ADDRESSING SECONDARY TRAUMATIC STRESS

Models and Promising Practices

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ADDRESSING SECONDARY TRAUMATIC STRESS: Models and Promising Practices

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EXECUTIVE SUMMARY

Secondary traumatic stress—behaviors and emotions resulting from knowing about a traumatizing event experienced by a client and the stress resulting from helping or wanting to help that client—is an occupational hazard for service providers who work with traumatized populations. Without adequate self-care and organizational support, secondary traumatic stress impacts not only the affected staff members, but also their clients, their families and friends, and their agencies through organizational dysfunction and costly employee turnover. Agencies that experience secondary traumatic stress are the same agencies that funders entrust with addressing some of the most challenging problems in our communities. The quality of services that those clients receive may be compromised when staff's well-being suffers. Thus, philanthropic support for education, prevention, and mitigation of secondary traumatic stress is a crucial component of effective, efficient, and humane service delivery.

The purpose of this study was to identify effective models and promising practices for supporting staff of community-based organizations who experience secondary traumatic stress. Of the many traumatized populations, this study focused primarily on immigrants, refugees, and asylum seekers, with the findings and recommendations intended to be generally applicable to other fields where STS is common. The study employed triangulation through the application of three methodologies: (1) a rapid literature review; (2) individual interviews with fifteen administrators/managers of programs or agencies that serve foreign-born populations; and (3) focus groups in four cities with a total of 29 staff who work directly with foreign-born populations. The organizations represented included both mainstream providers that include immigrants and refugees among their clients (e.g., social service agencies, hospitals) and organizations that primarily work with refugees and/or immigrants.

The rapid literature review of 127 studies on interventions for secondary traumatic stress (STS) identified nine studies meeting the methodological criteria for best practices. Best practices that emerged spanned both organizational and individual interventions. Best practice organizational interventions included improved work schedules, lower caseloads, more diverse caseloads, job rotation, organizational support, improved work environment, collegial support, and teambuilding. Best practice individual interventions included psychoeducation about stress, trauma, and STS; stress management training; debriefing and communication skills; relaxation and mindfulness; coping strategies; social support; counseling; and resiliency training. The research literature suggests common themes in best, promising, and emerging practices across varying contexts (e.g., immigration, child welfare, juvenile justice, health), providers (e.g., healthcare workers, therapists, social workers), and clients (e.g., victims of violence or abuse, refugees, medical patients).

The individual interviews with managers yielded six overarching themes that respondents believed are critical elements in addressing STS within organizations: leadership, workload, physical space, proactive supervision, peer support, and individualized approaches. The focus group findings confirmed those of both the literature review and the individual interviews. There were few differences in perspectives or experiences regarding STS between managers and direct-service providers. Likewise, there were minimal differences regarding STS across the focus group sites, despite their varied geography, history, and populations served. There also were no differences noted across types of organizations (e.g., legal, social services, medical). The three-pronged approach yielded consistent, recurrent themes related to preventing and mitigating STS. Further, the findings suggest that best practices for STS prevention and mitigation strategies have broad applicability across settings and populations.

STS is a workplace safety issue like any other, and should be treated as such through education, prevention, and mitigation.

Based on the overall study findings and adapting of organizational cultural competence[1], a model of organizational STS competence was developed as follows:

(1) **STS Blindness**: The organization is unaware of STS or does not believe it needs to be addressed.
(2) **STS Pre-Competence**: The organization is beginning to think about the issue but has not yet taken any action on it.
(3) **STS Competence**: The organization has taken action to address STS.
(4) **STS Proficiency**: The organization serves as a model for others for addressing STS.

Philanthropic actors that fund organizations which work with marginalized populations can partner with these agencies to move toward the STS proficiency level. They can do so by leveraging the six cross-cutting themes identified in this study and viewing these as the pillars of an STS proficient agency. For organizations to make the necessary changes for sustainability and wellbeing, philanthropic actors are encouraged to dedicate funding and programmatic support towards enhancing those pillars most relevant to an organization's current practices and identified needs.

(1) **Leadership**: Senior leadership are educated and engaged on the need to address STS
(2) **Workload**: Staff workloads are at a sustainable level
(3) **Workspace**: Workspaces are comfortable and confidential
(4) **Supervision**: Supervisors, practice proactive, trauma-informed supervision
(5) **Peer Support**: The organization provides opportunities for peer support
(6) **Individualization**: The STS approach is individualized for each staff member by honoring preferences and providing options

The research indicates a dearth of investments related to STS education, prevention, and mitigation. Philanthropy is uniquely positioned to fund this "invisible" need. The following are actions that foundations can take to foster STS proficiency:

(1) **Assess** their internal understanding of STS using the STS competency model.
(2) **Create** a learning community in partnership with funded programs to learn about STS and its impact on services and to assess STS competency.
(3) **Support** organizational efforts in addressing STS.
(4) **Recognize** that STS is complex, and the needs of staff experiencing its symptoms vary. Addressing these needs requires a nuanced look at the opportunities and challenges faced by agencies and their staff.

[1] Cross (1989).

INTRODUCTION

Secondary traumatic stress—behaviors and emotions resulting from knowing about a traumatizing event experienced by a client and the stress resulting from helping or wanting to help that client—is an occupational hazard for service providers who work with traumatized populations. Without adequate self-care and organizational support, secondary traumatic stress impacts not only the affected staff members, but also their clients, their families and friends, and their agencies through organizational dysfunction and costly employee turnover.

> "There's certain cases that are forever burned in your brain that you will go to your deathbed with."

The above statement from one of this study's interview respondents starkly captures the essence of secondary traumatic stress. Secondary traumatic stress, vicarious trauma, and compassion fatigue are occupational hazards for service providers who work with traumatized populations.[2] These terms are defined in the box on the following page. Although clearly distinct, these concepts are nonetheless closely related, and can be experienced simultaneously. For purposes of brevity, hereafter we will refer to them under the umbrella term "secondary traumatic stress" (STS).

> Although clearly distinct, these concepts are nonetheless closely related. For purposes of brevity, hereafter we will refer to them under the umbrella term "secondary traumatic stress."

Among the many traumatized populations in society are immigrants (particularly those who are undocumented, due to the ongoing uncertainty under which they live), refugees and asylees, asylum seekers, and other displaced populations. Their experiences are characterized by the triple trauma paradigm, which identifies potential traumas in the pre-migration stage (e.g., violence in the country of origin), the transit stage (e.g., dangerous border crossings, detention), and the resettlement stage (e.g., poverty, fear of deportation, culture shock).[3] STS has been documented among diverse staff working with these populations, such as asylum attorneys, immigration judges, caregivers working with Mexican and Central American migrants, public school educators refugee resettlement staff, and torture treatment providers, among others.[4] The current federal administration's harsh anti-immigrant rhetoric and its numerous executive actions on immigration enforcement, travel bans, and reductions in humanitarian programs such as the refugee resettlement program, have substantially increased traumatic stress among foreign-born populations, and hence, those who help them.[5]

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[2] Figley (1995)
[3] Center for Victims of Torture, 2005.
[4] Akinsulure-Smith et al., 2012, 2018; Lustig et al., 2008; Lusk & Terrazas, 2015; Piwowarczyk at al., 2009; Sanchez et al., 2018.
[5] Pierce, Bolter, & Selee, 2018.

Key Terms

Vicarious traumatization refers to a process of cognitive change resulting from chronic empathic engagement with trauma survivors. Vicarious traumatization represents the resulting cognitive shifts in beliefs and thinking that occur in workers in direct practice with victims of trauma. Examples … include … alterations in one's sense of self; changes in world views about key issues such as safety, trust, and control; and changes in spiritual beliefs.

Secondary traumatic stress relates to the … behaviors and emotions resulting from knowing about a traumatizing event experienced by a client and the stress resulting from helping or wanting to help [that] client. STS results from engaging in an empathic relationship with an individual suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that … person's trauma. The symptoms of secondary traumatic stress mirror the symptoms of post-traumatic stress disorder (PTSD) experienced by the primary victim of trauma. The experience of [STS] may include … intrusive thoughts, traumatic memories or nightmares associated with client trauma, insomnia, chronic irritability or angry outbursts, fatigue, difficulty concentrating, avoidance of clients and client situations, and hypervigilant or startle reactions toward stimuli or reminders of [the] client. The focal features of STS are the behavioral symptoms that mirror the PTSD presented in the primary victim(s) of trauma, not changes in cognition.

Compassion fatigue is … a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout…. The chronic use of empathy combined with the day-to-day bureaucratic hurdles that exist for many workers, such as agency stress, billing difficulties, and balancing clinical work with administrative work, generate the experience of compassion fatigue…. Compassion fatigue tends to occur cumulatively over time; whereas vicarious trauma and secondary traumatic stress have more immediate onset.

(Newell & MacNeil, 2010, p. 60-61)

Direct support for STS prevention and mitigation is rarely funded, whether due to lack of understanding, lack of will, or lack of prioritization. These organizational costs are not reflected in any budget line item. In order to inform the philanthropic sector and other stakeholders, we conducted this study to identify models and promising practices for supporting staff of community-based organizations who experience secondary trauma as a result of their work with these populations. The study employed triangulation through the application of three methodologies: (1) a rapid literature review; (2) individual interviews with fifteen program or agency administrators/mangers; and (3) focus groups in four cities with a total of 29 direct-service staff. Each methodology and its findings are presented below, followed by conclusions and recommendations based on the findings as a whole.

LITERATURE REVIEW

Summary

A rapid review of literature on interventions for secondary traumatic stress among providers who serve marginalized populations was conducted. Seven academic databases were searched for relevant publications published since 2000. Several layers of review resulted in a final 127 studies for in-depth review. Each study was characterized as a best, promising, or emerging practice based on a hierarchy of evidence. Best practices that emerged spanned both organizational and individual interventions. The evidence suggests that organizational interventions may be more effective in reducing STS than individual interventions.

Best practice organizational interventions included improved work schedules, lower caseloads, more diverse caseloads, job rotation, organizational support, improved work environment, collegial support, and teambuilding. Best practice individual interventions included psychoeducation about stress, trauma, and STS; stress management training; debriefing and communication skills; relaxation and mindfulness; coping strategies; social support; counseling; and resiliency training. The reviewed studies examined a wide variety of service providers and traumatized clients, as well as a wide variety of settings. This suggests that the identified best, promising, and emerging practices are generalizable and acceptable across many contexts, providers, and clients.

We conducted a rapid review of published literature on prevention and intervention programs for STS among service providers working with traumatized populations. The review was designed to address the following research question: "What is the effectiveness of prevention and intervention programs addressing STS among service providers working with traumatized populations, and what is the quality of evidence supporting this effectiveness?"

Methodology

A rapid review is an assessment of the state of knowledge about a policy or practice issue, by using systematic review methods to search and critically appraise existing research. The rapid review analyzes the quantity of literature on the topic of interest, and the overall quality of the literature and the direction of intervention effects. Such a review is useful for addressing issues needing quick decisions, such as developing policy recommendations.[6]

We conducted a broad search using the following academic databases: MEDLINE, CINAHL, PsycINFO, Social Work Abstracts, Social Services Abstracts, ASSIA, and PILOTS. The following Boolean search string was used:

[6]Grant & Booth, 2009.

"compassion fatigue" OR "secondary trauma*" OR "vicarious trauma" OR burnout
AND
intervention OR train* OR program OR therapy OR treatment OR workshop

A prior informal overview of the literature by the researchers revealed that there were few studies specific to STS among immigrant and refugee service providers. Therefore, the present search was not limited by client or provider population. Likewise, the previous literature overview revealed that rigorous studies were few; therefore, the search was not limited to randomized control trials, meta-analyses, or systematic reviews. The search was limited to studies published since 2000 in order to capture the state-of-the-art. Additionally, some databases allowed further restrictions on study methodology; we used such restrictions when available to limit the search to intervention evaluation studies. The study inclusion and exclusion criteria are shown in Table 1.

Table 1. Study Inclusion and Exclusion Criteria

Inclusion	Exclusion
Studies of STS intervention effectiveness (randomized controlled trials, quasi-experimental designs, case studies)	Studies of informal caregivers
Studies of STS correlates that are subject to intervention	Focus on primary rather than secondary trauma
Qualitative interviews with providers about STS	Studies of personality risk and resilience factors as related to STS
Literature reviews, meta-syntheses, and meta-analyses of STS interventions	Studies that neither describe nor imply any actionable intervention
Essays recommending STS interventions	Unpublished dissertations
	Studies published in a book that could not be accessed online
	Studies addressing general workplace stress, not STS specifically

The initial database search identified 537 potentially relevant articles. Application of the inclusion/exclusion criteria resulted in a final 127 articles for review (Figure 1). Each of the 127 studies was reviewed and classified as a best practice, a promising practice, or an emerging practice based on the hierarchy of evidence depicted in Figure 2. After each study was classified, the specific interventions across the studies were grouped into the highest evidence level available for that intervention. In other words, as indicated in the figure, a large body of emerging services supports a smaller group of promising practices which in turn support an even smaller set of best practices. Additionally, a few studies were identified that showed no effect of the intervention on STS; these were classified as "contraindicated practices." The following additional data were extracted from each reviewed study: methodology, country of study, work setting, provider population, sample size, client population, intervention, and outcome.

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram

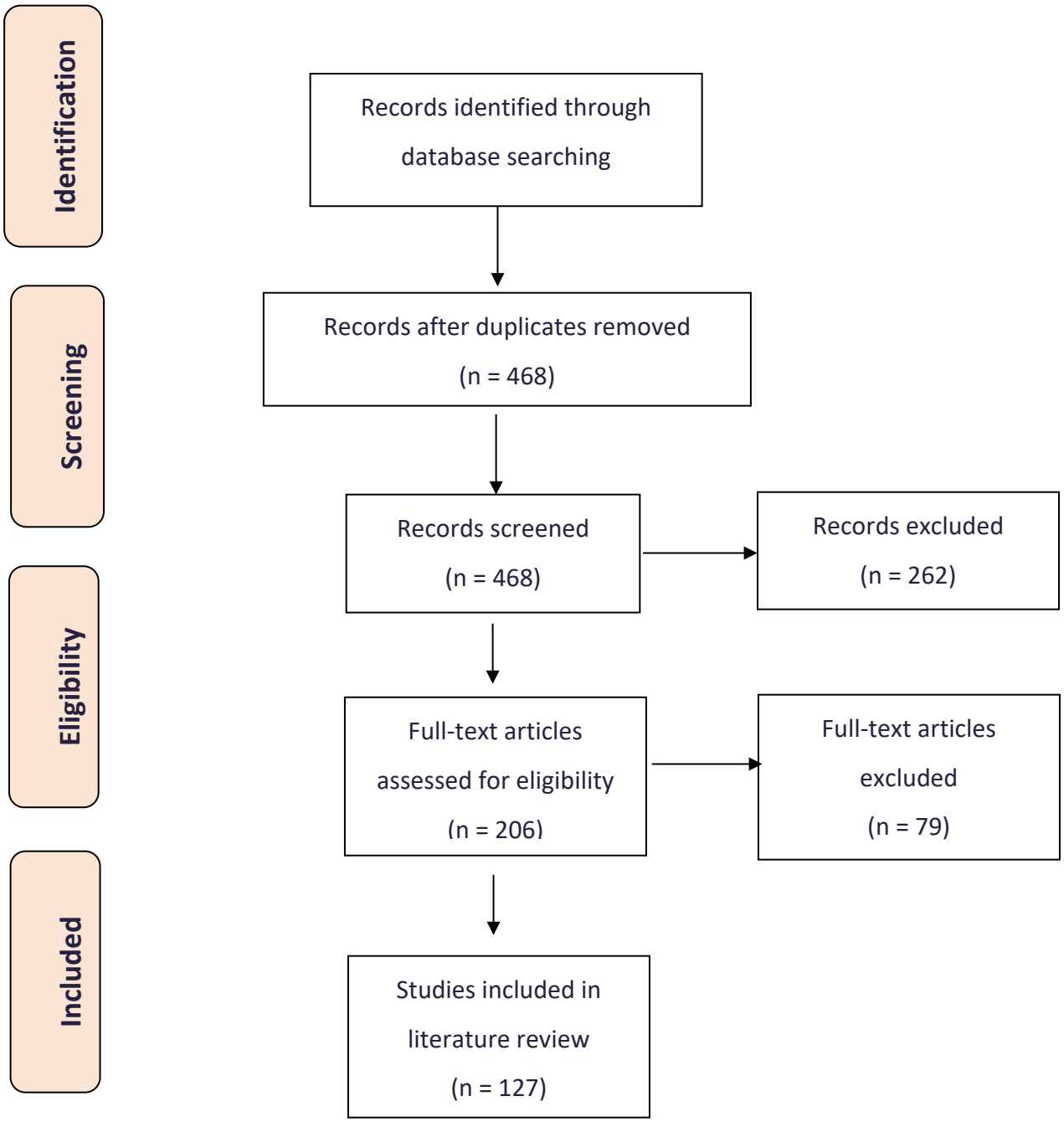
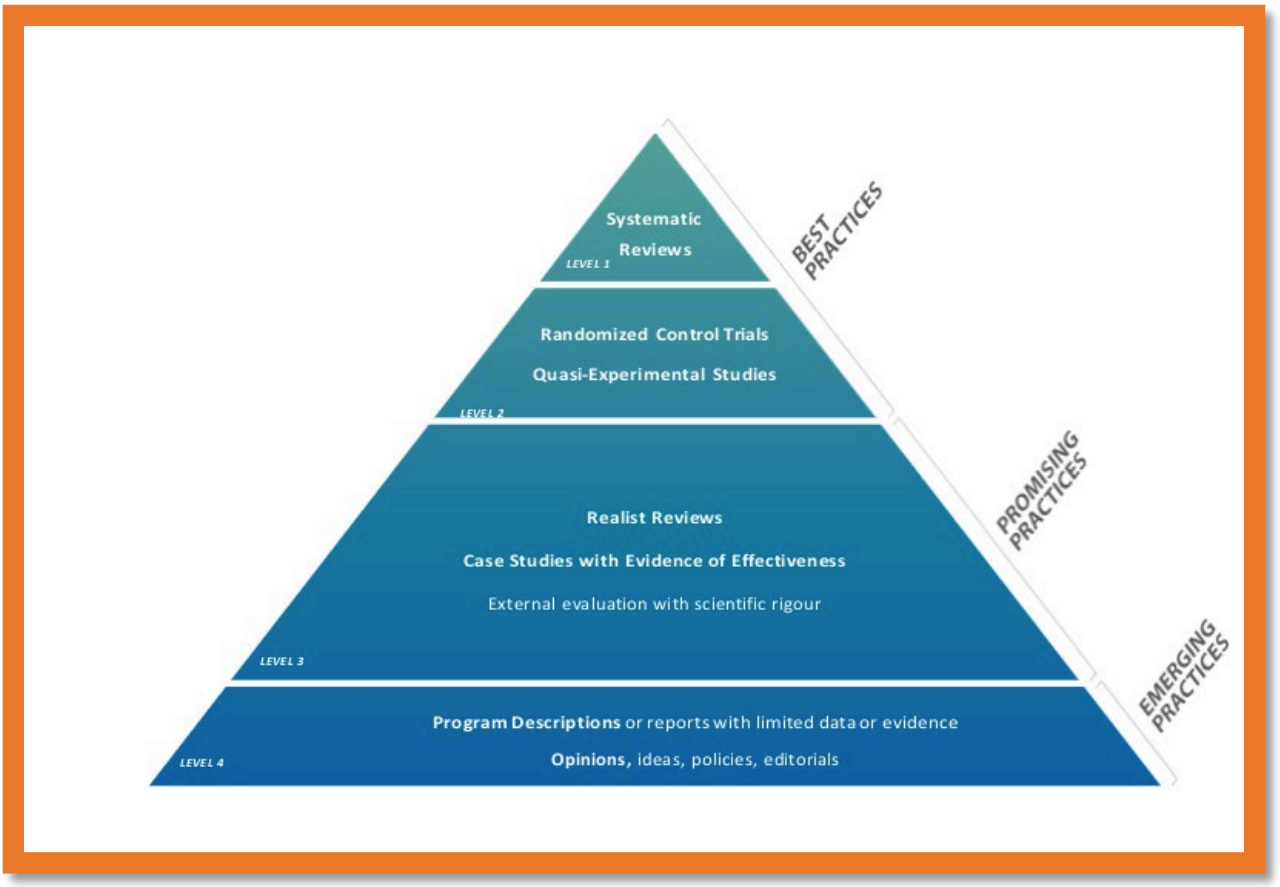


Figure 2. Hierarchy of Evidence Pyramid



Findings

Tables 2-6 summarize the characteristics of the studies. Of the 127 studies reviewed, nine were classified as best practices, 44 as promising practices, 68 as emerging practices, and six as contraindicated practices (Table 2). The studies were conducted worldwide, with the most frequent single country being the United States (Table 3). A variety of practice settings were represented, with multiple settings and medical settings being the most common (Table 4). Accordingly, most of the service providers were health care providers, therapists, counselors, mental health workers, and social workers (Table 5). The client populations were very diverse (Table 6). The best, promising, emerging, and contraindicated practices extracted from all 127 studies are described below. Six studies dealt specifically with refugees, including torture survivors (see Addendum).

Table 2. Study Methodology

Methodology	Best Practice	Promising Practice	Emerging Practice	Contraindicated Practice	Total
Opinion	0	0	30	0	30
Realist review	0	26	0		26
Cross-sectional survey	0	0	23	1	24
One-group pretest-posttest	0	11	0	1	12
Qualitative interviews	0	0	8	0	8
Case study	0	7	0	0	7
Program description/opinion	0	0	7	0	7
Systematic review	4	0	0	1	5
Randomized control trial	3	0	0	2	5
Quasi-Experiment	2	0	0	1	3
Total	9	44	68	6	127

Table 3. Country of Study

Country of Study	Best Practice	Promising Practice	Emerging Practice	Contraindicated Practice	Total
Various/multiple	4	24	27	1	56
USA	1	12	28	4	45
Australia	2	1	3	0	6
Israel	1	1	1	0	3
South Africa	0	0	3	0	3
Uganda	0	0	1	1	2
United Kingdom	0	2	0	0	2
Afghanistan	0	0	1	0	1
Canada	0	0	1	0	1
Ireland	0	1	0	0	1
Kenya	0	1	0	0	1
New Zealand	1	0	0	0	1
Portugal	0	1	0	0	1
Romania	0	0	1	0	1
Thailand	0	1	0	0	1
Germany	0	0	1	0	1
Total	9	44	68	6	127

Table 4. Practice Setting

Practice Setting	Best Practice	Promising Practice	Emerging Practice	Contraindicated Practice	Total
Multiple social service and healthcare settings	1	13	18	2	34
Medical	4	11	14	2	31
Disaster/emergency	2	5	3	0	10
Mental health/addictions	0	4	4	1	9
Academia	1	1	5	0	7
Military	0	2	5	0	7
Child welfare	0	2	4	0	6
Law enforcement	0	2	2	0	4
War/terror	1	0	2	0	3
Community	0	1	2	0	3
Intimate partner violence	0	1	2	0	3
Torture treatment	0	0	3	0	3
Animal care	0	2	0	0	2
Violence	0	0	0	1	1
Courtroom	0	0	1	0	1
Journalism	0	0	1	0	1
School	0	0	1	0	1
Rape crisis center	0	0	1	0	1
Total	9	44	68	6	127

Table 5. Provider Population

Provider Population	Best Practice	Promising Practice	Emerging Practice	Contraindicated Practice	Total
Health care providers	5	15	16	2	38
Therapists/counselors	1	6	20	2	29
Social workers	0	4	8	1	13
Various	0	8	3	0	11
Graduate students	1	1	6	0	8
Child welfare workers	0	4	3	0	7
Disaster responders	0	2	2	0	4
First responders	1	1	2	0	4
Teachers	1	1	1	0	3
Researchers	0	0	1	1	2
Interpreters	0	0	2	0	2
Refugee resettlement/ torture treatment providers	0	0	2	0	2
Animal care providers	0	2	0	0	2
Journalists	0	0	1	0	1
Judges	0	0	1	0	1
Total	9	44	68	6	127

Table 6. Client Population

Client Population	Best Practice	Promising Practice	Emerging Practice	Contraindicated Practice	Total
Various	1	17	23	2	43
Medical patients	5	11	12	2	30
Child abuse victims	0	3	6	2	11
Trauma victims	1	2	5	0	7
Military personnel/veterans	0	2	5	0	7
Intimate partner violence victims	0	1	5	0	6
Disaster victims	0	3	1	0	4
Refugees	0	1	2	0	3
Mental health/ addictions clients	0	0	3	0	3
Mass violence/ terrorism victims	0	1	2	0	3
Torture survivors	0	0	3	0	3
Animals and owners	0	2	0	0	2
Families	1	0	0	0	1
Schoolchildren	1	0	0	0	1
Crime victims	0	0	1	0	1
Sex offenders	0	1	0	0	1
Juvenile offenders	0	1	0	0	1
Total	9	44	68	6	127

Best Practices

Nine studies meeting the criteria of best practices were identified. It is noteworthy that all these studies have been published since 2011; thus, as illustrated in the previous hierarchy pyramid, these studies have built upon earlier promising and emerging practices and represent the most current evidence-based STS interventions.

Seven of the best practice studies focused on personnel in medical settings (i.e., nurses, first responders, medical students, and other healthcare personnel). One of these included a health care setting in a war- and terror-affected area.[7] The eighth study focused on schoolteachers following a natural disaster, and the last best-practice study was a meta-analysis focusing on trauma therapists in diverse settings.[8]

Across the nine studies, interventions that were found to be effective in reducing STS included organizational and individual strategies.

> The importance of organizational support for staff who are vulnerable to STS cannot be overstated.

Organizational Strategies

The importance of organizational support for staff who are vulnerable to STS cannot be overstated. A study of thirteen organizations worldwide that worked with victims of extreme trauma showed that “organizations with high stress and conflict levels exhibit considerable structural deficiencies and an atmosphere shaped by a reenactment of the traumatic world of clients. This chaotic, unstructured, unpredictable environment parallels the total absence of structure that exists when a victim is at a perpetrator's disposal.”[9] These authors found that staff in organizations with structural deficiencies showed STS symptoms, which abated after organizational transformation and structural improvement. They also found that caregivers in well-structured organizations exhibited almost no STS symptoms. Similarly, Bober & Regehr argued that "intervention strategies for trauma counselors that focus on education of therapists and augmenting coping skills unduly individualize the problem."[10]

Lower Caseload and Balanced Work Tasks

Providers’ exposure to clients’ trauma can be reduced by limiting their number of clients as well as balancing their work tasks to either (a) reduce the proportion of clients with trauma in the caseload; or (2) include other work tasks in addition to direct client contact, such as policy advocacy. In one promising study, participants reported that political engagement reduced their STS because it allowed them to channel their anger and sense of powerlessness regarding the insufficiency of social and justice systems for their clients.[11]

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[7] Berger & Gelkopf 2011.
[8] Hensel, Ruiz, Finney, & Dewa, 2015.
[9] Pross & Schweitzer, 2010.
[10] Bober & Regehr, 2006.
[11] Iliffe & Steed, 2000.

Organizational Support

This entails having the organization recognize, normalize, and destigmatize STS and help-seeking; providing physical safety and comfort; and providing opportunities such as time off and breaks.[12] Organizational destigmatization of STS may be particularly important for immigrant- and refugee-serving organizations, whose direct-service staff are often immigrants or refugees themselves from cultures where mental health problems carry a burden of shame. Staff may choose not to reveal their struggles with STS within their organizations for fear of being seen as weak or incompetent at their jobs. A promising component of organizational support is providing a mechanism whereby staff can identify systemic issues that exacerbate their STS and recommend solutions.[13] If such a mechanism is implemented, it is crucial to ensure there is accountability for reviewing, piloting, and transparently communicating the process by which recommendations are or are not implemented, so that staff feel heard.

Organizational destigmatization of STS may be particularly important for immigrant- and refugee-serving organizations, whose direct-service staff are often immigrants or refugees themselves from cultures where mental health problems carry a burden of shame.

Collegial Support

These studies identified the importance of collegial support in the form of being able to share one's STS experiences with coworkers. This may occur through one-on-one sharing or peer groups. The literature also encourages workplace respect and professionalism, positive feedback, staff recognition, and shared decision-making within an organization.[14]

Individual Strategies

Psychoeducation About Stress, Trauma, and STS

This approach was identified as a best practice in one study and as promising in nineteen others. This approach generally incorporates multiple components. For example, in the best practice study, Berger & Gelkopf studied nurses in well-baby clinics in war- and terror-affected areas in Israel.[15] The program is described in the box on the following page. In this randomized controlled trial, participants in the psychoeducational intervention had significantly lower post-test STS compared to participants in a wait list condition. As seen, this was a time-intensive, multi-component program including attending to the providers' own self-care and increasing their knowledge about attachment and trauma as pertains to their work. This study and the additional promising studies on psychoeducation imply that it is important for such training to be specific to the needs and experiences of the specific population being served for providers to feel properly educated and thereby capable in their roles.

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[12] Brend, Krane, & Saunders, 2019; Hesse, 2002.
[13] McNamara, 2010.
[14] Becvar, 2003; Berthold & Fischman, 2014; Chamberlain & Miller, 2009; Coetzee, & Laschinger, 2018.
[15] Berger & Gelkopf, 2011.

Best Practice Example:
Intervention for Nurses Working in War- And Terror-Affected Areas

The aims of the intervention were to provide nurses with psycho-educational knowledge pertaining to stress and trauma in infants and young children, to provide them with screening tools for identifying children and parents at risk of developing stress-related problems and to equip them with stress management techniques for both children and adults. This included knowledge regarding attachment theory and the development of the child-parent relationship, the processing of stressful and traumatic experiences, identifying personal strengths and acquiring new coping techniques. Additionally, nurses learned and practiced self-maintenance tools including skills such as breathing, meditation, relaxation, physical exercises, self-affirmation and guided imagery. Finally, techniques were taught and applied so as to enhance staff team-building and mutual support. The intervention was comprised of 12 weekly 6-h sessions in groups of 15-20 nurses. Each session included theoretical knowledge on various topics, experiential exercises where the examples from the nurses' work or personal life experience were shared, learned skills which were practiced during the session and homework assignments in between sessions. After the intervention, three five-hour supervision sessions were held monthly.

(Berger & Gelkopf, 2011, p. 604)

Stress Management Training

The effectiveness of stress management training was supported by two studies classified as "best practices" and further by four studies classified as "promising practices." These training programs typically involve several common elements. For example, a randomized controlled trial found positive effects of a half-day workshop to promote staff health and wellbeing.[16] Strategies for wellbeing and stress management were outlined and participants were encouraged to apply them in their own lives. Case studies specifically developed for the participants were incorporated, along with a holistic wellbeing framework and groupwork activities to encourage discussion about approaches to work, life and self-care. Some workshop topics included stressors relating to work-life balance, understanding wellbeing and resilience, mindfulness, barriers to looking after wellbeing, giving and receiving feedback and stress management strategies. The workshop duration was 4.5 hours including a 30-minute meal break where a catered meal was provided. Each workshop consisted of five to ten trainees and a specialist clinician facilitator.

[16] Axisa, Nash, Kelly, & Willcock, 2019.

Another example of effective stress management training is Critical Incident Stress Management (CISM).[17] This consists of the following components:

(1) Pre-trauma training: Stress Inoculation Training
(2) Debriefing: structured group based on Mitchell model of debriefing (one session, 1.5-2h)
(3) Individual follow-up: participants are assessed 1 month following the critical incident. Ongoing difficulties are identified. Treatment, if needed, is based on a cognitive behavioral approach.

Debriefing and Communication

As seen above, debriefing may be a component of a larger stress management intervention. Often, debriefing is vaguely defined, and presumably refers to discussing the incident and one's reactions to it with peers or supervisors. However, some structured debriefing approaches exists, such as Critical Incident Stress Debriefing (CISD), consisting of the steps shown in the following box. CISD is contraindicated for primary trauma victims as well as for single-session counseling for providers with STS, but if implemented over time, it appears effective in reducing STS.[18] In addition to debriefing, implementing intensive communication strategies such as frequent team meetings and conflict prevention also reduces STS.[19]

Relaxation and Meditation

Relaxation practices such as yoga, which often incorporates mindfulness, have been found effective in reducing STS.[20] Mindfulness is awareness that arises from intentional to the present moment without judgment.[21] For example, on study supported the effectiveness of a Brief Mindful Self-Care and Resiliency (MSCR) Intervention implemented with nurses.[22] MSCR was included as part of a larger workshop including education about STS. Five mindfulness sessions were held focus on the themes of autopilot, staying present, allowing/letting be, thoughts as thoughts, and review. Practices involving body and breath; body scan; mindful movement and stretching; sitting with the breath, body and thoughts; breathing space; and mindful eating were practiced. Other forms of meditation besides mindfulness, namely structured audio meditations and guided imagery, have shown to be promising.[23]

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[17] Phipps & Byrne, 2003.
[18] Jacobs, Horne-Moyer, & Jones, 2004; Phipps, 2003.
[19] Van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015.
[20] Ibid.
[21] Kabat-Zinn, 2003.
[22] Slatyer, Craigie, Heritage, Davis, & Rees, 2017.
[23] Cocker & Joss, 2016; Hevezi, 2016.

Best Practice Example: Critical Incident Stress Debriefing

(1) Introduction: facilitator emphasizes the educational component (i.e. to review symptoms and methods to prevent distress)

(2) Expectations and facts: facilitator encourages participants to describe the factual content in detail

(3) Thoughts and impressions: the facilitator may ask participants to describe what they thought, saw, heard, smelt etc. at different stages of the incident

(4) Emotional reactions: the facilitator enquires into the presence of acute stress reactions (e.g. fear, helplessness and guilt)

(5) Normalization*:* the facilitator stresses that these are normal reactions to such an event. Other common symptoms that may occur are covered

(6) Future planning/coping: discuss the availability of coping resources. Emphasis is on discussion with family and friends

(7) Disengagement: information is provided regarding available services (e.g. ongoing psychological therapy). Clients are given information as to the signs of poor coping

(Phipps & Byrne, 2003, p. 141)

Coping

Coping skills training appears to impact STS.[24] A meta-synthesis of 20 qualitative studies on STS found that coping in the form of organizational strategies such as peer support, supervision, and individual self-care reduced STS among a variety of helping providers.[25] Coping strategies were examined in one of the few reviewed studies of refugee service providers.[26] This study found that "maladaptive" coping behaviors such as self-distraction, humor, venting, substance use, behavioral disengagement, and self-blame were associated with increased STS. On the other hand, "positive" coping strategies such as active coping, emotional support, instrumental support, positive reframing, planning, and acceptance had no relationship with STS. Consequently, the authors concluded that reducing the maladaptive behaviors would have a greater impact on STS than promoting the positive coping strategies.

[24] Van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015.
[25] Cohen & Collens, 2013.
[26] Akinsulure-Smith, Espinosa, Chu, & Hallock (2018.

> In a study of refugee service providers "maladaptive" coping behaviors such as self-distraction, humor, venting, substance use, behavioral disengagement, and self-blame were associated with increased STS. On the other hand, "positive" coping strategies such as active coping, emotional support, instrumental support, positive reframing, planning, and acceptance had no relationship with STS. Consequently … reducing the maladaptive behaviors would have a greater impact on STS than promoting the positive coping strategies.

Social Support

Social support in the form of family and friends was identified as effective in reducing STS in three best practice studies and four promising practice studies.[27] However, the studies have not identified which types or combination of social support – emotional, instrumental, or informational – are most helpful.

Counseling

A systematic review identified counseling as an effective intervention for STS. [28] However, the type of counseling has generally not been specified. Cognitive behavioral therapy, crisis counseling, narrative therapy, art therapy, and Eye Movement Desensitization and Reprocessing (EMDR) show promise.[29]

Resiliency Training

This was identified as a best practice in four studies and further supported by two promising practice studies.[30] Two examples of unique resiliency programs are ERASE-Stress and the Compassion Fatigue Resiliency Program:

ERASE-Stress

This is a school-based intervention intended to enhance students' coping skills and resiliency strategies for dealing with traumatic stress.[31] A three-day workshop to train teachers to deliver the intervention to their students was conducted following an earthquake in New

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[27] Best practice studies: Greinacher, Derezza-Greeven, Herzog, & Nikendei, 2019; Hensel, Ruiz, Finney, & Dewa, 2015; Van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015.
Promising practice studies: Bride, Robinson, Yegidis, & Figley, 2004; Hecktman, 2012; Phelps, Lloyd, Creamer, & Forbes, 2009; Caringi & Pearlman, 2009.
[28] Van Mol et al., 2015.
[29] Cognitive behavioral therapy: Phelps, Lloyd, Creamer, & Forbes, 2009; Rohlf, 2018.
Crisis counseling: Naturale, 2007
Narrative therapy: Naturale, 2007; Mosek & Gilboa, 2016
Art therapy: Boyle, 2011; Hecktman, 2012; Mosek & Gilboa, 2016
Eye Movement Desensitization and Reprocessing (EMDR): Keenan & Royle, 2007.
[30] Best practice studies: Back, Deignan, & Potter, 2014; Berger, Abu-Raiya, & Benatov, 2016; Gillman et al., 2015; Slatyer, Craigie, Heritage, Davis, & Rees, 2017.
Promising practice studies: Cocker & Joss, 2016; Kinman & Grant, 2017.
[31] Berger, Abu-Raiya, & Benatov, 2016.

Zealand. The training included content on STS. Because the teachers had experienced the disaster just as their students had, trainers asked teachers to practice the skills themselves before delivering the training to their students. This randomized controlled trial showed that the ERASE-Stress training decreased STS among the teachers. This particular approach has unique ramifications for those who work with immigrants and refugees, as the staff themselves, particularly in refugee assistance programs, are former refugees who have experienced the same or similar traumas as the clients. However, it should also be noted that this intervention addressed a discrete traumatic experience, rather than the complex trauma that is often characteristic of refugee and some immigrant populations.

The ERASE-Stress approach has unique ramifications for those who work with immigrants and refugees, as the staff themselves, particularly in refugee assistance programs, are former refugees who has experienced the same or similar traumas as the clients. However, it should also be noted that this intervention addressed a discrete traumatic experience, rather than the complex trauma that is often characteristic of refugee and some immigrant populations.

Compassion Fatigue Resiliency Program

This approach consists of 4 90-minute sessions followed by a 4-hour retreat. It addresses the components shown in the following box. In a pilot study with 15 oncology nurses, this program was found to be effective in reducing STS.

Best Practice Example:
Compassion Fatigue Resiliency Program

(1) Living intentionally: developing and following one's professional covenant

(2) Learning to relax: relaxing even while involved in caregiving

(3) Self-validation: aiming to live and work with integrity rather than pursuing the acceptance and acknowledgement of others

(4) Connection: cultivating social support in the workplace

(5) Self-care: re-fueling and restoring energy and passion

(Back, Deignan, & Potter, p. e457).

Promising Practices

Two practices were repeatedly reported as promising but were not found in the best practice category: supervisory support and self-care. This may be because these are abstract and encompass many different aspects. They are also sometimes included with more comprehensive STS intervention programs, so that their unique effects may be difficult to evaluate.

Supervisory Support

The literature makes clear that not all supervisory support is equal. In order to be effective for ameliorating STS, the supervisor must acknowledge its existence, recognize its signs among staff, and proactively invite staff to discuss it regularly during supervision sessions.[32] Effective supervision must focus not only on resolving clients' traumas, but also that of workers. Organizational policies should undergird such supervisory practice.

Self-Care

Thirteen studies demonstrated self-care to be a promising practice. Posluns & Gall identified all the activities in Table 7 as promising self-care practices and classified them into domains.[33] As can be seen, there is substantial overlap between these activities and strategies already discussed earlier as best practices. It should also be noted that learning about self-care, developing a self-care plan, and implementing self-care activities are different processes that are likely to be associated with different impacts on STS.

[32] Brend, Krane, & Saunders, 2019.
[33] Posluns & Gall, 2019.

Table 7. Promising Self-Care Practices

Self-Care Domains	Self-Care Strategies
Balance	Acceptance and Commitment Therapy
	Mindfulness and meditation training
	Self-reflection
	Creative writing
	Leisure activities
	Varied work activities (e.g., teaching)
	Non work-related passions
	Non work-related relationships
	Holistic approach to health
	Professional and personal boundaries
	Time management
	Taking breaks
	Flexible work hours and locations
	Realistic work goals
Flexibility	Effective coping strategies
	Attitude of openness
	Adaptability
	Realistic self-expectations
	Cognitive reappraisal
	Self-compassion and acceptance
	Setting and reappraising goals
	Expressive writing and journaling
	Acceptance and Commitment Therapy
	Professional development
Physical Health	Sleep hygiene (e.g., self-monitoring sleep habits)
	Balanced diet and hydration
	Exercise
Social Support	Personal:
	Family
	Friends
	Personal psychotherapy
	Professional:
	Individual or group supervision
	Professional associations
	Colleague assistance programs
	University faculty
	Mentors/advisors
	Peer consultation
Spirituality	Spiritual connection
	Prayer
	Mindfulness
	Spending time in nature
	Practicing gratitude
	Meaning-making:
	Positive reappraisal
	Engaging in meaningful work
	Setting goals with life purpose
	Spiritual beliefs and activities (e.g., ultimate meaning of work)

Emerging Practices

Among the studies classified as emerging practices, four were unique in that they did not appear on either the best or promising practices lists. These were as follows.

Accelerated Recovery Program

This is a five-session standardized treatment protocol addressing the objectives shown in the following box. As seen, this is a package approach that combines many of the components previously identified as best or promising practices.

Emerging Practice Example:
Accelerated Recovery Program

The Accelerated Recovery Program:

(1) helps practitioners identify, understand, and develop a hierarchy of the events, situations, people, and internal experiences that trigger symptoms of compassion fatigue in their lives.

(2) helps practitioners review present personal methodologies of addressing these difficulties and begin developing self-treatment plans in four pathways to healing: skills acquisition, self-care, connection with others, and internal conflicts.

(3) helps to identify resources (external and internal) available to professionals that can be used to combat compassion fatigue.

(4) teaches self-soothing techniques.

(5) teaches mastery of state-of-the-art grounding and containment skills.

(6) engages practitioners in self-care, boundary-setting, and skills acquisition and highlights any impediments to full clinical potency.

(7) teaches mastery of the video-dialogue, a technique for internal conflict resolution and self-supervision.

(8) facilitates the development of a self-administered after-care plan.

(Gentry, Branowsky, & Dunning, 2002, p. 10-11)

Compassion Training

This approach fosters compassion toward self and others; it may include incorporating loving-kindness concepts into mindfulness meditation.[34]

Sanctuary Model

This is a trauma-informed organizational approach developed in domestic violence shelters. It is intended to mitigate the trauma of clients as well as the STS of staff. Organizational components include a flattened hierarchy, welcoming of multiple perspectives, group consensus on norms, values, and expectations, psychoeducation, and a focus on safety, affect modulation, grieving, and emancipation.[35] Although this practice model per se is classified as an emerging practice, its elements are consistent with the previously-described organizational best practices.

Provider Resilience Mobile App

This free app for mental health professionals includes two assessment tools to increase self-awareness of current levels of burnout. It provides an overall graphic of the user's current resilience rating, a clock that counts down the days since the user's last vacation day, and interfaces that encourage users to become aware of factors that affect their resilience. The app also includes several tools to help enhance resilience and, including "I Need a Laugh" (humorous cartoons), "Physical Exercise" (stretching exercises that can be done at a desk), "Virtue Cards" (inspirational cards with motivational quotes), "Remind Me Why I do This" (videos of clients indicating how their treatment impacted their lives), and "Videos" (provides video information on compassion fatigue).[36] Use of this app was found to be promising in one study,[37] but ineffective in another,[38] hence it is classified here as an emerging practice.

Evidence-Based Practices for Client Trauma

It has been suggested that clinicians who utilize evidence-based practices (EBPs) with their trauma clients experience lower STS. The use of EBPs enhances clinicians' sense of competence and professional satisfaction.[39] Clinicians may also experience lower stress due to the structured nature of EBPs and their greater likelihood of producing successful outcomes for clients. However, if clinicians feel constrained to use EBPs in an inflexible manner without consideration for a client's unique needs, the clinicians' stress may increase.

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[34] Brito-Pons, & Librada-Flores, 2018.
[35] Madsen, Blitz, McCorkle, & Panzer, 2003.
[36] Wood, Prins, Bush, et al., 2016.
[37] Ibid.
[38] Jakel, Kenney, Ludan, Miller, McNair, & Matesic, 2016.
[39] Voss Horrell, Holohan, Didion, & Vance, 2011.

Contraindicated Practices

Six of the reviewed studies were classified as contraindicated practices because the tested interventions showed no effect on STS. However, in all but one of these studies, the tested interventions (i.e., STS education, debriefing, self-care, supervision) were already established by numerous other studies as best or promising practices; thus, the preponderance of evidence indicated that these interventions belonged in the best or promising categories. The one exception was Reiki treatment. A randomized controlled trial showed that Reiki had no effect on STS compared to either placebo or control conditions.[40]

[40] Novoa & Cain, 2014.

INDIVIDUAL INTERVIEWS

Summary

This qualitative study explored individual and organizational responses to secondary traumatic stress (STS) as experienced and perceived by mid-level managers in immigrant- and refugee-serving programs in the United States. A sample of fifteen respondents was selected using convenience and snowball sampling. The findings yielded six overarching themes that respondents believe are critical elements in addressing STS within organizations: leadership, workload, physical space, proactive supervision, peer support, and individualized approaches. Participants' responses in these individual interviews correspond with the findings on best and promising practices for addressing STS as identified in the preceding literature review. For example, both the best practice literature and these respondents stressed the need for both organizational and individual strategies. These interview findings also add further support to promising practices found in the literature review, specifically, the need for proactive supervision. Furthermore, the immigrant- and refugee-serving organizations described by these respondents did not appear to differ substantively from other human-service organizations in both the experience of STS and the responses to it, as supported both by these interviews and the previous literature review.

We conducted individual interviews with fifteen managers in agencies or programs serving immigrants, refugees, asylum-seekers, and other foreign-born populations.[41] The aim of these interviews was to gather the perspectives of these personnel regarding how secondary trauma is addressed in their agencies or programs.

Methodology[42]

Participants

Respondents were recruited through convenience and snowball sampling. Invitation e-mails were sent to the professional contacts of the researchers, GCIR leadership, and the project advisory board. Additionally, emails were sent to relevant listservs. Invitation e-mails also asked recipients to share them with their contacts. Interested persons were directed to complete a brief online survey to confirm that they worked in managerial positions in programs or agencies that serve foreign-born populations. The brief survey also collected basic demographic information (i.e., geographic location, length of time in their position, gender, age, race/ethnicity, nativity (whether they were born in the U.S.), and personal trauma history (yes or no). [43]

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[41] Direct-service staff participated in focus groups. which are described in the next section.
[42] The research protocol for the individual interviews and focus groups was approved by Solutions IRB, LLC.
[43] Additional diversity characteristics such as sexual orientation or disability status were outside the scope of this study.

A total of 56 respondents completed the screening survey. After omitting those who did not hold managerial positions, twenty participants were randomly selected from the remaining list. These twenty participants were sent a follow-up email informing them that they had been randomly selected and providing further details about the study. Those who expressed continued interest were contacted to set up an interview time. Due to scheduling conflicts leading to inability to participate, additional respondents were randomly selected until a final sample size of 15 was obtained. Participants received $100 each upon completion of the interview.

Interview

The data collection took place during December 2019 and January 2020. Each respondent was interviewed individually via web conferencing. The interview questions are shown in the box on the following page. Each interview lasted 30-45 minutes. The interviews were audio-recorded and transcribed.

Data Analysis

The transcripts were first analyzed by interview question. After obtaining a general sense of the responses, a set of representative quotations were selected to capture the consensus of the respondents, or, when relevant, to demonstrate respondents' divergent viewpoints. Secondly, the entirety of the interviews was analyzed to identify overarching themes. This was done using open coding whereby emergent themes were identified, as well as in-vivo coding whereby specific terms used by respondents were flagged when they represented an overall theme. Initial codes that were noted to occur across a majority of the interviews were subsequently combined into larger, overarching themes. Additionally, throughout this phase of the coding process, analytic memos were developed to note potential theoretical connections and practical implications.[44]

Findings

Respondent Characteristics

The fifteen respondents worked in 11 different states (California (2), Florida, Idaho, Maryland, Massachusetts, New Jersey, New York, North Carolina (2), Pennsylvania (2), Tennessee, and Texas (2)). All respondents worked in agencies or programs serving foreign-born populations, although not all served foreign-born populations exclusively. For example, some organizations provided mental health and/or social services to broader populations. These included advocacy organizations, social service organizations, refugee resettlement programs, health programs, programs for survivors of torture, and legal services. The respondents were mid-level managers, with the exception to two, who were the executive directors of their agencies. They had been in their current positions from one month to eight years. Thirteen respondents were female and two were male. Seven were aged 25-34 and eight were 35-44. In regard to race/ethnicity, nine identified as White, four as Latinx, one as African-American and one as Asian-American. Ten were born in the US while five were not. Seven had a personal history of trauma and eight did not.

[44] Saldaña, 2015.

Individual Interview Questions

1. Does your agency have a wellness policy for staff?
   a. What is included in the wellness policy?
   b. Are there any informal practices that promote prevention of burnout?
   c. How would you describe the culture of your organization?
2. Has your agency struggled with staff burnout and secondary trauma?
   a. What indicators have you seen to tell you that your staff is or is not struggling with these "occupational hazards"?
   b. What steps (if any) has your agency taken to respond to these concerns?
   c. If steps were taken, what were the results?
3. What impact does secondary trauma play in service delivery?
   a. Example: Case load planning? Client feedback requests?
4. Has your organization experienced negative outcomes due to staff secondary trauma responses?
   a. Secondary trauma responses may include: symptoms of depression, anxiety, substance abuse, cynicism, pessimism, acute stress reactions
5. Has your organization experienced positive outcomes in relation to staff vicarious resilience?
6. What, if any, ongoing support interventions does your organization provide?
   a. Supportive or reflective supervision
   b. Clinical supervision
   c. Access to mental health services
   d. Gym membership discounts
   e. Caseload changes
   f. Training
   g. Other
7. What barriers has your organization faced in implementing, promoting or maintaining staff-care programs?

a. Has your organization implemented a policy or informal practice that did not work? What happened?

8. On a scale of 1-5, how supported do you feel by your agency when you are experiencing burnout or STS? 1 being I cannot tell anyone and have to muscle through / 3 being I can talk to my supervisor to find a solution / 5 being I can avail myself of the STS prevention program my agency provides.
9. If we were to ask your newest direct service staff member, what would be their response? Why?
10. If we were to ask your most seasoned direct service staff person, what would be their response? Why?
11. If you were struggling with burnout, vicarious trauma, compassion fatigue, secondary trauma what indicators would your co-workers see in you?
12. If you were struggling with burnout, vicarious trauma, compassion fatigue, secondary trauma what steps would you take to heal?
    a. What role would you see your agency taking in your healing?
    b. What responsibility do you see your agency taking in your protection from these hazards?
13. How does secondary trauma and your organization's response to it compare to other agencies you have worked in previously? (Follow-up: what client population(s) were you working with previously?)
14. Do you think that your staff and overall agency has experienced more, less, or the same level of STS over the past several years?
15. If resources were not a barrier, what type of programming would you like to provide to your agency?
16. Anything else you would like to mention about your agency's response to staff exposure to burnout, vicarious trauma, secondary trauma, compassion fatigue?

Question-by-Question Responses

Organizational Wellness Policies

While none of the agencies appeared to have formal written wellness policies, they did all incorporate numerous wellness elements for employees. These were on a continuum from minimal support to a great deal:

> We have an EAP [Employee Assistance Program], but nobody uses it as far as I know, they forward emails to us from the EAP. They're like cheesy articles. As far as promoting wellness as an organization, I'd say no, we're not there yet.
>
> (Participant 2)

> We have acupuncture, massage and then just a wellness room, where usually there's knitting and other craft activities and things like that. Then an exciting thing that's just gonna be starting … is every Friday besides the first Friday of the month, we're gonna have—just for staff 30 minutes of yoga in the morning that we can participate in. Then the first Friday of every month is we have a staff potluck that is just there to … end the week and start the day off nicely, but it has been nice to have those little things to show that they care a little bit more about the staff self-care and stuff like that.
>
> (Participant 11)

Informal Practices

Respondents reported a variety of informal practices used to mitigate STS:

> I think some of those have been as simple as just a blackout period for meeting time from 12:00 to 2:00 p.m. during the day that meetings are not supposed to be scheduled during those times… Some of the resources they provide are having folks come into the clinic to do chair massages for teams if that's a need, cofacilitation of group discussions around …issues in the clinic, but then I think a large part of it is left up to the managers to provide space for colleagues to a wide range of different opportunities. Within our clinic space, a large part of that is meeting together, of course, and doing things outside of work, but then also during the work day of being able to find rest within that, and so we encourage people to take 5-10 minute breaks to go either for a walk around the block or to go get a drink, especially if there's been maybe an intense encounter with the patient or something within the clinic, and so those are some of the things that we encourage specific to our clinic setting.
>
> (Participant 1)

> We have an open-door policy, so my peers and I will come to each other and vent or process when we have a particularly tough appointment. We've recently started at the beginning of our clinical meetings doing a mindfulness meditation… and actually it was an intern who brought it up. It's not necessarily organizational, but it's something that we've done on an as-needed basis.
>
> (Participant 4)

Organizational Culture

Respondents generally describe their organizational culture as supportive:

> It's hard to define. We often use the term that we are trauma-bonded. Our peers are very, very close because we do share the weight of the work that we do. We support each other a lot, not as much through management. The culture here is to just work real hard and do whatever you have to do to get it done. We provide mental health services, but we don't really receive it.
>
> (Participant 2)

> We always make sure they are okay. We always ask them if they need help, they can ask for help because where I came from, our culture, asking for help is like a failure. But here in America, we are telling them, asking for help is not a failure. It doesn't mean you fail or it doesn't mean you cannot do that job. We are explaining how asking for help is very important. … As a community, we have that big issue right now. People they don't ask for help, and instead of asking for help, we have also very high suicide in our community.
>
> (Participant 4)

> I think everyone is pretty open and pretty compassionate and they love the work that they do and they love working with the population that we work with, and they had years working with the population. That helps a lot for me specifically because they have the experience. I think it's a very caring environment, which is probably why I've been able to be there for a while.
>
> (Participant 5)

Secondary Traumatic Stress

All respondents reported the existence of STS within their organizations. Indicators that were repeatedly cited included:

- Detachment/withdrawal
- Crying
- Illness/pain
- Anger
- Frustration
- Missing work
- Lateness
- Procrastination
- Confusion
- Fatigue
- Lack of motivation

All respondents reported the existence of STS within their organizations.

Respondents reported a variety of steps taken by their organizations to address STS. These ranged from what were considered trivial efforts to very concerted ones:

> It's very superficial. Just like lip service, like, "Well, we said we did this," so it was up to you to say you needed more.
>
> (Participant 2)

> The first thing I try and do is make myself available to them. I try and like, "What can I do to help? Let's sit and talk about what's going on. What do you need? You feel like you're not getting this. What is it that you need right now today to help you feel like you could get this done," or whatever? Kind of responding to the immediate crisis. Then long-term, really trying to encourage them to do things like take the day off. You have some vacation that you haven't used. I really think that you should consider taking a day off." Really trying to push them to recognize that these things are issues that they need to be paying attention to.
>
> (Participant 8)

Results of these informal efforts to address STS varied. While some respondents reported that results were highly individualized, others reported transformative results.

> Half the time, they'll be like, "Oh, yeah. You're right. I really should take a day off." Then half the time, it's like, "No, I can't take the day off because I'm so busy, and I just don't have time." It kind of goes back and forth. It really depends on the person. Some people are just better about recognizing those things in themselves, and others just aren't. I feel like it's a really personal thing that you have to try and learn.
>
> (Participant 8)

> I think a lot of times, there's almost a cathartic release in those moments. There's usually—if not peers—there's just the acknowledgment of how much they have going on, and so I think they are able to have a moment. I think we try to do it in a way where we are mirroring that same thing of providing compassion and dignity, and even in those moments, the same thing that we would wanna convey with the individuals we're working with—patients or clients. It feels like they tend to have that moment of release, and then a lot of times, people will come back after that meeting, maybe a day or two later, and just acknowledge. Yeah, you're absolutely right. Thank you for bringing that up. This is what I'm doing to work on those things.
>
> (Participant 1)

Impact on Service Delivery

Although all respondents acknowledged the deleterious effects of STS on staff, when it came to its impact on service delivery, some respondents insisted STS had no impact, while other recognized its negative effects:

> I don't think that our clients pick up on it or if they do, they don't tell us. I don't think client services have been impacted … our clients are still getting the 100 percent.
>
> (Participant 2)

> In terms of the how the clients are treated, … because there is that support and resiliency that guards direct service staff from certain dynamics within the workplace but also helps inform their resiliency in their work, I think it's not as strongly felt with the community.
>
> (Participant 4)

> If somebody's showing up late, missing their appointments with clients, not communicating effectively, that of course affects the clients and services that they're receiving. If the staff is missing appointments, then the client is probably missing the appointment as well and missing out on potential services. Especially if it's something as important as an asylum appointment, that can greatly influence the client's case. I think it just breaks down the trust between staff and clients. It makes the clients more unwilling to work with us or put up their own boundaries.
>
> (Participant 12)

> When you've heard the same story 500 times, it has less of an impact…I think it interferes with your ability to respond appropriately, or with the sense of urgency that you maybe did with the first ten stories you heard like that.
>
> (Participant 13)

Negative Outcomes of STS

All but two of the respondents indicated that STS has affected staff's personal functioning as well as organizational functioning:

> I think just those feelings of we're paralleling that experience with our patients where our feeling of overwhelmed or unsure of what to do is mirroring what that patient is bringing into the clinic. (Participant 1)

> I think that we sometimes may focus more on one case than another, or maybe not wanting to deal with the one that's giving us a hard time. … I think you probably start to disengage with clients.
>
> (Participant 5)

> I've been here for 10 years. I think that mental health hasn't been anything that we ever discussed about until maybe four years ago. I'm gonna say maybe the first five-six years, the turnover was extremely high. I think having a staff member last no more than a year was the norm, so that was a really big reflection of the organization just lacking that connection. I think it's just not the organization, but the culture on its own, regarding legal and immigration.
>
> (Participant 9)

Vicarious Resilience

All but one of the respondents indicated that their staff experienced vicarious resilience stemming from client's own growth or success. Respondents described this in terms of joy and meaningfulness:

> I think when you see even little things that keep going right with clients or some positive outcomes, I think all staff… get their love of the job and what they're here for often gets reawakened and momentum starts back up again, especially if someone is feeling burnt out or something like that.
>
> (Participant 11)

> That's the thing that keeps staff in it and reaffirms [what they do] so then it's something that we focus on as a team, sharing success stories and celebrating every small victory, and we do that through group emails, group texts, and share pictures of our clients…. They'll send a note to everyone to celebrate some victory or to share what someone's kid is doing, some good report card. I think that that's one of the most important things to lift up in the work.
>
> (Participant 14)

Organizational Support

About one-third of the respondents indicated that their agencies utilized supervision (they did not distinguish between supportive, reflective, or clinical supervision), debriefing, provided access to mental health services for staff, offered discounted gym memberships, provided training on STS, provided relaxation/mindfulness training, and were making efforts to improve their physical space. None of the respondents reported their organizations ever offering training in communication skills, coping skills, emotional intelligence, or resiliency training.

Barriers to Staff Care

The following were consistently reported as barriers to implementing, promoting, or maintaining staff care programs:

Barriers to Staff Care

- Pressure to meet productivity metrics
- Work overload/insufficient staffing
- Lack of senior leadership understanding and support
- Mistrust/lack of staff buy-in

Perceived Support

Respondents were asked to rate how supported they feel by their agency when they are experiencing STS. A one to five rating scale was used, with a one being "I can't talk to anyone, and I just have to muscle through;" three being "I can talk to my supervisor and find a solution;" and five being "I can avail myself of the secondary stress traumatic stress prevention programs my agency provides." Most respondents rated their perceived support in the 2-3 range:

> I think it depends on the situation 'cause in my opinion I don't always go to my supervisor for the support but maybe other staff, so I would say usually a three.
>
> (Participant 11)

> I would say three… Part of that is my own personality, that I [don't] display emotions. It's hard for me to talk about feelings and stuff. Some of it's just that I would not necessarily ask for help the first time. I would probably wait till it's about to boil over. Our organization is not, at that point, really set up for a whole lot of self-care. That's why I wanna put it in the middle, 'cause I think I could, but some of it's my own personality. Some of it's the organization.
>
> (Participant 6)

A small number of respondents rated their perceived support at the low end of the scale:

> I would think it's the first one where there's no support… Just 'cause I just don't think there's an open discussion about leaning on each other for that type of support. It's just a given that you go through the motions of vicarious trauma as part of your job.
>
> (Participant 10)

> I would have to say on the lower scale. I actually went to my board … and told them that I was feeling really stressed out and asked for them to pay for therapy and to allow me to do that on work time. I got some resistance to that. It was kind of like, why do you need it? It's like, have you not been watching the news for the last two years? That was really frustrating for me … to be put in that position where I had to justify how I was feeling.
>
> (Participant 8)

Likewise, a small number of respondents rated their perceived support in the 4-5 range:

> I would say a five… The atmosphere has been one of excitement with the new things that we're implementing. Everybody's been very open with each other and supportive. HR, for example, has ensured that we are aware of the programs available and has made us comfortable accessing those services.
>
> (Participant 12)

> A four… I can talk to my supervisor but … also that I don't even have to. Doesn't even need to be a conversation, and I can just work from home, take the day off, go to my therapist, and … I don't [even] have to talk to her. I can call her and be freaking out [and it's] okay … so it is, I think, the culture of our department.
>
> (Participant 14)

When asked about how supported they think their newest staff members feel, respondents typically rated the perceived support level as similar to their own. However, when asked how they think their most seasoned staff members feel, respondents rated the perceived level as higher (generally in the 4-5 range):

> She is the founder… she doesn't see [STS issues] or doesn't care. It's hard to tell which.
>
> (Participant 3)

> I think they would tell you that there is a lot of support and that, especially management, that we really try to do what we can to support the staff.
>
> (Participant 8)

Healing Strategies

Respondents reported using the following strategies to decrease their own STS:

- Vacation
- Breathing techniques
- Counseling/therapy
- Mindfulness
- Medication
- Peer support
- Work fewer hours/see fewer clients
- Sleep
- Take a day off
- Increase social activities
- Exercise

Perceived Role and Responsibility of Agencies in Addressing STS

Although a small number of respondents felt that mitigating STS was their sole personal responsibility, most believed that their agencies had a significant role to play:

> I'll say providing me information resource, and asking me if I need help or no.
>
> (Participant 4)

> I'm hoping that we can create an organizational shift, and an actual policy to be able to support folks that are in that situation. If somebody is needing to take time off because they're burned out, then it's okay to call that personal time, and maybe not sick time, and creating safe spaces where we're able to support each other I think is something maybe we're doing off the record. Maybe if we can institutionally implement that, and promote it a lot more, I think would also show a shift in how people are handling things, and what direction the organization is able to do to create a nicer environment for the employees.
>
> (Participant 9)

> The relative flexibility that I have here and access to resources … that enable me to take care of my health, to flex my schedule, to go to appointments when I need to and be able to do that without losing my job.
>
> (Participant 15)

Going further, most respondents believed that their agencies had a responsibility to address STS:

> I think that being able to have a policy in place is a really big one because hopefully that policy will also articulate what caseload is; will articulate what stressful policies are, and other stressors that we're dealing with on a daily basis; to take those into consideration and be kinder with each other. Maybe looking for funding opportunities to take that burden off of the staff.
>
> (Participant 9)

> I do feel like in this field that is their responsibility to have supports in place that happen during work hours. That it's not just an employee's responsibility to take care of themselves because the work that we do is inherently traumatizing. I mean, literally, we work with torture survivors. I sit through exams and it's traumatizing. I think it's up to the organization to see what works best and how to support, whether that's doing a group supervision or therapy or individual, whether that's having an art group, or even something stupid like a potluck. I don't know, but I think that the organization needs to figure it out and offer that support on the company's dime.
>
> (Participant 2)

Comparisons with Previous Employers

Some respondents had worked previously in other social service settings. Comparing their current agency's STS response with those of prior employers, respondents reported a variety of experiences:

> I had the opportunity to start negotiating to change jobs with another agency. I was amazed by the opportunities and the programs that they had to support the physical and the mental wellbeing of the clients. They did have a lot of gym memberships, wellness programs that promoted walking, no smoking, healthy eating and they had a reward program that would give a lot of incentives to the staff to take care of themselves. That reward program included money, getting items. I felt a culture of people being really excited and inclined to take care of themselves in that way and participating in the wellness programs that they had just because of the incentive that the agency provided. I felt that that was amazing. I ended up working with them but I hope that it's something that every agency will consider, and also within the best of their abilities to the staff.
>
> (Participant 7)

> Honestly, I think it's very similar. In the end, I think what we're offering here is much different than what I've had access to in the past with the wellness activities and the conversations that happen, although even if things aren't actually being implemented, they're at least talking about it. I think a lot of … the differences also come down to the actual individual supervisor that you have and how you feel and if you're comfortable talking about certain things with them as well.
>
> (Participant 11)

> Well, I left my last job because I was burnt out. There was no … support. The job was working as a first response in an ER for people experiencing mental health crises. It could get crazy. You're hearing a lot and dealing with a lot.
>
> (Participant 12)

Change in STS Over Time

One respondent reported less STS in their agency over the past several years:

> Less… because most of the time now we're talking about this kind of issue, we make sure we look after each other. We try to have more volunteers… We have now more than eight, nine people who volunteer, so we share the burden now.
>
> (Participant 4)

Similarly, another respondent attributed an absence of increased STS to organizational awareness and response:

> I think some of that has stayed the same … 'cause everyone that walks through our door has been through trauma, … but I think how we look at it has been changing. Now we have four on-site therapists for our clients, various different types of therapy as well, so I think that has just shifted a lot of this conversation as well and changed how we look … at trauma in general… Having the therapists here on staff, they've also been able to bring in the more clinical aspect and understanding of things, which I find can help direct service and other staff just understand what might be going on with clients, as well as with ourselves.
>
> (Participant 11)

It is notable that both these respondents indicated that the reduction in STS was associated with increased staff capacity, whether volunteer or paid.

Reduction in STS was associated with increased staff capacity, whether volunteer or paid.

The remaining respondents, however, reported an increase in STS over the past few years:

> I think the change in immigration … affects the type of clients that we see. Before, it was like clients would come and they wouldn't have their asylum … interview until … a year or so. The way immigration law has changed, it's like they have their immigration [hearing] sooner… Our therapists … do psychological assessments for asylum interviews, and so … they have less time to write those... Then we started doing work at detention centers, so our staff will drive like an hour, hour and a half to go to detention centers and do a psych assessment for that one day. Then the nature of … the cases, they're faster and staff … don't have as much time to write the assessments. In terms of case management … we've gotten more clients with families which in the past we would get … clients who came in without families... I think it also has to do with migration patterns and stuff like that. We have seen a growth in families which increases our load as case managers 'cause it's not just one client, but it's also their kids or their partner or their parents. It definitely increases loads and stuff.
>
> (Participant 5)

> I had a lot of turnover … and I know that the nature of the work has a lot to do with that. It's a job that is not meant for everybody…. I had more than a couple of the staff that I started working and right immediately they said, "I can't do this. I am an immigrant myself. I have my own experience and when I'm doing the job, I'm seeing everything that the client goes through. My own issues are resurfacing, and I can't do this." I had at least a couple of the staff doing that.
>
> (Participant 8)

[All but two] respondents … reported an increase in STS over the past few years.

> Everything that has to do with immigration policy trickles down to the community that we see here. I guess most directly, we do have an immigration services program here. We have accredited reps who are doing certain types of immigration applications and walking families through these processes. Just the increase in bureaucracy and delay and confusion that they're encountering working with federal agencies …has [limited] by a third to two thirds the number of cases they're able to successfully see completed within the usual amount of time. Just lots of delays…. Of course, all of the frequent policy changes, confusion about public charge, rumors, actual enforcement activities and deportation that's happened in the local community and all of the conversation and fear that kicks up—we've seen it become harder to do the work. We've seen communities, in many cases, kind of periodically retract from us. Then just on top of all of the ongoing day-to-day things… There's affordable housing issues and housing safety issues. Employment, economic issues. The constant barrage of policy changes and missteps and actively targeting the communities we work with that's been just an added level of stress and worry and delay. Really, I think, especially for the longer-term people, kind of a feeling of, "Gosh, what have I been working for for 15 years, for 25 years?" A lot of discouraging feelings, I think. And the feeling of, "It's never been this bad." That's something I've heard people say.
>
> (Participant 15)

Ideal Organizations

In envisioning an ideal STS mitigation approach in the hypothetical absence of resource limitations, respondents mentioned the following elements:

- Regular staff retreats and lunches
- More office space/break rooms
- More information about how to access supportive resources
- Increased staffing/decreased workload
- On-site individual or group therapy
- Staff training
- More vacation time
- Increased salaries to feel more valued, fairly compensated, and less financially stressed
- On-site massage, yoga, relaxation, acupuncture, meditation
- Mutual support groups
- On-site treadmills, standing desks
- Decreased work hours
- Going outdoors during workday

Overarching Themes

Six major themes that cut across both respondents and specific questions were identified from the data analysis. These are shown in Figure 3 and each is detailed below.

Figure 3. Overarching Themes in Addressing Secondary Traumatic Stress

Leadership

Respondents consistently stressed the importance of support for addressing STS by senior leadership. Most respondents expressed a lack of leadership support:

> A lot of times, leadership don't address some of the trends or burnouts or trauma. It becomes more gossip among staff and employees instead.
>
> (Participant 4)

> I was for yoga. I remember bringing this up so many times I'm, like, "Can we have something for staff?" 'Cause we do have volunteers that come to serve our clients. I'm, like, "Can we have it for staff?" …So far, I feel like nothing.
>
> (Participant 5)

> Managers and supervisors have just not thought about it as much or put any thought into, "How is this affecting my staff?"
>
> (Participant 6)

In contrast, one respondent described an agency where leadership was highly supportive:

> I think the culture is one where… leadership really emphasizes it being a familial environment where…we acknowledge the fact that everyone working here is a whole person, and that work is one part of many priorities and elements in someone's life. For example, I think a good illustrator of this approach is that we have a set amount of PTO days… but our executive directors are very clear that if we need to take a mental health day and we don't have the PTO for it or just wanted to use our PTO for something else, they encourage us just to contact your supervisor and say, I really can't do it today. I need a mental health day, and it's excused, and nobody will ask you about it, so in that way, I think it's really supportive... If we do acknowledge that we've hit a boundary and we need a break, it's respected. I have not experienced any pushback, nor have I given any to my team, so if someone wants to come in at 11:00 the next day or needs to work from home, needs to leave early, those things are all easy for us to do.
>
> (Participant 14)

Such leadership responsibilities were seen to extend to board members as well as senior staff:

> It's important for the board to be involved and to make sure that staff are also being cared for because they're in charge of the organization as a whole as well. I think that they're often left out of it. If things are being mismanaged or staff are being abused, or if there's high turnover, those should all be signals that something needs to happen.
>
> (Participant 2)

> My board, they have no idea, from one week to the next, how I'm feeling or how I'm doing... the board sometimes is very detached.
>
> (Participant 13)

Workloads

Respondents unanimously described their organizations' workloads as overwhelming:

> It can be very fast-paced, and there's definitely a culture of working through your lunch and not taking [time] for yourself.
>
> (Participant 11)

> Everybody's always in overdrive.
>
> (Participant 13)

> People [are] overwhelmed.
>
> (Participant 14)

These unreasonable workloads were consistently cited as a reason staff don't use secondary trauma resources made available to them:

> You have the best intentions of how you're gonna take care of yourself, but then the work always seems more important than that.
>
> (Participant 13)

> There's no time to access things that help with self-care. I started going to therapy but I don't have time for it anymore. There's just not the time or the manpower to implement. We used to have a yoga lunch hour and that was taken away 'cause we didn't have enough staff time to attend to it and it just got in the way of the work hour.
>
> (Participant 2)

> The staff-serenity room was something that everybody really wanted, and it doesn't get used as often as I thought it was going to be used… At the end of the day, they feel like they don't have time to go up there. What they're doing is more important, and they want to get it finished.
>
> (Participant 13)

Several respondents stressed the importance of staff care to occur during work hours:

> I do feel like in this field that is their responsibility to have supports in place that happen during work hours…. the organization needs to figure it out and offer that support on the company's dime.
>
> (Participant 9)

> I'm a big advocate that we need that self-care at work because … not everyone has time to take care of themselves outside work. Little things like making time to go for a walk with a coworker for 30 minutes during lunch or something like that, those little things really help get me back on track.
>
> (Participant 11)

> The place that I would say was a bit better–formally organized to combat vicarious trauma, had more in place–like, "We're hiring you as full time, but we only expect you to work 32 hours a week, and here's why."
>
> (Participant 15)

Unreasonable workloads were consistently cited as a reason staff don't use secondary trauma resources made available to them.

Physical Space

Several respondents mentioned their organizations having created collective spaces for breaks, lunch, or contemplation. However, individuals' own workspaces were often in need of improvement:

> I would like to have a door. I get burned out … by people asking me questions.
>
> (Participant 6)

> Not everybody has a window, and I know seeing the sunlight really helps. That's something that we've struggled with. We let people kind of decorate their own space and do some of that, but we really don't have the resources to—I know some people like standing desks, right, to do that sort of accommodation for certain people. Some people have music on. Some people do headphones. Those types of things, we allow, but the ability to really make our office flexible unfortunately is not really an option.
>
> (Participant 8)

> We have this beautiful, fairly new building that they built kind of in the time when open offices were a big thing. It has only a few staff with doors that close which is not ideal… for trauma-informed care. We have that challenge for confidentiality and focus.
>
> (Participant 15)

One participant described how their organization had improved the employees' space:

> We are definitely outgrowing our space, but this was something that in our new strategic plan staff really raised concerns about … what our workspaces were like in the places where we could meet our clients, and this past year they … repainted all of our offices, which made a big difference. They've also created consultation spaces that're just for meeting with clients or [when] staff need [an]other, quieter place to work or things like that, and we've also in those consultation spaces have really decluttered, taken everything out that's not needed... Some teams have gotten brand-new furniture. Everyone got new chairs, which made a big difference 'cause a lot of that really does impact just how you're feeling day to day, even—we only had hand-dryers in the bathrooms, and I think right before the holidays they now have paper towels in them, too. Little things like that has actually made a big difference for us.
>
> (Participant 11)

Proactive Supervision

As noted earlier, respondents did not distinguish between supportive, reflective, and clinical types of supervision. However, there was a very clear distinction between proactive and passive supervision. Proactive supervision entails supervisors explicitly and consistently asking their staff members about their STS and coping strategies:

> Supervision is used not just to review individual cases, but to also check in with the actual person, and how they're doing handling the kind of information that we are exposed to… I think it's been helpful for me to be very explicit about how I wanna be accessible during supervision, and what the purpose is. You know, again, not just reviewing individual clients and their productivity, but checking in with them and being very explicit about it's okay when you're struggling with something or … your caseload is feeling too high, or you need a break—that we're communicating openly about that.
>
> (Participant 13)

> It's up to you, as a supervisor, to initiate that rapport with her. Otherwise, she's not gonna tell you anything that she's facing, and then this is all gonna blow up at the end.
>
> (Participant 4)

> I have weekly meetings with my staff. It doesn't fail like if I was to cancel a meeting, it's a concern that doesn't allow a person to be available… There is always an open line of communication and regular communication so that everybody is up to date with what's happening. When you have that open line and frequent communication with the staff, you are able to identify early what's happening.
>
> (Participant 7)

Proactive supervision includes modelling the desired behavior, which is a struggle for some:

> From the supervisory perspective I would also say modelling that to your staff because I could be talking to them saying, "What are you doing to take care of yourself" or talk about boundaries but if I don't model that myself, let's say I'm emailing them at the 10:00 at night and expecting them to answer me … I may be confusing the staff.
>
> (Participant 7)

> I think I'm not always the best at being a good example of that because I tend to work all hours. I might leave at 5:00 'cause I have to go run a personal errand, but then I'm sending e-mails at 11:30 or midnight or sometimes even 1:00 or 2:00 in the morning. For myself even, I think because I grew up as an attorney anyway in this environment of not really feeling like I had much help, I do—I think I struggle more with being a good example to them of what they should be doing.
>
> (Participant 8)

> I make a point to attend those things as well… Showing that I support them and am going to some of these other activities that we have helps a lot.
>
> (Participant 11)

In contrast to proactive supervision, passive supervision entails supervisors discussing STS issues only if the staff members themselves raise them:

> I guess it pretty much depends on the person doing the role. It's open. If I would like to meet with somebody weekly, I can, but they gave it up to us as needed. How I have it right now is as needed.
>
> (Participant 7)

> As a whole there's not too much. I think a lot of that leads down to the actual individual teams and supervisors on that team, and in the sense that through supervision and meetings discuss what's going on, ways that they can be supported to help with their clients, see if there's a need to get some more support … [I]n the end it always comes down to that individual and whether they're willing to actually do it.
>
> (Participant 11)

Not all supervisors are able to recognize signs of distress in their staff, thus highlighting the need for active outreach and education:

> My EI [emotional intelligence] is not very high, so I tend to not notice something happening until they tell me like, " just had a nervous breakdown." Just from people talking about how stressed out they are, or they're feeling overwhelmed, or they have too much to do. Just people telling me directly.
>
> (Participant 6)

A potential barrier to implementing proactive supervision is that some supervisors view it as intrusive:

> We definitely don't do micromanaging. We kind of let people handle their own cases. We provide as much support as they want. We kind of leave it up to them to tell us what they need. That's kind of how it works. I think sometimes, it works really well, and sometimes, it just doesn't.
>
> (Participant 8)

Peer Support

Respondents consistently highlighted the value of peer support in mitigating STS. Such support could occur in person with an agency, in interagency forums, or via social media:

> The kind of culture we foster and that we're really intentional about, is making sure people have spaces to go and good relationships with their teammates, so if they need a half-hour to cry in someone's office, they feel comfortable doing that, and that happens quite frequently. I think that that's helpful as well, just knowing there's safe, non-judgmental spaces to process.
>
> (Participant 14)

> I would … give people an opportunity to just get together and emote some of their experiences. I've seen other organizations that have that or even lawyer associations that are formed that provide that kind of opportunity to people to talk about tough situations in their cases. I think that'd be helpful for the people that need it.
>
> (Participant 10)

> We have a Facebook page … and I think every state has their own one for their state. I said, "Is anybody else on here struggling with depression?" I had over 100 responses and likes and people saying, "Yes. Every day. Thank you for talking about this." I don't personally want there to be a stigma about it. I'm trying to talk about it and not be ashamed.
>
> (Participant 6)

Individualized Approach

The final cross-cutting theme extracted from the interviews was the necessity to give each employee the freedom to utilize whatever form of staff care works best for them, since everyone differs in their response to STS:

> It varies. Every person is really different.
>
> (Participant 8)

> That's a case-by-case, or person-by-person basis.
>
> (Participant 9)

> It depends on the person.
>
> (Participant 10)

One respondent provided an example of implementing an individualized approach to staff care:

> With my staff… I have had them create a self-care plan…It is something that I require of my staff to do… things that they need as staff to support them and help them feel safe and comfortable in the work environment… They don't necessarily have to share it with me. It's something that they can refer to throughout their work here… It starts with a self-care assessment and a lifestyles behavior worksheet. Determining how … characteristics of your lifestyle are impacting stress, mental health, your ability to cope with stress. Then there is a maintenance self-care worksheet. What are you doing now? What can you do to maintain it? Is there anything that you would like to add? Then there's an emergency self-care worksheet, so what can you do that's quick and in-the-moment if there is an emergency self-care need when you're working with a client and you're triggered or something like that.
>
> (Participant 12)

FOCUS GROUPS

Summary

Focus groups with front-line personnel serving marginalized populations were conducted in four cities: Miami, Chicago, El Paso, and Phoenix. Topics discussed included knowledge of secondary traumatic stress; perceived role and responsibility of the agency; organizational practices that promote and prevent secondary traumatic stress; and diversity, equity, and inclusion. The focus group findings confirm the findings of both the literature review and the individual interviews. There were few differences in perspectives or experiences across the four sites, despite their varied geography, history, and populations served. There also were no differences noted across types of organizations (e.g., legal, social services, medical). This further confirms the earlier findings which suggested that best practices for STS prevention and mitigation strategies have broad applicability across settings and populations.

We conducted four focus groups with front-line personnel, most of whom worked primarily with immigrants, refugees, and other foreign-born populations. The aim of this phase of the overall study was to gather these staff members' perspectives about how secondary trauma is addressed in their agencies or programs.

Methodology

Focus Group Sites

Following several rounds of discussions, four focus group sites were selected by consensus of GCIR leadership, the project advisory board, and the researchers. The general guiding criteria for selection were diversity in geography, immigrant/refugee groups, and local immigrant policy, as well as the presence of local professional networks of the project partners. The following cities selected are shown in the box on the following page.

Participants

Respondents were recruited through convenience and snowball sampling. Recruitment and demographic data collection were conducted in the same manner as for the individual interviews. A total of 80 respondents completed the screening survey. After omitting those who did not hold direct-service positions, ten participants in each site were randomly selected from the remaining list. These participants were sent a follow-up email informing them that they had been randomly selected, providing further details about the study, and asking to confirm their continued interest. The target size for each focus group was 6-8 participants as recommended in the literature;[45] in cases where those selected declined or did not respond, additional participants were randomly selected and contacted until the target sample size for each group was confirmed.

[45] Rabiee, 2004.

Focus Group Sites

Miami
This metropolitan area has the highest concentration of immigrants in the U.S. at 40%.[a] Starting with a large influx of Cuban refugees in the early 1960's, the city continues to be a destination point for diverse immigrant and refugee groups, primarily from Latin America and the Caribbean.

Chicago
This upper midwestern city, the third largest metropolitan area in the nation, has always been a gateway city to a large and changing immigrant and refugee population. Chicago has been identified as the No. 1 city in the country in its efforts to support immigrant integration, based on multiple metrics.[b]

El Paso
This city that shares an international border with neighboring Ciudad Juárez, Mexico, has been at the forefront of receiving large numbers of asylum-seekers from the Northern Triangle of Central America during the past several years.

Phoenix
This southwestern city with a large native-born and foreign-born Latinx population is the capital of a state that has enacted numerous anti-immigrant laws and ordinances in recent years.

(a. Migration Policy Institute, n.d.; b. New American Economy, 2020)

Focus Group Procedure

The focus groups took place during February 2020. Each focus group lasted approximately two hours. One of the researchers served as the focus group facilitator, asking semi-structured questions and verbally validating the responses through reflective listening. The other researcher took notes to identify emergent themes and asked follow-up questions as needed to gain further clarity or depth about participants' responses. The focus group questions are shown in the following box. The focus groups were audio-recorded and transcribed.

Focus Group Questions

1. What do you know about secondary traumatic stress?
2. What role does your agency play in your self-care and secondary traumatic stress prevention?
3. What self-care practices does your agency promote? In what ways?
4. What practices, in your organization or previous experiences, lend themselves to promoting burnout or secondary traumatic stress?
5. What practices, in your organization or previous experiences, lend themselves to promoting prevention of secondary traumatic stress?
6. What happens in your organization when someone seems to be struggling physically or emotionally?
7. What role does diversity play in responding to staff needs? Who has a voice in the agency?
8. In an ideal organization, what types of responses would an organization have to protecting against secondary traumatic stress?

Following the focus group, two brief self-care exercises were led by the facilitator in order to allow participants the opportunity to de-stress and reflect following the potentially stress-inducing focus group discussion. The first exercise was a one-minute guided meditation. Following this, the facilitator noted that this brief exercise could be done anytime, anywhere that the participants felt stressed in the future. The second exercise consisted of an "emotion color wheel" where participants identified emotions they most frequently experienced, or those they would like to experience more frequently. The facilitator encouraged participants to reflect, on their own, upon any insights gained from this exercise. Participants each received a complimentary lunch and $200 upon completion of the focus group.

Data Analysis

Thematic data analysis was conducted in the same manner as with the individual interviews, with the use of Atlas.ti software.

Findings

Respondent Characteristics

The respondent characteristics are summarized in Table 8. A total of 29 individuals participated, with 8 in each focus group except Phoenix, which had 5. The largest number of participants (12) worked in social service agencies, while a nearly equal number (11) worked in advocacy or legal organizations. The respondents' positions consisted primarily of attorneys (10) and case managers/program specialists (9). Most respondents (20) had been in their positions for 1-5 years. The vast majority (25) were female and aged 25-44 (22). Six of the 29 were foreign-born, and one-half (14) had a personal history of trauma. There was little variation across the sites in years in respondents' position, gender, age, and personal trauma history. Miami had a greater proportion of Latinx and foreign-born respondents, and Chicago had a more racially/ethnically diverse group overall, consistent with those cities' overall

population demographics. There were differences across sites in the positions held by respondents; the Miami group consisted almost exclusively of case managers/program specialists, the El Paso group consisted primarily of attorneys and a paralegal, and the Chicago group was most diverse in its occupational representation.

Table 8. Respondent Characteristics

City	Organization Type	Position	Years in position	Gender	Age	Race/ Ethnicity	Foreign-born	Personal trauma history	Total
Miami	Social services: 5 Legal: 1 Education: 2	Case manager/ program specialist: 7 Attorney: 1	< 1: 1 1-5: 4 6-10: 3	F: 8 M: 0	25-34: 2 35-44: 4 45-54: 1 55-64: 1	Latinx: 7 African-American: 1	Yes: 3 No: 5	Yes: 4 No: 4	8
Chicago	Social services: 2 Advocacy: 2 Medical: 3 Pastoral: 2	Physician: 2 Attorney: 2 Clinician: 1 Executive director: 1 Educator: 1 Social worker: 1	1-5: 6 6-10: 1 > 10: 1	F: 7 M: 1	25-34: 1 35-44: 4 45-54: 2 55-64: 1	White: 3 Latinx: 3 Asian-American: 1 Other: 1	Yes: 1 No: 7	Yes: 4 No: 4	8
El Paso	Social services: 3 Advocacy: 1 Legal: 4	Case manager/ program specialist: 1 Attorney: 5 Paralegal: 1 Clinician: 1	< 1: 1 1-5: 5 6-10: 2	F: 5 M: 2 Nonbinary: 1	18-24: 1 25-34: 4 35-44: 2 45-54: 0 55-64: 1	Latinx: 5 White: 3	Yes: 1 No: 7	Yes: 3 No: 5	8
Phoenix	Social services: 2 Advocacy: 3	Case manager/ program specialist: 1 Social worker: 2 Attorney: 2	1-5: 5	F: 5 M: 0	25-34: 3 35-44: 2	Latinx: 3 White: 2	Yes: 1 No: 4	Yes: 3 No: 2	5
Total	Social services: 12 Advocacy: 6 Legal: 5 Medical: 3 Pastoral: 1 Education: 2	Case manager/ program specialist: 9 Physician: 2 Attorney: 10 Paralegal: 1 Clinician: 2 Social worker: 3 Educator: 1 Executive director: 1	< 1: 2 1-5: 20 6-10: 6 >10: 1	F: 25 M: 3 Nonbinary: 1	18-24: 1 25-34: 10 35-44: 12 45-54: 3 55-64: 3	Latinx: 18 White: 8 African-American: 1 Asian-American: 1 Other: 1	Yes: 6 No: 23	Yes: 14 No: 15	29

Question-by-Question Responses

Knowledge about Secondary Traumatic Stress

All participants in all focus groups were able to articulate an accurate understanding of STS:

> You internalize someone else's trauma, but you end up going through the same stress that comes with it, so the depression and the emotions that come along with that trauma, even though it may not be yours.
>
> (Miami focus group participant)

> The aggregate is the factor, and how that's so different from primary trauma because I think hearing hundreds of thousands of stories in a certain vein of human suffering just takes a toll in a way that's quite different than primary trauma.
>
> (Chicago participant)

> You're having a conversation with somebody that completely doesn't know your work and there are times when you refuse to elaborate and explain exactly what you do because it just… you get those feelings.
>
> (El Paso participant)

Role of Agency in Self-Care and STS Prevention

Respondents felt that their employers had the responsibility to warn them about STS and address it in a substantive manner:

> I mean it's just like any other workplace safety, right? If I'm gonna slip on the floor, I need to know that I'm gonna slip on the floor.
>
> (Miami participant)

> Organizationally their responsibility is to say, not only how am I affecting the client's health but how am I affecting the employees and making sure they are doing right by both. Which necessarily is going to mean that you probably serve less people. But you will serve them better. And you'll leave the people who are doing this service better than you found them, which should be their responsibility even though I don't think it's required…. And it's fine to hire someone to come talk to people at an organizational meeting but if all they're going to do is like I could have read that on a PowerPoint, what are you actually doing to move us along in a way that is meaningful, nothing? And so then it feels like we're still where we were when we started this, only now you feel like you have less responsibility because you've done something about it, but actually what you did felt more hurtful.
>
> (Phoenix participant)

Organizational Strategies

Respondents reported a variety of strategies that their organizations have deployed to promote self-care and prevent STS. These included:

- Staff retreats
- Staff meetings
- Mindfulness
- Behavioral health insurance coverage
- Sick leave for mental health days
- Supervisors trained in trauma-informed supervision
- Monthly stipend for self-chosen self-care
- Collegial socializing (e.g., weekly free lunches)
- Sabbaticals

However, some agencies had made no efforts, while minimal efforts were perceived as insulting:

> There's nothing in our procedures that actually talks about the trauma that we might face, and the injury that we might face.
>
> (Chicago participant)

> As far as the organization is concerned, like I said, they do what they do, like one yearly health fair. That's where you're supposed to, like, yeah, go get a chair massage for 15 minutes. Then you should be good for the rest of the year.
>
> (Miami participant)

> We get a thing that will say, "Okay, if you're having a hard time, call this number." I'm not gonna call that number. No, I'm not gonna do it.
>
> (Miami participant)

At the other end of the spectrum, some organizations used creative means to address STS:

> One thing that we do at our staff meetings weekly is Den of Marbles. We give marbles and we receive marbles. Once the marbles are filled, then we go on our fun staff retreat. The process of the marbles is you give a marble to whomever… really kicked butt this week. They did all this and the other, and then a marble for myself for this, that, and the other. Basically, it's to alleviate the trauma and say you matter. The bit that you do matters, so for you to be able to find appreciation 'cause you do all this work, and a lot of the time, you don't get recognition for it. We're human. We want to get that little limelight, even for a second, but knowing that somebody sees what you're doing and putting in the work, and just to like, "Thank you. That was a very hard work. I appreciate you for that."
>
> (Miami participant)

> We got funding to seek therapy with therapist in Mexico. That's the only way we could get therapy in Spanish (via Skype) well enough to treat them and to be able to schedule it around their schedules. A lot of them, work 12 hours so it is hard to get them to even go to the therapy
>
> (El Paso participant)

Organizational Response to Staff Struggles

When asked what happens in their organizations when a staff member is visibly struggling physically or emotionally, respondents described a variety of actions:

> In my office, we work very closely together, literally on top of each other, so you can't cry, or something can't happen without everybody finding out. Thankfully, that's one good thing that we do have. Everybody kind of rallies around you.
>
> (Miami participant)

> At one point I was so stressed out I was forced to take a sabbatical. I was not given an option, they told me I had to take time off. It was helpful but it had to get to the point where it was just very evident what was going on. That's kind of what happened with everyone at our organization. At some point they will say ok do it but it's always once it's hit critical mass, and I think in my case it was just because they were afraid I was going to quit.
>
> (El Paso participant)

> I think in general people feel uncomfortable. The first thing they do is go call the social worker…and suggest they talk to their supervisor for the day off. It's often discomfort and let them handle it on their own.
>
> (Phoenix participant)

Many respondents spoke of the importance of collegial support, including both within and outside the organization. Such support was both emotional and practical:

> We're all pretty supportive. If somebody starts crying, I think people will be there to comfort them or whatever the case may be. I've had it happen many times where I'll have an attorney or somebody in my office, and then we started talking about it, and then we'll start crying. I know that the way that I deal with things is, for me, I welcome that, frankly, so I always tell staff what to do to save face. You can cry. It won't be the first or the last time somebody cries in my office. We talk through it a little bit.
>
> (Miami participant)

> Dealing with systematic things like courts being scheduled and having to be in three places at once, you know they don't care. So saying, "Hey, are you going to be down here, could you go to this hearing for me?", sort of working together more.
>
> (El Paso participant)

> A great program I found, it was on the refugee population, and we meet once a month… We first came together three years ago. We just were there for each other, and then we said, "What can we do to help?" That's how the organization grew, but that's always a place that I go to every month once a month and to talk with other providers who've gone through similar situations.
>
> (Chicago participant)

> On social media also, that's an outlet for us to vent about what's going on sometimes.
>
> (El Paso participant)

One participant offered the "Parable of the Choir":

> The note that is written that is humanly impossible to sing, and so the choir members take staggered breathing….: To me, that's a beautiful way of thinking of what we do. The work is always ongoing and more demanding than we're ever gonna finish, so we have to know when it's time to tap out, and we have to provide those spaces, and that's okay. You take time away, and I've got you right now, and then you'll get me later.
>
> (Chicago participant)

Diversity, Equity, and Inclusion

The subject of diversity, equity, and inclusion was one of the few that produced differing responses across the different focus group sites. In the Miami focus group, most participants felt that they and others had a voice within their organizations:

> I wanted to manage expectations with the wellness committee. They were like "Well, wow, this is one of the first times we've ever—places where we felt we actually were able to express our opinions and really be heard about things.
>
> (Miami participant)

> Everybody has a voice. There is an open-door policy that's actually open. What I've experienced sometimes is that there's always an undercurrent of people that are not satisfied, but then they talk amongst themselves, versus talking to the person that you need to be talking to in order to cause change to happen.
>
> (Miami participant)

However, one participant in the Miami group noted that supervisors' and staff members' perceptions of openness may differ:

> Then I think we were talking about doing whatever, feedback Fridays or something a particular time. Maybe it's once a month, where people from management sit in a conference room, and people can come in and ask questions or share ideas or whatever. That hasn't happened yet, but I think you quoted something interesting is that, I think, oftentimes, as the managers or the supervisors, we do feel like we have access for ideas to be heard, but that might not always be translated down.
>
> (Miami participant)

In the Chicago group, participants expressed feeling excluded within their organizations:

> You're constantly just then running into a wall' cause your voice is heard and it's acknowledged, but then nothing that happens.
>
> (Chicago participant)

> In our work, a lot of us need to give management a piece of it. "Please hear the stories of our clinicians and supervisors, the trauma that they're going through, the things that they're going through," and trying to let them know that, being human beings, there's another side to them other than just filling these slots, getting these tasks done.
>
> (Chicago participant)

In Phoenix, when discussing issue of staff diversity and inclusion within their organizations, respondents referred to institutional discrimination rather than to a direct association with STS. Thus, exclusion was an additional source of stress:

> I don't know what it's like to be a man, but I just feel like this is an especially huge problem for women, we have to be the hub. I can't count the number of times that people, even in my own family will say 'well you can't fall apart, you've got to keep it together.' Thanks for adding… And I think that happens to women inside organizations, … There's the issues that women deal with in general society that play out in the organization, but also issues that we have with each other in the organization. It's crazy the level of complexity. And then you add things like race or like money and it can get scattering where I have moments where I feel like I can't, it's too much. You literally feel like you can't stay and do your job, because you're going to wrong someone somehow. It's really hard to figure out how to mentally and spiritually protect yourself and at moments that you're getting it from other areas of your life.
>
> (Phoenix participant)

> When they're promoting someone or giving a raise, are they consistent? Is there a reason why? Or they aren't being transparent. And as time passes you're able to see that some individuals are able to be that voice, without being seen as problematic, but others will be seen as problematic or complaining.
>
> (Phoenix participant)

> Because our organization is run by white women, it has been difficult. I've seen job postings go up that have been whitewashed, so someone like me can't get into that position, even though I've been with the organization for several years. White women in other organizations that are seen as great writers so they are promoted into other positions, so I think they're trying their best, I understand that but I've seen several things throughout my years there that also play into this additional issue of women of color in non-profit organizations. And again, I think we talked about it, like you're heard, I feel like my supervisor hears me luckily. It's just that then it's taken up and it's not always, you know at the top leadership level, it's maybe talked about but then you don't hear anything.
>
> (Phoenix participant)

> Where I'm talking about is more like upper administration … I see things happen that I'm like, oh, you purposefully made this job for this person, to promote this person. But, later on someone else has to apply for it, you can't promote that person, what makes this if they are doing the same … can you sit and please reflect, you're not being transparent.
>
> (Phoenix participant)

Ideal Organization

In describing how their ideal organization would address STS, respondents mentioned:

> Bring it down to reality, … a way where it's … gonna motivate me to want to open up. It's better than just debriefing or something, but it's right there after when something happens, not that we've gotta wait … 'cause then sometimes, by that time, I've already worked it out, and thanks for nothing.
>
> (Miami participant)

> There need to be little points in the systematic structure of our organizations where we're all checking other people.
>
> (Miami participant)

> I would say require [self-care] so that nobody can take away that time from you, not even yourself.
>
> (Miami participant)

> Onsite counseling. I feel like I would happily see a therapist if I could make time for it, and so somebody coming into my office who's gonna be there for a day, and, yes, they would be contracted to be there from time to time, just to come in and be there for a day. If you wanted to see her, you can. If that was a regular thing, there was Therapy Thursday, I'd be all over that.
>
> (Chicago participant)

> It would be great to have internal mentors that take care of the staff needs. That's their whole job, to take care of the staff. Whether it's they need more training or they need help with resources, that kind of thing. In an ideal world you would have … its own department, that is there for just the staff needs. They don't have their own caseload.
>
> (El Paso participant)

> I can stay up until midnight writing a best interest recommendation but that doesn't mean the next day I get to come in late. I accept that we work more than 40 hours, but in a high stress job it just feels like, 'just get your job done and we're good'. That's the level of respect that I would like to see in an organization where you know you didn't disappear on us, we get what you were doing, we keep tabs on that but there's this real flexibility. And I don't mean flexible by like a half hour on either end of the day, I mean flexible like I worked my ass off and worked 15 hours yesterday so I'm coming in for like 3 today and nobody's gonna bat an eye at that.
>
> (Phoenix participant)

> Sabbaticals, flexibility in hours, flex time even for salaried people, massages, yoga and not talked about from top down like 'we're doing this really amazing thing for you so you better love it', this is for you, because you need it, everybody needs it.
>
> (Phoenix participant)

Overarching Themes

Two major themes that cut across focus groups and across specific questions were identified: additional stressors and barriers to reducing STS.

Additional Stressors

Two stressors were identified in addition to those already discussed above: the impact of the political environment and the additional stress on providers who are immigrants or refugees themselves.

Impact of Political Environment

Participants noted how political events of the past few years have added to their stress levels:

> We've always done hard work, and then the Trump Administration happened, and the work just got 10 times harder… Not even. Hundreds of times, whatever it is, and so when it's constantly something that is really moving and shifting and changing, and the vast majority of our staff are newer attorneys that are practicing within the first year or two of law. Immigration law is very complex to begin with in the first place, and they're going out into areas, and this is already very difficult.
>
> (Miami participant)

These political stressors were particularly prominent in El Paso:

> It is overwhelming and it feels like it has been getting faster over the past 18 months or a couple of years. Things are changing faster or breaking down faster in ways that are just harder and harder to stay on top of.
>
> (El Paso participant)

> My job was to like go to Washington DC or meet with visiting delegations and be part of telling those stories over and over again. And so that degree of repetition in talking about how bad things are down here was draining over the long term.
>
> (El Paso participant)

> The government continues to change policies that affect our population that we work with. They have such a thing as what's called policy Mondays where everybody would join via speakerphone we would listen to all the policy changes. And who can keep up with that? Our case management workers were the ones that were mainly affected. And it was constant.
>
> (El Paso participant)

Immigrant/Refugee Staff

Participants who were themselves immigrants or refugees experienced additional stressors:

> I was born in [redacted for confidentiality], and when I came here, I was very sick, and so I was lucky. I was able to get access to lifesaving interventions, but there is a medical trauma that I experienced which I have never been able to fully articulate… Then, on top of that, there's the layer of immigrant trauma, just growing up in a very hostile, unwelcoming environment for me was a wakening experience. We were terrorized for 10 years straight, so, obviously, that also informs my work with immigrants.
>
> (Chicago participant)

> I find it really difficult … speaking with a migrant in a language from my own country and hearing what they're doing and what they've been through and being sent back into that space.
>
> (El Paso participant)

> When I first started working at my organization, there were social workers but they all happened to be white. And I'm Latina, and with a migrant background. When I first started working there, they were like, "Oh, we finally have someone!" Then I also became the expert. I'm like, I'm not an expert, even though I'm [redacted for confidentiality], I'm not an expert at certain cases. I'm an expert at my own life kind of thing. But I've seen so many inconsistencies in that sense. When they need a face they call me. But if there's anything like, oh we worked on this case. I'm never given a thank you or heard, "Hey, she also worked on this case." … Then the moment I say that, it's like "Oh, here she goes complaining again" kind of thing. I think that adds a lot to it.
>
> (Phoenix participant)

Barriers to Reducing STS

Barriers to reducing STS included conflicting organizational expectations, workload, professional training, stigma, leadership, and funding.

Conflicting Organizational Expectations

Employers were often perceived as giving staff mixed messages:

> One of the constant issues I see is the inconsistent messaging or the leadership or management, saying "We don't want you to work too much, stop working too much" … but then [not] having the structures in place and being cognizant of what's taking time and having the space to process the secondary traumatic stress.
>
> (Phoenix participant)

> They could be telling you … "You need to just keep your composure." And where's my humanity? Then they turn around and they let you know, you need to be compassionate, and you need to be human. It's either one way or the other. I'm only human. … We're trying so hard to keep our composure and our professionalism, but at the same time, it's impacting us as humans, and I think organizations need to understand that and be more accepting of that.
>
> (Miami participant)

> Then things get augmented with things like merit-based raises. Raises are based on how many cases you can make or close … then you don't get the bonus or the merit raise and it just adds to you feeling like, well here I am… proving that I can't cut it. Because I can't. So there's inconsistent messaging clearly coming out of their mouths. But also in the structure and systems and the way they put it in place. And I think that's unfortunate because you can see things, you can see they were attempting to be encouraging. They were like, "No, I put in a bonus plan to encourage." But you've got to view the flipside of your carrot before you dangle it, or your punishment before you throw it out there.
>
> (Phoenix participant)

> I think in non-profits we try to say we're not corporate, but we are.
>
> (Phoenix participant)

> Certain organizations … are social-justice oriented, they are the people who have allegedly the higher moral ground in our world but looking at the work that we do and the missions that we have compared to how we treat each other, how management treats lower staff… time and time again they don't manage properly.
>
> (Phoenix participant)

> We are people. Everything is not money. You know what I mean?
>
> (Miami participant)

Workload

Workload was frequently cited as a barrier to efforts to reduce STS:

> Let's say we'll have … a mindful Monday where I would get somebody to come in to teach us mindful eating or mindful movement, or whatever it is, and I always get the response of, "Oh, yeah, we're really interested. We're gonna go. We're gonna go." Then I send out a calendar invite. Twenty people accept that they're coming. I get somebody to come, take time, do this for free 'cause we don't have funding to be able to pay people to come and provide these services, and then four or five people show up. I know it's not because people don't need it. Well, obviously, in theory, they wanted to do it. They accepted the invitation, but when it comes down to it, I think people have that pressure of the work that they're needing to do.
>
> (Miami participant)

> Because of the work volume, there just doesn't seem to be enough time. If you need to take off … you just come back to just more work. So it leads to a lot of people putting off the time off because you just don't want to come back to the mountain of work.
>
> (El Paso participant)

> But then I'm working during my vacation or day off. Sometimes I feel guilt about trying to take a day off.
>
> (Phoenix participant)

Professional Training

Participants noted clear delineations in how different professions prepare their practitioners to anticipate and address secondary traumatic stress, while others do not:

> I think that maybe a lot of you seem like you do social work, and these are kind of the things that you learn as part of your education, but lawyers are not taught those kind of things…. I mean we are really taught to not be vulnerable. You take a stand. You take a position. You make your argument, and being vulnerable or admitting that you need help is kind of like a sign of a weakness.
>
> (Miami participant)

> In medicine, I've been taught to just suck it up…. Deal with it here, and just process that, especially when I was in training, which was way bad, and like "this is just a bunch of crybaby stuff."
>
> (Chicago participant)

> Social workers … don't need to ask someone exactly what happened, where exactly did they touch you, did they put their penis like in your mouth… you have to be super specific, and as lawyers that's what we have to do over and over again… and that's not what social workers do because it's re-traumatizing and it's horrible for the client to go over and over and over again. … And that's very different, and I think social workers don't realize that always, and like the way you all are trained, your training versus what lawyers need to do to win their cases.
>
> (El Paso participant)

> We come from a background of social workers … and we're trained to do … counseling and all this stuff with the clients and families, but let an employee come in, who is also a human being, and somehow you can't translate what you've learned in school in classes into supervision and use the same ideology of treating the problem. … It's so bizarre to me to … have the same human being who is an MSW licensed professional sit in a supervision room and say, "Well, you just have to suck it up," or "You need to figure that out." It's always so mindboggling, and so I think that there's that, and there's also, while we are trained in professional counseling, we're not trained in leadership.
>
> (Miami participant)

Stigma

Participants identified stigma as a barrier to addressing STS:

> It's still kinda taboo. If you are not triggered within a week or month of that moment … and come in a month later, people are just like, "Why are you acting like this? It didn't happen to you."
>
> (Miami participant)

> There's like a lot of subtle competition between activists … about like who can be hard core enough, who can work the hardest and I end up feeling a lot of pressure because I think everyone has different limits and I have a different baseline than others do.
>
> (El Paso participant)

> But really I didn't participate because I didn't want to be honest and vulnerable in front of my colleagues and coworkers. I'm really pro-therapy and I've been going to the same therapist for like over 4 years and he's really great but I don't want to go to that space as an attorney in front of all of my colleagues.
>
> (El Paso participant)

> One participant suggested a way for organizations to bypass such stigma:
> Whatever it is, it has to be a part of the structure and it has to be mandatory. Otherwise, whatever is optional, there's always room for "I'm too needy so I have to access this, other people are not." If it were mandatory that you saw a clinician once a week, as part of "this is what we do at this agency, we know that you will need this and we honor that and it's just ok." So things that are structurally built into the system that have nothing to do with you, so that when you come into the system you clearly identify that it's not about you, it's about the job and it's a natural consequence of the job so this is something they're doing to take care of everyone.
>
> (Phoenix participant)

Leadership

Upper-level management was almost uniformly viewed as disinterested in STS:

> There's people in a boardroom making these decisions, and the decisions they're making aren't about people. They're about funding. Medicine isn't about people anymore. It's about running an effective business model, and not what I wanted in medicine.
>
> (Chicago participant)

> Management's perspective is that we need to have these slots filled, these tasks done. That's all we care about.
>
> (Chicago participant)

> We used to be closed on Fridays so that time could be used to get the administrative work done. We got a lot of push back from our executive director and our board. They were like, "Well, you guys aren't really accessible to people if you're not open," and it was really demoralizing for everyone.
>
> (El Paso participant)

Participants also described irony in the disconnect between upper management and staff:

> As you move up the ladder, sometimes you become jaded by the things that happened and occurred to you as a worker…. You didn't have all the self-care. You didn't have the support from your supervision, and you dragged that up the ladder with you. Now you're hovering over your employees doing the same thing. You're no longer seeing the clientele, so now, for you, it's, okay, now it's my turn to make the money.
>
> (Miami participant)

> They [management] haven't addressed their triggers for the most part. They haven't addressed their PTSD. …They escaped, and they never look back. You never look back to this road down here.
>
> (Miami participant)

One participant described her own pivot away from working with clients due to STS:

> I'm shifting away from direct service because this is all becoming a little too deep for me. It's been 17 years, and I can relate to everything you just said. I don't even know how else to say it, but just for me, because of my own background, I feel like it kind of becomes—it enters me. It enters me, and it's just trapped in me, and I can't release it. I take it home, so it's in my body.
>
> (Chicago participant)

Funding

Funding mechanisms were implicated in hindering organizations' capacity to address STS:

> We are measured by our output because that is how we get contracts. Most of us are funded by places that are like, "How much work can you do for less money than your competitors?"
>
> (Phoenix participant)

> It needs to go all the way to the funder because they're the ones who are requesting this from us. That's why I'm saying that the director, kind of her hands are tied 'cause it's either we do this, or our funding gets cut…. The funders also need to be aware of this, and the monitoring and evaluation portion, the audits that they do, all this stuff, it's something that needs to be on their radar.
>
> (Miami participant)

> We need more long-term multiyear funding for general support to staff. It's gotten somewhat better for some organizations to increase staff in response to what's happening. It's really delayed, the increased funding came in 12,18,24 months after the administration and dealing with that lack of response from funders in the meantime is a real problem. You need to have the stability to have staff and resources and programs over multiple years. And if you're constantly running around trying to chase down grant dollars, it's just another burden on top of everything else.
>
> (El Paso participant)

> Our directors are very good about saying "you can have all the training you want as long as it's free and as long as it's in the community. We're not going to pay you to go as close as New Mexico, if we offer to drive. They won't pay for that, there's not enough money. So a fund exclusively to help the direct care staff to seek and to use.
>
> (El Paso participant)

Additional Findings

The findings presented above echo much of the findings from the individual interviews. Additional themes of agreement between the individual interviews and the focus groups were the need for individualized approaches, and the value of proactive supervision:

> People are at different points along the evolution of understanding themselves and how they work and their personalities and how much of the trauma they take on from other people. And it's a constant learning process but I think it's really important that people respect other people's self-imposed boundaries.
>
> (Phoenix participant)

> There are times, where they're like, "We're giving you this amazing thing but then nobody is really connecting to it. So like people mentioned the spa deal, I don't want a massage myself, so instead asking people "what would you like to do?" would be very helpful and being listened to.
>
> (Phoenix participant)

> As social workers we have reflective supervision. Some teams are introducing that. But taking into consideration that some social workers are being supervised by an attorney. Training of an attorney in supervision is different, so how can a social worker who is just starting to feel comfortable, and recognizing the limitations of having an attorney as a supervisor... The conversation [among] the social workers is how can we replicate reflective supervision, but taking into consideration that some attorneys are not comfortable towards that aspect.
>
> (Phoenix participant)

CONCLUSIONS

This study undertook a multi-method approach to gain a comprehensive understanding of models and promising practices for supporting staff of community-based organizations who experience secondary trauma as a result of their work with immigrants, refugees, asylum seekers, and other marginalized populations. The three-pronged approach yielded consistent, recurrent themes related to preventing and mitigating STS. Mid-level managers and front-line staff had remarkably similar perspectives on how their organizations address STS, including a shared belief that upper management and funding entities can be either part of the problem or part of the solution, by perpetuating organizational cultures that either exacerbate STS, or by fostering organizational cultures that acknowledge and address STS. Furthermore, STS experiences were similar across various types of staff, settings, and client populations, and the three methodologies—literature review, interviews and focus groups—converged on similar findings regarding the existence of STS and methodologies to address it.

The organizations described in these interviews were in varying stages of recognizing the need for and implementing policies and practices to address STS. Some agencies did not view STS as an issue to be addressed; some were just beginning to discuss it, while others had taken some initial action, and yet others had very well-developed structures for addressing STS:

> There's nothing in our procedures that actually talks about the trauma that we might face, and the injury that we might face.
>
> (Chicago participant)

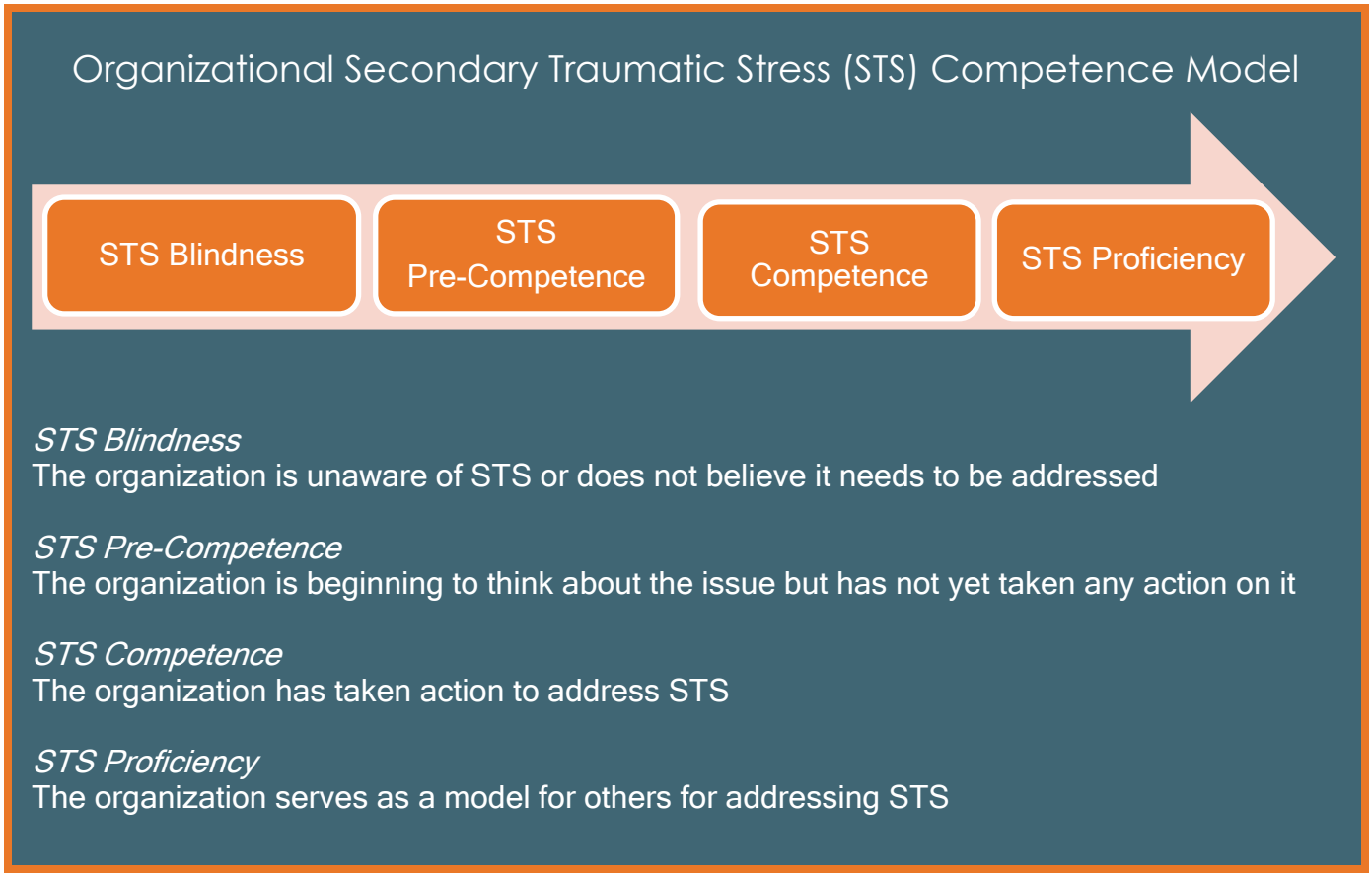
> A couple of us just went to a conference a couple weeks ago. We really discussed how important that was. Yes. We're thinkin' about it, tryin' to figure out somethin' we can do.
>
> (Participant 6)

> One thing that we do at our staff meetings weekly is Den of Marbles. We give marbles and we receive marbles. Once the marbles are filled, then we go on our fun staff retreat. The process of the marbles is you give a marble to whomever… really kicked butt this week. They did all this and the other, and then a marble for myself for this, that, and the other. Basically, it's to alleviate the trauma and say you matter. The bit that you do matters, so for you to be able to find appreciation 'cause you do all this work, and a lot of the time, you don't get recognition for it. We're human. We want to get that little limelight, even for a second, but knowing that somebody sees what you're doing and putting in the work, and just to like, "Thank you. That was a very hard work. I appreciate you for that."
>
> (Miami participant)

> We have a variety of things … that we offer. We have EAP, which is no cost to all of the employees. We do have [health insurance], which offers a wellness card. … We have … gym and other health and fitness related services…We do have presenters come in and talk about mindfulness and other stress-reduction techniques…We allow a flexible schedule to the extent appropriate and possible so that if staff needed to do something as simple as sleep in in the morning … they wouldn't be penalized for that. We are a very inclusive and diverse staff. I think that allows for a lot of cultural and language support within staff, so those informal support networks that we have here… I see a lot of staff decorate their offices to an extent that makes them feel comfortable. I think that

> that helps with the comfort level and creating a safe space that can help with those things…With my staff … I have had them create a self-care plan…We also started a new onboarding process … We have a very trauma-informed approach here not just for clients but for staff…We have our monthly …staff meeting… They are all primarily focused on something related to performance management tied in with self-care and health, whether it be physical or mental health.
>
> (Participant 12)

A classic model of agency competence as it pertains to culture identifies six levels of organizational cultural competence: (1) Cultural destructiveness, (2) cultural incapacity; (3) cultural blindness; (4) cultural pre-competence; (5) cultural competence; and (6) cultural proficiency.[46] An analogous model of organizational STS competence can be conceptualized by simply replacing the term "cultural" with "STS" on this scale. As such, this set of interviews did not reveal any organizations that could be characterized as STS destructive or STS incapacitated. The first quotation in the above set illustrates STS blindness: the agency appears unaware that STS is an issue that needs to be addressed. The second quotation provides an example of STS pre-competence: the organization is beginning to think about the issue but has not yet taken any action on it. The third quotation illustrates STS competence, meaning the agency has taken some steps to address STS. And the fourth quotation illustrates STS proficiency, meaning the agency serves as a model for others in addressing STS.



[46] Cross, 1989.

Most of the agencies discussed in these interviews fell into the pre-competence and competence categories. Consequently, philanthropic actors that fund organizations which work with immigrants, refugees, and other marginalized populations can help these agencies assess their level of STS competence and move forward from the pre-competence and competence levels to the proficiency level. Grantee organizations that address STS will be more productive, have less turnover, and provide better service to their clients, thus helping funders meet their goals (National Child Traumatic Stress Network (2011). Consequently, philanthropic actors and organizations that work with traumatized populations would benefit from taking stock of their STS competence.

Study Limitations and Implications for Future Research

The rapid literature review was limited by having only one reviewer perform the study selection and data extraction, excluding unpublished literature, including only articles published in English, and using primarily medical, psychological, and social services databases. Further, this rapid review precluded computation of effect sizes, which allow for the comparison of the relative impact of interventions on various outcomes with various provider and client populations.

The individual interviews and focus groups utilized a qualitative approach with the aim of discovering underlying themes in respondents' narratives. As such, the study was not designed to generate quantitative data such as frequencies, nor to examine potential correlations among variables. Further, the non-probability sampling method and the small sample size would make any such quantitative data nongeneralizable. Instead, the study aimed to obtain in-depth understanding of the experiences and perceptions of these respondents. Future research aiming for quantitative data may be undertaken building on the exploratory findings of this study.

RECOMMENDATIONS

The philanthropic sector is well-positioned to partner with community-based organizations to implement strategies to prevent and mitigate STS. Such strategies should leverage the six cross-cutting themes identified in this study and view these as the pillars of an STS proficient agency (please see box on next page). Agencies that experience STS are the same agencies that funders entrust with addressing some of the most challenging problems in our communities. The quality of services that those clients receive may be impacted by the quality of well-being that staff receive. Funders can respond to these organizational realities by accurately understanding the needs of frontline service providers, their managers and organizational challenges regarding STS, and by providing appropriate, flexible, informed support in the form of funding, training, and other actions. In this way, funders should indeed act as true "partners," while at the same time, acknowledging the power they hold to facilitate—or prevent—organizations from moving forward on the STS competence continuum.

The prevention and mitigation of STS is not a "one size fits all" answer. Organizations will need to reflect, with their staff, on what is working and what needs to improve to ensure the integrity of the organization's work is not eroded by secondary traumatic stress. While many organizations place their clients at the heart of what they do, the philanthropic sector can help make space for organizations to elevate their own wellbeing, as they implement their missions. Through learning communities and research-based initiatives, foundations have been valuable partners in services provided by non-profits. The introduction of STS programming in organizations, done in partnership with foundations, has the potential to strengthen these client services.

Funders, like agency leaders, need to recognize the normative nature of STS and the necessity for strong organizational policies and practices to address it. As noted by one of the focus group participants, STS is a workplace safety issue like any other, and should be treated as such through education, prevention, and mitigation. Funding agencies are also in an excellent position to educate and support executive directors. The findings of this study have shown that leaders may need training in opening space for staff to speak up and help staff process feelings and suggest ideas. Yet, leaders may also be alone and vulnerable in their position and need support in managing their own STS experiences. Thus, the range of supports that is made available to staff should also be available to executive directors, and funders should support those directors in utilizing those resources for themselves.

The findings of this study indicate that issues of diversity, equity, and inclusion should be addressed thoughtfully when supporting organizations' STS strategies. One of the biggest assets programs have is staff who can intimately understand the languages and cultures of their clients, while also supporting them through their programmatic skills. The findings showed that providers with an immigrant or refugee background experienced additional stress in working with immigrant or refugee clients within their organizations. It is likely that the same dynamic occurs among other minority group provider/client pairings. Thus, funders should ensure that such issues are explicitly addressed in any STS prevention and mitigation plan.

In conclusion, this study has identified models and promising practices for addressing STS. In order for organizations to make the necessary changes for sustainability and wellbeing, philanthropic actors will need to dedicate funding and programming towards enhancing the six pillars of STS proficient organizations. Toward this end, a menu of action options is presented on the page 69.

Six Pillars of an STS Proficient Agency

1. **Leadership**: Educate and engage senior leadership on the need to address STS

   Leadership is responsible for the overall programmatic and fiscal health of their organization. High turnover is a costly expense for an agency. The cost to hire and train a new employee is a major investment for an organization to make in a person who will not stay for more than a year or two due to STS and overwhelming work expectations. Agency boards and executive directors should hold each other accountable for receiving training on STS; its deleterious effects on staff, clients, and the organization; and the importance of supporting the STS needs of staff. Senior leadership should develop formal wellness policies. Boards and senior leadership must foster a culture of staff care.

2. **Workload**: Decrease staff workloads

   Workloads should be decreased to reflect a reasonable 40-hour work week. This may be accomplished through hiring of additional staff or the use of volunteers to handle some tasks. Workloads should also accommodate staff care during compensated work hours. STS is directly related to the provision of services; staff would not suffer from these symptoms if they worked in other fields. If self-care is accepted as a necessary condition for maintaining optimal client service and staff retention, then such self-care must be incorporated as a normal work activity.

3. **Workspace**: Create comfortable and confidential workspaces and retreat spaces.

   Workspaces that are chaotic not only create added pressure to work productivity, they can be triggering of STS experiences. Individual workspaces should be conducive to destressing. Natural light, privacy, and adequate work areas are needed. Office environments should have retreat spaces where employees can go for breaks, sunlight, or other reprieves.

4. **Supervision**: Practice proactive, trauma-informed supervision

   Trauma-informed supervision assumes that all staff have or will experience symptoms of trauma. Thus, supervisors should routinely ask their staff about STS symptomology and discuss ways to address it. Supervisors should not wait for staff to approach them about the issue. By discussing this, supervisors prepare staff for the potential experience of STS and decrease its potential impact on staff and the services they deliver. Supervisors should utilize the "Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision" (The National Child Traumatic Stress Network, 2018).

5. **Peer Support**: Enhance peer support opportunities

   Peer networks offer staff an opportunity to learn, grow, and support each other. Organizations should foster collegiality through informal gatherings and formal support groups. Organizations should explore opportunities for inter-agency peer support networks.

6. **Individualization**: Individualize the STS approach for each staff member and each organization.

   Each staff member should develop a self-care plan, the implementation of which is supported by the agency, through time allotment and wellness accounts to help fund activities. Similarly, each organization should have an STS prevention and mitigation plan targeted to its unique needs.

Philanthropic Actions for Fostering STS Proficiency

Using the STS competency model, foundations can assess their internal understanding of STS. A starting point would be a conversation to see what program leadership and staff understand about STS and its impact on programming. The next action step would be considering what types of STS programming might benefit foundation staff. It is also critical to identify where STS prevention fits into a foundation's funding strategy.

In partnership with funded programs, foundations can create a learning community to learn about STS and its impact on services and to assess STS competency. These learning communities can assist organizations to increase their awareness of STS and assist organizations to begin to strategize about how to respond to the risk their staff faces.

Foundations can use their funding tools to support organizational efforts in addressing STS. Some suggestions for using funding as a tool to support organizational needs are:

- Create grants specifically to address STS prevention needs.
- Create STS enhancements in current funding opportunities, by allowing organizations to use 10% of their proposed budget towards STS education, prevention, and mitigation.

In addition to building STS awareness within a foundation and its community of programs, the funder should consider creating access to STS prevention programs directly by creating a program or a fund, open to funded partners and their staff, to access support.

Funders and grantees must recognize that STS is complex, and the needs of staff experiencing its symptoms vary from additional staffing, to access to therapy, to increased compensation. Addressing these needs requires a nuanced look at the opportunities and challenges faced by agencies and their staff. It is important that foundations:

- Do not expect immediate change. Including STS prevention into the everyday functioning of an organization requires awareness and behavior change. It can't happen overnight.
- Do not be overly prescriptive. STS prevention strategies must address the unique needs of the staff and programs they work within and create space for flexibility and experimentation.
- Do not add additional requirements that may create additional stress, such as increased reporting specifically around STS education, prevention, and mitigation.
- Do not screen programs for STS competency as a pre-requisite for funding. In partnership with foundations, organizations can reach STS proficiency but they will need support in getting there. Requiring them to be proficient without the prerequisite awareness building and self-assessment will create an added barrier between foundations and organizations to the detriment of both staff and clients.

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Contraindicated Practices

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6*(1), 1.

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ADDENDUM

Studies Specific to Refugee Populations

Promising Practice

Newmeyer, M., Keyes, B., Gregory, S., Palmer, K., Buford, D., Mondt, P., & Okai, B. (2014). The Mother Teresa effect: The modulation of spirituality in using the CISM model with mental health service providers. *International Journal of Emergency Mental Health and Human Resilience, 16*(1), 13-19.

This study examined the impact of Critical Incident Stress Management (CISM) and spirituality in 22 mental health service providers working with refugees and indigenous residents in Kenya. Quantitative analysis of pre and post self-report instruments suggested that training and utilization of CISM techniques may be important in preventing future problems.… Spirituality serve[d] as a protective factor in moderating compassion fatigue.

Emerging Practices

Akinsulure-Smith, A. M., Keatley, E., & Rasmussen, A. (2012). Responding to secondary traumatic stress: A pilot study of torture treatment programs in the United States. *Journal of Traumatic Stress, 25*(2), 232-235.

This study assessed the secondary stress experiences of service providers (N = 43) within the National Consortium of Torture Treatment Programs in the United States and examined the supports offered by their organizations. Although these participants reported that their work with survivors of torture was stressful, 91% indicated that their organizations offered a variety of stress-reduction activities. Overall, participants reported that their own personal activities were the most effective stress reducers.

Akinsulure-Smith, A. M., Espinosa, A., Chu, T., & Hallock, R. (2018). Secondary traumatic stress and burnout among refugee resettlement workers: The role of coping and emotional intelligence. *Journal of Traumatic Stress, 31*(2), 202-212.

This study examined the prevalence rates of secondary traumatic stress and burnout among a sample of 210 refugee resettlement workers at six refugee resettlement agencies in the United States. The study also explored coping mechanisms used by service providers to manage work-related stress and the influence of such strategies and emotional intelligence on secondary traumatic stress and burnout. The findings showed that certain coping strategies, including self-distraction, humor, venting, substance use, behavioral disengagement, and self-blame, were strongly related to deleterious outcomes. Emotional intelligence was a negative correlate for all outcomes, above and beyond the effects of trauma, coping styles, job, and demographic characteristics.

Berthold, S. M., & Fischman, Y. (2014). Social work with trauma survivors: Collaboration with interpreters. *Social Work, 59*(2), 103-110.

This article addresses the need for effective collaboration between social workers and interpreters when the provider and survivor do not speak the same language. The impact of secondary trauma and organizational support on the work of social workers and interpreters were explored. Proposed curriculum components for training interpreters and the importance of therapy and ongoing supervision for interpreters were highlighted. The authors concluded that it is essential to prepare interpreters and social workers for the various challenges they will face in their collaborative efforts to serve survivors of severe human-perpetrated trauma, and organizational support is vital to the success of this work.

Pross, C. (2006). Burnout, vicarious traumatization and its prevention. *Torture, 16*(1), 1-9.

Two histories of caregivers working with torture survivors are described which exemplify the implications and consequences of secondary trauma. The article focuses on the conflict of roles when providing evaluations of trauma victims for health and immigration authorities. Caregivers working with victims of violence carry a high risk of suffering from burnout and vicarious traumatization unless preventive factors are considered such as: self-care, solid professional training in psychotherapy, therapeutic self-awareness, regular self-examination by collegial and external supervision, limiting caseload, continuing professional education and learning about new concepts in trauma, occasional research sabbaticals, keeping a balance between empathy and a proper professional distance to clients, protecting oneself against being misled by clients with fictitious PTSD. An institutional setting should be provided in which the roles of therapists and evaluators are separated. Important factors for burnout and vicarious traumatization are the lack of social recognition for caregivers and the financial and legal outsider status of many centers. Therefore, politicians and social insurance carriers should be urged to integrate facilities for traumatized refugees into the general health care system and centers should work on more alliances with the medical mainstream and academic medicine.

Pross, C., & Schweitzer, S. (2010). The culture of organizations dealing with trauma: Sources of work-related stress and conflict. *Traumatology, 16*(4), 97-108.

In a comparative qualitative study of 13 organizations worldwide working with survivors of extreme trauma, the relationship between work-related stress and conflict and the structure of the organization was examined. 72 caregivers, supervisors, and experts were interviewed and external organizational analyses and capacity assessments analyzed. The results showed that organizations with high stress and conflict levels exhibit considerable structural deficiencies and an atmosphere shaped by a reenactment of the traumatic world of clients. This chaotic, unstructured, unpredictable environment parallels the total absence of structure that exists when a victim is at a perpetrator's disposal. Organizations with low stress and conflict levels, however, proved to have fairly clear organizational structures. The results of this study show that structural shortcomings are an important source of work-related stress and conflict in organizations dealing with extreme trauma. Furthermore, the study raises the question whether the stress symptoms experienced by caregivers amount to a diagnosis of "secondary" or "vicarious traumatization". Caregivers in organizations with structural deficiencies show symptoms described by others as secondary traumatization. However, these symptoms subside after organizational transformation and structural improvement. It was found that caregivers in well-structured organizations exhibit almost no such symptoms.

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