If you spend much time in community mental health, or social work in general, two phrases pop up with regularity: "vicarious trauma" and "compassion fatigue." The textbook in my first social work class described the symptoms of vicarious trauma as follows: "decreased energy; lack of self-time; disconnecting from loved ones; social withdrawal; increased sensitivity to violence, threats, or fear; cynicism, generalized despair, and hopelessness."[1] Compassion fatigue is closely related; over time it gets hard to soak up the pain of others, and at a certain point you just get tired of it.

Lisa McCann and Laurie Ann Pearlman, two clinicians at the Traumatic Stress Institute in New Britain, CT, first wrote about the concept of vicarious trauma in a 1990 article.[2] According to

them, during sessions the experiences of the patient confront the schemas of the therapist, the beliefs about the world the therapist has (mostly unknowingly) developed to help make sense of life. We all have core schemas that are rooted deep within us: people are truthful, I am safe, the world is a good place. If someone or something challenges these schemas with an opposing narrative drawn from their own experience the therapist could begin to develop the symptoms described above.

You may have noticed that the symptoms of vicarious trauma seem to mirror those of posttraumatic stress disorder. Indeed, the mechanism of vicarious trauma works by the therapist introjecting (drawing into himself) the trauma of the client and thereby experiencing many of the same symptoms. Vicarious trauma, then, is a sort of PTSD for people's stories, and compassion fatigue is often the result.

Vicarious trauma is the dominant paradigm for describing how this sort of work can impact a mental health professional. We discussed it in my very first class at graduate school, the accreditation requirements of my clinic require me to attend a yearly training on it, and once a month we devote the entirety of our staff meeting to sharing what we have been hearing from our patients and how it has impacted us. When I began this work as an intern I was convinced that vicarious trauma lurked around the corner and was hypervigilant for any manifestation of the symptoms.

I did change. If a car drove past me slowly when I was out walking my dog I would flinch, remembering the stories I had heard where shots burst forth from unseen assailants behind the wheel. I became more hesitant to leave the house after dark. I stopped biking to my classes because every available route passed through a neighborhood home to an increased number of shootings.

I did not grow up here. I was born in the western suburbs, but my parents moved about three hours downstate when I was six months old. I grew up in a town of only about five hundred people;

the size of my graduating class was forty-two. My grandfather was the area's appliance repairman, so even if people didn't know who I was they would if I told them I was Ken Stanberry's grandson. Whatever violence existed in that community was an aberration. When I was eleven, there was a triple homicide within the school district, and while I remember being scared in a general way it didn't really threaten my sense of safety. I grew up with many of those same schemas vulnerable to vicarious trauma: I thought the world was mostly a good and safe place, that people were kind to each other, that when wrong occurred it would be punished appropriately. Has my work irreducibly shattered such notions? Yes and no.

As I've grown older, both as a person and as a therapist, I have become more aware of the deep hurt that we can do to one another, of the unfortunate pervasiveness of childhood trauma, the reality of mass incarceration, the ways that systematic disinvestment and implicit narratives of white supremacy have decimated many urban areas across America. That is of course traumatizing, but it's also the experience of the patients I treat. It's an unfortunate reality of the work I do that most of the people who perform such services are white and from relatively privileged backgrounds while the people we serve are more often poor people of color. One highly-cited study found an increased prevalence of trauma-related symptoms in social workers who work in settings similar to my own, but the average respondent had a mean age of 45.7 years, was female (88.5 percent), and was Caucasian (75.2 percent).[3] There are clearly other factors at play here.

There is something that changes in you by doing this work. You grow to see the world in a different way, to have some of your sunnier convictions distilled by experience. I'm not convinced that vicarious trauma is the best way to talk about this, though. By retaining the connection to posttraumatic stress disorder there is a subtle but noticeable emphasis upon the person inflicting the trauma. I've worked with an innumerable amount of clinicians, al-

most all of whom care deeply for their clients and want the best for them. If we see our clients as potential sources of trauma, though, this can't help but shift the way that we approach them. Suddenly they seem somewhat dangerous, overwhelmingly needy.

This is all the more distressing when we consider this is how most of society already sees my patients. We're all familiar with the standard conservative talking points about the very poor who receive benefits, however meager, from the government. The right routinely depicts them as both a burden and a threat to the rest of "us." We can't forget, though, that welfare was gutted not by a Republican but a Democrat, the same president who put mass incarceration on steroids through his crime bill. Both parties have failed the urban poor. Both consistently fail to consider their unique perspective and needs when it comes to policy.

Have my experiences changed my schemas about the world? Absolutely. Perhaps you've felt something similar as you've read through these pages. Most of us have structured our lives to avoid the stories of people like Jacqueline, Frida, Robert, Luis, and Anthony. If we do run across them it is usually as a statistic on the evening news, perhaps a brief bit of local color in a piece by a journalist who parachuted in over a weekend to chronicle the "real" Chicago. It is uncomfortable to sit with pain, and most of us would rather avoid it if we could. And we do.

I did not write this book to make people feel miserable. If you walk away from reading this and only remember the tragedies, you're missing at least half the story. I do not choose to work in this field and at this clinic out of some masochistic urge to wallow in the pain of others. I am deeply bothered by the injustices I see on a daily basis, yes, but it goes deeper than that. Vicarious trauma ultimately fails because it only tells part of the story.

Some therapists and others in the helping professions speak about a twin phenomenon of vicarious trauma, vicarious resilience. The idea of vicarious resilience is that working with patients

who have seen so much and yet manage to keep on moving can be inspiring, hopeful. Seeing how much another human being can bear and yet remain standing can make us marvel at what humans can accomplish. In my experience, such moments are often smaller than the trauma but even more crucial. I think of Frida working out a visitation schedule for her children and planning what they will do together, of Robert's burgeoning essential oils business, of Anthony caring for his mother.

Focusing on resilience can be dangerous in its own right. Think of the genre of college application essays that offer some version of "I went to (insert developing country) to help, but really it was me who was helped by them." My patients don't exist to provide uplifting stories for others' benefit any more than they are there to bring them down with stories of what they've endured.

The reaction required from those of us who don't share the situations of my patients (and I'm guessing that's most of my readers) is twofold. Yes, marvel at their ability to pull through, to make something despite the odds stacked against them. Most of them feel hopeful about their futures, so there is no reason we shouldn't as well. For those of us who have played a part in creating and sustaining the structures that make them miserable, though, we have to do more than simply praise their strength. We need to ask the hard questions about what created and often sustains their misery. Community trauma isn't something that arrives out of nowhere.

Why is the mental health establishment of which I am a part often so ill-equipped to treat minority populations? Why is the Department of Child and Family Services so broken? Why has the Chicago Housing Authority been unable to provide basic shelter to its citizens for decades even as it has record amounts of money in the bank? Why do Chicago Public Schools so often fail their students? What made Chicago so violent? These same questions could be asked of any major American city. An answer to just one of these questions would easily fill a book, and I don't pretend to

offer a comprehensive solution to any one of these issues in the space provided here.

If we accept the premise that each of these systems was created mostly by middle-class whites to serve the needs of middle-class whites, everything begins to fall into place. White supremacy isn't just about those who wear white hoods and burn crosses. Most of the institutions I've written about here were created in a era when it was just assumed that whites were the superior race and the American culture should be built around them because it belonged to them. Thankfully fewer and fewer people believe this now, but we remain stuck with this sorrowful legacy and must take active steps to demolish it if we want a more just and equitable future.

My experience has been vastly different from that of my patients mostly due to the color of my skin and the amount of money my parents made. The prevailing Horatio Alger myth that we make ourselves and our futures simply isn't true. For every self-made man (or woman) there are many others who tried and failed as well as thousands of others who never even had the chance. The poor were seen as both a nuisance and a moral evil by the Puritans who founded this country, and even though we've shed their theology we continue to hold onto their myth of self-reliance.

How can we shed this false stigma? It starts with exercising our rights as citizens to support policies that actually address social and cultural disparities. We also need to bring positive political energy back into our communities, to create solidarity with the poor and fight against the powers that would render them invisible. When Martin Luther King, Jr., was assassinated, he was in the midst of a Poor People's Campaign. King had noticed the gains of the Civil Rights Movement but also believed that racial justice could only proceed so far without economic justice. He assembled a multiracial coalition to protest the condition of the poor in America, creating a unified group who had never identified with one another before. King and his coalition developed the following

Economic Bill of Rights: the right to full-employment that paid a living wage, the right to a minimum income, the right to a decent home in the neighborhood where one wishes to reside, the right to an adequate education, the right to participate in government and have one's voice and perspective honored, and the right to good healthcare. King's draft of these demands, written less than two months before he was murdered, ends with these words: "without these rights, neither the black and white poor, and even some who are not poor, can really possess the inalienable rights to life, liberty, and the pursuit of happiness. With these rights, the United States could, by the two hundredth anniversary of its Declaration of Independence, take giant steps towards redeeming the American dream."[4]

We've missed King's goal, but that's no reason to stop trying. Mental health issues do not occur in a vacuum; they are influenced by and often triggered by our experiences. The bifurcation between mental and physical health is a relic of an earlier time that separated the mind from the body. What happens in and to the body shapes the mind and vice versa. Would my patients experience the same symptoms if they had not been born poor people of color on Chicago's South and West Sides? In some cases it's doubtful. Others may have experienced some symptoms that could be quickly addressed by ready access to care.

I've invited you into my work to introduce you to those experiencing mental illness, both the struggles and the joys they experience. If you can put this down and forget all about them I haven't done my job. King's vision still cries out to be realized. We need nothing less than a modern-day Poor People's Movement to aid up those who by circumstance of their birth are at a higher likelihood of experiencing suffering in all its forms. This may be uncomfortable for some, but the health, even the very idea, of our democracy depends upon it. We know what we need to change. History will judge us on how we respond.