



Advancing a Model of Secondary Trauma: Consequences for Victim Service Providers

Author: Colter Ellis and Kelly E. Knight

This is a postprint of an article that originally appeared in [Journal of Interpersonal Violence](#) on May 2018. The final version can be found at <https://dx.doi.org/10.1177/0886260518775161>.

Ellis, Colter, and Kelly E. Knight. "Advancing a Model of Secondary Trauma: Consequences for Victim Service Providers." *Journal of Interpersonal Violence* (May 2018). DOI:10.1177/0886260518775161.

Made available through Montana State University's [ScholarWorks](#)
scholarworks.montana.edu

Advancing a Model of Secondary Trauma: Consequences for Victim Service Providers

Colter Ellis, PhD¹ and Kelly E. Knight, PhD¹

Abstract

A burgeoning body of scholarship is attempting to understand, normalize, and ameliorate the emotional strain of victim service provision. The literature, however, has yet to fully theorize the hazardous process of empathetic engagement with victims. As a result, concepts, mechanisms, and outcomes are often conflated, making it difficult to understand the etiological path of this occupational risk. The goal of this article is to attend to this gap by accomplishing three objectives. The first is to engage with the perspective of symbolic interaction to theoretically ground a conceptual model of secondary trauma. The second objective is to propose a model of secondary trauma that acknowledges its inherently interactional, interpretive, and, thus, vicariously transmissible nature. The third objective is to begin the work of empirically supporting this model with data from a sample of victim service providers ($n = 94$) collected using in-depth interviews, focus groups, ethnographic participant observation, and community-based participatory research. Our findings suggest that victim service provision, in the form of empathetic engagement, can blur the boundary between self and other, and lead to a sense of damage in the self that manifests in unreliable self-agency, untrustworthy coherence of other, desensitized self-affectivity, and fractured self-history. This work has significant implications. We illustrate an important paradox by showing how victim service provision can be helpful

to victims but harmful to providers. We also offer a pathway for reducing this harm. By specifying mechanisms of damage, the model can be used to inform policies and practices supportive of victim service providers' health and well-being.

Keywords

trauma, victim service providers, empathy, secondary trauma, victims

Introduction

Victims of sexual assault, intimate partner violence, child neglect, and other forms of abuse depend on service providers to help them find safety, access resources, and seek justice. This work is critically important to survivors but often has negative consequences for those who work to help them (e.g., child protective service workers, sexual and domestic violence advocates, law enforcement, attorneys, mental and physical healthcare providers, and religious clergy). Many of these occupations have notoriously low job satisfaction and high turnover rates (American Public Human Services Association [APHSA], 2005; Faller, Grabarek, & Ortega, 2010; Mor Barak, Nissly, & Levin, 2001), which can increase operating costs for organizations and decrease the quality of services provided (Powell & York, 1992; Ullman & Townsend, 2007). As a result, a burgeoning body of literature has tried to document the emotional strain of this work (see Elwood, Mott, Lohr, & Galovski, 2011; Molnar et al., 2017; Sabin-Farrell & Turpin, 2003, for reviews). The scholarship, however, has yet to fully theorize the hazardous process of empathetic engagement with victims. As a result, concepts, mechanisms, and outcomes are often conflated, making it difficult to understand the etiological path of this occupational risk.

The goal of this study is to attend to this gap by answering the following overarching research question: What is the process through which victim service provision leads to secondary trauma? As such, the objectives of this article are threefold. The first is to engage with the sociological literature to theoretically ground a conceptual model of secondary trauma. We draw on the perspective of symbolic interaction to help explain how repeatedly taking the role of victims changes the intra-individual experience of the self. The second objective is to propose a conceptual model of secondary trauma that acknowledges its inherently interactional, interpretive, and, thus, vicariously transmissible nature. The third objective is to begin the work of empirically supporting this model by using qualitative data collected from a sample of victim service

providers ($n = 94$), defined broadly as professionals (or volunteers) who regularly work with individuals “confronted, attacked, assaulted, or violated by a perceived predator, resulting in serious short-term as well as long-term physical and/or mental injuries” (Burgess, Regehr, & Roberts, 2013, p. 10). Ultimately, this research shows how repeated emotional engagement with traumatized others can damage perceptions of the self, giving rise to the intra-individual process we define as secondary trauma.

Any study of secondary trauma necessitates an understanding of primary trauma. The term trauma, however, has become ubiquitous over the last several decades (Levine, 2015; van Der Kolk, 2014; van Dermoot Lipsky, 2009). Despite the term’s popularity, there is little consensus as to its precise meaning (Briere & Scott, 2014). McCann and Pearlman (1990) provide a popular operationalization of primary trauma, defining it as an event that (a) is sudden, unexpected, or non-normative; (b) exceeds the individual’s perceived ability to meet its demands; and (c) disrupts the individual’s frame of reference and other central psychological needs and related schemes (p. 10).

Even more difficult to define is the concept of secondary trauma. Nevertheless, there has long been a movement in the “helping” professions to understand the vicarious emotionality of service provision as an occupational hazard. This started with Freud’s (1910/1953) concern with counter-transference and includes the related concepts of vicarious traumatization (Pearlman & Mac Ian, 1995), secondary traumatic stress (Figley, 1999), compassion fatigue (Figley, 2002), trauma exposure response (van Dermoot Lipsky, 2009), burnout (Maslach, 1982), and moral distress (Jameton, 1984). Elwood et al. (2011) and Sabin-Farrell and Turpin (2003) provide useful reviews, and Newell, Nelson-Gardell, and MacNeil (2016) provide a visual timeline of their development, given definitional inconsistencies and conceptual overlap. Nevertheless, this body of scholarship shows that women (Baum, 2016; Cieslak et al., 2014), people with previous histories of primary trauma (Cunningham, 2003; Nelson-Gardell & Harris, 2003), and those with high trauma caseload exposures (Hensel, Ruiz, Finney, & Dewa, 2015) tend to have higher rates of secondary trauma. The research, overall, has struggled with many unavoidable methodological challenges (e.g., poor generalizability, cross-sectional data, and overlapping adversities). Regardless, these related concepts all point to the difficulties providers encounter when they are repeatedly asked to engage with victims.

Sociological studies of trauma are less common. Sociologists have largely focused on the collective experiences of shared trauma and the lasting effects (see Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004; Erikson, 1976). Traumas experienced during disasters (Erikson, 1976), slavery (Eyerman, 2001), or genocide (Alexander, 2012) become lasting cultural (Alexander et al.,

2004), historical (Heart, 2003), and intergenerational (Jacobs, 2011; Stein, 2009) processes that extend to influence even those who did not experience the events directly. Although these works make powerful contributions, the precise mechanisms of the inter- and intra-individual experience of indirect trauma remain largely unspecified. We believe this is due to the absence of an understanding of secondary trauma from the perspective of symbolic interaction.

Theoretical Framework

Symbolic interaction is a sociological perspective that works to understand micro-social and interpretive processes. The field has developed a concept of “self” that arises from interaction with others, as originally proposed by James (1892/1961) and Mead (1934). Later, Stern (1985) engages with the concept of self and argues that a core self emerges in infancy. He outlines the following four elements necessary for the capacity to have a self: (a) self-agency, described as the sense of authorship of one’s own actions; (b) self-coherence, described as having a sense of existing as a non-fragmented, physically whole being with boundaries and a locus of integrated action, as well as having coherence of form that is the sense that others are separate, enduring, and coherent entities; (c) self-affectivity, described as the sense of experiencing patterned inner qualities of feeling (affects) that belong with other experiences of self; and (d) self-history, described as having the sense of enduring, of a continuity with one’s own past so that one “goes on being” and can even change while remaining the same (p. 71). Although other senses of self can arise and change over a lifetime, Stern (1985) refers to these properties of the core self as “critical invariants” and “islands of consistency” that “provide organization to experience” (p. 72).

Within the symbolic interaction perspective, a person has an experience, becomes aware of the experience, and then labels or assigns meaning to it (Blumer, 1969). In essence, Stern’s (1985) core self organizes the original experience (what Mead called the “I”) that the person then becomes aware of (what Mead called the “me”). Together, the core self and self-awareness allow a person to perceive interactions with others (or interactions within her or himself), interpret them, and label these experiences. During the interpretation process, a person takes the role of the other to try to understand them. Role taking can include the act of empathetic engagement, which in this perspective, can be defined as “the arousal in oneself of the emotion one observes in another or the emotion one would feel in another’s situation” (Shott, 1979, p. 1328). This vicarious process can blur the boundary between self and other (Ruiz-Junco, 2017), which arguably has important consequences for victim service providers.

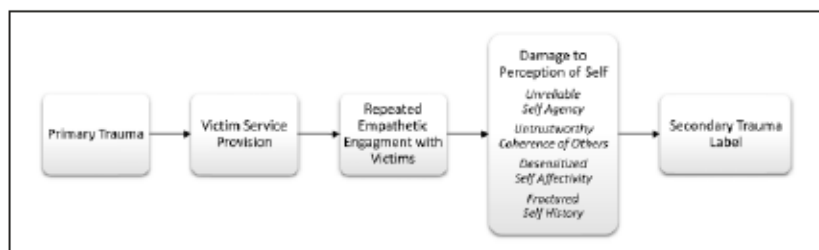


Figure 1. Conceptual model of secondary trauma.

Conceptual Model

We use these theoretical perspectives as a framework to help interpret and organize data about victim service providers' experiences. As outlined in Figure 1, first, our findings show how past histories of primary trauma can sometimes draw victim service providers into the work. Second, we argue that repeated empathetic engagement with victims can lead to a blurring of boundaries between self and others. Third, our data illustrate the process through which the self is perceived as damaged—in the form of unreliable self-agency, untrustworthy coherence of others, desensitized self-affectivity, and fractured self-history. Last, we argue that this inherently interactional, interpretive, and, thus, vicariously transmissible process is what is often labeled secondary trauma.

Method

Data Collection

Secondary trauma was not the original focus of this study. As a new research collaboration (between a White, male qualitative rural sociologist and a White, female quantitative victimologist, both new to Montana, and both with prior experience in victim service provision), we were conducting a state-wide victim needs assessment that focused on victim service providers, broadly defined. The goal was to conduct interviews and focus groups to identify key victimization issues not evident in official statistics due, often, to high rates of underreporting (Langton, Berzofsky, Krebs, & Smiley-McDonald, 2012), especially in rural areas (DeKeseredy & Schwartz, 2009). Our intention was to develop a long-term research agenda to help inform policy and improve service provision in Montana. During data collection, however, respondents repeatedly emphasized stories related to the difficulties of working with traumatized populations.

This theme appeared to cut across participants from community-based nonprofits and government organizations, male- and female-dominated professions, tribal and nontribal communities, and volunteer and professional staff. Following the principles of constructivist grounding theory (Charmaz, 2014; see also Strauss & Corbin, 1998) and analytic induction (Becker & Geer, 1960), we followed this emergent finding and progressively modified our interviews to include more opportunities for providers to discuss their own work experiences and health outcomes.

Individual Interviews and Focus Groups

Over the past 2.5 years, we have conducted in-depth, semi-structured qualitative interviews with $n = 38$ participants and five focus groups with $n = 56$ participants from three geographically distinct regions (Eastern, Southwestern, and Northwestern Montana).¹ We both conducted, together, all interviews and focus groups in-person, generally in providers' offices or nearby restaurants. We drove as many as 8 hr, one way, to meet participants.² We began by having participants sign consent forms and asked initial questions listed in a semi-structured interview guide (e.g., "please tell me about your work and involvement in, or knowledge of, victim services in your area"). Individual interviews typically lasted 1 hr but ranged from 30 min to 3 hr. Focus groups ranged from 2 to 3 hr and usually included a meal. As data collection continued and the theme of work-related health consequences became increasingly prominent, we emphasized the questions, "What inspires you to do this kind of work?" and "What effect does it have on you?" Interviews and focus groups were conversational and flexible, intending to generate narratives about experience and meaning (Gubrium & Holstein, 1997). Participants completed short demographic questionnaires at the end of their interview or focus group, and received \$20 for their participation. All interviews and focus groups were digitally recorded, and all study protocols were approved by Montana State University's Institutional Review Board. To protect anonymity, individual interviewees are given pseudonyms and focus group participants are identified by occupation.

Sample

We strove to interview providers from equivalent occupations in each of the three Montana regions. We focused specifically on child protective service workers, sexual and domestic violence advocates, law enforcement officers, attorneys, mental and physical healthcare providers, and religious clergy. This technique is known as "purposive sampling" and is used to draw a

theoretically driven, nonprobability sample of cases of specific interest (see Maxwell, 2012). Participant recruitment was done through local contacts. Early in the research, for example, we built a strong connection with the Montana Coalition Against Domestic and Sexual Violence leadership who introduced us to well-networked victim service leaders in each region.

Altogether, 94 victim service providers participated in this study. In terms of participant demographics, the average age was 43; 81% were women; 88% were White, 7% American Indian, and 3.5% Hispanic; 28% had graduate or professional degrees, 38% bachelor's degrees, 28% some college, and 5% high school education or less; and the median category for total family income was between \$60,000 and \$69,999. For comparison, the general population of Montana is 49% women; 88% White, 7% American Indian, and 4% Hispanic; 30% have a bachelor's degree or higher; and the median household income is \$47,169 (U.S. Census Bureau, 2015). Our sample is racially and ethnically similar to Montana's composition but our participants have higher-than-average education, have higher household income, and are disproportionately women. These differences make sense given the educational requirements for victim service providers and that women are often overrepresented in these fields.

Analytic Strategy

Following Lofland, Snow, Anderson, and Lofland (2006), data collection and analysis were conducted iteratively throughout the project. After each interview or focus group, we discussed key topics, compared field notes, and wrote and sorted memos. Our audio recordings were then transcribed, checked for accuracy, and coded in one NVivo 11 dataset. The coding process had three stages—initial, focused, and theoretical coding (Charmaz, 2014). No codes were developed a priori. First, initial codes were used to identify possible themes. The text was coded in NVivo with labels that closely reflected language used by participants. At this stage, we noticed the importance of providers' personal histories of primary trauma, their deep empathy, and intense work-related stress. We then modified our interview guide so these themes could be verified across interviews, refined to better reflect participants' experiences, or discarded as unique to an individual. Second, we sorted initial codes and checked for patterns, both within and between interviews and focus groups. This process, known as focused coding, groups codes and allows for more complex relationships to arise. At this stage, we noticed victim service providers were describing uncontrollable emotions, an intense distrust of others, a desire to numb their bodies, and a general feeling that they had become different people as a result of the work. In the third and

final stage, known as theoretical coding, we worked to understand the relationships among codes. At this stage, we began to employ Stern's (1985) theory of the core self as a general frame to help conceptualize the experience and process described by participants.

Ethnographic and Community-Based Participatory Research

In addition to formal interviews and focus groups, we attended eight practitioner trainings throughout the state to learn from presenters and interact with providers in attendance. Field notes document a total of 90 hr of ethnographic participant observation for each of us.³ In addition, at the end of year 1, our research focus came to the attention of a community engagement specialist at our university. As a social worker and a tribal member, she invited us to her reservation and introduced us to several American Indian service providers across a variety of agencies. We were subsequently invited to attend their intensive historical trauma and grief workshop (totaling 24 hr).

Out of the network we developed by participating in these trainings, and to build an equitable and mutually beneficial research partnership with providers, we created two ongoing community-based participatory research projects (Wallerstein & Duran, 2006) that established community advisory boards of victim service providers ($n = 7$ members each). These parallel projects, one organized in a rural native community and another in a rural predominantly White community, are focused on finding ethical ways to address secondary trauma among victim service providers. Our collaboration with these boards, along with our "full participation" (Adler & Adler, 1987) in practitioner trainings, served to support implementation (e.g., building relationships with community gatekeepers, assuaging concerns that the research might negatively impact participants, and determining how our research might help providers in the area) and data analysis (e.g., interpreting the data with community input and cultural competence and humility), as well as eventual dissemination of our research (e.g., planning future presentations of results to community audiences). Ultimately, however, this important work helped to deepen our contextual understanding of secondary trauma, the victim service providers we interviewed, and our model development.

Results

Primary Trauma and Selection Into Victim Service Provision

Previous research suggests a correlation between childhood maltreatment and selection into victim service professions (Elliott & Guy, 1993; Farber,

Manevich, Metzger, & Saypol, 2005; Nikčević, Kramolisova-Advani, & Spada, 2007). Some participants were surprisingly open about their histories of victimization, linking these experiences to their involvement in service provision. As disclosed by a court-appointed special advocate (CASA) volunteer during a focus group,

I have first-hand trauma, which is why I'm doing it in the first place, just growing up [with] really everything you can think of. I feel like I have two cases right now I can relate very well with each child. I'm strengthened, I feel like [pause] this whole thing is a calling to me. To me, I feel called to do it.

Participants tended to be more specific during individual interviews. Some gave detailed and emotional accounts of their personal histories of trauma. As Maggie, a 60-year-old director of a residential family crisis center, disclosed,

It was horrific . . . my mother was beaten unrecognizable . . . to where you wouldn't even know who she was . . . I had told [my mom] one time, I'm like, "You know what? When I, when I grow up, I'm gonna go to college because I want to help"—I thought I had to have this big college degree to do this, you know—"that I want to help kids who are abused."

Often, such accounts drew a narrative connection between personal histories of trauma and decisions to become providers. As previous research has shown, their sense of self may be deeply bound to their desire and ability to help others out of difficult situations (see Dunn, 2002; Kolb, 2014; Loseke, 1992).

This is not to say that all providers had successfully escaped abuse. As research shows, for those involved in abusive relationships, it is commonly a pattern across the life course and intergenerationally (Knight, Menard, Simmons, Bouffard, & Orsi, 2016). Patricia, a middle-aged domestic violence shelter worker who regularly helped clients secure orders of protection, told us,

And then when I was working here, after I was divorced, I was dating a guy and I broke up with him. I had to write my own protection order and I found out it's not that easy. I bet you I did it five or six times, because, "Oh, I don't want the judge to know that. Oh, no." Because I had to take it into the judge to get it signed, so I had to go to court and sit there and feel that tension.

Such shared traumatic realities (Dekel & Baum, 2009) blur the distinction between client and provider. This can bring up feelings of shame. Reflecting on this experience, Patricia went on to say, "How ridiculous that I had to do it." Beyond the shame and embarrassment, however, this situation was also an opportunity to solidify feelings of authenticity. Talking of her clients'

expressions of resentment and hostility, Patricia later said, "Sometimes they'll go, 'Well, you have no idea.' And I go, 'Really?' They think we're all just sitting here in our perfect lives." In sum, although not all providers disclosed a history of primary trauma, there appears to be a link between primary trauma and selection into victim service provision in our sample. Next, we will show that this can be an occupational asset that cultivates a sense of authenticity but may also increase the strain of victim service provision.

Repeated Empathetic Engagement

Primary trauma can become what Cahill (1999) calls "emotional capital" because these experiences help providers do their job by increasing their understanding of the situation or by allowing them deeper empathetic engagement with victims' experiences. Take this focus group exchange with a woman who worked as a domestic violence and sexual assault advocate:

Focus Group Participant: I personally don't think I could do the job if I hadn't been a survivor.

Author: Can you say more? What does that mean?

Focus Group Participant: I understand why they go back, I went back. I have a clear understanding of what it did to my children . . . I don't think that I could do my job if I hadn't experienced and gone through it . . . I come from it as a product of that situation . . . it helps to comfort them on a level, because if they want me to I'll disclose, "I was your child, this is how you can help."

This participant's personal history of abuse was an occupational asset, helping her better understand her clients' behavior. Without the ability to empathetically take the role of the abused, she doubted that she could do her work effectively.

Although previous histories of primary trauma may be an occupational asset, they can also complicate the work. For example, as Steve, a 40-year-old Army and National Guard veteran, now a child crime victim advocate employed by a small rural city, told us,

If you did an inventory of everyone that entered social work, you'd probably find a lot of those people had a background where they got involved in it because they had some event. You know, they're not going into social work for money. So not saying that's the wrong kind of people, but I'd say those people are already pre-dispositioned to some kind of maybe having a couple wires come out pretty quickly.

"Having a couple wires come out" was seen as largely unavoidable, especially for those who meaningfully engaged their clients empathetically. As John, a 60-year-old attorney specializing in family law and mediation, said, "you cannot be doing a lot of this work and not have it deeply affect you and the more compassionate you are, the more you empathize with your clients, the more you actually care about it and show up at their house if there's a call, the worse it gets."

Providers were constantly engaging with victims—at work, at home, and elsewhere—and this is likely to have empathetic consequences. For example, take this exchange between focus group participants. One participant described her domestic violence shelter as an "8:00 to 5:00 crisis, seeing everything horrible that people can do to each other." Another participant told the group that she regularly got messages from "random" Facebook friends, saying, "I have a friend in need, and can I get a [blank]?" She continued saying that this leads to a situation where, "... Friday night at 12 o'clock I'm responding to a Facebook message about somebody that needs shelter." A sexual assault advocate told us that she lied to strangers about her work as a way to avoid potential disclosures. As she said, "I mean, I can't tell you how many times people just disclose, disclose, disclose. And again, I'm an advocate, but when I'm on the airplane, I'm me! I don't want to!"

For the providers we interviewed, attending to victims often meant repeatedly engaging them empathically. When empathetic engagement includes that actual experience of other's physical, emotional, and cognitive states, it can cause significant and lasting psychological distress (Bloom, 2016). Kelsey, a 39-year-old clinical psychologist, described these consequences like this:

I think it's worse than a 50-pound weight because it's unconscious. I think [providers are] always moving around the world holding other people's shit. You can't see it but it's kind of like it's energetic. It's like when you're with somebody who feels like shit and you feel like shit, why?

As Clark (1997) said, "when a person empathizes with another at the joint level, he or she loses the sense of separateness from the other. 'I' becomes part of 'we'" (p. 36). Ruiz-Junco (2017) frames this process as "self-transcendent" empathy, argues that it dilutes "the boundaries between self and other," and notes that it tends to flourish in environments where empathizing with those who suffer is valued (p. 14).

In conclusion, for some providers, empathetic engagement is an important part of their work. It is the job of service providers to help victims feel safe,

calm, efficacious, connected, and hopeful (Hobfoll et al., 2007). This work has consequences for providers, but especially for providers with personal histories of trauma. These histories can be a form of emotional capital (Cahill, 1999) but can also blur the boundary between self and other (Ruiz-Junco, 2017). Close identification with victims can make empathetic engagement hazardous. As Bloom (2016) reminds us, emotional empathy can be destructive, especially when the other is perceived as similar to the self. In the next section, we will show how victim service provision, in the form of empathetic engagement, can have negative outcomes.

Damage to Perception of Self

Thus far, we have shown how repeated empathetic engagement with victims can lead to a blurring of boundaries between one's self and others. In what follows, we argue that this is especially dangerous for victim service providers. We do so by using Stern's (1985) anatomy of the core self as a template for organizing the ways in which the self can be perceived as damaged—in the form of unreliable self-agency, untrustworthy coherence of others, desensitized self-affectivity, and fractured self-history.⁴ We begin by presenting an analysis of how self-agency becomes unreliable.

Unreliable self-agency. Stern (1985) describes self-agency as “authorship of action” (p. 76). The disturbance of self-agency is one of the clearest symptoms of trauma. For example, a key characteristic of post-traumatic stress disorder (PTSD) is the involuntary intrusion of unwanted thoughts, feelings, and emotions. As van der Kolk (2014) puts it, “trauma robs you of the feeling that you are in charge of yourself” (p. 205). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) identifies symptoms such as involuntary memories, dreams, flashbacks, and intense or prolonged distress as sequelae of traumatic exposure (American Psychological Association [APA], 2013). These intrusive and involuntary actions were something clearly experienced by Jonathan, a 52-year-old police detective and leader of a “domestic violence action team.” His interest in stopping domestic violence started in his early 20s, while working as an emergency medical technician (EMT). Jonathan recounted a specific EMT call: “it was [a] pretty traumatic situation where the male partner in the relationship beat her terribly . . . and [she] never walked again. Never held her kid again.” Jonathan experienced vivid flashbacks as a result of his work. He described these events as deeply unsettling and outside his control:

A lot of times you'll be doing something very random like eating dinner out [at] a restaurant or whatever, and boom, all of a sudden you get this vivid, like you're right back there, you can smell the smells, everything. It'll come back and it's like, wow, where did that come from . . . and it's usually like a snapshot where you picture the scene again in your mind and everything becomes very real again. All your senses, smell, everything.

Such events destabilize the feeling of being the author of your own actions. They are intrusive and uncontrollable. Jonathan's experiences, however, were an extreme example in our data. Most participants had more subtle, although still significant, disturbances to their sense of self-agency.

Uncontrollable emotional responses, for example, were a pervasive theme. This was especially the case during a focus group with 10 domestic violence and sexual assault advocates from a rural county. One participant started by talking of her early days working as an advocate:

That was strange to me, because I had never experienced that in the workplace, where I felt such overwhelming anxiety . . . Or, like, days where I just really didn't even want to get out of bed because I'm like, "I don't know how my kids are gonna be today at work—like, if I'm gonna be able to cope with what they are coping with."

This started a larger conversation about emotions and the workplace, with other members speaking about the overwhelming nature of their work and unexpected outbursts of emotion. Starting to cry, another advocate said,

Yeah, like, I just, no, no I can't control it. I cry when I'm angry; I cry when I'm happy. Like, it doesn't matter [group laughter]. This is what my body does . . . When something comes up, you're like, "What the fuck was that?" And you're like, "I didn't think that was affecting me," but it is.

Although emotions can be unpredictable for anyone at times, these women found that their work with clients brought about overwhelming and unpredictable emotional responses more regularly. These responses were unexpected and out of context (e.g., "what the fuck was that") and led to the realization of the emotional strain of the work (e.g., "'I didn't think that was affecting me,' but it is").

Overwhelming emotional responses were often accompanied by disturbances in sleep, such as dreams, nightmares, or insomnia. For example, a domestic violence advocate said in a focus group, "I get nightmares that I've never got before. Definitely anxiety, definitely, like, different mental things that

happen.” Carl, a 43-year-old police officer, told us that while working on an especially stressful case, he tried to arrest his wife during a dream while he yelled, “Get on the ground. Put your hands beside you.” Corey, a 30-year-old CASA program manager, told us about the strain on her volunteers, by saying,

We have volunteers; I’ve seen volunteers cry. I’ve seen volunteers get angry with the system. We have a volunteer right now that has trouble sleeping and she’s having dreams of experiences of what the kids on her case went through. You see it . . . It got to the point where I wasn’t sleeping at night. I was dreaming about my cases, my kids, things that were going on, lost 20 pounds in a couple months . . . I was anxious, I was irritable, it was affecting my family.

Similarly, Samantha, a 38-year-old attorney specializing in domestic violence and sexual assault prosecution, told us of the difficulty she has sleeping. As she said, “I find myself waking up at 2 o’clock in the morning to text the officers on duty, because I know they’re [at work] so, I’m like, ‘Oh, hey, I can take care of this.’ And so I’m e-mailing at 2 o’clock in the morning and I’m texting.”

Taken together, Jonathan’s flashbacks, the uncontrollable and overwhelming emotions described by the domestic violence and sexual assault focus group, and the sleep disturbances common across multiple professions all point to a destabilization in a sense of self-agency. Rationally, they know that these memories, emotions, and sleep disturbances originate from within themselves, but there remains a feeling that they are not in charge of these actions. This is also consistent with the neurobiology of trauma (see Scott et al., 2015). As Cara, a 40-year-old sexual assault nurse examiner, told us, there are some stories so “terrifying . . . my head will not shut up about it.” Next, we explain how coherence of others becomes untrustworthy.

Untrustworthy coherence of others. Whereas self-agency is the sense that we are the authors of our actions, coherence of others is the sense that others are separate, enduring, and coherent entities (Stern, 1985). This allows us to reliably recognize others and connect them with past behaviors and experiences, for example, infants’ ability to recognize their caregivers and connect them with kindness (Lavelli & Fogel, 2002). The work of providers, however, may lead to a change in how providers recognize and think about others. This change happens when, for example, repeated exposure to rape victims, intimate partner violence, or abused children leads providers to see everyone as potential rapists, violent spouses, or child abusers.

For the providers we interviewed, teachers, family members, and others who rationally posed no threat, now put them on alert even when there was

no clear indication of danger. This was the case for Lisa, a 50-year-old family evaluation supervisor, in a small town:

It's been very slow, so you don't notice it until one day you go, whoa, where did I get that idea? . . . [it's the] way you look at people . . . I'm always evaluating, like, what's that person's history, where did you come from, what's your background? Does he have any criminal [history]? . . . School teachers going to school. Who is that person teaching my child and what are their qualifications and do they actually have a criminal background? . . . I think I became more critical and more cynical, more suspicious at CPS and then it's just carried on.

Although it is normal and healthy to want to know who your children are spending time with, even Lisa found her suspicions to be progressively “cynical” and connected to her work experiences. She lived in a constant state of misgiving, “always evaluating,” always on guard.

Roger's experience was very similar to Lisa's. A 50-year-old seasoned law enforcement officer, he had worked as a detective “in crimes against persons and crimes against children”—what he called the “‘sick shit’ division.” He had graphic and tragic stories about investigating sexual child abuse. Unlike Lisa, Roger did not see himself as cynical so much as aware of the reality. “I've seen too many of ‘I would have never thought he's doing that. I never would have thought he's doing this.’ I've seen it over and over and over and over.” Roger said this of his young daughter,

even our sons, who are adults, don't get to babysit her. They're like, “What do you mean? You can trust me.” “No. No male will babysit her alone. It's not going to happen.” “Well, what do you mean? Don't you trust us?” We said, “Yep, we trust you. No male will watch her.”

Roger had dealt with some truly horrific cases of child sexual abuse. These experiences had changed his trust for others so fundamentally that even his own adult children, who were otherwise perfectly trustworthy, could not be trusted.

We argue that the consistent engagement with people harmed by others may disrupt providers' faith in others. This creates the sense that anyone can be dangerous, and no one can be trusted. Likewise, Saakvitne and Pearlman (1996) point out that, “changes in self-trust and trust in others are also common as one is exposed to reports of dangers that couldn't be prevented and to the potential for betrayal by seemingly trustworthy people” (p. 36). The *DSM-V* also speaks of “persistent and exaggerated negative beliefs or expectations about oneself, others or the world” (APA, 2013, p. 272). As Roger's

point makes clear, this is not limited to strangers but also extends to close family members. Janet, a 32-year-old attorney specializing in domestic violence and sexual assault, put it this way, "I'm not sure I really trust my kids with anybody, even people that I know and love and care about and think are trustworthy." Next, follows an analysis of how self-affectivity becomes desensitized.

Desensitized self-affectivity. The capacity to experience, express, and share emotions creates "a familiar internal state despite the variety of eliciting events" (Stern, 1985, p. 90). From the patterned internal experience of individual emotions, to our general disposition across contexts, self-affectivity is a central invariant of core self (see Irvine, 2004, pp. 137-139). For service providers, empathy and caring are defining features of their affect. Studies show, however, that the work can make these difficult to maintain (Dunn, 2002; Konradi, 1999; Loseke, 1992). The providers in our study talked of a general shift in their emotional availability, even beyond their work role.

Participants used various words to talk about the change in their affect. One of the most prominent was feeling "desensitized." This sense of unfeeling was sometimes constructed as a self-protective boundary and was a central topic during a focus group with domestic violence and sexual assault service providers in a very rural area. As one participant said,

The trauma we take on dealing with our clients who have suffered extreme amounts of trauma, it's just a reality. We try to do boundaries and self-care and things to manage that and prevent it, but it's not always doable. You become somewhat desensitized to things that would shock other people. It's not shocking because you've heard it so much and it's not that, you know, we're not apathetic, [it's not that] we don't care, it's just we have to desensitize ourselves and it's a protection for our own self-care.

This desensitization can be an important occupational asset. As another participant indicated, "they're coming to us for that strength and support—I don't want to be stun-able. If we're more even keel for them, I find that they talk more and they get it out."

Although occupationally useful, this desensitization can carry over to other parts of providers' lives. Another participant discussed how the work interrupts her emotional availability to her children. "We take those things home with us. We try not to and we do, so it affects us after work as well in our home lives." In response to this comment, we asked the group if the work affects their romantic relationships. The response was an overwhelming "yes," with one participant saying loudly, "I don't have one," and another

saying, "I've been single for 5 years." In a different interview, when asked what resources would be helpful, Sally, a 37-year-old domestic violence attorney, replied, "a girlfriend for my husband [laugh] and a nanny for my children." These comments point to a general loss of providers' emotional availability to others.

Providers continually discussed a general sense of emotional unavailability. As Jody, a 39-year-old program coordinator for a women's shelter in a small isolated town, told us, "I've been recently kind of like recovering from a numbing binge, right? I'm going to Facebook, going to whatever, match.com, Facebook, Words with Friends, Netflix, and I would watch these intense shows like *Madmen*." Jody saw these behaviors as problematic and linked to her work. Similarly, Jacob, a tearful 47-year-old religious leader who runs what he called, "a faith-based batterer intervention program," talked of avoiding phone calls. He said that he would "just kind of check out" because the emotional strain of tending to victims' spiritual needs was more than he could handle.

Using drugs and alcohol was also a source of concern for providers, many of whom were trained to spot substance abuse indicators. As Brenna, a 38-year-old executive director, said,

In my 20 years in advocacy, 95% of the people smoked. And probably [an] equal number used alcohol to cope . . . I smoked for 20 years and just quit two summers ago, and it's absolutely a coping strategy, because it's like, this is the way I get out.

For Brenna, the need to numb or disassociate stands in opposition to a growing discourse about self-care. She continued,

So many years I got lectured about, "take care of yourself," "vicarious trauma," "self-care"! And it was all from this, like, "you should exercise." And I'm like, "I don't value my own body in a way that makes that a priority." I've been through too many traumatic events to think that should be a priority, right?

As a result of her work, Brenna found it best to keep her awareness away from her body.

Taken together, emotional unavailability and numbing point to a desensitization of affect. This may be a response to the unpredictable nature of their emotional, physical, and social worlds. These changes in affect do not stop when providers leave work, but impact their relationships and health behaviors (e.g., substance use and self-care) in other parts of their lives. As we will show next and in our last analysis, victim service provision can lead to a fractured self-history.

Fractured self-history. As Stern (1985) says, “a core self would be ephemeral if there were no continuity of experience” (p. 90). For some, the work fractures or changes the connection between who they once were and who they are now. Providers made statements such as, “my worldview is changing, I am changing” and “when I’m done with the work, I won’t be able to go back.” As these data have shown, their worlds often become less predictable, emotions less controllable, friends and family less trustworthy, and the desire to numb more seductive. A fracture in self-history was evident in Jody, mentioned earlier, who talked candidly about how the work had changed her:

I think that’s [the] ongoing damage that we always have when you enter into someone else’s horror . . . it changes who you are fundamentally, and I think there’s got to be a way to be able to answer that within yourself, saying, I’m okay with that, but I’m acknowledging I’m a different person. That’s an aspect of secondary trauma to me, that who I am is fundamentally different.

Jody draws a clear connection between the empathetic engagement of entering “into someone else’s horror” and becoming “fundamentally different” as a result. For most providers, this change is more than a shift in how they see the world.

Brenna describes the change as a “shift” in herself. As she said, “You know, doing this work for as long as I have, you can’t not be affected, both physically and, sort of, how you see the world.” Brenna linked her work in service provision to her struggles with substance use and relationships. These struggles eventually led her to confront these changes. “I had to deal with my own personal trauma. I had to deal with the trauma that I’ve lived through with other people.” Brenna’s reflexive awareness of her own trauma, and her empathetic experiences of others’ traumas, led to a significant change in how she experienced herself and the world.

Both Jody and Brenna continued to work as service providers. By contrast, Kelsey had decided to leave the work indefinitely. Kelsey was especially reflective about the toll the work had taken on her. According to mainstream standards, she was exceptionally successful, having attended a top program in clinical psychology, then completing a prestigious post-doc, and quickly starting a successful private practice in a desirable metropolitan area. At the age of 39, she abruptly quit her job and moved to Montana. When we interviewed her, she was working as a low-wage laborer. She told us about the process of realizing that her previous work was unsustainable:

I just became more and more acutely aware [that] when I help somebody else, I'm often shutting down something inside to do that. I don't have the capacity yet, right now, to be totally present with someone else's trauma and my own, and so I had to make a choice every day and I chose them and I do it again and again and again and I'm just really tired of it.

A combination of especially traumatic stories from clients and an extended meditation retreat had brought Kelsey to the conclusion that she could no longer do the work. She describe her life in this way:

When I was a therapist, it was still kind of in the box because the structure of my life held everything together, but now that there's no structure, I'm like a complete mess. That's why I'm going to go live at a retreat center because I feel like I need to be locked in a padded room, because I feel like the ego that kept me—I feel like a 3-year-old kid, totally dysregulated. All the things that kept me together, like my role in my family, my professional role, having this apartment, all of that has fallen away so it's kind of like I need to be rebuilt from the bottom up.

Kelsey, a profoundly competent and successful person, had the sense that she needed to be “rebuilt from the bottom up.” Like Jody and Brenna, the emotional strain of her work led to a significant change. This is akin to what Pearlman and Mac Ian (1995) call a “transformation that occurs within the therapist (or other trauma worker) as a result of empathetic engagement with the clients trauma experiences and their sequelae” (p. 558). Likewise, this transformation might also be referred to as change in “self-concept” (Charmaz, 1991; Gecas, 1982). Next, we conclude with a summary of our analysis and offer a definition of secondary trauma.

Conclusion

In this article, we present a theoretically framed and empirically grounded model that works toward describing and defining secondary trauma among victim service providers. To do this, we draw on the perspective of symbolic interaction. We began by showing that many victim service providers select into the field because of personal experiences with primary trauma. This is perceived as an occupational asset, as some participants believed it increased their capacity to do their jobs well. We then describe how repeated empathetic engagement with victims can lead to a blurring of boundaries between self and others. We argue that this is an occupational hazard that can damage victim service providers' sense of self in a number of important ways.

Specifically, we used Stern's (1985) concept of the core self to organize the different ways victim service providers experience the negative consequences of their work. To summarize, using plainer, less theoretical language, we first showed how self-agency can become unreliable—some victim service providers no longer have the sense that they are always authors of their own actions. Instead, they often feel out of control when they have emotional outbursts, intrusive memories, nightmares, and insomnia. Second, we demonstrated that some provider's perceptions of others' can become untrustworthy—often victim service providers no longer identify others as enduring and consistent entities. Instead, they can feel mistrustful, suspicious, and hypervigilant even of those they know well. Third, we illustrated how self-affectivity can become desensitized—some victim service providers no longer experience patterned inner qualities of feeling. Instead, they often feel emotionally unavailable, numb, and use substances to cope with their unreliable intra- and inter-personal experiences of the world. Fourth, we described how their self-history can become fractured—some victim service providers no longer have a sense of continuity with their own past and, while they "go on being," they are no longer the same. Instead, some feel different, that they have changed or shifted in a fundamental way.

To complete our model, we offer this definition of secondary trauma: secondary trauma is the label given to a process that results from repeated empathetic engagement with victims—a process that is inherently interactional, interpretive, and thus vicariously transmissible, and that results in damage to the perception of self. Our definition is close to, but distinct from, that of Pearlman and Mac Ian (1995) quoted earlier. We, however, use the lens of symbolic interaction to propose four micro-sociological mechanisms responsible for the transformation that victim service providers experience.

Discussion

Victim service provision brings workers into regular contact with traumatized populations and, therefore, makes an especially useful context for studying the transmission of trauma. Although our focus is on secondary trauma among victim service providers in rural Montana, this article has implications for the study of trauma broadly and in diverse settings. In addition, the sociological lens adds to the study of secondary trauma by providing a framework for understanding the interactive process of role taking, empathetic engagement, and, ultimately, the change in the *inter- and intra-individual* experience of self. Rather than just outlining the symptoms of trauma, we present a conceptual model of the etiology of this transformation. We encourage scholars to consider the perspective of

symbolic interaction when studying different types of trauma (e.g., sexual, intimate partner, community, and combat violence, as well as natural disasters and terrorism) and other risk factors (e.g., genetic, neurobiological, and neurocognitive; see Bomyea, Risbrough, & Lang, 2012; Schmidt, Keck, & Buell, 2015; Scott et al., 2015; Zoladz & Diamond, 2013 for reviews), as no one approach explains all responses to trauma.

This study has implications for the field of victim services. Our findings add to recent conversations questioning the positive and negative utility and ethics of empathy (e.g., Bloom, 2016; Ruiz-Junco, 2017). We illustrate an important paradox by showing how victim service provision can be helpful to victims but harmful to providers. We also offer a pathway for reducing harm. Our ethnographic participation in practitioner trainings, as well as systematic reviews of the academic and popular literatures, has shown us that there is a need for a theoretically and empirically grounded model of secondary trauma that can be used to guide trainings and inform intervention work, for which there is no empirical evidence (Bercier & Maynard, 2015). Specifically, our research can be used to support policies and practices that enhance providers' trust in themselves (i.e., self-agency), trust in others (i.e., coherence of others), presence and mindfulness (i.e., self-affectivity), and professional growth over time (i.e., self-history).

This research has important limitations. First, we presented a model that works toward describing the complex process of secondary trauma. It describes only individual-level processes and no other ecological drivers (e.g., organizational, cultural, and societal; van Dermoot Lipsky, 2009). Additional research is needed to increase its theoretical depth and to test its empirical validity and reliability using different samples and methodologies. This is an objective of future research. Second, we attended to only one aspect of victim service provision. Similar to Kolb (2014), our data reveal other important issues including bureaucratic demands, physical danger, low wages and devaluation, rapid turnover, and, in some rural areas, geographic and historical isolation. Our future research will need to disaggregate the consequences of these difficulties from the hazards of repeated empathetic engagement across different occupations. Third, in this article, we did not attend to the positive outcomes associated with victim service provision, such as the morally meaningful nature of the work (Kolb, 2014) and post-traumatic growth (Calhoun & Tedeschi, 2014). Our broader research agenda includes modeling the extent to which forms of resiliency can offset secondary trauma. Fourth, our findings are based on a mostly White and female sample of rural victim service providers. It is possible that the process of secondary trauma could unfold differently for men, in urban settings, or for those who do not have a history of primary trauma. These are important

directions for future research. Despite these limitations, this study gives voice to victim service providers who repeatedly “enter into someone else’s horror” and “live through” others’ trauma often to their own detriment. We hope this work adds to the body of sociological literature that attempts to understand, normalize, and ameliorate their often-pathologized experiences.

Acknowledgments

We would like to thank Dr. Leslie Irvine for her helpful advice on an earlier version of this manuscript, the anonymous reviewers for their thoughtful feedback, and all the study participants for their important work and willingness to share their stories.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Research reported in this submission was supported by the National Institute of General Medical Sciences of the National Institutes of Health (NIH) under Award Number P20GM104417. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

Notes

1. In addition, we conducted interviews with $n = 19$ participants and another five focus groups with $n = 27$ participants in a fourth sovereign American Indian region. Although the data collection process and findings were similar, they will be the focus of another manuscript, given the historical context in which the findings are situated. These data were collected with both tribal and university Institutional Review Board (IRB) approval.
2. One interview was finished over the phone.
3. Topics included trauma-informed care, resiliency, mindful caregiving, care for court-appointed special advocates (CASA) and other victim service providers, improving services for sexual assault survivors, sexual assault legal services and legislation, domestic violence fundamentals (for law enforcement), and improving system and service access among LGBTQ community members. One of us was also trained and certified through a 20-hr online Compassion Fatigue Train-the-Trainer program where she learned how to train organizational leaders to teach their staff about compassion fatigue and related issues.
4. Note that we are not positing that the core self is damaged, which would result in psychosis. Rather, it is our argument that empathetic engagement disrupts formerly consistent patterns of self-experience.

References

- Adler, P. A., & Adler, P. (1987). *Membership roles in field research*. Thousand Oaks, CA: SAGE.
- Alexander, J. C. (2012). *Trauma: A social theory*. Cambridge, UK: Polity Press.
- Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J., & Sztompka, P. (2004). *Cultural trauma and collective identity*. Berkeley: University of California Press.
- American Psychological Association. (2013). Post-traumatic stress disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Public Human Services Association. (2005). *Report from the 2004 child welfare workforce survey*. Washington, DC: Author.
- Baum, N. (2016). Secondary traumatization in mental health professionals: A systematic review of gender findings. *Trauma, Violence, & Abuse*, 17, 221-235.
- Becker, H. S., & Geer, B. (1960). Participant observation: The analysis of qualitative field data. In R. N. Adams & J. J. Preiss (Eds.), *Human organization research: Field relations and techniques* (pp. 267-289). Homewood, IL: Dorsey Press.
- Bercier, M. L., & Maynard, B. R. (2015). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice*, 25, 81-89.
- Bloom, P. (2016). *Against empathy: The case for rational compassion*. New York: Random House.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.
- Bomyea, J., Risbrough, V., & Lang, A. J. (2012). A consideration of select pre-trauma factors as key vulnerabilities in PTSD. *Clinical Psychology Review*, 32, 630-641.
- Briere, J. N., & Scott, C. (2014). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment (DSM-5 update)*. Thousand Oaks, CA: SAGE.
- Burgess, A. W., Regehr, C., & Roberts, A. R. (2013). *Victimology: Theories and applications*. Burlington, MA: Jones & Bartlett.
- Cahill, S. E. (1999). Emotional capital and professional socialization: The case of mortuary science students (and me). *Social Psychology Quarterly*, 62, 101-116.
- Calhoun, L. G., & Tedeschi, R. G. (Eds.). (2014). *Handbook of posttraumatic growth: Research and practice*. New York, NY: Routledge.
- Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. New Brunswick, NJ: Rutgers University Press.
- Charmaz, K. (2014). *Constructing grounded theory*. Thousand Oaks, CA: SAGE.
- Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, 11, 75-86.
- Clark, C. (1997). *Misery and company: Sympathy in everyday life*. Chicago, IL: The University of Chicago Press.
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48, 451-459.

- Dekel, R., & Baum, N. (2009). Intervention in a shared traumatic reality: A new challenge for social workers. *British Journal of Social Work*, 40, 1927-1944.
- DeKeseredy, W., & Schwartz, M. (2009). *Dangerous exits: Escaping abusive relationships in rural America*. New Brunswick, NJ: Rutgers University Press.
- Dunn, J. L. (2002). *Courting disaster, intimate stalking, culture, and criminal justice*. New Brunswick, NJ: Transaction Publishers.
- Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice*, 24, 83-90.
- Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review*, 31, 25-36.
- Erikson, K. T. (1976). *Everything in its path: Destruction of community in the Buffalo Creek flood*. New York, NY: Simon & Schuster.
- Eyerman, R. (2001). *Cultural trauma: Slavery and the formation of African American identity*. New York, NY: Cambridge University Press.
- Faller, K. C., Grabarek, M., & Ortega, R. M. (2010). Commitment to child welfare work: What predicts leaving and staying? *Children and Youth Services Review*, 32, 840-846.
- Farber, B. A., Manevich, I., Metzger, J., & Saypol, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology*, 61, 1009-1031.
- Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, 58, 1433-1441.
- Freud, S. (1953). The future prospects of psycho-analytic therapy: An address delivered before the Second International Psycho-analytic Congress at Nuremberg in 1910. In S. Freud (Ed.), *Collected papers: Vol. II. Clinical papers, papers on technique*. London, England: Hogarth Press. (Original work published 1910)
- Gecas, V. (1982). The self-concept. *Annual Review of Sociology*, 8, 1-33.
- Gubrium, J. F., & Holstein, J. A. (1997). *The new language of qualitative method*. New York, NY: Oxford University Press.
- Heart, M. Y. H.B. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35, 7-13.
- Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress*, 28, 83-91.
- Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., . . . Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, 70, 283-315.

- Irvine, L. (2004). *If you tame me: Understanding our connection with animals*. Philadelphia, PA: Temple University Press.
- Jacobs, J. (2011). The cross-generational transmission of trauma: Ritual and emotion among survivors of the Holocaust. *Journal of Contemporary Ethnography*, 40, 342-361.
- James, W. (1961). *Psychology: The briefer course*. New York, NY: Harper Torchbooks. (Original work published 1892)
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice Hall.
- Knight, K. E., Menard, S., Simmons, S. B., Bouffard, L. A., & Orsi, R. (2016). Life course and intergenerational continuity of intimate partner aggression and physical injury: A 20-year study. *Violence and Victims*, 31, 381-401.
- Kolb, K. H. (2014). *Moral wages: The emotional dilemmas of victim advocacy and counseling*. Berkeley: University of California Press.
- Konradi, A. (1999). "I don't have to be afraid of you": Rape survivors' emotion management in court. *Symbolic Interaction*, 22, 45-77.
- Langton, L., Berzofsky, M., Krebs, C., & Smiley-McDonald, H. (2012). Victimization not reported to the police, 2006-2010 (NCJ-238536). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.
- Lavelli, M., & Fogel, A. (2002). Developmental changes in mother-infant face-to-face communication: Birth to 3 months. *Developmental Psychology*, 38, 288-305.
- Levine, P. A. (2015). *Trauma and memory: Brain and body in a search for the living past: A practical guide for understanding and working with traumatic memory*. Berkeley, CA: North Atlantic Books.
- Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Thomson & Wadsworth.
- Loseke, R. (1992). *The battered woman and shelters: The social construction of wife abuse*. Albany: State University of New York Press.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.
- Maxwell, J. A. (2012). *Qualitative research design: An interactive approach* (Vol. 41). Los Angeles: SAGE.
- McCann, I. L., & Pearlman, P. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.
- Mead, G. H. (1934). *Mind, self, and society*. Chicago, IL: The University of Chicago Press.
- Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, 23, 129-142.
- Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social Service Review*, 75, 625-661.

- Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare*, 82, 5-26.
- Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2016). Clinician responses to client traumas: A chronological review of constructs and terminology. *Trauma, Violence, & Abuse*, 17, 306-313.
- Nikčević, A. V., Kramolisova-Advani, J., & Spada, M. M. (2007). Early childhood experiences and current emotional distress: What do they tell us about aspiring psychologists? *The Journal of Psychology*, 141, 25-34.
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558-565.
- Powell, M. J., & York, R. O. (1992). Turnover in county public welfare agencies. *Journal of Applied Social Sciences*, 16, 111-127.
- Ruiz-Junco, N. (2017). Advancing the sociology of empathy: A proposal. *Symbolic Interaction*, 40, 414-435.
- Saakvitne, K. W., & Pearlman, A. L. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. New York, NY: W.W. Norton.
- Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, 23, 449-480.
- Schmidt, U., Keck, M. E., & Buell, D. R. (2015). miRNAs and other non-coding RNAs in posttraumatic stress disorder: A systematic review of clinical and animal studies. *Journal of Psychiatric Research*, 65, 1-8.
- Scott, J. C., Matt, G. E., Wrocklage, K. M., Cmich, C., Jordan, J., Southwick, S. M., & Schweinsburg, B. C. (2015). A quantitative meta-analysis of neurocognitive functioning in posttraumatic stress disorder. *Psychological Bulletin*, 141, 105-140.
- Shott, S. (1979). Emotion and social life: A symbolic interactionist analysis. *American Journal of Sociology*, 84, 1317-1334.
- Stein, A. (2009). Trauma and origins: Post-Holocaust genealogists and the work of memory. *Qualitative Sociology*, 32, 293-309.
- Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York, NY: Basic Books.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Thousand Oaks, CA: SAGE.
- Ullman, S. E., & Townsend, S. M. (2007). Barriers to working with sexual assault survivors: A qualitative study of rape crisis center workers. *Violence Against Women*, 13, 412-443.
- U.S. Census Bureau. (2015). *QuickFacts Montana*. Retrieved from <https://www.census.gov/quickfacts/table/PST045216/30>
- van Der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.
- van Dermoot Lipsky, L. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler.

- Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health promotion practice*, 7(3), 312-323.
- Zoladz, P. R., & Diamond, D. M. (2013). Current status on behavioral and biological markers of PTSD: A search for clarity in a conflicting literature. *Neuroscience & Biobehavioral Reviews*, 37, 860-895.

Author Biographies

Colter Ellis is an assistant professor in the Department of Sociology and Anthropology at Montana State University. He received his PhD from the Department of Sociology at the University of Colorado at Boulder. His research focuses on rural communities and applies a social-psychological approach to the study of trauma, natural resources, and animal-human interaction.

Kelly E. Knight is an assistant professor in the Department of Sociology and Anthropology at Montana State University. She received her PhD from the Department of Sociology at the University of Colorado at Boulder. Her research examines developmental, life course, and intergenerational trajectories of victimization, substance use, and offending.