

Secondary Trauma in the Workplace:

Tools for Awareness,
Self-Care, and
Organizational Response
in Montana



MONTANA
STATE UNIVERSITY

Center for American Indian
and Rural Health Equity

Secondary Trauma in the Workplace:

**Tools for Awareness,
Self-Care, and Organizational
Response in Montana**

This book and the research reported in it were supported by the National Institute of General Medical Sciences of the National Institutes of Health under Award Numbers P20GM104417 and P20GM103474. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Acknowledgments

This book could not have been written without the support of many others. Truly, it is a collective effort.

First and foremost, we want to say thank you to all the victim service providers in Montana who work so hard each and every day to help those who are most vulnerable and at risk in our state. With our deepest gratitude and humility, this book is dedicated to you.

Additionally, the research that informed the creation of this book relied heavily on the participants who allowed us to interview them. To those participants, we thank you for your wisdom. Your knowledge has proven invaluable.

This project would not have been possible without the support of the Center for American Indian and Rural Health Equity (CAIRHE) and the Montana IDeA Network for Biomedical Research Excellence (INBRE) at Montana State University. These organizations provided both the funding for this project and invaluable guidance along the way.

We are also deeply grateful to the family members and friends who sacrificed their time with us so we could meet each month and work on this project, often late into the evening. We greatly appreciate your patience with us.

We also wish to acknowledge the people who offered their time and mentorship, big or small, to help us with this project. This includes: Alex

Adams, Cassandra Balent, Becka Barkley, Bruce Barrett, Annie Belcourt, Elizabeth Bird, Abi Blakeslee, Maya Bronston, James Burroughs, Matthew Byerly, Tara Condon, Rebecca DeLaittre, Terra Dion, Renda Dionne, Dennis Donovan, Bonnie Duran, David Eitle, Floyd Fantelli, Caroline Fleming, Rachel Gemar, Kaylin Greene, Allen Harmsen, Suzanne Held, Leah Helfrich, Susan Higgins, Neha John-Henderson, Elizabeth Kinion, Kelsey Martin, Stephanie Mollborn, Robyn Morrison, Samuel Murphy, Heather Olson, Beth Rink, Robin A. Robinson, Emily Matt Salois, Eleanor Sawyer, Inge Sengelmann, Carmen Byker Shanks, Hilary Shaw, Vanessa Simonds, Monica Skewes, Jessi Smith, Maggie Thorsen, Andreas Thorsen, Greer Wagner, and Jarad Walters.

About the Authors

Erin Clements is the child protection specialist supervisor for Child and Family Services (CFSD) in Gallatin County. In her work, she oversees and supports local staff and works directly with families to ensure children's safety. CFSD is a critical division within the Montana Department of Public Health and Human Services. Its mission is to "protect children who have been or are at substantial risk of abuse, neglect, or abandonment."

Colter Ellis is an assistant professor in the Department of Sociology and Anthropology at Montana State University. He received his PhD in 2011 from the Department of Sociology at the University of Colorado at Boulder. He is a qualitative methodologist whose research focuses on rural people and communities. His work has been published in journals such as the *Journal of Interpersonal Violence*, *Rural Sociology*, and *Sociological Quarterly*. He teaches courses in sociological theory, sociology of gender, and race and ethnicity, and is part of the faculty in Montana State University's Women, Gender, and Sexuality Studies program.

Kelly E. Knight is an assistant professor in the Department of Sociology and Anthropology at Montana State University. She received her PhD in 2011 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. Her work has been published in journals such as *Crime and Delinquency*, *Criminal Justice and Behavior*, and *Trauma, Violence, and Abuse*. She teaches courses in victimology, criminological theory, and the sociology of law enforcement.

Richard McLane is the recently retired deputy chief of the Bozeman Police Department (BPD). In this role, he worked to oversee the department's 65 sworn officers. BPD's mission is to "work in partnership with the citizens of Bozeman to improve the quality of life by identifying and resolving public safety concerns." Richard has a distinguished history with BPD, where he served in patrol, support services, and detective division assignments over the course of his 26-year career.

Katharine Osterloth is a sexual assault nurse examiner (SANE) and the program coordinator of the Forensic Nursing Program at Bozeman Health Deaconess Hospital. Her department provides medical forensic care to patients who have experienced rape, sexual assault, and other abuses. Katharine's commitment to offering consistent services to survivors of sexual assault was integral to the establishment of the Forensic Nursing Program at Bozeman Health Deaconess Hospital. The mission of the

program is to deliver timely, competent, and compassionate care to victims.

Christina Powell is the executive director of Help Center Inc. in Bozeman, whose programs include around-the-clock suicide and crisis intervention, Heart and Homes (a supervised visitation and family resource program), Help Center-211 (a hotline that refers callers to state and local health and human service programs), the Child Advocacy Center (an organization that aids in the investigation and prosecution of child abuse), and the Sexual Assault Counseling Center (SACC). Christina created the SACC in 1996 using trauma-based therapeutic and advocacy practices. SACC is Montana's only designated sexual assault center and remains the leader in providing trauma-based services for victims of sexual assault.

Anna Saverud began her legal career with the Montana Legal Services Association in the Domestic Violence Family Law Unit before transferring to the City of Bozeman in 2012. She is the domestic violence prosecutor for the city, specializing in evidence-based prosecution that seeks to limit the impacts of the criminal justice system on victims, improve victim safety, and increase offender accountability. In 2017, Anna was appointed the chief prosecutor for the City of Bozeman.

Alanna Sherstad began her work in survivor advocacy at the Sexual Assault Victim Advocate Center in Fort Collins, Colorado, where she served as the executive director for 10 years prior to moving to Montana in 2009. She is currently the director of the VOICE Center at Montana State University, which provides free and confidential services for people impacted by sexual assault, relationship violence, and stalking. The center's mission is to "provide a safe, highly confidential place on the Montana State University campus for survivors of sexual and domestic violence, offering support, advocacy, and resources."

Amy Katherine Talcott is a research assistant with the Center for American Indian and Rural Health Equity (CAIRHE) at Montana State University. She has been a freelance writer and editor for eight years.

Kelsen Young is the executive director of the Montana Coalition Against Domestic and Sexual Violence (MCADSV), a statewide nonprofit organization located in Helena. Kelsen has been with MCADSV since 2004. MCADSV is a membership organization that works with individuals and organizations to end domestic and sexual violence through social change, advocacy, education, public policy, and program development. Kelsen has been working in the movement against domestic

and sexual violence for more than 20 years. In order to sustain herself in this work, she tells people about Laura van Dernoot Lipsky's book *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others* wherever and whenever she can.

Contents

Introduction	2
Section I: Awareness	7
Tool 1 Understanding the Different Forms of Trauma	8
Tool 2 Recognizing the Consequences of Secondary Trauma	17
Tool 3 Weighing Risk Factors and Resiliency	23
Section II: Self-Care	27
Tool 4 Assessing for Secondary Trauma	28
Tool 5 Cultivating Mindfulness with Dr. Floyd Fantelli	34
Tool 6 Restoring the Nervous System with Dr. Abi Blakeslee	40
Section III: Organizational Response	51
Tool 7 Running Better Meetings	52
Tool 8 Implementing Low-Impact Debriefing	59
Tool 9 Connecting with Others with Robyn Morrison	64
Selected Bibliography	70

Introduction

This book is written for Montana’s victim service providers—the people who have chosen to dedicate their professional lives to helping the survivors of trauma. As providers, we are the ones working day in and day out with those who have endured some of the worst life has to offer, including sexual assault, child maltreatment, domestic violence, elder abuse, hate crimes, and other forms of violence, as well as traumas related to substance abuse, housing insecurity, accidents, natural disasters, and war.

For those of us in this line of work, secondary trauma—an umbrella term for the trauma that results from repeated empathetic engagement with traumatized populations—is a very real and very serious issue. Secondary trauma can result in a whole assortment of physical and emotional issues, as well as contribute to staff turnover and shortages in providers.

Like most providers working in Montana and across the nation, you may never have been taught that secondary trauma is a normal byproduct of your work, or been advised how you and the organization that employs you can effectively manage it. We want to change that.

Our Story

In late 2014, Drs. Kelly Knight and Colter Ellis, assistant professors of sociology at Montana State University, began traveling

across Montana. Their goal was to interview more than 100 victim service providers—social workers, mental and physical health-care providers, sexual and domestic violence advocates, police officers and attorneys, and others in the “helping professions”—to determine how to improve victim services in Montana.

In the midst of collecting all this data, one curiosity kept popping up: Montana providers, no matter their specific profession or region, continually emphasized the personal difficulties of working with traumatized populations. What Kelly and Colter were discovering through their research is something you probably already know: Helping survivors of trauma, though critically important, often has negative consequences for those of us who are employed in these professions.

And so the primary question of the project shifted, and a new question emerged: How can we improve victim services in Montana by first recognizing and then addressing the toll this work takes on providers themselves? What grew from the seeds of that question is the book you hold in your hands today.

The authors of this book, in addition to Kelly and Colter, are a group of inspirational and incredibly experienced leaders representing a variety of victim service occupations in Montana. We are also members of one of two community advisory boards that grew up

around this research project. Our board consists primarily of providers in Gallatin County. Together, by meeting monthly over the course of two years, we have systematically evaluated tools for addressing secondary trauma and developed this book—or “toolkit,” as we like to call it—to build awareness and offer solutions for providers in Montana. Kelly and Colter also helped organize a parallel project with providers working in a tribal community, which has resulted in a similar but distinct toolkit.

Overview of the Toolkit

This toolkit is divided into three sections designed to help you gain a comprehensive understanding of secondary trauma and learn how you might go about combating its effects.

- ***Section I: Awareness*** is intended to help you understand secondary trauma. The three tools in this section explain the different types of trauma, the physical and emotional consequences of secondary trauma, and the things that put you most at risk of suffering its effects.
- ***Section II: Self-Care*** consists of tools to help you mitigate the effects of secondary trauma and increase your resiliency. These tools focus on the importance of self-assessment, cultivating mindfulness, and restoring your nervous system.

- ***Section III: Organizational Response***

contains tools that organizational leaders can use to improve the work environment for providers and that providers can use to effect change in their organizations. That includes changing the way we hold meetings, teaching us better ways to debrief, and proposing more meaningful ways to interact with one another.

Join the Movement

Across the United States, a movement is growing to build awareness and educate about occupational-based secondary trauma. We hope you will join us in this movement as we work to strengthen some of Montana’s most important workers and the organizations that employ us. This toolkit is an important step in moving us toward that goal, but it is by no means exhaustive. The information contained in these pages is just the start, and we anticipate putting out further editions of this toolkit as the research on secondary trauma—including our own—develops.

Whether you have been on the job for a couple of days or a couple of decades, remember that this book was written by those who have been in your shoes. We know about the good days and the bad ones, the rewards and the horrors, the questioning of our choices and the reasons why we continue on anyway. We wrote this toolkit for you. And as you move along in your journey, more than anything else, we hope it reminds you that you are not alone.

An abstract painting featuring a vibrant orange and yellow sky, suggesting a sunset or sunrise. Below the sky, there's a dark, silhouetted horizon line. The foreground is composed of textured, layered brushstrokes in shades of pink, magenta, and purple, creating a sense of depth and movement.

SECTION I

Awareness

Tool 1

Understanding the Different Forms of Trauma

“Ultimately, we want victim service providers to be informed that secondary trauma is a normal process—it’s not pathological, and it’s not a weakness.”

—Dr. Kelly E. Knight

Before we delve into the concept of secondary trauma, let’s start by defining some other types of trauma: primary trauma, and historical and intergenerational trauma. From there, we will offer a definition and examples of secondary trauma to help you begin to understand what secondary trauma is—and what it is not.

Primary Trauma

Primary traumas (also called firsthand traumas) occur when significant, potentially life-altering events leave us feeling fearful, helpless, overwhelmed, and profoundly changed. These feelings result from experiences that are direct, meaning they happen to us personally or we see them happen to others. Events that cause primary trauma can be acute—in the case of a single occurrence, such as a severe car accident—or ongoing, in the case of an experience that happens over time, such as being abused or neglected as a child.

As you can imagine, there are many causes of primary trauma. Here are just a few:

- **Early childhood trauma** (physical, emotional, or sexual abuse, as well as neglect)
- **Domestic violence** (abuse by a spouse, partner, or other person close to you)
- **Sexual violence** (rape or other sexual assault)
- **Physical and gun violence** (shootings, stabbings, beatings, or similar acts of violence)
- **Community violence** (repeated exposure to violent acts in public areas, such as gang disputes, physical fights, or shootings)
- **Traumatic grief** (loss of a loved one in a violent or sudden manner, such as by murder, suicide, or drug overdose)
- **Natural disasters** (wildfires, floods, or earthquakes)
- **War zone violence** (bombings, terrorist attacks, or battlefield combat)

Historical and Intergenerational Trauma

When we talk about trauma in Montana, the concept of historical and intergenerational trauma is especially relevant to some of our most geographically and historically isolated areas, particularly our tribal communities.

Historical and intergenerational trauma are the traumas that are “inherited,” so to speak, from prior generations. Despite the fact that these traumas are not experienced directly, they can still leave their imprint on us. Like primary trauma, the effects of historical and intergenerational trauma can be physical, psychological, social, and economic. Historical trauma is unique, however, in that it is experienced at a community level.

The origins of historical trauma in American Indian communities, for instance, extend back to the time of European colonization and westward expansion. In the eighteenth and nineteenth centuries, historical trauma takes root with experiences of war, forced relocation, disease, malnutrition, broken treaties, and genocide. Moving into the twentieth century, historical trauma is the legacy of boarding schools, loss of language, and institutional racism and oppression. Today, it is the devastating social problems—poverty, alcoholism, drug addiction, violence, and suicide—that have resulted from continued, unrelenting injustices.

Other groups that may experience historical or intergenerational trauma in Montana include African Americans, whose ancestors may have been subjected to enslavement, segregation, racism, and institutional discrimination; Jewish Americans, who may be descended from victims of the Holocaust; immigrant groups,

particularly refugees and other individuals displaced by war, genocide, or natural disasters; and even families and communities that have suffered from intergenerational poverty, wherein multiple generations may have experienced hardships such as housing insecurity, insufficient health care, and prolonged unemployment.

“Traumatic experiences are cumulative. If one generation does not heal, problems are transmitted to subsequent generations. In some form, this cultural trauma affects every Native person. It sculpts how we think, how we respond emotionally. It affects our social dynamics and, at the deepest level, impacts our spirituality. Intergenerational trauma has wounded us deeply.”

—Dr. Martin Brokenleg, coauthor of the book *Reclaiming Youth at Risk: Our Hope for the Future* and member of the Rosebud Sioux

Much work is left to be done on the topic of historical and intergenerational trauma, but understanding these concepts can help us begin to unravel our own experiences of trauma and those of the people we are working to help.

Secondary Trauma: What It Is

Finally, we come to secondary trauma—the subject of this book. For those of us in the helping professions, our jobs require us to hear about or even witness the horrible and disturbing things that happen to other people

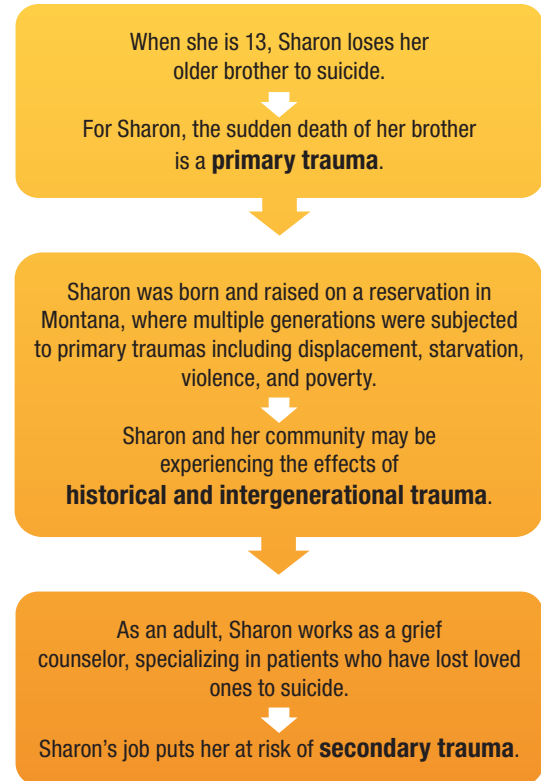
on a daily basis. When we talk about secondary trauma, we are talking about the trauma that can be “transferred” over to us after repeatedly engaging and empathizing with people who have been traumatized. Research has shown that the symptoms of secondary trauma can be just as real and personal as those of primary trauma, despite our not having experienced the disturbing event directly.

What jobs put us at risk of secondary trauma? Here are just a few examples of occupations in the victim services field:

- social workers
- advocates for survivors of sexual and domestic violence
- police officers, investigators, and dispatchers
- nurses, doctors, EMTs, and firefighters
- lawyers and judges
- therapists and counselors
- advocates for victims of elder abuse
- spiritual leaders and religious clergy
- staff and volunteers who assist in the above occupations

If you’ve never heard of secondary trauma, that may be because it goes by many other names. These include: *vicarious traumatization*, *secondary traumatic stress*, *compassion fatigue*, *burnout*, and *countertransference*. In the academic literature, each of these terms means something a little different. For the purposes of this book, these

Three Types of Trauma: An Illustration



differences are not particularly important. As you move through this book to examine definitions, consequences, and solutions, you will gain a fuller understanding of secondary trauma. For now, however, let's focus on three key concepts:

- 1. *Secondary trauma is an occupational hazard.*** It is a natural consequence of working to help those who have been traumatized. By defining secondary trauma as an occupational hazard, we accept it as a reality of our jobs that must be recognized and dealt with by both victim service providers and the organizations that employ us.
- 2. *Secondary trauma is a byproduct of empathetic engagement with individuals who have experienced firsthand trauma.*** Empathy is that thing we do when we try to help another person by putting ourselves in their shoes. While our ability to empathize may make us good at our jobs, we must also understand that vicariously engaging in another person's suffering can take a profound toll over time.
- 3. *Secondary trauma can have serious consequences for our health, both mental and physical.*** Secondary trauma may cause us to experience symptoms of trauma—tension headaches, exhaustion, and irritability, just to name a few—that

did not originate from our own experiences. By understanding that secondary trauma may be the cause of these symptoms, we can better begin to address them.

Secondary Trauma: What It Is Not

Now that we've gone over the definition of secondary trauma, let's talk about what secondary trauma is not. Secondary trauma is not a personal failing or a lack of resiliency. It does not signal an absence of willpower or commitment. It is distinctly different from our personal histories of trauma and the ongoing adversities we face in other areas of our lives. Although these things may complicate the issues surrounding secondary trauma, they are not the same thing.

It is especially crucial for providers to understand the difference between secondary trauma and regular work-related stress (e.g., feeling tense before a big presentation or tired after a particularly busy week). The difficulty of recognizing this distinction may cause us to initially dismiss the symptoms of secondary trauma, assuming they will dissipate over time—perhaps after gaining more experience on the job or once a particular benchmark has been reached. We may think, "Once I finish up with this case, I'll feel better," or "Once I get some downtime with my family this weekend, I'll be able to start fresh next week." The symptoms of secondary trauma will not disappear

over time, however. Its effects are cumulative and will typically only worsen if not recognized and addressed. We will discuss how to go about this in *Section II: Self-Care*.

Resources

- *Transforming the Pain: A Workbook on Vicarious Traumatization* (1996), by Karen W. Saakvitne and Laurie Anne Pearlman
- *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators* (1999), edited by B. Hudnall Stamm
- “The American Indian Holocaust: Healing Historical Unresolved Grief,” by Maria Yellow Horse Brave Heart and Lemyra M. DeBruyn

Tool 2

Recognizing the Consequences of Secondary Trauma

“It is an incredibly painful thing to raise a child, to be an appropriate mother, when you have a bad story to go with everything.”

—Katharine Osterloth

The negative impacts of secondary trauma are numerous and can affect not only individual victim service providers but also our interpersonal relationships, the organizations that employ us, and even the people that we work so hard to help. Understanding the consequences of secondary trauma will help us recognize them in ourselves and take steps to address them.

Individual Consequences

At an individual level, secondary trauma can manifest in symptoms both mental and physical. In Kelly and Colter’s research in Montana, providers reported feeling, as a consequence of their work, overwhelming emotions, a loss of trust in themselves and others, a psychological sense of numbness, and an overriding feeling that their jobs had changed them in fundamental and irreversible ways.

Interpersonal Consequences

Secondary trauma can also have an adverse effect on interpersonal relationships, including those with spouses, partners, children, friends, and coworkers. For those of us working day in and day out with traumatized individuals, it can be understandably difficult to remain emotionally present with our loved ones.

In the course of Kelly and Colter's research, many providers reported feeling that their family members do not want to hear about the day-to-day horrors of their work—nor do those providers necessarily want to expose them to that information. Instead, many of us turn to food, alcohol, or other substances. Sometimes our coping mechanisms may take the form of “checking out”—binge-watching television shows or mindlessly scrolling through the internet for hours every night. While these behaviors feel comforting in the short-term, in the long run they may alienate us further from those to whom we are closest.

In addition to distancing us from our loved ones, repeated exposure to the survivors of firsthand trauma has the potential to intensify our responses to everyday interactions and situations. A shelter worker who counsels abused women, for instance, may feel excessively angry at a romantic partner who raises his voice during an argument. A worker with Child Protective Services (CPS) may refuse to leave his

Physical and Psychological Consequences of Secondary Trauma

In her pioneering book *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, Laura van Dernoot Lipsky uses the term “trauma exposure response” to refer to what we, in this book, similarly call secondary trauma. Trauma exposure response, she writes, is “the transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet.”

According to van Dernoot Lipsky, these 16 items are common consequences of trauma exposure response:

- feeling helpless and hopeless
- a sense that one can never do enough
- hypervigilance
- diminished creativity
- inability to embrace complexity
- minimizing
- chronic exhaustion/physical ailments
- inability to listen/deliberate avoidance
- dissociative moments
- sense of persecution
- guilt
- fear
- anger and cynicism
- inability to empathize/numbing
- addictions
- grandiosity (an inflated sense of importance related to one's work)

young children with a babysitter. A lawyer who prosecutes sexual assaults may be unwilling to let her teenage daughter attend social events.

Organizational Consequences

When providers are suffering from secondary trauma, workplaces suffer as well. In the face of daily pain and suffering, it can be difficult for us to be our best selves at work. We may unintentionally unleash our distress onto colleagues in ways that seem irrational or abusive. And because, as the saying goes, one bad apple can spoil the bunch, the negative attitude of one employee can lead to a chain reaction wherein other employees begin to display the same behaviors, resulting in a toxic work environment. We may also begin to cast blame on the organizations we work for and become angry and resentful toward our work as a result. With organizational understanding of and responses to secondary trauma typically lacking or even nonexistent, it is easy to see how secondary trauma may exacerbate staff turnover and lead to shortages in providers.

We believe that when providers, our loved ones, and our workplaces suffer, so too do the individuals and communities we are trying to serve—in terms of both the quality of the services they receive and the availability of providers to help them through their trauma.

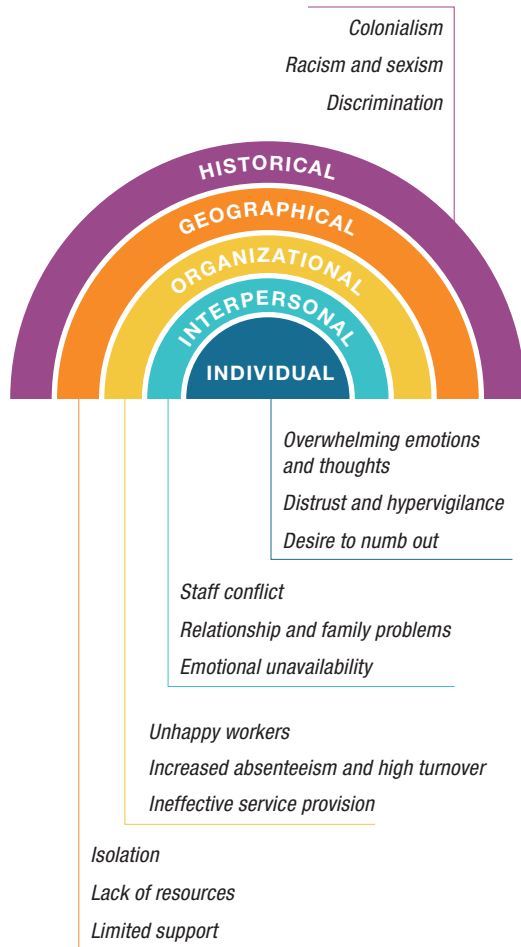
Geographical and Historical Context

Secondary trauma is even more complicated in Montana's most remote communities, particularly those that have been historically marginalized. Some of the providers Kelly and Colter interviewed are the only providers in an entire region, increasing their sense of isolation in their work. We must also never forget that the historical traumas of colonialism, racism, and structural discrimination form the backdrop against which many of us do our jobs. These inequalities can make secondary trauma even more potent. Clearly, the impact is complex. Social ecological models like the one on page 22 can help us organize the impacts of secondary trauma as they relate to separate but related contexts.

Resources

- *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others* (2009), by Laura van Dernoot Lipsky
- *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (2014), by Bessel A. van der Kolk

Social Ecological Context of Secondary Trauma



Tool 3

Weighing Risk Factors & Resiliency

“Victim service providers are asked, every day, to engage with people suffering tremendous pain. Without proper support, over time, this work can have a serious impact on their physical and mental well-being—that’s what we call ‘secondary trauma.’”

—Dr. Colter Ellis

What are the factors that put us most at risk of secondary trauma? The truth is, we don’t know for sure. Although we know more about secondary trauma than ever before, the science on the topic is still in its early stages. From the research that does exist, however, two important risk factors have surfaced: our exposure to trauma in the workplace, and our personal history of trauma.

Primary Trauma among Providers

In the course of Kelly and Colter’s research, a common theme emerged among victim service providers in Montana: For many of us, it was our personal histories of trauma that led us to pursue our current professions. Some of us were neglected or abused as children, while others have struggled with addiction or experienced domestic or sexual violence. In some cases, it

was not our firsthand experiences but rather the traumas of our loved ones—a mother’s broken bones at the hands of a boyfriend, a brother’s lost battle with heroin addiction, a friend’s struggles in the wake of a sexual assault—that led us into our chosen careers, hoping to offer the help that we could not then provide.

“I personally don’t think I could do the job if I hadn’t been a survivor. I understand why they go back. I went back.”

—An advocate for survivors of domestic and sexual violence in Montana

Regardless of the specific circumstances, it is important to consider how our personal histories and ongoing adversities may impact our work. On the one hand, personal experiences of trauma can be an occupational asset. They can make us better able to empathize with, protect, and advocate for the people who need our help. On the other hand, a history of personal trauma can be hazardous, as our heightened level of empathy with those suffering from experiences similar to our own may put us at a greater risk of secondary trauma.

Providers New to Trauma

While a history of primary trauma is common among providers, it is by no means universal. So what about those of us who came into our

work blind, armed only with a fierce desire to help others? A lack of exposure to trauma, while certainly fortunate in a personal sense, can present its own complications on the job. Our initial encounters with traumatized individuals may leave us feeling blindsided, overwhelmed, or inadequately prepared. We may even feel guilty for our own comparatively rosy pasts when confronted with the horrors faced by those we try to help. Regardless of our individual backgrounds, all providers are susceptible to secondary trauma—and if we are not paying close attention, we may end up suffering its effects without fully realizing it.

“You can’t do a lot of this work and not have it deeply affect you. The more compassionate you are, the more you empathize with your clients, and the more you actually care, the worse it gets.”

—A family law attorney in Montana

Resiliency

Given the many consequences associated with secondary trauma, it’s important to remember and care for the things that keep us resilient. What is resilience? In simple terms, it is the characteristics that help us “bounce back” after difficult experiences. To better understand resiliency, imagine a strong tree on a stormy day. The tree bends and sways against powerful gusts

of wind, held firmly upright by roots that run deep into the ground. In our work, the ability to bend and sway makes us resilient, allowing us to return to our true selves after enduring hardship.

Resiliency does not come to us magically, however. We have to cultivate it, both within ourselves and at our workplaces. When we consider the magnitude of the trauma we see each day in our work, the effort to build our resilience can be a lifelong process. Read on to *Section II: Self-Care* for tools designed to help you in this journey.

Resource

- “Vicarious Trauma and Resilience.” Published by the Office for Victims of Crime. Available at https://vtt.ovc.ojp.gov/ojpasset/Documents/VT_VT_and_Resilience_Training-508.pdf

SECTION II

Self-Care

Tool 4

Assessing for Secondary Trauma

“When regular tasks become burdens, when people around me seem to lack good intent, when everything becomes a responsibility instead of a pleasure—that’s when I know it’s time for me to intervene with myself.”

—Christina Powell

Because the research on secondary trauma is still developing, it can be difficult to assess the degree to which, if any, we may be experiencing its effects. Secondary trauma is particularly hard to address because, as mentioned in *Tool 3: Weighing Risk Factors and Resiliency*, some of us have been exposed to other forms of trauma—including primary, historical, and intergenerational trauma. Thus, it is difficult to know whether the symptoms discussed in *Tool 2: Recognizing the Consequences of Secondary Trauma* are a result of past traumas, of secondary trauma related to our work, or of other ongoing adversities in our lives. Interestingly, it could be the effects of all three interacting together that result in the constellation of symptoms and consequences described earlier in this book.

Questionnaires for Self-Assessment

Even though teasing apart the challenges we’ve experienced in our lives is difficult, researchers have tried to develop ways to assess secondary trauma and related concerns. A number of surveys and questionnaires are available online, most at no cost, that can help victim service providers measure the extent to which we may be suffering from secondary trauma. Several of these are listed in the “Resources” section at the end of this chapter.

In addition, on page 30 is a list of simple questions that may help us begin to think in a new way about our work, our coping strategies, and how our jobs may have changed us. As a simple first step in your self-care regimen, read through these questions and write down your answers. Then, six months from now, answer the questions again and compare your responses. Continue to do this every six months as you progress through your profession. We know from firsthand experience that it is not easy to make time to do this. Nonetheless, performing a self-assessment—either by answering the questions on page 30 or by completing one of the questionnaires listed in the resources—will typically take no more than 15 minutes, and setting a schedule to do this will help you track any changes you are experiencing over time.

Simple Questions to Begin Assessing Secondary Trauma:

- Why did you get started in this line of work?
- What effects does the work have on you?
- What do you do after a particularly difficult day at work?
- How do those close to you, namely your family and friends, think your work affects you? (Consider asking them directly.)
- What might help strengthen your resiliency?

Organizational Responsibility

A note to organizational leaders in the provider fields: Consider making assessments of secondary trauma a priority by setting aside a regular and recurring time for providers to answer questions about their levels of secondary trauma. These assessments may take the form of a solitary or a group activity. In reference to the questions above, for example, employees might be asked to write down and reflect on their answers as a measure of self-assessment, or the questions might be used to facilitate a discussion among a group of providers.

For workplaces that take up this challenge, it is critical to honor your employees' right to privacy. Remind providers that their answers to questions about secondary trauma are for their

eyes only. In cases where an organization does wish to collect survey responses from employees, those answers should be submitted voluntarily and anonymously, with the employer using averages or other means of summarizing results at the group level. Group discussions on the subject of secondary trauma should also be voluntary. This will protect providers from feeling like their jobs are in jeopardy if they disclose that they are suffering from the effects of secondary trauma.

Most importantly, once you've encouraged your employees to assess their exposure to secondary trauma, make sure you have a plan in place to help those who feel they are exhibiting symptoms. The remaining tools in this book can help you do just that.

Remember, secondary trauma is a normal but unfortunate response to repeated empathetic engagement with traumatized populations. As discussed in *Section III: Organizational Response*, secondary trauma is a workplace issue. It is an occupational hazard, not a personal failing of providers or their self-care routines. Providers should never feel blamed or judged for what is a normal byproduct of their work.

Resources

The surveys and questionnaires listed below can be accessed online, most of them at no cost.

Free for Personal Use

- **Secondary Traumatic Stress Scale (STSS)**
This instrument is designed to help providers assess whether they are experiencing symptoms associated with secondary trauma.
https://www.naadac.org/assets/2416/sharon_foley_ac15_militarycultureho2.pdf
- **Professional Quality of Life Scale (ProQol)**
The ProQol is designed to help those in the helping professions assess three areas: compassion satisfaction, secondary traumatic stress, and burnout.
http://www.proqol.org/ProQol_Test.html
- **PTSD Checklist for DSM-5**
This checklist is meant to diagnose individuals who may be suffering from post-traumatic stress, but it may also prove helpful to providers in assessing their own symptoms related to secondary trauma.
<https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>
- **Adverse Childhood Experience (ACE) Questionnaire**
This brief survey is intended to help individuals determine the degree to which

their childhood experiences put them at risk of problems later in life.

<https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>

Available for a Fee

- **Maslach Burnout Inventory (MBI) & Areas of Worklife Survey (AWS)**
A combination of two well-respected questionnaires, the MBI and AWS measure provider burnout and the qualities of a workplace that may contribute to or reduce the chances of burnout among staff. A costly but useful survey, this is a good option for organizations that wish to create a long-term program to measure and address secondary trauma among providers.
<http://www.mindgarden.com/184-areas-of-worklife-survey-maslach-burnout-inventory>
- **Trauma and Attachment Belief Scale (TABS)**
This measure was designed for individuals who have experienced firsthand trauma, but it may also prove useful for those at risk of secondary trauma.
<https://www.wpspublish.com/store/p/3011/tabs-trauma-and-attachment-belief-scale>

Tool 5

Cultivating Mindfulness

“Noticing the breath is a simple, effective, and nonintrusive personal intervention that can be done anytime and anywhere.”

—Erin Clements

What can be done to offset the effects of secondary trauma? We believe that learning to cultivate mindfulness is a good place to start. As defined by Jon Kabat-Zinn, founder of the Mindfulness-Based Stress Reduction program at the University of Massachusetts Medical School, mindfulness is “awareness that arises through paying attention, on purpose, in the present moment, non-judgmentally. It’s about knowing what is on your mind.”

Mindfulness and Secondary Trauma

Why is mindfulness relevant to the topic of secondary trauma? Because, as discussed in *Tool 2: Recognizing the Consequences of Secondary Trauma*, emotional numbness is a common symptom for victim service providers struggling with its effects. For those of us working with traumatized populations, we can hear only so many stories of pain and suffering before we begin to look for ways to mentally escape. In Kelly and Colter’s research in Montana, providers

reported drinking too much, watching too much television, and binge-eating to cope with the toll of their work. These attempts at shutting down can make it difficult to address the many effects of secondary trauma, as we must be emotionally present in order to recognize and successfully work through them.

“You don’t get to selectively numb. So if you’re going to numb out your sorrow, you’re also going to numb out any possible happiness you can have. If you are going to numb out the heartbreak, you’re going to numb out any ability to survive noticing what is beautiful.”

—Laura van Dernoot Lipsky, founder and director of the Trauma Stewardship Institute

Numbing can also prevent us from being effective providers. Distancing ourselves from our experiences robs us of our ability to be truly present with those we are trying to help. Additionally, as Laura van Dernoot Lipsky emphasizes in her 2015 TEDx presentation (see “Resources” for a link to that video), “If you are numb, you will not be able to gauge whether or not you are doing harm.” This is, of course, the opposite of what those of us in the helping professions want to do.

Cultivating mindfulness is a way to gently guide us back to the present moment. Eventually, it may allow us to find quiet in

an otherwise stressful day, notice and slow down our racing thoughts, and attend to the consequences of secondary trauma. With just a few dedicated minutes a day, you can establish a mindfulness practice that may help you reconnect with yourself and your work with clarity and intention.

Cultivating a Practice, with Caution

Learning to cultivate mindfulness can be a great tool. With practice, it can bring us a sense of peace and feel restorative. Sometimes, however, mindfulness can increase our awareness of unpleasant emotions, memories, and sensations. For example, we may begin to notice aches from old injuries or recall painful incidents that we have been unconsciously avoiding.

It is important to remember that mindfulness is like exercise—it takes practice. Start slowly, and consider seeking support from a skilled mindfulness practitioner who is trained in trauma. Should difficulties arise in your mindfulness practice, we encourage you to read *Tool 6: Restoring the Nervous System* to learn ways to work through the normal but sometimes unpleasant sensations that can surface during mindful meditation for individuals who have experienced secondary trauma.

Practicing Mindfulness of Breathing

Practicing mindfulness of breathing is a technique that has been studied for decades and practiced for centuries. Our friend Dr. Floyd Fantelli, a retired surgeon and meditation trainer in Bozeman, offers step-by-step instructions on the following pages for mindfulness of breathing. Try practicing this for 10 to 15 minutes daily.

Resources

- *Mindfulness in Plain English* (2011), by Bhante Henepola Gunaratana
- Meditation exercises by Dr. Floyd Fantelli are available for download at <http://bozemaninsightcommunity.com/category/dharma-talks>.
- “Beyond the Cliff.” Presentation by Laura van Dernoot Lipsky from the 2015 TEDx Conference. Video available at <http://traumas-tewardship.com/watch/#ted>.
- Insight Timer is a free meditation app that can help you establish a mindfulness practice. Available for download at <https://insighttimer.com>.

Mindfulness of Breathing Technique

SETTLE

Settle into a comfortable sitting position. ►

Close your eyes, either partially or completely. ►

Soften the muscles in your face and around your eyes. Soften your shoulders, your arms and hands, and your legs. ►

Sit with an erect but relaxed posture. ►

Take several deep breaths to help you become aware of the sensation of breathing. Then allow your breath to flow in its normal, ever-changing manner. ►

Choose to pay attention to your breath either at the tip of your nose or the rims of your nostrils, in your chest or abdomen, or wherever the sensations are the clearest. Once you make a choice, stick with it throughout the period of meditation. ►

Continue to keep your awareness focused on the sensations of the breath flowing in and flowing out. If watching the breath at the tip of your nose, notice the sensations in this area of your body as you inhale and as you exhale.

BREATHE

Now become aware of all aspects of the breath. We do this by focusing our attention on the different parts of the breath. Each breath has a beginning, a middle, and an end. ►

For the in-breath, pay attention to the beginning, middle, and end. ►

Notice the space between the in-breath and out-breath. ►

Pay attention to the out-breath beginning, middle, and end. ►

Notice the space between the out-breath and in-breath. ►

Now simply wait peacefully for the next in-breath to arrive. ►

Bring awareness to the peace that exists in every breath you take. ►

Now put all of your awareness on the entire circle of breath—in-breath, space, out-breath, space.

RETURN

Your attention will wander away from the breath. When it does, notice it and appreciate that moment of noticing, of waking up and being mindful. ►

Then gently return your attention to the breath and continue to follow it. Do not make any comments or judgments—just gently return your attention to the breath. ►

When you are able to stay in contact with the sensations of breathing, you may notice when you are breathing a short breath and when you are breathing a long breath. ►

As your awareness of the quality of each breath becomes clearer, you may also begin to notice for yourself whether the breath stays the same or whether it is constantly changing. Each breath is different from the one before. ►

Now let your breath calm itself. Just let the breath breathe on its own. Breathing is none of your affair. Thoughts are none of your affair. When we become aware of the wandering mind, we gently bring awareness back to the breath with kindness and gentleness—without judgment or commentary. ►

Continue with this meditation until your sitting period is over.

Tool 6

Restoring the Nervous System

“Learning how trauma is stored in the body and the strategies for safely processing traumatic experiences has made me a better therapist, advocate, and supervisor to our volunteer victim advocates.”

—Alanna Sherstad

As discussed earlier in this book, the consequences of secondary trauma can be both mental and physical, and as victim service providers it is important for us to track and manage what’s happening in our bodies. To do this, we can borrow techniques from an approach developed by Dr. Peter Levine called Somatic Experiencing® Trauma Resolution (sometimes called SE for short). Somatic simply means “body-oriented,” reflecting this approach’s core belief that trauma is something that imprints on the body as well as the mind.

SE is used around the world to treat trauma. Typically, it is clinicians who learn to use SE as part of their advanced training. For the purposes of this book, however, Kelly and Colter have worked with Dr. Abi Blakeslee, a faculty member at the Somatic Experiencing® Trauma Institute, to adapt a small part of the SE training program to help Montana providers prevent and reduce the consequences of secondary trauma.

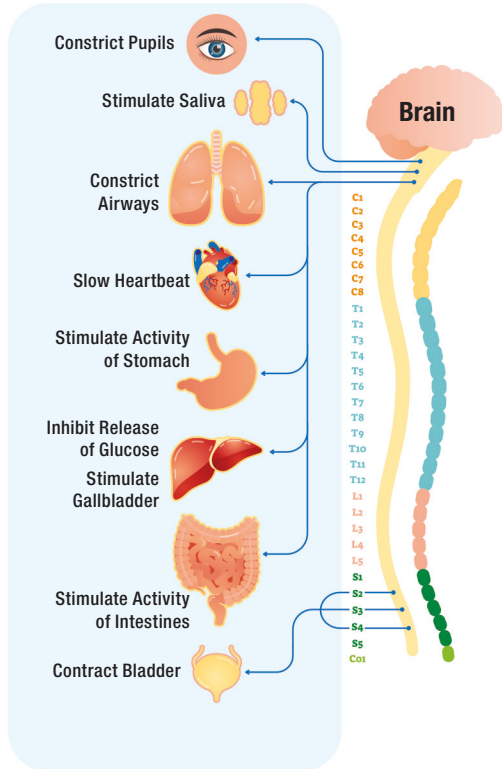
A Brief Introduction to Somatic Experiencing®

The concepts behind SE draw from neuroscience research exploring our involuntary physiological response to trauma. This research shows that our brains and bodies react to highly stressful or threatening situations much in the same way as animals do—namely, “flight, fight, or freeze,” sometimes called the defensive threat response cycle. Despite our similarity to other animals in this respect, humans seem to be unique in how the effects of our exposure to trauma can linger long after a triggering event. Dr. Levine was particularly interested in why wild animals, unlike humans, can quickly resume their normal activities after a traumatic experience. Think, for instance, of an elk calmly grazing in a field only minutes after being chased by a grizzly bear. Why can’t we do that?

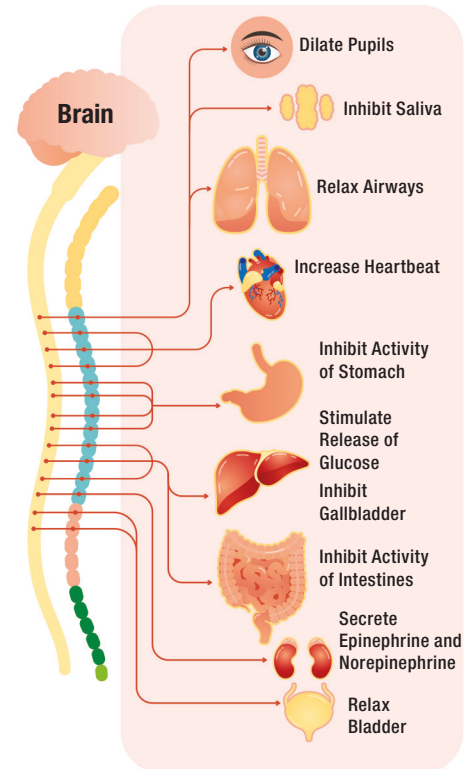
Dr. Levine concluded that the answer lies in the involuntary regulation of our autonomic nervous system (ANS). The ANS includes the sympathetic nervous system (SNS)—responsible for mobilizing energy during an emergency, including triggering key parts of the body’s defensive threat response cycle—and the parasympathetic nervous system (PNS), which controls the body’s reactions during times of resting and digesting. The PNS can also activate a “freeze” response in the face of a perceived threat.

Human Nervous System

Parasympathetic Nerves



Sympathetic Nerves



From the perspective of SE, trauma is not held in the event but in the nervous system. During a traumatic event, the body springs into action, with the SNS triggering a defensive threat response. After the threat has passed, the gentle PNS can return the body to its baseline after high surges of stress hormones. This often takes the form of trembling or the feeling of heat releasing. This natural cycle allows our bodies to return to a state of calm. From this relaxed and restored place, our physiology will indicate to us that the event has passed.

Unfortunately, the human brain often gets in the way. After a traumatic event, certain parts of the brain may suppress this involuntary process, thus disrupting the natural chain of reactions that allows our brains and bodies to return to their normal states. By tracking our physical sensations and how they relate to our experiences of trauma, SE helps us “complete” the interrupted process of the ANS.

Secondary Trauma and the Somatic Experiencing® Perspective

Our work as providers—particularly the task of listening and responding to the traumatic experiences of others—can activate our own defensive threat response cycle, even though we are not in actual danger. Therefore, to build our resiliency, we need to train ourselves to recognize our ANS threat response and get out of survival mode when it is not needed. Doing so

requires us to increase or expand what is called our “window of tolerance”—or the resilient zone for a nervous system, wherein it is moving optimally between arousal and settling—and learn when we have left the window and gotten stuck in an instinctual survival response.

Fortunately, paying attention to our nervous systems can help us track where we are in the window of tolerance and warn us when we are about to leave it. For example, we can learn to recognize when our SNS is activating a defensive threat response by looking for specific symptoms, like a racing heart, tense muscles, and rapid breathing. Likewise, we can learn to recognize when our PNS is attempting to shut us down into freeze by noticing other symptoms, such as low energy, numbness, and a sense of being disconnected from what is happening in the present moment.

Exercises

To track your position in the window of tolerance and restore your nervous system, ask yourself, “What is happening in my body right now?” If you sense symptoms like those listed above and suspect you may soon be kicked into survival mode, practicing the following five exercises can help you stay in the window.

- 1. Orienting:** Take a moment to look around. Notice what your eyes are drawn to that is pleasant. Take time to notice the light

and colors in the present moment. This can send signals to the brain that the threat, perceived or real, has passed. It may bring you out of a state of anxiety or a sense of fog. Afterward, take note, if you can, of the specific areas in your body that feel better. Does your chest feel more open? Do your shoulders feel more relaxed? Saying those things, either in your mind or out loud, can be helpful. Try to find positive words to describe how you feel better. Instead of “less tight,” for example, you can say “more relaxed,” which will often lead to more relaxation.

2. **Grounding:** Feel the areas of your body that are most connected to a physical sensation of heaviness. If you are seated, for example, you can ask yourself, “Do I feel more weight in my feet, my seat, or my back?” When we are in a fight, flight, or freeze state, we often lose connection to the calming, weighted presence of our legs. Again, afterward, take note if you feel more relaxed and describe the ways in which you feel better. Tell yourself, in your mind or out loud, where you feel those sensations of “betterness” in your body. For example, “I feel weight in my legs and more aliveness in my chest.”

3. **Self Contact:** Place your hands somewhere on your body that feels comforting and find a weight or pressure that feels calming. Some people like to place their hands together in front of them; rest them on their upper legs, chest, or stomach; or place one hand on the chest and the other on the stomach. You can also try placing your right hand under your left arm and then wrap your left arm around to your right shoulder. This can increase the feeling of being able to “hold” strong emotions. Now track how your body reacts to this pose. Where in your body do you feel different? Do any deep breaths occur on their own? Let any sensations of shakiness, heat, or vibration move through your body. Allow these sensations to just happen. Do not inhibit them, as they may be signs that your body is naturally coming out of a defensive threat response. Permitting these sensations to ripple through you can help your nervous system reset and prepare itself for the next thing that it needs to respond to. If you feel better, tell yourself, in your mind or out loud, what sensations changed and where you feel those changes in your body.

4. Movement: Notice where you feel uncomfortable in your body. Say to yourself, in your mind or out loud, what sensations feel uncomfortable and where they are occurring. For example, “My chest feels tight. The tension is in the shape of a tennis ball.” Allow your body to move, slowly and gently, in a way that feels comforting. Some people like to tap their feet or rock gently back and forth. Slow movements, rather than fast ones, are better for regulating the nervous system. Take some time and really feel the pleasantness of the movement. Then check back after a few minutes to see if you feel better in the area where you were uncomfortable before.

5. Visualization: If your defensive threat response is being activated by the memory of a situation where you wanted to fight or flee but could not, it may be helpful to visualize yourself as an animal who is facing the same situation but is able to run away or fight to protect itself. Imagine what your animal body would like to do in that situation. For example, you could picture yourself as an antelope swiftly escaping a pack of coyotes or a bear fiercely protecting herself and her cubs. Try slowly enacting these movements. Then, notice how they are connected to the threat response of fight or flight. Afterward, see if you feel

more whole and connected. If so, say to yourself, in your mind or out loud, how you feel better in your body.

With practice, these exercises will help your body move toward what is called self-regulation. Over time, you will have a greater capacity to deal with the chronic stressors associated with your work.

Resources

- *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness* (2010), by Peter A. Levine
- *Building Resilience to Trauma: The Trauma and Community Resiliency Models* (2015), by Elaine Miller-Karas
- Website for the Somatic Experiencing® Trauma Institute. Available at <https://traumahealing.org>.

SECTION III

Organizational Response

Tool 7

Running Better Meetings

“The longer you do the work, the more meetings you have. Sometimes entire weeks are filled with nothing but meetings! Rather than focusing on just what we do for work, I’ve learned to prioritize how we do that work. At the Montana Coalition Against Domestic and Sexual Violence, we’ve developed our meeting spaces to be more intentional, connected, and adaptive to different work styles. We place a high priority on getting things done efficiently while also caring for one another, building relationships, and celebrating our progress.”

—Kelsen Young

Meetings—love them or hate them (and let’s be honest, for most of us it’s the latter)—are an inescapable part of our jobs. For many, it’s the drawn-out and directionless nature of many meetings that makes them so unbearable. But for victim service providers, meetings can be problematic in a different way, as the unrecognized effects of secondary trauma can erode and sour our interactions in the workplace. Without clear intentions and mindful participation, meetings among providers can easily devolve into opportunities for us to lash out at our coworkers, “slime” them by blurting out the

details of our most disturbing cases, or engage in games of one-upmanship over whose cases are most difficult.

Fortunately, meetings offer us a unique opportunity to put our knowledge about secondary trauma, mindfulness, and our nervous systems to good use. Mindful participation in meetings takes effort, but with work it can reap benefits at both the individual and organizational levels.

Below is a list of tips we can use to make meetings more productive, more succinct, and—hopefully!—more enjoyable.

Tip 1: Show Up and Be There

This tip may sound easier than it actually is. The first step is this: show up, be on time, and stay until the meeting is over. Avoid ducking out. If you absolutely have to leave early, let someone (or everyone) know why. But just showing up is not enough. You also have to really be there. As providers, we often have a multitude of thoughts occupying our minds. It can be difficult to focus during meetings while more pressing issues await. Nonetheless, it is important for providers to temporarily set aside our outside concerns and be mentally present and attentive at meetings. Why are these simple ideas so important? Because showing up and really being there sends the message that we care. It sets the tone for mutual respect among colleagues and, in the longer term, creates

a work culture that values everyone's time equally. As providers, time is something that we never have enough of. We need all the time we can get—time to help others and time to help our nervous systems return to baseline. The last thing we need is to be wasting time in unproductive meetings that leave us feeling disrespected and frustrated.

Tip 2: Model Mindfulness Using Silence

Begin and end each meeting with a minute or two of silence. At first, this may feel strange, but the benefits will quickly become evident. Don't be surprised if your colleagues push back. After all, they are busy! They may initially think, "Why waste one or two precious minutes in what seems like uncomfortable silence?" Experience, however, has shown that our work can be chaotic and hectic. Often, as we sit down for a meeting, our minds are spinning. A moment of silence gives us the time we need to really arrive and be fully present. It also provides an opportunity to practice the habit of cultivating mindfulness, the benefits of which are discussed in *Tool 5: Cultivating Mindfulness*. Trust us—a couple minutes of silence, while awkward at first, may soon become your favorite part of a meeting.

Tip 3: Really Take Your Seat

Avoid slumping or slouching in your seat. Instead, sit upright and let your seat really support you. Plant your feet firmly on the ground. This demonstrates to others (and to your own brain) that you are prepared to engage in the meeting. Consider this group exercise: At the beginning of a meeting, ask everyone to stand up and then sit down again. Invite them to notice the body language of everyone in the room. Then ask everyone to stand up once more and say to them, "Now really take your seat!" Notice the difference.

Tip 4: Step Forward or Step Backward

In a meeting, are you a talker? Or are you more of a listener? This is an important thing to know about yourself and about your colleagues. If your tendency is to talk frequently during meetings, try to step back just a bit and be mindful of the involvement of others. This can be accomplished by practicing the "rule of three," or waiting for three people to speak before you rejoin the conversation. This ensures that everyone has an opportunity to have their voice heard. If you are on the shyer side, try to step forward by giving everyone the opportunity to hear your voice. Your colleagues will undoubtedly want to learn the wisdom you have gathered from all that listening.

Tip 5: Be Lean in Expression

When speaking, attempt to convey your point in a concise and direct manner. You may elaborate and clarify as needed, but remember that there is no need to repeat the same idea in different ways.

Tip 6: Limit “Sliming”

As providers, we often hear about or witness upsetting events, and it is only natural to wish to unload some of the weight of this knowledge onto others. We refer to this tendency as “sliming,” wherein we dump all the gruesome details of a case or event onto someone else, frequently a coworker, and often without that person’s consent. While in meetings, it is important that we limit sliming by sharing only the necessary amount of information about an unsettling case or incident. For a more in-depth discussion of this topic, see *Tool 8: Implementing Low-Impact Debriefing*.

Tip 7: Avoid Distractions and Allow Distractions

While it may seem contradictory, allowing distractions may be beneficial to our mental preservation. Activities such as doodling or tuning into the sights and sounds of the room can help alleviate some of the distress brought on by difficult topics. Do note, however, that while engaging in idle distractions may be useful for some, it may cause others to lose

focus entirely. It is therefore important to use personal judgment when deciding to allow or avoid distractions. Most importantly, when you are speaking during a meeting, bear in mind that coworkers who are allowing distractions are not necessarily being disrespectful but rather may need some separation from the topic.

Tip 8: Provide Strong Agendas

If you are in charge of a meeting, prepare a strong agenda beforehand and distribute it to attendees before gathering. Include an outline of topics to be discussed, as well as a start and an end time. The end time is particularly important to include, as providing a set period of time for the day’s business will keep the meeting progressing and give attendees a sense of relief in knowing when things will conclude.

Tip 9: Honor Confidentiality (but Do Not Promise It)

One antidote to trauma is trust. Whenever possible, honor confidentiality. Personal stories—either those of coworkers or of clients and cases—should remain between those attending the meeting. This helps create a sense of safety and encourages providers to participate openly. That said, it is very difficult to ensure strict confidentiality at a meeting. Rather than making a promise you cannot keep, ask everyone to honor confidentiality but remind them that you cannot control what is actually

said outside of the meeting. Acknowledging this tension will help colleagues learn what should and should not be said in a meeting and ultimately help reduce conflicts later on.

Tip 10: Create a Comfortable Space

Meetings are far more pleasant for everyone involved if they are held in a comfortable space. If you are in charge of a meeting, attempt to find a location that's big enough to accommodate everyone. Good ventilation and lighting are also ideal. At the start of the meeting, ask attendees whether the room feels too cold or too hot. Make adjustments to the temperature by opening or closing windows or tweaking heating or air conditioner settings. In addition, make access to the doorway unobtrusive. Provide food and refreshments when possible, but avoid unwittingly giving attendees time to over-caffeinate, which can make some of us agitated.

Tool 8

Implementing Low-Impact Debriefing

“There’s an old saying that goes something like, ‘Don’t break the silence unless you can improve it,’ which is what comes to mind when we talk about debriefing. I’m guilty of bursting into coworkers’ offices to vent about tough cases and just unload. It’s hard to be aware of how others are feeling when you’re so overwhelmed with your own stuff. Just because I need to get something off my chest doesn’t mean that another person needs to take it all on—and vice versa. There’s a balance to be found between being there for one another and not causing harm to those we turn to.”

—Anna Saverud

In this tool, we draw heavily from Françoise Mathieu’s *The Compassion Fatigue Workbook*, specifically the chapter titled “Low-Impact Debriefing: How to Stop Sliming Each Other.”

Debriefing is an indispensable tool that may help mitigate the consequences of secondary trauma among victim service providers. Research has shown that social support can act as a deterrent to stress and other negative outcomes, so it’s no wonder that many of us derive comfort from talking to someone after a

particularly difficult case or incident. In most workplaces, debriefing can happen informally (chatting with a coworker in the lunchroom) or formally (talking with a supervisor at a set time).

Additionally, debriefing is a critical tool because we are often unable or unwilling to share stories outside the workplace. In Kelly and Colter's research in Montana, providers reported feeling that they could not talk with friends and loved ones about their experiences at work. This is typically due to a combination of confidentiality issues and the fact that the particulars of our jobs are too disturbing for others to want to hear. Thus, without the option of debriefing with our colleagues, we risk feeling isolated and shut down.

Slim Your "Slime"

Some forms of informal debriefing can have a negative effect on the listener, particularly if that person is unprepared to receive the information or is already feeling overwhelmed by their own cases. Have you ever had a coworker stop you for a quick chat in the hallway, only to blurt out the graphic details of a case? Or perhaps you have found yourself inadvertently offering a play-by-play account of a particularly gruesome incident to a colleague over lunch? As mentioned in *Tool 7: Running Better Meetings*, we call this practice "sliming"—an appropriate term to describe how, much like a sneeze can transfer germs, the passing on of disturbing

information can "contaminate" the listener. Though the urge to share in this manner is understandable, sliming can contribute to secondary trauma among groups of providers and create a climate of cynicism and hopelessness in the workplace.

Finding Balance with Low-Impact Debriefing

So if sliming is off-limits but debriefing is key, what's a provider to do? Formal debriefings are one option, as they typically involve a controlled debriefing procedure with trained personnel. Formal debriefings are time-sensitive, however, and need to occur soon after the traumatic incident. What's more, Montana's rural communities often lack the personnel needed for formal supervision, meaning that formal debriefings are not an option for many of us.

Because of this, many providers and the organizations that employ us are turning to low-impact debriefing (LID). By forcing us to be conscious of how much detail we need to share in order to experience a sense of relief, LID can offer the same comforting effects of sliming while decreasing the risk of traumatizing the listener.

Familiarize yourself with the following four key components of LID: self-awareness, fair warning, consent, and limited disclosure.

1. **Self-Awareness:** Being self-aware means taking the time to assess the intensity of the topic you want to discuss. Consider its effects on you, and think about what details need to be shared in order for you to feel less burdened. With increased awareness, you can reduce the sliming effect your story may have on others.
2. **Fair Warning:** Before you share your story, warn the listener about the seriousness of what you are about to divulge. You may even announce the general focus of the story (for example, child abuse, sexual assault, or fatal injury). This gives the listener the opportunity to prepare to receive the unsettling information and determine if it will resonate with any personal vulnerabilities. The way we hear information greatly affects how we process it. Being prepared gives us the opportunity to ground ourselves and decreases the potential for negative impact.
3. **Consent:** Immediately after providing fair warning, ask the listener if they consent to hearing the story. Some listeners may say no, and that is OK. As providers, sometimes we can only handle so many difficult stories in the course of a day. If the listener provides consent, start sharing with the “outer circle” of information—that is, the general gist of the story. Provide more details only if the listener asks for and is ready to hear them.

4. **Limited Disclosure:** You might not need to share all the graphic details of a traumatic incident to find relief. Ask yourself two questions before sharing: What do I really need to share to feel better? How many details can this listener handle?

Resource

- *The Compassion Fatigue Workbook: Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization* (2012), by Françoise Mathieu

Tool 9

Connecting with Others

“Knowing myself and knowing why and how others on my team behave has helped me improve communication, job satisfaction, and efficiency.”

—Richard McLane

In this book, we have talked about awareness, self-care, and organizational response. Ultimately, we hope that these tools help expand the conversation about the importance of addressing secondary trauma in the workplace. In this final tool, we want to encourage you to connect with your colleagues and share what you’ve learned.

Connect with Colleagues

For us, one of the best parts of this project has been getting the chance to meet each month, share a simple meal, and learn from our collective experiences of trying to manage secondary trauma in the organizations we lead. Occasionally there were tears, but mostly there was laughter. If you make a similar effort to meet and share stories with others in your community who work with trauma, you might be surprised by how significant these conversations become for you.

Remember Limitations

Secondary trauma in the workplace is complex, and the tools we have presented are just the beginning. Our friend Robyn Morrison—who works as a coach and organizational development consultant to reduce secondary trauma in organizations in Helena and elsewhere—has taught us that there is no one-size-fits-all answer for how to best attend to self-care and the care of our organizations. With this in mind, it will be worthwhile to remember some limitations to the tools in this book:

- **Section I: Awareness** is intended to help us better understand secondary trauma. The three tools in this section explain the different types of trauma, the physical and emotional consequences of secondary trauma, and the things that put us most at risk of suffering its effects. The research on secondary trauma, however, is still in its early stages. Studying secondary trauma is especially challenging because different forms of trauma—primary, secondary, intergenerational, and historical—and their symptoms often overlap. Nonetheless, knowing our own histories of trauma and the effect our pasts can have on our work is an excellent place to start.

- **Section II: Self-Care** consists of tools to help us mitigate the effects of secondary trauma and increase our resiliency. The first tool in this section provides resources to assess and measure our exposure to secondary trauma and how it may be changing us over time. This tool does not, however, discuss the importance of evaluating our personality styles and those of our team members, which can impact how we respond to stress and secondary trauma. The second and third tools in this section explore mindfulness and restoring our nervous systems. Some of us will find these tools useful, while others may think they are silly. Similarly, meditation and Somatic Experiencing® may work for us at one point in our lives but less so at other times. We think that is OK. In this book, we use the metaphor of a toolkit for good reason—we encourage you to use the tools that are helpful and set aside those that are not.
- **Section III: Organizational Response** contains tools that organizational leaders can use to improve the work environment for providers and that providers can use to improve their own work environments. That includes changing the way we hold meetings and learning better ways to debrief. It's important to remember, however, that a great meeting is one that intentionally

accommodates the personality styles of everyone. For example, some styles are more direct in their communication, while others are indirect. Some focus on people and issues related to people, and some prefer to focus on tasks. One person may love to brainstorm, whereas another prefers to just get things done. We cannot assume that everyone will conform to the meeting style we describe in this book. Likewise, low-impact debriefing may not work in all settings. Use these tools as a starting point. Over time, you and your organization may develop different ways to help providers interact with one another.

Share Accountability

Providers cannot remedy secondary trauma alone. Even the best self-care is not enough. In Kelly and Colter's research, they often heard stories from providers who felt bad about themselves for exhibiting symptoms like those discussed in *Tool 2: Recognizing the Consequences of Secondary Trauma*. This is unacceptable. Secondary trauma is not something that can be solved with a bubble bath, a pedicure, or even the occasional day off. The sooner we accept secondary trauma as an occupational hazard, the sooner we can stop feeling guilty about the unfortunate but incredibly common ways our jobs affect us.

Recognizing and addressing secondary trauma as an occupational hazard requires a commitment on the part of both individual providers and our employers. The tolerance for conflict and abuse at the workplace needs to be lower—and investment in organizational processes designed to respond to, and even prevent, the ill effects of secondary trauma is essential. With time, these interventions may help increase the quality of care we provide to our communities and lower instances of staff turnover.

Commit to the Cause

At the end of the day, secondary trauma is not something we can walk away from. We need our jobs, and our jobs need us. Whether you are an individual working for a large organization or the boss of a two-person team, remember that though addressing secondary trauma is a complex process, we can all do our part to bring awareness to the issue and begin to implement changes to address it.

Cultures don't change through a single workshop (or toolkit). Organizations must stay committed to this issue. We hope you will join us in this commitment. Train others. Build awareness. Hold yourself and your organizations accountable. And by all means—share this book!

Resource

- Robyn Morrison is a coach and consultant, a certified professional behavior and motivator analyst, and a value-added associate with Target Training International. Visit her website at <http://robynmorrison.com>.

Selected Bibliography

Bozeman Insight Community, & Fantelli, F. (2018). Resources. Retrieved from <http://bozemaninsightcommunity.com/category/dharma-talks/>

Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: Solution Tree Press.

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*(1), 27-35.

Brokenleg, M. (2012). Transforming cultural trauma into resilience. *Reclaiming Children and Youth, 21*(3), 9-13.

Center for Disease Control and Prevention. (2018). Adverse Childhood Experiences (ACEs) Study. Retrieved from <https://www.cdc.gov/violenceprevention/acestudy/index.html>

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*(1), 75-86.

Ellis, C., & Knight, K. E. (Forthcoming). Toward a model of secondary trauma: Consequences for victim service provision. *Journal of Interpersonal Violence*.

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*(1), 25-36.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

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). Baltimore, MD: Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441.

Foundation for Human Enrichment. (2018). Somatic Experiencing Trauma Institute. Retrieved from <https://traumahealing.org>

Freud, S. (1988). The future prospects of psycho-analytic therapy. In B. Wolstein (Ed.), *Essential papers on countertransference* (pp. 16-24). New York: New York University Press. (Original work published 1900)

Gilmartin, K. M. (2002). *Emotional survival for law enforcement: A guide for officers and their families*. Tucson, AZ: E-S Press.

Gunaratana, B. H. (2011). *Mindfulness in plain English*. Somerville, MA: Wisdom Publications.

Heart, M. Y. H. B., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8(2), 56-78.

Heavy Runner, I. (2003). 'Miracle Survivors': Promoting resilience in Indian students. *Tribal College Journal of American Indian Higher Education*, 14(4), 15-17.

Heavy Runner, I., & Morris, J. S. (1997). Traditional native culture and resilience. *Center for Applied Research and Educational Improvement Research/Practice Newsletter*, 5(1), 28-33.

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(2), 83-91.

Insight Network, Inc. (2018). Insight Timer. Retrieved from <https://insighttimer.com>

Knight, K. E., Ellis, C., Murphy, S. T., Olson, H. N., Wagner, G. G., Dion T., & Gemar, R. (2018). Vicarious victimization and related forms of secondary traumatization. In B. Huebner (Ed.), *Oxford Bibliographies in Criminology*, New York: Oxford University.

Leiter, M. P., Maslach, C. (2000). Areas of Worklife Survey. Retrieved from <https://www.mindgarden.com/274-areas-of-worklife-survey>

Levine, P. A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. Berkeley, CA: North Atlantic Books.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, 2(2), 99-113.

Maslach, C., Jackson, S. E., Leiter, M. P., Schaufeli, W. B., & Schwab, R. L. (1996). Maslach Toolkit for General Use. Retrieved from <http://www.mindgarden.com/184-areas-of-work-life-survey-maslach-burnout-inventory>

Mathieu, F. (2012). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization*. New York: Routledge.

Miller-Karas, E. (2015). *Building resilience to trauma: The trauma and community resiliency models*. New York: Routledge.

National Center for Post-Traumatic Stress Disorder. (2013). PTSD Checklist for DSM-5 (PCL-5). Retrieved from <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

National Council of Juvenile and Family Court Judges. (1998). Adverse Childhood Events (ACEs) Survey. Retrieved from <https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>

Office of Victims of Crime. (2017). The vicarious trauma toolkit. Retrieved from <https://vtt.ovc.ojp.gov>

Pearlman, L. A. (2003). Trauma and Attachment Belief Scale™ (TABS™). Retrieved from <https://www.wpspublish.com/store/p/3011/tabs-trauma-and-attachment-belief-scale>

Pearlman, L. A. (2003). *Trauma and Attachment Belief Scale*. Los Angeles: Western Psychological Services.

Richardson, J. I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. Ottawa, ON: Public Health Agency of Canada, National Clearinghouse on Family Violence.

Saakvitne, K. W., Pearlman, L. A., & Abrahamson, D. J. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W. W. Norton.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers. *Clinical Psychology Review*, 23(3), 449-480.

Sansbury, B. S., Graves, K., & Scott, W. (2014). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma*, 17(2), 114-122.

Sotero, M. M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, 1(1), 93-108.

Stamm, B. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: The Sidran Press.

Stamm, B. H. (2010). *The Concise ProQOL Manual* (2nd ed.). Pocatello, ID: ProQOL.org.

van der Kolk, B. A. (2014) *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York: Viking.

van Dernoot Lipsky, L. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. Oakland, CA: Berrett-Koehler.

van Dernoot Lipsky, L. (2015). Beyond the Cliff [Video file]. Retrieved from <http://traumastewardship.com/watch/#ted>

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov/mastewardship.com/watch/#ted



Authors

Erin Clements

Colter Ellis

Kelly E. Knight

Richard McLane

Katharine Osterloth

Christina Powell

Anna Saverud

Alanna Sherstad

Amy Katherine Talcotta

Kelsen Young
