Resources

Continuing the Conversation:
An Expert Panel on Solutions for Addressing Secondary Traumatic Stress

Presented at the 37th International Symposium on Child Abuse, March 25, 2021
By members of the Secondary Traumatic Stress Consortium

Contact us: To reach individual members of the STS Consortium please visit our "about us" page: **https://www.stsconsortium.com/who-we-are**

Impact of the pandemic on the CAC world:

Covid-19 Resources (including downloadable infographics):

https://www.tendacademy.ca/covid19/

TEND Covid-19 Articles:

This is a Marathon, Not a Sprint: Strategies to Address Wear & Tear in Helping Professionals during Covid-19:
https://www.tendacademy.ca/marathon-not-sprint-covid19/

Today Spare a Thought for the Call center Operators:
https://www.tendacademy.ca/spare-a-thought-for-call-centre-operators/

Leaders are People too: Staying Well During Covid-19
https://www.tendacademy.ca/leaders-are-people-too/

Podcast with the National Children's Alliance:

One in Ten: ***This is a Marathon, Not a Sprint: Pacing Yourself through the Pandemic:***
https://www.buzzsprout.com/280046/3463774-this-is-a-marathon-not-a-sprint-pacing-yourself-through-the-pandemic

Videos:

SRCAC Video Series on Secondary Traumatic Stress: https://www.srcac.org/reflect-refuel-reset/

A shift in perspective, why it's time to stop using "Compassion Fatigue" Panel discussion with D. Tikasz, G. Sprang, B. Bride and F. Mathieu: **https://www.tendacademy.ca/shift-in-perspective/** (free of charge but login required)

Webinars:

CASA Presents: "Your Mental Health" Webinars - Compassion Fatigue in the Pandemic, Perspectives from an expert, a parent and a child abuse investigator: March 2021:
https://www.youtube.com/watch?v=V5Hoxz2ZgYw

The following two webinars are available through NCAC's Virtual Training Center. They are free of charge but require the user to log in:

Ask the Experts: Professional Resiliency in 2020: What Do We Know?
https://ncacvtc.org/#/online-courses/7dc8f034-a8b7-447b-a15f-5856ccdf546d

Nurturing a Hope-Centered Trauma-informed Response webinar
https://ncacvtc.org/#/online-courses/d761b783-978c-49bf-b2e9-2a426066db70

Articles about Covid, leadership and productivity:

The New Rules for Remote Work (Forbes):
https://www.forbes.com/sites/hbsworkingknowledge/2020/04/27/the-new-rules-for-remote-work-pandemic-edition/#3eede3327eb8

Why you should ignore all that coronavirus-inspired productivity pressure by Aisha, S. Ahmad
https://www.chronicle.com/article/why-you-should-ignore-all-that-coronavirus-inspired-productivity-pressure/

On Digital Minimalism and Pandemics – Cal Newport
https://www.calnewport.com/blog/2020/03/13/on-digital-minimalism-and-pandemics/

Books on Organizational Health

Fisher, P. (2016). *Resilience, Balance & Meaning Workbook.* Victoria, BC: Fisher & Associates Solutions Inc.

Fisher, P. (2015). *Building Resilient Teams.* Victoria, BC: Fisher & Associates Solutions Inc.

Pfeffer, J. (2018). *Dying for a Paycheck: How Modern Management Harms Employee Health and Company Performance – and What We Can Do About It. New York: HarperCollins.*

Embedding DEI in STS trainings – lessons learned/strategies

National Child Traumatic Stress Network Secondary Traumatic Stress Collaborative Group. Secondary Traumatic Stress: Understanding the Impact on Professionals in Trauma-Exposed Workplaces. UCLA-Duke National Center for Child Traumatic Stress: Los Angeles, CA & Durham, NC; In review.

Resources Specific to STS & Culture, Race, and Historical Trauma

Webinars:

Cultural Implications of Secondary Traumatic Stress: National Child Traumatic Stress Network Webinar: https://learn.nctsn.org/enrol/index.php?id=234

Secondary Traumatic Stress: A Fact Sheet for Organizations Employing Community Violence Workers: https://www.nctsn.org/sites/default/files/resources/secondary_traumatic_stress_community_violence_workers.pdf

It's Not All Black and White: Working with African-American Families in Post-Katrina New Orleans: National Child Traumatic Stress Network Webinar: https://learn.nctsn.org/enrol/index.php?id=351

Deconstructing White Privilege with Dr. Robin DiAngelo: https://youtu.be/DwIx3KQer54

Resources:

Implicit Bias Tests: https://implicit.harvard.edu/implicit/takeatest.html

Comas-Diaz, L.C., Hall, G.N., and Neville, H.A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist, 74* (1), 1-5.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*(3), 316–338.

Sandeen, E., Moore, K.M., and Swanda, R.M. (2018). Reflective Local Practice: A pragmatic framework for improving culturally competent practice in psychology. *Professional Psychology: Research and Practice, 19*(2), 142-150.

For updates about NCTSN resources, including the STS training slides email help@nctsn.org to be added to our e-bulletin listserv!

Core Curriculum on Childhood Trauma: An Introduction and Overview

The mission of the Core Curriculum on Childhood Trauma (hereafter Core Curriculum or CCCT) is to raise the standard of care nationwide for youth and families who have experienced trauma by raising the standard of education and training in core principles of childhood traumatic stress for their care providers. The Core Curriculum is being used across the United States to help mental health professionals incorporate trauma-informed care into their professional practice settings, including community-based mental health centers; teaching hospitals; graduate schools; terminal undergraduate programs; and internship, residency, and post-doctoral training programs.

The Core Curriculum is a major initiative undertaken by the UCLA/Duke University National Center for Child Traumatic Stress, in partnership with the National Child Traumatic Stress Network (NCTSN), the National Child Trauma Workforce Institute (NCTWI), and other Network collaborators to further the Network's mission of raising the standard of trauma-informed care for children and families nationwide.

A Strength-Based Approach

The Core Curriculum uses a strength-based approach that encourages learners to emphasize supportive factors and positive outcomes as strongly as risk factors and negative outcomes. This emphasis on strength-based critical reasoning and case formulation makes the Curriculum an especially useful complement to training in manualized interventions, which commonly focus on pathology and dysfunction. Many sites that have adopted the Core Curriculum utilize it as an educational tool either prior to, in parallel with, or after their students and staff have been formally trained in trauma-focused interventions.

As a practical necessity, most manualized treatments focus primarily on the more commonly-seen or "typical" client difficulties. However, the inherent complexity of each child's traumatic experiences and surrounding ecology often requires providers to tailor and adapt interventions according to each child's and family's specific needs, strengths, and life circumstances. A primary purpose of the Core Curriculum is to address this need by helping professionals to identify specifics factors that may be influencing a child's experience and taking steps to effectively address them. In particular, the Core Curriculum helps professionals to determine what they are trying to achieve, formulate a clear rationale as to why, and prioritize their intended course of action.

Core Curriculum General Learning Objectives

Each element of the Core Curriculum supports the acquisition of one or more of six general learning objectives. These broad-scope, cross-disciplinary learning objectives reflect recent calls for competency-focused training issued across multiple mental health disciplines including psychology, social work, and child psychiatry. These general learning objectives and their underlying intentions include:

1. Apply the 12 Core Concepts as conceptual lenses to frame information and guide critical reasoning about the case study.
   Intent: To provide learners with a conceptual framework that helps them to organize their foundational knowledge about child traumatic stress, while also capturing the richness and complexity of children's "real-life" traumatic experiences.

2. Identify ecological factors hypothesized to influence children's traumatic experiences and contribute to their post-traumatic adjustment.
   Intent: To strengthen learners' decision-making skills regarding which factors in a child's life and environment may be contributing, for good or ill, to children's traumatic experiences. Conversely, unidentified factors can lead to incomplete case formulation, inaccurate diagnosis, and less successful intervention planning and delivery.

3. Incorporate relevant ecological factors into a case conceptualization, and use that framework to evaluate the hypothesized contributions of different case factors and guide case-related reasoning.
   Intent: To help learners develop ways to organize, prioritize, and reason through the various roles that factors may play in a child's surrounding ecology in strength-based, trauma-informed ways.

4. Use critical reasoning to make judgments about the relative impact of various factors hypothesized to influence a child's traumatic experience and post-traumatic adjustment.
   Intent: To help learners examine their critical reasoning about case material, including how they sequence their planned course of action, to ensure they are using the best available evidence to guide their professional decisions and taking appropriate steps to minimize bias.

5. Clearly and accurately communicate appropriate trauma information to fellow professionals, clients, and family members within and across settings.
   Intent: To help learners develop effective language skills and communication patterns that support trauma-informed care.

6. Apply a trauma-informed conceptual lens to real-world aspects of professional practice, including assessment, case management, and treatment planning.
   Intent: To help learners view their professional work through a complex trauma-informed lens—one that extends beyond assigning diagnoses and prescribing treatment approaches to take in the rich phenomenological world in which children and families experience traumatic events.

Core Curriculum Elements

The Core Curriculum is a form of experiential learning. Instead of containing scripted lessons, the Curriculum contains a variety of elements that can be flexibly utilized to support the general learning objectives. The basic structure of a training involves a skilled facilitator who carries out three tasks. These include: (1) Determining the most important learning objectives for the audience of learners to be trained at a specific site. (2) Selecting the case that applies best to this audience, and choosing those Core Concepts that are most relevant to the training needs. (3) Using Problem-Based Learning (PBL) and appropriate learning tools to guide the learners in collaborative case discussions.

The Core Curriculum consists of multiple elements, including:

- **Detailed case studies** written by recognized experts in the field, which feature a range of types of childhood trauma. These case studies unfold in sections to help learners understand what it is like to live through a traumatic experience and its aftermath from a child's perspective.

- **The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families** (12 Core Concepts) serve as the Curriculum's primary conceptual framework for organizing foundational knowledge about trauma-informed care.

- **Problem-Based Learning (PBL)**, a highly interactive instructional method that invites learners to explore multiple perspectives as they work together to find solutions to complex problems. The facilitator acts as a guide to help small groups of learners collaboratively sort through the evidence, develop proposed explanations, decide how best to proceed, and determine what they still need to know to adequately address a child's traumatic experience. This is strengthened with tools to improve facilitator support and fidelity.

- **Instructional Tools**, including communication aids, interactive learning activities, and assessment measures, that are specifically designed to focus on one or more of the Core Curriculum's general learning objectives. These tools enable facilitators to work on specific learning objectives and assess learner progress and understanding at various points throughout the learning process.

Core Curriculum Case Studies

Core Curriculum case studies are designed to build decision-making skills from a strength-based perspective. These case studies feature a diversity of factual evidence, which challenges learners to use and strengthen their perspective-taking, critical reasoning, decision-making, case formulation, and communication skills. The variety of CCCT case studies available allows PBL facilitators to flexibly adapt the CCCT for a range of different training audiences, needs, and formats. The case studies currently include 5 full-length cases and 2 short cases. The full-length cases come with detailed facilitator guides to help identify and achieve a range of site-specific learning objectives.

Short Cases. Two short cases can be used flexibly for different applications, including brief trainings, pre-learning tasks, and assessment tools. These cases include:

Ella: A 5-year old Caucasian girl whose father is killed in a car accident, forcing the family to relocate. Ella was specifically written to feature each of the 12 core concepts and to be used primarily as an instructional tool, such as a pre—learning assignment.

Jaden: A 7-year-old biracial boy. He and his sibling were riding in a car driven by their drunk father when he hit and killed a pedestrian. Jaden was written to feature each of the 12 core concepts and to be used primarily as an assessment tool.

Full-Length Cases. The CCCT currently has five full-length case studies, each of which was written to highlight at least one to three core concepts. Each has an accompanying learning facilitator guide.

Amarika: An 18-month-old African American girl witnesses her mother being shot by stray gunfire while the two were playing at a park.

Juan: A 4 ½ year-old Latino boy is brought in after his preschool teacher reports inappropriate behavior towards other children. Sexual abuse is eventually uncovered.

Geraldine: A 9-year-old African American girl overhears her father kill her mother in an episode of extreme domestic violence.

Ibrahim: A 10-year-old Somali refugee boy is involved in a catastrophic bridge collapse while riding a school bus home from a summer camp trip with his younger brother and sister.

James: A 13-year-old Irish/German American boy reports ongoing physical abuse and domestic violence to his school teacher.

The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families

The 12 Core Concepts are foundational concepts of child traumatic stress that provide a framework for organizing and thinking through Core Curriculum case material. The Core Concepts help learners to focus their thinking about trauma-informed care through multiple lenses, such as the various traumatic moments that make up a traumatic experience, and the ways in which various ecological factors contribute to the experience and its aftermath. Applying the Concepts during hypotheses generation and testing encourages learners to adopt a strength-based perspective while strengthening their critical reasoning and case conceptualization skills. The 12 Core Concepts are available on the NCTSN website at: https://www.nctsn.org/resources/12-core-concepts-understanding-traumatic-stress-responses-children-and-families.

Problem-Based Learning: An Instructional Method for Strengthening Reasoning Skills

PBL is a collaborative learning experience that presents learners with complex problems resembling those encountered by practicing professionals. These complex problems contain multiple decision-making points that require learners to repeatedly sort through, integrate, and develop solutions for case information as it unfolds. Learners work in groups to reason through the problem, share different perspectives, and collaboratively propose and evaluate possible solutions to the problem under the guidance of a trained PBL facilitator.

In its basic form, the Core Curriculum guides learners through a four-step PBL process comprised of (1) **Facts**, (2) **Hunches and Hypotheses**, (3) **Next Steps**, and (4) **Learning Issues**. Each step in the PBL process is designed to help students slow down their thinking, check the impulse to make assumptions and immediately intervene, and instead gather relevant evidence and reason through various options in a systematic, logical, and transparent way. The Core Curriculum also contains an Instructional Toolkit composed of graphic organizing tools. These tools are designed to support case-based reasoning using a PBL format.

Working as a collaborative team, PBL groups engage in a variety of professional decision-making tasks. These tasks include: sorting through facts about the case, identifying important features of traumatic stress responses, conceptualizing case information, formulating hypotheses, gathering the best available evidence, weighing the evidence for or against their hypotheses, identifying information that is still missing, deciding on next steps, assigning learning issues to promote professional development, and communicating appropriately with other stakeholders. Selected CCCT exercises also encourage learners to plan how to integrate the trauma-informed methods they are learning into their professional settings and practices.

Instructional Tools

The general learning objectives call for practice in complex skills relating to ecological factor identification, case conceptualization, prioritization, and critical reasoning. Developing these complex skills requires in-depth exploration and rich discussions regarding the case material. To support these discussions, the Core Curriculum includes a range of graphic organizing tools. These tools support the construction of a shared understanding among group members. These tools also focus learners' attention on case factors that are most relevant to the course learning objectives, and encourage learners to incorporate multiple perspectives on the same problem. Each learning objective has its own tools to support its exploration and application to trauma-informed practice.

Vision Regarding the Impact of the Core Curriculum on the NCTSN.

Intended impacts of the widespread adoption of the Core Curriculum across the Network include:

1. Provide a framework for understanding the Core Concepts that underlie trauma-informed care and evidence-based interventions.
2. Use the Core Concepts to create a common language for communication within and across Network settings.
3. Use the Core Concepts in supervision and case conceptualization across a variety of educational and clinical settings.
4. Use CCCT case studies as a standard set of reference materials that network members can use to discuss clinical situations.
5. Prepare professionals to use critical reasoning in their work with children and families contending with traumatic events.
6. Improve collaboration and communication within and between Network sites.

Getting Involved

All Network sites—both actively funded and affiliate status—are strongly encouraged to invite a trained Core Curriculum facilitator to conduct a live in-person training demonstration at your site. A trained Core Curriculum advanced facilitator can work flexibly with you to tailor the training demonstration according to your specific staff needs and the time and space available. Please refer to **Answers to Frequently Asked Questions: The NCTSN Core Curriculum on Childhood Trauma** to learn more about on-site training opportunities and possibilities.

All requests relating to hosting a CCCT demonstration at your NCTSN site should be directed to:

Leslie Ross, Psy.D, Director, Core Curriculum on Child Trauma Implementation UCLA NCCTS, LeslieRoss@mednet.ucla.edu;

Laura Katz, LCSWR, Project Director for the National Child Trauma Workforce Institute (NCTWI), at Silberman School of Social Work at Hunter College laurakamermankatz@gmail.com

In your email, please CC: Mary Swai-Williams, Contract Administrator Associate National Child Trauma Workforce Institute, ms5357@hunter.cuny.edu.

This Introduction and Overview was completed in September, 2018, by members of the Core Curriculum Leadership Consortium and the Core Curriculum Interactive Learning Group. The authors include:

Christopher M. Layne, Ph.D., Director of Education in Evidence-Based Practice at the UCLA NCCTS

Hannah M. Grossman, Postdoctoral Fellow in Instructional Design at the UCLA NCCTS

Robert Abramovitz, MD, NCTWI Director, at Silberman School of Social Work at Hunter College

Laura Katz, LCSWR, NCTWI, at Silberman School of Social Work at Hunter College

Leslie Ross, Psy.D, Director of Core Curriculum Implementation, UCLA NCCTS

Margaret Stuber, MD, UCLA NCCTS

Core Curriculum on
Childhood Trauma

The 12 Core Concepts

Concepts for Understanding Traumatic Stress Responses in Children and Families

NCTSN The National Child Traumatic Stress Network

The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

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Correspondence Relating to the Core Curriculum on Childhood Trauma

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NCTSN members who have served on the NCTSN Core Curriculum on Childhood Trauma Task Force since its inception in 2007 include (in alphabetical order): Robert Abramovitz, Lisa Amaya-Jackson, Harolyn Belcher, Frank Bennett, Steven Berkowitz, Lucy Berliner, Margaret Blaustein, John Briere, Judith Cohen, Kathryn Collins, Lisa Conradi, Renee Dominguez, Abigail Gewirtz, Chandra Ghosh Ippen, Jessica Gledhill, Alessia Gottlieb, (the late) Kevin Gully, Lisa Jaycox, (the late) Sandra Kaplan, Victor Labruna, Audra Langley, Alicia Lieberman, Richard Kagan, Christopher Layne (Chair), Steven Marans, Ann Masten, Lou Ann Mock, Elana Newman, David Pelcovitz, Frank Putnam, Robert Pynoos, Gilbert Reyes, Leslie Ross, Arlene Schneir, Jo Sornborger, Joseph Spinazzola, Alan Steinberg, Virginia Strand (Co-Chair), Liza Suárez, William Saltzman, Glenn Saxe, Margaret Stuber, Elizabeth Thompson, Jim Van Den Brandt, Kelly Wilson, Jennifer Wilgocki, and Marleen Wong.

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12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

1. Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children's moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.

2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-*intrinsic* factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-*extrinsic* factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children's adjustment.

3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children's exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors' posttrauma emotional and behavioral functioning.

4. Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children's posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children's level of functioning at home, at school, and in the community. Children's posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

5. Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

6. Traumatic experiences affect the family and broader caregiving systems.

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children's and families' posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

7. Protective and promotive factors can reduce the adverse impact of trauma.

Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas *promotive* factors generally enhance children's positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include *child-intrinsic* factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include *child-extrinsic* factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children's ability to resist, or to quickly recover (by resiliently "bouncing back") from the harmful effects of trauma, loss, and other adversities.

8. Trauma and posttrauma adversities can strongly influence development.

Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).

9. Developmental neurobiology underlies children's reactions to traumatic experiences.

Children's capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This "danger apparatus" underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.

10. Culture is closely interwoven with traumatic experiences, response, and recovery.

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child's life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children's posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

The Secondary Traumatic Stress-Informed Organization Assessment Tool (STSI-OA) pandemic version - University of Kentucky Center on Trauma and Children (CTAC)

The STSI-OA is an assessment tool that can be used by organizational representatives at any level to evaluate the degree to which their organization is STS-informed, and able to respond to the impact of secondary traumatic stress in the workplace. The STSI-OA identifies specific areas of strength, and opportunities to implement STS informed policies and practices. The results of this tool can be used as a roadmap for future training and implementation activities in the area of STS and trauma-informed care:

To access the STSI-OAP: www.uky.edu/ctac/stsioa

Compassionate leadership & ethical dilemmas, how to be responsive to our staff during the pandemic

Recommended Resources

Loving Kindness meditation
Scott, E. (2020) How to Practice Loving Kindness Meditation
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SECONDARY TRAUMATIC STRESS SCALE – DSM 5

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb…….…..	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients…….….	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)……...	1	2	3	4	5
4. I had trouble sleeping……...	1	2	3	4	5
5. I felt discouraged about the future…….…..	1	2	3	4	5
6. Reminders of my work with clients upset me……..	1	2	3	4	5
7. I had little interest in being around others…….…..	1	2	3	4	5
8. I felt jumpy…….….	1	2	3	4	5
9. I was less active than usual…….….	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to…….	1	2	3	4	5
11. I had trouble concentrating……..	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients…….	1	2	3	4	5
13. I had disturbing dreams about my work with clients……...	1	2	3	4	5
14. I wanted to avoid working with some clients……..	1	2	3	4	5
15. I was easily annoyed…….....	1	2	3	4	5
16. I expected something bad to happen…….....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions……..…	1	2	3	4	5
18. I experienced negative emotions……...	1	2	3	4	5
19. I engaged in reckless or self-destructive behavior……	1	2	3	4	5
20. I unrealistically blamed others for the cause or consequences of the trauma(s) experienced by my client(s)……..	1	2	3	4	5
21. I had negative expectations about myself, others, or the world…….	1	2	3	4	5

Citation: Bride, B.E. (2013). The Secondary Traumatic Stress Scale, DSM 5 Revision. Unpublished Manuscript.

OLD Scoring Instructions for DSM -IV-TR:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score	_____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NEW Scoring Instructions for DSM - V:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 12, 14,)	Avoidance Score	_____
Negative Cognitions & Mood (add items 1, 7, 9, 17, 18, 20, 21)	Negative Cog/Mood	_____
Arousal Subscale (add items 4, 8, 11, 15, 16, 19)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NOTE: Item #5 "I felt discouraged about the future" does not align the DSM-5 symptom criteria for PTSD. As such, it is not included in the calculation of scores for the revised version of the STSS. However, it is retained in the instrument to allow calculation of DSM-IV congruent scores for comparison with prior studies.

SECONDARY TRAUMATIC STRESS SCALE – DSM 5 - Pandemic Version

The following is a list of statements made by persons who have been impacted by their work with pandemic-affected clients or patients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb……..…..	1	2	3	4	5
2. My heart started pounding when I thought about my work with pandemic-affected clients/patients…….	1	2	3	4	5
3. It seemed as if I was reliving the experiences of my pandemic-affected clients/patients……	1	2	3	4	5
4. I had trouble sleeping……...	1	2	3	4	5
5. I felt discouraged about the future……..…..	1	2	3	4	5
6. Reminders of my work with pandemic-affected clients/patients upset me……...	1	2	3	4	5
7. I had little interest in being around others……..…..	1	2	3	4	5
8. I felt jumpy……..….	1	2	3	4	5
9. I was less active than usual……..….	1	2	3	4	5
10. I thought about my work with pandemic-affected clients/patients when I didn't intend to……	1	2	3	4	5
11. I had trouble concentrating……..	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with pandemic-affected clients/patients…….	1	2	3	4	5
13. I had disturbing dreams about my work with pandemic-affected clients/patients……...	1	2	3	4	5
14. I wanted to avoid working with some clients/patients……..	1	2	3	4	5
15. I was easily annoyed……....	1	2	3	4	5
16. I expected something bad to happen…….....	1	2	3	4	5
17. I noticed gaps in my memory about pandemic-affected clients/patients sessions…….……	1	2	3	4	5
18. I experienced negative emotions……...	1	2	3	4	5
19. I engaged in reckless or self-destructive behavior……	1	2	3	4	5
20. I unrealistically blamed others for the cause or consequences of the pandemic experiences of my clients/patients..…..	1	2	3	4	5
21. I had negative expectations about myself, others, or the world…….	1	2	3	4	5

OLD Scoring Instructions for DSM -IV-TR:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score	_____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NEW Scoring Instructions for DSM - V:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 12, 14,)	Avoidance Score	_____
Negative Cognitions & Mood (add items 1, 7, 9, 17, 18, 20, 21)	Negative Cog/Mood	_____
Arousal Subscale (add items 4, 8, 11, 15, 16, 19)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NOTE: Item #5 "I felt discouraged about the future" does not align the DSM-5 symptom criteria for PTSD. As such, it is not included in the calculation of scores for the revised version of the STSS. However, it is retained in the instrument to allow calculation of DSM-IV congruent scores for comparison with prior studies.

How to Prevent Bad Moments from Ruining the Whole Day

What Is Rumination?

Rumination is when we get stuck in thinking about a stressful situation. When we are ruminating, we are still thinking about (and therefore still feeling stress about) situations hours or even days after a stressful event.

Rumination is a "looping" that happens because we mentally re-create a stressful experience that happened to us, to which our body reacts just as it would if we were in that situation right now. When we get emotionally "worked up" in response to this image, the brain creates even more mental images, which leads to more physical arousal, etc. Now we are stuck in a cycle between our imaging and our stress response that could go on for a long time. And if we are ruminating, we are less present for our next client, our family, or our next activity. Research has shown that the more time we spend in rumination, the less happy and effective we are. Rumination, then, is the exact opposite of being present in the moment (mindfulness).

How Do I Reduce My Tendency to Ruminate?

The propensity to ruminate is determined by two factors: 1) How we experience the level of threat in the circumstance, and 2) How quickly our physiological make-up allows us to recover. Some of us recover quickly and rarely ruminate. Others of us take longer to recover from a stressful event, and rumination is a near daily occurrence. Most workers in the helping professions, however, at least occasionally contend with ruminations about stressful situations.

There are strategies for reducing our tendency to carry stressful situations through the day. Some of these tips derive from rumination-focused cognitive therapy (R-CBT). By getting better at these skills, we can get better at putting stressful situations behind us and staying present:

1 Know the Difference Between Problem-Solving and Ruminating

This step is sometimes harder than it may appear. When we are thinking about a stressful situation, we may tell ourselves that we are trying to "work it out" in our mind or trying to solve the problem. Indeed, sometimes we are doing exactly that.

In order to manage our ruminations, we must catch ourselves when we are in a rumination. The key is to begin to improve our ability to make the distinction between problem-solving and ruminating (or to notice when our problem-solving has turned into rumination). This may be difficult in some cases, because sometimes we do mentally re-create situations in order to decide what we need to do to "fix" that situation. That is healthy problem-solving. But sometimes we are re-creating the situation in an endless loop that reduces our problem-solving ability and lowers our mood.

Healthy problem-solving is when we feel like we can do something about a stressful situation and are trying to decide what our action will be. When we are problem-solving, we feel empowered and are focused on what to do about the situation.

Rumination, on the other hand, is when we are focused on how unpleasant the situation was, and we can't do anything to resolve it. When we are ruminating, we feel stressed and unable to do anything about it. Perhaps we can't "fix" it because it already happened in the past, or because it is a circumstance that simply cannot be changed. In these situations, re-creating the scenario doesn't lead to action. Rather, it leads to the cycle of running the scenario in our mind, feeling stressed or upset about it, leading to us thinking more about it, and now we are stuck in the loop.

The first step in reducing a rumination, then, is to get better at noticing when you are ruminating. If you have difficulty knowing whether you are problem-solving or ruminating, ask yourself this question, "Is there something I need to do about this situation?" If the answer is yes, focus your thinking on what that action is. Plan this action in as specific detail as you can. If your answer to the question is no (the situation is already in the past, or there isn't anything you can do about it), re-creating the scenario will not be helpful to you.

2 Notice and Label When You Are Ruminating

Typically, your thoughts will move into rumination about a stressful event without your realization. When you become aware that you are stuck in a thought or image of a stressful event, signal to yourself that you are ruminating so you can take deliberate action. "I am not going to be able to fix this; I am just ruminating about it." "I'm just spinning on this thought and need to let it go." Or, simply, "I am ruminating and need to re-direct."

3 Actively Avoid Mind Wandering

Once you have noticed and labeled your rumination, you must decide to do something to actively change your mind-wandering state. Rumination happens when we let our minds wander without active focus. If you are passive, your thoughts will continue to return to the event that is the source of the rumination just like a tongue returning to that jagged tooth. Thus, the next step is to decide to change your mental state with deliberateness.

4 Short-Circuit the Imaging/Emotional Reacting Circuit for as Little as Two Minutes

Ruminations can be self-perpetuating, and therefore, can go on almost endlessly. As the cognitive event (us imagining the scene that distressed us) kindles the emotional response (agitation, fight-or-flight), that energizes the cognitive imaging, which leads to more emotional reaction. This closed circuit must be interrupted to allow your mind and body to reset. The good news? For normal ruminations, a distraction as little as two minutes can do the trick.

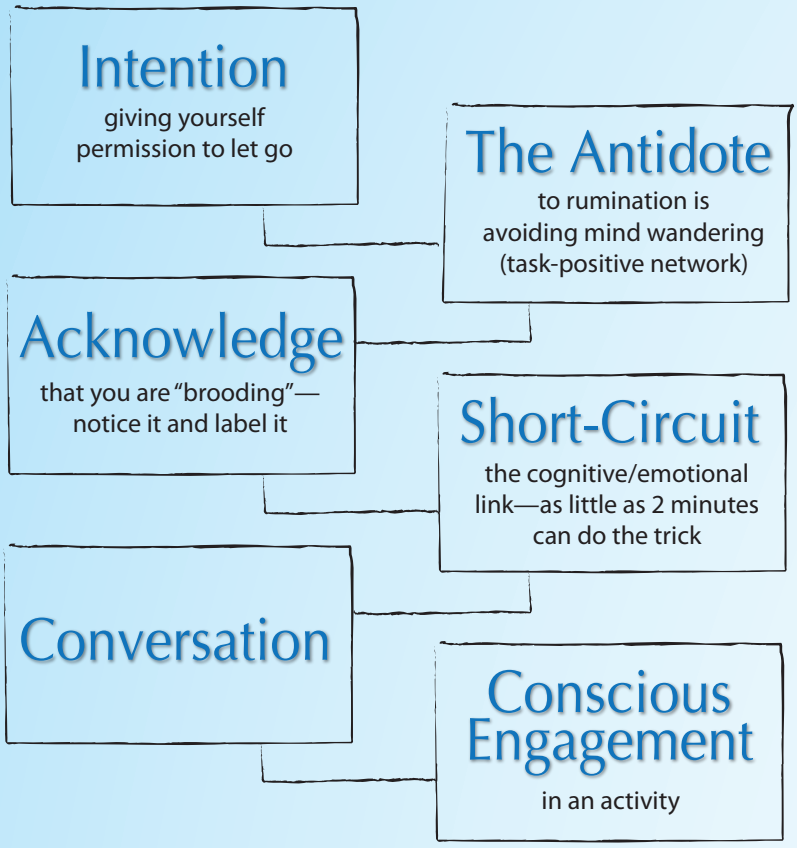
5 Converse with Someone

A very effective way of ending the kind of mind wandering that keeps ruminations active is—very simply put—to get out of your own head. That is, engage in a conversation with someone. The subject of the conversation isn't important; it doesn't even have to be about the situation you have been ruminating over. Conversation is a focused activity that directs our thoughts away from our ruminative process and we begin directing our attention into the subject of the conversation, and toward the other person. This simple action can be very effective at ending a rumination and interrupting the self-perpetuating loop. Furthermore, engaging in a conversation with a person with whom we like and feel safe, activates parasympathetic recovery and helps us return to our emotional and physical baseline.

6 Conscious Engagement in an Absorbing Activity

Any activity that effectively holds your attention away from the rumination—and away from your own emotional response to the situation—will break the self-perpetuating circuit of the rumination. But it needs to be an activity. Again, as little as two minutes may be effective—but if we step out of the rumination for 20 minutes or more, even better. The activity might involve physical exercise or be doing something that is mentally absorbing. Anything that effectively holds your attention for a sustained time will work. Think about it now—what activity can you engage in that will hold your attention for a sustained period? Have it in mind, so it can be your "go-to" when you need it. Will reading or TV watching work? The answer is in whether it is so completely absorbing to you that it eliminates mind wandering. For most of us, it will need to be something more active or engaging than merely watching a television show or our attention will flip back and forth between the show and our rumination, allowing the ruminative circuit to continue.

Steps to Manage Rumination



Examples of absorbing activities include:

- Reading
- Journaling about your thoughts and feelings
- Running
- Taking pictures
- Painting
- Baking
- Biking
- Building something
- Browsing bookstores or libraries
- Coloring
- Singing
- Swimming
- Swinging a golf club or tennis racket
- Dancing
- Drawing
- Fishing
- Walking

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This information derives from the CE-CERT Model (Components for Enhancing Clinician Experience and Reducing Trauma), Miller, 2016. For more information contact author at: bmiller.thirdwave@gmail.com.

Facilitator directs participants in a self-audit concerning their current supervision practices as it compares to the above.

SECONDARY TRAUMATIC STRESS CONSORTIUM

INDIVIDUAL WORKER GUIDANCE

GUIDANCE STATEMENT #1

Target:

The professional possesses evidence-informed knowledge about risks and strategies for mitigating secondary traumatic stress (STS).

Individual Professional Education:

Education about STS is essential to prepare the professional to anticipate exposure, to monitor their responses, and to know what actions to take when reactions are observed. Professionals (with support from their organization) participate in on-going, evidence-informed education and training on trauma and STS, the risks associated with secondary trauma exposure, and ways to enhance their own resiliency.

GUIDANCE STATEMENT #2

Target:

The professional will develop the ability to employ specific strategies for remaining within a zone of tolerance during exposure and recovery after reactivity.

Skill Development:

Professionals working in trauma-exposed environments need to develop specific emotion regulation and recovery skills to remain within a zone of tolerance and maintain well-being as they are exposed to secondary trauma. These skills include those that prepare them for secondary trauma exposure, as well as skills that support emotion regulation during exposure, and skills to assist them in emotional recovery after exposure. Professionals need to develop the ability to:

1. Continuously assess the presence of signs or symptoms of secondary trauma.
2. Employ the strategies identified in a personal risk assessment (see Guidance Statement #4) when indicated.
3. Support emotion regulation during exposure (e.g., using self-talk, active coping strategies, problem-solving, mindful compassion/self-compassion, breathing techniques).
4. Recover from episodes of high-intensity emotion (e.g., employing grounding skills, breathing techniques, mindfulness approaches).
5. Reflect upon, acknowledge, and articulate high-intensity emotion experiences to trusted peers or supervisors as appropriate.

GUIDANCE STATEMENT #3

Target:

The professional is able to cultivate and maintain beliefs that support their sense of well-being in their helping role.

Beliefs/Attitudes/Values:

Certain professional beliefs, attitudes, and values play a protective role for professionals exposed to secondary trauma. This requires that professionals define, cultivate, and enact specific beliefs and values that impart a sense of meaning, purpose, self-compassion, and openness to the difficult emotions and experiences that their role requires. This requires that the professional be able to:

1. Describe the importance of finding personal meaning in experiencing emotional distress from trauma work.
2. Define their own sense of purpose (professional calling) in seeking and accepting their current job role.
3. Make an active determination about their goodness of fit in their job role and in the organization.
4. Experience—or actively endeavor to cultivate—compassion for the client and self in difficult circumstances.
5. Frequently experience and express gratitude for aspects of their job role (e.g., the support of their co-workers, the significance of the job role, gratitude of clients).
6. Experience and express optimism about the effect of their efforts, a belief that what they do matters.
7. Accept the limits and boundaries of their professional role and accept the reality that some difficult circumstances may be beyond their influence.

GUIDANCE STATEMENT #4

Target:

The professional has identified their own personal profile of strengths and vulnerabilities to secondary trauma exposure for use in self-monitoring.

Reflection/Self Awareness:

Preparation for exposure to secondary trauma requires that professionals know their own strengths and vulnerabilities in response to that experience. Professionals are able to reflect and identify what these strengths and vulnerabilities are in order to anticipate what thoughts and behaviors they should self-monitor, and what circumstances are most likely to activate their own emotional arousal.

- Examples of vulnerabilities include: own individual and/or collective history of trauma, areas of their own emotional susceptibility, non-supportive or difficult work environment, and how their own experiences of equity, diversity, and inclusion might impact their response to work-related trauma exposure.
- Examples of strengths include: strong support from supervisors or peers, history of rapid resolution of stress response, good capacity for self-reflection.

GUIDANCE STATEMENT #5

Target:

The professional collaborates on a team of trusted colleagues, peers, or a community of practice with whom they can share thoughts and feelings concerning secondary trauma exposure.

Team Support:

It is important that professionals not be exposed to secondary trauma in isolation. Professional well-being requires that the professional acknowledge and process their thoughts and feelings in response to trauma exposure with a trusted other. This processing should be done in a manner that does not unnecessarily subject others to graphic traumatic material. It is important that the professional has a sense of the support of a team (internal or external to the workplace), and that they help to create and sustain a practice of reciprocal support.

GUIDANCE STATEMENT #6

Target:

In addition to team and organizational support, the professional possesses the willingness and capability to monitor their own well-being and uses strategies for mediating secondary trauma responses.

Oversight of Well-Being:

Professional well-being requires that the individual has the support of their organization and supervisor, but also that the professional be committed to consciously attending to their own physical and emotional health. The professional is able to continuously self-monitor the effect that their work is having on their sense of well-being, and that they actively respond whenever distress occurs. The professional possesses the capability to:

1. Identify strategies and opportunities for self-monitoring.
2. Articulate the effects of secondary trauma exposure on them personally.
3. Implement identified strategies for emotional regulation that occur in response to exposure.

GUIDANCE STATEMENT #7

Target:

The professional is able to determine when they would benefit from professional counseling or other external support and knows how to access that support.

External Professional Support:

When reactions to secondary trauma exposure begin to compromise the professional's well-being, knowledgeable professional support external to the workplace is indicated. In this circumstance, the professional seeks help from a trauma-informed mental health professional or spiritual or cultural support as needed. The professional is able to:

1. Identify—on self-reflection or in consultation with a trusted other—when external support is indicated.
2. Access such support.

SECONDARY TRAUMATIC STRESS CONSORTIUM

ORGANIZATIONAL GUIDANCE

Target: The organization has processes in place for providing on-going training concerning the nature of secondary traumatic stress (STS), the sources of STS, and strategies for mitigation of secondary trauma. This training is culturally responsive and evidence-informed. The training process includes advanced training to enable supervisors to provide continuous support to workers.

#1. ORGANIZATIONAL POLICIES, PROTOCOLS, AND PRACTICES

Target:

The organization has policies and active practices, including structuring workflow to minimize secondary trauma exposure and active strategies for promoting workforce resilience, which demonstrate commitment to the well-being of its workforce.

Organizations must demonstrate their awareness of and commitment to the well-being of staff exposed to secondary trauma. This commitment is communicated and demonstrated through the implementation of policies, protocols, and practices that promote workforce wellness stabilization and recovery.

#2. ORGANIZATIONAL TRAINING

Organizations must provide training and consultation that assist staff in understanding, preparing for, and dealing with secondary trauma exposure.

Organizational support of exposed staff requires training that includes the following elements or characteristics:

1. Is ongoing training and consultation and includes all levels of staff.
2. Provides information that normalizes responses to secondary trauma exposure.
3. Enables a common understanding of the characteristics and risks of work in a trauma-exposed environment.
4. Includes information about the psychobiology of stress and trauma.

continued

#2. ORGANIZATIONAL TRAINING (COTINUED)

5. Provides clear strategies to mitigate stress and trauma responses and to enhance resiliency.
6. Includes specialized additional training resources for senior leaders and supervisors guiding trauma-exposed teams. This will support leaders' ability to mitigate and address the common risks for adverse stress consequences to individual team members, promote reflective practice, and enhance team functioning and client services.
7. Includes a wide range of specialized training and education resources that are culturally sensitive and responsive, and that include evidence-informed resilience tools and strategies to support individuals, teams, supervisors, and managers.

#3. WORKFORCE SUPPORT

Target:

The organization has structured workloads to mitigate the secondary trauma exposure of the workplace. This structure includes flexible time for supervision and peer support processing, wellness activities, and training.

Organizations must systematically define and implement organizational workforce supports to reduce the risk of STS and increase staff wellness and resilience. Examples of such supports include:

1. Committing to organizational stress mitigation: Examples include formally allotting time in staff's daily schedules for risk reduction and skills-building activities; developing procedures and setting aside time for trauma processing with a peer or supervisor; encouraging staff wellness activities; allowing for periodic staff training; soliciting input from workers about helpful supports and responses to specific critical incidents.
2. Providing critical workforce resources, such as specific Employee Assistance Program (EAP) providers trained in STS who can provide clear support for workers experiencing provider distress and supervisors and organizational leadership who are also trained in STS.
3. Providing resources, such as organizational wellness programming, team-building, and focused efforts to create supportive work environments.

#4. ORGANIZATIONAL CULTURE

Target:

The organization explicitly nurtures a culture of psychological safety that acknowledges the hazards of working in a trauma-exposed environment and fosters team support and respect for personal boundaries.

Organizations must create and nurture a culture and climate that explicitly and implicitly:

1. Supports and ensures the physical safety and well-being of all staff.
2. Assures psychological safety for all employees.
3. Recognizes and acknowledges the challenges and hazards of working in trauma-exposed environments.
4. Recognizes and responds to the intersection of STS with culture, race, gender, and historical trauma requiring systemic change.
5. Fosters a sense of organizational cohesion, reflexivity, active listening, and mutual support.
6. Communicates the scope of the professional role and promotes healthy boundaries at work.

#5. SUPERVISION

Target:

The organization dedicates time and supports for the provision of qualified secondary trauma-informed supervision.

A critical support that an organization can provide staff is the support and direction of a supervisor who is secondary trauma-informed. Accordingly, organizations will provide supervisors who are trained and equipped to:

1. Identify supervisees who may be experiencing secondary trauma exposure and/or STS symptoms.
2. Create the space and structure to process these experiences in a supportive and encouraging manner that normalizes the experience.
3. Acknowledge, recognize, and address the impact of STS on themselves.
4. Use tools to ensure supervision is STS-informed.
5. Make referrals for additional support as needed.

#6. PRACTICES OF LEADERS

Target:

Organizational leaders model trauma and secondary trauma-informed behaviors and play an active role in developing a supportive and resilient workplace.

The practices of organizational leadership model awareness and promotion of wellness activities, which begins by leaders accepting an active role in the establishment of organizational awareness and promotion of a trauma-informed and compassionate workplace. Trauma-informed organizational practice includes applying trauma-informed principles to all staff as well as clients.

#7. ORGANIZATIONAL ASSESSMENTS AND MONITORING

Target:

The organization demonstrates the prioritization of workforce wellness through defined metrics that are continuously monitored, safeguarded for privacy, and responded to with priority.

As a means of prioritizing employee wellness and implementing continual organizational oversight, organizations will identify data and specific measures to continuously assess employee and organizational wellness. This includes tracking indicators that could be related to STS, such as staff turnover, absenteeism, and avoidance of trauma-related material. As a means of keeping the organizational effort a priority, the outcomes of these continuous measures will be prominent in the organization's data reports. Data collection and reporting must always respect issues of confidentiality and the privacy of the employee