CDC Ebola Response Oral History Project

The Reminiscences of

Crystal L. Frazier

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Crystal Frazier

Interviewed by Sam Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson, here today with Crystal Frazier. Today's date is March 22nd, 2016, and we're in the audio recording suite here at CDC's [Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. I'm interviewing Crystal as part of the Ebola [Response] Oral History Project. We'll be discussing her life and career, and especially her work supporting the Ebola response of the 2014 epidemic. Crystal, thank you for being here.

Frazier: Thank you for having me.

Q: Of course. For the record, could you please state your full name and current position with CDC?

Frazier: I am Crystal Lynn Frazier and I'm a health scientist.

Q: Great.

Frazier: However, by education, I'm a clinical psychologist.

Q: Ooh, we'll get into that. [laughter] Can you tell me when and where you were born?

Frazier: I was born in Camden, New Jersey. It's actually South Jersey. People usually are familiar with Atlantic City, that area.

Q: When?

Frazier: In 1960.

Q: Okay.

Frazier: Is that important? [laughs]

Q: We can take it out, too.

Frazier: No, it's fine. In 1960.

Q: [laughs] Is that where you grew up?

Frazier: I grew up in Camden until I was about ten, and then my family moved to suburbs. Camden is a city, and we moved to the suburbs when I was ten. The majority of the time I spent in the suburbs.

Q: Tell me about growing up first in Camden and then in the suburbs.

Frazier: Camden in the sixties and seventies was—where I lived was called Parkside. It was sort of a low, middle-income type area then. I grew up and I have three siblings and I grew up with my parents and my siblings and family around. Cousins and aunts and uncles, and that kind of thing. It was a good time. We were able to play outside. No one had to watch us every minute. We came in when the streetlights came on, that kind of thing. It was good. But the city started changing so my parents decided we probably should move, and that's what we did.

Q: How did it start changing?

Frazier: Different elements coming into the neighborhood. A little bit unsafe, so we decided to move. I was a little bit sad when we moved, lost a lot of my friends, that kind of thing.

Q: Then what was it like in the suburbs?

Frazier: I say the suburbs but actually it was the country then. It wasn't built up much at all, and it was a mixed community. Primarily Caucasian, so that was new to me. In Camden it was primarily African American. But it was good. We were welcomed. I had lots of friends in high school. I was actually the first Black homecoming queen in high school, which was kind of cool. I played sports, I ran track, I played basketball. I had a

good time. I was pretty popular in high school, looking back on it. Probably didn't study as much as I could [have]. I wasn't pushed, per se, academically. I had to complete my work and complete my homework, but I wasn't really pushed, which I regret a little bit, but that's okay. It was good. I finished. Still in touch with some friends from high school to this day.

Q: What did your parents do?

Frazier: My dad was a field engineer for IBM. One of the first minorities in that area in New Jersey. In South Jersey, anyway. My mother was a stay-at-home mother, which was great for us. We had dinner as a family on most nights. Don't really do that anymore. I don't see that as often. But my mother was there for us throughout our childhood so it was great. My dad worked hard. It was good.

Q: By the end of high school, what were you thinking about your future?

Frazier: I wasn't, actually. That's the whole—I didn't think a lot about my future I guess at seventeen. But somewhere along the line I started enjoying certain courses like biology, so I decided to do something in that arena, so I went into—I actually got an associate's degree in medical laboratory science, so I became a laboratory technician performing clinical laboratory tests in hospitals. Mostly hospitals then, large and small hospitals. It was fun, I enjoyed it. I like science. I was able to have a little bit of hands-on with the patients, but not too much. Enough for me to engage and interact with the

patients, but still some boundaries. I did that for several years. Probably about twelve years I worked at laboratories and hospitals, and some private laboratories as well.

Q: Is that still in New Jersey?

Frazier: Most of it was in New Jersey. During that time I also started back to school to get my bachelor's part-time while I worked. In about 1990 my husband—I'm married now—also worked for IBM and he was transferring to Atlanta so we moved to Atlanta. In '91 I think we came here to Atlanta. So I had to finish my bachelor's degree in a hurry because I wasn't quite finished. I actually had to challenge a course—test out of a course because I was running out of time. So I was able to do that and get my degree, and then we moved to Atlanta.

Q: I'm sorry, I probably missed it, but what was your bachelor's in?

Frazier: My bachelor's was in health education. Yes, it's actually health education. Not teaching. I didn't want to teach. I just wanted to continue sort of on that science path but get more into the education piece.

Q: If it's not teaching, what were you hoping to do?

Frazier: I actually went further. You couldn't really grow without a bachelor's degree, so that's the main reason I did go back to school because I wanted to grow in the field I was

in. It allowed me to grow into management and supervisory positions. That's the main reason. But I didn't want to limit myself because I knew I wasn't going to stay in medical laboratory science. I felt like I would branch out, so I got a little bit more of a broad degree, more of a general degree.

Q: Gotcha. So what happens when you come down to Atlanta?

Frazier: Well, wow. So working in laboratories and hospitals and private laboratories, I was familiar with entities like OSHA [Occupational Safety and Health Administration] and CDC. So I said to myself, if I'm moving to Atlanta, I'm going to go to work for the CDC. [Since I was] already familiar with it and I respected the agency. But it took me a year. So we moved here and I got a job in another laboratory for about a year, and then the position was advertised for CDC as a health scientist and they were looking for people with clinical laboratory experience and it was absolutely perfect. I applied and I was hired in 1992. In that position, pretty much I worked in the area of CLIA, Clinical Laboratory Improvement Amendments. It was really about quality control and quality assurance, laboratory improvements, that kind of thing. I wrote regulations, helped write regulations for clinical laboratories talking about how much education one would need to perform laboratory testing, how often you should run quality control, those kinds of things. It was very interesting I have to say.

Q: Who were some people you worked with early on?

Frazier: It's funny because I just ran into a couple of people today. I worked with people like Dr. Carilyn Collins. I think she's actually still here in some capacity. Tom Hearn. It was quite a few laboratorians then. Sharon Granade. These were all health scientists with experience in laboratory testing. A group of us were actually hired at the same time, so it's good to see them now. Twenty-four years later, I [still] run into folks across CDC. It's good to see [former colleagues].

Q: How long are you doing the lab improvement work?

Frazier: I did that for a few years. And again, I knew—I always had this [feeling] I wasn't quite there yet. It was very interesting, very rewarding, but that just wasn't it yet. I kept looking and exploring [other CDC opportunities] and that kind of thing. I moved around at CDC for several years in positions in policy and planning, those type of positions. A little bit of management, official work. During this time, I would attend lots of different sessions at CDC on various topics. Finally, that led me to psychology. It was several years. I'm probably fifteen years in at this point when I realized, okay, wow. I think I may have found my passion or something that I'm truly interested in. During that time, CDC reorganized. We reorganized probably three times now during my career, so we were undergoing another reorganization and I just felt like that was the opportune time for me to start selecting a school and get started on my psychology career.

Q: Do you remember anything specific that really caught your imagination or your excitement about psychology and turned you into that direction?

Frazier: There are actually a couple of areas. One would be the injury center here at CDC. They work on injury and suicide, and I found [that] very interesting. The other was the work around disabilities. Substance abuse was not necessarily CDC's, but they did touch on it with some work with SAMHSA [Substance Abuse and Mental Health Services Administration]. I still today really want to work in that area of substance abuse treatment or maybe research. I'm more of a clinician. I prefer sitting across from a client and helping them manage through whatever their issues are.

Q: Tell me about getting started in that direction.

Frazier: Oh man, getting started. I had very supportive supervision. Dr. Jay Bernhardt and then Katherine Lyon-Daniel, who happens to be head of communications for CDC, were my supervisors. This was 2007. She was one of my supervisors, so I approached her and Jay Bernhardt, who was the director. She was actually the deputy director of the National Center for Health Marketing, which was reorganized out. It doesn't exist now. But either way, I approached them and they were very supportive. I was actually able to go out on long-term training for a couple of years and focus just on schooling. I found the school, the Georgia School of Professional Psychology here in Georgia in Atlanta, which is pretty respected and well known in the psychology arena. My concern was that it would have been so difficult to do that type of program part time, so that's why I approached them to see if I could do long-term training. It was approved and so in 2007 I started full-time college again. How old was I? Probably forty-six or forty-seven at that point. It was

more than a notion. That first semester was—oh my goodness—outrageous. Most of the students in my classes were in their late twenties, early thirties. A couple of us were over forty-five-ish. It was very challenging, very rigorous. The first two years, because I was on long-term training, I was able to focus on [school]. Going forward after that, I had to go to school part-time and work so it became more challenging, but I just kept doing it. A course here, two or three courses here, that kind of thing. It also included practicums. So I was working, I was taking classes, and I had practicums where we literally conducted therapy sessions with clients or assessments. I was pretty busy. When I look back, I wonder how I did it. How did you do that? How did you do that? That was a seven-year journey. Actually, I just graduated two years ago.

Q: 2014.

Frazier: Yeah, 2014.

Q: Wow.

Frazier: Yeah. Seven-year journey.

Q: What degree did you end up with?

Frazier: I have a PsyD in clinical psychology.

Q: Any experiences from practicums or anything that really stick out vividly in your memory?

Frazier: Oh, man. Great experiences. So I had three different practicums. Generally, they lasted nine months and you take coursework at the same time. Then I had a full year of internship at the University of Texas Health Science Center in Tyler, Texas. But there were so many experiences. I had such a great time. I provided services for men and women, and group therapy for folks with depressions or anxieties. Even some psychotic disorders like schizophrenia. I spent probably a good nine months providing services to women in a substance abuse treatment center in College Park here. That was very interesting. Very rewarding. It's such a different culture. There's a huge culture of substance abuse that I learned about and just those women's lives—how some of them—one thing it did teach me was not to get caught up in the criminal justice system. Not even for something minor because again, you're at the mercy of the system no matter what is going on in your world or your life. You're at the mercy of the system. That was very, very interesting to me. But it also taught me a lot of women with substance abuse problems also have some other kind of co-occurring disorder. Many of them were suffering depression or anxiety or PTSD [post-traumatic stress disorder]. A lot of domestic violence and history of child abuse. It was very rewarding, and I still would like to get back in that arena today if I can. It was very rewarding.

Then in Texas, at my internship, I was working at a health science center which included a hospital, a medical hospital, a mental health hospital, a brain rehab [rehabilitation]

center, and also physicians' clinics. So I actually touched all of those during that year and worked side by side with the physicians. They're all about integrated health. It was really a team. The physicians, the nurses, the psychologists, and the dieticians. It was much more of an integrative health experience which I really, really enjoyed. I think if I had my druthers, that's probably the environment that I would be in for my career. Some type of integrated health environment because I've always had a love for medicine as well. So it kind of allowed me to combine those two arenas.

Q: That's fascinating.

Frazier: Yeah, it's very fascinating. Yeah. It was really rewarding.

Q: Just to get a timeline down, what year were you in Texas?

Frazier: In Texas? 2013 to 2014.

Q: So you basically ended up in Texas toward the end of your—

Frazier: Toward the end of my schooling, yes. You have to do a full-year internship and it's competitive. So you apply and you interview, and that's where I was selected. So I had to move to Texas for a year. I took a year off without pay and moved myself to Texas to do my internship.

Q: That sounds incredibly difficult.

Frazier: [laughs] Yes, yes. I didn't know anyone. I just had to do what I had to do. It ended up to be a great experience. I would do it again. I would go back if there were a reason or a need or an opportunity.

Q: Sorry I haven't asked about this. Tell me a bit about your husband.

Frazier: That would be my ex-husband now.

Q: Excuse me. Sorry.

Frazier: That's okay, I didn't share it with you. Before I started school in 2007, I took a course. Everybody had to take this course in writing, which once I transferred to psychology I didn't need that course but either way, that professor said, "Things will happen while you're in your doctorate program. Life will not end. You will go through things. You may come through this with your degree, you may not. You may be able to work through things, you may not." That's one of the things that happened to me. Somewhere along that line things happened and I ended up divorced. So I am divorced now. I was married thirty years so we are integrated into both families and it's probably going to remain that way. So yeah, it's a long time.

Q: Gotcha. Thank you. Can you tell me just how you—I guess the next thing would be what happens after you receive your degree?

Frazier: I come back to CDC. I move back to Atlanta, get an apartment briefly, and I return to CDC here at OSSAM [Office of Safety, Security, and Asset Management], work at OSSAM, and my supervisor, Caroline McDonald, who is wonderful, when I came back within the first week she said basically, "What do you want to do now? You've got all this schooling." I was actually in the OD [Office of the Director] working in policy and planning. The first thing she did was help me find somewhere where I could utilize the education that I earned. That was actually in the height of the Ebola epidemic. So when I came back, CDC and OSSAM under the leadership of Rick [Richard W.] Klomp was working on responder resilience and was looking for someone to stand up the well-being assessment process or program. However you want to term that. I came back and Caroline said, "I think I have a person for you." And I was transferred over to the WorkLife Wellness Office within OSSAM to stand up that program.

Q: What were your thoughts going in?

Frazier: I thought, this is perfect. It doesn't always happen like that. Many of us—a lot of times people go back to school and they get degrees and it takes them some time to really move into their area of expertise. I was so thrilled and I was able to move into that and work in the area of mental health and well-being for CDC responders. It was perfect timing. Nothing else to say. It was just perfect, perfect timing for me.

Q: Tell me about getting started.

Frazier: We built a plane while it was flying, so we were well into the Ebola crisis. Responders were deploying back and forth to varying countries. In the midst of that, probably November 19th, 2014 I think, we set up the Well-Being Assessment Program. What it consists of, essentially anyone who was deployed anywhere related to Ebola needed to sit down and take three self-assessments that really assessed the responder's level of resilience and their ability to bounce back, that type of thing. We assessed them for symptoms of anxiety and depression and also symptoms of PTSD. Depending on their scores on those self-assessments, if they scored in a certain range, I would reach out to them and have a well-being conversation just to make sure they were okay and to see if they had any concerns about deploying. This is actually part of the deployment clearance process, so if they didn't complete the assessments, the clinic would not sign off on clearing them to deploy. It's mandatory. So we're seeing all this influx of people with these assessments that we're reviewing using this new database system that wasn't quite ready for what we needed. We're still working actually to upgrade that system to get it where we need it. So the individuals would deploy and when they came back, they had to take the same assessments again so we could monitor them. Sometimes, people experienced some pretty traumatic events or witnessed some things that were traumatizing to them, so the scores actually varied. We are going to run analysis and statistics on all of the results to really study them more closely. But again, when they came back they had to take the assessments. If they flagged, which is what we called it,

they scored in a certain range, I would have another conversation with them again about their well-being, how they were doing. If indeed someone was displaying symptoms that were more than moderate—maybe moderate to severe—I had the ability to refer them to our Employee Assistance Program that's staffed with licensed counselors. That didn't happen often. We had [have] a very resilient group of people here at CDC. Many of them said this was the reason they came to CDC, so they were finally able to do what they came here for, which was frontline public health work. Ebola has wound down as we know. We're not deploying as many people, but they are still deploying so we do still see people taking the assessments. I know this is not about Zika, but what has happened is we are transitioning now. Ebola has slowed down dramatically and Zika is now picking up so we're doing a similar process for Zika responders. There's some discussion of expanding the well-being assessment piece to international deployments, so we're starting those discussions now.

Q: Right, so instead of just like for one outbreak response, it could be something that's continued.

Frazier: Right. It could be polio. Polio's ongoing now, but they're not part of the process. Currently they don't have to take assessments. We have a huge global health unit here at CDC who are placed all over the globe. Currently, they're not taking the assessments as well, so we're looking into that piece of it to—

Q: That raises a question for me. Were all people deployed wherever taking assessments? Like if someone was deployed to Dallas, for example, would they be taking an assessment?

Frazier: For Ebola?

Q: Yes.

Frazier: Yes. People who traveled—some people traveled to Geneva to give a talk on Ebola. Yes, they also were required to take the assessments. If they went through the EOC [Emergency Operations Center] as part of Ebola, basically they had to take—

Q: So even going through the EOC and staying here in Atlanta, you would take the assessment?

Frazier: Now, the folks who were detailed or working in the EOC did not take the assessments. However, there is some discussion of that as well because even work in the EOC can become pretty stressful over time. We actually do have another person on our team who goes over to the EOC and does well-being visits, has talks, teaches them exercises, stress management, and just checks on them periodically, which they appreciate.

Q: I'm sure they do.

Frazier: It's actually a growing program. I'm not sure where we'll end up. We are still building that plane, but we've gotten a lot further.

Q: Absolutely. I have a couple questions just following up on a couple things you mentioned. One is, can you tell me a little bit more about this new database system that you were working with and some challenges with that and how you're addressing them now?

Frazier: The system we use is called Medgate. Some other areas of CDC are using it as well. I know that the CDC clinic uses it. Our Employee Assistance Program, the counselors, use that system as well. One of our biggest issues—when someone goes in to complete the assessments, that's fine. It's all recorded, we can go and look at them and sign off on them. But we cannot tell—we could not tell by looking at them whether that person was pre-deployment, meaning they were heading out, or whether they were post-deployment, coming back. So we've been working with the Medgate administrators to try and get the system to where we can recognize certain things. We also couldn't tell—now that we have a second deployment, we couldn't tell if they were deploying for Zika or Ebola in our system. That is tracked completely by the EOC, but in our system we couldn't track that, which would make it very difficult to run any kind of analysis on the data if you cannot determine whether it was pre or post. After a number of months and meetings with our Medgate administrators, probably just thirty days ago, we're now able to discern whether they're pre or post. We can do that going forward. However, the issue

is we've got six thousand and some assessments prior to this upgrade that now we've got to figure out a way to go back in and put that piece in there so we can discern whether they're pre or post or redeployment.

Q: Is it something you think you'll be able to do?

Frazier: We should be able to do it. It requires a contract amendment because the work that needs to be done on the system is outside of scope. We've also had to go back and we've actually printed out a spreadsheet. They exported it. We literally had to manually go through the six thousand assessments—actually it's in an Excel spreadsheet—and identify which are pre and post. That was a huge task. We're still doing it. We have to confirm everything. We've done it once. Now we're going again so we can confirm what we did manually, and then the Medgate administrators will somehow upload that into the system. It's been a huge challenge.

Q: I can only imagine. Were people taking these assessments online or were they on paper?

Frazier: They're online. They're in that Medgate system. So essentially they go in the front end of the Medgate system, and we go in the back end and then review them and approve them and then call and talk to them if we need to. They get notice to complete the assessments as part of their pre-deployment checklist. There's a checklist that goes

out to everyone before they deploy and it would be listed as one of the things that they need to do, go in and complete the assessments.

Q: What was the range of responses that you got from people when you called them to say, "Hey, you've been flagged by our system." Actually, what do you say?

Frazier: That's interesting, too. It varied really from person to person. Overall, everyone is appreciative. Many people do have anxiety and they appreciate the opportunity to talk about it. Not enough to prevent them from deploying, but they just had the opportunity to sort of verbalize any concerns. For example, say if you had a history of panic disorder, is this deployment going to aggravate or exacerbate your panic? Just in talking to you I can kind of tell what's going on with you and to what level and whether or not we need to follow up on things. We were able to do that. We asked questions about their coping skills. How do you self-soothe? What do you do to self-soothe? So whether it's adaptive or non-adaptive, I mean drinking is not necessarily adaptive. Most people exercise, read books. We asked about support networks, family members who are generally part of their support network, those kinds of things. Is this your first deployment? If they were experienced deployers, it's less likely that they would have an issue. We asked about insight. Some people have poor insight, others have good insight. Meaning they recognize when they're starting to become overwhelmed, need to take a break. Others just keep going and going until it's over the top and they can't function. We ask those kind of questions, talk about those kind of things, and then just open it up and let them know—ask them if there's anything that they want to discuss or any concerns.

A lot of people are concerned about their work. “Is it going to sit there until I get back and somebody—” and it happens. Unfortunately, sometimes people’s work will sit there till they get back and that in and of itself causes some anxiety. Some were hesitant about going, but go because they don’t want to disappoint their supervisors. You have that discussion. Okay, let’s weigh that out. What’s important here? If you're going, if you feel like you're being pushed to go, are you going to be as effective? Are you going to function at the level you need to? Those kind of things. So it’s all over the place.

Actually, one of the assessments called the CD-RISC [Connor-Davidson Resilience Scale] is twenty-five questions and that’s the one that assesses your ability to—your resilience, your ability to bounce back. That had a couple of questions on it that gave our scientists, our deployers, angst. It had a question, for example, that asked about making decisions on a hunch without knowing why. We are an agency full of scientists. We don’t make decisions on a hunch. Had a question about faith. Lot of concerns on, why are you asking me about religion? Our response was, the assessment was validated on various populations. We didn’t make it up, we didn’t select the questions. We made sure we’d picked one that was statistically sound and validated on varying populations. But faith and religion are associated with resilience, so that’s probably why the question is there. We do listen to our employees, we do listen to the people we talk to, and we also noticed that the results were trending a little bit lower because of those questions. So we did research and come up with another assessment. Actually, it’s the same assessment but it’s just a ten-question version. In the ten-question version, those three questions are

removed. That was huge because we were getting several comments about those questions. Some people were flagging because of those questions because they would endorse zero, "not at all." That would make their score lower and they would flag, so we were getting false positives. So we made a change.

Q: Rick Klomp mentioned a little bit about that, too, and a question I had—I don't think I thought to ask him, but now that you bring it back up, what does it mean for a study or a set of questions to be validated? You don't have to go in depth or anything.

Frazier: That's okay. You definitely want to use an assessment that has been validated. What that means is that there have been studies [and statistical analyses across varying populations. You'll get a range that's called a normal range, or a therapeutic range. There are several different terms for it.] Actually, we took the results from the CD-RISC 25 and had our biostatistician—Melissa Danielson is her name, great person—run and perform data analysis on the CD-RISC 25 so we could come up with our therapeutic range for the CD-RISC 10. This is actually huge because the CD-RISC 10 [range] is based on our population. We didn't look at other populations that were studied. Our results are based on CDC employees. That's a gold standard.

Q: Yeah, tailored to the population.

Frazier: Exactly. We can't get any better than that.

Q: Gotcha. I have a range of things I'm interested in. How are you doing?

Frazier: I'm fine.

Q: Good, okay. I'm wondering about like you mentioned that with the databases—sorry, I'm kind of going backwards here. In the process, maybe you've done some of this already but of analyzing the results. What kinds of questions do you ask of the data that's been put in there and what kind of questions can you answer?

Frazier: Our goal is we're just now starting the data analysis process and what our goal is really, first of all to see—and we already know this, but whether this process is useful. Whether there's utility for just doing this entire process. We're looking at questions. We want to get a sense of the ranges of results for our employees. We want to look at which questions trend higher or trend lower. We want to look at how many folks endure symptoms of PTSD. We don't have many. For example, we can look at the individual questions on each assessment to help us learn where to focus in our trainings. So, if everybody's struggling or many people are struggling with the question about humor. There's a question on the CD-RISC that talks about, "I can find humor in most situations." Not everybody can do that. I don't mean funny ha-ha, but sometimes we have to lighten up a little bit to try and get through things. A lot of people struggle with that. They're very focused, very serious, and that can be detrimental in some ways. We can actually pinpoint questions and look for areas to focus on with our employees. We also want to look at, if we have a number of people, for example, endorsing depression

symptoms on the Kessler [Psychological Distress Scale] 10, maybe we want to use another assessment that breaks out the depression symptoms more so we're capturing more about that. There are a lot of different areas for us to look at. Really it's about process improvement, so we're really going to delve in and study the numbers and see what we can do. Do we need to change assessments? Should we offer them more often, are we offering them too often currently? You know, that kind of thing.

Q: So are part of the assessments kind of people evaluating the assessment? Is that how you're able to pull data to analyze what you're doing or how—sorry, that's not a very clear question.

Frazier: No, that's okay. Analyzing the actual questions to see how people respond to them.

Q: Right, but I'm thinking about analyzing the efficacy of the assessments. Were there processes where you asked responders to directly comment on their experience with the assessments?

Frazier: We are going to do that. That's another piece of our evaluation, but we haven't gotten to that component yet. We do intend to do that, evaluate the evaluations, evaluate the assessments. We do get comments, but we haven't done it formally yet and we will do that, too. We actually just brought an ORISE [Oak Ridge Institute for Science and Education] fellow onboard who will focus on that evaluation piece with us. That will be

her main focus, to help us evaluate the process top to bottom and see where we need to make improvements. That includes reaching out to those who have completed the assessments to get their thoughts. We will do that, absolutely.

Q: I know you must have worked pretty close with Rick Klomp and with probably Laurie [A.] Jones?

Frazier: Yes.

Q: And Lisa maybe to some extent.

Frazier: Lisa [Elizabeth] McDaniel, mm-hmm.

Q: Can you tell me about working with them or any other people who you spent time with? You mentioned Melissa, the biostatistician.

Frazier: Right. I was lucky enough to really become part of a good group. Rick was already there. He was very welcoming. He's clearly the expert. He's been working on resilience for a number of years now, so he's clearly the expert. He's definitely our go-to person. But he's very welcoming and very receptive of others coming into his arena, so to speak. He's very supportive of each of us actually in the resilience group. While he's very busy generally teaching, training others in the area of resilience, he's always available to us as needed. He's not hands-on with the assessment piece per se but he has a

great grasp obviously of what's going on and can explain and talk about it with anybody at any level. Luckily, he doesn't have to go in the system and press the buttons and the keys like I do.

Laurie is great. Laurie takes care of another piece of the resilience process where she offers everyone returning from deployment an opportunity to sit and talk with her about their experience. It might be some mental well-being questions in there, but a lot of it is about the process, what they experienced. So she does that and she also backs me up. When I'm not able to go into Medgate or I'm out of the office and we need to talk to someone before they deploy, Laurie does that for me as well. She does a great job. Lisa does, too. Lisa also backs me up. So I have two backups primarily because somebody has to be available to go in the system. Oftentimes we'll get calls from the CDC clinic, "Hey, this person is deploying tomorrow. Can you take a look and let us know?" So someone has to be available all the time, every day. We have had instances where we had people deploying over the weekend and luckily for me, Laurie Jones is Commissioned Corps so she's available 24/7 [twenty-four hours a day, seven days a week], so they called her if it was on the weekend. But we each have a primary role and we back each other up. We'll bounce questions and thoughts off of each other because each of us have had well-being conversations. That's the conversations we hold with deployers who have flagged results. We also do the same when it comes to process improvement. How can we make this process better, more efficient, more effective? That kind of thing. All three of us, Laurie, Lisa, and myself, are all licensed professionals so it makes it very easy to back each other up, because you really need someone with that kind of training who can sit down and talk

to you or whomever and focus on those nuances, get a sense of how you're presenting, the words you use, the way you act, sit, whether you're fidgeting or whether you're calm, and that kind of thing. You're trained to pick up on those nuances, so it's good that we have each other. Rick, too, as you know, is a licensed professional. It's a good group.

Q: Wow. You really focus quite a bit on little details that tell you something.

Frazier: Absolutely. Yes. When people talk, they tell you a lot about themselves by what they share and then what they may emphasize and what they may not emphasize. Just in how they present or their affect, so whether they're saying, "I'm fine. I'm doing well." But they have tears in their eyes. Or they're saying, "Nothing's wrong." But they have tears in their eyes. Or they're smiling and laughing when they're talking about something traumatic. They're smiling and giggling. That's incongruent. There's an issue there so we talk through it and see what's really going on. You can get a good sense of someone. It's not perfect. We could do clinical interviews which take about an hour. We don't talk to someone for an hour unless it's absolutely necessary. If we did a full clinical interview, we could learn a lot more about the person. We talk to them enough to get a sense of their well-being and their functioning and whether or not we need to refer them. Then, if there is an issue, we will collaborate with the clinic. I've done that on several occasions, collaborate with the clinic about what I found during a conversation, and together we'll make a determination. "Well, should we approve this person? Should we put any stipulations on them?" We've had a couple of people where we had some question or some concern, but it wasn't enough to not approve them to deploy, but what we did

instead was conduct a well-being visit via phone halfway through their deployment. So we will follow up on people during deployment if necessary.

Q: When you mention the clinic, is that the Employee Assistance Program or is that something different?

Frazier: No, the occupational health clinic is the CDC's medical clinic. That's where the staff go to get their vaccines and they get a medical checkup before they deploy. I'm not certain what that entails. That's their expertise. But part of that clinic process is the assessments. They have to take the assessments as well and that also informs the clinic's decision. If we have concerns, we talk to the clinicians and together we—or if they have concerns, they saw someone who maybe didn't take the assessments yet but they've seen them and they have concerns, they may contact us and say, "What do you think about this?"

Q: Were you doing the mid-deployment assessments with people?

Frazier: No. We don't do mid-deployment assessments currently. But we don't know. That might happen for long-term, people who are deployed long-term. That's going to be part of the discussion we're looking at to expand the entire process, but currently we don't do mid-term. We do pre and post.

Q: But there were a couple individuals who were flagged and it was decided to assess them?

Frazier: Yes, you can flag and still deploy. That's what our conversation is. If we have the conversation and we have very minimal or no concern, then—and we also put a note, so this is all recorded as part of the medical record so anyone we speak with, we enter a clinical note in the Medgate system so that's recorded in their medical record. But if they flagged and we had some concerns but not enough, they don't have to take the assessments again during deployment, but we will call them and have a conversation with them during deployment.

Q: Right. I think I had misunderstood something. I thought that there were a couple of individuals who were flagged and then were followed up mid-deployment maybe not by you but by the clinic or somebody else.

Frazier: That's possible. I wouldn't be aware if the clinic followed up, but I know we have followed up on a few people mid-deployment.

Q: You have?

Frazier: Yes. Absolutely.

Q: Was that you or Rick or Laurie?

Frazier: Whoever's available. What we try to do if you establish a relationship with someone and they need a follow-up, we try to have the same person follow up so you build that rapport. So if I saw them, then I would reach out to them mid-deployment.

Q: What kinds of questions do you ask them that might be different or the same?

Frazier: They are actually the same. For example, you may have someone with a diagnosis of PTSD, so they flagged but they're not so symptomatic that they can't function. So when you call them, you'll just see how they're doing. "Are you practicing self-care? Are you monitoring yourself? How is your anxiety level?" Just get them to talk to you about how things are going. "Are you getting rest?" Sometimes when they deploy, they work twenty-one days straight without—so, "Are you getting rest? Are you talking to your supervisor, letting them know that you're starting to feel more and more anxious?" Or whatever. Just a pretty in-depth conversation about their well-being, making sure that they're okay, and giving them resources. So they can call EAP while they're there. They can actually call the Federal Occupational Health Office 24/7. They have licensed professionals on staff all the time. We make sure they know what resources we have for them.

Q: One thing that brings to mind is one thing that Rick really emphasized in my interview with him I think last week was a lot of care to make sure that people don't feel put upon

when they're flagged and they're asked more questions. Because you don't want to freak someone out and get in their way. Can you talk to me a little bit about that?

Frazier: It's a little bit of finessing. When you do contact somebody, there are concerns. I'll send a calendar invite and it says that, "I would like to speak to you about the assessments that you completed." And I always say, "I look forward to talking with you." You know, that kind of thing to soften it up. Then when we meet, it's very conversational. Even though I'm looking to pick up certain things, it's very conversational. "How are you? How are you doing? Is this your first deployment?" If they have experience. "Tell me about some of your experiences with overseas assignments." Most people don't mind. They don't feel like you're prying. I don't say, "Do you have a history of suicide? Are you taking any medication?" Now, if they want to tell me they're taking medication, that's fine. We'll have that discussion. But because that is part of the medical appointment, I don't need to ask that. If they share it, we'll talk about it. That kind of thing. But I don't make it very clinical. So since I make it conversational and I assure them it is confidential—I do have to put a note in the system because it's part of your medical record, one or two people had a concern about that and they were Commissioned Corps and they wanted to know if it would impact their promotions. I said, "I don't see any glaring concerns. It's not going to impact anything." There was some of that. But most people appreciate it. Oftentimes you're reminding them to take care of themselves because they're so busy taking care of others. A lot of the physicians that I spoke with [are] great at taking care of others. Many are good at taking care of themselves, but not always. So it's just a reminder to take care of you as well.

And we'll talk about different coping strategies, different ways to self-soothe, and I learn from them as well. Sometimes they teach me things.

Q: What are some things that you learned?

Frazier: Some of the meditation strategies that some of the folks use. Even just—like I said, a lot of people read, a lot of people exercise, many meditate. It was—sorry if my memory is getting me. One person shared, it was a technique that she and her loved one used when they contacted each other. It was just a little nuance in their communications that was hugely helpful for them. You learn from each other. A lot of the stress is actually, I think I mentioned, work-related. Particularly when it was the end of the year and it was time to go through evaluations. That's a lot of work for people to go through, to prepare them, to meet with staff. You add that on top of your duties related to Ebola, it becomes pretty stressful. It varied by the time of year as well.

Q: That makes sense. I appreciate the distinction that you're kind of drawing between the clinical side of things, the medical side of things, and then what you're doing which you would characterize that as resiliency or as—

Frazier: Right. We categorize it as resilience. It's kind of gray. We don't want people to think that we're providing some sort of therapy because we're not. But it's still clinical. We are putting a note in the system, so it still has a clinical component but it's more like

a modified clinical interview or—I lost my term, come on, you help me with this. Triage. It's almost like a triage.

Q: That makes sense. "You might need this. Here are the resources for that."

Frazier: Right. And if we recognize something or we hear something or they express some concerns, then we will take care of that. We'll handle it or follow up for them. We try not to make it clinical because that's not what people are signing up for.

Q: Right. Question out of left field. You mentioned that it was really nice to have Laurie and Lisa and Rick to bounce ideas off of. Can you think and give me like a specific instance in which that was really helpful for you having that community of people?

Frazier: It may be down in the weeds because we're really hands-on, so [we] look at the assessments. We were having some issue with duplication of people on, for example, how should we handle this? Because we still want to keep it confidential. If this person is flagged [on the assessments] and they also say, yes, I want to talk to Laurie [through her process], who would be the best person to handle? Should it be me because it's a bit more clinical, the assessments? Or should it be Laurie with the more general conversation about process? But then she can also glean how someone is doing because of her training. There are several of what may appear to be small items that we talk about but they actually have a huge impact. If you're overwhelming someone, you're talking to them two or three times, they're not going to want to come back and talk to you at all. So figure out

a way to give them what they need, get the results of the assessments, have a conversation with them once, and allow them to go do what they're deployed to do. A lot of database issues that we had to work through. Even signing notes. We had issues with signing clinical notes. Had to make some changes in the system. We still have a glitch. It looks like if I sign a note and Laurie goes in and signs a note on that same person, my note somehow disappears. We still have a few glitches that we have to work out. One of the other things we do is bounce off of each other how we handle our conversations with people. We don't ask exactly the same questions, but we get the same information. Does that make sense?

Q: Yeah.

Frazier: We want to get the same information but you have that sort of leeway to be the clinician that you are to get that information.

Q: What would cause you to phrase something in a specific way rather than another? Like, the context, like personality?

Frazier: Right. If someone's a little bit more defensive, you might want to ask them about "how do you self-soothe" a little bit differently. You might even start with the lead-in, "When I'm stressed or anxious, here's some of the things I do. I'd be curious to hear what you do. What do you do to kind of—" instead of more of a direct question. "On the K10 assessment, you scored a four on this which makes it look like you have a little bit of

anxiety. What's going on with that?" One is more clinical, one is more conversational. Just trying to do that in a way that it doesn't appear clinical.

Q: I get the sense that that's something that you really appreciate, that it's something you really respect and it's up your alley. Is that right?

Frazier: Absolutely. It is up my alley. And we're actually trained. I mean, you're trained to interview people for various reasons and you have to learn different techniques to do that because I can say the same sentence to you and you perceive it completely different than if I said those same words to somebody else. You have to learn. It's hard to learn your person in twenty minutes. However, you can get a sense of what your person might look like just from their results. I don't mean physically. I mean present like. You can almost get a sense of that just from looking at the results, you kind of know what to expect.

Q: Gotcha. Thank you. I know you're probably limited in what all you can tell me because of confidentiality, but can you give me just in broad strokes some of the things you heard back from—let's start with pre-deployment like assessments. Is that possible?

Frazier: Yeah, in broad strokes. So I'm kind of mixing two things here: my assessments and Laurie's post-briefings with people. We've actually pulled together themes that are non-identifiable. Just themes that people tend to talk about when they come back, and that involves before they go. Some of the things that people talk about or—not knowing

exactly what their role is going to be until they get there, which you can imagine can cause some anxiety. “What am I going to do? Is it going to be in my area of expertise?” You know, that kind of thing. Sometimes it’s, “I wasn’t picked up from the airport. There was no one there to get me. I’m here in this country and I don’t know anybody.” Sometimes it’s actual things they saw like sick children, or death and dying. It’s really across the gamut, but if it’s process-related things like, “I didn’t know what I was going to do,” there are people who have made improvements [based] on a lot of those comments. So trying to get people that information as soon as possible is huge because it reduces the stress and anxiety level.

Q: Who would you give that information to?

Frazier: It actually goes to the EOC, the DRMU.

Q: Deployment Risk Mitigation Unit, right?

Frazier: You're right. Under Jeff [Jeffrey B.] Nemhauser. [They really take those comments and if there’s a way to make process improvements—you do hear the same comments kind of over and over again.] When you do that, then obviously you need to make some kind of change. It’s a lot of that. It’s a lot of concern, I think I mentioned, about the work. “Is my work going to sit while I’m gone?” Or “My work is sitting while I’m gone so I’m stressed out.” For the post, we look a lot at reintegration. When they come back from deployment, how long does it take them to really get back into their

routine with their family, with their friends, with their work? So a lot of conversation and concerns around reintegrating. Early on, as you can imagine, it was a huge piece around stigma when they came back. People not wanting to be around them, people saying, "Keep your children home from school. Don't come to a family event." I think CDC did an awesome job with really addressing that piece of it. But that was huge.

Q: This is as well a question—were you involved in doing—were you—within the space in which you worked, was that a lane in which you could counter the stigma? Or was that not even part of what you were doing and so it wasn't?

Frazier: That was a lane where you may not counter it, but you help someone process through it. Like how they're feeling, how it impacts them, how they can navigate through it even though they're still subjected to it. That's a little bit more clinical, but that would be our lane to handle it.

Q: I hear what you're saying. Do you have any last things that you'd like to talk about? Not just from the Ebola response, but from your life, career?

Frazier: I don't know. I guess I would say, first of all, I feel like I've been blessed. I never thought I'd be at CDC for twenty-four years. Prior to coming to CDC, working in different labs in laboratory science, it's a career where people change employments often. I did a lot of that when I was younger and then I came here. The good thing about CDC is you can change areas within CDC and still be a CDC employee. There's so much

opportunity within, you don't necessarily have to leave the agency to get experience in your expertise. That really made the difference for me. That's probably why I'll retire from CDC more than likely. It's just been wonderful that I was able to progress in my career at my pace and in the areas that I wanted to, where my interests were. And then have supportive people around me, supervisors and colleagues, that allowed me to do that or supported me in that process. I think that's what's occurring even with resilience with Rick. Just that opportunity to work in the field that I'm passionate about. Then I will mention, too, that I also have a practice. I practice part time. I know this is not CDC related.

Q: No, it's good.

Frazier: But I practice part time on the outside. One day a week I see clients. That allows me the really clinical, if you will, the hardcore clinical piece because that's where my passion is. The clinical piece. That sustains me enough to where—my work at CDC is very rewarding, but it's not the clinical piece that I want. That kind of helps me balance it. I still have my hand in it enough for now until I retire. Then I'll likely get much, much more involved in the clinical side of the house.

Q: In the clinical, is that where you're able to—I don't know if now but sometime in the future kind of scratch that itch for substance abuse counseling?

Frazier: Yep. I may do some of that individually, client to client if necessary. But I'm also going to look for opportunities maybe for some group [work]. Maybe get involved in a substance abuse program. My passion is working with adolescent girls and women. I'll find some activities in that arena. Going forward, actually, I'll probably do some of that now.

Q: You don't have to go in depth but can you tell me briefly about that and your interest in that?

Frazier: I think it comes from my work at my practicum in the substance abuse program, which was actually—it was a milieu and it's a five-day-a-week program. So those women were there from eight to three thirty, five days a week, and you were intimately involved in their well-being. Their substance abuse treatment, there are interventions that we would do in addition to treating their depressions and their PTSDs. Just watching these women evolve back to functioning, thriving adults is huge because some of the stories are just ridiculously daunting. Some of them have been through huge issues throughout their lives, but yet—talk about resilience. But yet, they continue to make the effort to try and come out of that and have as normal of a life as possible. So just kind of watching people who are really fighting for their lives in every way they can is just so rewarding to watch happen.

Q: Sounds inspiring.

Frazier: Then of course teenage girls. I just enjoy working with young brains. [laughs] A lot of them have some issues, but they listen to every word. Even though you might not think they're listening, and they may squirm and make faces and roll their eyes, they actually listen and appreciate the attention and they listen to every word that you say. And they come back. Even when you do something that makes them angry, like some things you have to share by law with parents and that kind of thing; even when you do that, they still come back because they just appreciate that attention and that someone cares about them and that someone is advocating for them. I enjoy that.

Q: Thank you. You don't have to mention this, but I just heard you mention the word retire a couple times. Is that something you're thinking about for like the mid-term maybe and then spending more time in your practice?

Frazier: Mm-hmm. I think I have about four more years, four and a half more years actually till—that's what the system tells me, until I can retire. [laughs] So my goal is now to get myself where I need to be financially so if I choose to retire and focus strictly on clinical psychology work, I can do that. For me, when I do retire and focus on that, I don't want to be overwhelmed. I don't want to work forty, sixty hours a week. So I have to get myself to a place where clearly I can afford to do that. I may or may not retire. It really depends on where I am here in my career. We'll see how that happens or what happens with that. Actually, the whole mental health arena is growing in focus, even here at CDC. We're looking at areas for mental health, where we should be involved, where

we should increase the research, what should our strategy be around mental health. So who knows? Maybe more opportunity even here at CDC. But for now, for me, resilience.

Q: Beautiful.

Frazier: I'm pleased.

Q: Anything that we might have missed? Any last thoughts or reflections?

Frazier: I don't think so. I really just appreciate the opportunity to do this. I had no idea obviously that this was happening but Rick shared it with me. I really appreciate being part of it.

Q: I can't tell you how much I appreciate hearing about your experiences. It's an honor.

Frazier: Thank you. I didn't deploy, so usually you hear from people and their experiences when they deployed. Which is awesome but—so now I guess—I don't know, I think I downplayed my role so to speak. And talking to you, it helps me realize how important it is actually, the work that we're doing.

Q: Absolutely. And now more than ever when you're talking about making the things that you did part of the system. It's huge.

Frazier: It is, and that's my takeaway today. It's huge.

Q: Thank you, Crystal.

Frazier: Thank you.

END