though difficult, can increase sense of meaning and purpose and be encouraging to clients.

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## Final Thoughts

- Working with complex cases is difficult and therapists may be vulnerable to burnout.
- Pay attention to your own experience and seek consultation regularly.
- 3 areas of experience to pay attention to:
  - Spirituality
  - Responsibility
  - Grief

It is unfair to ask our clients to do work we are not willing to do ourselves.

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“Somewhere between internalizing the ethic of martyrdom and ignoring ongoing crisis lies the balance we must find in order to sustain our work.”

Van derhoot Lipsky and Burk, 2009

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# Thank you!

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